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**Managing Doctor-Patient Relationships and Turnover Intention in Chinese Hospitals  
with Commitment HRM: The Moderating Role of Pragmatism**

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## **ABSTRACT**

A deteriorating doctor-patient relationship (DPR) and an increasing turnover of doctors are two challenges faced by Chinese public hospitals. The literature suggests that commitment human resource (HR) practices may translate into better DPR and lower turnover intention. Given that pragmatism is an important cultural value in Chinese society, this study aims to understand the extent to which pragmatism may affect the relationships among commitment HRM, DPR, and turnover intentions of doctors in China.

A moderated SEM analysis with 508 samples shows that commitment HR practices are effective in improving DPR for all doctors surveyed, but its effect on turnover intention depends upon the pragmatism-level of the respondents. Specifically, pragmatism has a significant moderation effect in the paths established from commitment HR practices to DPR and turnover intention in such a way that, in the low-pragmatism sample, commitment HR practices are associated with better DPR, while DPR is associated negatively with lower turnover intention.

## **Key Words**

Pragmatism, Commitment HR Practices, Doctor-Patient Relationships (DPR), Turnover Intention, Hospital Management

## INTRODUCTION

Healthcare management policy makers are currently concerned about tackling the deteriorating doctor-patient relationship (DPR) that is raising a question among Chinese healthcare physicians: “*to be or not to be a doctor*” (see Pan et al. 2015). The tension of DPR, including workplace violence, has contributed to an increasing turnover intention among Chinese doctors (Lin et al. 2014).

A solution may reside in the growing evidence that human resource management (HRM) is an important tool for improving employee well-being and delivering high-quality patient care in China (Cooke and Bartram 2015; Fan et al. 2014). Evidence associated with the beneficial outcomes of HRM (Bartram et al. 2007; Boselie, Paauwe, and Richardson 2003), especially commitment HRM (Xiao and Tsui 2007), favors a view that commitment HRM policies should be given priority because they may positively impact DPR (Liu et al. 2015) and lower turnover (Ma et al. 2016).

However, previous findings might not always be replicated in Chinese healthcare contexts due to the cultural value of pragmatism (Li and Wu 2016; Stephens 2009). In other words, commitment HRM assumes the employees reciprocate to positive investment, but this assumption may not hold in a pragmatism-based situation in which decision-making is mostly of a transactional nature, a situation common in current Chinese hospital settings (Cooke and Bartram 2015). This study challenges this assumption by testing a boundary condition of commitment HRM policies in healthcare settings in China.

By so doing, this paper’s primary contribution enriches the HRM literature in the healthcare sector (Leggat, Bartram, and Stanton 2011) by introducing cultural values of pragmatism that could challenge existing assumptions. This study reasons that an existing moderating effect has profound implications to enhance hospital management policies, notably in addressing DPR and turnover under the influence of pragmatism. Also, in practical terms,

this study offers insights to enhance hospital management in addressing DPR and turnover issues in Chinese hospitals.

This paper starts by presenting an overview of Chinese healthcare reform and institutional change in public hospitals, and the enduring conflict of doctor-patient relationships and emerging turnover issue as outcomes of the reform and change. This paper then reviews related theories that support the development of the hypotheses and discuss the research design. This paper concludes by discussing the results and implications.

## **BACKGROUND AND THEORETICAL FRAMEWORK**

### *Chinese Healthcare Reforms and Doctor-Patient Relationship*

Along with China's opening up policy at the end of 1970s, the Chinese healthcare system has undergone two major phases of reform: the first round is a market-oriented reform from the early 1980s to 2002, and the second is a comprehensive reform from 2003 to the present (World Health Organization [WHO] 2015). An important outcome of the marketization reforms was the continuous reduction of government subsidies to less than 10% by 2000 (Ramesh and Wu 2009). As a result, the marketization prompted by healthcare reforms since the 1980s in China turned public hospitals into "for-profit" organizations maintaining their survival and development (Cooke and Zhan 2013) through user charges and pharmaceutical mark-ups (Dong, Christensen and Painter 2014). Hospitals encourage doctors to overprescribe drugs, medical tests, and treatments in order to meet the expenses of their own personal pay and hospital revenues (He 2014), creating serious ethical violations, corruption, and injustice in the society at large. The over diagnosing and overprescribing make patients and families pay out-of-pocket fees and then lead to mistrust of doctors.

