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Relationships Among Work-Family Conflict, Organizational Silence, Peer Support, and Turnover Intention of Second Child Nurses in China

HUANG Xiaoqiong

Doctor of Management

Supervisor:
PhD Maria de Fátima Salgueiro, Associate Professor
ISCTE University Institute of Lisbon

May, 2021

BUSINESS
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Declaration

I declare that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university and that to the best of my knowledge it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed:  Date: 2021.5.14

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Abstract

This empirical study is based on a survey among Chinese nurses. Nurses in 216 secondary and tertiary level hospitals were selected using convenience sampling method, and 3,974 valid questionnaires were obtained. Four scales were adopted: Work-Family Conflict Scale, Organizational Silence Scale, Peer Support Scale and Turnover Intention Scale. IBM SPSS Statistics and AMOS were used.

The results showed that the work-family conflict, organizational silence and peer support of Chinese nurses were all at medium to high levels. Nurses without children had lower levels of work-family conflict than nurses with a child or children; nurses with one child had lower levels of work-family conflict than nurses with two or more children; compared with nurses without children, nurses with a child or children had lower levels of turnover intention; work-family conflict positively influenced turnover intention; peer support negatively influenced organizational silence and turnover intention; organizational silence positively influenced turnover intention.

Work-family conflict and peer support had both direct and indirect effects on turnover intention; organizational silence had a direct effect on turnover intention; and peer support and organizational silence mediated the relationship between work-family conflict and turnover intention.

This study explored the formulation of motivational management strategies. The factors influencing nurses' turnover intention and the relationships among them were discussed. The results showed that the number of children influences nurses' work-family conflict, organizational silence, peer support, and turnover intention. This study provides insights for nursing managers to improve nursing management models and health policies.

Keywords: Nurses; Turnover intention; Work-family conflict; Organizational silence; Peer support

JEL: I18; M51

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Resumo

Este estudo é baseado num questionário junto de enfermeiras chinesas, com recurso a amostragem por conveniência. Foram selecionadas enfermeiras de 216 hospitais chineses e validados 3974 questionários. Utilizaram-se quatro escalas para medir as dimensões "conflito trabalho-família", "silêncio organizacional", "apoio dos pares" e "intenção de saída". A análise estatística foi feita com IBM SPSS Statistics e AMOS.

Os resultados mostram níveis médios a altos nas dimensões conflito trabalho-família, silêncio organizacional e apoio dos pares. As enfermeiras sem filhos apresentaram níveis mais baixos de conflito trabalho-família do que aquelas que têm filhos. Por outro lado, as enfermeiras com um único filho demonstraram níveis mais baixos de conflito trabalho-família do que as que têm dois ou mais filhos. No que se refere à variável intenção de saída as enfermeiras com uma ou mais crianças mostraram níveis mais baixos de intenção de saída, enquanto que o conflito trabalho-família influenciou positivamente essa intenção. O apoio dos pares influenciou negativamente o silêncio organizacional e a intenção de saída; o silêncio organizacional influenciou positivamente a intenção de saída. O conflito entre trabalho e família e o apoio de pares tiveram efeitos diretos e indiretos na intenção de saída; o silêncio organizacional teve um efeito direto na intenção de saída; o apoio dos pares e o silêncio organizacional mediaram a relação entre o conflito trabalho-família e a intenção de saída.

Este estudo explorou a formulação de estratégias de gestão motivacional. A autora discutiu os fatores que influenciam a intenção de saída das enfermeiras, e sua inter-relação. Os resultados mostram que o número de crianças influencia o conflito trabalho-família, o silêncio organizacional, o apoio dos pares e a intenção de saída. Este estudo fornece insights para os gestores de enfermagem com vista à melhoria dos modelos de gestão de enfermagem e das políticas de saúde.

Palavras-Chave: Enfermeiras; Intenção de saída; Conflito trabalho-família; Silêncio organizacional; Apoio dos pares

JEL: I18; M51

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摘 要

本研究是一项以中国护士为研究对象的实证研究，研究者通过工作关系并采用便利抽样的方法，抽取中国二级及以上医院 216 家的护士为目标人群，最终获得有效问卷 3974 份。本研究采取了工作-家庭冲突、组织沉默、同事支持和离职倾向 4 项量表。采用 IBM SPSS Statistics 25.0 和 AMOS 24.0 进行统计学处理。

结果显示，中国护士的工作-家庭冲突、组织沉默、同事支持水平均处于中国中等偏上水平；未生育子女的护士的工作-家庭冲突显著低于生育子女的护士；一胎护士的工作-家庭冲突显著低于二胎及以上的护士；与未生育子女的护士相比，生育子女护士的离职倾向更低；工作-家庭冲突与离职倾向呈正相关；同事支持与组织沉默和离职倾向均呈负相关；组织沉默与离职倾向呈正相关。

工作-家庭冲突和同事支持对离职倾向的影响都包括直接影响和间接影响两部分；组织沉默对离职倾向则起直接影响作用；同事支持、组织沉默在工作-家庭冲突和离职倾向起中介作用。

本研究探索建立激励管理策略，作者讨论了护士离职倾向的影响因素及他们之间的相关性。研究结果显示，护士生育子女数量与工作-家庭冲突、组织沉默、同事支持和离职倾向之间存在相关性。本研究为护理管理者改善护理管理模式和卫生政策提供了启示。

关键词：护士；离职倾向；工作-家庭冲突；组织沉默；同事支持

JEL: I18; M51

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Chapter1: Introduction

1.1 Research background

1.1.1 The development history of China's nursing industry

The development of nursing in China is inseparable from the attention from and support of the Communist Party of China (CPC) and the government. Back in the Revolutionary War period, former Chairman Mao Zedong wrote the inscriptions of "respect nurses; love nurses" and "nursing work is of great political importance" for Yan'an Nurses Association. Former presidents, including Mr. Li Xiannian, Mr. Jiang Zemin, and Mr. Hu Jintao all presented awards to Florence Nightingale Medal recipients. Former premiers, including Mr. Zhou Enlai, Mr. Li Peng, Mr. Zhu Rongji, and Mr. Wen Jiabao all met nurses on various occasions. And former honorary presidents of the Chinese Nursing Association, including Mr. Deng Yingchao and Ms. Chen Muhua, as well as former ministers and vice-ministers of health, all gave specific guidance on nursing work. Guided by Florence Nightingale, the founder of nursing profession and modern nursing education founded modern nursing, nursing has always been closely linked with the humanitarian spirit of caring for life as well as healing the wounded and rescuing the dying. With rigorous work attitudes and advanced nursing technology, the majority of nurses in China work conscientiously in the front line of nursing, making important contributions to protecting people's health and promoting the development of healthcare undertakings. In the 20th century, nursing as a profession was established, developed, and matured. Besides, with the changes in the medical model, treatment-oriented traditional nursing has shifted to people-oriented holistic nursing. The knowledge system of nursing has been gradually established and improved. New theories, methods, and techniques of nursing have been applied in practice. The idea of "putting patients first" has been further reinforced. Psychological care, pain nursing, specialist care, community care, senior care, and hospice care have been further strengthened. The scientific, practical, and humanistic nature of nursing has been fully reflected. Nursing is playing an increasingly important role in promoting and maintaining human health.

In China, the nursing profession appeared at the end of the 19th century when nurses were introduced from the West to the church hospitals in China's coastal areas. In 1888, Johnson, a

nurse of the United States, founded the first nursing school in Fuzhou. Ms. Zhong Maofang, the first Chinese nurse to serve as the vice president of the Chinese Council of Nurses, put forward that the Chinese name of "nurse" should be changed from "kanhu" to "hushi", which means to protect and nurture. In 1909, the Federation of Nursing Organizations was established, later known as the Chinese Council of Nurses, the predecessor of the Chinese Nursing Association.

In 2005, China's Ministry of Health promulgated and implemented the *Outline of China's Nursing Development Plan (2005-2010)* (The Ministry of Health of the People's Republic of China, 2005), which put forward that according to a survey conducted by the Ministry of Health among more than 400 hospitals across China in 2005, the average ratio of nurses to beds in wards was 0.33:1, and more than 95% of the inpatients in hospitals relied on their family members or nurses to take care of them. To reduce the labor cost of nurses, hospitals employed temporary nurses, which seriously affected the stability and development of the nurse team. On the other hand, nurses' service awareness, service concept, professional quality, and technical skills fell short of the development of clinical medical technology and people's needs for diversified health services. The professional development of nurses lagged behind that of clinical medicine. Therefore, the development goals and priorities of nursing in the "Eleventh Five-Year Plan" period were clarified. The overall goals were: To strengthen the development of nurses, improve their overall quality, standardize their professional behavior, improve the quality of nursing service and professional technology, expand nursing services, strengthen nursing management, standardize nursing education, promote the coordinated development of nurses' vision, social economy, and medical technology, and meet people's needs for health services.

In 2011, China's Ministry of Health promulgated and implemented the *Outline of China's Nursing Development Plan (2011-2015)* (The Ministry of Health of the People's Republic of China, 2011), which proposed to strengthen the development of the nursing human resources, vigorously cultivate and train nursing professionals, implement the relevant standards of nurse allocation, allocate more nurses to primary hospitals, optimize the structure of the nursing team, and improve the service capacity of the nursing team. Measures should be taken to increase the total number of registered nurses in China to 2.86 million by 2015. The number of registered nurses per thousand population should reach 2.07, and the ratio of licensed (assistant) doctors to registered nurses in China should reach 1:1-1.2. Efforts should be made to increase the percentage of nurses in hospitals of all levels. By 2015, the ratio of doctors to nurses in community health service institutions should be between 1:1 and 1:1.5. The

structure of the nursing team should be optimized, and the team of clinical nurses stabilized. The personnel system and income distribution system in hospitals should be improved, and a scientific performance appraisal mechanism established. The income distribution, professional title promotion, reward, and performance appraisal of nurses should be based more on their clinical performance to create a good atmosphere where there is more pay for more work, good pay for good performance, and equal pay for equal work and to retain nurses working at the clinical frontline.

In 2016, China's Ministry of Health promulgated and implemented the *Outline of China's Nursing Development Plan (2016-2020)* (The Ministry of Health of the People's Republic of China, 2016), according to which measures should be taken to increase the supply of nursing services and promote the rational allocation of resources for quality nursing services. As China's socio-economic development entered a "new normal", population aging became a more serious issue, new urbanization was accelerating, and supply-side structural reform further released the multi-level and diversified health needs of the public. It was imperative to accelerate the development of nursing and closely align the connotations of nursing services with the health needs of the public. Advancing the "Healthy China" initiative and continuously deepening the reform of the medical and health care system have brought rare opportunities for the development of nursing. It was explicitly put forward at The Fifth Plenary Session of the 18th Central Committee of CPC that efforts shall be made to change the focus on the treatment of diseases to the focus on people's health. Nursing serves the entire process of a person's life, from birth to sickness and to death, and plays an important role in meeting people's physical, psychological, and social needs. Compared with the socio-economic progress, the development of health and family planning undertakings, and people's health needs, the development of nursing care in China is also faced with challenges. First, there is a shortage of nurses; nurses are unevenly distributed; and the professional quality and service capacity of nurses need to be improved. Second, the systems and mechanisms to mobilize the initiative of nurses are yet to be improved. Third, the connotations of nursing services need to be constantly enriched, and the scope of nursing services further expanded.

1.1.2 The four challenges facing China's nursing industry

China has a large population and a vast territory. The economic development is uneven across its various regions, and the level of medical services varies greatly from region to region, with

weak medical infrastructure in central and western regions as well as rural areas. As the aging trend persists, healthcare for the elderly is bound to face challenges. The demand of the elderly for health care and life services significantly exceeds that of other industries. Besides, nowadays people pay more and more attention to their health and often go to hospitals for medical checkups, which also leads to an increase in the demand for health workers. Guo (2017, May 10), deputy director of the Bureau of Medical Administration, National Health and Family Planning Commission, mentioned at a press conference in 2017 that China's nursing industry was faced with four challenges, which is still true today. The first challenge is the shortage of nurses, which is strongly related to the accelerated population aging in China; the second challenge has to do with the low stability of the nursing team. Nursing may seem an ordinary profession, but it has very high requirements. Nurses need to face risks and work night shifts. As a result, nurse turnover has become an issue of concern. The third challenge is the imbalance in the sex ratio of the nurses. Although the number of male nurses in China has increased a lot in the past few years, the absolute number is still relatively small. In clinical practice, male nurses are especially needed to undertake emergency and provide psychiatric care. The fourth challenge concerns the difficulty to extend the nursing career. Guo Yanhong said that it is important to find ways to allow Chinese nurses to continue working in clinical positions at the age of 40, 50, and even after retirement.

1.1.3 The status quo of nursing human resources in China

In 2001, there was still a huge gap between the ratio of nurses to doctors in China and that in developed countries, with the former lagging far behind the standard of 1:2 required by China's Ministry of Health (Xu & Tan, 2001). According to the *World Health Statistics 2015* published by the World Health Organization (WHO), the average number of nurses (including midwives) per 10,000 population across the world was 28.6 in 2015. Specifically, the number in Europe was 80.2 and that in the American region 44.9. However, the number in China was only 16.6 (WHO, 2015). It can be seen from the comparison that back in 2015, the number of nurses per capita in China failed to reach the global average and seriously lagged behind that in Europe and the American region.

Currently, China's nursing industry is characterized by a low proportion of nurses in hospitals, a significant shortage of nurses, and huge nursing workload. Hospitals in China are classified into different levels. The ratio of doctors to nurses varies in different levels of hospitals. The level of a hospital is determined according to the assessment of its

qualifications, such as size, ability to carry out scientific research, human resources, technical strength, and medical equipment, as per the Standards for Level-to-Level Administration of Hospitals in China. After review, hospitals are classified into three grades, namely, primary, secondary, and tertiary hospitals. These three grades are further subdivided into three subsidiary levels, A, B, and C. In addition, one special level, 3AAA, is reserved for the most specialized hospitals. Hence, hospitals in China are divided into three grades and ten levels. Xu et al. (2016) found in their study that the ratio of doctors to nurses in developed countries ranged from 1:3 to 1:3.5, whereas the ratio in China was 1:1.6 in tertiary hospitals and 1:1.57 in secondary hospitals. This ratio is up to standard in only a quarter of the hospitals in China. The shortage of nurses occupying budgeted posts is particularly serious in tertiary hospitals where the nursing workload is huge, leading to physical and psychological burnout among nurses in the long term.

Besides, China's nursing industry was also faced with some other issues, such as "nurses staying on the payroll without reporting for duty", "unreasonable utilization of human resources", "low stability", and "high turnover" (Feng et al., 2013). These problems have only made the shortage of nurses more serious. In other words, the nursing industry in China is faced with dual challenges, namely, low stability of the nursing team and high turnover of nurses.

1.1.4 The context for the implementation of the second-child policy in China

It was officially decided at the Fifth Plenary Session of the 18th CPC Central Committee held in 2015 that a "universal two-child policy" would be implemented. Fertility, which is related to population continuity and social progress, has received a lot of attention from the whole society in recent years. China is the most populous country in the world. It experienced two waves of the baby boom, respectively in the 1950s and between 1962 and 1972. After the 1980s, the rate of population growth accelerated, with an increase of 100 million people every five to seven years. Such a large population was bound to exert huge pressure on socio-economic development. In this context, to alleviate the contradiction between population growth, economic development, and social resources, the 12th National Congress of the Communist Party of China held in 1982 introduced the ''family planning policy'' as a basic national policy. The strict control of population growth, adherence to good prenatal and postnatal care, and improvement of population quality are directly related to the further improvement of people's living standards and are also fundamental tasks crucial for

generations to come. The family planning policy has been the core of China's population policy. It has undergone a development process of repeated exploration and continuous improvement. According to the report on the population and family planning work issued by the National Population and Family Planning Commission in 2007, the development of China's family planning policy has undergone four stages (National Population and Family Planning Commission, 2007, July 9).

The first stage lasted from the founding of New China to the late 1950s when the first wave of the baby boom occurred. During the period of economic recovery and the First Five-Year Plan, China experienced quick recovery and development of the national economy. The rapid economic development stimulated the rise of the fertility rate. Back then, the government not only failed to adopt a planned policy of population control in a timely manner, but also took a series of administrative and economic measures to, directly and indirectly, encourage births despite all the downsides. In 1953, China conducted the first national population census, the results of which showed a net increase of more than 46 million people within the four years after the founding of New China. As this trend continued, the contradiction between the unplanned population growth and the planned development of the national economy began to emerge. CPC and the People's Government began to be aware of the necessity of dealing with the uncontrolled growth of the population. In 1956, former Chairman Mao Zedong presided over and formulated the National Program for Agricultural Development (Draft), in which it was put forward that: "Birth control and planned birth shall be advocated in all densely populated areas, except for the areas inhabited by minority groups". Renowned economists, such as Ma Yinchu and Shao Lizi, together with other scholars, also put forward propositions on controlling population growth successively. However, in the second half of 1957, the Anti-Rightist Campaign began. And due to the influence of the "left-wing" ideas, the view of Ma and other scholars on birth control became the target of criticism. This situation seriously influenced the population policy and led to the uncontrolled growth of the population. In the eight years from 1950 to 1957, China's population increased by 105 million, with an average annual increment rate of 22.4‰.

The second stage lasting from the late 1950s to the late 1960s was a period when family planning was mentioned again but immediately sabotaged by the turmoil caused by the "Cultural Revolution". In 1963, China's population growth rate reached 43.37 ‰. This uncontrolled and rapid growth of the population once again attracted the attention of the state. In October 1963, China's CPC Central Committee approved and forwarded the decision of the State Council at the Second Urban Work Conference and put forward that "the Central

Government and local authorities should set up family planning committees to specifically lead family planning work". It also proposed that measures should be taken to increase public awareness, provide technical guidance, appropriately modify provisions inconducive to family planning by relevant departments, and advocate late marriage. The population increase attracted more attention from the state government, which believed that family planning would be of great significance to carrying out planned economic development, guaranteeing the health of women and children, and appropriately arranging the lives of the public and that it was an important matter relating to the national economy and people's livelihood. Meanwhile, China's State Council decided to set up the Family Planning Office to include family planning in the government agenda. In 1965, CPC and the People's Government introduced a series of policies and measures to control population growth, such as advocating the production and free distribution of oral contraceptives, improving birth control technology, integrating healthcare and family planning, strengthening publicity, education, and technical guidance on family planning, integrating the efforts on family planning, improving people's lives, and arranging labor forces reasonably. It also put forward population growth targets. The popular slogan at that time was: "One is enough. Two are perfect. Three are excessive." Right after the implementation of family planning work, the "Cultural Revolution" began. This unrest also seriously affected and sabotaged the family planning work. During the period of upheaval, the state took corresponding measures to control population growth, and many people still implemented family planning according to their own needs and interests. However, leading authorities at all levels suffered a negative impact, and various correct policies and systems were compromised. As a result, on the whole, there was a prevalence of anarchism in family planning work, which led to the lack of government control in family planning and uncontrolled population growth. In the 1960s, the average population growth rate in China was high. From 1962 to 1970, the average annual increment rate of the population reached 26‰, with the total fertility rate reaching 5.91. China's population increased by a total of 170 million in nine years, marking the second wave of the baby boom of New China.

The third stage referring to the 1970s was a period of remarkable results from the family planning policy. After 1970, former premier Zhou Enlai did a lot of work that laid a foundation for China's family planning work despite mountains of difficulties as well as the interference and destruction by the "Gang of Four". Due to his efforts, China's birth rate began to decrease year by year. In 1971, China's State Council approved and forwarded the Report on Carrying out Family Planning Well issued by China's Ministry of Health, Ministry of Commerce, and Ministry of Chemical Industry. It was put forward in the Report that:

Efforts shall be made to strengthen the leadership of family planning and carry out in-depth publicity and education to instill the idea of late marriage and family planning into the consciousness of the general public in all areas except for sparsely populated areas inhabited by ethnic groups and other regions. In terms of family planning publicity and education, the slogan of "late marriage, long birth interval, and two children" was put forward. In the same year, at the National Planning Work Conference chaired by former premier Zhou Enlai, population growth indicators were included in the national economic plan for the first time. In this period, new progress was made in the formulation and implementation of family planning policies and measures, and the work on population theory also achieved progress in the later stage; some policies and regulations unfavorable to family planning were gradually modified, and some policies and regulations conducive to the control of population growth formulated. And it was explicitly stipulated in national laws that "the state advocates and implements family planning"; family planning work organizations at all levels were adjusted and equipped with professional cadres, and the experience of carrying out family planning work over the years was summarized; scientific research institutions and technical teams dedicated to family planning were further developed, and the production and supply of contraceptives strengthened; the government proposed to reward couples with only one child; The Marxist population theory began to be widely disseminated, and population theory training courses and seminars were successively held, which laid the ideological foundation for carrying out family planning.

The fourth stage starting from 1979 was a new stage of family planning. Family planning was made a national policy. In the seven years from 1979 to 1985, China's birth rate remained at around 19‰, and its natural growth rate about 12.5‰, with a total fertility rate of about 2.3. It became a universally acknowledged fact that China's fertility rate declined rapidly, which proved that implementing family planning to control population growth is feasible in a socialist country.

Entering the 21st century, China's population growth gradually showed a trend of "low birth rate, low death rate, and low growth rate". It can be seen that the family planning policy had played a huge role in adjusting the population size and structure. However, with the rapid change of population structure, the negative effects brought by family planning gradually emerged. China's fertility rate started to drop rapidly all the way to 1.6 in 2012, which was lower than the sustainable development level of 2.1. Such a significant drop brought a series of consequences (Dou, 2020).

In terms of the labor force, statistics showed that starting from 2012, China's working-age population decreased by millions every year for three consecutive years. Besides, aging started to be a problem in the existing working-age population. These changes came as huge shocks to China, a country known as "the factory of the world" for a long time, because its labor supply was no longer inexhaustible. Mr. Cai Fang, director of the Institute of Population and Labor Economics at the Chinese Academy of Social Sciences, told a journalist from the *Economic Information Daily*: "By 2013, China's working-age population will no longer grow, followed by zero growth and then negative growth. The year 2013 will be a landmark turning point." According to calculations, China's demographic dividend would end in 2013.

In addition, the rapid aging of the population will have a profound and far-reaching impact on China's labor market, socio-economic development, old-age support, social security, and other fields. In this context, there is an urgent need to adjust the population policy. China has more than 150 million one-child families. The basic functions of the family to provide an orderly context for procreation and old-age care are weakened. Faced with the heavy burden of old-age care, many one-child families tend to feel powerless and helpless.

The implementation of the family planning policy and too low fertility rate in China will not only lead to the aging of the population and shortage of labor force but also reduce the growth rate of the economy. Experts predicted that with the disappearance of the demographic dividend characterized by the decrease in the working-age population, China's potential GDP growth rate was expected to decline from an average of 10.3% from 1995 to 2010 to 7.6% during the "Twelfth Five-Year Plan" period. These statistics proved that had China failed to adjust its family planning policy, it would have lost the last opportunity to alleviate population aging, so much so that a series of very severe socio-economic problems would have come into existence. Therefore, from the perspective of reduced population dividend, opening up the "selective two-child policy" (couples were allowed to have a second child if either parent was an only child) was not only necessary but also inevitable.

