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Workplace ostracism in healthcare: Association with job satisfaction, stress, and perceived health

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Abstract

Aims: To examine (1) the association between healthcare workers' workplace ostracism and job satisfaction, stress and perceived health, and (2) whether this relationship is mediated by loneliness and self-esteem.

Design: A cross-sectional study.

Methods: Healthcare ($N = 569$) managers and employees (nurses, practical nurses, doctors and social workers) in Finland responded to a semi-structured survey in January 2021 and evaluated their experiences of workplace ostracism, job satisfaction, stress, perceived health, loneliness and self-esteem during the last year. To examine the association of these variables, linear regression and mediator model tests were performed.

Results: Workplace ostracism had a clear direct association with job satisfaction, stress and perceived health. Loneliness fully mediated the relationship between workplace ostracism, stress and perceived health, and partly mediated the association between workplace ostracism and job satisfaction. Self-esteem partly mediated the association between workplace ostracism, stress, job satisfaction and perceived health.

Conclusion: The experience of workplace ostracism in organizations is a significant factor in job satisfaction, stress and perceived health. Healthcare organizations could strengthen job satisfaction and increase workers' well-being by strengthening social relationships in the organization and, via that, reducing turnover intention.

Implications for the profession and patient care: This study gives understanding and information to the healthcare profession on how workplace ostracism affects work well-being and workplace relationships. Workplace ostracism decreases interaction, which can also endanger patient care if information is not openly exchanged.

Impact: This study indicated that workplace ostracism weakened job satisfaction more than loneliness. More commonality and consideration for others at work are needed because these factors may help increase work well-being and decrease exits from working life. Further research is needed on why workplace ostracism occurs in healthcare workplaces.

Reporting Method: STROBE.

Patient or Public Contribution: No patient or public contribution.

There is a statistician on the author team and state which author: Samuli Koponen.

KEYWORDS
perceived health, healthcare, job satisfaction, loneliness, nurse, nursing, self-esteem, stress, workplace ostracism

1 | INTRODUCTION

The healthcare sector is facing a global crisis in terms of its workforce. Concerns about how the workforce will cope and be sufficient in the future are growing. An increasing number of countries have difficulties finding enough motivated and committed nurses (Halcomb et al., 2018), and during the COVID-19 pandemic, reports of fatigue among healthcare workforces have increased (Sagherian et al., 2021). It is a strong challenge that exists concerning how to encourage and support healthcare professionals in their work, to continue working and to avoid premature exit from the healthcare sector or working life. It is necessary to focus on those factors that undermine work well-being and job satisfaction and try to fight against them (Giorgi et al., 2016).

One reason for job dissatisfaction can be workplace ostracism (Ferris et al., 2008). Interestingly, workplace ostracism is often overlooked in the healthcare professions, although the phenomenon is quite common in healthcare (Qi et al., 2020) and may weaken the quality of care of patients (El-Guindy et al., 2022). Workplace ostracism has been defined, for example, as "exclusion, rejection, or ignoring of an individual (or group) by another individual (or group) that hinders one's ability to establish or maintain positive interpersonal relationships, work-related success, or favourable reputation within one's place of work" (Hitlan et al., 2006, p. 217). Experienced rejection increases employees' emotional burden, and it may lead to turnover intentions (Pierre et al., 2019). In recent years, there has been a growing debate in Finland about nurses changing careers. Even 26% of young nurses had often considered quitting, and one reason was job dissatisfaction (Flinkman, 2014).

Ostracism is a universal phenomenon that manifests in any age group, culture, or organization (Williams, 2007). Workplace ostracism surveys have been conducted largely in Asian countries, where people tend to emphasize collectivistic values such as harmonious interpersonal relationships (e.g., Yaakobi, 2020). There is evidence (e.g., Bedi, 2019, p. 26) indicating Western culture may be less collectivist, and due to this, the impact of ostracism on disengagement may be more significant than in, for example, Asian culture. Therefore, the recent research indicates an absolute necessity to conduct studies in different countries that value individualistic characteristics (e.g., Chung & Kim, 2017). Finnish culture is strongly individualistic, where privacy and achievement are appreciated as well as surviving alone (e.g., Rantanen & Toikko, 2015, p. 293). In Finland and the Nordic countries at all, workplace ostracism has been limited to study. In addition, previous workplace ostracism studies in healthcare have mostly focused on only nurses (e.g., Qi et al., 2020; Shafique et al., 2020). Therefore, we also considered other occupational groups (nurses, practical nurses, doctors and social workers) and managers from all levels. This paper focuses on workplace ostracism in Finnish healthcare and its association with stress, job satisfaction, perceived health, the mediated role of loneliness and self-esteem. There is a need to clarify and understand the relationship between workplace ostracism and work well-being in healthcare association with the selected factors.

2 | BACKGROUND

The healthcare industry is strongly people-oriented, and healthcare work is often done in teams. Hospitals are social environments and offer a good opportunity to interact and communicate with colleagues and patients (Elhanafy & Ebrahim, 2022). However, workplace ostracism undermines this interaction (Robinson et al., 2013). Those who are ostracized have a negative image of co-workers and the work environment, which leads to a decrease in job satisfaction (Ferris et al., 2008). We suggest that good relationships and feelings of belongingness at work may help remain at work.

Human well-being and the issue of job satisfaction are of crucial importance in the public domain, where low performance can lead to lost lives (Bogodistov & Botts, 2016). Traditionally, job satisfaction has been defined as a personal experience indicating an individual's satisfaction with her/his job. Several factors affecting job satisfaction have been identified, such as interaction with colleagues and relationships with patients, co-workers and managers (Lu et al., 2012). Exclusion and rejection from others threaten the sense of belongingness within the work community (Baumeister & Leary, 1995; Williams, 1997).