Cooke and Bartram (2015) argue that when individuals bear high costs, as consumers they in turn have high expectations of services from the medical staff and hospitals at all levels.

“Patients’ poor experiences and often unmet expectations can accumulate, result in doubt into an individual doctor’s treatment and a general distrust in health care professionals and finally may break out into open doctor–patient conflicts” (Hu and Zhang 2015: 1651). Since doctors are afraid of being accused of misdiagnosis, they resort to defensive behaviors, particularly by over prescribing in order to avoid making a mistake (Pan et al. 2015). In a survey of more than 500 licensed doctor in Shenzhen City, China, He’s (2014) study reveals that more than 80% of physicians practice defensive medicine in the form of prescribing unnecessary diagnostic tests, drugs, and therapeutic interventions. Such defensive behaviors further increase the distrust and anger against doctors and result in the increasing tension in DPR, thus creating a vicious circle.

This pragmatic approach of DPR in which public hospitals act as for-profit businesses and “patients” as “consumers”, has brought suffering to both patients and doctors. For example, a study by Lin et al. (2014) showed that violence against doctors resulted in doctors’ burnout, job dissatisfaction, and turnover intention. Meanwhile, a nationwide survey indicated that 70.9% of Chinese doctors would choose another occupation given the opportunity (He 2014) and a further 65% would not wish their children to attend medical schools (Chinese Medical Doctor Association [CMDA] 2015).

### *Institutional Change and Turnover of Doctors in Public Hospitals*

Until the 2009 reform, the healthcare sector was one of the few areas that remained under the planned economy system, and public hospitals were run as part of the government administration. For example, the scale and level of the hospital, number of beds, and personnel quotas were determined by administrative health departments, and senior hospital managers were typically appointed by local governments with attached official ranking status. Medical staff were given budgeted posts instead of signing employment contracts with the hospital in the same manner as any other government employees, and almost all Chinese doctors were

employed full time and not allowed to work for any other medical organization. Therefore, the mobility and turnover of medical professionals in public hospitals in China was constrained to a very low level under the planned economy approach. This situation has changed since 2009, with new medical policies giving extended rights to certified doctors and with the emergence of private hospitals as discussed below.

In March 2009 the Chinese government issued a guiding policy document, *Deepening the Health System Reform or 'New Healthcare Reform Plan'* (*Xin Yi Gai 新医改*), aiming to establish universal health coverage by 2020. The main goals of this round of reform were to change public hospitals, reform the HRM and the management systems of healthcare institutions, strengthen the capacity of delivery, and establish an essential medicine system with specific policies in health financing reform (Dong et al. 2014; WTO 2015).

A more recent initiative of this round of healthcare reform is to allow doctors to offer medical services at multiple sites by pushing a multi-site medical practice in an attempt to increase doctors' motivation and resource sharing by different healthcare units. In 2014 the *Notice on Developing and Standardizing Multi-site Medical Practice of Certified Physicians*, issued by the National Health and Family Planning Commission, endorsed this provision.

At the same time, the Chinese government has been decentralizing and deregulating the hospital management system. Public hospitals have become legal entities with rights to independently recruit, allocate, and manage employees and with autonomy to establish internal incentive mechanisms. Gradually, the personnel management of China's hospitals has been transformed from a national and unified employment model to an autonomous employment system in which hospitals have independent rights to recruit clinical talent and design positions according to human resource planning. Along with this institutional change, clinician turnover has emerged as an issue due to the "pull force" of opportunities in the medical market and the

“push force” of escalating tensions and conflict between patients and doctors in public hospitals, which will be discussed next.

As part of the reform initiated in 2009, the Chinese government encouraged non-governmental entities to invest in hospital services. As of the end of April 2017, while private hospitals increased to 16,876, public hospitals continued to decrease to 12,602, accounting for 43% of all hospitals in China – a 15% decrease compared with 2012 (National Health and Family Planning Commission 2017). The decrease in the number of public hospitals coupled with the decentralization of their personnel management system, as well as the emergence of joint-ventured and private hospitals, contribute to a substantial rise of medical staff turnover rate, particularly of senior professionals in China’s public hospitals (Zhang, Zhang, and Wang 2016). While the turnover intention of general medical and nursing staff has been extensively studied, research on the turnover rate of senior clinical doctors is scarcer, although there is an indication that those with more senior titles are more easily dissatisfied with their work conditions (CMDA 2015). Additionally, the more senior the title, the more sought after these professionals are in the human resource market, where they may find a more satisfying platform for career development and thus more chances of further reemployment.