In this context, the Fifth Plenary Session of the 18th CPC Central Committee officially decided to implement the "universal two-child" policy. From the macro perspective, the adjustment of the fertility policy may alleviate the above pressure, promote the development of the national economy, and extend the "demographic dividend". In the year when the policy was implemented, the number of newborns reached 17.86 million, an increase of 1.31 million over the previous year.

1.1.5 Increased willingness to have a second child among nurses in China since the

implementation of the two-child policy

For the purpose of this study, "second child nurses" refers to nurses who have two children and those who are pregnant with a second child.

Most Chinese people are under the influence of traditional fertility concepts. For example, they tend to think that "having both a son and a daughter is a sign of a complete family" and that "having more children means having more blessings". Ma (2004) pointed out that traditional Chinese culture is the sum of various historical thoughts and cultures of the Chinese nation, including the cultures in various ideological or material forms. This cultural system is based on feudal relations and small-scale peasant economy, with ethics and politics as the core, blood relation as the link, and family as the basic unit. The semi-closed geographical environment of the Chinese Mainland is also related to the generation of traditional Chinese culture to a certain extent. In other words, China's geographical environment is the background of the generation and development of its traditional culture. Fertility culture is the abstraction, reflection, and materialization of traditional culture in fertility activities. Therefore, the generation and development of the fertility culture are not isolated but attached to the development and evolution of the whole cultural system. Its generation cannot be separated from traditional culture, and its change is invariably marked by the evolution of the traditional cultural system.

The modern fertility concept is mainly influenced by the policy and economic development level of a country. Liu (2015) pointed out that the modern fertility concept has undergone subtle changes with the introduction of the "universal two-child" policy. On the one hand, people no longer give birth to children for utilitarian purposes nowadays. Instead, they give birth to children to experience the joy of being with children. On the other hand, people now pay more attention to children's education, which leads to the rising cost of raising a child.

The fertility concept tends to have a decisive impact on fertility behavior. Wang and Wang (2013) analyzed the significance, status quo, problems, and willingness of implementing the "selective two-child policy" among Chinese people of childbearing age by comprehensively using the original data of the 2011 Comprehensive Survey on China's Social Conditions and the 2012 Survey on Hot Issues Concerning Family Well-Being in China. Their study suggested that in 2012, the average number of children one family was willing to have was 1.86, and that was 1.91 in rural areas and 1.79 in cities and towns, respectively. After the implementation of the "universal two-child" policy, the percentage of Chinese

women of childbearing age who were willing to have a second child was 42.0%. An analysis of the factors influencing the rate of having a second child showed that region, place of domicile, age, occupation, and gender of the first child all affected the intentions of women of childbearing age to have a second child (Zha et al., 2020). Women in eastern China were more willing to have a second child than those in western China. Yang and Shi (2020) found in their survey on the fertility intentions of the people of childbearing age in Guizhou Province that 49.5% of them were willing to have a second child. Zhong et al. (2017) found that the fertility intentions of the people of childbearing age in Guangdong Province were as high as 68.4%. Zhang (2019) pointed out in a survey on the intentions of the working women of childbearing age in Wuhan City that 41.79% of them were willing to have a second child. In terms of gender, a study suggested that women have stronger intentions to have a second child than men (Chen et al., 2014). In terms of age, as couples get older, their intentions to have two children get weaker (Shi & Yang, 2014). The older the first child is, the more reluctant the couples are to have a second child (Zhang, Yin, & Xu, 2014). From the perspective of socio-economic factors, there are also differences in fertility intentions among regions of different economic development levels. Specifically, the lower the economic development level, the lower the intention to have a second child (Zhou, 2015). Living standards determine the abundance of a family's material and spiritual life and can also affect the family's intention to have children to a certain extent. The higher the living standards, the more likely a couple where either the husband or wife is from a single child family is to have a second child (Niu et al., 2015). Lu et al. (2020) found in their study that the higher the education level of female health workers, the lower the rate of having two children. They also found that female doctors with higher education levels have a longer interval between the first child and the second child compared to their counterparts with lower levels of education.

"Implementation of the universal two-child policy" can also lead to a series of effects. The first is the impact on individual families. Parents are paying more attention to their children's education, which will increase the cost of raising a child, thus causing a sense of ambivalence among people suitable for childbirth. A family's fertility choice is a process of mutual negotiation between family members. This process may trigger the conflict between husband and wife, between parents and children, and between elders, affecting the harmony and stability of the family to a certain extent. It can also lead to parent-child conflict. Specifically, having a second child may trigger strong mood swings in the first child because the first child might worry that the love given to him/her by parents will be taken away by the second child. This might also lead to conflict between couples and their parents. Parents, who

belong to the older generation, tend to be deeply influenced by the traditional fertility concepts that "having both a son and a daughter is a sign of a complete family" and that "having more children means having more blessings". They prefer their children to have two children and believe that one child may feel lonely. This does nothing but increases family conflict.

The second is the stress on women's employment. Pregnancy may affect women's career development planning. To protect women's fertility rights and interests, China introduced relevant regulations to safeguard women's right to take maternity leave. For enterprises, paid maternity leave will undoubtedly increase their financial burden. Therefore, to "reduce" such loss, enterprises often discriminate against women in recruitment. In other words, women have to meet stricter requirements when seeking jobs. Besides, after the implementation of the universal two-child policy, more and more working women become mothers of two children. As a result, these working women put more effort into the family and shift their focus to the family. Although such a shift can contribute to family harmony, it is not for the benefit of enterprises (Wang et al., 2019).

The current policy will influence around 90 million Chinese women of childbearing age, including 40.26% of nurses who plan to have a second child (Liu & Li, 2016). A nurse's career planning is a process where the organization and the nurse make joint efforts to build a career path and the nurse matches and coordinates with the organization's job demand through her/his work performance so that the organization and the nurse can have both their needs met and achieve mutual benefit. Given the heavy workload and shortage of nurses and based on the traditional view of the female role and sex characteristics, the birth of a second child is bound to affect nurses' attitude towards their profession (Wu et al., 2013).

1.1.6 Dilemmas facing nursing management since the implementation of the second-child policy in China

Nursing is a profession characterized by "heavy responsibilities, high work intensity, a tight schedule, and a shift system", which lead to energy and emotional exhaustion. Hsu et al. (2010) found in their study that most nurses are overworked and tend to suffer from emotional disturbance, as well as physical and mental burnout, as they work in high-stress environments for a long time, which leads to reduced job satisfaction.

With the implementation of the two-child policy, more and more nurses decide to have a second child, which has brought many challenges to clinical nursing work and nursing

managers. As shown in the study conducted by Ding, Zhai, and Wu (2017), nurses who choose to have a second child tend to bring negative impacts to clinical work. Specifically, more pregnant nurses mean that more nurses will take maternity leave. And second child nurses cannot work night shifts or can only work shorter night shifts due to pregnancy and breastfeeding. As a result, there will be fewer nurses available for working night shifts, making scheduling difficult. Nursing is a profession requiring both physical labor and mental labor. As more nurses choose to have a second child and most of them play a key role in their departments, the remaining nurses have to take on heavier workloads and shoulder more responsibilities, leading to lower quality of care.

As mentioned above, there is a shortage of nurses in China (Wu et al., 2013). Besides, the nursing profession is characterized by a heavy workload, high occupational risks, and unclear career prospects. In this context, as more and more senior nurses plan to have a second child, young nurses need to take on heavier workloads, leading to reduced job satisfaction, which further leads to increased turnover intention (Xu et al., 2016). Increased turnover intention is also found among contract-based nurses, who are taking up a greater and greater percentage in the total number of nurses. Xu et al. (2016) found in their study that the percentage of contract-based nurses had increased to 53.74%, exceeding the percentage of nurses occupying budgeted posts for the first time. The turnover intention among contract-based nurses has always been high as they tend to be younger and have more alternatives. As some of them plan to have a second child or already have two children, their turnover intention is bound to even higher. The average age of nurses in China is getting younger, which has become a prominent feature of the composition of nurses. Survey results show that the percentage of nurses who are under the age of 35 accounted for 77.0% of all nurses, of which those under the age of 25 increased rapidly (32.7%) (Xu et al., 2016). With the promotion of medical reform and quality nursing services, a large number of young nurses entered the industry to provide clinical care. The “post-80s” became the majority of clinical nurses. However, they are also the majority of nurses who plan to have a second child. Besides, the increase in the number of children might cause family conflict for second child nurses (Tao & Shen, 2018). Work-family conflict influences both family and work and form a vicious cycle, directly influencing nurses’ normal work and quality of life at the organizational level as well as the individual level. Some nurses may suffer from dysphoria, tension, and anxiety, which have a negative impact on their work and family life.

In summary, with the implementation of the second-child policy, the shortage of nurses and increased workload for nurses have become common phenomena; nurses are less

proactive in putting forward suggestions and have less initiative at work; second child nurses, who are strained in time, tend to ask for leave more frequently, reduce participation in department activities, and strange themselves from peers. Due to the increase in the number of children and more and more busy work, they tend to experience significant emotional fluctuations. Should they fail to develop a correct understanding of their situation and handle such issues properly, conflict is bound to occur between their work and family and/or with their peers. In that case, hospitals will have to manage the risks of nurse turnover. Since the implementation of the second-child policy, the number and percentage of second child nurses have been increasing. Hospitals will be faced with a new round of fertility peak, which will bring various challenges to hospitals and managers. The problems faced by second child nurses, such as work-family conflict, organizational silence, low levels of peer support, and high turnover intention are becoming more and more prominent (Nei, Snyder, & Litwiller, 2015). It is imperative for me to study and explore a nursing management model suitable for the context of a large percentage of second child nurses and provide policy support in this regard.

At present, the domestic and international studies on the relationships among work-family conflict, organizational silence, colleague support, and turnover intention are mostly concentrated on employees of other industries. There is a lack of such study among nurses. Most studies on work-family conflict, organizational silence, colleague support, and turnover intention are focused on such factors as the status quo and influencing factors, research and measurement of scales, theoretical basis, sources of stress, occupational burnout, and job satisfaction. Very few studies are dedicated to the nursing industry. Considering the particularity of the nursing industry and the fact of second child nurses, the results of existing research cannot simply apply to the nursing industry. Therefore, we still need to conduct a large number of empirical studies for analysis and demonstration, so as to provide suggestions for nursing managers and policy makers to timely intervene and ensure the stability of the nursing team.

1.2 Research dilemma, objective and questions

China’s nursing industry is faced with many challenges, such as inadequate nursing human resources, a huge demand for nurses, the dominance of female nurses, the increasing percentage of second child nurses since the implementation of the second-child policy, as well

as increased stress and turnover intention faced by second child nurses at work. These challenges have negatively influenced the stability of the nursing team.

It has been found in management practice that since China stepped into the second child era, some negative trends have appeared in nursing workplaces. For example, more and more nurses ask for leave; hospitals are understaffed; nurses' workload has increased; nurses' work initiative has reduced; nurses are less motivated to express their views or put forward suggestions; peers are estranged from each other. In addition, nurses are faced with a tighter and tighter work schedule, which causes them to express mood swings. Nurses who lack adequate awareness may suffer work-family conflict, conflict with peers and organizational silence, which results in increased turnover intention within the nursing team. In recent years, most nursing managers unanimously hold that the problems related to work-family conflict, organizational silence, peer support and turnover intention among second child nurses are becoming more and more prominent. However, no existing research has put forward management models and policies suitable for second child nurses. The management dilemma and challenge for hospitals and hospital managers remain to be addressed.

This study aims to explore the solutions to reducing the turnover intention of the second child policy by developing an in-depth understanding of Chinese nurses and the relationships among work-family conflict, organizational silence, peer support, and turnover intention of the second child nurses after the implementation of the second child policy as well as study and explore a nursing management model suitable for the context of the implementation of the two-child policy. On this basis, this study endeavors to put forward suggestions for nursing managers and recommendations for policymakers to make timely interventions for ensuring the stability of the nursing team.

To achieve the research purpose, the following research questions are put forward:

1. Which are the factors influencing nurses' turnover intention and how do they relate to each other?

2. How does the number of children a nurse has influence their work-family conflict, organizational silence, peer support and turnover intention?

3. Which are the influences of the second child era on Chinese nurses' turnover intention in the context of the second child peak among Chinese nurses?

4. Is the turnover intention of second child nurses influenced by work-family conflict, organizational silence and peer support?

5. Can a suitable nursing management model and healthcare policies be proposed for China's nursing management in the context of the implementation of the "universal two child policy"?

1.3 Research methods

This study is an empirical study based on a survey among Chinese nurses. A convenience sampling method was adopted and nurses of secondary hospitals and above in seven regions of China, namely, the northeast, south, southeast, south central, east, southwest and northwest regions, were selected as participants. The researcher explained the purpose of the present study and the content of the questionnaire to the hospital managers and asked for their consent. Then based on the proposed theoretical model and research hypotheses, the researcher designed a questionnaire and sent the WeChat link of the questionnaire to the hospital managers for a questionnaire survey. The hospital managers forwarded the link to nurses who voluntarily participated in this study and explained to the nurses the purpose of the study. To ensure authenticity and reliability, the questionnaires were filled in anonymously. And to ensure the validity and integrity, all items of the questionnaire were designed as "required questions".

Hence, a questionnaire survey method was used to collect data, and the questionnaire was used to assess four dimensions, namely, work-family conflict, organizational silence, peer support and turnover intention. A database was created using Epidata 3.1 software. Double parallel entry rule was observed for the data entry. Besides, two logical correction error checking procedures were performed to ensure that the data entering the analysis stage were reliable. Then, IBM SPSS Statistics25.0 and AMOS 24.0 were used for statistical analysis.

Cronbach's a was used for reliability analysis of the scales to ensure their internal consistency. Exploratory and confirmatory factor analysis were adopted for validating the scales. Descriptive statistical analysis, correlation analysis and hypothesis testing were used to characterize the nurses and investigate differences according to various socio-demographic characteristics of the nurses.

Structural equation modelling was used for testing the research hypotheses, and the structure of the path coefficients was estimated and tested. Model fit indices were used to assess model-data fit.

1.4 Structure of the thesis

This thesis consists of six chapters. Apart from this chapter of introduction, the remaining chapters deal with literature review and theoretical framework, research methods, research results, discussion, as well as conclusions and suggestions for future research. A detailed introduction of the remaining chapters follows:

Chapter 2: Literature Review and Theoretical Framework. The existing theories and models about turnover intention are reviewed and summarized to identify its antecedents, including work-family conflict, organizational silence, and peer support. The concepts of, and progress of research on, these antecedents are reviewed; finally, the theoretical hypotheses of this study are put forward, and the proposed research model is presented.

Chapter 3: Research Design and Methods. This chapter describes the demographic variables of the participants, measurement tools, data collection methods, technical roadmap, and statistical analysis methods.

Chapter 4: Research Results. First, an introduction to the basic characteristics of nurses is given, including their personal characteristics, work and income, and family environment. Second, a general description of nurses' work attitudes is provided. Third, difference analyses are made regarding nurses' work-family conflict, organizational silence, peer support, and turnover intentions under different factors. Fourth, the correlations among demographic and sociological characteristics, work-family conflict, organizational silence, peer support, and turnover intention are analyzed. Finally, a structural equation model to explain turnover intention as a function of organizational silence, work-family conflict and peer support is tested and presented.

Chapters 5: Discussion. A thorough discussion of the results is provided, and the implications of this study are highlighted.

Chapter 6: Conclusions and Suggestions for Future Research. On the basis of the results and analyses, research conclusions are presented, and policy recommendations put forward.

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Chapter 2: Literature Review and Theoretical Framework

Over the years of my work as a nursing manager, I have found that work-family conflict, organizational silence and peer support are issues often overlooked in management. Besides, I often hear these three key words mentioned in my conversations with second child nurses. Meanwhile, it seems to me that the turnover intention among second child nurses has a tendency to increase. After reviewing the literature, I found that studies in other industries have shown that work-family conflict, peer support and organizational silence are associated, and they also lead to turnover intention. The present study was conducted in light of the above management dilemmas.

2.1 Research on turnover intention

2.1.1 The concept and classification of turnover intention

Turnover refers to an employee's behavior of ending his/her employment relationship with the employer and leaving the current organization. From the academic perspective, turnover can be understood in the broad sense or in the narrow sense. In the broad sense, turnover is a movement or flow of labor, a movement of workers from one place to another place (movement between regions) or from one occupation to another occupation (inter-vocational movement), or transfer from one industry to another industry (inter-industry movement). It also includes the inflow and outflow of employees from a specific organization, such as a government agency, a company, and a factory (Song, 2014). Zhang (1998) held that turnover can be regarded as a sociological discussion of social mobility, covering regional mobility, career change, change of employer or company, and job change within an organization. Zhang (2011) and Price (2001) held that turnover is a change in the state of an individual as a member of the organization. In the narrow sense, turnover refers to the process where an individual who gets material benefits from an organization terminates his/her relationship with the organization as a member of the organization or forsakes the membership of the organization from which he/she used to gain monetary reward (Zhang, 2011). The above definitions of turnover all focus on the movement of workers from inside the organization to outside the organization. In addition to the classification from the broad sense and the narrow

sense, the traditional classification method classifies turnover into voluntary turnover and involuntary turnover based on the willingness of members. Voluntary turnover occurs when employees willingly choose to leave their positions. It is also known as resignation; involuntary turnover usually involves employees being let go by the organization instead of them willingly leaving their positions. Involuntary turnover appears in the forms of dismissal and expulsion (Zhu, 2006). However, this classification method has been questioned by some scholars. For instance, Dalton, Krackhardt, and Porter (1981) pointed out that the traditional method of categorizing employee turnover as voluntary or involuntary turnover would overstate the gravity of turnover on the organization.

Turnover intention, as an important predictor of employees' actual turnover behavior, has received widespread attention from scholars since it was put forward. There is a clear difference between employees' turnover intention and their actual turnover behavior. Turnover intention is just a thought or a will where an employee, after having worked in an organization for some time, has an idea to leave the current organization to seek other job opportunities due to dissatisfaction with the current job, or other reasons. The turnover intention of an employee will not necessarily translate into turnover behavior. Scholars have more or less reached a consensus on the definition of turnover intention. For example, the definition of turnover put forward by Mobley, Horner, and Hollingsworth (1978) basically consists of the elements of dissatisfaction, psychological withdrawal, and seeking external job opportunities. They define employees' turnover intention as a chain of comprehensive psychological manifestations including psychological withdrawal and the intention to leave after experiencing dissatisfaction and grievance at work, evaluation of the possibility of finding alternative jobs, and seeking new jobs through multiple channels. Porter and Steers (1973) believed that turnover intention is employees' psychological intention to escape after experiencing negative emotions. Price (2001) also pointed out that turnover intention encompasses many psychological aspects, such as employees' emotions, desires, attitudes, and intrinsic motivations for turnover behavior. Mobley (1977) also proceeded from the perspective of negative emotions and argued that employees will form turnover intention after experiencing dissatisfaction and grievance at work. And the formation of this intention is a process consisting of such steps as developing the idea of leaving, seeking external job opportunities, as well as evaluating and comparing the advantages and disadvantages of the current job with alternative job opportunities. When these steps are completed, employees will form either high or low turnover intention, and turnover intention is the last step for employees to leave the organization. In summary, most scholars agree that turnover intention

is the best and most direct antecedent for predicting employee turnover behavior, and it is the last psychological stage before an employee shows turnover behavior.

Nurses' turnover intention is the last stage of the psychological decision-making process nurses experience before leaving their jobs. Turnover intention in this context can be further classified into the intention to leave the ward, the intention to leave the organization, and the intention to leave the nursing profession (Hasselhorn et al., 2005). Undoubtedly, turnover intention at each stage may affect the stability of nurses' willingness to work, state of work, work behavior, as well as their creativity and performance. The present study defines nurses' turnover intention as individual nurses' psychological process of leaving their jobs. A higher level of turnover intention entails a higher chance of voluntary turnover.

2.1.2 Classification of nurses' turnover intention

Based on the definition of turnover put forward by Hasselhorn et al. (2005), the present study classifies turnover intention into the intention to leave the ward, the intention to leave the organization, and the intention to the nursing profession.

(1) The intention to leave the ward refers to the situation where a clinical nurse has the idea of leaving the clinical frontline but is still willing to work in other positions in the same hospital. It falls within the scope of intra-organizational labor transfer.

(2) The intention to leave the organization refers to the situation where a clinical nurse has the idea of leaving the organization but is still likely to engage in clinical care in another hospital or healthcare organization. It is a form of inter-organizational labor transfer.

(3) The intention to leave the nursing profession refers to the situation where a clinical nurse has the idea of no longer engaging in nursing-related professions after resignation but intends to engage in work other than nursing. It belongs to inter-occupational labor transfer.

2.1.3 Theoretical models of turnover intention

Foreign scholars have introduced various employee turnover models, such as the classical March and Simon (1957) model, the expanded model of turnover (Mobley, 1977), and the unfolding model (Lee & Mitchell, 1994). The present study is mainly based on the Causal Model of turnover put forward by Price (2001). According to their models, employee turnover is mainly determined by four types of variables, namely, structural variables, individual variables, intervening variables, and environment variables. Structural variables, also known as exogenous variables, refer to job autonomy, distribution equity, salary and benefits,

promotion opportunities, and social support. Individual variables refer to employee's job engagement and positive or negative emotions. Intervening variables refer to organizational commitment, job satisfaction, and turnover intention. Environment variables represent constraints on intent to stay resulting from non-work settings such as external opportunities. The Price model, which combines the research results in multiple academic fields, has strong predictive power of employees' process of psychological change.

2.1.4 Existing research on nurses' turnover intention

2.1.4.1 Existing research on nurses' turnover intention abroad

The research on nurses' turnover intention started in the 1980s in foreign countries. Researchers analyzed various factors influencing nurses' turnover intention based on the participant-determining arrangement, Roderick model, Mobley model, Price model, and other turnover models, in conjunction with questionnaire surveys on turnover intention. The existing studies on nurses' turnover intention in foreign countries were mainly conducted among on-the-job nurses. The research methods include quantitative research, qualitative research, interventional research, longitudinal research, and mixed research. Meng, Zhou, and Cheng (2010) found in a large-scale survey that job satisfaction and organizational commitment are negatively correlated with nurses' turnover intention. Flinkman, Isopahkala-Bouret, and Salanterä (2013) discovered in a qualitative longitudinal study of three registered nurses in Finland that the process from having turnover intention to showing turnover behavior is a long and complex one for young nurses. And they suggested that nursing managers should detect nurses' turnover intention in the early stage and take effective measures to reduce nurses' turnover behavior. The Japanese scholars Takase, Teraoka, and Yabase (2016) found in a survey of 1,337 registered nurses that psychological contract and professional development opportunities can help increase nurses' retention rate. In summary, existing research is mainly focused on the process of nurses' turnover, the reasons for the turnover of nurses working in special clinical departments, interventions in turnover intention, nurse retention, and a factor analysis model for turnover intention.

