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The Influence of Workload, Employee Silence and Trust in Management on Work Outcomes Among Australian Allied Health Workers During COVID-19

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ABSTRACT

Little research has been undertaken on one of the largest and, arguably, critical workforces in the health sector—Allied Health (AH) professionals. These professionals encompass a diverse range of healthcare experts, including radiographers, psychotherapists, and occupational therapists (excluding doctors, nurses, and paramedics), and they are frequently deployed in hospital settings as part of multidisciplinary teams. As such this research explores the impact on workload on this highly integrated group and their ability to work effectively. Through an online survey with both closed and open-ended questions, this study investigates the impact of increased workload on employee silence and its potential adverse effects on engagement and the intention to leave of this critical workforce - allied health professionals. The survey sample consisted of 1160 participants, including radiographers, psychotherapists, and occupational therapists, with 334 participants providing comments in the open-ended questions. We discovered that trust in management significantly moderates the detrimental effects of workloads on these variables, particularly the intention to leave. The findings of this research contribute to the human resource management (HRM) literature in two significant ways. First, our study enhances the employee silence literature by addressing issues under management's purview for control and change. Second, it advances our understanding of protective resources that can mitigate the negative consequences of workloads on employee silence, thereby bolstering engagement and retention intentions. It is important for an HRM audience as we argue that perceived workload expectations impact employee voice systems negatively where there is an erosion of trust with management. However, by building trust through open communication and feedback, HRM can decrease AH professionals' intention to leave.

1 | Introduction

The healthcare sector emerged as the critical frontline in the battle against COVID-19. Health workers faced substantial and demanding workloads during this period (Nancarrow and Borthwick 2021). One group within the healthcare system that remained somewhat understated throughout this crisis was Allied Health (AH) professionals. AH encompasses a broad range of health professionals such as radiographers, psychotherapists, and occupational therapists (excluding doctors, nurses, and paramedics) and critically often work in hospitals in multidisciplinary teams (Allied Health Professions 2023). Whilst these workers play a vital role in providing essential care for people with chronic physical illnesses, mental health issues and disabilities (Loan-Clarke et al. 2010), they face workplace challenges, such as insufficient resources, long working hours,

Practitioner Notes

- What is currently known?
  - There is limited research on Allied health (AH) professionals.
  - Recruitment and retention of AH professionals is an issue for the health industry.
- What this paper adds?
  - High workloads can deplete resources, prompting employees to resort to silence as a coping mechanism.
  - Building trust can increase engagement and decrease intention to leave.
  - Perceived workload expectations impact the voice systems, putting additional pressure on an already stretched industry.
- Implications for practitioners?
  - Build trust through open communication, regular feedback and recognising employees.
  - Implement a job needs analysis and job redesign to amend workload pain points.

excessive demands, aggressive patients, and new and changing regulations (Dolea et al. 2010). Such challenges are exacerbated by high workloads in the healthcare sector, which need more attention in the HRM literature. In this context, the role of HRM in managing AH professionals' workload is critical for their wellbeing, retention and quality of care (Townsend and Wilkinson 2010).

To address these issues, we draw upon the Conservation of Resources (COR) theory (Hobfoll 1989, 2011) as a theoretical framework that is best able to investigate the impact of increased workload on employee silence and its potential adverse effects on engagement and the intention to leave among AH professionals. COR theory posits that individuals strive to obtain, retain, and protect their resources, and stress occurs when these resources are threatened or lost. Applying COR theory allows us to explore how the depletion of resources due to high workload can lead to defensive behaviours such as employee silence, which in turn affects engagement and turnover intentions. Moreover, the role of trust in management as a moderating factor is critical in this framework. Trust in management can serve as a resource that mitigates the negative effects of workload on employee silence, enhancing engagement and reducing turnover intentions. This study aims to fill the gap in the literature by examining these dynamics among AH professionals during the COVID-19 pandemic, thereby contributing to a more nuanced understanding of the interplay between workload, employee silence, trust in management, and work outcomes in the HRM context.

AH professionals offer specified assistance to doctors and nurses either within a hospital setting (such as radiographers), or within community outpatient services (such as physiotherapists). However, AH professionals often find it difficult to voice concerns due to communication issues such as physical distance or locations and perceived power imbalances between AH professionals and registered nurses or doctors and management (Seaton et al. 2021). This is important to note, as an increasing body of AH research highlights that effective communication is essential for quality healthcare services (Kwame and Petrucka 2021). Chalmers et al.'s (2023) systematic review of AH indicates that engagement between health organisations and AH professionals improves healthcare processes and services (Chalmers et al. 2022), overall performance (Boaz et al. 2015), and increases innovative patient care. Indeed, unintended patient harm can be attributed to failures in communication, underpinned by a lack of trust and closed-loop communications (Weller et al. 2014). As such, Sheehan et al. (2021) have called for the paucity of research in communication in healthcare, particularly regarding AH, to be addressed.

Workload and its associated challenges arise when employees are tasked with various responsibilities but cannot meet expectations within the given time and resource constraints (Cohen et al. 2023). Recent healthcare research has emphasised the consequences of overwhelming workloads, demonstrating their connection to heightened stress levels (Grochowska et al. 2022) and an increased intention to leave the profession (Zhou et al. 2022). Although considerable research has been conducted on workload, relatively few studies have investigated the relationship between increased workload and employee silence and its effects on engagement and intention to leave, particularly in demanding work environments such as the pandemic (Patton 2020). Such an exploration has the potential for a more comprehensive understanding of the behaviours exhibited by AH professionals and their impact on enhancing their engagement while reducing intentions to leave.

Employee silence in healthcare carries significant consequences. Those who refrain from voicing their concerns to those in authority inadvertently perpetuate avoidable patient harm (Jones et al. 2021). International evidence strongly indicates that healthcare organisations where employees feel comfortable expressing their concerns and where these concerns are met with appropriate responses tend to deliver superior patient outcomes with heightened patient safety and satisfaction, reduced operational costs, and enhanced staff morale and wellbeing (Schmiedhofer et al. 2021; Wilkinson et al. 2015; Wu et al. 2021). Many healthcare professionals face significant barriers that deter them from raising their voices. Consequently, they are hindered by fear of potential negative consequences, the risk of organisational inaction, and the deeply ingrained desire to fit in (Jones et al. 2021). Healthcare organisations must address AH silence due to the close working relationships with other health professionals (nurses/doctors) to ensure the quality of patient care throughout a patient's experience within the healthcare system (Seaton et al. 2021). The relationship between healthcare providers (such as knee surgeons and physiotherapists) is crucial for continuity of care and high patient care outcomes.

