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Withdrawal Behaviors Syndrome: An Ethical Perspective

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ABSTRACT. This study aimed to elucidate the withdrawal behaviors syndrome (lateness, absence, and intent to leave work) among nurses by examining interrelations between these behaviors and the mediating effect of organizational commitment upon ethical perceptions (caring climate, formal climate, and distributive justice) and withdrawal behaviors. Two-hundred and one nurses from one hospital in northern Israel participated. Data collection was based on questionnaires and hospital records using a two-phase design. The analyses are based on Hierarchical Multiple Regressions and on Structural Equation Modeling with AMOS. Affective commitment was found to mediate the relationship between different dimensions of nurses' ethical perceptions (caring climate, formal climate, and distributive justice) and their intent to leave work. Lateness was found to be positively related to absence frequency which was found negatively related to intent to leave. Males were late more frequently than females, while seniority was related only to absence frequency. The findings indicated that each withdrawal behavior exhibits unique relationships. The results may help policy makers to focus on improving the ethical environment in order to increase nurses' commitment and reduce their intent to leave. Improving the ethical environment may be achieved through ethical education for nurses which may promote ethical considerations becoming an integral part of nurses' work.

KEY WORDS: absence, distributive justice, ethical climate, ethical perceptions, intent to leave, lateness, nurses, organizational commitment, organizational justice, withdrawal behaviors

Introduction

Withdrawal behaviors and behavioral intentions have long been at the center of health care research on nurses (Carraher and Buckley, 2008; Somers, 2009). *Withdrawal behaviors* refer to a set of attitudes and behaviors used by employees when they stay at the job but for some reason decide to be less participative (Kaplan et al., 2009). In the present study, we focused on three key indicators from among the wide array of potential withdrawal symptoms: lateness, absence, and intent to leave work. The importance of studying nurses' withdrawal behaviors cannot be overstated. Nurses' withdrawal behaviors are very costly and result in decreased standards of patient care. They also cause increased pressure on those left in the job, resulting in decreased morale on the wards and possibly further turnover (Borda and Norman, 1997; Shaw et al., 2005).

Previous studies (Hackett and Bycio, 1996; Staw and Oldham, 1978) indicate that withdrawal behaviors do not have exclusively detrimental effects for an organization. They argued that withdrawal behaviors may give employees a needed break from stress and might be expected in response to a wide range of noxious aspects of the work role. Thus, by withdrawing, all these employees may return to work with higher motivation which in turn can ultimately increase organizational effectiveness.

On the other hand, recent studies (Carmeli, 2005; Hart, 2005; Johns, 2003; Koslowsky, 2009; Ulrich et al., 2007) found that these withdrawal behaviors stem not only from unavoidable situations, but also from avoidable ones resulting from perceived unethical conditions which reduce organizational commitment and organizational effectiveness. All these findings point to the relevance of examining whether ethical perceptions may predict withdrawal behaviors among nurses. The questions that this study tried to answer are: what are the interrelations between ethical perceptions, organizational commitment, and the three above-mentioned

withdrawal symptoms (lateness, absence, and intent to leave work), and what model can best describe these relationships among nurses.

Theoretical background

The withdrawal syndrome

Lateness is described as arriving late to work or leaving before the end of the day (Koslowsky, 2000) and has been recognized as having motivational antecedents. Theoretically, it is classified into three dimensions: chronic, unavoidable, and avoidable. *Chronic lateness* is a response by the employees to a bad work situation. Relevant antecedents to chronic lateness are, for example, lack of organizational commitment and job satisfaction. *Avoidable lateness* occurs when employees have better or more important activities to do than to arrive on time. Leisure-income tradeoff and work–family conflicts may be positive antecedents to this type of lateness. *Unavoidable lateness* is due to factors beyond the employee's control, such as transport problems, bad weather, and accidents (Blau, 1995).

Work absence is "the lack of physical presence at a behavior setting when and where one is expected to be" (Harrison and Price, 2003, p. 204). Sagie (1998) distinguished between two basic types of absence: *voluntary absences*, which are normally under the direct control of the employee and are frequently exploited for personal issues such as testing the market for alternative prospects of employment, and *involuntary absences*, which are usually beyond the employee's immediate control.

Recent literature reviews emphasized absence as a variable related not only to the individual's demographic characteristics but also to the organizational environment and social context (Felfe and Schyns, 2004; Martocchio and Jimeno, 2003). Previous studies on nursing have indicated that musculoskeletal disorders, back pain, mental problems, lack of support in the workplace, low level of perceived fairness, and negative social relations represent risk factors for sickness absence (Eriksen et al., 2004; Josephson et al., 2008; Petterson et al., 2005;)

Intent to leave work is normally viewed as a proxy for actual voluntary turnover (Carraher and Buckley, 2008; Griffeth et al., 2000; Lambert and Hogan, 2009), which is one of the most detrimental behaviors to organizational effectiveness (Morrow and McElroy, 2007; Shaw et al., 2005) and costs organizations billions of dollars per year (Podsakoff et al., 2007). The theory of reasoned action suggests that intention is a psychological precursor to a behavioral act (Ajzen and Fishbein, 1980). Based on this notion, a nurse who nurtures the thought of leaving his/her work is more likely to do so if the right conditions exist. Nurses who intend to leave their organizations may reduce their efforts at work. Those who consider leaving are often the more qualified employees, who are more likely to find alternate employment, and this may jeopardize organizational standards and affect colleagues' motivation and efforts (Josephson et al., 2008; Parry, 2008). Previous studies in nursing indicated that the lack of professional opportunities, restricted professional autonomy, unsatisfactory salary, and poor job satisfaction contribute to a general intent to leave the workplace (Fochsen et al., 2005; Morrell, 2004).

Four major theoretical constructs for the internal structure of withdrawal attitudes and behaviors have been suggested for describing the relationships between various withdrawal behaviors: independent, spillover, compensatory, and progression (e.g., Johns, 2003; Koslowsky et al., 1997). According to the independent model, withdrawal behaviors have different causes and functions, and should therefore be unrelated to each other. Thus, employees can choose the form of withdrawal that best suits them (Hulin, 1991). The spillover model posits that withdrawal behaviors are positively related, without specifying any temporal or sequential relationship (Beehr and Gupta, 1978). Thus, an individual is likely to react to certain antecedents with a set of withdrawal behaviors rather than with just one (Koslowsky et al., 1997). The compensatory model proposes that similar antecedents causes specific forms of withdrawal to be negatively correlated (Nicolson and Goodge, 1976). The most common model is the progressive model, which posits that withdrawal manifestations occur in progression, starting with relatively mild forms of psychological withdrawal, such as occasional lateness, moving to more severe forms such as absence, and ending with the most severe forms such as intent to leave work and actual turnover (Koslowsky et al., 1997).

In conclusion, the literature does not seem to afford a clear indication of the interrelations between the main withdrawal behaviors. Rather, the findings are actually somewhat ambiguous. A few researchers reported that no relationship exists (Ross, 1988), others reported negative relationships (Nicolson and Goodge, 1976), some reported positive relationships (Iverson and Deery, 2001; Leigh and Lust, 1988), while still others claim that there is no sequential relationship between them and they can occur concurrently (Benson and Pond, 1987; Wolpin et al., 1988). These diverse findings indicate that withdrawal behaviors may have different patterns. We, therefore, examined the relationships between different predictors and withdrawal behaviors in order to study these patterns and understand the withdrawal syndrome.

