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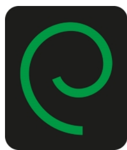

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Occupational power differentiates employee impacts under continuing change

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Abstract

Purpose – The purpose of this paper is to investigate whether occupational social contexts differentiate the processing of changes in the employment relationship, as represented by the psychological contract. Specifically, this study investigates the impact of the psychological contract and justice, with negative affectivity (NA), on medical practitioners or administrative staff in healthcare.

Design/methodology/approach – Samples of 54 medical practitioners (30 percent) and 122 administrative staff (59 percent), primarily providing public services, responded to a cross-sectional survey. Data were analyzed using multiple regression analyses.

Findings – Among medical staff, psychological contract obligations were associated with lower commitment and psychological distress, whereas fulfillment was associated with higher commitment and job satisfaction, yet higher distress. Distributive justice was associated with lower distress, and NA was associated with higher distress. Among administration staff, fulfillment was associated with commitment and job satisfaction, and NA was associated with lower job satisfaction and higher distress. Essentially, reforms are likely to have more impact on less powerful occupations.

Practical implications – Psychological contract fulfillment is a key predictor of hospital employees' commitment and satisfaction, placing clinicians, particularly, under pressure. To retain employees, hospitals must keep their promises. Further, occupational power activates the role of obligations, with practitioners having negative outcomes and holding the organization to account until the obligations are fulfilled.

Originality/value – This study highlights the differential nature of the psychological contract among healthcare employee groups, with differences depending on occupational power.

Keywords Justice, Job satisfaction, Organizational commitment, Psychological contract, Psychological distress, Occupational power

Paper type Research paper

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Introduction

Healthcare is an industry in almost constant change (Greener, 2005; Rodwell and Teo, 2008), resulting in the public services being transformed over the last two decades across several countries such as the UK and Australia (Thomas and Davies, 2005). For example, in the Australian context, reforms include those from the National Health and Hospitals Reform Commission (2009). Studies examining these changes at the employee level have found that despite, or because, the changes are intended to increase efficiency and reduce costs, there are negative effects on employee-level outcomes (Brunetto *et al.*, 2010; Korunka *et al.*, 2003; Teo *et al.*, 2012).

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Organizational changes influence individual employees and their perceptions and expectations about their relationship with the organization, often altering the mutual obligations between employee and employer, their psychological contract (Schalk and Freese, 2000). Therefore, the concept of the psychological contract is a key starting point to examine processes occurring at the employee level during organizational change (Schalk and Freese, 2000). However, most of the organizational change literature fails to consider the diversity of participants in change programs, treating them as homogenous (Martin *et al.*, 2006).

Organizational change tends to increase the salience of employees' group identities, particularly for the most powerful occupation within healthcare (Greener, 2005) – the doctors, who can be contrasted to other occupations in healthcare, such as administration (Martin *et al.*, 2006). These power differences embodied in the respective occupations have been found to be associated with oppressed group behavior in healthcare (DeMarco and Roberts, 2003) and, in terms of organizational change, the lower status staff may experience greater threat of negative consequences than higher status staff (Martin *et al.*, 2006).

Similarly, the psychological contract is based on social exchange theory, where individuals are motivated by maintaining a balance between inputs and outputs as part of an ongoing process of exchange (e.g. Homans, 1958). Yet, the social context profoundly affects the social exchange, particularly in terms of the roles of participants, group standards, the nature of collectives, differences in power and the overlapping nature of exchanges (Blau, 1964). Over time the impact of the social context is that the processes of "exchange relations become differentiated," where the individuals with substantial power and resources are less responsive to social forces (Blau, 1964, p. 128). Consequently this study investigates the nature of these differentiated social contexts, by considering occupations at differing ends of the hierarchical power structure in terms of their employment relationship, as embodied at the employee level by the psychological contract, within a continuously changing healthcare context.

