# PERCEIVED WORKPLACE ENVIRONMENT AND MENTAL HEALTH OF MEDICAL PROFESSIONALS IN PUBLIC HOSPITALS

**Dr Manisha Agarwal**
Associate Professor, Department of Psychology,
Banaras Hindu University, Varanasi (U.P.)
E-mail : manisha12529@gmail.com

**ABSTRACT**

The present study examined the relationship between the hospital workplace environment in terms of perceived organizational support, inter-professional support, and participation in decision making, with the mental health of medical professionals as indicated by reported levels of psychological well being and psychological morbidity in central and state level public hospitals in eastern parts of Uttar Pradesh. Participants consisted of medical and para-medical professionals employed under the state-level (N=50) and central-level (N=50) hospitals. Statistical analysis of the data revealed that the state and central level hospitals were significantly different on the dimensions of the perceived work environment and levels of psychological well-being and psychological morbidity reported by the participants. Stepwise regression analysis showed that while participation in decision making failed to emerge as an antecedent of the mental health status of employed medical professionals, perceived organizational support positively predicted mental well-being among participants working only in the state-government hospitals and also negatively predicted psychological morbidity among the participants working in these hospitals. In the central-government hospitals, inter-professional support negatively predicted psychological morbidity among the participants. The study has important implications for Indian hospitals which are currently facing problems of workforce retention due to the demands placed on medical professionals by the perceived inadequacy of the workplace environment.

***Keywords :*** *Work place, Environment, Mental health, Professional, Public hospital.*

**INTRODUCTION**

The health care system in India, as in many other countries, has undergone major technological, organizational and financial changes during the last decades which have resulted in fundamental changes in the work conditions of medical professionals. Increasingly physicians are moving to managed care and salaried practices where their autonomy is more constrained. In such settings, management has more responsibility for physician satisfaction, as well as for other staff and patient care. Medical professionals are seen as super-humans and the expectation of self-sacrificing is higher than in other professions. On the other side, health

policies and healthcare systems are changing rapidly and these changes may have consequences for the mental and affective well-being of healthcare professionals.

The rapid changes in medical practice in the past quarter century have stimulated considerable interest in measuring physicians' perceptions and attitudes about their work (Freeborn, 2001). Interest has increasingly been focused on understanding the role working conditions play in terms of serious issues facing hospitals today, including the well-being and retention of medical professionals (Gershon, Stone, Zeltser, Faucett et al., 2007). Financial productivity incentives have been introduced resulting in increased economic efficiency but also a worsening of medical professionals' working conditions in terms of decreased influence and autonomy (Burdi & Baker, 1999; Friedman, 1995; Williams, Konrad, Scheckler, Pathman et al., 2001). Thus, medical professionals are becoming more marginalized, with less power and control over their own work situation, at the same time as external factors are exerting a growing influence on the working conditions of the medical professionals, and other professions are heading for the management positions (Friedman, 1995, Williams, Konrad, Scheckler, Pathman et al., 2001, Arnetz, 2001; Forsberg Axelsson & Arnetz, 2000).

In India the spending on health care is 6% of gross domestic product (GDP), the state expenditure is only 0.9% of the total spending. Thus only 17% of all health expenditure in the country is borne by the state, and 82% comes as 'out of pocket payment' by the people. This makes the Indian public health system grossly inadequate and under-funded (Goel & Kumar, 2007). In addition to these internal conditions, globally the health care system has also experienced an external pressure to increase efficiency. WHO and the International Society for Quality in Health developed five core standards applicable to all hospitals, in accordance with international requirements, in 2003. The standards are mainly generic with the focus on patients, staff and the organizational management. Standard 4 is related to development and maintenance of conditions for the hospital as a healthy workplace. It also states about implementations of comprehensive human resource strategies and participation of subordinates in decision making through its sub standards (Goel & Kumar, 2002).

Several studies in western countries have described a perceived decreasing autonomy, influence and participation and a loss of control among the medical profession (Burdi and Baker, 1999, Forsberg, Axelsson & Arnetz, 2001, Linzer, Visser, Oort, Smets et al., 2001). These factors may be important contributors to an undesirable workplace in the hospital setting. A healthy work climate in healthcare organizations may therefore be determined by presence of innovative human resource management practices, procedures to facilitate communication, conflict resolution, organizational and co-workers support and participation in decision making at work place. Participative management practices include the involvement of supervisor and subordinate in information processing, decision making and problem solving. Supportive leader behaviours and a generally facilitative organizational climate may be subsumed under a variable entitled "perceived organizational support." Eisenberger, Huntington, Hutchison, and Sowa (1986) demonstrated that individuals tend to "form global beliefs concerning the extent to which the organization values their contributions and cares about their well-being" (p. 504). Specifically, individuals evaluate the behaviour of organizational agents towards them and infer the general motive underlying that treatment, with the categories that are considered important varying considerably between organizations and between persons. Some individuals might base their sense of perceived organizational support (POS) upon such factors as the organization members' willingness to provide them with special assistance or special equipment in order to complete a project. Others might develop a strong sense of POS based upon the organization members' willingness to provide them with additional opportunities for training in an area that was of particular interest to them. Furthermore, employees are frequently sensitive to relevant environmental and organizational constraints that might limit the ability to provide them with desired rewards (Eisenberger, Cummings, Armeli, & Lynch, 1997).