The recuperative role of withdrawal behaviors

One of the explanations for nurses' withdrawal behaviors is the Conservation of Resources (COR) model of Burnout. This model is centered on environmental and cognitive factors associated with resources, defined as those ''objects, personal characteristics, conditions, or energies that are valued in their own right or that are valued because they act as conduits to the achievement or protection of valued resources'' (Hobfoll, 2001, p. 339). The COR theory suggests that people strive to obtain, protect, and foster valued resources and minimize any threats of resource loss. Threats of resource loss are usually in the form of role demands and efforts expended toward meeting such demands. In a work context, stress is caused chiefly because the rate at which work demands use up employee resources is typically greater than the rate with which resources are replenished (Halbesleben, 2006).

Consider the nursing profession: nurses can use withdrawal behaviors as a means to protect their internal resources so as to continue to perform well on the job, which may increase hospital effectiveness (Hackett and Bycio, 1996). Thus, withdrawal behaviors might be functional to employees in a variety of ways. *Some* may provide time to recover from physical illness or psychological exhaustion. *Others* may simply be seen as a way to restore perceived equity to the employment relationship. This study will expand upon this latter function of withdrawal behaviors – restoring perceived equity to the relationship between nurse and hospital – by studying how ethical perceptions may affect a nurse's withdrawal behaviors, in the event that the nurse perceives that her hospital does not fulfill her expectations.

Ethical perceptions

The rapid changes taking place in healthcare increase ethical questions which may affect nurses' behaviors (Deshpande and Joseph, 2008). Two measures of ethical perceptions were investigated in the present study: *ethical climate* and *organizational justice*. These were selected because of increasing research interest in them in recent years, and because they represent different aspects of ethical perceptions. The *ethical climate* represents employees' perceptions about organizational norms regarding behavior and decisions that bear ethical content (Cullen et al., 2003; Victor and Cullen, 1988). In other words, an ethical climate will reflect to what extent the ethical dimensions of the organizational culture have been incorporated and implanted throughout the organization by processes of socialization so that ''employees *perceive* the existence of normative patterns in the organization with measurable degree of consensus'' (Victor and Cullen, 1988, p. 103).

Victor and Cullen (1988) proposed a two-dimensional model of ethical climate. One dimension represents three basic ethical approaches: egoism (maximizing self-interest), benevolence (maximizing joint interests), and principle (adherence to ethical principles). The second dimension represents the various levels of analysis: individual, local (organizational), and cosmopolitan (societal). Cross-tabulation of the two dimensions produces nine ethical climates. Victor and Cullen (1988) organized these nine ethical climates into five principal categories: (1) *caring* (egoism at the cosmopolitan level and benevolence at all levels, where employees have a genuine interest in each others' welfare, both inside and outside the organization), (2) *instrumental* (egoism on the individual and local levels, where personal and organizational interests are most important), (3) *rules* (principle on the local level, where employees are mainly guided by

organizational rules and procedures), (4) *law-and-code* (principle on the cosmopolitan level, where employees are guided by laws, regulations, and professional codes), and (5) *independence* (principle on the individual level, where employees are guided by personal convictions and personal morality).

In a study conducted in Israel, Shapira-Lishchinsky and Rosenblatt (2009) identified two factors that emerged as the most powerful and valid predictors of organizational outcomes. These factors were named *caring* and *formal* and were adopted in the present study due to their relevance to the Israeli system (the site of the present study). *Caring climate* is characterized by the employees' genuine interest in each other's welfare, both inside and outside the organization, corresponding to the original "caring" dimension of Victor and Cullen (1988) model. A *formal climate* emphasizes organizational rules and encourages respect for them. It combines two of Victor and Cullen's (1988) factors: rules and law-and-code. Since a formal climate is based on transparent procedures, it is perceived as protecting employees from abusive treatment by management and others. Both types of ethical climate, i.e. caring and formal, and especially how they are perceived by employees, may predict employees' behavior on the job (Peterson, 2002).

Organizational justice is another concept of organizational ethics that is used to describe equity in the workplace (Greenberg, 1995) and taps how employees' perceptions of equity are determined and how these perceptions influence organizational outcomes. Organizational justice research has focused on two key dimensions: *distributive justice*, which refers to the fairness of the outcomes an employee receives (Adams, 1965) and *procedural justice*, which describes the fairness of the procedures used to determine organizational outcomes (Pillai et al., 2001).

In this study, we focused on nurses' ethical perspective because it has been shown that nurses expect fairness in their workplace (Deshpande, 2009; Deshpande and Joseph, 2008; Elovainio et al., 2004; O'Donohue and Nelson, 2007; Purvis and Cropley, 2003), and that their perceptions of such fairness affect their work attitudes and behaviors. Thus, if nurses perceive that their ethical expectations are not fulfilled, they will compensate for this disenchantment by withdrawal behaviors.

Nursing and ethical perspective

Nurses are faced with ethical issues on a daily basis because of inadequate staffing, inappropriate budget allocation, situations in which patients are discussed inappropriately, and sometimes a climate of withholding information (Corley et al., 2001; Deshpande et al. 2006; Fry and Daffy, 2001; Metcalf and Yankou, 2003; Moore, 2000). The quality of nurses' ethical decisions has a significant impact on the quality of healthcare (Loewy and Loewy, 2004). For example, De Casterle et al. (2008) found, in a meta-analysis of nine studies from four countries, that conformist practices by nurses represent a major barrier to their taking appropriate ethical action. Raines (2000), in a study of 229 oncology nurses found that they experienced 32 different types of ethical dilemmas over a period of 1 year, and some of these dilemmas were experienced on a daily basis. In Israel, although all nurses in Israel are encouraged to obtain an academic degree (Birenbaum-Carmeli, 2007; Ehrenfeld et al., 2007; Fawcett et al., 2007), their average salaries are among the lowest of all academic professionals in the public sector (Wage and Work Agreement Administrator, 2008). Any of these factors is likely to engender perceptions of unjust rewards, creating a climate that does not foster a desire to spend more time at the hospital and encouraging withdrawal behaviors.

Relations among different dimensions of ethical perceptions

Each of the ethical concepts below represents nurses' perceptions. The ethical climate signifies the aspect of workplace environment and organizational justice represents managerial actions. These two concepts are closely interrelated. Gilligan (1982) viewed the ethics of care and justice as interrelated, since both revolve around responsibility and social relationships and both consider morality as the means for resolving interpersonal conflicts. Formal climate is closely related to distributive justice, since these two concepts focus on the employees' rights and on the structure of rules and regulations that protects their rewards.

Although some of the values included in the ethical perceptions presented here may be potentially

conflicting (e.g., caring vs. equality-based distributive justice), the competing values model (Quinn, 1988) asserts that although tension between conflicting values is inevitable, it may contribute to organizational effectiveness. This gives some credence to our integrative approach to the ethics concepts presented here and leads to our first hypothesis:

Hypothesis 1: The ethical climate (caring, formal) and distributive justice are positively related to each other.

The ethical element in withdrawal behaviors

One of the common characteristics of the withdrawal behaviors discussed in the present study is that they are, for the most part, under the employee's control. This means that they have a considerable voluntary component. Thus, in many cases, the nurses' ethical perspective plays a key role in explaining decisions to withdraw from work (Blau, 1994). Many established foundational theories, including equity theory (Adams, 1965), inducements–contributions theory (March and Simon, 1958), and social exchange theory (Thibault and Kelly, 1959) note the role of withdrawal behaviors as a means by which employees can withhold inputs from an organization. According to their theories, withdrawal behaviors are often controllable forms of input reduction. Additionally, withdrawal behaviors permit an employee to reduce the cost of an aversive job by engaging in more pleasurable activities while still maintaining the economic benefits offered by the job (Harrison et al., 2006).