Senior doctors’ turnover in recent years has been on the increase with strong evidence that tense relationships between doctors and patients, and workplace violence punctuated by medical disputes, play a significant role in their decision (Lin et al. 2014). Due to the insufficient investment in healthcare, doctors in Chinese public hospitals are chronically overworked, while receiving low pay and little or none of the recognition they deserve from society. The frequent occurrence of violent attacks and bodily injuries make personal safety a top concern of China’s doctors since they often become the victims of violence. For example, Wang’s research (2012) found that personal safety and social respect were the top concerns of 65% of the doctors surveyed, in contrast with 53% who asserted that their utmost priority was



to cure patients' diseases. Similarly, Ding et al. (2014) argue that doctors who have suffered workplace violence are twice as likely to foster turnover intention as those who have not. Thus, the tension and conflict in DPR turn out to be the "push effect" for turnover behavior of doctors in public hospitals. So, the lower is the level of perceived DPR by doctors, the higher is the turnover intention. Accordingly, this paper hypothesizes that *DPR is negatively associated with turnover intention (H1)*.

A commonly used solution to tackle high turnover in China is to promote commitment HR practices (Ma et al. 2016) and in recent years Chinese hospitals have been increasingly exploring different HR approaches to cope with competition. Strategic HR scholars contend that control and commitment HR practices represent two different HR styles (Arthur 1994; Boselie et al. 2003; Ma et al. 2016; Xiao and Tsui 2007). While control HR imposes compliance with rules and regulations on employees, the commitment approach focuses on motivating employees to contribute higher levels of discretionary behaviors through participation in decision-making and teamwork (e.g. Collins and Smith 2006). Recent studies suggest that China-based HRM systems consist of both control and commitment (Ma et al. 2016; Su and Wright 2012). In this study this paper applies the concept of commitment HR that focuses on practices such as participation in decision-making, internal communication, and teamwork (Xiao and Tsui 2007). Commitment HR practices are known to promote positive outcomes (Kehoe and Wright 2013; Ma et al. 2016), which drives the hypothesis that *commitment HR practices are positively associated with DPR (H2)*.

### *Pragmatism and Individual Values*

The effectiveness of HRM policies should be considered in its societal context (Brewster 1999), an assertion known in the field of strategic HRM as the contextual argument (Martín-Alcazar, Romero-Fernandez, and Sanchez-Gardey 2005). One important cultural value that

pervades Chinese society and determines both ethical and heuristic behaviors is its embracement of pragmatism. This orientation has been present for centuries in Chinese philosophy and culture, and has been extensively studied from different perspectives, but to the best of our knowledge, it has never been approached from the viewpoint of how it may affect employees' decisions to stay or leave an organization.

In organizational studies, Hofstede's fifth cultural dimension, "long term orientation" (first named Confucian dynamics), was introduced in 1988 after an extensive survey conducted with Chinese subjects. This dimension reflects how extensively societies seek to face future challenges through solutions that have been used in the past (Hofstede and Bond 1988). Short-term oriented societies are normative based, while long-term oriented societies are pragmatic (as they favor more relativism). Traditional Chinese scientific thinking is recognized as being deeply pragmatic (Li and Wu 2016; Stephens 2009), which explains why Dewey was so eagerly received and continues to be followed in China with extensive translations of his works. Although this cultural characteristic was briefly rejected in the 1950s because it favored incremental change through education (reform) over radical change (revolution) as a way to improve societies (Sun 1999), it was revived in the 1980s, along with the reform and opening (Li and Wu 2016), which endorsed pragmatism, openness, and economic liberalization (Ip 2009). The most well-known expression of pragmatism from this period came from Deng Xiaoping's thought on the white or black cat – "*Never mind whether the cat is black or white, so long as it catches mice*". Collective and individual utility considerations paved the way for the modernization of China after 1978.

The predictable shift in cultural values that ensued matches Casson's (2006) view in which cultural dimensions influence economy: individualism *versus* collectivism, pragmatism *versus* proceduralism, degree of trust, and level of tension / competition. If not matched with high trust, rising pragmatism (along with individualism) may favor utilitarianism and

consequentialism, which in the case of healthcare, are opposed to deontology and collectivism (Garbutt and Davies 2011).