2.1.4.2 Existing research on nurses' turnover intention in China

A retrieval of such research databases as CNKI, Wanfang, and Weipu shows that the research on nurses' turnover took a late start in China, and that the research on nurses' turnover intention was first carried out in 2000. Most studies are quantitative, with a few master dissertations combining quantitative approach with qualitative approach. Most studies are

based on surveys of the nurses in a certain hospital or a certain department. Therefore, the samples are quite limited and not representative. Most studies focus on nurses' turnover intention, factors related to their turnover intention, and factors influencing their turnover intention. There are few studies aimed at exploring the interventions in nurses' turnover intention. Besides, domestic research failed to pay attention to the specific items of the various factors influencing nurses' turnover intention and the weight of each item in explaining the reasons for nurses' turnover. In other words, domestic studies lack the modeling of the multi-factor path of nurses' turnover intention (Guo & Li, 2008). As a result, domestic research can hardly achieve an in-depth understanding of the relationships among the factors related to nurses' turnover. More attention should be paid to this aspect.

2.1.5 Factors influencing nurses' turnover intention

2.1.5.1 Research on factors influencing nurses' turnover intention abroad

Given the current healthcare environment characterized by an urgent shortage of nursing human resources, it is very necessary for nursing leaders and hospital managers to fully understand the factors influencing nurses' turnover intention. Foreign scholars have made unremitting efforts in this respect. For example, Heinen et al. (2013) carried out a multi-joint and cross-sectional survey of many countries and found that an average of 9% clinical nurses had the intention to leave nursing profession. Their study identified seven factors as the main reasons, namely, age, gender, time in employment, leadership style, healthcare relationships, nurse participation in hospital affairs, and burnout. Flinkman, Leino-Kilpi, and Salanterä (2010) had an integrated review of 31 research papers and arrived at the conclusion that demographic and work-related factors are the main reasons for nurses' turnover intention. Besides, Koy et al. (2015) found in their empirical study that the main factors influencing new nurses' turnover intention are work environment, social support, work obstacles, organizational commitment, job satisfaction, and job burnout.

2.1.5.2 Domestic research on factors influencing nurses' turnover intention

Given the grim reality of the high turnover of nurses in China, the discussion about the factors influencing nurses' turnover intention has gradually become a popular topic. Most studies examine the intention of clinical nurses to leave the organization from the perspective of hospital managers. Macau scholars Chan et al. (2009) found from their survey and analysis that wages and benefits are the main factors influencing nurses' turnover intention. Taiwanese scholars Liu et al. (2016) found from a regression analysis of the factors influencing nurses'

turnover intention that singlehood, low levels of education, and working environment are main predictors of nurses' turnover intention. In addition to those, work support, work safety, professional identification, workload, and work-family balance are secondary predictors. The researcher searched and analyzed the relevant papers published in recent years on nurses' turnover in CNKI, Wanfang, and Weipu database and found that most studies on the factors influencing nurses' turnover behavior are focused on nurses' turnover intention. More specifically, researchers regard turnover intention as the antecedent of nurses' turnover, and the variables related to turnover intention are mostly related to concepts of behavioral psychology, such as organizational commitment, job satisfaction, work stress, career commitment, and work values. In summary, the factors influencing nurses' turnover intention are diverse and complicated. Foreign researchers have conducted in-depth research on the analysis of influencing factors and model construction of clinical nurses' turnover intention and have achieved fruitful research results. Chinese scholars have also conducted related research on the turnover intention of clinical nurses. Therefore, the existing research can serve as references for the present study in terms of the type of nurses' turnover intention model, the selection of variables, and the analysis of predictors. Below is a summary of the existing studies on nurses' turnover intention:

(1) Most studies separately explore the influencing factors of the turnover intention of nurses who have left their organizations and the influencing factors of the turnover intention of nurses who are still in service. Due to the huge difficulty to collect data on the influencing factors of the turnover intention of clinical nurses, most studies often ignore the influencing factors of nurses' turnover intention or the limited analyses of the reasons for nurses' turnover are not comprehensive enough. Therefore, there is a lack of thorough and in-depth research on the factors influencing nurses' turnover intention.

(2) Existing studies on nurses' turnover intention mostly focus on factors with a single feature, such as nursing practice environment, nurses' turnover intention, and job satisfaction. There is a lack of comprehensive study of the different influencing factors from different perspectives.

(3) Most existing studies on nurses' turnover intention simply divide nurses' turnover intention into three dimensions, namely, turnover intention I, turnover intention II, and turnover intention III, or simply measure the degree of clinical nurses' intention to leave the organization in the future or in the past year. As a result, there is lack of sufficient research on the predictive models of clinical nurses' turnover intention.

Based on a comprehensive literature analysis, Yang, Ju, and Liu (2016) believed that the following eight factors are the main reasons leading to turnover: First, the dimensions of emotional exhaustion, mental distance from job, and job burnout are positively related to turnover intention, and a low sense of accomplishment is negatively related to turnover intention; second, management methods, hospital policies, and compensation can jointly explain 24.4% of the total variation in turnover intention, with management methods and hospital policies having the most significant impact on turnover intention; third, a fair, reasonable, transparent, and competitive compensation package can improve nurses' salary satisfaction and reduce their turnover intention; fourth, the total score of nurses' work-family conflict is positively related to their turnover intention; fifth, turnover intention scores decrease as age increases; sixth, good career development prospects and continuous learning can improve nurses' job satisfaction; seventh, the different dimensions of the career plateau have different influences on different organizational effect variables; and eighth, organizational identification has a significant influence on employee turnover intention.

In summary, studies on the factors influencing nurses' turnover are common. But currently, there are few studies on the turnover intention of second child nurses in China. As second child nurses are gradually growing into the majority of the nursing teams in hospitals, it is very important to pay close attention to the causes and influencing factors of their turnover intention so as to prevent the turnover of these nurses.

2.2 Research on work-family conflict

2.2.1 Concept of work-family conflict

In the early days, there was a lack of consensus regarding the description of work-family conflict in the academic community, and most descriptions were related to the roles people play. Kahn et al. (1964) defined work-family conflict as the conflict resulting from the incompatibility between job needs and family needs, or the difference in the requirements by a person's work role and family role. Greenhaus and Beutell (1985) emphasized that work-family conflict refers to the conflict between work and family roles caused by the incompatibility in time, strain, and behavior between job stress and family stress. Specifically, time-based conflict is caused when a person's devotion of time to the requirements of one role makes it difficult for the person to fulfill requirements of another role. For example, if a person fails to help his/her children with homework due to overtime work or fails to go to

work on time due to the need to take care of his/her parents, the impossibility of meeting both needs at the same time will inevitably lead to conflict due to the transience of time. Strain-based conflict is caused by the strain from a person's participation in one role that makes it difficult for the person to fulfill requirements of another role. For example, when negative emotions accumulated at work make a person unable to get along with his/her family or the person cannot fully concentrate on work because his/her family members are sick, the person is faced with the strain from both work and family and can hardly distinguish between the two sources of strain. In such cases, it is only reasonable that conflict will arise due to the mutual influences between the two sources of strain. Behavior-based conflict refers to the conflict caused when specific behaviors required by one role make it difficult to fulfill the requirements of another role. Take women for example. They are required to be independent, decisive, and strategic at work. Meanwhile, as wife and mother, they are expected to be considerate, gentle, and less aggressive. If they fail to adjust their own behaviors according to the needs of these different roles, conflict is bound to arise. A comparison of the definition of work-family conflict by various scholars shows that the definition put forward by Greenhaus and Beutell (1985), which analyzed the dimensions of time, strain, and behavior, is more detailed and comprehensive. Therefore, this definition has become the universally-acknowledge definition in the academic community. Subsequent studies further elaborated on the structure of work-family conflict. For example, Frone, Russell, and Cooper (1992a) acknowledged that work-family conflict is the mutual interference between work and family and that work affects family (work-to-family conflict) while family also affects work (family-to-work conflict). On this basis, they built up a comprehensive model of the work-family interface and held that these two dimensions are positively correlated. Greenhaus and Beutell (1985) validated the bidirectional nature of the conflict between work and family. The study conducted by Gutek, Searle, and Klepa (1991) further suggested that the three types of work-family conflict are all bidirectional in nature, constituting the six dimensions of conflict (See Table B.1 in Annex B).

At present, the view on the bidirectional nature or dichotomy of work-family conflict has been universally recognized, and in-depth studies on this view have been carried out. The results of most studies suggest that work-family conflict is more serious than family-work conflict. Some even believe that work-family conflict is three times more serious than family-work conflict (Greenhaus & Beutell, 1985). In other words, work-family conflict has a much stronger influence on individuals and thus has more research value. A review of relevant literature at home and abroad shows that there are much more studies on work-family

conflict than on family-work conflict. Poelmans, Stepanova, and Masuda (2008) found that positive spillover can lead to higher levels of job and life satisfaction, whereas negative spillover tends to cause negative influences on work or family. For example, employees who are blamed by leaders at work may go back home with negative emotions. As a result, they may not be in the mood of participating in family affairs. In worse cases, they might even vent their anger on their families. As a supplement to the spillover theory, compensation theory is defined as the tendency of one person to use the satisfaction they get from one domain to compensate for the lack of satisfaction they feel in another domain. There are two forms of compensation, namely, supplemental compensation and reactive compensation. Supplemental compensation refers to a person's reduction in their devotion to a domain they are dissatisfied with while increasing devotion to another domain they are satisfied with. In other words, supplemental compensation is about the redistribution of effort and time between the domains one is satisfied with and those they are dissatisfied with. Reactive compensation refers to a person's response to dissatisfaction in one domain by getting compensation in another domain (Edwards & Rothbard, 2000).

2.2.2 Theories related to work-family conflict

Western scholars began to study work-family conflict quite early and their research on this topic is relatively in-depth. They have put forward some basic theories related to this topic, including role theory, compensation theory, and border theory, which have laid the theoretical foundation for subsequent research by scholars from various countries.

(1) Role theory distinguishes work and family as two independent systems. Individuals perform different roles in each system (Qiu, 2012). For example, a woman might simultaneously play the roles of leader, colleague, and subordinate at work, while playing the roles of mother, wife, and daughter in family. This shows the necessity for individuals to switch between different roles. Role conflict occurs when playing a certain role renders it difficult for the person to play another role. Allen (2001) held that role theory well explains the three sources of work-family conflict: First, the conflict in expectations between role performers and messengers, which tends to blur one's roles or even cause role conflict; second, the pressure of one role stands in the way of completing the tasks of another role; third, individuals have too high expectations for their roles, leading to role overload. Allen (2001) believed that role theory well explains the impacts of the environment of different roles on conflict and is conducive to identifying the causes of conflict. However, the theory

regards such impact as individuals' passive adaptation to the needs of the environment while ignoring individuals' subjective initiative. Therefore, it has limited contribution to studying the strategies to balance conflict.

(2) Spillover theory and compensation theory. Spillover theory argues that individuals tend to unconsciously bring their values, emotions, or behavior to the family domain. Similarly, they would also bring their attitudes and behaviors in family to their work domain. Spillover effects can be positive or negative. Positive spillover can help individuals gain high levels of job or life satisfaction, whereas negative spillover will have negative influences on work or family. For example, employees who are blamed at work might return home with negative emotions. As a result, they might not be in the mood of participating in family affairs and might even let out their anger on their families. This will lead to work-family conflict. Compensation theory, as a supplement to the spillover theory, argues that individuals tend to rely on satisfaction from one domain to compensate for dissatisfaction in another domain. Edwards and Rothbard (2000) further divided compensation into supplemental compensation and reactive compensation. Supplemental compensation refers to one's reduction of devotion to the domain they are dissatisfied with to increase devotion to the domain they are satisfied with. It is essentially a redistribution of effort and time between the domains of dissatisfaction and satisfaction; reactive compensation refers to a person's response to dissatisfaction in one domain by getting compensation in another domain

(3) Clark (2000) and Allen (2001) put forward the "work-family border theory". Allen (2001) held that work and family are two different domains with their own scope. Border, which defines the scope of work and the scope of family, is the starting point of activities in different domains. He also came up with the concepts of border crosser and border maintainer, and divided border into physical border, secular border, and psychological border. Border crossers refer to those individuals who frequently transfer between work and family, whereas border maintainers refer to those who maintain the scopes and borders of these two domains. Conflict often arises between work and family as border crossers and border maintainers often have different understandings of the borders of these two domains. Border theory also points out that individuals would establish "work-family borders" of different levels of strength based on the needs of different roles (Clark, 2000). Permeability and elasticity are used to measure the strength of this border. The higher the permeability, the higher the possibility of conflict; and the higher the elasticity, the lower the possibility of conflict. Bulger, Matthews, and Hoffman (2007) pointed out that this theory regards work-family conflict as the result of the interactions between individuals and their surroundings and highlights individuals'

initiative in the process of conflict formation. They held that this theory played a guiding role in the subsequent studies on the strategies to balance the conflict between work and family.

2.2.3 Existing research on work-family conflict

2.2.3.1 Research on the antecedents of work-family conflict

The studies carried out by foreign scholars on the reasons for work-family conflict, or antecedents, can be summarized in the following three aspects:

(1) Incompatible needs between work and family. Work (family) needs refer to individuals' commitment to and responsibility for their corresponding roles. They are also an important factor causing stress to different roles. The studies carried out by Byron (2005) and Boyar et al. (2008) suggested that variables in the work domain, such as role ambiguity, conflict, overload, working hours, and job involvement, are closely associated with work-family conflict (WFC), whereas variables in the family domain, such as role ambiguity, conflict, overload, number of children, and family involvement, are highly correlated with family-work conflict (FWC).

(2) Influence from social support. Social support, which is mainly reflected in the work domain, consist of formal support and informal support. "Family-friendly" policies implemented by organizations, such as flexible working hours system and telecommuting, belong to formal support; informal support refers to the emotional support or instrumental support between leaders and peers. Behson (2005) further argued that informal support has a stronger influence on work-family conflict than formal support, and that support from leaders can better predict work-family conflict than support from peers or the organization.

(3) Individual differences. Individual difference variables mainly include demographic and personality variables such as gender, age, and marital status. These variables are related to the positioning of social roles. In the traditional sense, "men are bread winners, while women are housekeepers". In other words, when individuals measure the responsibilities and commitments of different roles, men focus more on work while women tend to focus more on family. Hence, men experience more FWC, whereas women experience more WFC (Gutek, Searle, & Klepa, 1991). Allen (2001) argued that married people are more likely to experience work-family conflict than their unmarried counterparts and that people in different age groups experience different levels of WFC and FWC. Matthews, Bulger, and Barnes-Farrell (2010) held that individuals ages between 29 and 45 years have a stronger sense of WFC and FWC than those under 29 years old or above 45 years old. Besides, (Boyar et al., 2008) found that

age is significantly negatively correlated with FWC. However, the study by Post et al. (2009) suggested the opposite to be true. It can be seen from above that the antecedents of work-family conflict are diverse. Work-family conflict can originate from work or family affairs, or from measures taken by the industry or other social organizations, or from individuals' own or others' concepts and values. In addition, conflict is not caused by a single reason. Instead, it might be the result of the joint impact of several factors. Only by identifying the antecedents can we better formulate the strategy to resolve conflict.

2.2.3.2 Research on the outcome variables of work-family conflict

The studies on the outcomes of work-family conflict are mainly focused on the two domains, namely, work and family. Given the large number of studies, the outcomes in work domain (See Table B.2 in Annex B) and those in family domain (See Table B.3 in Annex B) are presented below.

It can be seen from the above analysis that the negative outcomes produced by WFC are mostly in work domain, whereas the negative outcomes produced by FWC trend to appear in family domain. Besides, there is a cross correlation between the outcomes in work domain and those in family domain (Grzywacz & Bass, 2003). In other words, the outcomes of work-family conflict are reflected in different domains due to the difference in antecedents. However, due to the cross-domain correlation between variables, the outcomes in one domain will eventually indirectly influence the other domain no matter which domain it influences directly. Specifically, family interference caused by WFC will react on work domain, undermining work performance; similarly, work interference caused by FWC will affect family domain, resulting in reduced quality of family life. Conflict is bound to influence both work and family as long as it exists.

2.3 Organizational silence

2.3.1 Concept of organizational silence

In the literary folktale entitled *The Emperor's New Clothes* written by Danish researcher Hans Christian Andersen, the emperor has no clothes on. However, his officials and the common people are afraid of being thought as fools. So, instead of telling him the truth, they choose to praise his "suit" as beautiful. In fact, this is not just a folktale. It is also a reflection of reality in many organizations. In many cases, members of an organization should have put forward some opinions or suggestions based on their personal knowledge and work experience for

better development of the organization. However, most of them choose to withhold their views instead. This phenomenon is referred to as "organizational silence" in management, known as employee silence, as well Wang (2009). Rosen and Tesser (1970) found in study that employees would choose to be silent about the things they are concerned with under certain circumstances and that individuals in an organization would choose to remain silent in order not to deliver "negative messages" to their superiors. This phenomenon is referred to as "silence effect". Pinder and Harlos (2001) classified organizational silence into two types, namely, quiescent silence and acquiescent silence. Dyne, Ang, and Botero (2003) argued that organizational silence does not include unconscious silence. They held that organizational silence is employees' intentional effort to withhold work-related ideas, information, and views. Therefore, based on the study conducted by Pinder and Harlos (2001), they further classified organizational silence into acquiescent silence, defensive silence, and prosocial silence based on employees' intrinsic motivation to remain silent. Specifically, acquiescent silence refers to the acquiescence or submission to the views or opinions of others. On the surface, it may appear that the person agrees to other people's views. But in reality, they have given up their own views and chosen to remain silent. Acquiescent silence is a relatively passive behavior of obedience. Defensive silence is an intentional, purposeful, and active behavior of self-protection. Compared with acquiescent silence, defensive silence consists of a stronger subjective will because employees should withhold their opinions and information under the premise of thinking about and having alternatives. Prosocial silence refers to employees' intentional, purposeful, and active withholding of views for the sake of benefiting others or achieving cooperation.

It can be seen from the above definitions of organizational silence in existing literature that organizational silence should possess the following characteristics: First, it is a conscious and purposeful silence behavior of the members of an organization. Second, organizational silence refers to the situation where employees withhold their views on addressing the potential issues of the organization which they are already aware of. Organization silence among nurses refers to the situation where nurses could have expressed their opinions, suggestions, and views on the problems in the nursing organization based on their own experience and knowledge accumulated in their career so as to optimize and improve the work of the nursing organization, but for some reasons choose to withhold some or all of their opinions, suggestions, and views (Yang, 2016).

In reality, due to factors such as the cultural atmosphere of the department, leadership style, personality, and interpersonal relationships, nurses rarely speak out the problems they

have identified or give their suggestions. Instead, they simply choose to remain silent. Such behavior could become risk factors of clinical adverse events and render it impossible to reflect nurses' professional value and personal value. Exploring organizational silence among nurses is of important practical significance to motivating nurses to express their own ideas and suggestions, improving quality of nursing care, and promoting the development of hospitals (Sun et al., 2014).

Zheng et al. (2008), the first scholars to study organizational silence in China, drew from the research results of foreign scholars. They defined organizational silence as a phenomenon where employees could have put forward some constructive suggestions and ideas based on their knowledge and experience to facilitate the improvement in certain aspects of the work of their department or organization, but for some reasons, withhold their views or selectively express their personal views. This definition has been recognized and adopted by most scholars in China. Hence, based on a thorough understanding of the connotations of organizational silence put forward by Zheng et al. (2008), organizational silence among nurses refers to a phenomenon where nurses could have put forward some opinions or suggestions conducive to the development of the nursing organization based on their theoretical knowledge and work experience so as to improve certain aspects of work in the nursing organization, but for some reasons choose to keep their views to themselves or selectively express their views.

2.3.2 Structure of organizational silence

Many scholars have established their own organizational silence structures based on their own research. For example, Pinder and Harlos (2001) classified organizational silence into acquiescent silence and quiescent silence. The former describes the phenomenon where individuals resign themselves to the views of others while withholding their own ideas. It is a negative attitude. The latter refers to individuals' active effort to withhold their views in order to maintain relationships and protect themselves. Dyne, Ang, and Botero (2003) classified organizational silence into acquiescent silence, the act of withholding own's views due to obedience, defensive silence, where one keeps silent as a sign of self-protection due to fear, and prosocial silence, where one withholds some ideas for the sake of the interests of others or the collective (Morrison & Milliken, 2000).

In light of China's actual management reality, scholars in China drew from the relevant studies on organizational silence abroad and also divided organizational silence into different dimensions.

In the context of China's cultural background, Zheng et al. (2008) carried out an empirical study based on a questionnaire survey among 928 respondents and arrived at the three dimensions of organizational silence: The first dimension is acquiescent silence where employees give up their views because they believe that their views would not influence the organization's final decision. The second dimension is indifferent silence where employees are not willingness to express their views because they are not willingness to invest too much time and effort in improving the organization due to a low sense of organizational identification and belonging. The third dimension is defensive silence where employees choose to keep silence because they worry that expressing their suggestions would affect the interests of peers or superiors, which would lead to interpersonal problems and cause harm to themselves. The division of organizational silence into these three dimensions has been acknowledged and cited by many scholars in subsequent studies. Besides, Liang (2009), based on investigation and research, divided organizational silence into four dimensions, namely, prosocial silence, withdrawal silence, avoidant silence, and defensive silence. Wang (2013) divided organizational silence into three dimensions, namely, institutional silence, cultural silence, and structural silence from the macro perspective. Zhao (2010) conducted an empirical study and arrived at the three dimensions of organizational silence, namely, silence caused by the fear for interpersonal relationships, silence caused by individuals' low sense of self-esteem, and silence caused by system barriers in the organizational (Zhao, 2010).

2.3.2 Causes of organizational silence and existing literature on organizational silence

Organizational silence is caused by various reasons. The existing studies on organizational silence carried out by foreign scholars such as Morrison and Milliken (2000) as well as Bowen and Blackmon (2003) are mainly focused on three aspects, namely, organizations and managers, peers, and the individual characteristics of employees.

Scholars at home and abroad have identified many reasons for organizational silence. For example, Ashforth and Humphrey (1995) considered that most employees choose to remain silent because they worry about being labeled with "negative emotions", which would adversely affect their career development. Morrison and Milliken (2000) believed that managers who are reluctant to accept negative feedback are the main reason for organizational

silence. LePine and Van Dyne (2001) argued that organizational silence is more likely to occur among employees with low self-esteem. Edmondson (2003) held that the sense of safety given by leaders can reduce the occurrence of organizational silence. Bowen and Blackmon (2003) believed that members tend to withhold their ideas to avoid being isolated by others when they find that their ideas are contradictory to those of the majority. Van De and Van Der (2003) found that power distance has a positive influence on organizational silence and that although organizational silence can avoid direct conflict between organizations and individuals to some degree, it has a negative influence on organizational learning and innovation. Organizational silence refers to the phenomenon where negative information in the organization gets hidden, which causes leaders to be unable to receive true feedback and consequently make wrong decisions. Bedeian and Day (1964) argued that managers may deliberately reduce restraint behaviors to reduce fear among employees and thus encourage employees to express constructive opinions and suggestions. Vakola and Bouradas (2005) found in their study that the negative attitude shown by managers when employees give suggestions will increase the likelihood of organizational silence among employees. Besides, the study by Mary (1998) indicated that gender has an influence on organizational silence. Due to the influence by their mindset, women are more likely to choose organizational silence than men. Donaghey et al. (2011) found that organizational silence will stand in the way of organizational innovation and development.