In the case of nursing, lateness, absence, and intent to leave work may have adverse effects on patients, who are entitled to proper care (Deshpande and Joseph, 2009; Nielsen et al., 2002; Parry, 2008). Time lost because of *lateness* is often not given back, while time lost due to *absence* (e.g., when the nurse reports absence at the last minute) is usually made up by colleagues who are normally busy with their own duties, thus adding to their regular workload. Latecomers and absent nurses thus negatively affect their colleagues, exhibiting inconsiderateness for the interests of their colleagues. Nurses who entertain *thoughts of leaving*, even when present on the job, are likely to invest less effort at work, either because of lower motivation or because of time needed to search for an alternative job. In addition, these withdrawals are also likely to have an adverse effect on patient-centered care (Ulrich et al., 2007), and the patients' interests may be compromised for the personal interests of the withdrawing nurses. Thus, according to the traditional theories, withdrawal behaviors can be motivated by various personal and work-related reasons, and they all may share elements of unethical behavior among employees (Hart, 2005; Olson, 1998; Ones et al., 2003; Koslowsky, 2009), and in this study, among nurses.

However, we should also consider that the changes which have occurred in employment arrangements in this decade have led to a destabilizing of the relationship between employee and employer (Kabanoff et al. 2000). Prior to these changes, the employment relationship was constructed around an individual's loyalty, commitment, and trust in the employing organization. In return, the employer provided job security and career prospects. Today, however, the individual is required to demonstrate more responsibility and multiskilling, and to function under conditions of role ambiguity (O'Donohue and Nelson, 2007). Thus, the individual professional employee's allegiance and career aspirations move away from the organization and are transferred onto the profession. (O'Donohue and Nelson, 2007; Purvis and Cropley, 2003; Thompson and Bunderson, 2003). These changes in the work world, together with the implications of the COR model explained previously, may encourage us to consider that withdrawal from the hospital by lateness, absence, or intent to leave, do not *necessarily* signify withdrawal from the patient. This decade has seen professional ideology become dominant in the decision-making of employees (O'Donohue & Nelson, 2009; Thompson & Bunderson, 2003), and that has had a positive effect on work behaviors affecting patient care (O'Donohue and Nelson, 2007).

Ideological currency, when applied to the nursing profession, might include such occupational ideals as professional competence, expertise and excellence, client focus, or social ideas, such as the right of every member of the community to access high quality health services regardless of their individual socio-economic status. Consequently, when nurses have a commitment to the ideology and ethics of nursing,

reflecting an ''other'' orientation that goes beyond the traditional dyadic employee–organization relationship, this may lead them to an increased effort to protect their patients from the negative consequences of ''unethical'' organizational decisions, rather than to withdrawal from the patient (O'Donohue and Nelson, 2007; Purvis and Cropley, 2003).

The relationship between ethical perceptions components and withdrawal behavior

When the climate in the organizational focuses on high morality, employees may respond by refraining from deviant behavior such as withdrawal behaviors (Hutchison et al., 1986; Peterson, 2002; Wimbush and Shepard, 1994). More specifically, nurses will be less likely to withdraw from work when they perceive their workplace as characterized by a caring climate in which their emotional and other needs are taken into account, or where there is a formal climate in which the transparency of rules and regulations protects them from managerial abuse of their rights (Deshpande and Joseph, 2008).

Studies on distributive justice show consistently that employees expect organizational decisions to be fair, and that they engage in negative reactions to the organization when they believe that they are subject to unjust outcomes (Greenberg, 1995; Moorman, 1991). From this perspective, withdrawal behaviors are among the various means available for restoring an inequitable employment relationship (Blau et al., 2004; Carraher and Buckley, 2008). Consider absence research, where past absenteeism has been found to predict subsequent absenteeism; stability of absenteeism over time may in part be due to employees' ethical perceptions. The individual differences perspective on organizational ethics posits that individuals who have negative ethical perceptions will engage in more undesirable behaviors (Elovainio et al., 2004; Ones et al., 2003).

All these raise the question of what can explain the presumed link between nurses' ethical perceptions and withdrawal behaviors. Based on the extensive literature on organizational behavior, where organizational commitment emerges as a powerful explicator of employees' work behaviors (Cohen, 2003; Cohen and Freund, 2005), we suggest that organizational commitment may best explain the relationships between nurses' ethical perceptions and withdrawal behaviors, thus constituting a mediating variable.

The role of psychological contract in nurses' withdrawal behaviors

Previous studies indicate that a violation of the psychological contract may damage the employment relationship, giving rise to anger generated by betrayal of trust (Rousseau, 1995); this, in turn, has the potential to reduce organizational commitment and increase withdrawal behaviors (Geurts, 1995; Nicholson and Johns, 1985; Purvis and Cropley, 2003; Robinson and Rousseau, 1994). The psychological contract is created when an individual perceives that his or her contributions obligate the organization to reciprocate, and it is the individual's belief in the obligation of the organization to meet his expectations that constitutes the contract. The reciprocity in the psychological contract is unique for each person that accepts it (Rousseau, 1995). Therefore, it is logical to place the emphasis on the individual's subjective perception.

Cavanagh (1996, p. 80) describes the psychological contract as a ''*sophisticated* set of expectations and rules which forms the psychological basis for the continuing commitment of an employee to his/her employer''. Indeed, the latest studies expanded the interpretive framework for the psychological contract (Bunderson, 2001; O'Donohue and Nelson, 2007; Thompson and Bunderson, 2003) and indicate an additional perspective, namely, the ideology-infused contract (O'Donohue and Nelson, 2009). Thompson and Bunderson (2003, p. 574) define ideological currency as ''credible commitments to pursue a valued cause or principle that are implicitly exchanged at the nexus of the individual-organization relationship''. Thus, by broadening the range of contract terms included in the psychological contract, the ideology-infused contract provides a means for exploring the link between professional ideologies and the psychological contract for professional employees (O'Donohue and Nelson, 2007).

In the case of a *transactional perspective*, the individual approach is egoistic and instrumental, focusing on benefit to oneself. The currency of

transactional exchange is reasonably explicit, short-term, and economic in nature. Such an exchange assumes rational and self-interested parties, and does not result in ongoing interdependence. For *relational perspective*, the individual approach is interdependence through a commitment to the collective interest over self-interest, focusing on benefits accruing to both the individual and the organization; its currency is socio-emotional in nature and, therefore, less clear, and it evolves over time. In the case of an *ideology-infused perspective*, the focus is shifted beyond the individual and the organization to a third-party beneficiary, defined in general terms as society. Thus, an ideology-infused psychological contract reflects a value-oriented model of human nature, where the notion of benefit to society may transcend personal gain in the eyes of an employee (O'Donohue & Nelson, 2009; Thompson & Bunderson, 2003).

Employees sometimes perceive violation of a contract even in the absence of direct personal mistreatment by an organization. Psychological contracts can be violated *not only* when the organization abandons its obligations to provide economic (transactional) and socio-emotional (relational) support to the employee, *but also* when the organization fails to exemplify some principle or to fulfill an implied ideological obligation (Thompson and Bunderson, 2003). There is abundant evidence in the existing literature to indicate that ideology can play a key role in defining and shaping the individual–organization relationship. For example, George (2001) argues that for many employees, "the real motivation comes from believing that their work has a purpose and that they are part of a larger effort to achieve something truly worthwhile" (p. 42) and Collins and Porras (1996) suggest that successful organizations adopt cause-driven missions in an attempt to fulfill the moral expectations of their employees. However, the existing literature does not elaborate on how employees react to unmet ideological obligations, for example, when the employers do not share their employees' ethical perceptions. As a result, the organizational literature is poorly equipped to explain the phenomena resulting from an ideological breach based on ethical expectations.

Incorporating ideology into the interpretive framework of the psychological contract allows a more useful consideration of the influence of values and ethical standards of behavior in today's changing employment environment. If an employee perceives that the organization has failed to meet its ethical obligations, he may see this as a breach of the psychological contract (O'Donohue and Nelson, 2009; Sims and Keon, 2000), which may affect his behavior.