The emergence of individual-focused pragmatism in healthcare, expressed in consequentialism, can change the logics of group relationships and translate into instrumental opportunism. This corrodes the moral grounds that ensure the primacy of collective interest, and an instrumental-based ethical climate may foster corruption in hospital settings (Stachowicz-Stanusch and Simha 2013). Following this perspective, pragmatism is defined in this study from an individual point of view as putting considerations of utility (for oneself) above any other type of consideration when making professional decisions.

All in all, pragmatism may be an important dimension to consider when studying organizational behavior because of its potential to change outcomes from value-based variables such as commitment HR practices. This paper therefore hypothesizes that *individual pragmatism moderates the relationships between commitment HR, DPR, and turnover intention in such a way that previous hypotheses (H1 and H2) hold only for the low pragmatism condition (H3)*. The conceptual model tested in this research is summarized in Figure 1.

**Insert Figure 1 about Here**

## **METHOD**

### *Sample*

A total of 1,500 questionnaires were sent to contact persons, all of them members of the Guangdong Hospital Association, in 33 public tertiary hospitals of eight cities in Guangdong province. These contact persons then distributed the questionnaires in their hospitals with an accompanying letter explaining the study's purpose and inviting participation. After completion, the questionnaires were mailed back to the research team. Six hundred and

ninety questionnaires were returned, 508 of which were valid, corresponding to an initial response rate of 46% and a final one of 34%.

Most of the respondents worked for large-scale hospitals with more than 1000 beds (70%). Forty-one percent reported having worked in healthcare for more than 15 years and 32% for 6 to 15 years. Men accounted for 56%, and the majority of the respondents were married (86%). Forty-three percent of the respondents have a PhD or a master's degree. It was difficult to obtain data from senior doctors in China, which explains the low response rate, making the 508 sample of this study rather unique.

### *Measures*

**Commitment HRM:** Following Xiao and Tsui (2007) and based on our understanding of the work environment in Chinese hospitals, this study constructed a 5-item scale to measure high commitment management practices that reflect key practices such as participation in decision-making, internal communication, and team work.

**DPR:** When measuring the doctor-patient relationship, context matters (Eveleigh et al. 2012), but this study was not able to find a reliable measure of DPR developed for Chinese healthcare, specifically. Therefore, based on previous studies (e.g. Hu and Zhang 2015), this paper reasoned that medical competence of doctors, trust, and communication between doctors and patients are essential elements of DPR. Thus, DPR was measured with a 4-items scale accordingly. Following Mobley et al. (1979), turnover intention was measured by four items asking about intentions to quit the job. The above scales were scored on a 5-point rating scale ranging from (1) "strongly disagree" to (5) "strongly agree". The items, validity, and reliability indicators are shown in Table 1 for all constructs.

**Insert Table 1 about Here**

Pragmatism: The measure of pragmatism was drawn from Forsyth and Berger's (1982) typology on ethical ideology, in which pragmatism or individually centered ethics is the common denominator in three of the four types of ethical ideology (situationism, subjectivism, absolutism, and exceptionism). Four initial items expressed the degree of individual gain respondents reported in feeling attached to the organization. The items are "I will lose a lot if I leave here", "I feel secure by staying in a familiar working environment", "Working in a new hospital will make me lose the support and respect gained here", "I stay because of the good benefits". After removing one item (Working in a new hospital will make me lose the support and respect gained here) due to low commonality, a factor analysis showed a single factor valid solution (KMO=.676, Bartlett's  $X^2=405$ ; 3df,  $p<.001$ ), explaining 68% total variance, and with a lowest loading of .770. The three-item scale showed good reliability ( $\alpha=.76$ ) and was scored on a 5-point rating scale ranging from (1) "strongly disagree" to (5) "strongly agree". Due to its moderator role in Moderated SEM (MSEM), this study opted to dichotomize the pragmatism variable by cutting off all cases averaging 4.0 or above as representatives of high pragmatism (N=211). All other cases matched the low pragmatism conditions (N=297).

As common method variance is a potential risk in cross-sectional research (Podsakoff, MacKenzie, and Podsakoff 2012), this study conducted Harman's test by probing validity of a single factor solution that showed unacceptable fit indices (CMIN/df=14.593,  $p<0.001$ ; CFI=0.72; PCFI=0.59; RMSEA=0.16; SRMR=0.11). This result suggested that the data were not significantly biased by an underlying common method factor.

Additionally, this study also considered socio-demographics, namely gender (1=Male, 2=Female), hospital size (beds 1= $\leq 500$ , 2=500-1000, 3=1001-1500, 4=1501-2000; 5= $>2000$ ), and education (1=Basic up to 7=PhD).