The theory of belongingness is built on the idea that the individual has a need to belong (Baumeister & Leary, 1995). According to the need-threat theory, ostracism threatens four fundamental needs: belongingness, self-esteem, control and a meaningful existence (Williams, 2001, p. 60). After being ostracized at work, employees try to reinforce their thwarted needs and reconnect with others (Williams, 1997). If, despite the effort, an employee cannot connect with colleagues, it may increase stress, weaken resources and lead to various harmful phenomena, such as increased anger, sadness, or depression (Williams, 1997, 2009). These, in turn, lead to reduced health conditions (Ferris et al., 2008; Wu et al., 2012).

Hobfoll (1989) identified workplace ostracism as a stressor that threatens the resources employees need. Conservation of Resources Theory (COR) is a stress theory that describes the motivation that makes individuals maintain their existing resources and look for new ones (Hobfoll, 1989). According to the COR, different stressors at work, including workplace ostracism, can deplete employees'

resources and subsequently even cause job burnout (Shafique et al., 2020). Stress has been defined as a "particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p. 19). According to COR, stress and workplace ostracism cause the employee to experience resource loss. Then s/he begins to save personal resources by ignoring, for example, a colleague's need for help or the needs of clients and patients. A worker has a need to preserve his/her own resources at work and seeks to protect them and reduce threats that may degrade the available resources. In light of the COR, it can be assumed that the repeated experience of ostracism eventually exhausts the employee due to the subsequent increased stress. This is also supported by the view that different diseases may lead to higher absenteeism, personnel turnover, conflicts and consequently lower job satisfaction (Shafique et al., 2020).

Experiencing workplace ostracism may reduce health conditions because of increased stress and feelings of loneliness (Gou et al., 2021). Previous research indicated that loneliness at work increases, for example, employee turnover (Ayazlar & Guzel, 2014). This view follows COR, stating that persistent exposure to workplace ostracism depletes an individual's resources. This may finally lead to alienation from the work community (Williams, 2007). According to belongingness theory, many "psychological difficulties reflect emotional and behavioral reactions to perceived threats to social bonds" (Baumeister & Leary, 1995, p. 521).

We assume that repeated loneliness excludes the individual from interactions with others and may therefore also undermine self-esteem. The definition of self-esteem is multidimensional, and therefore it is difficult to define it unambiguously. James (1950, 1890) describes self-esteem as born of an assessment of one's ability or personal success in the areas where individuals wish to succeed, and he defines self-esteem as the ratio of "our actualities to our supposed potentialities". According to James (1950, 1890), success in those areas that have little personal significance likewise has little impact on self-esteem. We assume that work is basically important for every individual, and therefore success at work is significant. According to several theoretical frameworks, self-esteem can change according to social rejection and acceptance, and because of this issue, perceived social approval and acceptance are integral and powerful bases (Cooley, 1902; Coopersmith, 1967). Those who have been rejected have defined their self-esteem as worse than those who have been noted (Blackhart et al., 2009). Therefore, the experience of one's low self-esteem may have already arisen before the ostracism or be a result of ostracism (Chung, 2015). According to a recent study (Johnson et al., 2020), healthcare workers with low self-esteem are almost three times more likely to suffer from high levels of stress. Research has also indicated that low self-esteem has a direct effect on job burnout and an indirect effect through stress (mediating variable) (Johnson et al., 2020). In contrast, high self-esteem predicts success and well-being in different areas of life, such as relationships, work and health (Orth & Robins, 2014).

In addition to human relationships, there are organizational factors associated with workplace ostracism that may serve as explanatory variables for the occurrence of workplace ostracism. In this paper, organizational justice and job control are explanatory variables for workplace ostracism. Previous studies have indicated that perceived organizational support mitigates the adverse effects of workplace ostracism (e.g., Sarfraz et al., 2019). Williams (1997) indicated that people who have been ostracized perceive a loss of control and feel that they do not have a way to stop the ostracism. Hence, we assume that if employees have control of their own job, or/and receive support and justice from an organization, experienced workplace ostracism is reduced.

3 | THE STUDY

3.1 | Objective

The aim of this study is to investigate the association of healthcare workers' (nurses, practical nurses, doctors, social workers and managers) workplace ostracism on job satisfaction, stress and perceived health. An additional aim is to examine whether loneliness and self-esteem mediate the relationship between ostracism and stress, job satisfaction and perceived health. Based on the theoretical background, we postulate the following three hypotheses:

Hypothesis 1. Workplace ostracism decreases (a) job satisfaction; (b) perceived health; and (c) increases stress.

Hypothesis 2. Loneliness mediates the relationship between workplace ostracism and (a) job satisfaction; (b) stress; and (c) perceived health.

Hypothesis 3. Self-esteem mediates the relationship between workplace ostracism and (a) job satisfaction; (b) stress and (c) perceived health.

4 | METHODS

4.1 | Design

Our study was a cross-sectional random sample of specific healthcare professional groups and managers from two university hospitals in Finland. The study was designed to collect experiences about workplace ostracism as well as workers' well-being during the year 2020.

4.2 | Participants

We recruited the participants using two hospital liaison officers. The aim of the study and explanation of the term ostracism were

introduced to all respondents in the cover letter of the questionnaire in the writing guidelines. Respondents gave their consent at the beginning of the survey, after reading the cover letter. Given the timing of the data collection (COVID-19) it was neither meaningful nor appropriate to collect data from all staff at the university hospitals. However, we wanted to collect as wide a range of data as possible. Therefore, the study population consisted of a group of respondents that were as large and as heterogeneous as possible from the perspective of different work environments. The following occupational groups were included in the study: nurses, practical nurses, doctors, social workers, head nurses, middle managers and general managers (who also had either a professional qualification as a nurse or a doctor). Occupational therapists, physiotherapists, speech therapists, pharmacists, hospital chaplains and psychologists were excluded because those occupational groups are not in Finland. As a rule, employees are involved in the day-to-day work of every work unit. Those professions are such as specific experts to be called in separately to the department. When considering the sample size, the possible loss of respondents was also considered.