Organizational commitment as a mediator between ethical perceptions and withdrawal behaviors

Meyer and Allen (1997) identified three types of organizational commitment: *affective, normative*, and *continuous*. *Affective commitment* refers to employees' emotional attachment to the organization, and their identification and involvement with it. *Normative commitment* reflects a sense of obligation to continue working for the organization. *Continuous commitment* refers to people's external reasons for staying with the organization, such as the cost associated with leaving it. The general consensus is that organizational commitment is strongly related to work outcomes and job performance (Blau et al., 2006; Luchak and Gellatly, 2007; Meyer et al., 2002; Nogueras, 2006). Nevertheless, the relationship between organizational commitment and work outcomes may not be universal for all types of commitment. Studies showed that affective and normative commitment positively affect work outcomes, including withdrawal behaviors, whereas continuous commitment showed little or negligible relationships of this type (Cohen, 2003: Luchak and Gellatly; 2007; Meyer et al., 2002). In the field of nursing, the strong service element associated with the vocation of nursing might lead to the dominance of affective and normative commitment (Somers, 2009).

The mediating effect of organizational commitment on the relationship between nurses' ethical perceptions and withdrawal behaviors can be explained by the social exchange theory (Robinson and Rousseau, 1994), which proposes that the parties in any given relationship seek balance and fairness in the relationship. According to the psychological contract, the organization provides resources that address the employee's values, and in exchange, the employee offers his loyalty and commitment. When the employees perceive that the

organization has failed to meet its ethical obligations, personalized attachments are compromised (Bundeson, 2001), and the employees may seek ways to recover the benefits to which they feel entitled, for example, through withdrawal from work (Kickul, 2001; Turnley et al., 2004).

However, the processes put into operation by the psychological contract are not all uni-directional. Previous studies suggest that even when employees are deeply committed to fulfilling ideological objectives, they will demonstrate tolerance in circumstances when the organization fails to achieve ideological victories. This is explained in two ways: first, because the very pursuit of the ideology is in itself its own reward, and also, because those who pursue ideological rewards are generally predisposed to having a future-oriented perspective and willingness for delayed gratification concerning the organization (Thompson and Bunderson, 2003).

In contrast to economic and socio-emotional obligations, which usually require relatively short-term gratification, employees who base their organizational relationship on more remote ideological goals will be more likely to exhibit tolerance for short-term breaches of the psychological contract, if they are persuaded that the organization has not abandoned its commitment to the long-term objective. Similarly, Morrison and Robinson (1997) contend that the likelihood of organizational violation depends on whether the larger social contract, which is the context for organizational action, adequately justifies the breach. If employees realize that the ideology to which they are committed must be counter balanced against other legitimate values, their emotional response to the perceived breach may be assuaged.

In line with this theory, we argue that ethical perceptions may affect the ideological component of the social exchange to which nurses react. These ethical perceptions reflect the values guiding nurses' behaviors (Schein, 1990). When nurses do not feel at ease with organizationally endorsed values, they reciprocate with a lower level of commitment, which may in turn lead to unfavorable work attitudes and behaviors (Bundeson, 2001; Kwantes, 2003), depending on how severe they perceive the ideological breach to be.

Based on the O'Donohue and Nelson (2007) study, which established that perceptions of the psychological contract are best understood by reference to an ideological currency; and based on the most common model of withdrawal syndrome, the progressive model, which proposes that withdrawal behaviors occur in progression, starting with relatively mild forms of psychological withdrawal and moving on to more severe forms, we believe that such an ideological breach will have a greater effect on the more severe withdrawal behavior, i.e., intent to leave, than on the other "mild" withdrawal behaviors (lateness, absence). Organizational commitment thus acts more significantly as a mediator in the relationships between nurses' ethical perceptions and intent to leave than it does on the other withdrawal behaviors. This leads to the second hypothesis:

Hypothesis 2: Organizational commitment (affective, normative) will mediate the relationship between ethical perceptions (ethical climate, organizational justice) and intent to leave more significantly than the relationship between ethical perceptions and lateness or absence.

Figure 1 summarizes the study model and hypothesis 2.

Method

Population and sample

Two-hundred and one nurses from one hospital in northern Israel participated in the study. The selection of the hospital was pragmatic, based on finding an institution where the hospital's head nurse and the nurses were willing and available to participate voluntarily. The reason for conducting research in only one hospital stems from the differences in defining lateness and absence, which vary among the hospitals in Israel depending on the hospital type: public, governmental, or private. Therefore, we choose one hospital with a uniform definition of lateness and absence in all its departments (e.g., in public hospitals in Israel, lateness is defined as being more than 5 min late while in private hospitals, it is generally defined as being only more than 1 min late).

All subjects received a formal letter describing the study goals and informing them that the study was

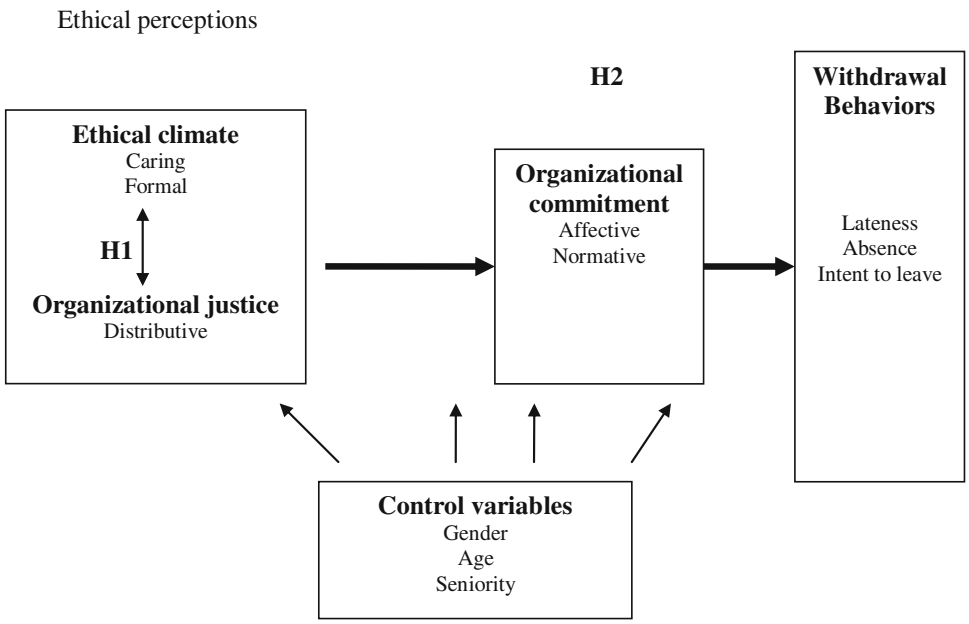

Figure 1. Summary of the research model.

undertaken in order to collect data about the characteristics of Israeli nurses' withdrawal behaviors and their ethical perceptions. The letter also stipulated the researchers' obligation to maintain anonymity according to the Helsinki Treaty. This was a contributing factor in obtaining the nurses' consent to participate and may explain the fact that the response rate was 75%.

The nurses came from diverse clinical backgrounds (e.g., cardiology, intensive care, oncology, and geriatrics). Eighty percent of the participants were women. The participants' mean age was 36.28 years (SD = 9.50). The hospitals' mean seniority was 9.68 years (SD = 7.35) and the mean job seniority was 12.76 years (SD = 8.52); 77% of the nurses had tenure and the others were employed through temporary contracts. These background characteristics are typical of the Israeli health system (Israeli Central Bureau of Statistics, 2005), indicating that the respondents accurately represented the Israeli nurse population.