### *Data Analysis Strategy*

This study started by testing the psychometric quality of measures. This was done with Confirmatory Factor Analysis, which allows for the test of construct validity (Hair et al. 2011) and is complemented by convergent and divergent validity testing on the basis of AVE following Fornell and Larcker (1981) criteria. Reliability was tested with Composite Reliability (Jöreskog and Sörbom 1982).

CFA and SEM goodness of fit may be assessed with a variety of fit indices. Following Hair, Anderson, Babin, and Black's (2010) review of literature and recommendations, and taking into consideration that the fit indices cutoff criteria should be adjusted to model complexity and sample size, this study adopted the following thresholds: ratio between Chi square and degrees of freedom (CMIN/DF) should be set below 3.0 but significant p values are expectable for large samples, such as the one in this study (meaning  $X^2$  statistics can be discarded). Comparative fit index (CFI) should be above .95; RMSEA should be below .07 (cumulative with CFI above .92), and SRMR should be below .08 (cumulative with CFI above .92). For a stricter measure, this study may refer to Hu and Bentler (1999), who required cumulatively the following thresholds:  $CFI > .95$ ;  $RMSEA < .06$  and  $SRMR < .08$ .

Following group identification (Low vs. High pragmatism), this study tested for mean differences between these groups for all variables under study with ANOVA (as this study might expect that some mean differences occur, in order to suggest group moderation effects). The moderation was then tested with Moderated Structural Equation Analysis (MSEM) on the basis of Byrnes' (2004) guidelines. Technically, this study followed a process of sequentially imposing constraints by first comparing the unconstrained model with a structural invariant model and finally with a measurement invariant model (in which regression weights and structure are both matched between groups).

## *Results*

This section first shows descriptive statistics (means, standard deviation) and then bivariate statistics (Table 2). The findings from SEM analyses are shown thereafter to test hypotheses.

### **Insert Table 2 about Here**

There are significant mean differences in commitment HR practices [ $F(1, 506)=181.09^{**}$ ], DPR [ $F(1, 506)=98.877^{**}$ ] and turnover intention [ $F(1, 506)=127.622^{**}$ ] in which the low pragmatism group reported lower means for commitment HR practices and DPR and higher means for turnover intention than the high pragmatism group. Socio-demographics do not vary significantly between groups.

The bivariate analysis (Table 2) shows significant correlations between socio-demographics, where gender and education are not independent (males have an average higher education level in both groups). Also, there are positive correlations between hospital size and turnover intention in both groups, while DPR and education are positively correlated but only in the low pragmatism group. Last, as expected, commitment HR practices correlate significantly with DPR and turnover intention in a meaningful direction in both groups. DPR correlates with turnover intention but only in the low pragmatism group, which suggests the expected moderation effect.

Hypothesis testing is conducted in a more robust way with SEM, as it competitively tests for covariances between item errors. The full integrated model showed a strong covariance between one of the turnover intention items (“leaving because of bad prospects of hospital”) and commitment HR practices leading to unacceptable levels of fit indices (CMIN/df=5.634,  $p<0.001$ ; CFI=0.91; PCFI=0.72; RMSEA=0.096; SRMR=0.12). Thus, after removing this item, the solution presented acceptable fit indices (CMIN/df=2.561,  $p<0.001$ ; CFI=0.97; PCFI=0.74; RMSEA=0.055; SRMR=0.06) and this study could proceed to hypothesis testing.

H1 and H2 were tested simultaneously and, for the overall sample, a significant negative association ( $b=-.273$ ,  $p<.001$ ) was found between DPR and turnover intention, which corroborates H1, *DPR is negatively associated with turnover intention*. There is also a positive significant association ( $b=.717$ ,  $p<.001$ ) between commitment HR practices and DPR, which supports H2, *commitment HR practices are positively associated with DPR*. Overall, the integrated model from commitment HR practices to DPR, and DPR to turnover intention are supported.

To test H3 this study dichotomized pragmatism and conducted a nested multi-group path model to examine potential moderating effects of pragmatism (high vs. low). In this approach, SEM was estimated separately for the two groups and the magnitude of the regression coefficients can be compared using a critical ratio z test (Byrne, 2013). The MSEM goodness of fit is judged by CMIN/df, CFI, PCFI and RMSEA, using criteria as stated in the data analysis strategy section.