In this paper, we use the terms Organizations A and B, depending on where we collected the data. We collected data from as similar units as possible from both organizations (e.g., outpatient clinics and wards from both organizations), which were selected according to the occupational group criteria mentioned above. However, due to differences in the organizations the selection was not completely identical, but the sample can be considered representative of departments focused on the operational, polyclinical and inpatient activities of the two university hospitals. The representativeness of the sample was then checked based on the information that was available from both organizations. Figures for Organization A were 86.6% women, and in Organization B, 81% women. The average age in Organization A was 43.5 years, and in Organization B, it was 44 years. The percentage of those who work in a managerial position was 11.9% in Organization A and 16.5% in Organization B. Comparative figures for our sample of respondents were 86.6% women, the average age was 43 years and those who work in a managerial position were 17.9%. Those numbers indicate that our study sample was representative of both organizations with sufficient accuracy.

A power analysis was performed prior to conducting the survey, according to which the number of responses to the survey was 362 (effect size 0.3, alpha 5%, power 90%). Based on this, it was possible to estimate enough questionnaires to be sent. In total, 5423 employees got this questionnaire. The questionnaire was answered by 573 health and social care employees (four did not give permission to use their answers; total $n = 569$). The response rate was 10.5%.

4.3 | Data collection

The data was collected in January 2021 as a web-based survey. A semi-structured questionnaire was sent by email to different types of units, considering the job description, the form of working hours and the size of the work unit. To obtain a sample of respondents that was as heterogeneous as possible, different types of outpatient clinics, emergency departments, surgical units, inpatient wards and intensive care units were included. The obstetrics and gynaecology clinics were excluded due to commitments. Departmental staff received an email inviting them to take part in the survey. Participation in the survey was voluntary. When the survey was sent, the number of responses was tracked. At 2 weeks, a reminder message was sent to answer the survey. The survey was closed on the pre-arranged date. Anonymity was assured.

4.4 | Ethical considerations

The research topic is very sensitive, and this is considered in the cover letter of the questionnaire. The first page of the survey gave information about the research and use of personal data in this research, in line with the GDPR (General Data Protection Regulation) guidelines of the European Union. Responding to the survey was voluntary. Research permits had been obtained for both organizations. The research ethics committee of the University of Eastern Finland supported the implementation of the research. There was no specific funding for the study.

4.5 | Measures

The suitability, usability and understandability of the questionnaire were tested with the help of healthcare workers and local managers ($n = 60$). The form of inquiry and the distributions into the variables were found to work with small corrections (such as some guidance and phrasing). The questionnaire comprises 88 questions (11 background questions, 4 open-ended questions and 73 structured questions). All scales used in this study have been widely used and tested in previous studies. In the recent study, the parts of the questionnaire presented in this chapter were examined. Open-ended questions were excluded.

The respondents were asked to rate their experiences of workplace ostracism during the last year. We are aware that because of the workload caused by the pandemic, workplace ostracism (a) may have been over interpreted, or (b) sought to respond as negatively as possible to be seen as working conditions in the healthcare sector. However, there was no reason in the data that could be predicted with certainty, which could be the real confounding factor. Dependent variables were job satisfaction, stress and perceived health. Independent variables were workplace ostracism, gender, years in healthcare, education, job control and organizational justice. Mediator variables were self-esteem and loneliness.

4.5.1 | Dependent variables

Job satisfaction was measured with two questions (v. Eisinga et al., 2013) derived from the Job Diagnostic Survey (JDS)

developed by Hackman and Oldham (1975). The questions were, "Generally speaking, I am very satisfied with this job." and "I frequently think of quitting this job." JDS measures the personal affective reactions a person experiences in her/his work (1 = *strongly disagree* to 5 = *strongly agree*). The scale for quitting was reverse scored. Higher mean scores indicate good job satisfaction. Cronbach's $\alpha = .76$.

Experienced stress was estimated by asking one question: "Do you feel stress nowadays?" (1 = *not at all*, 5 = *very much*; Elo et al., 2003). Before the question it was clarified that, "Stress refers to a situation where a person feels tense, restless, nervous, or anxious or has difficulty sleeping when things are constantly bothering their minds."

Perceived health was estimated by asking one question, "How is your health compared to others of your age?" (1 = *good*, 5 = *bad*). The scale was reverse scored. High scores indicated good health condition.

4.5.2 | Independent variables

A 10-item scale (Ferris et al., 2008) was used to assess workplace ostracism. The scale was translated to Finnish as a double-blind back-translation by two authorized translators and was found to correspond to the original English version. This scale was used for the first time in Finnish. The scale included 10 items such as: "Others ignored you at work" (1 = *never* to 7 = *always*). The answers were calculated together with higher mean scores indicating a higher level of workplace ostracism. Cronbach's α for this scale was .93.

Control at work was measured with a QPS Nordic (General questionnaire for psychological and social factors at work; Wännström et al., 2009). The sample includes nine items, such as "Can you influence decisions concerning the persons you will need to collaborate with?" (1 = *very seldom or never*; 5 = *very often or always*). The full measure is presented in Appendix 1. A sum variable was calculated based on these nine items. Higher mean scores indicate a good possibility of influencing their own work. Cronbach's $\alpha = .87$.

Organizational justice was measured with a Colquitt (2001) shortened version by Elovainio et al. (2010). The measure consists of three dimensions: procedural justice, interpersonal justice and informational justice. In this study, we used it as a one-sum scale. It includes eight questions, such as "Has your supervisor seemed to tailor his/her communications to individuals' specific needs?" (1 = *totally disagree* to 5 = *totally agree*). Higher mean scores indicate higher organizational justice. Cronbach's $\alpha = .87$.

4.5.3 | Mediator variables

Self-esteem was measured with the Rosenberg self-esteem scale (Rosenberg, 1965). The respondents answered according to how much they agreed with the 10 assertions about self-esteem, such as "On the whole, I am satisfied with myself." (1 = *strongly disagree* to 5 = *strongly agree*). The answers were calculated together. Higher mean scores indicate good self-esteem. Cronbach's $\alpha = .86$.