In this study, we examine the role of trust in management on the workload-silence relationship, exploring how this dynamic may be influenced in demanding work environments with high workloads, especially among AH professionals. We investigate the mediating role of employee silence on the relationship between workload, employee engagement and intention to leave. We choose trust in management as a moderator because AH professionals are confronted with an increased workload

imposed by the healthcare sector and increasingly demanding clients/patients (Turato et al. 2022). Trust in management does not alleviate heavy workloads but will help AH professionals better manage the effects of silence and its negative consequences on their engagement and intention to leave (N. K. Kougiannou et al. 2021). For example, trust in management fosters a climate of psychological safety (Newman et al. 2017), where employees feel comfortable expressing their concerns and seeking assistance when needed. In organisations with high levels of trust, employees are more likely to perceive silence as unnecessary or counterproductive because they trust that their voices will be heard and their concerns addressed by management. Therefore, this could provide more detailed insight into the behaviours of AH professionals and be a factor in improving engagement and reducing intentions to leave.

We chose intention to leave because one of the greatest challenges currently faced by the Australian public health service sector is high staff turnover and well-being (Cosgrave et al. 2018). Research shows that compared with doctors and nurses, allied health workers are twice as likely to leave their jobs (Campbell et al. 2013). We focus on engagement because decreased work engagement is the most important contributor to poor mental health (Cohen et al. 2023). The Australian public health system is threatened by a shortage of satisfied and well-trained healthcare workers. Thus, there is an urgent need for organisations to implement strategies to manage these issues better.

Our study draws on the conservation of resources (COR) theory (Hobfoll 1989, 2011). COR can inform and influence work patterns and practices, aiming to attain a better balance between resource depletion and acquisition and offers an adaptable framework over others, such as Job Demands-Resources (JD-R) and Role theories. Firstly, COR theory offers a broader focus, encompassing personal and social, providing a more comprehensive understanding of individuals' well-being amidst dynamic challenges. Secondly, COR theory's emphasis on individual resource dynamics, adaptability, and resilience aligns well with the complex and uncertain nature of COVID-19 lockdown environments, allowing for a nuanced exploration of coping mechanisms and resource management strategies. Thirdly, its applicability across diverse life domains beyond the workplace ensures relevance in studying stress and adaptation among AH professionals facing multifaceted demands. In the context of our research, we apply this theory to shed light on the experiences of AH professionals facing substantial challenges in their healthcare roles during COVID-19. This was central to this study, Melbourne where over 85% of AH professional are located in the state of Victoria, was one of the most locked down cities during the paramedic and we saw this as an opportunity to assess work patterns and practices under the harshest of condition to identify how resilient the systems were, to enable issues, problems and weaknesses to be identified and addressed to ensure the systems capabilities were improved.

Our research draws on a diverse sample of AH professionals, such as radiographers, psychotherapists, and occupational therapists, employing a mixed methods approach. In the quantitative phase, we investigate the relationship between workload, engagement, intention to leave, the mediating role of silence and the moderating effect of trust in management on the workload-silence relationship. These are important relationships to explore as research has found that excessive workloads are linked to negative perception of fairness and equity and silence where these issues are not addressed and this impacts on trust in management. Studies the health sector reinforce these points. Tangirala and Ramanujam (2008), for example, found when procedural justice climate was higher, employee silence was weaker. Mawuena and Mannion (2022), study indicated that severe resource constraints and high workload deplete personal resources and create an unsupportive environment for staff and leads to systemic silence. In terms of trust and silence Jones and Kelly (2014), study of the healthcare sector in the UK found the trust deficit to be a key element in the reluctance of staff raising issues because they were either not being listened to (Pinder and Harlos 2001) and fears about victimisation occurring in the wake of raising concerns (Donaghey et al. 2011).

Data were gathered from 1160 AH professionals in Victoria, Australia, during the pandemic. Additionally, qualitative data were collected to explore the role of trust in management. This was accomplished through qualitative survey responses from 334 AH professionals, prompted by an open-ended question following the quantitative survey. This qualitative inquiry aims to provide nuanced insights into the dynamics of AH professional workplaces. The qualitative stage allows the researchers to draw deeper meaning and in-depth insights into the issues surrounding AH professional workplaces.

This research contributes to the HRM literature by addressing a notable gap: the limited exploration of employee silence and its effects on work engagement and turnover intentions among a critical health group - AH professionals (Cohen et al. 2023). Our study enhances the understanding of employee silence by focussing on issues within management's control and potential for change. It sheds light on protective resources that can mitigate the negative impact of workloads on employee silence, thereby improving engagement and retention intentions. This insight is crucial for HRM, as perceived workload expectations can negatively affect employee voice systems when trust in management erodes. By fostering trust through open communication and feedback, HRM can reduce AH professionals' intention to leave.

2 | Theoretical Framework and Hypotheses Development

2.1 | The Relationship Between Workload, Engagement and Intention to Leave: The Mediating Role of Employee Silence

In the increasingly turbulent environment generated by the pandemic, there is growing interest in how job-related perceptions of workloads relate to employees' intention to leave (Meacham et al. 2023; Tham et al. 2023). To undertake this research, we draw on COR theory (Hobfoll 1989), which focuses on the function of stress and how individuals attempt to manage their role demands. Specifically, COR theory assesses the interconnection between individual and external resources, demands that could deplete reserves, individual internal stress

responses and resultant individual behavioural outcomes (Hobfoll et al. 2018).

When examining AH professionals' silence, COR theory offers a more versatile framework for understanding its relationship with trust in management, intention to leave, and engagement, as opposed to JD-R and Role theories. Firstly, silence is closely linked with OCB and is intertwined with aspects of trust in management rather than solely related to workload or overload. Secondly, rooted in trust, individuals' interpretations are more likely to be shaped by their perceptions rather than job demands. These interpretations focus on the fear or futility individuals perceive in decisions to withhold resources and remain silent rather than on job demands alone, where both high and low demands may influence silence. In this context, we argue that COR theory, with its emphasis on resource allocation to both voice and silence, provides a more relevant framework for this research, as it revolves around an internal assessment of resource allocation.