Inter professional relationships too act as social support network and as buffer against various types of occupational problems. A healthy relation with co-workers, supervisor and subordinates automatically reduces work conflicts and enhances cooperation, productivity and overall well-being of members. It has also been pointed out that organizational support may be an important factor for mitigating work environment stressors (Vultee, Axelsson & Arnetz, 2007). These conditions may be related to the work climate of medical professionals and are logically prior to the social psychological variables that describe the experience of working in a particular place (West, 2001). All these factors are also important in creating high turnover rates for medical professionals, which may become extremely expensive for health care systems, and undermine the wellbeing of medical professionals (Buchbinder, Wilson, Melick & Powe, 1999, Filipsson, 1999; Williams, Konrad, Scheckler, Pathman et al., 2001; Misra-Herbert, Kay & Stoller, 2004). Therefore how medical professionals perceive their quality of work life may directly affect their potential development, their sense of autonomy and can finally affect their mental health and total well-being.

Well-being is an important issue in every work environment, but its importance is significantly higher in the field of medicine as medicine is involved with critical decisions regarding public health. Unhealthy work conditions along with personal vulnerability most likely contribute significantly to psychiatric morbidity in medical professionals and thereby affect the physical and

psychological health of medical professionals in hospitals through problems like heavy work load, professional status, difficult relations in the work place, lack of organizational support and problems in carrying out professional roles. Unhealthy and stressful work environment ultimately affect mental health in the form of psychological malfunctioning and correlates with a greater likelihood of low self esteem, low subjective and overall well-being among medical professionals.

There is mounting evidence that the health and well-being of medical professionals is decreasing, partly due to their work situation. (Buchbinder,Wilson, Melick & Powe, 1999; Filipsson, 1999; Johnson, 1997). This group, however, is the most often compromised (Uncu, Bayram & Bilgel, 2006). Changes in health policies have also contributed to an increased level of stress among medical professionals. Previous research has documented mortality and morbidity in medical professionals and suggests that this group may be at considerable risk of illness and other stress related problems (Cooper, Rout & Faragher, 1989, Sutherland, & Cooper, 1992). Psychological problems among health care professionals were earlier reported in Western societies but are now becoming evident in the Indian context. Hospital work often requires coping with some of the most stressful situations found in any workplace. The job strain model proposed by Karasek (1979) classified medical practice as a profession with high demand. The high demand nature of medical practice is well documented. In 2000, the country had 1.25 million doctors and 0.8 million nurses. That translates into one doctor for every 1800 people and showing the work pressure on doctors (Goel & Kumar, 2007).

Literature suggests that high demanding' jobs are likely to have a long-term negative impact on worker lifestyle and may result in psychological problems (Quick, Quick, Nelson & Hurrell, 1997). The relationship between working conditions and the level of psychological distress in employees has been explored in a number of studies. Hardy et al. (1998) found that short and long-term behavioural and psychological effects of stress are apparent in practitioners working in a health-care setting. A number of these stressors are intrinsic to medical practice, such as working with emotionally intense issues, suffering, fear, sexuality, failures, and death. Stressors identified in the medical profession are to a great extent psycho-social in their origin. As a consequence, it would be expected that physicians should be at increased risk for emotional distress (Appleton, House & Dowell, 1998).

Studies indicate a consistent association between psychological distress and long working hours, high demands at work, low control at work, low social support at work, and job insecurity. Workers in hospitals must deal with life-threatening injuries and illnesses complicated by overwork, under-staffing, tight schedules, lack of organizational and co-workers support, paper-work, intricate or malfunctioning equipment, complex hierarchies of authority and skills, dependent and demanding patients, and patient deaths, all of which are significant contributors to stress (Lindo, Binns, Grenade, Jackson et al., 2006). Studies have further indicated anxiety and depression, as sign of psychological malfunctioning in the medical profession (Caplan, 1994, Jones and Jonestan, 2000). Aust, Rugulies, Skakon, Scherjer et.al. (2007) found that high levels of demands at work and problematic interpersonal relations at work were associated with lower self-rated mental health. Some other studies have also shown that adverse workplace factors can increase the risk psychological and behavioural problems in medical professionals (DeJonge, Mulder and Nijhuis, 1999, Bourbonnais and Mondo, 2001, Eriksen, Tambs & Knardahl, 2006).