Loneliness was covered by only one question: "Do you feel lonely?" (1 = *never* to 5 = *repeatedly*; v. Kotwal et al., 2022). Before the question, it was clarified that "In this study, loneliness refers to emotional loneliness, which means an emotional experience that there is no one to talk to about one's own thing. A situation where there may be a lot of people around you, but you still feel alone."

4.6 | Data analysis

IBM SPSS version 27 (descriptive statistics, correlations and linear regression analyses) and Stata/IC 15.1 for Windows (mediator models) were used to analyse the data. The analysis did not differentiate between hospital responses but looked at them together.

In the first step, the association between job satisfaction/stress/perceived health and the independent variable workplace ostracism (Model A) was analysed. In the second step (Model B), independent variables such as gender, years in healthcare and education were added to Model A. Because nurses were the biggest occupational group, they were placed as a reference group. In the third step, (Model C) organizational justice and control at work were added to Model B. These variables were used as they have been earlier found to have a strong effect on the dependent variables, and Model C shows whether ostracism has an independent effect in addition to job control and organizational justice. All categorical variables were treated as dummy variables in the linear regression analyses. Gender was binary (women/men). There was one (1) "other gender", and three (3) respondents did not wish to say gender. These four (4) were treated as missing values in the regression analysis.

The variable can function as a mediator if regression analyses show statistically significant relationships on three levels (Baron & Kenny, 1986). First, the independent variable (workplace ostracism) must be a statistically significant predictor of the dependent variable(s) (job satisfaction, stress and perceived health). Second, the independent variable (workplace ostracism) must be a statistically significant predictor of the mediator (loneliness and self-esteem). And third, the mediator must be related to the dependent variable(s). All these steps should have a direct effect. Once statistical significance was determined, we proceeded to the fourth step. There is full mediation if beta (β) weight reduces and becomes non-significant. If beta (β) weight reduces and remains significant, this is a case of partial mediation. In addition, we applied Sobel's (1982) statistics to detect direct and indirect effects in each of the mediated ways (Baron & Kenny, 1986).

4.7 | Validity and reliability

The workplace ostracism scale (Ferris et al., 2008) has been widely used in previous workplace ostracism studies. In our sample,

Cronbach's alpha value was 0.93 for experienced workplace ostracism, indicating very good internal consistency. This also indicated that the translation from the original language to Finnish has been successful. The JDS (Hackman & Oldham, 1975) can provide useful information when used properly (Taber & Taylor, 1990). In our sample, the Cronbach's alpha value was .76. Stress was measured using only one question. Stress has theoretically grounded associations with indicators, for example, health and psychosocial work characteristics. Therefore, it is possible to get enough good information about stress experience by using one question: "Do you feel stress?" (Elo et al., 2003). The evaluation of perceived health also included only one question. It is a simple and personal question where the respondents can themselves evaluate their own state of health condition at a general level. Organizational justice was measured with a Colquitt (2001) shortened version (Elovainio et al., 2010). In our sample, Cronbach's alpha was 0.87, indicating good internal consistency. Control at work was measured with a QPS Nordic measure. In QPS, job satisfaction correlated significantly with job control (Wännström et al., 2009). In our sample, Cronbach's alpha was .87, indicating good internal consistency. The self-esteem scale by Rosenberg (1965) is used and is one of the most used self-esteem measures. In our sample, Cronbach's alpha was .86, indicating good internal consistency. In this sample, respondents evaluated loneliness using one question. Kotwal et al. (2022) indicated that a single question about loneliness misclassified only 3% by the longer measure in their study. According to this, it was a valid way to evaluate loneliness with a single question. The question included a clarification of what loneliness means in this study.

5 | RESULTS

5.1 | Characteristics of the sample

The study participants ($N=569$; $n=486$ working in patient work, $n=87$ working in management positions at different levels) ranged in age from 21 to 66 years (mean 43 years, $SD=11.14$). Female participants represented the majority of the sample ($n=493$, 86.6%). Participants had worked in the healthcare sector for an average of 17.7 years and in their current position for an average of 8 years. Most employees worked at various outpatient policlinics in the hospitals ($n=194$, 34.3%). Employees working in social care represented a minority of the sample ($n=19$, 3.5%). The detailed demographics of the sample are presented in Table 1.

As many as 73.4% of respondents ($n=417$) had experienced workplace ostracism, at least in some form. Most frequently, workplace ostracism was experienced as a failure to respond to a greeting in the workplace (54.4%). The least frequent workplace ostracism was experienced when someone had stopped talking to an employee (14.6%). Workplace ostracism was experienced by all occupational groups in the survey, including managers. Table 2 presents the amount of workplace ostracism experienced in relation to colleagues of the same occupational group. The amount of experienced workplace ostracism did not differ between occupational groups (ANOVA df = 4, df = 563, $F=.424$, $p=.791$).

Before the regression analysis correlation between variables was estimated using Spearman's correlation coefficient (Table 3). This allowed us to reveal that workplace ostracism correlated negatively with job satisfaction ($r=-.366$, $p<.01$), perceived health

TABLE 1 Demographic characteristics of the sample.

	N	Mean	SD	Min	Max
Workplace ostracism	568	1.53	0.73	1.0	5.9
Years in the industry	568	17.72	11.02	1.0	46.0
Job satisfaction	569	3.72	1.03	1.0	5.0
Stress	566	2.96	.98	1.0	5.0
Perceived health	562	2.04	.96	1.0	5.0
Job control	549	23.33	7.42	9.0	45
Organizational justice	556	25.95	6.51	8.00	40
Loneliness	569	2.33	1.00	1.0	5.0
Self-esteem	569	3.33	0.52	1.50	4.0
			N		%
Participants					
Female			493		86.6
Male			72		12.7
Other sex / do not want to say			4		0.7
Education					
Practical nurse			65		11.4
Nurse			325		57.1
Doctor			73		12.8
Social worker			19		3.3
Managers			87		15.3
Work unit					
Ward			173		30.4
Operational unit			128		22.7
Policlinic			194		34.3
Emergency			26		4.6
Social care			19		3.5
Government			25		4.6
Total			569		100

TABLE 2 Proportions of experienced workplace ostracism within occupational groups.