The psychological contract

The psychological contract is an employee's beliefs regarding entitlements agreed to by their employer, providing they fulfill their own obligations (Rousseau, 1990). Unlike formal or implied contracts, the psychological contract is inherently perceptual (Robinson, 1996). Psychological contracts have the elements of obligations/promises, fulfillment and breach (Anderson and Schalk, 1998). Obligations are employee beliefs of what the organization is obliged to do based on organizational promises (Robinson, 1996). Whereas fulfillment assesses specific obligations (e.g. promotion and advancement, or training and pay; Rousseau, 1990) and breach assesses the extent to which obligations are broken at a broad level (Gakovic and Tetrick, 2003). That is, the degree of fulfillment indicates the level of promised obligations received, but breach assesses the extent to which the promises are perceived as broken.

The psychological contract predicts a range of key outcomes across various occupations, including organizational commitment (an indicator of turnover), job satisfaction and psychological distress (Mallette, 2011; Robbins *et al.*, 2012; Sturges *et al.*, 2005; Tekleab *et al.*, 2012). Psychological contract obligations have been linked with job satisfaction and intent to leave (Tekleab *et al.*, 2012), while fulfillment has been linked with organizational commitment, job satisfaction and organizational citizenship behavior (Lambert *et al.*, 2003; Sturges *et al.*, 2005). Psychological contract breach is thought to have more intensely negative outcomes and is associated

with mistrust of management, feelings of violation, lowered job satisfaction and organizational commitment, and increased intent to leave (Zhao *et al.*, 2007). More recently, breach has also been linked with poor employee health (Robbins *et al.*, 2012). Yet, how employees react to psychological contract breach can be influenced by their evaluation of organizational justice (Robinson and Morrison, 2000).

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Organizational justice

Organizational changes, such as those under NPM, are likely to impact perceptions of justice, either in terms of resource allocation (distributive justice), process fairness (procedural justice) and interactional justice, given the importance of leadership and communication in change (Cobb *et al.*, 1995). There are four types of justice: procedural, distributive, interpersonal and informational (Colquitt, 2001). Procedural justice is concerned with the perceived fairness of procedures leading to employers' decisions, while distributive justice refers to the fairness of the decisions themselves. Interpersonal justice concerns the perceived treatment and respect one receives from their employer, while informational justice concerns the amount and adequacy of the information one receives from their employer regarding organizational decisions. Organizational justice is inherent to organizational change with the equity-based practices common in pay-for-performance systems and the general allocation of resources impacting distributive justice (Cobb *et al.*, 1995).

Organizational justice is associated with employee attitudes such as job satisfaction and organizational commitment (Colquitt *et al.*, 2001), and poor employee health, in particular mental health (Robbins *et al.*, 2012). Perceived justice can reduce employees uncertainty, particularly during periods of stress (Judge and Colquitt, 2004). Among healthcare employees, organizational injustice has been associated with increased distress (Sutinen *et al.*, 2002). Of the four types of justice, distributive justice has been found as the type most strongly linked with mental health outcomes, possibly because distributive justice concerns perceptions of outcomes and rewards rather than the processes by which these are decided (Robbins *et al.*, 2012).

However, if employees perceive a psychological contract breach, yet feel that the organization acted fairly, justice acts as a mitigating influence on employee outcomes (Turnley and Feldman, 1999). Alternatively, breach may increase negative outcomes if the employee feels the organization acted unfairly (Morrison and Robinson, 1997). Although the moderating effects of justice on psychological contract breach have been suggested numerous times, few papers have investigated possible interactions between psychological contract breach and organizational justice, and of those that have done so, not all justice types are included (e.g. Tekleab *et al.*, 2005; Turnley and Feldman, 1999). Rather, an investigation into all types of justice and the psychological contract is required.

Negative affectivity (NA)

Both the psychological contract and organizational justice are perceptual and subsequently the role of individual differences in perceptions is likely to be important (Turnley and Feldman, 1999). Consequently, key perceptual influences, such as NA, may need to be included in investigations of such constructs, especially in studies with stress-related variables (Burke *et al.*, 1993). NA is a dispositional trait, where those with high NA tend to be more frequently worried, distressed and upset than those low in the trait (Watson *et al.*, 1988). Those high in NA may be more likely to respond negatively, and to a greater extent, to a perceived breach of the psychological contract (Turnley and Feldman, 1999). Further, although few studies have investigated NA

in relation to employee perceptions of fairness, initial evidence suggests that NA is an influential factor, and should be considered (Turnley and Feldman, 1999). Therefore, in examining the effects of psychological contract and justice on employee outcomes, it would be beneficial to also consider the effects of NA.