**OBJECTIVES AND HYPOTHESES**

As the above review suggests medical professionals are at increased risk of psychological disturbances due to their workplace environments. But this issue has not yet been investigated in the context of medical professionals working in Indian hospitals. It is well known that in India, public health services are provided mainly by government hospitals at the central and state levels. These hospitals serve a large portion of Indian population at minimum or no cost. There are differences between state and central government hospitals in terms of service conditions, benefits, work load, facility, setup, administration and management of hospitals. Still, there is scarce knowledge of how working conditions are related to the level of psychological distress in Indian medical professionals. Based on the above review the present study was conducted with the objectives of examining:

a) the perceived differences in dimensions of the hospital work environments, the demographic characteristics and mental health status in terms of reported levels of psychological well-being and psychological morbidity among medical professionals working in central and state government hospitals,

b) the nature of the relationship between medical professionals' perceptions of certain dimensions of the work environment in hospitals, such as the levels of perceived organizational support, inter-professional support and participative climate, with their mental health status in terms of psychological well-being and psychological morbidity, and

c) the relationship between demographic characteristics of medical professionals and their mental health status in terms of psychological well-being and psychological morbidity.

Based on the above objectives it was hypothesized that:

1. In comparison to state government hospitals, reported levels of perceived work environment dimensions,

namely, perceived organizational support, inter-professional support and participative climate, would be higher in central government hospitals.

2. In comparison to medical professionals working in state government hospitals psychological well-being would be higher and psychological morbidity would be lesser among medical professionals working in central government hospitals.

3. Significant differences in demographic characteristics are likely to emerge between medical professionals working in central hospitals and medical professionals working in state hospitals.

4. Dimensions of the perceived work environment in hospitals, namely, perceived organizational support, inter-professional support and participative climate would have more positive relationship with psychological well-being among medical professionals working in central government hospitals in comparison to the state government hospitals, but would have a negative relationship with levels of psychological morbidity.

5. Higher levels of salary, years of service, promotions and age would have positive relationship with psychological well-being but would have negative relationship with psychological morbidity among medical professionals in the two types of hospitals.

## METHODOLOGY

Participants: A sample of medical and para-medical staff (N=100) employed under the state-level medical services and central-level medical services of the railways, working in government hospitals, participated in the study. From the state-level hospitals of Uttar Pradesh, participants consisted of 50 doctors and para-medical personnel. Similarly, participants from central government railway hospitals consisted of 50 doctors and para-medical personnel. Physicians, surgeons, pathologists, radiologists, dentists and anesthetists comprised the sample of medical doctors while the para-medical participants consisted of members from the nursing staff, lab-technicians, x-ray technicians and personnel related to hospital care services.

Measures and Procedure: Levels of perceived organizational support, participative climate, inter-professional support, mental well-being and psychological morbidity were measured using Likert-type five-point rating scales. Perceived Organization Support (POS) was measured by the scale reported by Eisenberger et al. (1986). It contained 8 items and the Cronbach reliability co-efficient of the scale was 0.85. The participative climate in hospitals was measured by a modification of the scale reported by Gupta (2006). The scale contained 10 items which were modified to suit the requirements of the hospital work environment and the Cronbach reliability coefficient was 0.84. The scale for measuring inter-professional support was developed by the researcher on the basis of interviews with a small number of medical professionals. It contained 4 items and its reliability coefficient was 0.86. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was used to assess the psychological well-being of medical professionals. The scale consisted of 14 items covering both positive affect and positive functioning and its reliability coefficient was 0.94. The GHQ-12 was used to assess levels of psychological morbidity in terms of psychological malfunctioning and short-term changes in mental health. The scale consisted of 12 items and its reliability coefficient was 0.90. Responses were taken on 5-point scales for each item in all the five scales. Demographic information related to age, years of service, salary and promotions received was also obtained.

The participants were approached on the hospital premises after obtaining the permission of the Chief Medical Superintendent in each of the hospitals surveyed and the consent of each participant was also obtained. Any confusion regarding the purpose of the study was explained to them and they were assured of the anonymity of their responses.

## RESULTS

Data were statistically analyzed for examining the differences in the levels of demographic characteristics, perceived work environment dimensions and levels of psychological well-being and psychological morbidity among the medical professionals working in central and state level hospitals through t-tests. Data were also analyzed for examining the hypothesized patterns of relationships between the demographic variables and participants' perceptions of the work environment with the mental health status dimensions of medical professionals through correlation and step-wise regression analysis.