Education	% in relation to the same occupation (N)
Practical nurse	76.9 (50/65)
Nurse	74.5 (242/325)
Doctor	71.2 (52/73)
Social worker	78.9 (15/19)
Manager (all levels)	67.4 (58/86)
Total	73.4 (417/568)

TABLE 3 Descriptive statistics and correlations ($N = 569$).

	Mean	SD	1	2	3	4	5	6	7	8
1. Gender	—	—	1							
2. Years in healthcare	17.71	11.02	.013	1						
3. Workplace ostracism	1.53	1.03	.087*	.093*	1					
4. Job satisfaction	3.72	1.03	−.060	−.010	−.360**	1				
5. Stress	2.96	0.98	−.001	−.114**	.225**	−.356**	1			
6. Perceived health	2.04	0.96	−.086*	−.005	−.166**	.186**	−.323**	1		
7. Organizational justice	25.95	6.51	−.130**	.060	−.299**	.543**	−.190**	−.078	1	
8. Job control	25.33	7.42	−.071	.172**	−.218**	.346**	−.136**	−.068	.438**	1

*$p < .05$. **$p < .01$.

TABLE 4 Association of workplace ostracism on job satisfaction (standardized regression coefficients, β).

	Model A	Model B	Model C
Workplace ostracism	−.337***	−.334***	−.182***
Gender		.005	.040
Years in healthcare		−.025	−.029
Education (ref. nurses)			
Practical nurses		.075	.036
Social workers		.067	−.009
Doctors		.096**	−.007
Managers		.153***	−.033
Job control			.125
Organizational justice			.456***
R^2	.114	.141	.346
Adjusted R^2	.112	.129	.335

**$p < .01$. ***$p < .001$.

TABLE 5 Association of workplace ostracism on stress (standardized regression coefficients, β).

	Model A	Model B	Model C
Workplace ostracism	.207***	.230***	.168***
Gender		−.004	−.017
Years in healthcare		−.168***	−.116***
Education (ref. nurses)			
Practical nurses		−.069	−.052
Social workers		.021	.054
Doctors		.042	.085
Managers		.112	.190***
Job control			−.061
Organizational justice			−.180***
R^2	.043	.080	.114
Adjusted R^2	.041	.067	.098

***$p < .001$.

($r = -.124$, $p < .01$), organizational justice ($r = -.272$, $p < .01$), job control ($r = -.198$, $p < .01$) and self-esteem ($r = -.319$, $p < .01$), and positively with stress ($r = .244$, $p < .01$) and loneliness ($r = .429$, $p < .01$).

TABLE 6 Association of workplace ostracism on perceived health (standardized regression coefficients, β).

	Model A	Model B	Model C
Workplace ostracism	.158***	.153***	.146***
Gender		.153	.028
Years in healthcare		.022	.022
Education (ref. nurses)			
Practical nurses		.006	.007
Social workers		−.011	−.007
Doctors		−.040	−.036
Managers		−.059	−.051
Job control			−.008
Organizational justice			−.017
R^2	.025	.031	.031
Adjusted R^2	.023	.017	.014

***$p < .001$.

The first regression analysis (Model A) explores the effect of workplace ostracism on job satisfaction, stress and perceived health (Tables 4–6). In the second step (Model B), the models were adjusted for individual factors. Nurses were the biggest occupational group, so it was set as a reference group in the models. Individual factors do not appear to have either a significant association with workplace ostracism or an effect on the relationship between workplace ostracism and dependent variables. In the last step (Model C), the models were adjusted for job control and organizational justice.

Workplace ostracism had a clear association with job satisfaction ($\beta = -.337$, $p < .001$; v. Table 4, Model A). In the second step (Model B), when it was adjusted for individual factors, the association between workplace ostracism and job satisfaction was almost unchanged ($\beta = -.334$, $p < .001$; v. Table 4, Model B). According to the analysis, doctors and managers were more satisfied with their jobs compared with nurses. However, this association disappeared when job control and organizational justice were controlled for. This would suggest that job satisfaction is driven by job control and organizational justice. In the last step (Model C), when adjusting for job control and organizational justice, the association between workplace ostracism

and job satisfaction decreased significantly ($\beta = -.182$, $p < .001$), but workplace ostracism still had a significant effect on job satisfaction. The explanatory power of the model increased by 20 percentage points.

In the examination between workplace ostracism and stress, the overall explanatory power was clearly lower (v. Table 5). When adjusting for individual factors, the association between workplace ostracism and stress increased ($\beta = .230$, $p < .001$). Years in healthcare were the only individual variable associated with stress; the fewer years in healthcare, the more workplace ostracism was experienced. When adjusting for job control and organizational justice the association between workplace ostracism and stress decreased. But still, the relationship between workplace ostracism and stress remained significant. In Model C, organizational justice reduced managers' stress.

The relationships between perceived health and workplace ostracism were rather similar to the relationship between workplace ostracism and stress and job satisfaction. The effect of workplace ostracism on perceived health decreased only slightly when adjusting for individual factors, job control and organizational justice (v. Table 6).

After the regression analyses, we performed the mediator analyses. We summarize the results of the mediation tests in Figures 1 and 2. Loneliness mediated 19.3% of workplace ostracism's effect on job satisfaction, 78.2% of stress and 65.5% of perceived health. Results of the Sobel test indicated that the mediating effects of loneliness (z value range from 7.441 to −3.673, all $p < .001$) were all statistically significant.

Self-esteem mediated 8.8% of workplace ostracism's effect on job satisfaction, 30.5% of stress and 42.3% of perceived health. Results of the Sobel test indicated that the mediating effects of self-esteem (z value from range 4.314 to −3.064, all $p < .001$) were all statistically significant.