Data collection

Data collection was performed using a two-phase design. In the first phase, the nurses answered anonymous questionnaires related to their description of the existing ethical climate and organizational justice as they perceive it, their organizational commitment, and personal background. Each nurse put the questionnaires into an envelope, entered a code number on the envelope, and gave the envelope to the secretary of his/her department. In the second phase, which was carried out 1 year later, each nurse answered an anonymous ''intent to leave work'' questionnaire. The nurse then put the ''intent to leave'' questionnaire and copies of his/her first half-year lateness records and the next half-year absence records (without identifying the nurses' names), which were supplied by the department secretary, all with the original code, in an unmarked envelope and again gave the envelope to the secretary of the department. The codes helped the researchers to link the questionnaires from the first phase to relevant data from the second phase.

The author of this study selected different time periods for the two measures: half a year to measure lateness and over the subsequent half-year, an additional half-year period to measure absence, since absence and lateness are contaminated measures. Thus, for example, if a nurse is absent for five consecutive days, he/she obviously cannot be late during this time period.

Variables and measures

Lateness

Lateness data were obtained from the hospital records by calculating the number of times a given nurse arrived six or more minutes after the shift began. The rationale for defining lateness as 6 min or more draws on hospital policy which defines lateness as arriving six or more minutes after the shift began and is supported by previous studies that indicated that this length of time is normatively unacceptable in various organizations (Blau, 1994, 1995; Blau et al., 2004). The data indicated 21.9 cumulative percent of 0–5 lateness frequency events; 15.8 cumulative percent of 7–13 lateness frequency events; and 13.7 cumulative percent of 14–39 lateness frequency events.

Work absence

The work absence measure was based on absence frequency (not duration) as recorded in the hospital records, that is, the number of times a nurse was absent during the reported period regardless of the number of days lost. It is generally believed that absence frequency is the best measure of voluntary absence, whereas absence duration (total number of days lost) is the best reflection of involuntary absences (Blau et al., 2004; Sagie, 1998). Absence frequency was chosen as the dependent variable because the purpose in this study was to investigate the interrelations between ethical perceptions, organizational commitment, and withdrawal behaviors, which reflect the nurses' choice of whether or not to come to work. The data indicated 70.6 cumulative percent of 0–2 absence frequency events; 16.5 cumulative percent of 3–5 absence frequency events; 5.5 cumulative percent of 6–7 absence frequency events; and 7.4 cumulative percent of 9–25 absence frequency events.

The choice of a 6-month period to report lateness and absence frequency was based on a reasonable time-span in which hospitals normally retain records with these data (Johns, 1994). Another reason is that a 6-month time-span produces a valid picture of nurse lateness and absence, because it represents half of a work year.

Intent to leave work

This measure tapped the nurses' intent to leave their work (e.g., "I often think about quitting my hospital"). It was adopted from the Walsh et al. (1985) 5-item intent to leave scale. Shapira-Lishchinsky (2009), who used this scale in studies of Israeli employees, reported a reliability rate of $a = 0.92$.

Ethical climate

This variable elicited the nurses' description of the existing ethical climate as they perceive it. Victor and Cullen's (1988) original 27-item ethical climate scale, translated into Hebrew by Rosenblatt and Peled (2002), was used. Since our model called for two dimensions (caring and formal), a factor analysis (principal components, Varimax rotation) of the Hebrew version of the scale was performed.

This analysis yielded six factors, the first two of which correspond to the two dimensions selected *a priori* for the study, namely: (a) "caring" climate, defined as a climate of concern for the welfare of all hospital members (e.g., "In this hospital, people look out for each other's interests," corresponding to the friendship and social responsibility dimensions of the original index; $a = 0.83$, 13.26% of the explained variance), and (b) "formal" climate, defined as a climate of compliance with professional and social codes and with the hospital rules and regulations (e.g., "Everyone is expected to stick to hospital rules and procedures," corresponding to both rules and procedures, law-and-code dimensions of the original index; $a = 0.87$, 28.42% of the explained variance). All other factors proved negligible in relation to the factors: caring and formal climate (4.36–8.79% of the explained variance).

Organizational justice

This 21-item measure was based on Moorman (1991) and was translated into Hebrew by Rosenblatt and Hijazi (2004). A factor analysis (principal components, Varimax rotation) yielded three factors, of which the first, representing the dominant types of justice (distributive), was selected for the present study. Distributive justice assessed the fairness of various hospital outcomes (e.g., "I am fairly paid or rewarded, considering my job responsibilities"), including pay level, work schedule, and work load ($a = 0.87$, 44.26% of the explained variance). All

other factors proved negligible (6.90–8.90% of the explained variance) in relation to the distributive justice factor.

Organizational commitment

Factor analysis (principal components, Varimax rotation) based on Meyer and Allen's (1997) original 22-item measure yielded six factors. The first two, representing the dominant types of commitment (affective and normative), were selected for the present study. Affective commitment items (e.g., "I really feel as if this hospital's problems are my own") addressed the nurses' perceptions of their reasons for wanting to remain in their hospital fund (seven items, $a = 0.84$, 22.67% of the explained variance). Normative commitment items ("One of the main reasons I continue to work in this hospital is that I believe loyalty is important") addressed the nurses' perceptions of the reasons why they ought to remain in their hospital (six items, $a = 0.77$, 18.76% of the explained variance). Continuous commitment proved negligible relative to the factors: affective and normative commitment (5.37% of the explained variance).

Response options for all items ranged from 1 = strongly disagree to 5 = strongly agree.

Control variables

A set of control background variables that were likely to be related to withdrawal behaviors and organizational commitment (Borkowski et al., 2007; Cohen, 1993; Wright and Bonett, 2002) were used. These included personal variables such as gender (0 = men, 1 = women), age, and hospital seniority.

Data analysis

The proposed model describes the mediating effect of organizational commitment (affective/normative) on the relationship between nurses' ethical perceptions (caring climate, formal climate, and distributive justice) and withdrawal behaviors (lateness, absence frequency, and intent to leave work). Since the statistical tools (Hierarchical Multiple Regressions Analyses, SEM with AMOS) are based on the assumption of the normal distribution of variables, we tested the distributions of the variables and found that lateness and absence did not meet the assumption of normality; therefore, we used the log transformation for these variables.

Two statistical procedures were performed in order to examine whether there is a mediating effect. First, we adopted Kenny et al.'s (1998) causal step approach. In this approach, four criteria must be met to support a mediating effect: The independent variables must be related to the mediators; the independent variables must be related to the dependent variables; the mediators must be related to the dependent variables, with the independent variable included in the model. Mediation is considered full if the relationship between the independent and the dependent variables is no longer significant in the presence of the mediator.

Then, Structural Equation Modeling (SEM) with AMOS was used for two purposes: first, in order to confirm our previous findings based on the Hierarchical Multiple Regressions and on the correlation analyses; and second, in order to obtain a general perspective about the proposed multivariate model, which is illustrated in the same figure: lateness, absence, and intent to leave (according to Kenny et al., 1998, only one withdrawal behavior present in each regression). Thus, the advantages of the SEM include graphical modeling interfaces which represent multiple dependents and their relationships to their predictors (Arbuckle, 2006; Blakely et al., 2005).