The current study

Organizational changes alter the psychological contract at the employee level (Schalk and Freese, 2000), yet most of the organizational change literature does not consider the diversity of participants in change programs (Martin *et al.*, 2006) despite individuals with substantial power and resources being able to differentiate their exchange relations (Blau, 1964). A context with large differentials of social context in terms of occupation is healthcare, which has an occupationally oriented hierarchical structure, where medical practitioners are a relatively powerful occupation and non-executive administrative staff are lower in the hierarchy (Ellefsen and Hamilton, 2000).

The nature of the differentiation in social exchange processes is operationalised in this study by investigating the relationship between the psychological contract (i.e. obligations, fulfillment and breach), organizational justice (i.e. procedural, distributive, informational and interpersonal) and NA, as influences on organizational commitment, job satisfaction and psychological distress for medical practitioners and administrative staff, respectively.

Psychological contract obligations and fulfillment, and organizational justice are hypothesized to be positively associated with organizational commitment and job satisfaction, and negatively associated with psychological distress. Conversely, it was hypothesized that psychological contract breach and negative affectivity would be positively associated with psychological distress, and negatively associated with organizational commitment and job satisfaction. Differences in the pattern of relationships between the two occupational groups will be explored.

Methodology

Participants

The sample consisted of medical practitioners and administrative staff employed at a large maternity hospital and its associated facilities, primarily providing public services and paid for conducting public work, in a metropolitan location in Australia. Paper surveys were distributed to each facility through their internal mail system and responses received. A response was received from approximately 30 percent ($n = 68$) of the medical practitioners and 59 percent ($n = 150$) of the administrative staff over a two week period. For the medical practitioners, 40 of the respondents were female and 28 were male. Most of the medical respondents had been employed by the organization for nine years or less (87 percent), with 29 percent having been employed with the organization for less than 12 months, 37 percent between one and four years and 21 percent between five and nine years. Of the 150 administrative staff who responded, 140 were female and ten were male. Approximately 24 percent had been employed by the organization for less than 12 months, 29 percent for one to four years, 24 percent for five to nine years and 23 percent for ten years or more.

Measures

Psychological contract. Psychological contract breach was measured using the five items of perceived breach from Robinson and Morrison (2000), and psychological

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contract obligations and fulfillment were measured using two seven-item subscales from Rousseau (1990). For the breach items participants indicated how much they agreed with statements about their psychological contracts (e.g. "my employer has fulfilled the promises made when hired") on a five-point rating scale from 1 (Disagree strongly) to 5 (Agree strongly). The obligations and fulfilment scales used the same seven items (e.g. "pay based on current level of performance"). Participants rated the degree they felt the organization owed them the item from 1 (Not at all obligated) to 5 (Very obligated) and fulfilled its obligations in providing the item from 1 (Not at all fulfilled) to 5 (Very well fulfilled).

Organizational justice. Organizational justice was measured using a 20-item measure developed by Colquitt (2001), composed of four subscales: procedural, distributive, interpersonal and informational justice. Items were rated across five-points from 1 rarely to 5 very often.

Negative affect. NA was measured using the negative subset of ten items from the Positive and Negative Affect Schedule (Watson *et al.*, 1988). Each item named an emotion (e.g. "scared" or "upset") asking participants to report how often they had experienced the emotion over the previous week on a five-point scale ranging from 1 (Very slightly or not at all) to 5 (Very much).

Organizational commitment. Organizational commitment was measured using an eight item affective commitment scale developed by Allen and Meyer (1990). Participants indicated the degree each statement (e.g. I really feel as if this organization's problems are my own) reflected their point of view on a five-point rating from 1 (Disagree strongly) to 5 (Agree strongly).

Job satisfaction. Job satisfaction was measured using a six-item job satisfaction scale developed by Agho, Price, and Mueller (1992), scoring statements (e.g. "I find real enjoyment in my job") on a five-point rating from 1 (Strongly disagree) to 5 (Strongly agree).