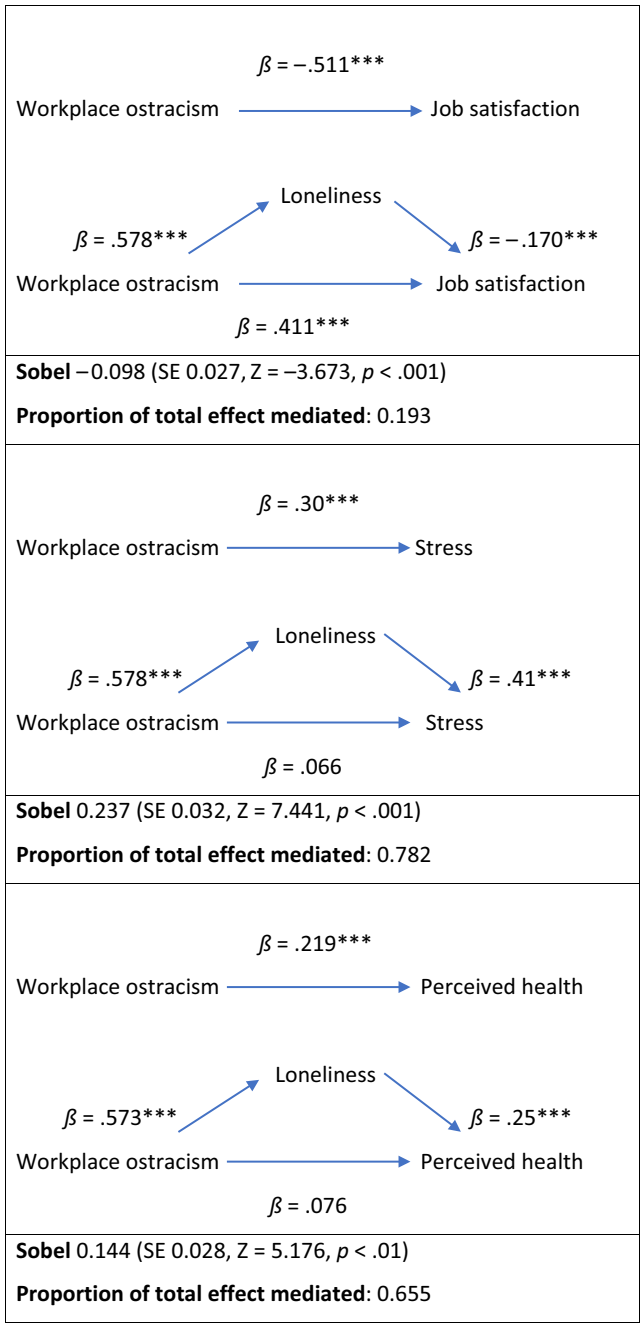

FIGURE 1 Loneliness as a mediator between workplace ostracism and job satisfaction, stress and perceived health. ***$p < .001$.

6 | DISCUSSION

Although research on workplace ostracism has been conducted to an increasing extent since the 2010s, in the healthcare context, knowledge about the phenomenon is still limited. This study is partly a response to this deficiency, and it brings to light a phenomenon that is very harmful from the point of view of well-being and coping at work. This study investigated the effect of healthcare workers' workplace ostracism on job satisfaction, stress and perceived health. In addition, we indicated that loneliness and self-esteem mediate the relationship between ostracism and job satisfaction, stress and perceived health.

It is worrying that up to 73% of respondents reported experiencing workplace ostracism in the past year. In 2021, El-Guindy et al. (2022) researched in Egypt the incivility and ostracism in the workplace among staff nurses and their relation to the quality of care. In that study, 57% of staff nurses ($N = 100$) had a low level of workplace ostracism. In addition, the second recent study by Ahmed and Mahmoud (2020) reported that two-thirds of nurses ($N = 349$) had experienced a moderate level of workplace ostracism. Although we had in this study other professional groups than only nurses, it is possible to examine the results in an indicative way in relation to each other. Interestingly, when comparing the incidence of workplace ostracism within occupational groups, the highest incidence of workplace ostracism was found in social workers and the lowest in managers. However, the incidence was, on average, very similar. It is worrying that there is so much ostracism in the healthcare sector, regardless of the occupational group to which it belongs.