COR theory contends that, to preserve resources, workers should concentrate on retaining, protecting, and building them (Hobfoll 1989). COR theory states that individuals experience stress when they perceive their resources are under threat, when there is actual depletion of resources, or when there is insufficient renewal or replenishment of depleted resources (Hobfoll et al. 2018). It views resources as wide and varied, encompassing various aspects of individual characteristics, circumstances deemed valuable to individuals, and the systems that facilitate their acquisition. For example, this could consist of equipment or tools, support from co-workers and organisations through resource management, and its structured communication system (voice) to enhance engagement and trust (Hobfoll 1989). This enhanced emphasis on resources, as contrasted with JD-R, covers personal, social, and material resources. Such a broader perspective allows researchers to explore a more extensive range of factors affecting stress and well-being beyond solely the interaction between job demands and resources.

A central tenet of COR theory is that the loss of resources holds greater importance than acquiring them initially. This principle underpins the concept of resource investment, which suggests that individuals will prioritise investing in resources to build reserves. Ideally, they aim to foster a positive accumulation of resources over time, creating a spiral of resource gains. This strategy is a protective measure against potential losses (Halbesleben et al. 2014). A key reason for developing a resource spiral is that resource loss can initiate a negative spiral effect. In this scenario, resources become depleted, and this ongoing erosion of resources can ultimately adversely affect individual well-being, as indicated by factors such as work engagement and trust in management. These factors can serve as resource caravans to compensate for the loss (Hobfoll et al. 2018), which can lead to an intention to leave.

Drawing upon COR theory, we assert that in this turbulent environment, increasing workloads, as an antecedent to job stress, can result in the dispersion of resources, potentially rendering individuals ineffective in their roles (Mittal and Bhakar 2018). As such, individuals facing increased workloads often experience heightened stress and burnout (Cohen et al. 2023). Increased workload may also encompass workplace situations in which employees feel compelled to perform tasks beyond their skill and resource capabilities or with insufficient resources provided to them (Tang and Vandenberghe 2021). As a coping mechanism, individuals may withdraw resources in terms of interactions or communication with management, that is, silence, driven by the perceived futility of effecting change or the fear of becoming a target.

This resource insufficiency sets the stage for resource-demand stressors, which can trigger a resource-demand spiral. In contrast to JD-R theory, which highlights job resources as a buffer against the negative effects of demands—implying that an increase in demand requires more resources, which may not always be feasible in contexts like AH—COR theory focuses more on individuals' perception and handling of resources. These resources are crucial for coping with heightened demands. When confronted with increased demands in their workload, individuals are likely to react defensively, disengaging and withdrawing from elements such as voice systems, thereby resorting to silence as a coping mechanism to conserve their resources and mitigate the factors contributing to a potential loss spiral (Hobfoll et al. 2018). This is important because silence may not overtly manifest itself initially. It could serve as an indication or the first signs of a workforce experiencing stress. Therefore, its emergence may not be readily identifiable, requiring HR to take proactive measures to detect it in its early stages. Addressing it promptly is essential, as there may be issues within HR's purview that, if left unresolved, could escalate into more significant problems. Secondly, it is widely recognised that clear lines of communication and trust are vital for the effective functioning of any organisational system (Holland et al. 2011). Consequently, when silence permeates, it will likely proliferate and become challenging to address and resolve (Weller et al. 2014). Once established, silence may detrimentally impact the organisation's effectiveness (Chalmers et al. 2023; Kwame and Petrucka 2021), which can be detrimental, particularly within the healthcare context. In the long term, at an individual level, these work environments will likely significantly affect work engagement to the point where AH specialists may consider leaving the profession as a means of coping (Gould-Williams et al. 2014).

Employee silence is a worker's 'motivation to withhold or express ideas, information, and opinions about work-related improvements' (Van Dyne et al. 2003, 1361) and can be linked to trust, or more precisely, the absence of trust towards management among the workforce (Wilkinson et al. 2015). This proactive strategy, intentionally withholding information, is viewed as a survival strategy by the workforce (Tangirala and Ramanujam 2008). While employee silence may appear as an individual decision, it is shaped within the context of management attitudes and decision-making (Donaghey et al. 2011). Employees' decision to voice or remain silent will be influenced by their expectations about truly being listened to and organisational norms that might encourage or discourage voice (Wilkinson et al. 2015). For example, a climate of silence can be created amongst employees in workplaces where speaking up is perceived as precarious or simply futile (Pinder and Harlos 2001). If employees perceive that speaking up may deplete their social or psychological resources due to potential negative

consequences from management, they may opt for silence as a protective mechanism to conserve their resources. Such employee perceptions may be created when management behaviour exhibits intolerance to alternate views or dissent and the potential for sanctions (Hickland et al. 2020). Management can be receptive to employees voicing concerns about workplace problems but very resistant to changes in working conditions (Donovan et al. 2016). This paradox of (ineffective) institutional voice structures can perpetuate silence over a range of issues, thereby organising employee voice out of the communication process or what has come to be identified as structured silence (Donaghey et al. 2011).

This structured silence is facilitated by organisational policies and practices, which create a culture of silence by negating genuine voice and can be more easily identified and studied through management inaction, lack of responsiveness or a 'deaf-ear syndrome' (Harlos 2001). The subtle aspect of structured silence is that whilst organisations may have in place voice systems and structures, it does not necessarily mean they will be effective communication channels nor that management will be responsive to employee input (Holland et al. 2011), or act upon them (Morrison and Rothman 2009). Organisational policies and practices that discourage genuine dialogue and responsiveness from management, that is structured silence, contribute to the depletion of employees' resources, thereby perpetuating a culture of silence. This depletion of resources, whether social, psychological, or tangible, is a barrier to voicing concerns and reinforces the cycle of silence within the organisation.

International evidence strongly suggests that healthcare institutions that cultivate an environment where employees feel empowered to voice their concerns and where those concerns are addressed effectively typically achieve better patient outcomes (Schmiedhofer et al. 2021; Wilkinson et al. 2015; Wu et al. 2021). Therefore, examining employee silence in the AH context is crucial, where effective communication is paramount for quality healthcare services (Kwame and Petrucka 2021). Such examination is vital for assessing the value and efficacy of employee voice systems and, by extension, gauging the level of management's appreciation for employee input (Detert and Burris 2007). The results of this culture can undermine the employment relationship as the organisation moves into a 'spiral of silence' which can lead to increased disengagement, conflict and turnover (Bowen and Blackmon 2003). As such, we posit that:

Hypothesis 1. *Workload is positively related to employee silence.*

Hypothesis 2a. *Employee silence mediates the relationship between workload and intention to leave.*

Hypothesis 2b. *Employee silence mediates the relationship between workload and work engagement.*

2.2 | Trust as a Moderator

Trust plays a crucial role in the context of employee silence, serving as both a foundational element and a mitigating factor within workplace dynamics. Trust, defined as a psychological state encompassing the intention to accept vulnerability based on positive expectations of another's intentions or behaviour (Rousseau et al. 1998), is essential for fostering open communication and effective teamwork. This positive environment is vital for employees to voice their concerns and engage fully in their roles (N. K. Kougiannou et al. 2022), thereby preventing the detrimental effects of silence. Drawing from COR theory, trust operates as a resource caravan, enhancing resource creation and providing a buffer against resource loss. It contributes to a supportive work environment where employees feel valued and secure, especially during challenging times. In this light, trust can mitigate the negative impacts of increased workloads by fostering perceptions of fairness and support (N. K. Kougiannou et al. 2021), which are crucial for maintaining engagement and reducing the likelihood of silence.