Psychological distress. Psychological distress was measured using the ten-item Kessler-10 (Kessler *et al.*, 2002) where participants rated how often they experienced issues relating to health in the past 30 days (e.g. "did you feel so restless you could not sit still?") from 1 (All the time) to 5 (None of the time).

Data analysis

Medical practitioners. Prior to analyses, 13 participants were excluded due to missing over a third of values for any scale. After excluding univariate and multivariate outliers, $n = 53$ for organizational commitment and psychological distress and $n = 54$ for job satisfaction. The mean, standard deviation and Cronbach's α coefficients were calculated, along with the correlations between variables and are presented in Table I.

Administrative staff

Prior to analyses, 25 participants were excluded due to missing over a third of values for any scale. After excluding univariate and multivariate outliers, $n = 121$ for organizational commitment, $n = 122$ for job satisfaction and $n = 120$ for psychological distress. The mean, standard deviation and Cronbach's α coefficients were calculated for each study variable with this sample of participants, along with the correlations between variables and are presented in Table II.

Preliminary statistics checked for missing data, outliers and the assumptions of multiple regression analyses (Tabachnick and Fidell, 2007), indicating that a square

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Variables	M	SD	1	2	3	4	5	6	7	8	9	10	11
1. Negative affect	15.53	5.04	(0.83)										
2. Psychological contract breach	13.39	4.04	0.26	(0.85)									
3. Psychological contract obligations	22.72	5.54	0.20	0.12	(0.85)								
4. Psychological contract fulfillment	20.78	5.46	−0.23	−0.36	0.23	(0.85)							
5. Procedural justice	19.00	6.56	−0.35	−0.58	−0.10	0.53	(0.87)						
6. Distributive justice	11.43	4.36	−0.20	−0.44	−0.10	0.48	0.63	(0.89)					
7. Interpersonal justice	15.50	3.60	−0.24	−0.47	−0.06	0.48	0.61	0.52	(0.90)				
8. Informational justice	15.83	6.00	−0.30	−0.55	−0.24	0.46	0.66	0.68	0.77	(0.94)			
9. Organizational commitment	23.87	6.65	−0.31	−0.36	−0.27	0.56	0.46	0.26	0.37	0.44	(0.88)		
10. Job satisfaction	23.80	4.95	−0.37	−0.36	−0.03	0.50	0.32	0.25	0.20	0.33	0.53	(0.89)	
11. Psychological distress	15.81	5.40	0.33	0.33	0.10	−0.18	−0.32	−0.33	−0.17	−0.29	−0.22	−0.49	(0.89)

Note: Cronbach α coefficients are in parentheses on the diagonal

Table I. Means, standard deviations, correlation coefficients and Cronbach's α coefficients for the medical sample

Variables	M	SD	1	2	3	4	5	6	7	8	9	10	11
1. Negative affect	15.25	5.39	(0.86)										
2. Psychological contract breach	12.41	4.37	0.29	(0.87)									
3. Psychological contract obligations	21.30	6.09	0.06	0.06	(0.89)								
4. Psychological contract fulfillment	19.28	5.16	−0.08	−0.43	0.24	(0.87)							
5. Procedural justice	19.46	7.26	−0.17	−0.42	0.00	0.40	(0.93)						
6. Distributive justice	9.86	4.52	−0.13	−0.57	−0.10	0.53	0.59	(0.94)					
7. Interpersonal justice	15.47	4.55	−0.18	−0.43	0.05	0.48	0.59	0.48	(0.95)				
8. Informational justice	17.18	5.80	−0.13	−0.43	−0.05	0.44	0.70	0.55	0.80	(0.95)			
9. Organizational commitment	25.95	6.19	−0.20	−0.49	0.09	0.44	0.35	0.41	0.29	0.28	(0.84)		
10. Job satisfaction	20.84	5.30	−0.24	−0.34	0.04	0.38	0.27	0.39	0.15	0.13	0.59	(0.90)	
11. Psychological distress	15.85	5.19	0.75	0.15	0.02	0.05	−0.07	−0.03	0.00	0.01	−0.20	−0.34	(0.88)