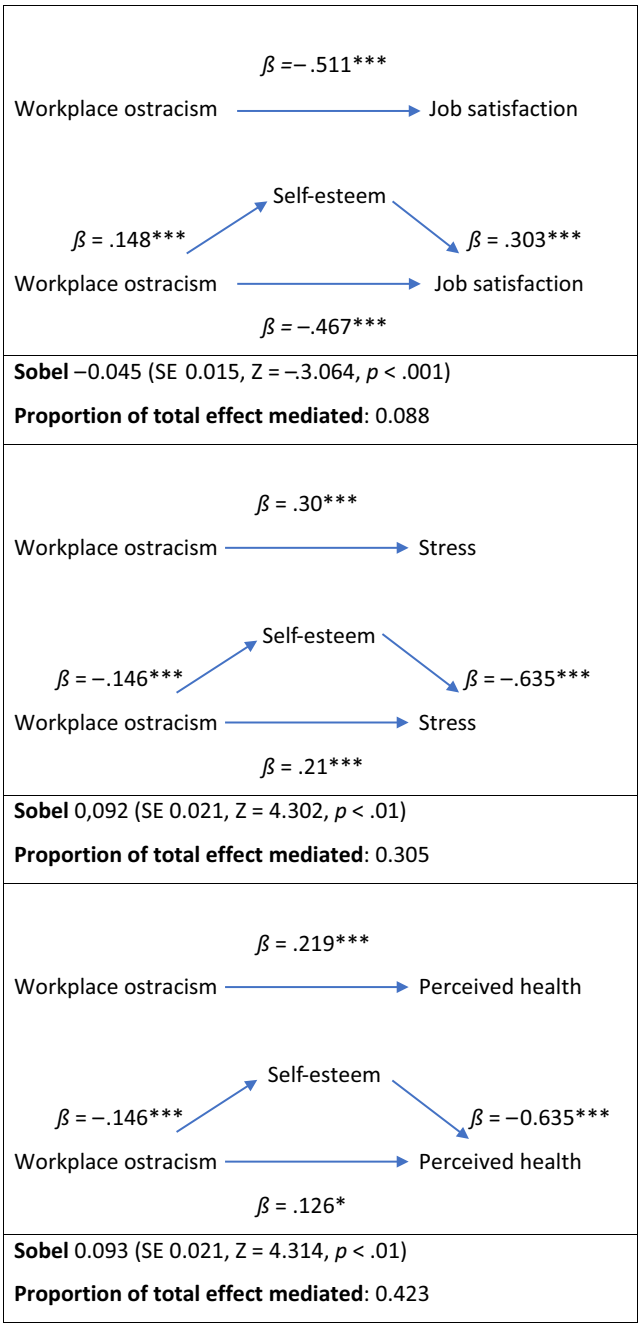

FIGURE 2 Self-esteem as a mediator between workplace ostracism and job satisfaction, stress and perceived health. $^{*}p < .05$, $^{***}p < .001$.

Our main findings indicated that workplace ostracism has the strongest association with job satisfaction. Workplace ostracism shapes nurses' perceptions of undesirable relationships with coworkers and influences actions that might lead to unethical behaviour (Qi et al., 2020). This kind of behaviour is harmful and reduces job satisfaction, as our results indicate. In addition, workplace ostracism has the strongest direct association with perceived negative health conditions without any factors. Those who experienced workplace ostracism did not enjoy their work and considered leaving it. Organizational justice strongly correlates with job satisfaction and moderately with job control. This indicated that the experience of being equal to other employees means a lot, as does autonomy at work and the possibility to use one's skills.

A common stereotypical image of nurses and healthcare workers overall is that they are emotionally sensitive and can understand patients' emotions and worries. Many nurses say that they consider emotional work a significant part of their job (Gray, 2010). Experienced workplace ostracism can reduce good mood at work and manifest in work with patients (Robinson et al., 2013). In this study, the association between workplace ostracism and job satisfaction was statistically significant. Even though job control and organizational justice are typically indicators of job satisfaction, the connection between workplace ostracism and job satisfaction remains. This result is congruent with previous studies (e.g., Ferris et al., 2008). This finding is in line with the premises of the need threat theory (Williams, 1997), as experienced workplace ostracism can decrease job satisfaction because workplace ostracism threatens an individual's need to keep control, experience belonging with co-workers and a meaningful existence. However, according to belongingness theory, individuals have different needs regarding belonging to others (Baumeister & Leary, 1995). Employees who have a high need to experience inclusion are more likely to perceive exclusionary behaviour that threatens their need to belong. Therefore, those with a high need to belong is based on a real human need, while those with a low need to belong are less likely to perceive exclusion from the behaviour of co-workers. This may explain why some are more sensitive and reactive when they experience potential ostracism at work. It is possible that healthcare employees are more sensitive than some other occupational groups in this respect (e.g., Gray, 2010).

However, several previous studies from other occupational groups than healthcare have indicated that workplace ostracism causes different sorts of negative consequences, such as a low level of satisfaction with colleagues and supervisors (Hitlan et al., 2006), psychological and physical health problems (Baumeister & Leary, 1995), and high work stress (Wu et al., 2012). Sarfraz et al. (2019) demonstrated that workplace ostracism and stress had a significantly positive relationship. Our results indicated the same relationship. In addition, this study demonstrated that organizational justice weakened the relationship between workplace ostracism and stress. Equal treatment presumably strengthens the sense of belonging and therefore reduces experienced stress. Further, when workers experience equal treatment, it reduces their tendency to feel a need to compete to maintain their position and place as a member of their community.

Workplace ostracism causes many health problems such as burnout (Shafique et al., 2020), restlessness, depression and anxiety (Ferris et al., 2008; Wu et al., 2012), to name a few. In addition to an association with stress and job satisfaction, this study revealed an association with perceived health condition. Association with workplace ostracism and perceived negative health condition was clearest without any influence from other factors. This result indicated that experience of workplace ostracism and its relationship to

perceived health is not dependent on, for example, gender or work years in healthcare.

Our mediator models indicated that perceived loneliness is a significant experience. Loneliness fully mediated the association between workplace ostracism, stress and perceived health and partly mediated between workplace ostracism and job satisfaction. Examining loneliness in the context of workplace ostracism is not straightforward. It is difficult to prove whether the feeling of loneliness existed even before the experience of rejection, or whether loneliness was caused by rejection. In addition, in this study it was not sure whether respondents had thought of loneliness in general, or loneliness only at work. According to the COR "individuals strive to obtain, retain, foster and protect those things they centrally value" (Hobfoll, 2010, p. 128). Experienced loneliness threatens relationships with others and may cause stress, and further individuals to seek restoration of interpersonal relationships to normal. With workplace ostracism, this attempt can be useless, and the employee will eventually remain completely alone. This can explain our result that loneliness fully mediated the association between workplace ostracism, stress and perceived health. However, our results indicate that loneliness only partly mediates the relationship between ostracism and job satisfaction. A major part of the effect of workplace ostracism on job satisfaction is direct.

According to Wesselmann et al. (2012), those who usually felt lonely did not experience rejection as severely as non-loners because they were already accustomed to being ignored. In this study, loneliness appeared to be a significant factor. Loneliness in mediation models eliminated the direct effect of workplace ostracism on stress and perceived health. Instead, according to Wright (2005), those who experienced loneliness at work have lower levels of job satisfaction. In this study, loneliness partly mediated the association between workplace ostracism and job satisfaction and explained only 19.3% of the total effect of workplace ostracism on job satisfaction. Despite this, loneliness is a serious matter. Emotional loneliness and workplace ostracism damage employees psychologically and greatly reduce job satisfaction (Uslu, 2021). According to the theory of belonging (Baumeister & Leary, 1995), the individual has a need to have at least a minimum number of interpersonal relationships. Importantly, loneliness at work not only spreads from person to person but also weakens the ties of a lonely employee to others within the work community (Cacioppo & Hawkley, 2009).