Table 1 presents the differences between the means of the the variables understudy for state-government and central-government employed medical professionals. These two groups of medical professionals were found to be significantly different on all dimensions of demographic characteristics, perceived work environment and mental health status. Results showed that although state employed medical professionals received less salary ($t=2.73$, $p<0.01$) and lesser number of promotions ($t= 3.01$, $p<0.01$) than central-government employed medical professionals, they had spent greater number of years as employees ($t= 3.76$, $p<0.01$) and their mean age was also higher ($t= 2.39$, $p<0.01$) than central-government employed medical professionals. Regarding the workplace environment, state employed medical professionals perceived less inter-professional support ($t=4.75$, $p<0.01$) as well as organizational support ($t=4.68$, $p<0.01$) and reported lower levels of participation in decision making process of the organization ($t=5.37$, $p<0.01$) than the central-government employed medical professionals. State employed medical

professionals also reported significantly higher levels of psychological morbidity (t=9.01, p<0.01) and lower level of mental well-being (t=5.53, p<0.01) as compared to the central-government employed medical professionals.

Table 2 presents the correlations between the variables understudy with dimensions of mental health status of central and state-government employed medical professionals. Results show that among the demographic variables, salary was negatively correlated (r = -.29) and age was negatively correlated with mental well-being (r = -.29) but salary was positively correlated with psychological morbidity (r=.42,) among the central government employed participants. Among the dimensions of the perceived work environment, inter-professional support was negatively correlated with psychological morbidity (r= -.30). Results of correlation analysis for the sample of state employed medical professionals showed that among the demographic variables, years of service were positively correlated with mental well-being (r=.36). Among the dimensions of the perceived work environment, participative climate and inter-professional support were positively correlated with mental well-being (r = .28; r =.34) while perceived organizational support was positively correlated with mental well-being (r = .34) but negatively correlated with psychological morbidity (r = -.42).

Results of stepwise multiple regression analysis (Table 3) for medical professionals working in central-level hospitals, showed that among the demographic variables, salary

**Table 1. Showing significance of the differences between the means of variables for medical professionals in central and state hospitals (N=100)**

| | State | | Central | | |
|---|---|---|---|---|---|
| Variables | Mean | Std. Deviation | Mean | Std. Deviation | t-test |
| Salary | 2.32 | .71 | 2.92 | 1.38 | 2.73** |
| Years of Service | 21.5 | 9.15 | 14.98 | 8.14 | -3.76** |
| Promotions | .96 | 1.03 | 1.64 | 1.17 | 3.08** |
| Age | 48.92 | 8.23 | 44.98 | 8.26 | -2.39** |
| POS | 22.44 | 4.05 | 27.76 | 6.94 | 4.68** |
| Participation | 29.62 | 7.11 | 37.12 | 6.85 | 5.37** |
| Inter Professional Support | 12.2 | 3.40 | 15.1 | 2.65 | 4.75** |
| Psychological morbidity | 32.94 | 6.16 | 21.62 | 6.4 | -9.01** |
| Well-being | 49.52 | 8.69 | 58.62 | 7.76 | 5.53** |

* p<.05; **p<.01

**Table 2. Showing correlations of variables with the mental health status dimensions of medical professionals in central and state level hospitals (N=100)**

| Predictor Variables | Central Hospitals (N=50) R values | | State Hospitals (N=50) R values | |
|---|---|---|---|---|
| | Psychological morbidity | Psychological well-being | Psychological morbidity | Psychological well-being |
| Salary | .42** | -.29* | -.04 | -.12 |
| Years of service | -.01 | -.10 | -.16 | .36** |
| Promotion | .09 | -.06 | -.01 | 08 |
| Age | .17 | -.29* | -.21 | .27 |
| Participation | -.21 | .11 | -.12 | .28* |
| Inter-professional support | -.30* | .03 | -.20 | .34** |
| Perceived Organizational Support | -.03 | -.69** | -.42** | .34** |
| Psychological morbidity | 1.00 | -.69** | 1.00 | -.50** |
| Mental well-being | -.69** | 1.00 | -.50** | 1.00 |

* p<.05; **p<.01

**Table 3. Stepwise regression analysis of the demographic variables with psychological morbidity among medical professionals working in central and state level hospitals. (N=100)**

| Central Hospitals | | | | | | |
|---|---|---|---|---|---|---|
| Variables | R | R sq. | R Square change | % Variance | Beta Coefficient | t ratio |
| Salary | .42 | .17 | .17 | 17.3 | .42 | 3.17 |
| **State Hospitals** | | | | | | |
| No variables entered the equation | | | | | | |

* p<.05; **p<.01

**Table 4. Stepwise regression analysis of the demographic variables with mental well-being among medical professionals working in state and central level hospitals. (N=100).**

| Central hospitals | | | | | | |
|---|---|---|---|---|---|---|
| Variables | R | R sq. | R Square change | % Variance | Beta Coefficient | t ratio |
| salary | .29 | .08 | .08 | 8.2 | -.29 | -2.07 |
| **State hospitals** | | | | | | |
| Years of service | .36 | .13 | .13 | 12.6 | .36 | 2.63 |