The study conducted by He, Ma, and Tjitra (2006) suggested that the relationships between co-workers could also be a cause of organizational silence. Zheng (2017) held that organizational silence will lead to lower job satisfaction of employees and even lead to job burnout. Jia (2009) found in her study that organizational silence will hinder the creativity of employees and indirectly impede organizational innovation. Studies also revealed that organizational silence tends to occur among employees in groups with conservative ideas and strict systems (He, 2010; Li, Ling, & Liu, 2012). Y. Li et al. (2014) studied the correlation between nurses' work engagement and organizational silence based on a structural equation model and concluded that organizational silence occurs less frequently among nurses with higher levels of work engagement. These nurses dare to express their views, have positive emotions and psychology, and play significant roles in the development of the nursing team. Yin et al. (2016) argued that the silence behavior of nurses has clear disadvantages: The first is the negative influence on the organization, reflected in organizational culture, organizational decision-making, and organizational communication; the second has to do with the negative impact on nurses. Specifically, organizational silence negatively affects nurses'

trust in their department and the hospital, undermines their work initiative, causes them to experience negative emotions and perform emotional labor, and may even lead to occupational aversion, turnover intention, and destructive behaviors, thereby increasing nurse turnover. The study conducted by Zhong et al. (2016) suggested that nurses' silence behavior has a positive influence on work alienation and a negative influence on organizational climate. In China, organizational silence among nurses is at the medium level, and most silence behaviors belong to acquiescent silence or defensive silence. Most nurses choose to remain silent because they think their suggestions and views are irrelevant or almost irrelevant to the final decisions of their leaders or because they want to avoid interpersonal estrangement from their leaders. Wang (2016) analyzed the relationship between nurses' negative emotions and silence behavior and concluded that nurses' negative emotions have a positive influence on their silence behavior. In summary, organizational silence is a negative behavior that hinders organizational development to some extent.

2.4 Peer support for nurses

2.4.1 Concept and dimensions of peer support

There has not been a uniform definition of peer support in existing literature. Peers work together, cooperate with each other, and stand equal to each other. In the beginning, Etzion (1984) defined peer support as an interpersonal exchange relationship in established through emotional attention, instrumental support, and information provision organizational environment. On this basis, Colella and King (2004) explained peer support to be the emotional, evaluation (feedback), and information support provided by individuals with similar demographic characteristics and similar experience. Dennis (2003) argued that peer support can be understood as the support provided to each other by people at the same level (of a similar age, with the same social status, and having similar abilities). She also extended the definition of peer support to the healthcare sector by putting forward that peer support is a type of social network where supporters are those who possess experiential knowledge and have similar characteristics with the supported and are able to provide emotional, evaluation, and information support to individuals with potential or existing health problems. She emphasized that the experiential knowledge possessed by supporters mainly refers to knowledge of stress management. Landsman (2001) defined peer support as the level of assistance and support from peers perceived by individuals. Settoon and Mossholder (2002)

defined peer support as the care and attention individuals receive from other members of the organization. Chinese scholars Yi, Zhan, and Ye (2014) argued that peer support is a support provided by individuals or groups facing the same work environment and feelings. Ye (2008) held that due to China's traditional medical model, peer support has different connotations in the nursing industry. In addition to support among peers, the support from hospital managers is also worthy of attention. Therefore, peer support for nurses refers to the emotional, instrumental, and information support provided to nurses by leaders and head nurses with some expertise and experience or such support provided among nurses with similar work experience.

2.4.2 Existing literature on peer support

In recent decades, foreign and domestic scholars have conducted a lot of research on peer support. Many theories and experiential studies have validated that social support, as a type of supportive resources or supportive behavior, has a regulating effect on individuals who are under the stimulation of pressure and thus alleviates pressure by reducing psychological stress response and maintaining good emotional experience (Xiao & Yang, 1987). In terms of nature, social support can be categorized into two types. One is actual support, including direct material support and assistance in social networks and group relationships. The other is perceived support, which mainly refers to the availability of support and satisfaction with support. In terms of content, social support mainly consists of instrumental support, emotional support, information support, and peer support (Liu & Huang, 2010). Peer support, as a form of social support, has been applied to various occupational groups abroad for nearly three decades. Taormina and Law (2000) held that peer support, which is based on group relationships and individual participation, plays its positive role or has positive influences through alleviating individuals' negative emotions such as nervousness and anxiety, reducing job burnout, and improving emotional exhaustion by way of influencing individuals' perception and evaluation of stress sources. It is essentially a form of stress management. For nurses, in addition to self-support as well as support from family and friends, the remaining support mainly comes from nursing managers, head nurses, and peers. The study conducted by Stokes and Wilson (1984) indicated that social support has a much more significant influence on women than on men. Therefore, it can be seen from the special nature of the nursing industry that peer support will inevitably become an important intervention method for stress management among nurses.

Back in earlier days, peer support had already been applied to many occupational groups broad (Schwartz & Sendor, 1999). In recent decades, more and more studies on peer support for nurses have been carried out. Coffey (2000) confirmed through his study that the most popular way of stress management for nurses is peer support. Peer support can act as an intermediary factor between stress and health and have a positive effect on nurses' physical and mental health by influencing their assessment and response to stress (Jones et al., 2015). Schroeder and Worrall-Carter (2002) found in a qualitative study of the head nurses of operating rooms that peer support as well as trainings and courses related to stress management can help nurses relieve work stress. Scholars have found that peer support plays an important role in reducing nurses' anxiety, doubt, or fear, reducing depersonalization among nurses, and increasing nurses' work enthusiasm (Cañadas-De la Fuente et al., 2015; Kitaoka & Masuda, 2013; A. Li et al., 2014). Besides, peer support for nurses can also contribute to easing their emotional exhaustion and thus increase nursing productivity and patient satisfaction (Sundin, Hochwalder, & Bildt, 2009; Wittenberg-Lyles, Goldsmith, & Reno, 2014). Peer support in foreign countries is more diversified. It can be provided by such institutions as hospitals, communities, and families, or online, and its forms include self-help, one-on-one consultation, professional support, and volunteer services (Bowles, Mackintosh, & Torn, 2001). Domestic research on peer support started relatively late, and most studies are focused on teachers. Wang and Ye (2004) first came up with the idea of establishing a nurse peer support system in hospitals and evaluated the implementation effect. They pointed out that the establishment of a peer support system provided psychological support for nurses and has a positive influence on reducing work stress. In addition, they also emphasized that maintaining good relationships with peers is conducive to reducing conflicts and contradictions and increasing stability and solidarity of the nursing team. On this basis, Li et al. (2010) focused on the application of peer support to nurse-patient disputes and formulated effective nursing service remedial measures and emergency plans for handling nurse-patient disputes to increase the success rate of dispute resolution. Yi, Zhan, and Ye (2014) explored the correlations between peer support for nurses and such factors as job burnout, job satisfaction, and psychical health. In addition, Liu, Zhu, and Wang (2015) found in their study on the correlation between peer support for nurses and solidarity among nurses that increasing peer support for nurses can contribute to increased solidarity among nurses.

2.5 Research on the relationships among work-family conflict, organizational silence, peer support, and turnover intention

2.5.1 Research on the relationship between work-family conflict and turnover intention

As mentioned in Section 2.2, both work-family conflict and its various dimensions are positively associated with turnover intention. In other words, the stronger the work-family conflict, the higher the turnover intention. There is a serious shortage of nurses in Grade A tertiary hospitals in Anhui Province, with over 98% of the nurses being female. Besides, nurses have very little time off work on festivals, holidays, and weekends. Instead, they always have to work overtime, which seriously affects the time they could devote to taking care of their families. In particular, second child nurses need to devote more effort and time to their families. The tension between work and family has led to work-family conflict and a lower quality of life. When work needs interfere with family needs, individuals and their family members can show more tolerance. However, organizations will not allow nurses' family needs to get in the way of their work. Being in this conflict for a long time will lead to increased turnover intention and even actual turnover among nurses. This phenomenon is in line with the results of the studies conducted by foreign scholars Dåderman and Basinska (2016), as well as those by Chinese scholars Ma, Bao, and Mao (2017) and Zhou et al. (2018).

Existing literature suggests that work-family conflict might be one of the key factors leading to turnover intention. Domestic and international scholars have carried out a large number of studies on this. For example, Frone, Russell, and Cooper (1992a, 1992b) found in their studies that work-family conflict is significantly positively associated with turnover intention reflected in that employees with stronger work-family conflict tend to have turnover intention and leave their jobs. Mesmer-Magnus and Viswesvaran (2005) summarized the views of scholars and put forward that when work-family conflict gets serious, employees are more likely to leave their jobs and that work-family conflict has a stronger influence on turnover intention compared to family-work conflict. Elloy and Smith (2004) also arrived at a similar conclusion. However, Mesmer-Magnus and Viswesvaran (2005) held a different view. They argued that work-family conflict and family-work conflict have the same predictive power for turnover intention. It has been evidenced that clinical nurses have a stronger tendency to leave work due to the difficulty of striking a balance between work and family (Masuda & Sortheix, 2012; Tromp, van Rheede, & Blomme, 2010).

Chinese scholars are also conducting more and more in-depth research in this regard. It has been found that work-family conflict has a moderately negative influence on turnover intention in both the IT industry in Shanghai (Zheng, Zheng, & Chen, 2006) and among nurses in hospitals (Cheng et al., 2008). However, Liu and Zhao (2006) held a different view. They argued that work-family conflict has no significant influence on turnover intention. Yuan (2006) studied the employees in the enterprises and public institutions in Wuhan and found that stronger work-family conflict will cause employees to experience more occupational fatigue and thus have higher levels of turnover intention. A recent study carried out by Pan and Chen (2012) suggested that the behavior-based conflict dimension of work-family conflict has a significant influence on turnover intention whereas the time-based conflict and strain-based conflict dimensions are not able to effectively predict turnover intention. Nie and Xie (2018) studied the turnover intention of family-supportive supervisors based on the matching hypothesis and found that work-family conflict can better predict turnover intention than family-work conflict. It can be seen that scholars have different views regarding the influence of work-family conflict and that of family-work conflict on turnover intention. This study is focused on the influence of work-family conflict on turnover intention.

Spector et al. (2007) compared a large number of data and concluded that in individualism-dominated countries, work-family conflict has a more significant influence on job satisfaction and turnover intention than in collectivism-dominated countries. Wang and Zhang (2016) summarized the literature on work-family conflict from a cross-cultural perspective and found that family interests outweigh personal interests in China while family interests' equal personal interests in the U. S. As most existing studied were conducted in Western or American context, the research results are limited to some extent. It remains to be discussed whether the research conclusions and suggestions can be applied worldwide. In other words, the cross-cultural applicability of the research conclusions drawn by Western scholars remains to be further tested. Currently, China has entered the new era of industry upgrading and innovation. It has changed from a capital-importing country to a capital-exporting country. The implementation of the "second child" policy will undoubtedly aggregate the work-family conflict faced by employees.

Work and family are two very important components of a nurse's life. Work-family conflict is the result of the imbalance between one's work and family roles. It can be concluded from the literature review that work-family conflict is an important determinant of turnover intention. Therefore, deepening the research on work-family conflict in the Chinese

context can, on the one hand, help break the cultural limitation of the concentration of studies in Western context, and on the other hand, help enterprise managers formulate more targeted human resources strategies to help employees strike a balance between work and family and reduce their turnover intention. In light of the existing literature, the researcher puts forward the first hypothesis of this study:

H1: Work-family conflict positively influences nurses' turnover intention.

2.5.2 Research on the relationship between organizational silence and turnover intention

The study conducted by Yang (2017) suggested that organizational silence was at the medium level among nurses working in the Intensive Care Unit (ICU), their job satisfaction was at a medium-to-low level, and their turnover intention was high. Besides, the study also suggested significant differences in organizational silence and job satisfaction among nurses of different ages and with different working years and income. ICU nurses with different working years differ significantly in turnover intention. There are significant correlations between the organizational silence, job satisfaction, and turnover intention of ICU nurses. Organizational silence can directly influence turnover intention or indirectly influence turnover intention through the mediating effect of job satisfaction. Job satisfaction partially mediates the relationship between organizational silence and turnover intention.

Vakola and Bouradas (2005) showed through an empirical study that there is a negative correlation among employees' silence behavior, organizational commitment, and job satisfaction. The higher the level of silence behavior, the lower the level of organizational commitment and job satisfaction. Chinese scholars Qian and Zhan (2005) found through a factor analysis and empirical study of communication satisfaction and its influences that a positive communication climate is conducive to a higher level of job satisfaction. Morrison and Milliken (2000) made a theoretical analysis and argued that a low sense of commitment and low levels of trust caused by organizational silence will reduce employees' intrinsic work motivation and job satisfaction until having a more profound and far-reaching impact: lower productivity or a higher turnover rate. Wang (2011) found in her study that organizational silence can predict employees' turnover intention through the mediating roles of job satisfaction and emotional commitment. Wang and Liu (2017) identified a positive correlation between organizational silence and turnover intention. Zhou (2012) found through an analysis of the silence behavior of knowledge-based employees and the associations of its various dimensions with turnover intention that the silence behavior of knowledge-based employees

and its two dimensions, namely, acquiescent silence and indifferent silence, are significantly positively associated with turnover intention and that defensive silence is significantly associated with turnover intention. Based on the existing literature, the researcher puts forward the following hypothesis:

H6: Organizational silence positively influences nurses' turnover intention.

2.5.3 Research on the relationship between peer support and turnover intention

Peer support refers to the mutual help and support between people of similar social status. It is an interpersonal exchange relationship within an organization established through emotional attention, instrumental support, and information provision (Etzion, 1984). Peer support can help support seekers reduce anxiety, fear, and doubt (Taormina & Law, 2000) and acquire warmth, love, a sense of belonging, and a sense of security (Uchino, 2006). Back in the 1970s and the 1980s, foreign scholars had started to focus on the application of peer support to alleviate nurses' occupational stress (McCloskey, 1998). Larrabee et al. (2003) held that positive peer relationships, effective cooperation between doctors and nurses, and high levels of team cohesion can not only improve nurses' job satisfaction, but also reduce their intent to leave.

Zhang et al. (2014) proved through their study that increasing the confidence and consciousness of peer support and self-support and increasing nurses' sense of belonging and sense of responsibility can help foster a harmonious professional atmosphere and that the establishment of a peer support system can help increase nurses' intention to stay and reduce their turnover rate. Fagerberg and Kihlgren (2001) argued that a harmonious work atmosphere characterized by mutual learning, mutual support, and experience sharing among nurses is critical for individuals' professional identification as well as the development of professional knowledge and skills. The establishment of a peer support system nurtures the peer relationships of mutual support and mutual trust, enhances the cohesion of the nursing team, increases nurses' work vitality, and improves their comprehension, thereby ultimately reducing their turnover intention.

In summary, the above studies all point to the negative association between peer support and turnover intention. Therefore, the researcher puts forward the following hypothesis:

H4: Peer support negatively influences nurses' turnover intention.

2.5.4 Research on the relationship between work-family conflict and organizational silence

Work-family conflict has been identified as a cause of nurses' increased job burnout, increased negative emotions, fluctuating work attitudes, and reduced job satisfaction. Wang (2016) found through a study of psychiatric nurses that negative emotions are positively associated with silence behavior. Besides, other factors associated with organizational silence include nurses' work engagement (Jin, Li, & Sun, 2017) and job satisfaction (Yang, 2017). Therefore, the researcher puts forward the following hypothesis:

H2: Work-family conflict positively influences organizational silence among nurses.

2.5.5 Research on the relationship between work-family conflict and peer support

While reviewing the existing literature on the antecedents and outcomes of work-family conflict, I found there is no consensus on the relationship between work-family conflict and peer support. But on the whole, the majority of the existing studies suggest that work-family conflict is negatively associated with peer support; The study carried out by Xue (2014) suggested that social support is negatively related to both work-family conflict and family-work conflict. Specifically, when social support is strong, individuals tend to experience less family-work conflict, in which case individuals will not have to make unnecessary effort to deal with family trivialities. Instead, they can focus all their energy on work and be more concentrated on work, and thereby achieving better work performance; conversely, when social support is weak, individuals tend to experience more family-work conflict, in which case they tend to experience anxiety and stress at work, leading to worse work performance. The results of the study conducted by Li (2003) indicated that family support can help reduce work-family conflict. For example, if one's parents or baby-sitter can share some housework and take care of the child or children, the person will have more free time to deal with work or family emergencies. He/she will also be able to devote more time to work or other domestic affairs. Besides, work support such as peer support with shift and a softer deadline granted by leaders can also help reduce work-family conflict. On this basis, the researcher puts forward the following hypothesis:

H3: Work-family conflict negatively influences peer support for nurses.

2.5.6 Research on the relationship between peer support and organizational silence

There are very few studies on the association between organizational silence and peer support. Organizational silence is caused by various reasons. The existing studies by such scholars as Morrison and Milliken (2000) as well as Bowen and Blackmon (2003) mainly focus on three aspects, namely, organization and managers, peers and employees' personal characteristics. In light of this situation, the researcher puts forward the following hypothesis:

H5: Peer support negatively influences organizational silence among nurses.

2.5.7 Research on the mediating roles of organizational silence and peer support in the influence from work-family conflict on turnover intention

According to the turnover intention model proposed by Price (2001), employee turnover is mainly determined by four variables, namely, structural variables, individual variables, intervening variables, and environment variables. Individual variables refer to employees' work engagement and positive or negative emotions; intervening variables consist of organizational commitment, job satisfaction and turnover intention; environment variables include constraints on intent to stay resulting from non-work settings such as external opportunities and kinship responsibility. Failure to perform the kinship responsibility of taking care of families due to a tight work schedule is likely to cause work-family conflict. Structural variables, also known as exogenous variables, consist of job autonomy, job stress, distribution equity, compensation, promotion opportunities, and social support. Social support consists of the degree of job support from supervisors, coworkers, and relatives. This model assumes that all structural variables indirectly influence turnover through job satisfaction and organizational commitment, where job stress is a whole with four dimensions, namely, resource scarcity, role ambiguity, role conflict, and workload. Kahn et al. (1964) defined work-family conflict as the conflict arising from the incompatibility between work needs and family needs, or the difference in the requirements by a person's work role and family role. There are very few studies on the mediating roles of organizational silence and peer support in the relationship between work-family conflict and turnover intention. Based on the above literature review, the researcher puts forward the following two hypotheses:

H7: Organizational silence mediates the effect from work-family conflict on nurses' turnover intention.

H8: Peer support mediates the effect from work-family conflict on nurses' turnover intention.

2.5.8 Research on the mediating role of organizational silence in the influence from peer support on turnover intention

The study by He, Ma, and Tjitra (2006) suggested that peer relationships can also lead to organizational silence. Some scholars held that peer support plays an important role in such aspects as relieving nurses' anxiety, doubt or fear, reducing the depersonalization of nurses, and increasing their work enthusiasm (Cañadas-De la Fuente et al., 2015; Kitaoka & Masuda, 2013; A. Li et al., 2014). Wang (2016) analyzed the association between nurses' negative emotions and silence behavior and held that nurses' negative emotions have a positive influence on silence behavior. On the whole, organizational silence restrains the development of organizations to some extent, and is considered to be a negative behavior.

Based on the above literature, the researcher puts forward the last hypothesis of this study:

H9: Organizational silence mediates the effect from peer support on nurses' turnover intention.

2.6 Summary of literature review and proposal of theoretical model and research hypotheses

As mentioned above, most of the existing studies on the relationships among work-family conflict, organizational silence, peer support, and turnover intention are focused on employees from different industries. Only a few studies explore such relationships in the nursing industry. Nurses are a special group, and nursing is a job requiring both physical and mental labor. In China, due to the lack of nurses and a heavy workload, together with the arrival of the second child fertility peak, high occupational risks, and unclear career prospects, turnover intention is high among nurses. Considering the special nature of the nursing profession, especially the lack of studies on second child nurses, the results of existing research cannot be generalized to the nursing industry.

Most existing studies on work-family conflict, organizational silence, peer support, and turnover intention focus on the status quo, influencing factors, analysis and measurement of scales, and theoretical basis. Stress sources, job burnout, and job satisfaction are found to be

main influencing factors. Besides, existing literature mainly deals with the influence of a single factor, such as work-family conflict, organizational silence, and peer support, on turnover intention. The relationships among individual factors, work-family conflict, organizational silence, peer support, and turnover intention have not been considered for integrated research. Thus, further research needs to be carried out to find out whether the above variables play a key role in second child nurses' turnover decision. Research on peer support for nurses was conducted relatively late in China, and most existing studies in this regard are just supplementary research based on the existing research by foreign scholars. Therefore, a large number of empirical studies need to be conducted from different perspectives to keep up with the times, analyze the research findings, and improve the conclusions.

This study explores the differences in statistical variables among work-family conflict, organizational silence, peer support, and turnover intention, and explores the relationships among them. By doing so, this study aims to provide an empirical basis for easing nurses' work stress, stabilizing the nursing team, and improving patient satisfaction and the quality of care.

China is now faced with a rapid economic expansion and accelerated social transformation. With the implementation of the universal two-child policy, more dramatic inter-generational conflict characterized by sudden changes is bound to occur. In addition, Chinese people have been known for their strong pioneering spirit. They tend to go where opportunities take them. Such a tradition might also influence the turnover intention of Chinese employees. Therefore, more local studies should be carried out in light of China's own cultural background and reality. In this context, the present study is an attempt to enrich the theories on nurses' turnover intention put forward by Chinese scholars. Second, this study aims to provide reference for organizations to formulate effective human resource management strategies in practice and help employees balance their relationships and face the problems that arise. Third, by exploring the causality, this study can provide useful reference for reducing the turnover rate of second child nurses and reduce their turnover intention.

Based on a review of the existing literature, and in light of the objective of this study, the researcher puts forward the following theoretical model with relevant hypotheses (see Figure 2.1).

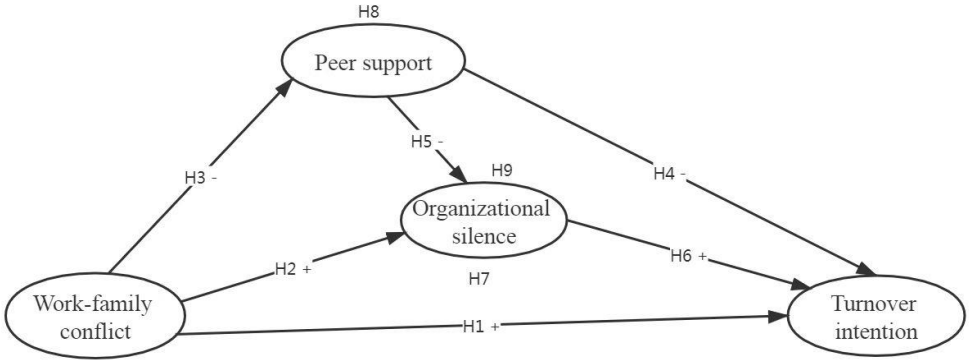

Figure 2.1 Proposed theoretical model

H1 Work-family conflict positively influences nurses' turnover intention.

H2 Work-family conflict positively influences organizational silence among nurses.

H3 Work-family conflict negatively influences peer support for nurses.

H4 Peer support negatively influences nurses' turnover intention.

H5 Peer support negative influences organizational silence among nurses.

H6 Organizational silence positively influences nurses' turnover intention.