In this study, we also examined the mediation role of self-esteem between workplace ostracism, job satisfaction, stress and perceived health. Self-esteem partly mediated the association between workplace ostracism and job satisfaction, stress and perceived health. This result is parallel with Fatima et al. (2017). In their study they examined the mediating role of self-esteem between workplace ostracism and employee silence: self-esteem only partly mediated the association between workplace ostracism and employee silence (Fatima et al., 2017). Low self-esteem causes employees to feel less worthy and competent (Williams, 2009). According to the need threat theory, humans have fundamental needs, such as meaningful existence (Williams, 1997). Theoretically, the COR emphasizes losses, threats and common concerns of employees (Hobfoll, 2010), and if employees have low self-esteem, it is possible they may think they are of less worth to the organization. However, in this study, self-esteem only partially explained experienced job satisfaction, stress and health conditions. It may be possible that self-esteem is so deeply formed into personality that it does not change markedly despite experienced workplace ostracism.

Finally, although this study was the first workplace ostracism research in Finland, which has a strongly individualistic culture, our results are very similar to previous studies around the world. Due to this, it can be concluded that the universality of this phenomenon in this context is correct (e.g., Ferris et al., 2008; Williams, 2007).

6.1 | Strengths and limitations of the work

The study's major limitation is the cross-sectional design and sample of only two university hospitals. Due to this, we must be cautious when interpreting observed associations as causal. Especially regarding self-esteem, which is typically supposed to change slowly, the causal interpretation should be made with caution. In addition, it is worth noting the weakly adjusted R^2, especially in models of the association of workplace ostracism with stress and perceived health. The strength of our study was that this is the first workplace ostracism research from Finnish healthcare and from Northern countries overall. It represented two large university hospitals from Finland with heterogeneous work units and occupational groups. This is therefore a unique addition to the research on workplace ostracism, especially in healthcare. This allowed us to indicate whether occupational group plays a role in the prevalence of workplace ostracism. Secondly, the measures used in the study were earlier developed and tested and proved to be valid in this study. Thirdly, the statistical reliability of the study is improved by obtaining more responses than the number required for power analysis. Although the response rate to the survey could have been higher, it should be noted that the indicators corresponded well to the total working population of hospitals. However, it is worth considering that the data were collected during the COVID-19 pandemic. Collecting the data at another time could have produced a better response rate, as the fatigue and rush at work caused by the pandemic may have affected responsiveness. The pandemic has also caused unprecedented changes in people's personal and social lives, including outside work (Galanaki & Gkinopoulos, 2022; D'Alessandro et al., 2022), and it may be influenced by respondents' experiences, especially in health conditions and loneliness. In addition to these factors, there is still very little awareness in Finland about what the term *(workplace) ostracism* means, and this may also have reduced the response rate. The representativeness of the sample is quite good, despite the low response rate, because the survey was answered heterogeneously by representatives of several different professional groups from different work units in both hospitals. A critical examination of the results must consider the specificities of the healthcare sector.

6.2 | Recommendations for further research

In the future, studies should investigate other mechanisms that could explain how different organizational or personal factors affect workplace ostracism. Secondly, it is important to be aware of the cultural context in which this research has been conducted. A shared and experienced culture influences workplace ostracism (Yaakobi, 2020). Future studies might consider clarifying respondents' cultural backgrounds and comparing how these affect experiences of workplace ostracism. Thirdly, it would be worthwhile to study the relationship between workplace ostracism and healthcare employees' attitudes and intentions and investigate those factors associations with turnover or occupational identity. Lastly, a potential area for future studies would be qualitative research on workplace ostracism, which has thus far been studied mainly using quantitative methods. Qualitative research could provide a deeper understanding of workplace ostracism as an individual experience and as a collective and societal phenomenon.

7 | CONCLUSION

According to the results of this study, workplace ostracism is a very detrimental phenomenon, especially in terms of job satisfaction. If job satisfaction decreases, the problem is not just with the individual but throughout an organization. Job satisfaction is the sum of several factors. All these elements are linked by interaction as well as related to the fulfilment of one's own human needs. Our results indicated that well-being at work and job satisfaction are not only the responsibility of individuals, but they are also built on the cooperation of the entire organization at all levels. Identifying and preparing for the causes of emotional loneliness in the workplace would be important for achieving the organization's goals and good well-being at work. An experience of organizational justice and workplace ostracism was related theoretically and practically to the conservation of resources-, need threat-, and belongingness theories, and provided practical perspectives for healthcare professionals. If an employee can feel that decisions and paying attention to others are equal, s/he does not have to fight for his/her position and there are sufficient resources for work. If the healthcare sector can in the future pay more attention to inclusion and belongingness in work environments, this may result in higher numbers of nurses and other staff willing to work in healthcare fields.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version. Contributions are: Sirpa M. Manninen: Responsible for the study's conceptual development, theoretical content, statistical analysis, methodological content, drafting the manuscript and revising it for critically important content. Samuli Koponen: Responsible for the statistical analysis drafting and revising the manuscript and methodological content. Timo Sinervo: Responsible for the drafting, revising the manuscript and methodological and theoretical content. Sanna Laulainen: Responsible for drafting and revising the manuscript and theoretical content.

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No conflict of interest has been declared by the authors.

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DATA AVAILABILITY STATEMENT

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APPENDIX 1

QPS Nordic (general questionnaire for psychological and social factors at work).

1. If there are alternative methods for doing your work, can you choose which method to use?
2. Can you in.fluence the amount of work assigned to you?
3. Can you influence decisions concerning the persons you will need to collaborate with?
4. Can you influence decisions that are important for your work?
5. Can you set your own work pace?
6. Can you decide yourself when you are going to take a break?
7. Can you decide the length of your break?
8. Can you set your own working hours (flexi time)?

OBS! Version in Finnish also included question 9. Can you decide when to contact customers? (Elo et al., 2003, p. 45).