* p<.05; **p<.01

**Table 5. Stepwise regression analysis of the perceived work environment dimensions with psychological morbidity among medical professionals working in central and state level hospitals. (N=100)**

| Central hospitals | | | | | | |
|---|---|---|---|---|---|---|
| Variables | R | R sq. | R Square change | % variance | Beta Coefficient | t ratio |
| Inter professional support | .30 | .09 | .09 | 9.1 | -.30 | -2.21 |
| Perceived organizational support | .47 | .22 | .13 | 13 | .61 | 2.80 |
| **State hospitals** | | | | | | |
| Perceived organizational support | .42 | .18 | .18 | 17.7 | -.42 | -3.21 |

* p<.05; **p<.01

**Table 6. Stepwise regression analysis of the perceived work environment dimensions with mental well-being among medical professionals working in state and central level hospitals. (N=100)**

| State hospitals | | | | | | |
|---|---|---|---|---|---|---|
| Variables | R | R sq. | R Square change | % variance | Beta coefficient | t ratio |
| Perceived organizational support | .34 | .12 | .12 | 11.8 | .34 | 2.53 |
| **Central hospitals** | | | | | | |
| No variables entered the equation | | | | | | |

* p<.05; **p<.01

positively predicted 17.3 percent variance in psychological morbidity with a beta value of .41 (p<.01) whereas none of the demographic variables predicted psychological morbidity among medical professionals working in state-level hospitals (Table 3). Results of stepwise regression analysis also showed that salary negatively predicted 8.2 percent variance in mental well-being of medical professionals with a beta of -.286 (p<.01) for central level hospitals, while the years of service positively predicted 12.6 percent variance in mental well-being of medical professionals working in state hospitals with a beta of .35 (p<.01; Table 4).

Regarding perceived work environment dimensions, results showed that among medical professionals working in central hospitals, perceived organizational support positively predicted 13 percent variance in psychological morbidity with a beta coefficient of .61 (p<.01) and inter-professional support negatively predicted 9.1 percent variance in psychological morbidity with a beta value of .30 (p<.01) while perceived organizational support negatively predicted 17.7 percent variance in psychological morbidity with a beta value of -.42 (p<.01) ) among medical professionals working in state hospitals (Table 5). Table 6 shows that none of the perceived work environment dimensions predicted mental well-being of medical professionals working in central hospitals but perceived organizational support positively predicted 11.8 percent variance in mental well-being of medical professionals working in state hospitals with a beta of .35 (p<.01).

## DISCUSSION

The present study was conducted with the aim of investigating the effects of differences in the perceived work environment of central level and state-level government hospitals on the mental health status of employed medical professionals consisting of the paramedical and medical staff. The study therefore examined the differences in the perception of dimensions of the hospitals' work environment by the medical professionals, their demographic characteristics and reported levels of mental health status in terms of their psychological well-being and psychological morbidity in the two types of hospitals. Findings supported the hypothesized relationships to a considerable extent. The central level hospital was reported to have significantly higher levels of the dimensions of perceived work environment, namely the perceived organizational support, participative climate and inter-professional support as compared to the state government hospital. Among the demographic variables, the medical professionals in the central level hospital had significantly higher salary, fewer numbers of years of service and lower average age with more promotions as compared to those working in stat-government hospitals. In consonance with the trend, medical professionals in the

central level hospital had lower levels of psychological morbidity and higher levels of psychological well-being as compared to their counterparts in the state-level hospitals. The results thus strongly supported the hypothesis that central level government hospitals would be perceived more positively by their employees as compared to the state level government hospitals which would in turn have consequences for their mental health status.

Findings related to the hypothesized patterns of relationships between the demographic characteristics of medical professionals with their mental health status in terms of psychological well-being and psychological morbidity, however, revealed some unexpected trends. Among the demographic variables, results revealed that salary of participants was positively related with psychological morbidity among participants and was negatively related with their psychological well-being in the central level hospital but had no relationship with the mental health status of participants in the state-level hospitals. Findings further indicated that the salary of participants in the central level hospital was a significant negative predictor of their level of psychological well-being but a significant positive predictor of the level of their psychological morbidity. It appears that the salary of participants in the central level hospital is not perceived as adequate in spite of the fact that they receive more salary than the participants in the state level hospital. Even though the sample is a small representation of the huge body of human resources working in the government-owned hospitals at the central level, the findings clearly indicate that dissatisfaction with the human resource policies of the central government as related to the amount of compensation for services rendered in the healthcare sector may be largely responsible for the dismal quality of healthcare prevalent in these government-owned hospitals. Moreover, the positive relationship of salary with psychological morbidity among healthcare professionals could also affect the efficiency of the functioning of government-run hospitals.

However, in the state-level hospital, the duration of service of participants had significant positive relationship with their psychological well-being. These results again confounded the expected patterns of relationships. It is indeed peculiar that a longer duration of service should have a positive effect on the psychological well-being of the health professionals only in the state-level hospitals. At the conjectural level it may be surmised that a number of medical professionals in the state medical services may also be engaged in private consultancy and could thereby supplement the compensation in terms of salary received from a regular job. Hence the longer they are in service the more likely it is that their job adds to their demand as reliable medical professionals which in turn may enhance their psychological well-being.