Note: Cronbach α coefficients are in parentheses on the diagonal

Table II. Means, standard deviations, correlation coefficients and Cronbach's α coefficients for the administrative sample

root transformation of NA was required for the psychological distress regression for the medical staff and a square root transformation of NA was required for the job satisfaction regression for the administrative staff. For each occupational group, three hierarchical multiple regressions were conducted using psychological contract

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variables (i.e. breach, obligations and fulfillment), justice variables (i.e. procedural, distributive, interpersonal and informational) and NA to predict each outcome (i.e. organizational commitment, job satisfaction and psychological distress). Centered variables were used to create interaction variables between psychological contract breach and each of the justice variables (Tabachnick and Fidell, 2007). For each outcome, the block order of variables entered into the multiple regression equation was: negative affect, psychological contract and justice variables and interaction variables.

Results

Medical practitioners

The final regression models presented in Table III explained a statistically significant amount of variance in organizational commitment ($R^2_{adj} = 0.54^2$, $F(12, 40) = 6.12$, $p < 0.001$), job satisfaction ($R^2_{adj} = 0.211$, $F(12, 41) = 2.18$, $p = 0.032$) and psychological distress ($R^2_{adj} = 0.620$, $F(12, 40) = 8.07$, $p < 0.001$). Psychological contract obligations were associated with lower organizational commitment ($B = -0.47$, $p < 0.001$), and lower psychological distress ($B = -0.23$, $p = 0.027$), while psychological contract fulfillment was associated with higher organizational commitment ($B = 0.72$, $p < 0.001$) job satisfaction ($B = 0.52$, $p = 0.005$) and psychological distress ($B = 0.25$, $p = 0.046$). Of the organizational justice variables, distributive justice was associated with lower psychological distress ($B = -0.32$, $p = 0.017$). NA was associated with higher psychological distress ($B = 0.68$, $p < 0.001$).

Administrative staff

The final regression models explained a statistically significant amount of variance in organizational commitment ($R^2_{adj} = 0.300$, $F(12, 108) = 5.28$, $p < 0.001$), job satisfaction ($R^2_{adj} = 0.228$, $F(12, 109) = 3.98$, $p < 0.001$) and psychological distress ($R^2_{adj} = 0.612$, $F(12, 107) = 16.61$, $p < 0.001$). Psychological contract fulfillment was

(Step) Variable	Organizational commitment			Job satisfaction			Psychological distress		
	B	SE B	β	B	SE B	β	B	SE B	β
(1) Negative affect	0.02	0.14	0.01	−0.21	0.13	−0.21	5.75	0.80	0.68**
(2) Psychological contract breach	−0.29	0.23	−0.17	−0.29	0.22	−0.24	0.29	0.15	0.24
(2) Psychological contract obligations	−0.57	0.14	−0.47**	−0.06	0.13	−0.06	−0.21	0.09	−0.23*
(2) Psychological contract fulfillment	0.89	0.17	0.72**	0.47	0.16	0.52*	0.23	0.11	0.25*
(2) Procedural justice	0.11	0.16	0.11	−0.06	0.15	−0.08	−0.06	0.10	−0.08
(2) Distributive justice	−0.41	0.22	−0.26	−0.10	0.21	−0.09	−0.36	0.14	−0.32*
(2) Interpersonal justice	−0.18	0.34	−0.10	−0.48	0.34	−0.35	0.19	0.24	0.14
(2) Informational justice	0.15	0.22	0.13	0.20	0.21	0.25	0.03	0.14	0.04
(3) Breach × Procedural justice	−0.01	0.04	−0.06	0.00	0.04	0.00	−0.02	0.03	−0.13
(3) Breach × Distributive justice	0.10	0.07	0.28	0.03	0.06	0.11	−0.04	0.04	−0.17
(3) Breach × Interpersonal justice	0.06	0.12	0.14	0.05	0.11	0.15	0.14	0.08	0.44
(3) Breach × Informational justice	−0.07	0.07	−0.25	−0.04	0.07	−0.19	−0.05	0.05	−0.26

Notes: For the regression on psychological distress, NA has been subject to a square root transformation. *$p < 0.05$; **$p < 0.001$

Table III. Results of multiple regression analyses for the medical practitioners

associated with higher organizational commitment ($B = 0.36, p = 0.002$) and job satisfaction ($B = 0.34, p = 0.003$). NA was associated with lower job satisfaction ($B = -0.17, p = 0.048$) and higher psychological distress ($B = 0.81, p < 0.001$). The results of the multiple regressions for the administrative staff are presented in Table IV.