When employees feel that their workload is reaching unsustainable levels and they lack proper channels to communicate these concerns, they may turn to silence as a coping mechanism. This silence signifies a lack of voice and a sense of being undervalued by the organisation, resulting in disengagement and, eventually, a desire to leave (N. K. Kougiannou et al. 2022). In such contexts, trust plays a pivotal role in alleviating the adverse impacts of increased workload on employee silence. The essence of trust in the employment relationship is the quality of the social exchange (Blau 1964), which evolves over time. Trust in management, seen as a valuable workplace resource, can mitigate the impact of workload by fostering perceptions of support and fairness, reducing the threat perception associated with heavy workloads. In environments of trust and support, employees reciprocate by voicing concerns rather than staying silent, contributing to positive employer-employee relationships. When organisations (management) decrease (genuine) voice opportunities to the extent that employee silence emerges, a downward spiral in trust may be observed (Bowen and Blackmon 2003). This spiral will likely hinder information flow, making decision-making processes seem less transparent and, consequently, less trustworthy, affecting resource allocation and undermining the quality of outcomes (K. Kougiannou et al. 2015; N. K. Kougiannou et al. 2021). Moreover, it can lead to a perception of a significant power imbalance in the relationship, heavily favouring management (N. K. Kougiannou et al. 2022).

In the context of employee silence, the lack of trust it creates results in a system with inconsistent ground rules for communication, exacerbating disengagement and resulting in an intention to leave (N. K. Kougiannou et al. 2021). Therefore, higher levels of trust in management buffer the negative impact of workload on silence by fostering open communication, transparency, and a sense of fairness in decision-making processes. Conversely, lower levels of trust intensify the positive relationship between workload and silence, leading to greater employee disengagement and turnover intentions. As such, we posit that:

Hypothesis 3. *Trust in management moderates the relationship between workload and silence, such that the positive relationship between workload and silence is weaker at higher levels of trust in management.*

Drawing from COR theory, high workloads can deplete resources, prompting employees to resort to silence as a coping mechanism. However, trust in management, perceived as a valuable resource, fosters support and reduces the need for coping via silence. Additionally, trust cultivates psychological safety (Newman et al. 2017), where employees feel comfortable expressing concerns, diminishing the need for silence. Moreover, trust correlates with organisational commitment (Chen et al. 2015), further promoting work engagement and reducing turnover intentions despite workload challenges. Thus, trust in management is crucial for creating a culture of collaboration and engagement within organisations, buffering the negative impacts of high workloads and encouraging employees to voice their concerns rather than remain silent:

Hypothesis 4a. *Trust in management moderates the indirect effect of workload on intention to leave via silence, such that this indirect relationship is weaker at higher levels of trust in management.*

Hypothesis 4b. *Trust in management moderates the indirect effect of workload on work engagement via silence, such that this indirect relationship is weaker at higher levels of trust in management.*

Figure 1 below illustrates the indirect and moderated effects discussed above.

3 | Methods

3.1 | Sample

To test the research model, in collaboration with the Victorian Allied Health Professional Association (VAHPA), an online survey was distributed via their newsletter e-mail to VAHPA members within their database. Our study employed a survey method to gather quantitative data, with qualitative comments provided as an additional analysis. The primary focus was on understanding the relationships between workload, employee silence, trust in management, engagement, and intention to leave. The qualitative data, obtained from an open-ended survey question, was used to provide deeper insights into the quantitative findings. We received a total of 1160 responses from AH professionals via this anonymous survey between August and September 2022. Additionally, 334 respondents provided comments, that is qualitative data, regarding their work environment and issues. The survey covered a diverse range of over 25 job roles, including Medical Imaging Technologists (18.9%), Occupational Therapists (18.5%), Physiotherapists (19.8%), Social Workers (10.9%), and Speech Pathologists (7%). Most respondents were working full-time (60%), with a mean age of 43.09 (SD = 11.78) and 16.4% were male. Regarding educational level, 29.7% of the respondents had a bachelor's degree, 4.7% had a master's degree, and 9.1% had a graduate diploma. The identities of respondents were kept anonymous and confidential in line with university ethics protocols.

3.2 | Measures

3.2.1 | Workload

We measured workload using five (Spector and Jex 1998). Sample items included 'How often is there a great deal to be done?' and 'How often does your job leave you with little time to get things done'. A five-point Likert-type scale was used with anchors of 1 (less than once per month or never) to 5 (several times per day).

3.2.2 | Silence

Employee silence was measured by a six-item scale (Knoll and van Dick 2013). Sample items included 'I remained silent because of fear of negative consequences' and 'I remained silent because nothing will change anyway'. A five-point Likert-type scale with anchors of 1 (strongly disagree) to 5 (strongly agree) was used.

3.2.3 | Intention to Leave

We used a three-item scale to measure employee turnover intention (Cammann et al. 1983). Sample items included 'How frequently do you think about getting out of the healthcare industry' and 'How likely is it that you will explore other career opportunities'. A five-point Likert-type scale with anchors of 1 (very unlikely) to 5 (very likely) was used.

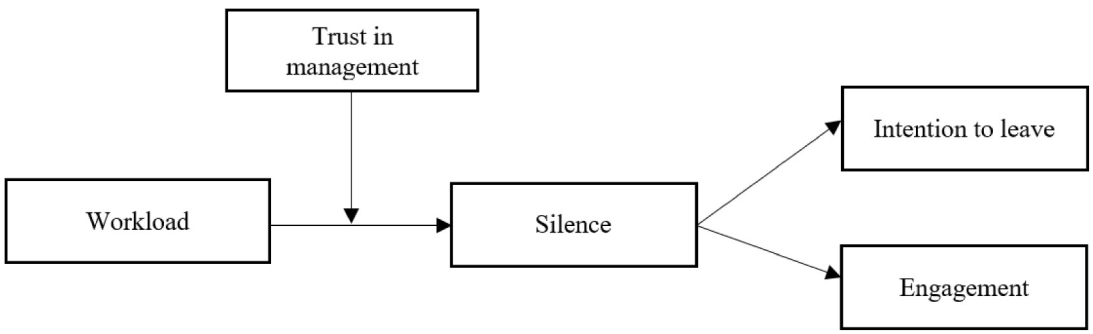

FIGURE 1 | Proposed theoretical model.