Findings related to the hypothesized patterns of relationships between medical professionals' perceptions of certain dimensions of the psychological work environment in hospitals, namely, perceived organizational support, inter-professional support and participative climate, with their mental health status in terms of psychological well-being and psychological morbidity, also revealed some unexpected trends. Although perceived participative climate failed to significantly predict psychological well-being as well as psychological morbidity among medical professionals at both the central and state levels, the dimension 'inter-professional support' negatively predicted psychological morbidity among medical professionals working in the central-level hospital.

Conversely explained, this finding lends support to the contention that higher levels of co-operation and support between people working in the different departments and specialities should have a positive effect on the mental status of healthcare employees in terms of reduced levels of psychological morbidity among the different categories of medical professionals. In a study on 731 staff working in mental health crisis resolution/home treatment teams in England, Metcalfe, Metcalfe, Bradley, Mariathasan and Samele (2008) suggested that creating a culture of engaging leadership is critical, since it not only predicts the performance of teams, it also predicts a range of positive affective outcomes, including high levels of motivation, job satisfaction, job and organisational commitment, as well as wellbeing indicators, including high levels of fulfilment, self-esteem, self-confidence, and reduced levels of stress and emotional exhaustion. But as the results of the present study indicated, this finding was relevant only for the central level hospital while no such positive effects of inter-professional support on the mental health status of employees emerged in the state-level hospitals.

The third dimension of perceived work environment, namely, perceived organizational support, also emerged as a significant predictor of mental health status of medical professionals in a somewhat unexpected manner. As hypothesized, perceived organizational support negatively predicted psychological morbidity and positively predicted psychological well-being among medical professionals in the state-level hospitals. Perceived organizational support was earlier found to be influenced by policies, procedures and decisions indicative of the organization's concern with employee welfare and the organization's favourable evaluation of employee contribution. Previous studies have already indicated that perceived organizational support was positively related to perception of HRM practices such as perceived sufficiency of pay and perceived sufficiency of family oriented policies and actions (Guzzo, Noonan and Elron, 1994), high quality employee supervisor relationships, favourable developmental training experiences and promotions, (Wayne, Shore & Liden, 1997), clearly stated guidelines defining appropriate work

behaviour and job demands, supportive communications with immediate supervisors and upper management and procedural justice in performance appraisal decisions (Moorman, Blakely and Nichoff, 1998). Further, employees who experienced a strong level of POS theoretically felt the need to reciprocate favourable organizational treatment with attitudes and behaviours that in turn could benefit the organization (Eisenberger et al., 1986). In support of this social exchange perspective, research has revealed that POS is positively related to job attendance and measures of job performance (Eisenberger, Fasolo, & Davis-LaMastro, 1990), the tendency to help co-workers (Shore & Wayne, 1993), the tendency to offer constructive suggestions for organizational improvement, and affective organizational commitment. Overall, it appears that employees with higher levels of POS are likely to be more committed and possibly more willing to engage in extra role or "organizational citizenship" behaviours (Organ, 1988) than are employees who feel that the organization does not value them as highly. Additionally, some work also suggests that POS may be beneficial to the individual as well as to the organization. In an earlier study of nurses caring for AIDS patients, George, Reed, Ballard, Colin, and Fielding (1993) reported that both POS and social support moderated the relationship between extent of exposure to AIDS patients and negative mood, such that those with the lowest levels of POS evidenced the strongest relationship between mood and exposure. Moreover, perceived organizational support was reported to be negatively related to negative outcomes for the organization such as absenteeism and turnover intentions (Eisenberger et al, 1986).

But as against the expected trends, perceived organizational support had a positive relationship with psychological morbidity among the participants in the central level hospital and no significant relationship at all with their psychological well-being. It is likely that perceived organizational support may be used by employees as an indicator of the organization's benevolent or malevolent intent in the exchange of employee effort for reward and recognition.

## CONCLUSION

The present study may have important implications for Indian healthcare system which is currently in the process of offering a plethora of services to customers hailing largely from India and from neighbouring countries. The Indian hospital sector consists of private hospitals, "nursing homes" and government and charitable missionary hospitals. Government and missionary hospitals determine their charges according to patients' income levels and treat poor patients freely. Nursing homes charge higher, market-determined rates. They offer services in just a few medical specialties, owned and operated by physicians who worked with them. Nursing homes cannot afford the latest medical technology, but they provide more intimate settings than government hospitals. The low income group hardly manages to access private nursing home services unless otherwise crucial to survival; they prefer government or charity-run hospitals. Upper-class people, on the other hand, can access nursing home services and other cosmetic health services. Nursing homes – small hospitals, most with fewer than 25 beds offer fewer medical specialty services and are owned and operated by physicians who work in them (Rehman & Qureshi, 2008)