Results

The means, standard deviations, and correlations for the study variables are presented in Table I. In general, the correlations between the ethical variables were as expected. All ethical perceptions were significantly intercorrelated, thus confirming Hypothesis 1, supporting our integrative approach in considering the ethical variables. Men exhibited more lateness than women, and seniority was positively related to age and absence frequency. Only intent to leave work (but not lateness or absence) was significantly related to all ethical perceptions. The two dimensions of organizational commitment were related to all ethical variables, as well as to intent to leave work (which was not correlated to normative commitment). This suggests that organizational commitment may mediate the relationship

TABLE I
Means, standard deviations, and correlations

		M	SD	2	3	4	5	6	7	8	9	10	11
1	Gender[a]			0.118	0.035	0.039	0.045	0.038	0.064	0.032	−0.144**	0.006	−0.210
2	Age	36.29	9.50	–	0.668**	−0.052	0.052	−0.028	0.058	0.090	0.029	0.100	−0.100
3	Seniority	9.69	7.36	–	–	0.059	0.192	0.113	0.124	0.096	0.006	0.126**	−0.055
4	Caring climate	3.16	0.59	–	–	**(0.83)**	0.433**	0.440**	0.570**	0.299**	0.006	0.048	−0.280**
5	Formal climate	4.00	0.53	–	–	–	**(0.87)**	0.310**	0.431**	0.240**	−0.097	−0.060	−0.273**
6	Distributive justice	3.66	0.69	–	–	–	–	**(0.87)**	0.438**	0.092*	−0.044	0.072	−0.289**
7	Affective commitment	3.55	0.60	–	–	–	–	–	**(0.84)**	0.340**	−0.012	0.042	−0.451**
8	Normative commitment	3.32	0.58	–	–	–	–	–	–	**(0.77)**	0.050	−0.018	−0.223
9	Lateness	8.35	12.98								1	0.447**	0.016
10	Absence frequency	3.61	6.65									1	−0.166*
11	Intent to leave work	2.21	1.01	–	–	–	–	–	–	–	–	–	**(0.95)**

Notes: $N = 201$, *$p < 0.05$, **$p < 0.01$, [a]men = 0, women = 1; internal consistency reliability estimates (alphas) are presented in parentheses along the diagonal.

between ethical perceptions and intent to leave (but not lateness or absence).

However, previous studies have indicated that organizational commitment affects ethical perceptions and withdrawal behaviors such as lateness and absence among other professions (e.g., Shapira-Lishchinsky, 2007; Shapira-Lishchinsky and Rosenblatt, 2010; Podsakoff et al., 2007). This, then, provides the basis for using the Kenny et al. (1998) method of measurement, in addition to simple correlations, in order to examine the mediating effect of organizational commitment upon the relationship between ethical perceptions and other withdrawal behaviors such as lateness and absence (in addition to intent to leave). According to their study, a series of Hierarchical Multiple Regressions were used to test for the mediated relationships formulated in Hypothesis 2. Findings pertaining to the first criterion in the mediation analysis (independent variables relating to the mediating variable) are presented in Table II. All the ethical perceptions and control variables were included in two separate analyses for affective and normative commitment. Affective commitment was found to be related to all ethical variables, whereas normative commitment was related only to the caring climate. No significant relationships were found between the control variables and the two dimensions of organizational commitment. This result partially satisfied Kenny et al.'s (1998) first criterion.

Findings pertaining to the second criterion in the mediation analysis (independent variables relating to the dependent variable) are presented in Table III, Step 1. All ethical variables were found to be directly related to intent to leave work, but not to lateness or absence frequency. No significant relationships were found between the control variables and the three dimensions of withdrawal behaviors.

Findings pertaining to the third criterion in the mediation analysis (mediating variable relating to the dependent variable, with the independent variables included in the model) are presented in Table III, Step 2. Only affective (but not normative) commitment was significantly related to intent to leave work (but not to lateness or absence frequency) in the presence of all ethical perceptions and control variables. Finally, testing for the fourth criterion of the mediation analysis, we looked at the remaining relationships between ethical perceptions and intent to leave work in Table III, Step 2. The relationships

TABLE II

Relationship of the study variables to organizational commitment (affective, normative) using Hierarchical Multiple Regression Analysis

	Affective commitment		Normative commitment	
	B	SE	*B*	SE
Constant	3.508***	0.206	3.095***	0.211
Age	−0.007	0.006	0.000	0.007
Gender	0.160	0.122	0.176	0.125
Seniority	0.017	0.008	0.009	0.008
Constant	0.643***	0.362	1.935***	0.443
Age	0.002	0.005	0.002	0.007
Gender	0.022	0.099	0.120	0.122
Seniority	0.001	0.007	0.004	0.008
Caring climate	0.386***	0.072	0.260**	0.088
Formal climate	0.254**	0.077	0.147	0.094
Distributive justice	0.156*	0.056	−0.067	0.069
	R^2 = 38.2%		R^2 = 33.4%	

Notes: $N = 201$, **$p < 0.01$, ***$p < 0.001$

between all ethical variables and intent to leave work disappeared, suggesting full mediation. Thus, Hypothesis 2 was partially supported: Affective commitment mediated the relationship between caring climate, formal climate, distributive justice, and intent to leave work. This hypothesis was only partially supported because we had hypothesized that in addition to the mediating effect for intent to leave, we would find a modest mediating effect concerning lateness and absence, which we did not find.

As we explained before, the study model was also illustrated by SEM in order to represent all the three withdrawal behaviors and control variables in the same figure. The SEM's model with completely standardized path coefficients for the model is presented in Figure 2. According to Chen et al. (2008) and Hu and Bentler (1999), there is a need to use several GOF (Goodness of Fit) measures in order to minimize the error rate in the suggested model. In the present study, all the calculated GOF measures show a well goodness of fit with the data, $X^2 = 38.97$, $p = 0.15$; $X^2/\text{df} = 1.26$; RMSEA = 0.036; NFI = 0.915; CFI = 0.93; IFI = 0.95; TL = 0.95. The overall model explained 40% of the variance in affective commitment, 10% of the variance in normative commitment, and 21% in intent to leave work.

Similar to correlations findings, Figure 2 illustrated that all ethical variables were positively and significantly related to each other ($0.31 < r < 0.44$, $p < 0.001$). In relation to the mediating effect, Figure 2 indicated positive and significant relationships between caring and formal climate and each dimension of organizational commitment. Only distributive justice was found to be related only to affective (but not to normative) commitment. Furthermore, only the relationship between affective (but not normative) commitment and intent to leave work was negatively and significantly related ($\beta = -0.45$, $p < 0.001$). The direct relationships between the ethical variables and withdrawal behaviors were not significant in the presence of organizational commitment dimensions. Thus, the SEM illustration (Figure 2) demonstrates the partial support of Hypothesis 2 which was found in the Hierarchical Multiple Regressions results, regarding the mediating effect (above).

A positive relationship was found between lateness and absence frequency ($\beta = 0.34$, $p < 0.001$), and a negative relationship was found between absence frequency and intent to leave work ($\beta = -0.11$, $p < 0.05$). No significant relationship was found between lateness and intent to leave work. Males tended to be late more frequently than females and seniority weakly related to absence frequency.