The models compared are: the null model, the unconstrained model, the constrained for equal loadings, the constrained for equal regression weights, and the constrained for both factor loadings and regression weights.

### **Insert Table 3 about Here**

The SEM model is presented as follows (coefficients for high pragmatism above arrows, for low pragmatism, below arrows).

### **Insert Figure 2 about Here**

The high and low pragmatism groups show equivalent significant association between commitment HR practices and DPR with betas of .71 ( $p<.001$ ) and .54 ( $p<.001$ ) respectively.



However, for the relationship between DPR and turnover intention there is a striking contrast between these groups. The high pragmatism group shows a non-significant relationship ( $b=.02$ ,  $p=.797$ ) while the value for the low pragmatism reaches a significant level ( $b=.22$ ,  $p<.01$ ). This lends support to the existence of a moderation effect of pragmatism, as the second path (*H2, commitment HR practices are positively associated with DPR*) kept the same findings while the first path (*H1, DPR is negatively associated with turnover intention*) revealed a change in the findings according to the two subsamples. Therefore, H3 was supported.

## **DISCUSSION**

Using a sample of doctors from 33 tertiary public hospitals in China, this study examined the moderator effect of pragmatism on the relationship between commitment HRM policies and turnover intention via DPR. This study reasons that this model allows mitigating the growing tension and conflict in the doctor-patient relationships and the emerging high turnover of healthcare professionals in Chinese public hospitals. The study reveals that commitment HR practices is positively associated with the DPR and that overall DPR is negatively related with turnover intention. Furthermore, the results suggest that pragmatism moderates the association between DPR and turnover intention in the model.

This study contributes to integrating HRM in the healthcare sector with DPR and turnover intention, indicators of its outcomes of patient care and healthcare workforce, providing new evidence supporting the link between commitment HR practices, patient care, and work attitudes. In light of the limited but increasing evidence on the association between HRM and the beneficial outcome in healthcare organizations (e.g. Leggat et al. 2010; Liu et al. 2015), this study represents an initial attempt to examine the associations among commitment HR practices, DPR, and turnover intention in the Chinese healthcare sector. Our overall findings support employing commitment HR practices in the Chinese hospital context, and

demonstrate the value of commitment HRM in improving patient care like DPR and in retaining senior hospital managers and doctors by reducing turnover intention.

However, literature on commitment models assumes a set of individual values that enact the expected positive outcomes from these commitment practices. Such an assumption is a necessary condition for the effectiveness of these models but, as in all cases, assumptions can be the weakest point in any model. Our study challenges the assumption that in China's hospital settings the commitment model holds independently from individual-value considerations such as pragmatism.

Findings show a complex scenario. On the one hand, this study found significant differences in means for DPR and turnover intention, in which the low pragmatism group reported lower commitment HR, lower level of DPR, and higher turnover intention. This could be an expression of a stronger sensitivity and disappointment with prevailing consumerism and opportunism in hospital settings, as low-pragmatism individuals will be keener to rely on value-based criteria. Also, high pragmatism individuals are more aligned and benefit from the emerging pragmatic system, and thus quite understandably report higher commitment HR, higher level of DPR, and lower turnover intention. This can be taken as a dynamic that will favor high-pragmatism in healthcare and drive low-pragmatic individuals out of the system.

Pragmatism, as shown in this study, might be a two-edged sword, because having it to some degree would be necessary to withstand the pressures of organizational change. Too little will create rigidity and prevent the necessary flexibility, but too much would push the individual into the utilitarianism grounds, which may lead to sacrificing professional mission as a doctor to save lives and protect physical wellbeing, creating ethical challenges in a healthcare setting.

When taking the sample as a whole and disregarding the pragmatism level, findings follow the expected path from commitment HR practices to DPR to turnover intention, which matches

Hypotheses 1 and 2. The moderation findings do show a contrasting behavior between DPR and turnover intention, in which DPR plays some role in explaining turnover intention in the low pragmatism group while it no longer has any explanatory power in the high pragmatism group. The findings have critical implications for China's hospital management policy-making when applying commitment HRM to cope with the two critical issues most of them face: escalating negative DPR and emerging high doctor turnover.

### *Implications and Future Research*

These findings have two implications: 1) commitment HR practices can be an effective tool to implement policies that counter deteriorating DPR in the Chinese healthcare sector, and 2) commitment HR practices will have a different influence on turnover intention via DPR whereby only the low pragmatic individuals will be less likely to quit from their hospitals.