Large government hospitals generally have better facilities than nursing homes, but they are widely believed to provide poor-quality care. They fail to maintain their advanced equipment, train their technicians and do not publicize their capabilities to doctors who refer patients (Ensor and Witter, 2001). These conditions have led to dissatisfaction and demand for high quality medical care owing to critical gaps in infra structure, workforce satisfaction, equipment, essential diagnostic reagents and drugs (Arjunan et al., 2002). As against the state of affairs in government hospitals, top managers in private hospitals such as those of LIFENET (Rehman & Qureshi, 2008) motivate staff by underlying employees' important roles. LIFENET hospitals reportedly consider team spirit essential to an organization and success as a business. Employees are required to understand LIFENET's larger mission and many have a strong sense of community which has grown out of personal relationships within the departments and an array of hospital-wide events. Awards are given to recognize dozens of employees, many from maintenance and housekeeping departments. Achievements include outstanding attendance, punctuality, intramural sports achievement and honesty. Since retention of competent professionals is a major problem for the government-run healthcare sector, the present findings indicate that governmental human resource policies which have mainly targeted the industrial sector should also focus on the betterment of the hospitals' organizational and work conditions and its effects on the mental health status of healthcare professionals, as highlighted by this study, in both the state and central level government hospitals.

## REFERENCES

Appleton, K., House, A. & Dowell, A. (1998). A survey of job satisfaction, sources of stress and psychological symptoms among general practitioners in Leeds. British Journal of General Practice, 48, 1059-1063.

Arjunan, K.K., Nair, M., Kutty, R., Thankappan, K.R., Vijayakumar, K. and Gregory, J. (2002). Report on standardization of medical institutions in the Kerala Health Services Department, available at: w.prodindia.com/files/PROD132/Report%20STANDARDIZATION%20OF%20MEDICAL%20INSTITUTIONS%20IN%20%20KERALA.doc

Arnetz, B. B. (2001). Psychosocial challenges facing physicians of today. Social Science & Medicine, 52 (2), 203-213.

Aust, B., Rugulies, R., Skakon, J., Scherjer, T. & Jensen, C. (2006). Psychosocial work environment of hospital workers: validation of a comprehensive assessment scale. International Journal of Nursing Studies, 44, 814-825.

Bourbonnais, R., & Mondor, M., (2001). Job strain and sickness absence among nurses in the province of Quebec. American Journal of Industrial Medicine 39 (2), 194–202.

Buchbinder, S.B., Wilson, M., Melick, C.F. & Powe, N.R. (1999). Estimates of costs of primary care physician turnover. American Journal of Managed Care, 5 (11), 1431-1438.

Burdi, M.D. & Baker, L.C. (1999). Physicians' perceptions of autonomy and satisfaction in California. Health Affairs, 18 (4), 134-145.

Caplan, R.P. (1994). Stress, anxiety, and depression in hospital consultants, general practitioners, and senior health service managers. British Medical Journal, 309, 1261–1263.

Cooper, C. L., Rout, U. & Faragher, B. (1989). Mental health, job satisfaction, and job stress among general practioners. British Medical Journal, 298, 366-370.

De Jonge, J., Mulder, M.J., & Nijhuis, F.J. (1999). The incorporation of different demand concepts in the job demand-control model: effects on health care professionals. Social Science & Medicine 48 (9), 1149–1160.

Eisenberger, R., Cummings, I., Armeli, S., & Lynch, P. (1997). Perceived organizational support, discretionary treatment, and job satisfaction. Journal of Applied Psychology, 82, 812-820.

Eisenberger, R., Fasolo, P., & Davis –La Mastro, V., (1990). Perceived organizational support and employee diligence, commitment and innovation, Journal of Applied Psychology, 75, 51-59.

Eisenberger, R., Huntington, R., Hutchison, S., & Sowa, D. (1986). Perceived organizational support. Journal of Applied Psychology, 71, 500-507.

Ensor, T. and Witter, S. (2001). Health economics in low income countries: adapting to the reality of the unofficial economy, Health Policy, 57, 1-13.

Eriksen, W., Tambs, K. & Knardahl, S. (2006). Work factors and psychological distress in nurses' aides: a prospective cohort study. BMC Public Health, 6, 290-301.

Filipsson, A. (1999). Large increase of male physicians with stress correlated symptoms. The Swedish Medical Journal, 49, 5474-5482.

Forsberg, E., Axelsson, R. & Arnetz, B. (2000). Effects of performance-based reimbursement in Healthcare. Scandinavian Journal of Public Health, 28 (2), 102-110.

Forsberg, E., Axelsson, R. & Arnetz, B. (2001). Effects of performance-based reimbursement on the professional autonomy and power of physicians and the quality of care. International Journal of Health Planning and Management, 16 (4), 297-310.