3.2.4 | Work Engagement

We measured engagement using nine items from Schaufeli et al. (2002). Sample items included 'At work, I feel bursting with energy' and 'I am enthusiastic about my job' (1 = never, 7 = everyday).

3.2.5 | Trust in Management

We measured trust in management by using four items from Brockner et al. (1997). Sample items included 'I feel confident that senior management will always try to treat me fairly' and 'Senior management is sincere in its attempts to take account of employees' points of view' (1 = strongly disagree, 5 = strongly agree).

3.2.6 | Control Variables

We also controlled for age (number of years), gender (0 = male; 1 = female), and education (1 = Vocational/technical qualifications; 2 = Diploma; 3 = Graduate diploma; 4 = Bachelor; 5 = Honours; 6 = Master; 7 = PhD; 8 = Other) because these factors can influence their turnover intention (e.g., Knudsen et al. 2009) and work engagement (e.g., Agarwal 2014).

3.3 | Quantitative Data Analysis

SPSS (Version 29) was used to analyse the data, descriptive statistics and reliability. We used Hayes' (2015) PROCESS macro to assess our hypotheses, employing 5000 bootstrapped samples and 95% confidence intervals (CIs).

Before testing the hypotheses, we conducted a Confirmatory Factor Analysis (CFA) to ensure that our focal variables had satisfactory discriminant validity. A five-factor measurement model (i.e., workload, silence, intention to leave, work engagement, and trust in management) provided a good fit to the data (χ^2 (314) = 1370.242, SRMR = 0.041, RMSEA = 0.054, CFI = 0.942, TLI = 0.934), and was superior to alternative models, including a four-factor model in which engagement and intention to leave were combined (χ^2 (318) = 2268.834, SRMR = 0.061, RMSEA = 0.073, CFI = 0.893, TLI = 0.880), a three-factor model in which silence, engagement, and intention to leave were combined (χ^2 (321) = 4070.059, SRMR = 0.113, RMSEA = 0.101, CFI = 0.795, TLI = 0.773), and a two-factor model in which workload and trust in management were combined, and silence, intention to leave, and engagement were combined (χ^2 (323) = 5445.159, SRMR = 0.126, RMSEA = 0.118, CFI = 0.720, TLI = 0.691).

The use of cross-sectional self-report data may be vulnerable to Common Method Variance (CMV). To examine the CMV, we conducted a common latent variable method by fixing all unstandardised factor loadings associated to this method factor to 1 and making it uncorrelated with other latent variables (Schermuly and Meyer 2016). The model with a method factor obtained a good fit, $\chi^2(313) = 1360.922$, $p < 0.001$, SRMR = 0.041, RMSEA = 0.052, CFI = 0.943, TLI = 0.935. We followed Castanheira (2016) by using CFI difference to compare this model with the original five-factor model. In our study, the CFI difference (0.001) was smaller than 0.01, which suggests CMV did not substantially influence the results (Cheung and Rensvold 2002).

3.4 | Qualitative Data Analysis

Qualitative data was collected from an open-ended survey question: 'Do you have any comments you wish to share about your work that may be relevant or you feel has not been addressed in the survey?' A total of 334 participants provided detailed responses regarding their workplace concerns. Data analysis involved initial pattern content analysis and axial coding (Locke et al. 2020). This content analysis entailed organising and reducing data to find meaning (Linneberg and Korsgaard 2019). Two coders read and analysed survey responses to ensure reliability until saturation, and codes were captured based on current literature and emergent themes from the data. Each coder read raw data. We identified several codes: *OHS directives, management and HR trust, burnout, understaffing, difficulty replacing staff, intention to leave, and forced silence*. During axial coding, initial codes were analysed to identify relationships amongst the codes to create themes. The connections established among the initial codes revealed several key themes: *trust in management, workload concerns, management perpetuating silence, and workers' intention to leave*.

The qualitative findings are presented as an additional analysis subsection at the end of the results section to provide context and deeper understanding of the quantitative results.

4 | Results

4.1 | Quantitative Findings

Descriptive statistics and correlations among variables are presented in Table 1. As expected, workload was positively correlated with employee silence ($r = 0.27$, $p < 0.01$). Employee silence was positively correlated to intention to leave ($r = 0.29$, $p < 0.01$) and negatively correlated with engagement ($r = -0.31$, $p < 0.01$). This provides preliminary support to some of the hypotheses. We provide more complete tests of our hypotheses below.

4.2 | Hypotheses Testing

We tested our hypotheses using Hayes' (2015) PROCESS macro with 5000 bootstrapped samples and 95% confidence intervals (CIs). To support Hypothesis 1, we found workload was positively related to silence ($B = 0.25$, SE = 0.03, $p < 0.001$). To support Hypothesis 2a and 2b, we found employee silence was positively related to intention to leave ($B = 0.23$, SE = 0.03, $p < 0.001$) and negatively related to work engagement

TABLE 1 | Means, standard deviations, and correlations.

Variable	M	SD	1	2	3	4	5	6	7	8
1. Age	43.09	11.78								
2. Gender	0.84	0.37	0.02							
3. Education	5.58	1.79	0.00	0.03						
4. Workload	4.13	0.90	−0.11**	−0.02	−0.05	0.90				
5. Silence	2.79	1.06	−0.31**	−0.03	−0.04	0.27**	0.96			
6. Turnover intention	2.80	1.00	−0.07*	−0.08**	−0.01	0.27**	0.29**	0.78		
7. Engagement	4.79	1.29	0.11**	0.09**	0.01	−0.07*	−0.31**	−0.38**	0.91	
8. Trust in management	3.16	0.80	−0.02	−0.01	−0.03	−0.03	−0.02	−0.03	0.07*	0.76

Note: $N = 1160$. Gender (0 = male; 1 = female); education (1 = Vocational/technical qualifications, 2 = Diploma, 3 = Graduate diploma, 4 = Bachelor, 5 = Honours, 6 = Master, 7 = PhD, 8 = Other). Reliabilities are on the diagonal.
*$p < 0.05$.
**$p < 0.01$.