First of all, in support of hypotheses 1 and 2, DPR was positively associated with both commitment HR practices and turnover intention in the overall sample. These findings imply that turnover intention might be reduced by introducing commitment HR practices to improve DPR. Our results are consistent with the arguments that HRM focused on participation and empowerment might improve patient care quality (e.g. Leggat et al. 2010; Liu et al. 2015). The finding suggests that Chinese healthcare organizations should value teamwork, effective collaboration, and open communication (e.g. Fan et al. 2014). Therefore, this study argue that commitment HR practices characterized by participation in decision-making, good internal communication, and team work can be the "one stone" to "kill the two birds" of the deteriorating DPR and turnover issues faced by many Chinese hospitals.

However, a competing interpretation will state that high pragmatic individuals are those who are more effective in resisting poor DPR, as it does not push them into wanting to quit. This apparent resistance can stem from several reasonable causes such as focusing more on

personal benefits, being less emotionally engaged with patients and patients' relatives, or being more "looking-to-oneself" instead of being concerned with the overarching logic of the system. An alarming implication of this finding for the ongoing healthcare reform in China is that, should consumerism and opportunism in hospital settings continue, fewer low pragmatic individuals will stay and serve in hospitals while more high pragmatic ones will stay and continue the "for-profit" mentality, thereby worsening DPR. This has systemic implications that should not be overlooked by policy makers.

Additional implications concern deciding first about the extent to which DPR is important in preventing turnover intention, and second, whether pragmatism should be taken as a critical variable. Findings suggest that DPR can be managed to prevent turnover in low pragmatic individuals, but managers will lack this tool for high pragmatic individuals. So, findings indicate that pragmatism matters for managers and policy makers. It might not matter to the point of radically changing models but it will help in connecting or disconnecting specific HR processes such as investing in commitment HR practices to counter a plausible increase in turnover intention due to poor DPR.

From HRM ethics and stakeholder perspective (see Greenwood and Van Buren 2017), HR managers should be cautious in recruiting and placing high pragmatic individuals in clinical positions in order to ensure the interests of patients are respected. However, one must acknowledge that the overall model does have considerable power in explaining DPR (51%) but quite modest power in turnover intention (7%). This implies a word of caution, as other predictors of turnover intention would need to be taken into consideration in future research and leads to questions such as: is pragmatism a too-much-of-a-good-thing variable? How does it relate with position abuse in DPR? Should pragmatism be a relevant variable in HRM, not only for DPR-turnover intention, but also for many other value-based processes? Further research may explore such questions.

Some limitations need to be acknowledged. First of all, this study is a cross-sectional one, so it is impossible to draw causal inferences. The second limitation is the use of self-report measures, which are prone to subjective bias. Last, this sample is not representative of all kinds of hospitals, although the sample comprises the most important players in putting policies into action in more populated urban areas, i.e. senior doctors from large-scale hospitals. These limitations may be resolved in future studies by employing a longitudinal research design with a more representative sample and by including objective measures such as number of doctor-patient disputes or conflicts and actual turnover rate.

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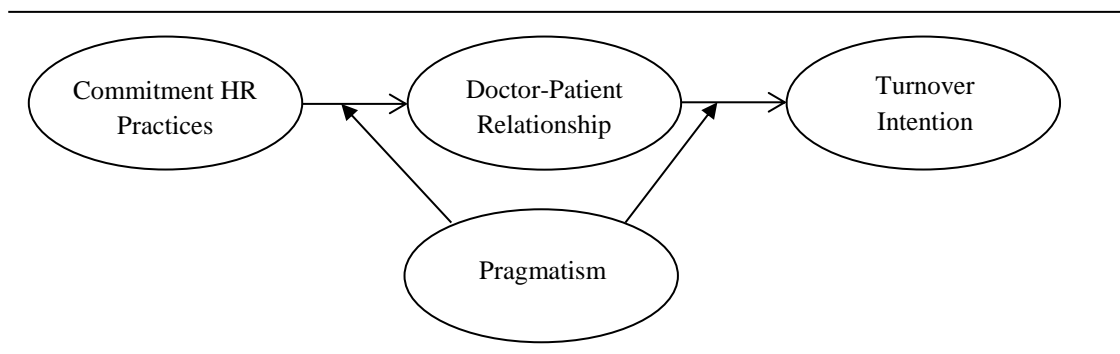
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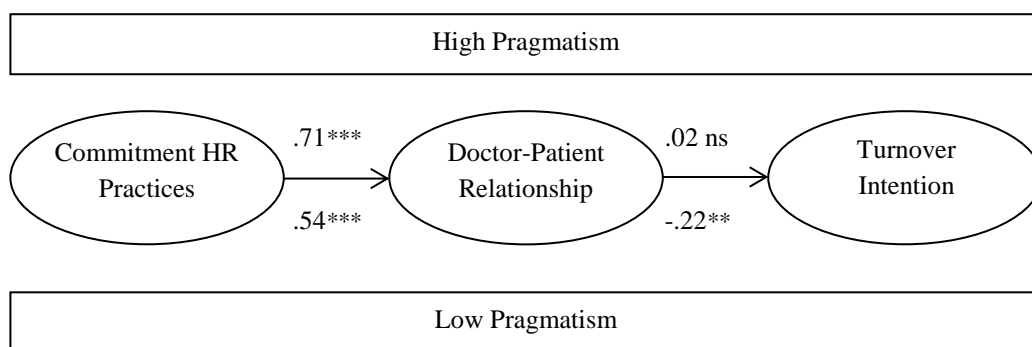
**Figure. 1**