H7 Organizational silence mediates the effect from work-family conflict on nurses' turnover intention.

H8 Peer support mediates the effect from work-family conflict on nurses' turnover intention.

H9 Organizational silence mediates the effect from peer support on nurses' turnover intention.

Chapter 3: Research Design and Methods

The present study adopted a convenience sampling method and selected nurses of secondary hospitals and above in seven regions of China as participants. Then based on the theoretical model and research hypotheses proposed in the previous chapter, the researcher adopted a questionnaire survey method to analyze the status quo and validate the proposed theoretical model and research hypotheses.

3.1 Participants

The participants of this study were nurses from secondary hospitals or above in China.

Inclusion and exclusion criteria were formulated. The inclusion criteria were: (1) Nurses who had signed an employment contract with the surveyed hospitals, including nurses occupying budgeted posts (permanent employees), contract-based nurses, and nurses employed through employment agencies; (2) nurses with the nurse certificate who had worked in the hospital for more than half a year; (3) nurses who signed the informed consent to participate in this study; (4) nurses without physical or mental illness; (5) nurses with good communication skills. The exclusion criteria were: (1) Nurses who had a history of fetal malformation, stillbirth induced labor, mental illness, or critical illness; (2) nurses who were unwilling to participate in this study; and (3) nurses who were suffering from antenatal depression.

3.2 Measurement tools

Based on the above theoretical model, this study intends to measure work-family conflict, organizational silence, peer support, and turnover intention. In addition, it can be known from the above literature review that factors such as demographic, work, and organizational characteristics, as well as family and work environment, can also influence turnover intention, and that these factors also influence work-family conflict, organizational silence, and peer support. The relevant definitions, as well as the measurement tools and methods are as follows:

3.2.1 Work-family conflict

Greenhaus and Beutell (1985) reviewed relevant terms and found that "work-family conflict" is the most frequently used one. This study uses this term. They also defined work-family conflict as a special form of conflict between different roles where the stress of work role and the stress of family role are incompatible with each other due to the irreconcilability between the needs from work and those from family, rendering participation in both work role and family role more difficult. Work role interferes with family role, while family role also interferes with work role. The interference is mutual, and the conflict is two-directional. In other words, there are work-family conflict and family-work conflict, emphasizing the interference by work role and that by family role, respectively (Feng, 2017).

The Work-Family Conflict Scale was formulated by Netemeyer, Boles, and McMurrian (1996). There were two sub-scales used to evaluate the degree of work-family conflict and the degree of family-work conflict, respectively. Each sub-scale consists of five items, adding up to a total of ten items. The work-family scale formulated by Netemeyer, Boles, and McMurrian (1996) is the most widely used scale and has been evidenced by domestic and international literature to have a high degree of reliability and validity. Therefore, this study adopted the scale and translated it into Chinese to arrive at the work-family conflict questionnaire consisting of the following ten items:

(1) My job requirements have affected my family life;

(2) My work schedule makes it difficult for me to fulfil my family responsibilities;

(3) I did not complete what I wanted to do because of the work that I had to do;

(4) Work stress made it difficult for me to flexibly arrange my family activity plan;

(5) I had to change my family activity plan due to my job responsibilities;

(6) The requirements from my family members have affected my normal work;

(7) I have to delay work due to family reasons;

(8) Sometimes I am unable to complete planned work, such as going to work on time, finishing daily tasks, and working overtime;

(9) My family has affected my work, such as working on time, finishing daily tasks, and working overtime;

(10) Family stress has affected my work performance.

The work-family conflict situation of the participants was assessed through their answers to the above ten items. Specifically, Items 1-5 evaluate the degree of work-family conflict, and Items 6-10 measure the degree of family-work conflict.

A five-point Likert scale was adopted to calculate the scores of participants' answers, from 1 = "totally disagree" to 5 = "totally agree". The average score of all the selected items reflects the participants' overall work-family situation. The higher the score, the stronger the conflict.

3.2.2 Organizational silence

Morrison and Milliken (2000) first defined organizational silence as a phenomenon where employees could have put forward ideas, suggestions, and views based on their knowledge and experience to facilitate the improvement in certain aspects of the work of their department or the organization but for some reasons withhold their views or selectively express their views.

Organizational silence was measured by the Employee Silence Behavior Questionnaire developed by Zheng et al. (2008), which classifies organizational silence into three dimensions, namely, acquiescent silence, indifferent silence, and defensive silence, and consists of the following 12 items:

(1) Leaders have almost made decisions, and my opinions will not make a big difference;

(2) My opinions will not affect the current situation;

(3) It is nearly impossible for leaders to adopt my suggestions;

(4) Leaders will not change some decisions, and it makes little difference for me to speak out my views;

(5) I choose to remain silent about others' deficiencies and negligence in work to avoid affecting my relationships with peers;

(6) I might as well withhold my views in order not to become the target of criticism;

(7) There is no need for me to offend leaders or peers;

(8) I get along well with everyone. So, it is better for me to withhold my own opinions;

(9) Other people's affairs are not my business, and there is no need for me to talk about them;

(10) I do not care about the affairs of the hospital;

(11) As the Doctrine of the Mean suggests, less talking means fewer responsibilities;

(12) I do not have a strong attachment with the hospital. So, there is no need for me to give any comments.

In the above scale, Items 1-4 measure the degree of acquiescent silence; Items 5-8 evaluate the degree of indifferent silence; and Items 9-12 assess the degree of defensive

silence. A five-point Likert scale was adopted to calculate participants' scores: specifically, 1 means "never", 2 means "seldom", 3 means "sometimes", 4 means "often", and 5 means "always". This questionnaire has been applied and acknowledged by scholars in various fields and has been widely applied in the measurement of organizational silence among Chinese employees. It is the most reliable tool for measuring the organizational silence level of Chinese employees. The higher the score, the higher the level of organizational silence, overall and for each of the three dimensions.

3.2.3 Peer support

Peer support for nurses refers to the emotional, instrumental, and information support provided to nurses by leaders and head nurses with some expertise and experience or such support provided among nurses with similar work experience in the same work environment.

The level of peer support for nurses was measured by the Peer Support Scale, which was a revised version of the scale translated from relevant scales developed by foreign scholars into Chinese by experts with backgrounds in medicine and psychology. And the revisions were made in light of nurses and hospitals in China (Greene & Grant, 2003). The scale mainly consists of eight dimensions, divided into two subscales, namely, Subscale A and Subscale B. Subscale A is the Head Nurse Support Scale, which deals with one dimension consisting of nine items. It reflects nurses' evaluation of the support from head nurses; Subscale B consists of 21 items used to evaluate nurses' perceived support from their peers. The 21 items focus on seven dimensions, namely, subjective support, cooperation, empathy, awareness raising, goal setting, action plan, and process management evaluation, and each dimension is composed of two or three items. The 30 items are as follows:

(1) The head nurse spends time understanding my goals and expectations;

(2) The head nurse cares whether I have achieved my goals;

(3) The head nurse has been paying attention to various opportunities beneficial to my career development in the hospital;

(4) The head nurse always praises me after I complete important tasks;

(5) The head nurse can provide me with effective feedback on my work;

(6) The head nurse gives me suggestions on how to improve my work when I need such suggestions;

(7) The head nurse supports my desire for additional training or education for better development in the future;

(8) The head nurse provides me with work tasks that could help me develop new skills;

(9) The head nurse assigns to me special tasks which can promote my development in the hospital;

(10) The help provided by my peers is effective in reducing my work stress;

(11) I value my time spent in building up a peer support system;

(12) The peer support system has significantly relieved my work stress;

(13) Peers respect my choice and encourage rather than force me to participate in department activities;

(14) Peers provide me with a supportive environment where I feel safe to talk about my feelings;

(15) Peers give me various kinds of support, especially the support I need;

(16) Peers always seem to understand my views;

(17) Peers always recognize my feelings and show that they understand my feelings;

(18) Peers allow me enough time to express my feelings before giving advice;

(19) I have a clearer understanding of the problems I face after communicating with peers;

(20) Questions from peers can help me think better about my problems;

(21) Peers use detailed examples to provide me with feedback and suggestions;

(22) Communication with peers makes me realize that the goals I have set can be achieved despite the difficulties;

(23) Communication with peers makes me aware of the importance of having clear goals;

(24) Communication with peers makes me realize that any goals I have set can be quantified;

(25) Peers can help me make clear, simple, and feasible plans;

(26) Peers help me focus on how to succeed instead of studying old problems;

(27) Peers always take my action plan seriously;

(28) Peers always ask me about the progress of my goals;

(29) Peers always help me make up for the deficiencies in my work;

(30) Peers always acknowledge my progress and success and give me encouragement.

The nine items of Subscale A of the above scale refer to Items 1-9, and the 21 items of Subscale B refers to Items 10-30.

A five-point Likert scale was adopted to calculate the participants' scores: specifically, 1 means "strongly disagree", 2 means "disagree", 3 means "neither agree nor disagree", 4

means “agree”, and 5 means “strongly agree”. The higher the score, the higher the degree of peer support.

3.2.4 Turnover intention

Turnover refers to an employee’s behavior of ending his/her employment relationship with the employer and leaving the current organization. Nurses’ turnover intention is the last step before nurses leave their organization. It can be further classified into the intention to leave the ward, the intention to leave the organization, and the intention to leave the nursing profession.

The Turnover Intention Scale used in this study is the Chinese Turnover Intention Scale highly relevant to nurses developed by Hua (2014). This scale consists of four items: (1) I often have the idea of leaving the nursing profession; (2) I think I will submit resignation in the near future and look for another job; (3) I believe that with my professional skills, I can easily find a job that gives full play to my skills in other hospitals; (4) I will choose to leave the hospital if I am given the chance.

A five-point Likert scale was adopted to calculate participants’ scores: specifically, 1 means “strongly disagree”, 2 means “disagree”, 3 means “neither agree nor disagree”, 4 means “agree”, and 5 means “strongly agree”. The higher the score, the higher the level of the nurse’s turnover intention.

The number of items, number of dimensions, score range, and propensity score matching of the scales of work-family conflict, organizational silence, peer support, and turnover intention are summarized in Table 3.1

Table 3.1 Basic information about the scales used in this study

Name	Developer	Dimension(s)	Items	Score	Propensity score matching
Work-Family Conflict Scale	Netemeyer, Boles, and McMurrian (1996)	2	10	1-5	The higher the score, the stronger the conflict
Organizational Silence Scale	Zheng et al. (2008)	3	12	1-5	The higher the score, the higher the level of organizational silence
Peer Support Scale	Greene and Grant (2003)	8	30	1-5	The higher the score, the higher the level of peer support
Turnover Intention Scale	Hua (2014)	1	4	1-5	The higher the score, the higher the level of turnover intention

3.2.5 Demographic, work and organizational characteristics

Based on the literature review, this study included the following demographic characteristics: gender, age, marital status, educational background, professional and technical titles, position/post, and contract type, as follows:

(1) Gender: Male or female;

(2) Age: 20-29 years old, 30-39 years old, 40-49 years old, and over 50 years old;

(3) Marital status: Unmarried, married, and others (such as divorced);

(4) Educational background: Technical secondary school graduate or below, junior college graduate, college graduate, postgraduate or above;

(5) Fertility circumstance: Nullipara, mother of one child, mother of two or more children

(6) Professional and technical titles: Junior title, intermediate title, vice senior title, senior title, and no title;

(7) Position/Post: General nurse, clinical teacher, head nurse or deputy head nurse, director of the nursing department, administrative personnel, and others;

(8) Contract type: Permanent employee, contract-based employee, and temporary employee;

(9) Does your current health status affect your job salary? Yes or no?

(10) Night shift: Yes or no, and how many times;

(11) What is your salary?

(12) Number of siblings, degree of financial burden, and situation of family members.

3.3 Data collection and organization

The present study adopted a questionnaire survey method. The target population included the nurses in secondary hospitals, with a focus on second child nurses. For the feasibility of sampling, a convenience sampling method was adopted and copies of the questionnaire of this study were distributed to the nurses in June 2020 in order to measure their demographic, work, and organizational characteristics, as well as items of the four scales and open questions. All the questionnaires were self-administered. The specific distribution process is as follows:

In terms of the sample hospitals, the researcher utilized her professional connections to approach secondary hospitals and above in seven regions of China, namely, the northeast, south, southeast, south central, east, southwest, and northwest regions. Then the researcher explained the purpose of the present study and the content of the questionnaire to the hospital

managers and asked for their consent. The managers of 216 secondary hospitals and above agreed to participate in the study and to try to involve their nurses. Based on the theoretical model and research hypotheses put forward in the previous chapter, the researcher designed a questionnaire and sent the WeChat link of the questionnaire to the hospital managers, who then forwarded the link to nurses who voluntarily participated in this study and explained to the nurses the purpose of the study. To ensure authenticity and reliability, the questionnaires were filled in anonymously.

Unqualified questionnaires were eliminated in strict accordance with the inclusion and exclusion criteria, as well as the following principles: Questionnaires with unanswered items in the scales of work-family conflict, organizational silence, peer support, or turnover intention; questionnaires with highly concentrated answers or answers forming a wavy curve; and questionnaires with more than three questions concerning demographic, work, or organizational characteristics unanswered or answered in an illogical way. Epidata 3.1 software was used to build and merge the database uniformly. Data were entered in accordance with the double parallel entry rule, and logic correction error checking procedures were performed twice to ensure that the data entering the analysis phase were credible. After the above process, 3,974 valid questionnaires were recovered. The process of valid data integration is shown in Figure 3.1. Refer to Annex A for the complete version of the questionnaire.

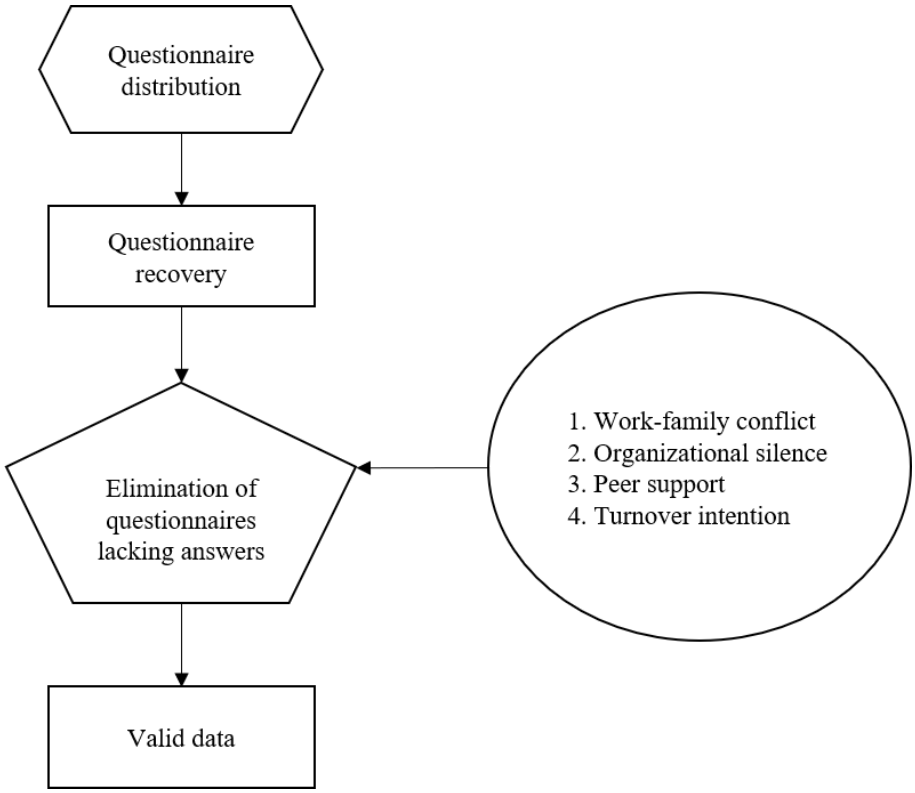

Figure 3.1 The process of data collection

This study ensured strict quality control in the process of data collection and data entry. The collected data had high reliability to ensure better data quality. The technical roadmap is shown in Figure 3.2.

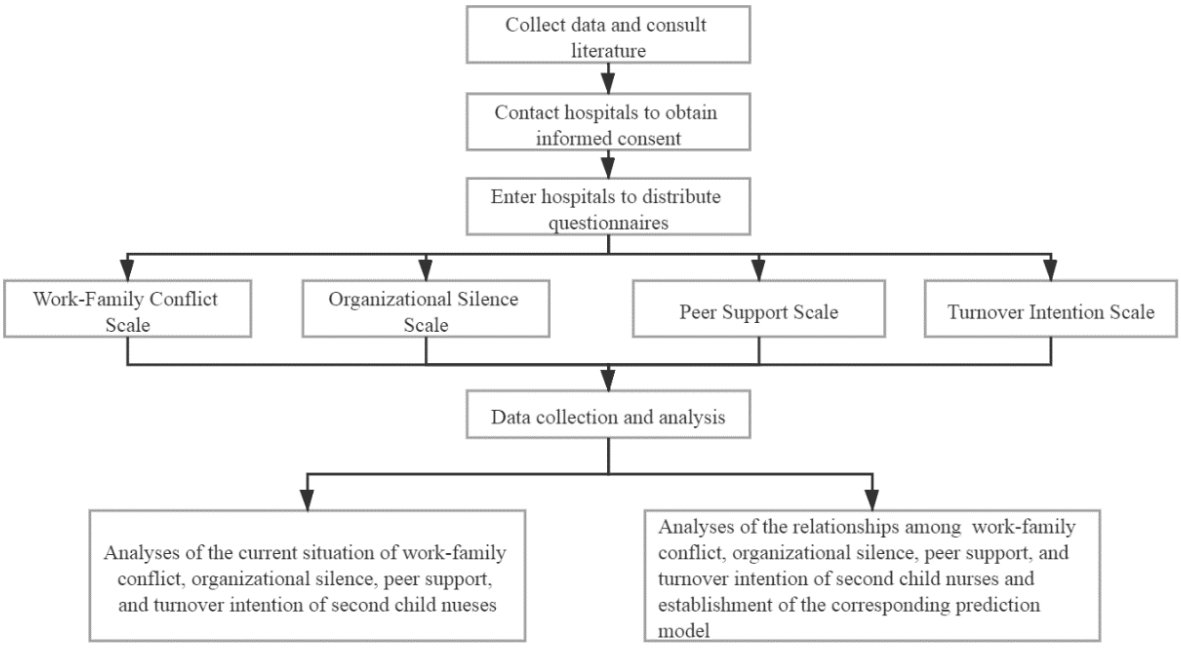

Figure 3.2 Technical roadmap

3.4 Statistical analysis

The software IBM SPSS Statistics 25.0 and AMOS 24.0 were used for statistical analysis.

Reliability analysis: Cronbach's α was used for reliability analysis, so as to assess the internal consistency of the scales. It is generally believed that a scale with a Cronbach's α value of 0.70 or higher can be considered as a reliable scale.

Validity analysis: Factor analysis was used to assess the validity of the scales. KMO and the Barlett's spherical test were used to determine whether the scales met the factor analysis conditions: It is generally believed that KMO value should exceed 0.70 and that Bartlett's spherical test $p < 0.05$. Exploratory factor analysis (EFA) was used to first assess construct validity of the scales; confirmatory factor analysis (CFA) was used to confirm construct validity of the scales. After conducting CFA, items that do not meet the requirements of the dimensions of the scale were deleted; validity analysis and verification were carried out after optimization.

Statistical description: For the measurement data that followed a normal distribution, mean ± standard deviation was used for description; for the data that did not follow a normal

distribution, medians (interquartile range) were used for statistical description. The enumeration data were described by rate and proportion.

Correlation analysis: The Pearson correlation coefficient was used to analyze the correlation between two quantitative variables. The correlation between two ordinal variables was computed using the Spearman correlation coefficient.

Difference analysis: homogeneity of variance was confirmed by the Levene test; *t* test or one-way analysis of variance were used for testing differences in means. The LSD method was used to compare each two groups. When the assumption of homogeneity of variance was not met, Kruskal-Wallis H test was used to test differences in distributions. $P<0.05$ means the difference is statistically significant.

Structural equation modelling: AMOS 24.0 was used to build the structural equation model proposed in this study, to estimate the path coefficients and to test the proposed research hypotheses. Goodness of fit indices were used to assess the degree of fit between the actual data structure and the theoretical structure. The judgment criteria of the relevant fit indices are shown in Table 3.2.

Table 3.2 Fit indices used to assess the goodness of fit of the structural equation model and their critical reference values

Goodness of fit index	Code	Reference value
Minimum discrepancy per degree of freedom	CMIN/DF	< 3.0～5.0
Root mean square error of approximation	RMSEA	< 0.050～0.080
Normed fit index	NFI	> 0.90
Relative fit index	RFI	> 0.90
Incremental fit index	IFI	> 0.90
Non-standard fit index	TLI	> 0.90
Comparative fit index	CFI	> 0.90
Parsimony normed fit index	PNFI	> 0.50

Source: Wu (2009)

Chapter 4: Research Results

The results of this study consist of six aspects: First, socio-demographic characteristics of the nurses; second, a general description of nurses' work attitudes; third, comparisons of nurses' levels of work-family conflict, organizational silence, peer support, and turnover intention by socio-demographic characteristics, work requirements and income levels, and family situation; fourth, comparisons of second child nurses' levels of work-family conflict, organizational silence, peer support, and turnover intention by socio-demographic characteristics as well as work and family situation; fifth, a comparison of levels of work-family conflict, organizational silence, peer support, and turnover intention of nurses with different demographic characteristics, work and family situation by number of children; and sixth, the estimates of the structural equation model proposed to explain second-child nurses turnover intention as a function of nurses' work-family conflict, organizational silence and peer support.

4.1 Socio-Demographic characteristics of the nurses

4.1.1 Demographic characteristics

All the 3,974 participants in this study are female. 85.1% of them were aged between 18 and 39 years; 57.8% had worked in the nursing profession for no more than 10 years; 43.9% were working in Wenzhou City; those working in tertiary A hospitals accounted for 65.9%; 47.2% were working in internal medicine departments or surgery departments; 41.7% had a senior nurse title; 74.8% were general nurses; 73.0% had a bachelor's degree; 59.0% were permanent employees of their respective hospitals (see Table 4.1).

able 4.1 Demographic characteristics of the nurses

Variable	Group	n	%
Age (years old)	18-29	1689	42.5
	30-39	1692	42.6
	40-49	523	13.2
	≥50	70	1.7
Length of service (years)	≤5	1184	29.8
	6-10	1113	28.0
	11-15	753	18.9
	16-20	455	11.5
	≥21	469	11.8
Location [a]	Wenzhou City	1739	43.9
	Other cities of Zhejiang Province	1157	29.2
	Cities outside Zhejiang Province	1069	27.0
Hospital level	Grade A tertiary hospital	2617	65.9
	Grade B tertiary hospital	529	13.3
	Grade A secondary hospital	611	15.4
	Grade B secondary hospital	217	5.5
Department [b]	Pediatrics department	162	4.3
	Obstetrics and gynecology department	309	8.2
	Emergency department	430	11.4
	Internal medicine department	984	26.2
	Operating room	217	5.8
	Surgery department	788	21.0
	ENT department	454	12.1
	ICU	243	6.5
	Other departments [c]	171	4.5
Title	Nurse	833	21.0
	Senior nurse	1657	41.7
	Supervisor nurse	1245	31.3
	Co-chief nurse	207	5.2
	Chief nurse	32	0.8
Position	General nurse	2974	74.8
	Clinical teacher	506	12.7
	Head nurse and deputy head nurse	427	10.7
	Director of nursing	32	0.8
	Administrative staff or others	35	0.9
Level of education	High school/technical secondary school graduates or below	91	2.3
	Junior college graduates	928	23.4
	College graduates	2900	73.0

Variable	Group	n	%
Type of employment	Postgraduates or above	55	1.4
	Permanent employees	2346	59.0
	Contract-based employees	874	22.0
	Temporary employees	754	19.0

Note: a. Nine people did not fill in their locations; b. 216 people did not fill in their departments; c. Other departments include departments of anesthesiology, reproductive medicine, imaging, traditional Chinese medicine, and administration.