($B = -0.37$, SE = 0.04, $p < 0.001$). The indirect relationship between workload and turnover intention via silence was significant ($B = 0.06$, SE = 0.01, 95% CI = [0.04, 0.08]). We found that the indirect relationship between workload and engagement via silence was significant ($B = -0.09$, SE = 0.02, 95% CI = [−0.12, −0.07]). Hence, Hypothesis 2a and 2b were both supported.

Hypothesis 3 examined the moderating effect of trust in management on the relationship between workload and employee silence. The results showed a significant interactive effect ($B = -0.07$, SE = 0.03, $p < 0.01$; see Figure 2 for the interaction pattern). The relationship between workload and employee silence was stronger when trust in management was low (below 1 SD) (simple slope = 0.33, $t = 8.04$, $p < 0.001$) compared to when trust in management was high (above 1 SD) (simple slope = 0.18, $t = 4.62$, $p < 0.001$). This result shows that the positive effect of workload on employee silence was stronger when employees had a low level of trust towards management. For Hypothesis 4a and 4b, we comprehensively tested the entire moderated mediation model. The results suggested that the positive indirect effect of workload on turnover intention via silence was stronger under a low level of trust in management ($B = 0.08$, SE = 0.01, 95% CI = [0.05, 0.10]) rather than under a high level of trust in management ($B = 0.04$, SE = 0.01, 95% CI = [0.02, 0.07]). For Hypothesis 4b, at a lower level of trust in management, the indirect effect of workload on work engagement via silence was $B = -0.12$, SE = 0.02, 95% CI = [−0.16, −0.08], whereas at a higher level of trust in management, the indirect effect was $B = -0.07$, SE = 0.02, 95% CI = [−0.10, −0.04]. Hence, Hypothesis 4b was supported. Results are presented in Table 2.

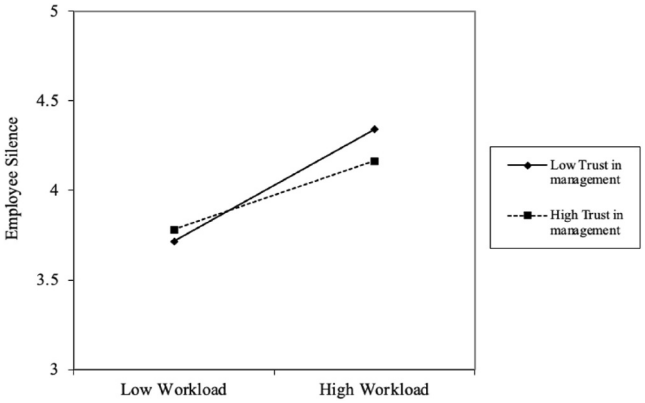

FIGURE 2 | The moderating effect of trust in management on the relationship between workload and silence.

4.3 | Qualitative Findings

4.3.1 | Trust in Management

Many participants expressed a lack of trust in management regarding daily operations during the pandemic, with their main concern revolving around the safety of both patients and workers. Several responses indicated management was perceived as disregarding occupational health and safety (OHS) directives:

> Unsafe OHS about certain procedures, risks involving blood, procedure location, training and competence of other health professionals.
>
> (AH2)

Participants also signalled that trust in managers and HR was also lacking:

> I don't trust my managers; however, I am very fortunate to work with dedicated and skilled clinicians.
>
> (AH111)

> [management] that forget to process staff pay on time or reliably. It's pretty insulting considering the standard of work we perform, the stress and responsibilities of the job.
>
> (AH32)

As noted by COR theory, trust can foster a positive work environment conducive to open communication and effective teamwork. If trust is lacking, as seen in these examples,

TABLE 2 | Regression results for hypothesis testing.

	Silence		Turnover intention		Engagement	
Variables	**B**	**SE**	**B**	**SE**	**B**	**SE**
Constant	4.03***	0.15	2.13***	0.19	5.55***	0.24
Age	−0.03***	0.00	0.00	0.00	0.00	0.00
Gender	−0.04	0.08	−0.19**	0.07	0.28**	0.10
Education	−0.02	0.02	0.01	0.02	−0.01	0.02
Workload	0.25***	0.03	0.20***	0.03	−0.05	0.04
Trust in management	−0.02	0.03				
Workload × Trust in management	−0.07**	0.03				
Silence			0.23***	0.03	−0.37***	0.04

Note: $N = 1160$. Unstandardised coefficients (standard errors) are reported.
*$p < 0.05$.
**$p < 0.01$.
***$p < 0.001$.

resources can become limited through the lack of a resource caravan, as such the trust between staff and managers.

4.3.2 | Workload Concerns

Workload was a common concern for participants, indicating emotional toll and burnout that resulted from increased and heavy workloads:

> Constantly asked to work extra shifts, rosters posted only a few days ahead and leave requests approved or declined at the last minute so unable to adequately plan your time away from work.
>
> (AH37)

Participants also noted that due to understaffing, their workload had increased without support from their managers and organisations:

> Currently continuously understaffed, doing the job of two or three people. More OT shifts than ever before. Work-life balance dramatically tipped towards work.
>
> (AH52)

However, one participant did state that positions within their organisation were now being filled, and as such, workload had returned to 'normal':

> The new staff are experienced, and we have an excellent team. My workload has therefore reduced to more 'normal' levels. My manager is excellent, and we can have honest and constructive conversations. After a really challenging (at times awful) two years, I am feeling happy and optimistic about the future.
>
> (AH61)

Drawing from COR theory, high workloads can deplete resources, prompting employees to experience burnout, however, as seen above, when workloads are manageable, employees have the effective resources to complete their job tasks.

4.3.3 | Management Perpetuating Silence

Participants indicated they were discouraged from voicing concerns due to poor workplace cultures. Rather than actively choosing to, they felt forced into silence, as participants explained:

> I don't feel safe to raise important issues with our executive for fear of persecution.
>
> (AH109)

Participants further explained that they felt they would be punished or bullied for voicing concerns:

> ...bullying and other toxic behaviours by management to stop staff from speaking up about issues, bullying and targeting staff for speaking up about increasing workloads and positions not being back filled, leadership by fear and control of staff to prevent issues from being discussed among staff due to constant threat of who next will be targeted and bullied by management...
>
> (AH21)

If employees perceive that speaking up may deplete their social or psychological resources due to potential negative consequences from management, they may opt for silence as a protective mechanism to conserve their resources. Such employee perceptions may be created when management behaviour exhibits intolerance to alternate views or dissent and the potential for sanctions (Hickland et al. 2020).