TABLE III

Hierarchical Multiple Regression Analyses: mediation of the relationship between the study variables and withdrawal behaviors by affective and normative commitment

	Step 1: The relationship between independent variables and withdrawal behaviors						Step 2: Step 1 including affective and normative commitment					
	Lateness		Absence frequency		Intent to leave		Lateness		Absence frequency		Intent to leave	
	B	SE	*B*	SE	*B*	SE	*B*	SE	*B*	SE	*B*	SE
Constant	0.723★★★	0.192	0.237	0.162	3.098★★★	0.346	0.723★★★	0.192	0.237	0.162	3.098★★★	0.346
Age	0.002	0.006	0.001	0.005	−0.004	0.011	0.002	0.006	0.001	0.005	−0.004	0.011
Gender	−0.264	0.118	0.098	0.101	−0.702	0.205	−0.264	0.118	0.098	0.101	−0.702	0.205
Seniority	0.004	0.008	0.005	0.006	−0.006	0.014	0.004	0.008	0.005	0.006	−0.006	0.014
Constant	0.981★	0.506	0.426	0.406	6.287★★★	0.705	0.777	0.539	0.464	0.429	6.750★	0.718
Age	0.001	0.006	0.001	0.005	−0.014	0.01	0	0.006	0.001	0.05	−0.013	0.01
Gender	−0.258	0.12	0.089	0.102	−0.571	0.194	−0.264	0.12	0.091	0.102	−0.552	0.187
Seniority	0.006	0.009	0.007	0.007	0.013	0.013	0.005	0.009	0.007	0.007	0.013	0.013
Caring climate	0.051	0.091	0.061	0.073	−0.187★	0.141	0.015	0.102	0.024	0.083	0.046	0.148
Formal climate	−0.028	0.105	−0.143	0.082	−0.395★★	0.149	−0.05	0.11	−0.166	0.085	−0.243	0.149
Distributive justice	−0.077	0.077	0.045	0.062	−0.261★	0.109	−0.069	0.079	0.028	0.062	−0.176	0.108
Affective commit.							0.03	0.107	0.128	0.088	−0.568★★★	0.148
Normative commit.							0.087	0.084	−0.07	0.066	−0.051	0.121
	R^2 = 22.8%		R^2 = 21.6%		R^2 = 45.1%		R^2 = 25%		R^2 = 26%		R^2 = 52.4%	

Note: $N = 201$, ★$p < 0.05$, ★★$p < 0.01$, ★★★$p < 0.001$, [a]men = 0, women = 1.

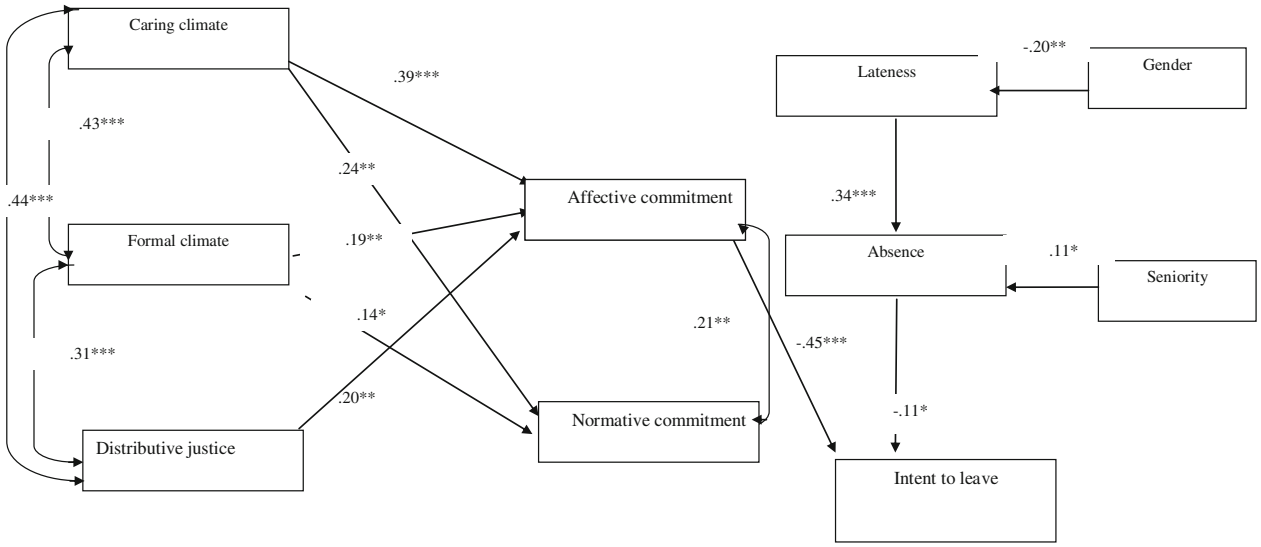

Figure 2. The mediating effect of affective commitment between organizational ethics and withdrawal behaviors ⋆$p < 0.05$, ⋆⋆$p < 0.01$, ⋆⋆⋆$p < 0.001$, [a]men = 0, women = 1.

Discussion

Nurses are at the forefront of healthcare services. It is thus vital to discover what may impact their withdrawal behaviors syndrome. Since previous studies both outside of Israel and among Israeli employees indicate that ethical perceptions affect organizational commitment and withdrawal behaviors such as lateness, absence, and intent to leave (Cohen and Freund, 2005; Gaziel, 2004; Luchak and Gellatly, 2007; Somers, 2009; Wasti, 2003), we therefore, simultaneously considered three withdrawal behaviors (lateness, absence, and intent to leave work) and three organizational ethics indicators (caring climate, formal climate, and distributive justice). Affective commitment was shown to be a factor that helps explain these relationships only as a mediator for intent to leave work but not for lateness and absence. These findings emphasize the legitimacy of focusing on specific withdrawal behaviors instead of aggregating them under a single general concept such as job withdrawal.

The fact that the mediating effect of organizational commitment was found only for intent to leave work but not for the other withdrawal behaviors may be explained by several reasons: first, in contrast to both lateness and absence, which reflect actual work behaviors, intent to leave work represents an inner psychological state, where nurses experience behavioral intentions directed toward their workplace. Based on Rousseau's (1995) social exchange theory, it is conceivable that the intent to leave work, which represents an intention to behave, will be more firmly related to the nurses' ethical perceptions than to lateness and absence, which represent actual behaviors. Second, based on the progressive model which assumes that intent to leave is a more severe withdrawal behavior than lateness or absence, we believe that the long term ideology-infused component, the dominant component of the psychological contract and an intrinsic motivational factor, will affect the most long term of the withdrawal behaviors, namely, intent to leave. Third, in the Israeli context, it seems that nurses will choose less to be late or absent because of the Israeli health system which is characterized by rules and regulations in the case of unjustified lateness or absence (e.g., deducting from nurses' salaries). Given the fact that the nurses' lateness or absence can be directly observed by their environment (e.g., co-workers, head nurses, and medical doctors), the nurses' negative perceptions of the organizational ethics would have almost no effect on their lateness or absence because of the strict enforcement of the regulations

involved. However, behaviors that are discretionary, such as intent to leave, which cannot be directly observed by the nurse's environment, can be affected adversely to some extent in response to negative ethical perceptions about the workplace.

The study findings are inconsistent both with Josephson et al. (2008), who found that similar predictors, such as being subjected to social exclusion or negative consequences of organizational change, are predictors of both absence and intent to leave the workplace, and with Podsakoff et al's (2007) meta-analysis which demonstrates that different predictors affect the same withdrawal behaviors. In their meta-analysis, they demonstrate that stressors account for a significant amount of variance in turnover intention, turnover, lateness, and absence as a result of indirect effects through strain, job satisfaction, and organizational commitment.

On the other hand, Somers' (2009) study, which was conducted on a sample of 288 hospital nurses, supports the present findings. Somers found that lateness and absence produced weaker results than turnover intentions when taking affective and normative commitment into account. Furthermore, Carraher and Buckley (2008) conducted a study on a sample of 386 nurses and found that perceptions of distributive justice were significantly related to turnover, but not to absenteeism.

The social exchange theory (Rousseau, 1995) can be used to argue that when nurses are disenchanted by the ethics of their hospital, they may reduce their commitment and entertain thoughts of leaving, a mind-set which implies a diversion of energy and time which may be spent on a job search. Although the intent to leave work is unquestionably a legitimate attitude on the part of employees, the management may perceive it as involving an unethical element, because intent to leave may lead the employee to less investment in the organization.