Discussion

The pattern of results observed in this study suggests that among both the medical practitioners and administrative staff, the psychological contract is important for work-related outcomes. Among medical practitioners, it appears the psychological contract is also important for health-related outcomes. With regard to organizational justice, contrasting past research indicating the two constructs are quite similar (e.g. Robbins *et al.*, 2012), among these samples justice did not lead to similar outcomes. Only among medical practitioners did justice have any effect. NA led to work and health-related outcomes among both occupational groups. The differences in the pattern of relationships between the two groups indicates that occupational power influences the effects of the psychological contract and demonstrates the utility of investigating the psychological contract among employees within the healthcare industry.

More specifically, the results suggest that psychological contract fulfillment is important for both medical practitioners and administrative staff. Both occupational groups reported higher organizational commitment and job satisfaction when they perceived their obligations as being fulfilled, which is consistent with past research (Lambert *et al.*, 2003; Mallette, 2011; Sturges *et al.*, 2005) and supported the hypothesis in regards to fulfillment leading to higher job satisfaction and organizational commitment. The perception of obligations did not influence any of the outcomes among administrative staff; however, among medical practitioners perceptions that the organization had made promises were associated with less organizational commitment, and less distress. These differences may be due to a power differential between the

(Step) Variable	Organizational commitment *B*	SE *B*	*β*	Job satisfaction *B*	SE *B*	*β*	Psychological distress *B*	SE *B*	*β*
(1) Negative affect	−0.03	0.09	−0.03	−1.40	0.70	−0.17*	0.72	0.05	0.81**
(2) Psychological contract breach	−0.30	0.15	−0.22	−0.15	0.14	−0.12	−0.04	0.09	−0.04
(2) Psychological contract obligations	−0.01	0.09	−0.01	−0.03	0.08	−0.03	0.02	0.05	0.03
(2) Psychological contract fulfillment	0.42	0.13	0.36*	0.34	0.11	0.34*	−0.02	0.08	−0.02
(2) Procedural justice	0.03	0.11	0.04	0.10	0.10	0.14	−0.03	0.07	−0.05
(2) Distributive justice	−0.01	0.16	−0.01	0.10	0.16	0.09	0.10	0.10	0.09
(2) Interpersonal justice	0.00	0.19	0.00	−0.02	0.17	−0.02	0.11	0.11	0.10
(2) Informational justice	0.07	0.16	0.06	−0.16	0.14	−0.18	−0.01	0.09	−0.01
(3) Breach × Procedural justice	−0.04	0.03	−0.17	0.00	0.02	−0.01	0.00	0.02	−0.01
(3) Breach × Distributive justice	−0.01	0.03	−0.04	−0.03	0.03	−0.11	0.03	0.02	0.11
(3) Breach × Interpersonal justice	0.01	0.04	0.05	−0.05	0.04	−0.17	0.02	0.02	0.08
(3) Breach × Informational justice	10.03	0.04	−0.11	0.01	0.03	0.05	0.00	0.02	−0.02

Notes: For the regression on job satisfaction, NA has been subject to a square root transformation. $*p < 0.05$; $**p < 0.001$

Table IV. Results of multiple regression analyses for the administrative staff

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groups, where for the medical practitioners they may not feel as obligated to perform at a high level, if they perceive the organization has an obligation that is yet to be fulfilled. However, when the obligations are fulfilled, medical practitioners are more committed and satisfied with their job. They are also more distressed, which may be as a result of feeling under pressure where they now need to give back to the organization and maintain their standard of work. These results highlight the nature of the psychological contract as an exchange between the employer and employee and indicate the utility in applying the psychological contract to employees in the healthcare industry.