4.3.4 | Workers' Intention to Leave

Participants indicated their intention to leave due to the high workload and stress felt:

> After 30 years in my profession...I have never felt that I wanted to leave until now. The pressure on the staff is unrelenting, the bad days are every day and I am exhausted with trying to keep my team motivated and even vaguely happy.
>
> (AH8)

> I have decided to leave my profession and embark on an alternate career due to the burnout from my jobs.
>
> (AH139)

Participants also observed that replacing departing workers was equally challenging, resulting in an unending cycle of escalating workloads as workers continued to leave:

> A major issue is staffing (or lack of) in public health-people are leaving and it's difficult to replace them. Remaining staff are left to cover the gaps. This has had a tremendous effect on our workload. The hospital has done nothing to support staff with this issue.
>
> (AH5)

As detailed above, high workloads and a lack of trust can deplete resources, prompting employees to possibly resort to silence as a coping mechanism. The additional issue here is the perpetuation of silence through management, which can be linked to a lack of trust. However, trust in management, perceived as a valuable resource, fosters support and reduces the need for coping via silence. Moreover, trust correlates with organisational commitment (Chen et al. 2015), further promoting work engagement and reducing turnover intentions despite workload challenges.

5 | Discussion

Based on COR theory (Hobfoll et al. 2018), our study initially revealed that elevated perceptions of workload induce a resource loss spiral, depleting individuals of their cognitive and emotional resources. Consequently, individuals are more likely to react defensively by resorting to higher levels of employee silence. They do this as a coping mechanism to prevent further resource loss, as remaining silent is less resource-intensive than speaking up and is likely to protect them from additional resource loss, particularly in situations where challenging the status quo might result in the loss of social resources due to potential disapproval by others (Van Dyne et al. 2003). Whilst employee silence might assist in protecting an individual from further resource loss, the inhibition of an individual's expression can also cause strain and, ultimately, harm individual well-being (Erdoğan et al. 2022). This, in turn, leads to lower levels of engagement and higher levels of intention to leave as individuals psychologically and physically withdraw further to conserve their depleted and scarce resources.

Second, our research offers critical insights into how trust in management, as a vital resource, interacts with increased work demands and its impact on engagement and retention. The results of our study confirm the moderating role of trust in management. When AH professionals have a high level of trust in management, it serves as a protective mechanism, helping them navigate the challenges posed by increased workload. This high trust fosters a sense of security and support in the work environment, which, in turn, mitigates the negative impact of workload on employee silence, engagement, and intention to leave. Conversely, employees become more vulnerable to the adverse consequences of heightened workload when trust is low. AH professionals with lower trust are more likely to respond to increased work demands with silence and exhibit decreased engagement and heightened intentions to leave, perhaps as a coping mechanism without a supportive management relationship. Our findings resonate with Montgomery et al. 's (2023) emphasis on the need for supportive leadership to mitigate silence. By fostering a culture of trust and open communication, leaders can significantly reduce the incidence of employee silence.

The qualitative findings reveal an active resource loss spiral through a lack of trust, excessive workload concerns, and managers perpetuating silence through fear and futility of achieving change, all contributing to a lack of work engagement and a clear intention to leave. Participants have notably expressed a lack of trust in management, and the presence of structured silence has made them unable to approach managers with their concerns. Consequently, they cannot utilise management knowledge and emotional support as resources, potentially resulting in a negative resource loss spiral (Hobfoll et al. 2018) and an inadequate replenishment of key resources (Hobfoll 1989). Additionally, workloads deplete resources within the resource pool, creating a resource depletion spiral, leaving AH professionals feeling exhausted and stressed, decreasing work engagement and increasing their intention to leave (Mittal and Bhakar 2018). Managers perpetuating silence and essentially 'punishing' AH professionals for utilising voice platforms take further resources away from employees, exacerbating their well-being and stress concerns and deepening the lack of trust in the employment relationship (Tang and Vandenberghe 2021). If resources are not replenished, they are further eroded by other workplace stressors. Therefore, we have highlighted how issues related to the lack of trust in management, workload concerns, and managers perpetuating silence contribute to a resource loss spiral for AH professionals (Walker et al. 2024). This manifests as decreased work engagement within the workplace and is underscored by participants expressing a strong desire to leave the profession, even after an extended service period.

6 | Theoretical Contributions

When healthcare professionals hold back their concerns, the consequences are significant and widespread. Their silence inadvertently perpetuates the occurrence of preventable harm to patients, an issue of utmost gravity. The current study enhances our understanding of how employees' perceptions of their workload influence their decision to remain silent and how this, in turn, affects their engagement and intentions to leave. Furthermore, we explore how the quality of their trust relationship with management can moderate these effects. Our qualitative investigation reaffirms the results obtained through

quantitative analysis and, importantly, sheds light on the factors contributing to high workload perceptions and silence. These factors include understaffing and insufficient support from both managers and the organisation.

The theoretical significance of our study is twofold. First, it contributes to the employee silence literature by addressing issues within the purview of management, which has often been overlooked in contemporary research. While recent scholarly interest in employee silence has grown (Sherf et al. 2021), efforts to explore the implications of employee silence have largely centred around organisational consequences (Lam and Xu 2019). Notably, research is beginning to explore the impact of employee silence on individual attitudes and behaviours, such as job satisfaction and commitment (Xu et al. 2015), burnout and turnover intentions (Shipton et al. 2024). However, there remains a paucity of research in this field. Thus, our current study responds to calls for more research on employee silence that provides a broader perspective on its consequences for individuals. Moreover, our study builds on the findings of Lainidi et al. (2023), who conducted an integrative systematic review revealing the complexity of measuring silence and voice behaviours in healthcare. Our study contributes to this discourse by providing empirical evidence on the role of workload and trust as pivotal factors, offering practical insights into mitigating silence and its negative impacts on individual and organisational outcomes. This approach aligns with and further elaborates on the complex dynamics identified by Lainidi et al., particularly in the healthcare sector where employee silence can have significant implications for patient safety and quality of care.