4.1.2 Work requirements and income levels

The results of the survey among the 3,974 nurses showed that 72.1% of them needed to work night shifts, and 45.4% of them had to work four night shifts per month. The annual salary (after tax) of 50.6% of the participants ranged between RMB 50,000 and RMB 100,000 in 2019. Furthermore, 75.4% of the nurses held that their health status had no effect on their jobs (see Table 4.2).

Table 4.2 Nurses' work requirements and income level

Item	Group	n	%
Whether there is a need to work night shifts	Yes	2867	72.1
	No	1107	27.9
Frequency of night shift (times per month) [a]	1	111	4.0
	2	133	4.8
	3	355	12.9
	4	1250	45.4
	5	411	15.0
	≥6	492	17.9
Annual income (RMB 10,000/year)	≤5	608	15.3
	＞5, ≤10	2011	50.6
	＞10, ≤15	923	23.2
	＞15, ≤20	367	9.3
	＞20	65	1.6
Whether health status had influenced the job	Yes	978	24.6
	No	2996	75.4

Note: a. 1,222 participants did not fill in the frequency of night shift.

4.1.3 Family situation

69.1% of the 3,974 participants were married; 82.0% of them had siblings, with 73.7% of them having one sibling or two siblings; 64.1% of them were parents (41.4% had one child; and 22.7% had two or more children); and even though 58.0% of the participants had felt financial burden, 65.8% of the participants believed that their family members did not cause them financial burden (see Table 4.3).

Table 4.3 Nurses' family situation

Item	Group	n	%
Marital status	Unmarried	1157	29.1
	Married	2745	69.1
	Others: Divorced/separated/widowed	72	1.8
Single child or not	Yes	715	18.0
	No	3259	82.0
Number of siblings [a]	1	1597	49.0
	2	806	24.7
	3	573	17.6
	≥4	283	8.7
Number of children	None	1427	35.9
	One	1646	41.4
	Two or more	901	22.7
Whether there is financial burden	Yes	2304	58.0
	No	1670	42.0
Whether your family members cause you financial burden	Yes	1359	34.2
	No	2615	65.8

Note: a. 715 participants did not fill in the number of siblings.

4.2 A general description of nurses' work attitudes

The overall scores of the four scales used in this study - WFCS, OSS, PSS and TIS - were computed as the average of the responses of the nurses to the items measuring each scale. Scores range from 1 (lower levels) to 5 (higher levels). See Table 4.4 for details.

Table 4.4 The scores of nurses' work-family conflict, organizational silence, peer support, and turnover intention

Scale	Code	Number of items	n	Max	Min	Mean	Std-Dev
Work-Family Conflict Scale	WFCS	10	3974	5.00	1.00	2.71	0.80
Organizational Silence Scale	OSS	12	3974	5.00	1.00	2.91	1.17
Peer Support Scale	PSS	30	3974	5.00	1.00	3.59	0.89
Turnover Intention Scale	TIS	4	3974	5.00	1.00	2.73	1.17

4.2.1 A description of the Work-Family Conflict Scale

The maximum score of the Work-Family Conflict Scale (WFCS) is 5.00 points, and the minimum score 1.00 points, leading to a mean score of 2.71 points, with a standard deviation of 0.80. Item 5 had the highest average score (3.55 points), and Item 7 the average lowest score (2.09 points) (see Table 4.5)

Table 4.5 A description of the nurses' Work-Family Conflict Scale

Item	Code	Max	Min	Mean	Std-Dev
1. My job requirements have affected my family life;	WFCS1	5	1	2.93	1.07
2. My work schedule makes it difficult for me to fulfil my family responsibilities;	WFCS2	5	1	3.08	1.06
3. I did not complete what I wanted to do because of the work that I had to do;	WFCS3	5	1	3.02	1.11
4. Work stress made it difficult for me to flexibly arrange my family activity plan;	WFCS4	5	1	3.28	1.15
5. I had to change my family activity plan due to my job responsibilities;	WFCS5	5	1	3.55	1.10
6. The requirements from my family members have affected my normal work;	WFCS6	5	1	2.40	1.02
7. I have to delay work due to family reasons;	WFCS7	5	1	2.07	0.97
8. Sometimes I am unable to complete planned work, such as going to work on time, finishing daily tasks, and working overtime;	WFCS8	5	1	2.37	1.17
9. My family has affected my work, such as working on time, finishing daily tasks, and working overtime;	WFCS9	5	1	2.09	1.03
10. Family stress has affected my work performance.	WFCS10	5	1	2.26	1.05
Total	WFC	5	1	2.71	0.80

4.2.2 A description of the Organizational Silence Scale

The maximum score of the Organizational Silence Scale is 5.00 points, and the minimum score 1.00 points, leading to a mean score of 2.91 points, with a standard deviation of 1.17.

Item 2 had the highest average score (3.47 points), and Item 12 the lowest average score (2.22 points) (see Table 4.6).

Table 4.6 A description of Nurses' Organizational Silence Scale

Item	Code	Max	Min	Mean	Std-Dev
1. Leaders have almost made decisions, and my opinions will not make a big difference;	OSS1	5	1	3.43	1.18
2. My opinion will not affect the current situation;	OSS2	5	1	3.47	1.18
3. It is nearly impossible for leaders to adopt my suggestions;	OSS3	5	1	3.25	1.13
4. Leaders will not change some decisions, and it makes little difference for me to speak out my views;	OSS4	5	1	3.28	1.20
5. I choose to remain silent about others' deficiencies and negligence in work to avoid affecting my relationships with peers;	OSS5	5	1	2.81	10.4
6. I might as well withhold my views in order not to become the target of criticism;	OSS6	5	1	2.94	1.07
7. There is no need for me to offend leaders or peers;	OSS7	5	1	3.20	1.21
8. I get along well with everyone. So, it is better for me to withhold my own opinions;	OSS8	5	1	2.85	1.05
9. Other people's affairs are not my business, and there is no need for me to talk about them;	OSS9	5	1	2.68	1.07
10. I do not care about the affairs of the hospital;	OSS10	5	1	2.27	1.01
11. As the Doctrine of the Mean suggests, less talking means fewer responsibilities;	OSS11	5	1	2.58	1.02
12. I do not have a strong attachment with the hospital. So, there is no need for me to give any comments.	OSS12	5	1	2.22	1.03
Total	OSS	5	1	2.91	1.17

4.2.3 A description of the Peer Support Scale

The maximum score of the Peer Support Scale is 5.00 points, and the minimum score 1.00 points, leading to a mean score of 3.59 points, with a standard deviation of 0.89 points. The highest average score appeared in Item 13 (3.88 points), whereas the lowest average score in Item 1 (3.20 points) (see Table 4.7).

Table 4.7 A description of nurses' Peer Support Scale

Item	Code	Max	Min	Mean	Std-Dev
1. The head nurse spends time understanding my goals and expectations;	PSS1	5	1	3.20	1.02
2. The head nurse cares whether I have achieved my goals;	PSS2	5	1	3.25	1.01
3. The head nurse has been paying attention to various opportunities beneficial to my career	PSS3	5	1	3.31	1.03

Item	Code	Max	Min	Mean	Std-Dev
development in the hospital;					
4. The head nurse always praises me after I complete important tasks;	PSS4	5	1	3.47	0.98
5. The head nurse can provide me with effective feedback on my work;	PSS5	5	1	3.57	0.93
6. The head nurse gives me suggestions on how to improve my work when I need such suggestions;	PSS6	5	1	3.67	0.93
7. The head nurse supports my desire for additional training or education for better development in the future;	PSS7	5	1	3.52	0.97
8. The head nurse provides me with work tasks that could help me develop new skills;	PSS8	5	1	3.50	0.97
9. The head nurse assigns to me special tasks which can promote my development in the hospital;	PSS9	5	1	3.42	0.97
10. The help provided by my peers is effective in reducing my work stress;	PSS10	5	1	3.74	0.87
11. I value my time spent in building up a peer support system;	PSS11	5	1	3.63	0.84
12. The peer support system has significantly relieved my work stress;	PSS12	5	1	3.69	0.83
13. Peers respect my choice and encourage rather than force me to participate in department activities;	PSS13	5	1	3.88	0.87
14. Peers provide me with a supportive environment where I feel safe to talk about my feelings;	PSS14	5	1	3.69	0.89
15. Peers give me various kinds of support, especially the support I need;	PSS15	5	1	3.72	0.86
16. Peers always seem to understand my views;	PSS16	5	1	3.67	0.83
17. Peers always recognize my feelings and show that they understand my feelings;	PSS17	5	1	3.68	0.62
18. 18. Peers allow me enough time to express my feelings before giving advice;	PSS18	5	1	3.69	0.81
19. I have a clearer understanding of the problems I face after communicating with peers;	PSS19	5	1	3.74	0.80
20. Questions from peers can help me think better about my problems;	PSS20	5	1	3.76	0.79
21. Peers use detailed examples to provide me with feedback and suggestions;	PSS21	5	1	3.62	0.81
22. Communication with peers makes me realize that the goals I have set can be achieved despite the difficulties;	PSS22	5	1	3.59	0.80
23. Communication with peers makes me aware of the importance of having clear goals;	PSS23	5	1	3.66	0.80
24. Communication with peers makes me realize that any goals I have set can be quantified;	PSS24	5	1	3.63	0.81
25. Peers can help me make clear, simple, and feasible plans;	PSS25	5	1	3.55	0.84

Item	Code	Max	Min	Mean	Std-Dev
26. Peers help me focus on how to succeed instead of studying old problems;	PSS26	5	1	3.53	0.84
27. Peers always take my action plan seriously;	PSS27	5	1	3.57	0.83
28. Peers always ask me about the progress of my goals;	PSS28	5	1	3.51	0.83
29. Peers always help me make up for the deficiencies in my work;	PSS29	5	1	3.60	0.82
30. Peers always acknowledge my progress and success and give me encouragement.	PSS30	5	1	3.64	0.82
Total	PSS	5	1	3.59	0.89

4.2.4 A description of the Turnover Intention Scale

The maximum score of the Turnover Intention Scale is 5.00 points, and the minimum score 1.00 points, leading to a mean score of 2.73 points, with a standard deviation of 1.17 points. The highest average score appeared in Item 1 (3.00 points), whereas the lowest average score in Item 2 (2.47 points) (see Table 4.8).

Table 4.8 A description of nurses' Turnover Intention Scale

Item	Code	Max	Min	Mean	Std-Dev
1. I often have the idea of leaving the nursing profession;	TIS1	5	1	3.00	1.20
2. I think I will submit resignation in the near future and look for another job;	TIS2	5	1	2.47	1.14
3. I believe that with my professional skills, I can easily find a job that gives full play to my skills in other hospitals;	TIS3	5	1	2.77	1.02
4. I will choose to leave the hospital if I am given the chance.	TIS4	5	1	2.70	1.24
Total	TIS	5	1	2.73	1.17

4.3 Comparing nurses' levels of work-family conflict, organizational silence, peer support, and turnover intention by demographic characteristics

This section compares and analyzes nurses' levels of work-family conflict, organizational silence, peer support, and turnover intention by demographic characteristics. When the Levene's test showed heterogeneity of variance the Kruskal-Wallis H test was conducted. The central tendency was expressed using the median M, and the tendency of dispersion was expressed using the interquartile range IQR. The results of the analysis are shown in Table 4.9.

The results show that the scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses of different age groups are statistically significant (WFCS, F=32.229, p<0.001; OSS, F=7.442, p<0.001; PSS, F=8.517, p<0.001; TIS, F=62.333, p<0.001). Specifically, compared to nurses aged 50 years or older, nurses aged between 18 and 29 years had significantly lower levels of peer support and significantly higher levels of turnover intention (both p<0.001), nurses aged between 30 and 39 years had significantly higher levels of work-family conflict, organizational silence and turnover intention (WFCS: P<0.001; PSS, p=0.010; TIS, p<0.001), and nurses aged between 40 and 49 years had significantly higher levels of turnover intention (p=0.043); compared to nurses aged between 40 and 49 years, nurses aged between 18 and 29 years had significantly lower levels of peer support and significantly higher levels of organizational silence and turnover intention (all p<0.001). Nurses aged between 30 and 39 years had significantly lower levels of peer support and significantly higher levels of work-family conflict, organizational silence, and turnover intention (all p<0.001); compared to nurses aged between 30 and 39 years, nurses aged between 18 and 29 years had significantly lower levels of work-family conflict (p<0.001).

The scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses with different length of service are all statistically significant (WFCS, F=30.803, p=0.001; OSS, H=38.819, p<0.001; PSS, F=9.335, p<0.001; TIS, F=55.132, p<0.001). Compared with nurses having no less than 21 years of work experience, nurses with no more than five years of work experience had significantly higher levels of organizational silence and turnover intention as well as significantly lower levels of peer support (OSS, p=0.009; TIS, p<0.001; PSS, p<0.001); nurses with six to ten years or 11 to 15 years of work experience had significantly higher levels of work-family conflict, organizational silence, and turnover intention as well as significantly lower levels of peer support (all p<0.001); nurses with 16 to 20 years of work experience had significantly higher levels of work-family conflict and turnover intention (WFCS: P=0.001; TIS, p<0.001; PSS, p=0.047). Furthermore, compared with nurses having 16 to 20 years of experience, nurses with no more than five years of work experience had significantly lower levels of work-family conflict and significantly higher levels of turnover intention (WFCS, p=0.001; TIS, p<0.001); nurses with six to ten years or 11 to 15 years of experience had significantly higher levels of work-family conflict, organizational silence, and turnover intention as well as significantly lower levels of peer support (nurses with six-ten years of experience: WFCS, p=0.002; OSS, p<0.001; TIS, p<0.001; PSS, p<0.001; nurses with 11-15 years of experience:

WFCS, p=0.002; OSS, p=0.003; TIS, p<0.001; PSS, p=0.008); compared with nurses having 11 to 15 years of experience, nurses with no more than five years of work experience had significantly lower levels of work-family conflict (p<0.001), and nurses with six to ten years of work experience had significantly higher levels of turnover intention (p=0.015); and compared to nurses with six to ten years of work experience, nurses with no more than five years of experience had significantly lower levels of work-family conflict and significantly higher levels of turnover intention (WFCS, *p<0.001*; TIS, p=0.019).

The scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses from different locations are all statistically significant (WFCS, F=11.056, p<0.001; OSS, F=19.625, p<0.001; PSS, F=4.149, p=0.016; TIS, F=10.064, p<0.001). Compared with nurses working in Wenzhou City, nurses working in other cities of Zhejiang Province had significantly higher levels of peer support and turnover intention (PSS, p=0.013; TIS, p=0.014). Nurses working in places other than Zhejiang Province had significantly lower levels of work-family conflict, organizational silence, and turnover intention (WFCS, p=0.001; OSS, p<0.001; TIS, p=0.013); compared with nurses working in other cities of Zhejiang Province, nurses working in places outside Zhejiang Province had significantly lower levels of work-family conflict, organizational silence, peer support, and turnover intention (WFCS, p<0.001; OSS, p<0.001; PSS, p=0.010; TIS, p<0.001).

The scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses working in hospitals of different levels are all statistically significant (WFCS, F=8.516, p<0.001; OSS, F=6.762, p<0.001; PSS, F=9.101, p<0.001; TIS, H=22.149, p<0.001). Compared with nurses working in Grade A tertiary hospitals, nurses working in Grade B tertiary hospitals had significantly higher levels of work-family conflict, organizational silence, and turnover intention as well as significantly lower levels of peer support (WFCS, p=0.002; OSS, p<0.001; TIS, p=0.002; PSS, p<0.001), and nurses working in Grade A secondary hospitals had significantly higher levels of work-family conflict, organizational silence, and turnover intention as well as significantly lower levels of peer support (WFCS, p<0.001; OSS, p=0.011; TIS, p=0.001; PSS, p<0.001); compared with nurses working in Grade B tertiary hospitals, nurses working in Grade A secondary hospitals had significantly lower levels of work-family conflict and organizational silence (WFCS, p=0.001; OSS, p=0.035); compared with nurses working in Grade A secondary hospitals, nurses working in Grade B secondary hospitals had significantly lower levels of work-family conflict and organizational silence as well as significantly higher levels of peer support (WFCS, p<0.001; OSS, p<0.001; PSS, p=0.048).

The scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses working in different departments are all statistically significant (WFCS, F=9.046; p<0.001; OSS, H=55.750, p<0.001; PSS, F=3.161, p=0.001; TIS, F=6.274, p<0.001). Compared with nurses working in pediatric departments, nurses working in surgery departments had significantly higher levels of work-family conflict (p=0.013); nurses working in ICUs had significantly higher levels of work-family conflict and significantly lower levels of peer support (WFCS, p=0.04; PSS, p=0.019); nurses working in emergency departments and operation rooms had significantly lower levels of peer support (EDs, p=0.04; ORs, p= 0.035); nurses working in ENT departments had significantly lower levels of turnover intention (p=0.007), and nurses working in other departments had significantly lower levels of work-family conflict, organizational silence, and turnover intention (WFCS, p=0.006; OSS, p=0.020; TIS, p=0.002); compared with nurses working in obstetrics and gynecology departments, nurses working in surgery departments had significantly higher levels of work-family conflict (p=0.019), nurses working in ICUs had significantly lower levels of peer support (p=0.049), and nurses working in ENT departments and other departments had significantly lower levels of work-family conflict, organizational silence, and turnover intention (ENT departments: WFCS, p=0.009; OSS, , p=0.001; TIS, p=0.001; other departments: WFCS, p<0.001; OSS, p<0.001; TIS, p<0.001); compared with nurses working in emergency departments, nurses working in surgery departments had significantly higher levels of work-family conflict (p=0.008), and nurses working in ENT departments and other departments had significantly lower levels of work-family conflict, organizational silence, and turnover intention as well as significantly higher levels of peer support (ENT departments: WFCS, p=0.005; OSS, p=0.001; TIS, p<0.001; PSS, p=0.001; other departments: WFCS, p<0.001; OSS, p=0.001; TIS, p<0.001; PSS, p=0.022). Compared with nurses working in internal medicine departments, nurses working in operation rooms had significantly lower levels of work-family conflict (p=0.023), and nurses working in ENT departments had significantly lower levels of work-family conflict, organizational silence, and turnover intention as well as significantly higher levels of peer support (WFCS, p<0.001; PSS, p=0.002; OSS, p<0.001; TIS, p<0.001), and nurses working in other departments had significantly lower levels of work-family conflict, organizational silence, and turnover intention (WFCS, p<0.001; OSS, p=0.001; TIS, p<0.001). Compared with nurses working in operation rooms, nurses working in surgery departments and ICUs had significantly higher levels of work-family conflict (surgery departments, p=0.002; ICUs, p=0.019), and nurses working in ENT departments and other departments had significantly lower levels of work-family

conflict and turnover intention as well as significantly higher levels of peer support (WFCS, p=0.006; TIS, p=0.005; PSS, p=0.002). Compared with nurses working in surgery departments, nurses working in ENT departments had significantly lower levels of work-family conflict, organizational silence, and turnover intention as well as significantly higher levels of peer support (WFCS, p<0.001; OSS: p=0.009; TIS, p<0.001; PSS, p=0.023), and nurses working in other departments had significantly lower levels of work-family conflict, organizational silence, and turnover intention (WFCS, p<0.001; OSS: p=0.008; TIS, p<0.001); compared with nurses working in ICUs, nurses working in ENT departments and other departments had significantly lower levels of work-family conflict, organizational silence, and turnover intention as well as significantly higher levels of peer support (ENT departments: WFCS, p<0.001; OSS, p<0.001; TIS, p<0.001; PSS, p=0.001; other departments: WFCS, p<0.001; OSS, p<0.001; TIS, p<0.001; PSS, p=0.011).

The scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses with different titles are all statistically significant (WFCS, H=79.571, p<0.001; OSS, H=38.696, p<0.001; PSS, F=10.852, p<0.001; TIS, F=433.020, p=0.002). Compared with chief nurses, nurses, senior nurses, and supervisor nurses had significantly lower levels of peer support and significantly higher levels of turnover intention (nurses: PSS, p=0.001; TIS, p<0.001; senior nurses: PSS, $p<0.001$; TIS, p<0.001; supervisor nurses: PSS, p=0.002; TIS, p<0.001). Compared with co-chief nurses, nurses had significantly lower levels of peer support and significantly higher levels of turnover intention (both p<0.001), senior nurses had significantly higher levels of work-family conflict and organizational silence as well as significantly lower levels of peer support (all p<0.001), and supervisor nurses had significantly higher levels of work-family conflict and significantly lower levels of peer support (p<0.001); compared with supervisor nurses, nurses had significantly lower levels of work-family conflict and significantly higher levels of turnover intention (WFCS, p<0.001; TIS, p=0.006), and senior nurses had significantly higher levels of organizational silence and turnover intention as well as significantly lower levels of peer support (OSS, p=0.002; TIS, p<0.001; PSS, p=0.016); compared with senior nurses, nurses had significantly lower levels of work-family conflict and significantly higher levels of turnover intention (WFCS, p<0.001; OSS, p<0.001; TIS, p=0.033).

The scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses with different positions are all statistically significant (WFCS, F=9.782, p<0.001; OSS, H=114.479, p<0.001; PSS, H=86.998, p<0.001; TIS, F=44.259, p<0.001). Compared with nursing department directors, general nurses had significantly higher levels of

work-family conflict, peer support, and turnover intention as well as significantly lower levels of organizational silence (WFCS, p=0.023; PSS, p=0.047; TIS, p=0.001; OSS, p<0.001), and clinical teachers had significantly higher levels work-family conflict, organizational silence, and turnover intention (WFCS, p=0.001; OSS, p=0.002; TIS, p=0.018); compared with head nurses and deputy-head nurses, general nurses and clinical teachers had significantly higher levels of work-family conflict, organizational silence, and turnover intention as well as significantly lower levels of peer support (general nurses: WFCS, p=0.004; OSS, p<0.001; TIS, p<0.001; PSS, p<0.001; clinical teachers: All p<0.001). Compared with clinical teachers, general nurses had significantly lower levels of work-family conflict and significantly higher levels of turnover intention (WFCS, p<0.001; TIS, p=0.006); compared with administration staff and others, general nurses and clinical teachers had significantly higher levels of work-family conflict and significantly lower levels of peer support (general nurses: WFCS, p=0.023; PSS, p=0.003; clinical teachers, WFCS, p=0.001; PSS, p=0.032), and head and deputy-head nurses had significantly lower levels of peer support (p=0.009).