The lack of a relationship between perceived breach and any of the outcomes is in contrast to previous research (Robbins *et al.*, 2012; Zhao *et al.*, 2007) and may reflect a selection artifact that further highlights the high occupational power of medical staff. That is, medical practitioners who are high in demand, particularly in a metropolitan location, who experienced a psychological contract breach may have left the organization prior to the survey period, which would result in the medical staff remaining at the time of the survey having no relationship between breach and the outcomes. For the administrative staff, however, the results are difficult to understand, as breach has been demonstrated to influence employee outcomes across a range of occupations (e.g. Robbins *et al.*, 2012; Zhao *et al.*, 2007), albeit not within a hospital setting. One suggestion may be that being a low power occupation within the hospital setting, administrative staff expect their contracts to be breached to some degree, thus when they are fulfilled they experience many positive outcomes as found above, but when they experience breach they are not affected, because some breach is expected – they are that oppressed.

In contrast to past research that has illustrated the importance of organizational justice among healthcare staff (e.g. Mallette, 2011) no relationship was found between procedural, interpersonal, or informational justice and the outcomes in this study in either of the occupational groups. This is perhaps surprising given that the psychological contract and organizational justice are conceptually related constructs (Robbins *et al.*, 2012), suggesting that among healthcare staff, employees are less concerned about organizational decision-making processes and outcomes and are more concerned about what was promised to them, and whether they receive it, particularly as this general pattern of results was evident across both groups.

Among medical practitioners, a relationship between distributive justice and psychological distress was apparent, where higher justice was associated with lower distress. That is, perceptions of inequity may affect personal distress levels among medical practitioners, but do not appear to affect work-related outcomes. Since medical practitioners are a relatively powerful occupation who may be involved in the hospital's decision making, their occupational power may have influenced the effect that organizational justice has been found to have in other contexts. Given that administrative staff are considered lower in the organizational hierarchy than other hospital employees (Ellefsen and Hamilton, 2000), it may be the case that these staff do not expect the same treatment. Similarly, the interactions did not influence any of the outcomes investigated, suggesting that among these occupations, organizational justice may not influence the effects of the psychological contract. However, more research is required in order to determine whether organizational justice does have a moderating effect on the psychological contract within this context, as has been suggested in other contexts (Morrison and Robinson, 1997; Robinson and Morrison, 2000).

For both occupational groups, NA was associated with psychological distress, and among administrative staff, also lowered job satisfaction. That is, individuals high in NA were more likely to score negatively on outcomes, particularly strain (Burke *et al.*, 1993). These results highlight the importance of considering this trait in research focussing on perceptual variables such as the psychological contract and organizational justice, and support the few studies that have found NA to be an important factor in this type of research (e.g. Turnley and Feldman, 1999).

Limitations

The most important limitation in the current study is the small sample. While a benefit of the current study was the focus on one organization and hence external influences such as variation between human resource policies (i.e. participants would be exposed to the same standards and policies) were controlled for, future research would benefit from larger sample sizes, which may be better attained by approaching multiple organizations. Further, the study was cross-sectional and thus the findings must be interpreted with caution. Longitudinal research would better demonstrate the effects of the psychological contract, and change to the employee relationship over time. Additionally, examining participants perceptions of change, and how they associate this change to the psychological contract would be beneficial.

Conclusion

With the organizational change literature often not considering the potential for participants in change programs to have differential mechanisms for processing change (extending Martin *et al.*, 2006), this study found that the occupation's social context differentially impacted employees' perceptions and expectations about their relationship with the organization. The results of this study suggest that occupation is a key contextual consideration for examining the impact of change on the psychological contract, which had previously only been proposed in more general terms (e.g. Schalk and Freese, 2000). Employees consistently experience positive outcomes when their psychological contract is fulfilled. Yet, in this hierarchical context, occupational power activates the role of obligations, with medical practitioners holding the organization to account until the obligations are fulfilled, but then placing themselves under pressure to meet their side of the exchange.

Consequently, hospital managers need to be careful what they promise, with medical practitioners being in high demand by employers and generally able to seek work elsewhere with ease. Conversely, lower status staff process more negative consequences than higher status staff, resulting in a more reactive response pattern. Overall, this study has highlighted the need to consider the differential processing of organizational change by occupation when implementing reforms in hierarchical contexts such as hospitals. Essentially, reforms are likely to have more of a negative impact on employees in less powerful occupations. However, across the board, to retain employees, hospitals must keep their promises.

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