Model linking HR practices, DPR and Turnover Intention



**Figure 2**

SEM Model and Path Coefficients



**Table 1**

## Validity and Reliability of Constructs

Construct	Items	CFA Index	Cronbach's alpha	Composite Reliability	AVE
Commitment HR Practices	1) participation in decision	CMIN/DF=2.200; p=.05; CFI=.99; PCFI=.50; RMSEA=.05; SRMR=.018	.85	.86	.55
	2) internal communication channels				
	3) leadership's acceptance of suggestions from employees				
	4) teamwork				
	5) people oriented management systems in place				
Doctor-Patient Relationship	1) medical competence	CMIN/DF=1.18; p=.308; CFI=0.99; PCFI=.33; RMSEA=.02; SRMR=.01	.79	.80	.52
	2) communication between doctor and patient				
	3) patient's trust in the treatment process				
	4) problem-solving through communication				
Turnover Intention	1) often talking about leaving current employer	CMIN/DF=2.602; p=.074; CFI=0.99; PCFI=.33; RMSEA=.05; SRMR=.017	.78	.79	.50
	2) looking for new job within one year				
	3) determined to leave for new career opportunity				
	4) leaving because of bad prospect of hospital				

**Table 2**

## Descriptive and bivariate analysis

	Mean (s.d.) Low Pragm 297	Mean (s.d.) High Pragm 211	1	2	3	4	5	6	Comparison statistics (X <sup>2</sup> ; ANOVA)
1.Gender	1.41 (.49)	1.48 (.50)	<b>1</b>	.312**	.135	.004	-.009	-.084	X <sup>2</sup> =2.546
2.Education	4.07 (1.76)	4.19 (1.67)	.273**	<b>1</b>	-.069	-.069	-.001	.030	F(1,506)=.583
3.Hosp_size	3.30 (1.19)	3.37 (1.22)	.111	-.063	<b>1</b>	-.004	.203**	.240**	F(1,506)=.415
4.CHP	3.01 (.58)	3.72 (.57)	-.015	.074	.011	<b>1</b>	.611**	-.167*	F(1,506)=181.09 **
5.DPR	3.26 (.54)	3.76 (.58)	-.090	.119*	.006	.418**	<b>1</b>	.013	F(1,506)=98.877 **
6.TI	2.54 (.69)	1.83 (.69)	.076	-.058	.184**	-.257**	-.232**	<b>1</b>	F(1,506)=127.622 **

High pragmatism group above diagonal, low pragmatism group below diagonal, for gender, Education, and Hospital size Cramer's V is reported. \*p<0.05; \*\*p<0.01

**Table 3**

Fit indices of the additive models (multi-group analysis)

Model	CMIN/DF	p	CFI	PCFI	RMSEA PCLOSE	[LO90-HI90]
Null	17.971	<.001	.000	.000	.183 [.176-.190]	.000
Unconstrained	1.918	<.001	.959	.732	.043 [.033-.052]	.888
Same factor loadings	1.864	<.001	.957	.801	.041 [.032-.051]	.932
Same regression weights	1.904	<.001	.958	.749	.042 [.032-.052]	.901
Same factor loadings and regression weights	1.921	<.001	.954	.815	.043 [.033-.052]	.900