The scores of work-family conflict and turnover intention of nurses with different levels of education are all statistically significant (WFCS, H=13.300, p=0.004; TIS, F=3.919, p=0.008). Compared with nurses having a master's degree, college graduates and below had significantly higher levels of turnover intention (high school/technical secondary school graduates or below, p=0.002; junior college graduates, p=0.019; college graduates, p=0.040); compared with college graduates, junior college graduates had significantly lower levels of work-family conflict (p=0.003), and high school/technical secondary school graduates or below had significantly lower levels of work-family conflict and significantly higher levels of turnover intention (WFCS, p=0.008; TIS, p=0.015).

The scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses with different types of employment are all statistically significant (WFCS, F=16.585, p<0.001; OSS, F=16.499, p<0.001; PSS, F=4.491, p=0.011; TIS, F=19.624, p<0.001). Compared with permanent employees, contract-based employees had significantly lower levels of work-family conflict (p<0.001), and temporary employees had significantly lower levels of work-family conflict, organizational silence, and peer support as well as significantly higher levels of turnover intention (WFCS, p=0.006; OSS, p<0.001; PSS, p=0.023; TIS, p<0.001). Compared with contract-based employees, temporary employees had significantly higher levels of work-family conflict and turnover intention as well as significantly lower levels of organizational silence and peer support (WFCS, p=0.034; TIS, p<0.001; OSS, p=0.004; PSS, p=0.003).

In summary, the results indicate that: (1) In terms of age, nurses aged 18-29 years had the highest levels of turnover intention; nurses aged 30-39 years had the highest levels of work-family conflict and organizational silence; and nurses aged 50 years or older had the highest levels of peer support; (2) As to length of service, nurses with no more than five years of experience, those with 6-10 years of experience, and those with 11-15 years of experience had high levels of organizational silence and turnover intention. Besides, nurses with 6-10 years of experience and those with 10-15 years of experience had high levels of work-family conflict; nurses with no less than 21 years of experience had the highest levels of peer support and the lowest levels of turnover intention; (3) In terms of location, nurses located in other cities of Zhejiang Province had higher levels of work-family conflict, peer support, and turnover intention; (4) As to hospital level, nurses working in Grade A tertiary hospitals had the highest levels of peer support and the lowest levels of turnover intention; (5) When department is concerned, nurses working in surgery departments and intensive care units had high levels of work-family conflict and turnover intention; and nurses working in ENT departments and other departments had low levels of organizational silence and turnover intention as well as high levels of peer support; (6) In terms of title, nurses, senior nurses, and supervisor nurses had high levels of organizational silence and turnover intention, as well as low levels of peer support; chief nurses had high levels of peer support and low levels of turnover intention; (7) With regard to position, general nurses had the highest levels of organizational silence and turnover intention; head nurses and deputy head nurses had the highest levels of peer support and the lowest levels of turnover intention; (8) As to level of education, college graduates, postgraduates and above had low levels of turnover intention; (9) With regard to type of employment, temporary employees had the lowest levels of peer support and the highest levels of turnover intention, while permanent employees had the highest levels of work-family conflict.

Table 4.9 Average levels of work-family conflict, organizational silence, peer support, and turnover intention of nurses by demographic characteristics

Item	Group	n	Work-family conflict			Organizational silence			Peer support			Turnover intention		
			M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test
Age (Year)	18-29	1689	26.24	7.99	32.229***	34.98	10.37	7.442***	107.08	20.98	8.517***	11.40	3.87	62.333***
	30-39	1692	28.42	7.80		35.54	9.90		106.95	21.22		11.16	3.90	
	40-49	523	25.54	7.64		33.18	9.33		111.45	21.04		9.09	3.71	
	≥50	70	24.37	8.12		34.46	9.50		113.57	21.14		8.10	3.70	
Length of service (Year)	≤5	1184	25.57	7.97	30.803***	36.00	15.00	38.819***a	107.54	20.78	9.335***	11.26	3.82	55.132***
	6-10	1113	28.39	7.58		36.00	12.00		106.05	20.80		11.64	3.85	
	11-15	753	28.48	8.09		36.00	13.00		106.36	21.76		11.20	4.01	
	16-20	455	27.03	7.96		34.00	12.00		109.66	21.80		10.20	3.80	
	≥21	469	25.29	7.60		33.00	13.00		112.41	20.55		8.73	3.66	
Location	Wenzhou City	1739	27.14	7.91	11.056***	35.83	10.14	19.625***	107.23	20.94	4.149*	10.93	3.85	10.064***
	Other cities of Zhejiang Province	1157	27.71	7.67		35.11	9.99		109.23	21.18		11.30	4.01	
	Cities outside Zhejiang Province	1069	26.14	8.25		33.40	9.78		106.93	21.43		10.55	4.00	
Hospital Level	Grade A tertiary hospital	2617	26.75	7.90	8.516***	34.58	10.04	6.762***	108.88	21.00	9.101***	11.00	5.00	22.149***a
	Grade B tertiary hospital	529	27.91	7.41		36.42	10.00		105.66	21.19		12.00	5.00	
	Grade A secondary	611	28.02	8.50		35.72	10.01		104.49	20.86		12.00	6.00	

Item	Group	n	Work-family conflict			Organizational silence			Peer support			Turnover intention		
			M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test
	hospital													
	Grade B secondary hospital	217	25.69	8.00		34.06	9.98		107.79	22.53		12.00	5.00	
Department	Pediatrics department	162	26.52	7.88	9.046	36.00	13.25		109.65	19.15		11.06	3.86	
	Obstetrics and gynecology department	309	26.96	8.49	***	36.00	14.00		108.21	21.43		11.04	4.04	
	Emergency department	430	26.95	8.21		36.00	13.25		105.66	21.70		11.09	4.17	
	Internal medicine department	984	27.72	7.80		36.00	14.00	55.750 ***a	106.77	21.79	3.161 **	11.16	3.97	6.274 ***
	Operating room	217	26.37	7.11		35.00	11.50		105.04	20.13		11.00	3.72	
	Surgery department	788	28.20	7.86		36.00	13.00		107.62	20.86		11.26	3.88	
	ENT department	454	25.45	8.01		34.00	12.00		110.44	21.60		10.09	3.96	
	ICU	243	28.10	7.29		37.00	13.00		104.65	18.45		11.43	3.92	
	Other departments	171	24.15	7.82		31.00	11.00		110.03	19.80		9.73	3.48	
Title	Nurse	833	26.00	10.00	79.571	35.00	13.00		107.56	21.50		11.09	3.97	
	Senior nurse	1657	28.00	9.00	***a	36.00	14.00	38.696 ***a	106.29	20.99	10.852 ***	11.45	3.84	33.020 ***
	Supervisor nurse	1245	29.00	10.00		35.00	13.00		108.20	21.15		10.62	3.96	
	Co-chief nurse	207	25.00	9.00		33.00	10.00		115.01	19.29		8.56	3.51	

Item	Group	n	Work-family conflict			Organizational silence			Peer support			Turnover intention		
			M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test
Position	Chief nurse	32	26.00	11.50	9.782***	33.00	12.75	114.479***a	119.63	19.24	86.998***a	8.19	3.81	44.259***
	General nurse	2974	27.02	7.97		36.00	13.00		104.00	30.00		11.31	3.90	
	Clinical teacher	506	28.61	8.09		35.00	11.00		108.00	28.00		10.79	3.85	
	Head nurse and deputy head nurse	427	25.84	7.46		32.00	11.00		119.00	24.00		8.76	3.69	
	Director of nursing	32	24.19	6.42		28.00	4.75		117.00	12.75		9.13	3.51	
	Administrative staff or others	35	23.94	7.97		33.00	13.00		100.00	30.00		9.34	3.14	
Level of education	High school/technical secondary school graduates or below	91	27.00	14.00	13.300**a	35.00	15.00	7.407a	104.96	22.07	1.342	11.90	4.54	3.919**
	Junior college graduates	928	27.00	10.00		35.00	14.00		107.67	21.17		11.07	3.97	
	College graduates	2900	28.00	10.00		36.00	13.00		107.73	21.02		10.88	3.92	
	Postgraduates or above	55	28.00	9.00		34.00	16.00		112.20	25.82		9.78	3.75	
Type of employment	Permanent employees	2346	27.61	7.84	16.585***	35.62	9.94	16.499***	107.86	21.12	4.491*	10.75	3.90	19.624***
	Contract-based employees	874	25.85	7.79		33.35	9.85		108.95	21.20		10.75	3.92	
	Temporary employees	754	26.68	8.35		34.81	10.40		105.85	21.10		11.74	4.04	

Note: a. Levene test results showed non-homogeneity of variance. Hence, Kruskal-Wallis H test was used. The central tendency was indicated by median (M), and the tendency of dispersion was represented by inter-quartile range (IQR). ***: $p<0.001$; **: $p<0.01$; *: $p<0.05$.

4.4 Comparing nurses' levels of work-family conflict, organizational silence, peer support, and turnover intention by work requirements and income levels

This section compares and analyzes nurses' levels of work-family conflict, organizational silence, peer support, and turnover intention by work requirements and income levels. When the Levene's test showed heterogeneity of variance the Kruskal-Wallis H test was conducted. The central tendency was expressed using the median M, and the tendency of dispersion was expressed using the interquartile range IQR. The analysis results are shown in Table 4.10.

The scores of nurses' work-family conflict, organization silence, peer support, and turnover intention regarding whether they needed to work night shifts are all statistically significant (WFCS, t=9.096, p<0.001; OSS, t=70.445, p＜0.001; PSS, t=24.390, p=0.011; TIS, t=167.723, p<0.001). Compared with nurses who did not need to work night shifts, nurses who needed to work night shifts had significantly higher levels of work-family conflict, organizational silence, and turnover intention as well as significantly lower levels of peer support.

The scores of nurses' work-family conflict, organization silence, peer support, and turnover intention regarding the number of night shifts per month are all statistically significant (WFCS, F=3.475, P=0.004; OSS, H=43.273, p＜0.001; PSS, F=11.579, p＜0.001; TIS, H= 86.162, p<0.001). Compared with nurses who needed to work no less than six night shifts per month, those who worked one night shift per month had significantly lower levels of work-family conflict, organizational silence, and turnover intention as well as significantly higher levels of peer support (WFCS, p=0.009; OSS, p<0.001; TIS, p<0.001; PSS, p＜0.001), and those who worked two or three night shifts per month had significantly higher levels of peer support and significantly lower levels of turnover intention (those who worked two night shifts per month: PSS, p=0.001; TIS, p=0.012; those who worked three night shifts per month: PSS, p=0.029; TIS, p=0.001); nurses who worked four night shifts per month had significantly lower levels of work-family conflict and turnover intention (WFCS, p=0.025; TIS, p<0.001); compared with nurses who worked five night shifts per month, nurses who worked one or three or four night shift(s) per month had significantly lower levels of work-family conflict, organizational silence, and turnover intention as well as significantly higher levels of peer support (nurses who worked one night shift per month: WFCS, p=0.002;

OSS, $p<0.001$; TIS, $p<0.001$; PSS, $p<0.001$; nurses who worked three night shifts per month: WFCS, $p=0.012$; OSS, $p=0.005$; TIS, $p<0.001$; nurses who worked four night shifts per month: $p=0.003$; OSS, $p<0.001$; TIS, $p<0.001$), nurses who worked two night shifts per month had significantly lower levels of organizational silence and turnover intention as well as significantly higher levels of peer support (OSS, $p=0.005$; TIS, $p<0.001$; PSS, $p=0.006$); compared with nurses who worked four night shifts per month, those who worked one night shift per moth had significantly lower levels of organizational silence and turnover intention as well as significantly higher levels of peer support (OSS, $p=0.003$; TIS, $p<0.001$;PSS, $p<0.001$), nurses who worked two night shifts per month had significantly higher levels of peer support ($p=0.016$); compared with nurses who worked three night shifts per month, those who worked one night shift per month had significantly lower levels of organizational silence and turnover intention as well as significantly higher levels of peer support (OSS, $p=0.012$; TIS, $p<0.001$; PSS, $p<0.001$); compared with nurses who worked two night shifts per month, those who worked one night shift per month had significantly higher levels of peer support and significantly lower levels of turnover intention (PSS, $p=0.001$; TIS, $p=0.021$).

The scores of work-family conflict, organization silence, peer support, and turnover intention of nurses with different levels of income after tax are all statistically significant (WFCS, $H=12.926$, $p=0.012$; OSS, $H=18.601$, $p=0.001$; PSS, $F=7.646$, $p<0.001$; TIS, $H=79.241$, $p<0.001$). Compared with nurses earning an annual income of more than RMB 200,000/year, those earning an annual income of no more than RMB 50,000/year had significantly lower levels of peer support and significantly higher levels of turnover intention (PSS, $p=0.001$; TIS, $p<0.001$), nurses earning an annual income between RMB 50,000/year and RMB 100,000/year had significantly lower levels of peer support and significantly higher levels of organizational silence and turnover intention (PSS, $p=0.002$; OSS, $p=0.008$; TIS, $p<0.001$), nurses earning an income between RMB 100,000/year and RMB 150,000/year or nurses earning an income between RMB 150,000/year and RMB 200,000/year had significantly lower levels of peer support (RMB 100,000<annual income≤RMB 150,000, $p=0.015$; RMB 150,000<annual income≤RMB 200,000, $p=0.036$); compared with nurses earning an annual income between RMB 150,000/year and RMB 200,000/year, nurses earning an annual income of no more than RMB 50,000/year had significantly lower levels of peer support and significantly higher levels of turnover intention (PSS, $p=0.011$; TIS, $p<0.001$), nurses earning an annual income between RMB 50,000/year and RMB 100,000/year had significantly higher levels of work-family conflict and turnover intention (WFCS,

p=0.023; TIS, $p<0.001$), and nurses earning an annual income between RMB 100,000/year and RMB 150,000/year had significantly higher levels of turnover intention (p=0.033); compared with nurses earning an income between RMB 100,000/year and RMB 150,000/year, nurses earning an annual income of no more than RMB 50,000/year had significantly lower levels of peer support and significantly higher levels of turnover intention (PSS, p=0.010; TIS, $p<0.001$), and nurses earning an annual income between RMB 50,000/year and RMB 100,000/year had significantly higher levels of turnover intention ($p<0.001$); and compared with nurses earning an annual income between RMB 50,000/year and RMB 100,000/year, nurses earning an annual income of no more than RMB 50,000 had significantly lower levels of work-family conflict (p=0.007).

The scores of work-family conflict, organization silence, peer support, and turnover intention of nurses with different health status are all statistically significant (WFCS, t=17.277, p<0.001; OSS, t=11.536, $p<0.001$; PSS, t=-5.280, $p<0.001$; TIS, t=14.076, p<0.001;). Nurses whose health affected their work had significantly higher levels of work-family conflict, organizational silence, and turnover intention as well as significantly lower levels of per support.

In summary, in terms of whether there is a need to work night shifts, nurses who need to work night shift had higher levels of work-family conflict, organizational silence, and turnover intention, as well as lower levels of peer support. As to number of night shifts per month, nurses who need to work more night shifts had higher levels of work-family conflict, organizational silence, and turnover intention, as well as lower levels of peer support. With regard to annual income, nurses with lower levels of annual income had higher levels of organizational silence, and nurses with lower levels of peer support had higher levels of turnover intention. When it comes to whether health has affected work, nurses whose health has affected work had higher levels of work-family conflict, organizational silence, and turnover intention, as well as lower levels of peer support.

Table 4.10 Average levels of work-family conflict, organizational silence, peer support, and turnover intention of nurses by work requirements and income levels

Item		n	Work-family conflict			Organizational silence			Peer support			Turnover intention		
			M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test
Whether there is a need to work night shifts	Yes	2867	27.75	7.88	9.096 ***	35.79	10.08	70.445 ***	106.69	20.85	24.390 ***	11.43	3.88	167.723 ***
	No	1107	25.22	7.88		32.84	9.66		110.38	21.71		9.66	3.83	
Number of night shifts per month	1	111	26.28	7.48	3.475 **	32.00	11.00	43.273 ***a	119.36	21.66	11.579 ***	9.00	4.00	86.162 ***a
	2	133	28.01	7.72		36.00	12.50		110.80	19.76		11.00	5.00	
	3	355	27.40	7.72		36.00	13.00		107.25	19.78		11.00	5.00	
	4	1250	27.49	7.63		36.00	14.00		106.26	21.37		12.00	4.00	
	5	411	28.83	8.25		37.00	12.00		105.17	19.97		12.00	5.00	
	≥6	493	28.43	8.12		36.00	12.75		104.11	19.78		12.00	6.00	
Annual income (Unit: thousand yuan per year)	≤50	608	27.00	10.00	12.926 *a	35.00	14.00	18.601 **a	105.94	22.35	7.646 ***	12.00	6.00	79.241 ***a
	＞50，≤100	2011	28.00	10.00		36.00	14.00		107.19	21.21		12.00	5.00	
	＞100，≤150	923	28.00	10.00		35.00	13.00		108.79	20.73		10.00	5.00	
	＞150，≤200	367	27.00	10.00		35.00	11.00		109.47	19.68		10.00	5.00	
	＞200	65	26.00	9.50		32.00	11.00		115.42	19.15		9.00	4.00	
Whether health has affected work	Yes	978	30.67	7.50	17.277 ***b	38.14	10.04	11.536 ***	104.63	21.65	-5.280 ***	12.44	3.97	14.076 ***
	No	2996	25.86	7.75		33.94	9.83		108.73	20.90		10.44	3.82	

Note: a. Levene test results showed non-homogeneity of variance. Hence, Kruskal-Wallis H test was used. The central tendency was indicated by median (M), and the tendency of dispersion was represented by inter-quartile range (IQR). b. Given heterogeneity of variance, *t* values that do not assume homogeneity of variance were adopted. ***: $p<0.001$； **: $p<0.01$； *: $p<0.05$.

4.5 Comparing nurses' levels of work-family conflict, organizational silence, peer support, and turnover intention by family situation

This section compares and analyzes nurses' levels of work-family conflict, organizational silence, peer support, and turnover intention by family situation. When the Levene's test showed heterogeneity of variance the Kruskal-Wallis H test was conducted. The central tendency was expressed using the median M, and the tendency of dispersion was expressed using the interquartile range IQR. Given that peer support was featured by heterogeneity of variance, *t* values that do not assume homogeneity of variance were adopted. The analysis results are shown in Table 4.11.

The scores of both work-family conflict and turnover intention of nurses with different marital status are statistically significant (WFCS, F=36.271, p<0.001; TIS, H=20.419, p<0.001). Specifically, compared with unmarried nurses, married nurses had significantly higher levels of work-family conflict and significantly lower levels of turnover intention (both p<0.001), and nurses with other types of marital status (divorced/separated/widowed) had significantly higher levels of work-family conflict (p<0.001); compared with married nurses, nurses with other types of marital status (divorced/separated/widowed) had significantly higher levels of work-family conflict (p=0.009).

Compared with nurses who are the only children of their families, nurses who are not the only children of their families had significantly higher levels of work-family conflict (t=-2.116, p=0.034).

The scores of turnover intention of nurses with different numbers of siblings are statistically significant (H=22.921, p＜0.001). Compared with nurses with no less than four siblings, nurses with one or two sibling(s) had significantly higher levels of turnover intention (both p＜0.001); and compared to nurses with three siblings, nurses with one sibling had significantly higher levels of turnover intention (p=0.020).

The scores of work-family conflict, peer support, and turnover intention of nurses with different numbers of children are all statistically significant (WFCS, F=45.456, p<0.001; PSS, F=3.715, p=0.024; TIS, H=32.758, p<0.001). Compared with nurses having no children, nurses with one child had significantly higher levels of work-family conflict and peer support as well as significantly lower levels of turnover intention (WFCS, p<0.001; PSS, p=0.010; TIS, p<0.001), and nurses with two or more children had significantly higher levels of

work-family conflict and significantly lower levels of turnover intention (both $p<0.001$); compared with nurses with one child, nurses with two or more children had significantly higher levels of work-family conflict ($p<0.001$).

The scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses with or without financial burden in family are statistically significant (WFCS, $t=19.864$, $p<0.001$; OSS, $t=12.137$, $p<0.001$; PSS, $t=-7.586$, $p<0.001$; TIS, $t=12.438$, $p<0.001$). Compared with nurses without financial burden in family, nurses with financial burden in family had significantly higher levels of work-family conflict, organizational silence, and turnover intention as well as significantly lower levels of peer support.

The scores of work-family conflict, organizational silence, peer support, and turnover intention of nurses whose family members caused or did not cause them financial burden are all statistically significant (WFCS, $t=20.547$, $p<0.001$; OSS, $t=11.969$, $p<0.001$; PSS, $t=-5.697$, $p<0.001$; TIS, $t=10.601$, $p<0.001$). Compared with nurses whose family members did not cause them financial burden, nurses whose family members caused them financial burden had significantly higher levels of work-family conflict, organizational silence, and turnover intention as well as significantly lower levels of peer support.

In summary, in terms of marital status, unmarried nurses had high levels of turnover intention, and other nurses had the highest levels of work-family conflict. As to whether they are only children or not, nurses who are not only children had higher levels of work-family conflict. Regarding the number of siblings, nurses with no less than four siblings had lower levels of turnover intention. When number of children is concerned, nurses with two or more children had the highest levels of work-family conflict, and nurses with no children had the highest levels of turnover intention. Concerning whether there is financial burden in the family and whether family members cause financial burden, nurses with financial burden in the family and nurses whose family members cause financial burden had higher levels of organizational silence and turnover intention, as well as lower levels of peer support.

Table 4.11 Average levels of work-family conflict, organizational silence, peer support, and turnover intention of nurses by family situation

Item	Category	n	Work-family conflict			Organizational silence			Peer support			Turnover intention		
			M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test
Marital status	Unmarried	1157	25.46	8.02	36.271***	34.87	10.33	1.097	107.02	20.68	0.906	12.00	5.00	20.419***a
	Married	2745	27.63	7.82		34.97	9.92		108.01	21.36		11.00	5.00	
	Others	72	30.08	8.56		36.68	10.63		107.63	10.98		11.00	7.00	
Only child or not	Yes	715	26.47	8.07	-2.116*	34.98	10.46	0.034	108.33	22.55	0.810b	11.05	3.90	0.879
	No	3259	27.17	7.93		34.97	9.96		107.58	20.84		10.91	3.96	
Number of siblings	1	1597	27.20	7.95	0.308	36.00	12.00	3.209a	107.78	20.83	0.152	11.00	5.00	22.921***a
	2	806	27.20	8.22		35.00	14.00		107.47	20.67		11.00	5.00	
	3	573	26.91	7.54		35.00	13.00		107.51	20.77		11.00	5.00	
	≥4	283	27.42	7.76		35.00	13.00		106.93	21.53		10.00	5.00	
Number of children	0	1427	25.80	7.94	45.456***	35.10	10.36	0.208	106.83	20.97	3.715*	12.00	5.00	32.758***a
	1	1646	27.05	7.78		34.87	10.03		108.79	21.41		11.00	5.00	
	≥2	901	28.99	7.93		34.94	9.59		107.16	20.91		11.00	5.00	
Whether there is financial burden in the family	Yes	2304	29.08	7.56	19.864***b	36.59	9.76	12.137***b	105.56	20.81	-7.586***	11.59	3.97	12.438***
	No	1670	24.23	7.64		32.73	10.02		110.69	21.28		10.04	3.74	
Whether family members cause financial burden	Yes	1359	30.44	7.46	20.547***b	37.57	9.72	11.97***	105.08	20.90	-5.697***	11.84	4.01	10.601***
	No	2615	25.28	7.63		33.62	9.95		109.09	21.16		10.46	3.83	

Note: a. Levene test results showed non-homogeneity of variance. Hence, Kruskal-Wallis H test was used. The central tendency was indicated by median (M), and the tendency of dispersion was represented by inter-quartile range (IQR).

b. Given heterogeneity of variance, *t* values without assuming homogeneity of variance were adopted. ***: $p<0.001$; **: $p<0.01$; *: $p<0$.