The finding that a caring climate appeared together with affective commitment as predictors of intent to leave work is not surprising in a health context, where care for patients is a predominant value and the ideology component is a dominant factor in the psychological contract. The finding that the formal climate may also affect intent to leave work may be explained by the bureaucratic health system and the nurses' response to bureaucratic formalism. In this case, rules and regulations are not perceived as necessarily symbolizing rigidity, but rather may be seen as protective mechanisms for ensuring transparency and fair treatment of the nurses.

The direction of the mediating effect and the interrelations of the ethical perceptions afford credence to our integrative approach, where these ethical perceptions were considered within a single cohesive theoretical framework. This integrative approach to perceptions of organizational ethics contributes to the existing literature, since the three ethical perceptions were traditionally studied separately with reference to employees' withdrawal behaviors.

In the present study, affective commitment may have been more sensitive than normative commitment to perceptions of organizational ethics because of the emotional element in the former. Nurses who perceive their workplace as ethical may reciprocate with feelings of gratitude and appreciation, which are probably linked to emotional attachment more than to a sense of obligation (normative commitment) (Peterson, 2002).

Our findings demonstrate that each behavior retains its unique characteristics, as attested by each withdrawal symptom being related to a different variable (or set of variables). For example, males were late more often than females, while seniority was related only to absence frequency. Studies focusing on gender career choice showed that one of the main considerations of female employees is that working conditions suit the traditional female role and reduce their work–family conflict (WFC) (Boyar et al., 2005; Ladebo, 2005). It, therefore, seems that female nurses try to keep their jobs by making an effort to be on time more than males do.

Furthermore, studies showed that years of service (seniority) affect voluntary absence (Ingersoll, 2004; Liu and Meyer, 2005). At an advanced stage in the nursing career, high seniority involves tenure and eligibility for social benefits, which make it harder to fire employees. This may explain why longer seniority was correlated with higher voluntary absence.

A closer examination of the study results may support the existence of different withdrawal behavior relationships. The fact that a positive relationship was found between lateness and voluntary absence may support a partial progressive model

which posits that withdrawal behaviors occur in progression (e.g, starting with lateness and then moving to absence). The relationship is defined as partial because a low negative relationship was observed between voluntary absence and intent to leave work. The fact that a negative relationship was found between voluntary absence and intent to leave may support the partial compensatory model. It is defined as partial because a negative relationship was not found between lateness and absence frequency. In any case, the negative relationship that was found between voluntary absence and intent to leave does not contradict the established theory that voluntary absence is considered less severe withdrawal behavior than intent to leave. The independent forms model which suggests that withdrawal behaviors are unrelated was not supported, since significant relationships were found between the withdrawal behaviors.

In summation, considering previous studies (Deshpande, 2009; Purvis and Cropley, 2003) which indicate that unethical behavior by employees can negatively impact not only public trust and the reputation of the hospital, but also its long-term financial soundness, the findings of this study have serious implications for healthcare managers and administrators.

Implications of the findings

Theoretically, the present study contributes to the knowledge on nurses' perceptions of the psychological contract based on the relationship between ethical perceptions, organizational commitment, and withdrawal behaviors, by simultaneously considering various aspects of ethics and different withdrawal behaviors in the workplace. Previous studies usually focused on one dimension of ethical perception or of withdrawal behavior at a time, whereas the present results offer an integrative framework and focus attention on the mediating role of organizational commitment as a consistent link between a spectrum of ethical perceptions and nurses' withdrawal behaviors.

Practically, hospitals should promote high standards of caring, formal climate, and distributive justice which may improve their contribution to the psychological contract, especially to the ideology-infused component, which may ultimately increase nurses' affective commitment. In the long term, nurse management may find that the psychological contract offers their nurses a powerful means of professional leverage in their aim of ''keeping their nurses'', despite the economical, political, and bureaucratic constraints under which they work. Promoting the ethical environment, which may increase nurses' commitment, may reduce not only nurses' intent to leave but also impact on turnover at the hospital, thus saving money to the health system.

Improving the ethical atmosphere in the organization may be achieved through leaders and nurses workshops that focus on ethics education and this may encourage an environment where ethical considerations become part of the decision-making process of the nurses. As recent studies have shown, education in ethics had a significant impact on the ethical behavior of hospital employees and can help reduce moral stress and improve patient care (Deshpande et al., 2006; Hanson, 2005). Our findings suggest broadening the ethics modules in nursing schools by teaching healthcare and ethics in an integrative approach in order to address ethical issues that nurses might face in the workplace.

Strengths, limitations, and future study

This article attempted to explain an integrative phenomenon with variables and constructs that have usually been presented separately in the literature, thereby presenting an innovative approach to withdrawal behaviors. Methodologically, this study was based on nurses' self-reports, hospital records, and appointing separate time intervals to measure each behavior which allowed for uncontaminated measures in the model, which may strengthen the accuracy and quality of the study.

This study suffers from several limitations and the findings should be viewed with some caution. The sample was drawn from the nursing population in one hospital. This is a limited sample which may consider our study as an exploratory study. Thus, the findings should be tested as to whether they can be applicable to other hospitals and occupations in Israel. In addition, one must consider the generalizability of research based on a framework developed in one nation and whether it will prove valid in other countries.

Although predictors such as organizational ethics and organizational commitment seem to be most appropriate for voluntary behaviors (Koslowsky, 2009), it is often difficult to classify a particular incident as an example of voluntary or involuntary withdrawal behavior. In any case, the present study attempted to cover a large number of withdrawal behaviors by postulating the existence of several types of antecedents where one or a combination of them may provide an adequate explanation.

A basic argument in the study model is the direction of causality that emanates from ethical perceptions which relate to organizational commitment, and which in turn affect withdrawal behaviors. The causal flow in the literature is generally uni-directional (Koslowsky, 2009). However, investigators have argued that a causal effect in the opposite direction is also a reasonable expectation (Clegg, 1983). The present study's design of a two-phase study at different points in time supports the causal (uni-directional) model which argues that work perceptions lead to behaviors.

As we have maintained, psychological contracts can be violated not only when the hospital abandons its obligations to provide economic and socio-emotional support to the nurses but also when the hospital fails to fulfill an implied ideological obligation. Since we may assume that negative ethical perceptions may lead to ideology contract breach, future studies should attempt to study more deeply the relationship between nurses' ethical perceptions, ideological contract, organizational commitment, and withdrawal behaviors.

Concerning the changes in employees' perceptions regarding their professional ideology and the COR model, which points out the advantages of lateness and absence, we encourage developing studies to find whether withdrawal behaviors affect patient care and harm patient treatment, and if so, how and in which cases. This future study is significant, considering the theoretical background whereby most research studies assume that withdrawal behaviors are undesirable (e.g., Blau et al., 2004; Carraher and Buckley, 2008; Johns, 2003; Koslowsky, 2009; Lambert and Hogan, 2009). This is especially so when we consider a severe withdrawal behavior (intent to leave), which may be causing the current shortage of nurses in Israel and many other countries (Borda and Norman, 1997; Coomber and Barriball, 2007; Ehrenfeld et al., 2007; Fawcett et al., 2007; Krausz et al., 1995).

In addition, although traditionally, withdrawal behaviors have been of interest to administrators because of their associated cost, future studies should investigate whether these costs may be balanced against the benefits of employees' withdrawal behaviors although these benefits are difficult to measure directly. In the case of nursing, the potential losses associated with the use of overtired nurses, poor service, and errors caused by overwork are not hard to imagine.

Finally, although our findings indicate that the theoretical mechanism only considers intent to leave, the general framework could be used as a basis for future theory building. In fact, the findings considering the difference between the various withdrawal behaviors and their interrelations suggest that the theory is incomplete and that scholars should consider, in addition to ethics, other models such as the conservation of resources model and additional variables such as burnout, challenges, and hindrances stressors.

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