Additionally, by integrating silence literature and COR theory, we present a unifying framework to understand how our work environment (i.e., workload) can influence employee silence, thereby impacting individual well-being and attitudinal outcomes relevant to the individual (i.e. engagement) and organisation (i.e. intention to leave). Through findings from our qualitative study, we explore the underlying contributing factors behind perceptions of high workload (e.g., understaffing, and poor support from managers and the organisation). In doing so, our study advances the employee silence literature by providing a comprehensive framework to explore the antecedents of silence and its implications for individual well-being and attitudinal outcomes. Specifically, combined with past research, our study's findings suggest that how organisations design workloads can influence how individuals choose to communicate, potentially leading to higher levels of employee silence. Silence can negatively impact individual well-being and simultaneously have significant implications for organisations, as it may encourage individuals to consider leaving the profession. Furthermore, our study adds to the work of Knoll et al. (2019), who investigated the negative effects of differentially motivated forms of employee silence on burnout. By examining the reciprocal relationship between silence and burnout, they highlighted those imposed forms of silence (i.e., acquiescent and quiescent) significantly impact depersonalisation and emotional exhaustion. Our research extends these findings by demonstrating how organisational design, that is workload and management practices, can exacerbate or mitigate these outcomes.

Second, this study enhances our understanding of protective resources that can mitigate the adverse impact of workloads on employee silence, as well as (dis)engagement and intentions to leave. In line with COR theory (Hobfoll 1989), our research established that higher levels of trust function as protective resources, aiding in averting the loss or threat of individual resources when confronted with elevated workloads. Trust thereby shields individuals from resorting to employee silence and its resultant negative effects on the individual. Our study's findings reinforce earlier scholarly work that argued for the pivotal role of management in setting a climate that may discourage individuals from voicing concerns (Pinder and Harlos 2001). This emphasises the critical role that management and HRM play in preventing, minimising, or managing employee silence (Yao et al. 2022). Furthermore, our qualitative inquiry identifies factors such as perceived disregard for OHS directives and bullying behaviours by managers in response to employees voicing concerns as key contributors to lower levels of trust in management.

7 | Future Research Directions

While our study has shed valuable light on the intricate relationship between workload perceptions, employee silence, and its consequential impact on individual well-being and attitudinal outcomes at both individual and organisational levels, it is essential to acknowledge the study's limitations. The reliance on open-ended questions in the qualitative data collection may have limited the depth of our understanding regarding the lived experiences of AH professionals about silence and trust within the workplace. Future research should consider employing more in-depth methods, such as interviews or focus groups, to comprehensively explore AH professionals' workplace experiences. In addition, our quantitative data is cross-sectional, which cannot establish causality. We conducted an additional statistical analysis to rule out the possibility of reverse causality. We ran a competing model in which we posited that employee silence is caused by intent to leave. We compared the Akaike information criterion (AIC) for the two competing models, and the one with the smallest AIC value is preferred (Kline 2005). The AIC value of our hypothesised model was 10112.122, and that of the competing model was 10293.938, indicating that our hypothesised model was a better fit and hence demonstrated that the hypothesised mediation sequence was more appropriate This provides some assurance to our results. We urge future research to use longitudinal data to corroborate our findings.

8 | Practical Implications

This research carries significant practical implications, particularly considering that AH professionals constitute the largest cohort within the healthcare system and integrated within many teams. As such, they play a pivotal role in facilitating seamless patient care, from initial intake to ongoing management and treatment. As such, we recommend that HR managers and organisations concentrate on nurturing trust within their workforce that supports well-being and counteracts the development

of silence and possible intentions to leave. This can be accomplished by fostering transparency and openly sharing information, including updates on organisational matters at the senior leadership level, avoiding withholding resources or making decisions in secret, providing regular feedback, and setting an example for employees while empowering them through recognition. Additionally, it is crucial to collaboratively review and adjust employee workloads as necessary to support mental health and well-being. Regular feedback mechanisms where employees receive constructive input from their managers can help create a culture of trust and transparency. Conducting regular town hall meetings and open forums allows AH professionals to voice their concerns directly to senior management, fostering a sense of being heard and valued. Additionally, establishing anonymous reporting channels ensures that employees can express concerns without fear of retaliation, with the assurance that these reports will be taken seriously and acted upon promptly.

Workloads, especially during and since the COVID-19 crisis, have been perceived to increase due to patient demand and the departure of AH professionals from the profession (Coto et al. 2020). Conducting a comprehensive job needs analysis can identify workload pain points and areas where AH professionals are overburdened, with direct input from the employees themselves. Job redesign, job crafting and role clarification can ensure that job roles and responsibilities are manageable and clearly defined, potentially involving hiring additional staff, redistributing tasks, or providing additional resources to support AH professionals. Offering flexible working arrangements, such as adjustable shifts, or part-time options, can further alleviate workload pressures and improve work-life balance. These factors have been found to increase job satisfaction and within the control of management to facilitate.

Employee silence among AH professionals has significant implications for HRM practices. HRM can foster psychological safety by implementing a range of initiatives. Training and education initiatives can enhance communication skills and conflict resolution, empowering professionals to address concerns effectively. Investing in leadership development cultivates supportive leaders who promote trust and openness. Performance feedback mechanisms can recognise and reward employees for proactive communication, while conflict resolution protocols prevent disputes from contributing to silence. HRM practices are vital in creating a culture of openness, trust, and communication, thereby improving patient safety, team dynamics, and the effectiveness of AH professionals.

Specific strategies for AH professionals include promoting interdisciplinary collaboration between AH professionals and other healthcare staff to improve communication, reduce misunderstandings, and enhance overall patient care. In addition, implementing regular health and well-being assessments can monitor stress levels, job satisfaction, and overall mental health, providing access to counselling services and mental health resources as needed.

Such measures not only benefit the employees but also enhance the overall quality of patient care. Addressing the challenges faced by AH professionals requires a multifaceted approach that includes building trust, addressing workload issues, enhancing psychological safety, and fostering open communication. These practical strategies are essential for improving the work environment for AH professionals, leading to better engagement, reduced turnover intentions, and higher quality patient care. In saying this we also concur with Lainidi et al. (2023), that to be able to continue to develop practical implications, more research is required to determine the contextual factors and how different types of situations might become triggers, including leadership styles both at senior policy making level and supervisor or first-line manager level. These are critical in managing the culture of fairness and processes, which are key factors significantly affecting silence behaviours.

9 | Conclusion

Employee silence and lack of trust poses challenges for AH professionals. In the health professions, effective communication among team members is vital for quality of patient care; silence impedes information sharing and coordination, hindering comprehensive patient care increasing concerns of errors which can jeopardise patient safety. Addressing barriers to communication and fostering a culture of trust are vital for supporting allied health professionals' well-being, enhancing patient care, and improving organisational effectiveness in healthcare settings.

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Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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