Freeborn, D.K. (2001). Satisfaction, commitment, and psychological well-being among HMO physicians. Permanente Journal, 174, 13-18.

Friedman, E. (1995). The power of physicians: autonomy and balance in a changing system. American Journal of Medicine, 99 (6), 579-586.

George, I.M., Reed, T.F., Ballard, K A., Colin, I., & Fielding, I. (1993). Contact with AIDS patients as a source of work-related distress: Effects of organizational and social support. Academy of Management Journal, 36, 157-171.

Gershon, R.R.M., Stone, P.W., Zeltser, M., Faucett, J., Macdavitt, K. & Chou, S.S. (2007). Organizational Climate and Nurse Health Outcomes in the United States: A Systematic Review. Industrial Health, 45, 622-636.

Goel, S.L., & Kumar, R. (2007). Hospital administration and management: Theory and practice. New Delhi: Deep & Deep Publication.

Goel, S.L., & Kumar, R. (2002). Management of hospitals (vol. 2). (Ed) New Delhi: Deep & Deep Publication.

Guzzo, R. A., Noonan, K. A. & Elron, E., (1994). Expatriate managers and the psychological contract, Journal of Applied Psychology, 79, 617.

Hardy, S., Carson, J. & Thomas, B. (1998). Occupational stress: Personal and professional approaches. Cheltenham: Stanley Thornes.

Johnson, J. (1997). Empowerment in future work life. Scandinavian Journal of Work Environment and Health, 23 (4), 23-26.

Jones, M.C. & Johnston D.W. (2000). A critical review of the relationship between perception of the work environment, coping and mental health in trend nurses, and patient outcome. Clinical Effectiveness in Nursing, 4, 75-85.

Karasek, R.A. (1979). Job demands, job decision latitude and mental strain: implications for job re-design. Administrative Science Quartels', 24, 285- 308.

Lindo, J.L.M., Binns, A.M., Grenade, J.L., Jackson, M., & Shearer, D.E. (2006). Mental Well-being of Doctors and Nurses in Two Hospitals in Kingston, Jamaica. West Indian Medical Journal, 55 (3), 153-159.

Linzer, M., Visser, M.R., Oort, F.J., Smets, E.M., McMurray, J.E. & De Haes, H.C. (2001). Predicting and preventing physician burnout: results from the United States and the Netherlands. American Journal of Medicine, 111 (2), 170-175.

Metcalfe, B.A.; Metcalfe, J.A.; Bradley, M.; Mariathasan, J; & Samele, C. (2008). The impact of engaging leadership on performance, attitudes to work and

wellbeing at work: A longitudinal study. Journal of Health Organization and Management. 22, 586-598

Misra-Herbert, A.D., Kay, R. & Stoller, J.K. (2004). A review of physician turnover: rates, causes, and consequences. American Journal of Medical Quality, 19 (2), 56-66.

Moorman, R. H., Blakely, G. l., & Niehoff, B. P. (1998). Does perceived organizational support mediate the relationship between procedural justice and organizational citizenship behavior? Academy of Management Journal, 41, 331-357.

Organ, D. W., (1988). Organizational Citizenship Behavior, Lexington, MA: Lexington Books.

Quick, J.C., Quick, J.D., Nelson, D.L., & Hurrell. J.J. (1997). Preventive stress management in organizations. Washington DC: American Psychological Society.

Rehman, Z, & M.N. Qureshi, (2008). LIFENET hospitals (India): developing new services' case study. International Journal of Health Care Quality Assurance, 21, 274-288.

Shore, L. M., & Wayne, S. J., (1993). Commitment and employee behavior : Comparison of affective and continuance commitment with perceived organizational support. Journal of Applied Psychology, 78, 774-780.

Sutherland, V.J., & Cooper, C.L. (1992). Job stress, satisfaction, and mental health among general practitioners before and after introduction of new contract. British Medical Journal, 304, 1545-1548.

Uncu, Y., Bayram, N. & Biljel, N. (2006). Job related affective well-being among primary health care physicians. European Journal of Public Health, 17 (5), 514–519.

Vultee, P. J. V., Axelsson, R. & Arnetz, B. (2007). The impact of organizational settings on physician wellbeing. International Journal of Health Care Quality Assurance, 20 (6), 506-515.

Wayne, S. J., Shore, L. M. & Liden, R. L. (1997). Perceived organizational support and leader-member exchange: A social exchange perspective. Academy of Management Journal, 10, 82-111.

West, E. (2001). Management matters: the link between hospital organization and quality of patient care. Quality in Health Care, 10, 40-48.

Williams, E.S., Konrad, T.R., Scheckler, W.E., Pathman, D.E., Linzer, M., McMurray, J.E., Gerrity, M. & Schwartz, M. (2001). Understanding physicians' intentions to withdraw from practice: the role of job satisfaction, job stress, mental and physical health. Health Care Management Review, 26 (1), 7-19.