4.6 Comparing second child nurses' work-family conflict, organizational silence, peer support, and turnover intention by demographic characteristics as well as work and family situation

See Table 4.12 for the comparison of second child nurses' work-family conflict, organizational silence, peer support, and turnover intention by demographic characteristics as well as work and family situation.

The scores of organizational silence and turnover intention of second child nurses in different locations are all statistically significant (OSS, F=8.521, p＜0.001; TIS, F=3.130, p=0.044). Compared with second child nurses in Wenzhou City, second child nurses in places outside Zhejiang Province had significantly lower levels of organizational silence and turnover intention (OSS, p＜0.001; TIS, p=0.032); compared with second child nurses in other cities of Zhejiang Province, second child nurses in places outside Zhejiang Province had significantly lower levels of organizational silence and turnover intention (OSS, p=0.036; TIS, p=0.021).

The scores of peer support of second child nurses working in hospitals of different levels are statistically significant (t=3.726, p＜0.001). Second child nurses working in secondary hospitals had significantly lower levels of peer support than second child nurses working in tertiary hospitals.

The work-family conflict and organizational silence scores of second child nurses of different types of employment are statistically significant (WFCS, F=5.420, p=0.005; OSS, F=4.333, p=0.013). Compared with second child nurses who are permanent employees, contract-based nurses had significantly lower levels of work-family conflict (p=0.002), and temporary employees had significantly lower levels of organizational silence (p=0.005).

The scores of work-family conflict, organizational silence, peer support, and turnover intention of second child nurses who needed or did not need to work night shifts are statistically significant (WFCS, t=6.695, p<0.001; OSS, t=6.337, p＜0.001; PSS, t=-3.911, p ＜0.001; TIS, t=6.827, p<0.001). Compared with second child nurses who needed to work night shifts, second child nurses who did not need to work night shifts had significantly lower levels of work-family conflict, organizational silence, and turnover intention as well as significantly higher levels of peer support.

The scores of peer support of second child nurses with different levels of annual income are statistically significant (t=-2.433, p=0.015). Second child nurses with an annual income of no more than RMB 100,000 had significantly lower levels of peer support than second child nurses with an annual income of more than RMB 100,000.

The scores of work-family conflict, organizational silence, peer support, and turnover intention of second child nurses with different health status are all statistically significant (WFCS, t=8.148, p<0.001; OSS, t=6.274, p＜0.001; PSS, t=-3.078, p=0.002; TIS, t=7.204, p<0.001). Compared with second child nurses whose health status affected their work, second child nurses whose health status did not affect their work had significantly lower levels of work-family conflict, organizational silence and turnover intention as well as significantly higher levels of peer support.

The scores of work-family conflict, organizational silence, peer support, and turnover intention of second child nurses regarding the two items "Does your family have financial burden" and "Do your family members cause you financial burden" are statistically significant (Whether there is financial burden in family: WFCS, t=8.170, p<0.001; OSS , t=5.557, p＜0.001; PSS, t=-2.954, p=0.003; TIS, t=6.006, p＜0.001; whether family members cause your financial burden: WFCS, t=8.696, p<0.001; OSS, t=6.609, p＜0.001; PSS, t=-2.894, p=0.004; TIS, t=5.571, p＜0.001). Compared with second child nurses who had financial burden in family, second child nurses who did not have financial burden in family had significantly lower levels of work-family conflict, organizational silence, and turnover intention as well as significantly higher levels of peer support.

In summary, in terms of location, second child nurses located in other cities of Zhejiang Province had the highest levels of turnover intention. As to hospital level, second child nurses in tertiary hospitals had higher levels of peer support. With regard to type of employment, second child nurses who are permanent employees had the highest levels of work-family conflict. Regarding whether there is a need to work night shifts, second child nurses who need to work night shifts had higher levels of work-family conflict, organizational silence, and turnover intention, as well as lower levels of peer support. When it comes to annual income, second child nurses earning no more than 100,000 yuan a year had the lowest levels of peer support. In terms of whether health status affects work, whether there is financial burden, and whether family members cause financial burden, second child nurses whose health status affects work, those who have financial burden in family, and those whose family members

cause financial burden had higher levels of work-family conflict, organizational silence, and turnover intention as well as lower levels of peer support.

Table 4.12 Average levels of work-family conflict, organizational silence, peer support, and turnover intention of second child nurses by demographic characteristics as well as work and family situation

Item	Category	n	Work-family conflict			Organizational silence			Peer support			Turnover intention		
			M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test
Location	Wenzhou City	451	30.00	10.00	4.190[d]	35.57	9.68	8.521***	106.29	21.05	2.035	10.74	3.86	3.130*
	Other cities of Zhejiang Province	228	30.00	9.00		35.04	9.29		109.91	20.72		11.28	4.16	
	Places outside Zhejiang Province	218	29.00	11.00		33.50	9.67		106.18	20.68		10.25	3.85	
Hospital level	Tertiary hospital	699	29.00	8.04	0.009	35.13	9.59	1.089	108.54	20.43	3.726***	10.75	3.91	0.045
	Secondary hospital	202	29.00	7.56		34.30	9.60		102.36	21.88		10.73	4.11	
Department	Internal medicine department	228	29.36	7.69	2.482	35.78	9.97	1.263	106.43	22.15	1.520	10.79	3.94	2.165
	Surgery department	171	30.00	7.48		34.78	8.98		107.15	20.27		11.27	3.80	
	ED/OR/ICU [a]	201	29.12	7.58		35.25	9.35		105.16	20.37		10.85	4.08	
	Other departments	301	28.06	8.50		34.20	9.79		109.04	20.60		10.34	3.95	
Type of employment	Permanent	642	29.53	7.72	5.420**	35.43	9.34	4.333*	107.21	21.08	0.051	10.90	3.99	1.653
	Contract-based	178	27.41	8.08		34.43	9.78		106.76	19.18		10.37	3.72	
	Temporary	81	28.25	8.76		32.23	10.75		107.58	23.33		10.36	4.18	
Work night shifts or not	Yes	576	30.31	7.56	6.695**[c]	36.43	9.68	6.337***	105.13	20.99	-3.911***	11.40	3.94	6.827***
	No	325	26.66	8.03		32.30	8.86		110.75	20.31		9.58	3.71	
Annual	≤100	503	29.21	8.03	0.904	35.49	10.02	1.928	105.65	21.62	-2.433	10.90	3.94	1.357

Item	Category	n	Work-family conflict			Organizational silence			Peer support			Turnover intention		
			M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test
Income (thousand yuan per year)	＞100	398	28.73	7.80		34.26	9.00		109.06	19.84		10.54	3.96	
Whether health status affects work	Yes	220	32.52	7.23	8.148** c	38.40	9.71	6.274***	103.40	21.47	-3.078**	12.37	4.12	7.204***
	No	681	27.86	7.81		33.83	9.29		108.37	20.60		10.22	3.76	
Whether there is financial burden	Yes	602	30.49	7.48	8.170** c	36.18	9.38	5.557***	105.93	20.44	-2.510*	11.29	4.00	6.006***
	No	299	25.98	7.96		32.46	9.56		109.63	21.64		9.64	3.63	
Whether family members cause financial burden	Yes	379	31.56	7.35	8.696** c	37.37	9.42	6.609***	104.92	20.49	-2.743**	11.59	4.08	5.571***
	No	522	27.13	7.82		33.19	9.34		108.78	21.08		10.13	3.74	

Note: Given homogeneity of variance, *t* values without assumption of the homogeneity of variance were adopted. d. Levene's test results indicated heterogeneity of variance, so Kruskal-Wallis H test was adopted. The central tendency was indicated by median (M), and the tendency of dispersion was represented by inter-quartile range (IQR). ***: $p<0.001$; **: $p<0.01$; *: $p<0.05$.

4.7 Comparing levels of work-family conflict, organizational silence, peer support, and turnover intention of nurses with different demographic characteristics, work and family situation by number of children

Table 4.13 shows the comparison of the levels of work-family conflict, organizational silence, peer support, and turnover intention of nurses with different demographic characteristics, work and family situation by number of children.

When the level of hospital is concerned, the scores of work-family conflict and turnover intention of nurses working in hospitals of different levels and of nurses working in tertiary hospitals with different number of children across the three levels of hospitals are all statistically significant (WFCS, F=40.612, p<0.001; TIS, F=8.904, p＜0.001). Compared with nurses who did not have a child, nurses with one child as well as those with no less than two children had significantly higher levels of work-family conflict and significantly lower levels of turnover intention (nurses with one child: both p＜0.001; nurses with no less than two children: WFCS, p<0.001; TIS, p=0.011); compared with nurses with one child, nurses with no less than two children had significantly higher levels of work-family conflict (p<0.011). Besides, the scores of work-family conflict, peer support, and turnover intention of nurses working in secondary hospitals with different number of children are all statistically significant (WFCS, F=5.570, p=0.003; PSS, F=6.109, p=0.002; TIS, H=15.240, p＜0.001). Compared with nurses who did not have a child, nurses with one child had significantly higher levels of peer support and significantly lower levels of turnover intention (PSS, p=0.009; TIS, p=0.003), and nurses with no less than two children had significantly higher levels of work-family conflict and significantly lower levels of turnover intention (WFCS, p=0.001; TIS, p=0.002); compared to nurses with one child, nurses with no less than two children had significantly higher levels of work-family conflict and significantly lower levels of peer support (WFCS, p=0.020; PSS, p=0.001).

In terms of type of employment, the scores of work-family conflict and turnover intention of permanently employed nurses with different numbers of children were statistically significant (WFCS, F=29.567, p<0.001; TIS, H=29.810, p＜0.001). Compared with nurses who did not have a child, nurses who had one child had significantly higher levels of work-family conflict and significantly lower levels of turnover intention (WFCS, p=0.031; TIS, p＜0.001), and nurses with no less than two children had significantly higher levels of

work-family conflict (p<0.001); compared with nurses with one child, nurses with no less than two children had significantly higher levels of work-family conflict and turnover intention (WFCS, p<0.001; TIS, p=0.008). Besides, the scores of work-family conflict of contract-based nurses with different numbers of children were statistically significant (F=6.319, p=0.002). Compared with nurses without children, nurses with no less than two children had significantly higher levels of work-family conflict (p<0.001). In addition, the scores of work-family conflict and turnover intention of temporary nurses with different numbers of children were statistically significant (WFCS, F=6.756, p<0.001; TIS, F=6.048, p=0.002). Compared with nurses who did not have a child, nurses with one child had significantly higher levels of work-family conflict and significantly lower levels of turnover intention (WFCS, p=0.001; TIS, p=0.001), and nurses with no less than two children had significantly higher levels of work-family conflict and significantly lower levels of turnover intention (WFCS, p=0.014; TIS, p=0.001).

As to annual income, the scores of work-family conflict and turnover intention of nurses with an annual income of no more than RMB 100,000 with different numbers of children are all statistically significant (WFCS, F=35.407, p<0.001; TIS, F=3.603, p=0.027). Compared with nurses who did not have a child, nurses with one child had significantly higher levels of work-family conflict (p<0.001), nurses with no less than two children had significantly lower levels of work-family conflict and significantly lower levels of turnover intention (WFCS, p<0.001; TIS, p=0.008); compared with nurses with one child, nurses with no less than two children had significantly higher levels of work-family conflict (p=0.001). Besides, the scores of work-family conflict and turnover intention of nurses with an annual income of more than RMB 100,000 with different numbers of children are statistically significant (WFCS, F=18.386, p＜0.001; TIS, H=28.984, p<0.001). Compared to nurses who did not have a child, nurses with one child had significantly lower levels of turnover intention (p＜0.001), and nurses with no less than two children had significantly higher levels of work-family conflict (p<0.001); compared with nurses who had one child, nurses who had no less than two children had significantly higher levels of work-family conflict and turnover intention (WFCS, p<0.001; TIS, p=0.006).

Regarding whether there is financial burden in family, the scores of work-family conflict and turnover intention of nurses who had financial burden in family with different numbers of children are all statistically significant (WFCS, F=19.866, p<0.001; TIS, F=6.662, p=0.001). Compared with nurses who did not have a child, nurses with one child or nurses with no less

than two children had significantly higher levels of work-family conflict and significantly lower levels of turnover intention (nurses with one child: WFCS, p=0.001; TIS, p=0.003; nurses with no less than two children: WFCS, p<0.001; TIS, p=0.001). Compared with nurses who had one child, nurses with no less than two children had significantly higher levels of work-family conflict (p<0.001).

Regarding whether there is financial burden in family, the scores of work-family conflict, peer support, and turnover intention of nurses who had no financial burden in family with different numbers of children are all statistically significant (WFCS, F=11.244, p<0.001; PSS, F=4.497, p=0.011; TIS, F=19.200, p<0.001). Compared with nurses who did not have a child, nurses with one child had significantly higher levels of work-family conflict and peer support as well as significantly lower levels of turnover intention (WFCS, p=0.013; PSS, p=0.005; TIS, p<0.001), and second child nurses had significantly higher levels of work-family conflict and significantly lower levels of turnover intention (WFCS, p<0.001; TIS, p<0.001); compared with nurses with one child, second child nurses had significantly higher levels of work-family conflict and significantly lower levels of peer support (WFCS, p=0.001; PSS, p=0.048).

In summary, when hospital level is concerned, nurses with two or more children had the highest levels of work-family conflict, whereas nurses without children had the highest levels of turnover intention among all nurses working in tertiary hospitals; among all nurses working in secondary hospitals, nurses with two or more children had the highest levels of work-family conflict and the lowest levels of peer support, and nurses without children had the highest levels of turnover intention. When it comes to type of employment, nurses with two or more children had the highest levels of work-family conflict among all permanent employees, contract-based employees, and temporary employees. As to annual income, among nurses with an annual income of no more than 100,000 yuan and those with an annual income of more than 100,000 yuan, nurses with two or more children had the highest levels of work-family conflict and nurses with no children had the highest levels of turnover intention. In terms of whether there is financial burden in family, nurses with two or more children had the highest levels of work-family conflict and turnover intention among nurses who have financial burden in family. In comparison, among nurses who do not have financial burden in family, nurses with no children had the lowest levels of peer support and the highest levels of turnover intention, and nurses with two or more children had the highest levels of work-family conflict.

Table 4.13 Average levels of work-family conflict, organizational silence, peer support, and turnover intention of nurses by demographic characteristics, work and family situation by number of children

Item	Category	Number of children	n	Work-family conflict			Organizational scale			Peer support			Turnover intention		
				M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test
Hospital level	Tertiary hospital	None	1130	25.64	7.75	40.612***	34.87	10.34	0.299	107.58	21.14	1.210	11.22	3.80	8.904***
		One	1317	26.98	7.55		34.77	10.06		108.88	21.32		10.57	3.92	
		Two or more	699	29.00	8.04		35.13	9.59		108.54	20.43		10.75	3.91	
	Secondary hospital	None	297	26.40	8.61	5.570**	35.28	9.90	1.678	103.98	20.08	6.109**	12.00	4.00	15.240***a
		One	329	27.35	8.65		35.97	10.40		108.44	21.79		11.00	6.00	
		Two or more	202	29.00	7.56		34.30	9.60		102.36	21.88		11.00	5.00	
Type of employment	Permanent	None	606	26.34	8.00	29.567***	35.40	10.00	1.562	108.90	21.54	2.633	10.00	5.00	29.810***a
		One	1098	27.18	7.61		36.24	10.44		106.65	20.35		12.00	4.00	
		Two or more	642	29.53	7.72		35.43	9.34		107.21	21.08		11.00	5.00	
	Contract-based	None	364	24.92	7.55	6.319**	33.09	9.69	1.339	109.00	30.00	4.756a	10.74	3.97	1.233
		One	332	26.03	7.78		33.07	10.02		109.00	30.50		10.93	3.98	
		Two or more	178	27.41	8.08		34.43	9.78		107.00	29.25		10.37	3.72	
	Temporary	None	457	25.79	8.10	6.756**	34.91	10.39	2.850	107.33	20.26	1.331	12.17	4.07	6.048**
		One	216	27.99	8.49		35.21	10.30		104.84	21.05		11.79	3.96	
		Two or more	81	28.25	8.76		32.23	10.75		107.58	23.33		10.36	4.18	
Annual	≤100	None	1142	25.77	8.14	35.407	34.95	10.59	0.648	106.53	21.40	2.260	11.47	3.93	3.603

Item	Category	Number of children	n	Work-family conflict			Organizational scale			Peer support			Turnover intention		
				M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test	M	SD/ IQR	test
income (thousand yuan per year)		One	974	27.71	8.04	***	35.37	10.16		107.98	21.48		11.26	4.07	*
		Two or more	503	29.21	8.03		35.49	10.02		105.65	21.62		10.90	3.94	
	＞100	None	285	25.94	7.09	18.386 ***	35.71	9.38	2.887	108.04	19.13	0.935	11.00	4.00	28.984 ***a
		One	672	26.10	7.29		34.15	9.80		109.97	21.26		10.00	5.00	
		Two or more	398	28.73	7.80		34.26	9.00		109.06	19.84		10.00	5.00	
Whether there is financial burden in family	Yes	None	748	27.91	7.73	19.866 ***	36.66	9.85	0.800	104.61	20.22	1.171	12.01	3.89	6.662 **
		One	954	29.12	7.31		36.81	9.92		106.08	21.47		11.44	3.98	
		Two or more	602	30.49	7.48		36.18	9.38		105.93	20.44		11.29	4.00	
	No	None	679	23.48	7.50	11.244 ***	33.39	10.64	2.559	109.27	21.52	4.497 *	10.71	3.66	19.200 ***
		One	692	24.21	7.51		32.20	9.55		112.53	20.76		9.54	3.77	
		Two or more	299	25.98	7.96		32.46	9.56		109.63	21.64		9.64	3.63	

Note: a. Levene test results showed non-homogeneity of variance. Hence, Kruskal-Wallis H test was used. The central tendency was indicated by median (M), and the tendency of dispersion was represented by inter-quartile range (IQR). ***: $p<0.001$; **: $p<0.01$; *: $p<0.05$

4.8 An analysis of the correlations among demographic characteristics, work-family conflict, organizational silence, peer support, and turnover intention

Table 4.14 shows the results of the analysis of the correlations among demographic characteristics, and the scale scores of work-family conflict, organizational silence, peer support and turnover intention. Pearson and Spearman correlations were computed depending on the measurement properties of the variables.

In terms of demographic characteristics, the positive correlations hospital level, title, and level of education have with work-family conflict, as well as the negative correlation between type of employment and work-family conflict, are all statistically significant (p<0.05); the positive correlation between hospital level and organizational silence, as well as the negative correlations length of service and position have with organizational silence are all statistically significant (p<0.05); the positive correlations age, length of service, and title have with peer support as well as the negative correlation between hospital level and peer support are all statistically significant (p<0.05); the positive correlation between type of employment and turnover intention as well as the negative correlations age, length of service, title, position and level of education have with turnover intention are all statistically significant (p<0.05).

As to job and income, the positive correlation between annual income and peer support as well as the negative correlation between annual income and turnover intention are both statistically significant (p<0.05). The positive correlation between the number of night shifts and turnover intention as well as the negative correlation between the number of night shifts and peer support are both statistically significant (p<0.05).

When family is concerned, the positive correlations marital status and number of children have with work-family conflict are both statistically significant (p<0.05); the negative correlations marital status, number of siblings, and number of children have with turnover intention are all statistically significant (p<0.05).

The correlation analyses of the four scales showed that the negative correlation between organizational silence and peer support, as well as the positive correlations organizational silence have with work-family conflict and turnover intention are all statistically significant (r= -0.430, 0.448, 0.493, respectively; p<0.05); the negative correlation between work-family conflict and peer support, as well as the positive correlation between work-family conflict and

turnover intention are statistically significant (r=- 0.292, 0.483, respectively; p<0.05); the negative correlation between peer support and turnover intention is statistically significant (r=-0.348, p<0.05).

A summary of the structure of the bivariate Pearson correlations among the scores of the four scales is depicted in Figure 4.1. From this correlation analysis it is possible to conclude that the signs (positive or negative) of the computed correlations are in line with the signs of the influences among the four scales postulated in research hypotheses H1 to H6 (recall Figure 2.1).

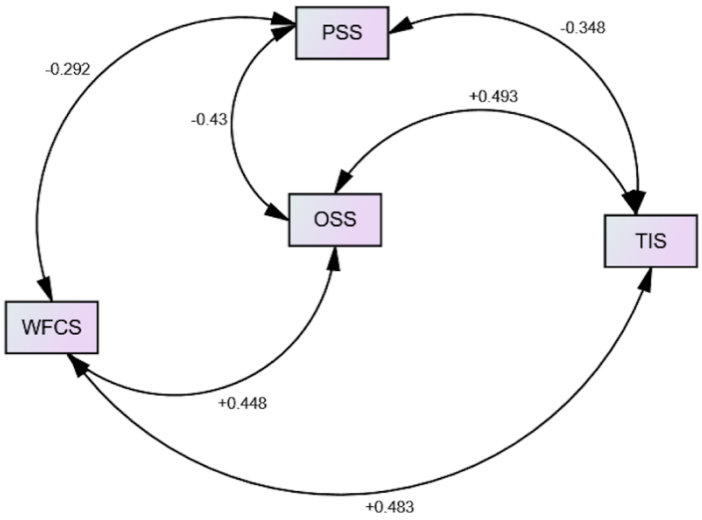

Figure 4.1 Pearson correlations among the scores of the four scales (WFC; OS; PS and TI)

Table 4.14 An analysis of the correlations among demographic characteristics, work-family conflict, organizational silence, peer support and turnover intention[a]

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Age	-														
2. Length of service	0.957**	-													
3. Hospital level	-0.016	0.013	-												
4. Title	0.807**	0.793**	-0.048**	-											
5. Position	0.498**	0.500**	0.074**	0.517**	-										
6. Level of education	0.373**	0.327**	-0.239**	0.491**	0.217**	-									
7. Type of employment	-0.376**	-0.331**	0.026	-0.442**	-0.198**	-0.360**	-								
8. Number of night shifts	-0.187**	-0.166**	0.132**	-0.169**	0.201**	-0.141**	0.167**	-							
9. Annual income	0.388**	0.360**	-0.333**	0.400**	0.251**	0.358**	-0.346**	-0.275**	-						
10. Marital status	0.661**	0.653**	-0.006	0.552**	0.307**	0.303**	-0.252**	-0.092**	0.225**	-					
11. Number of siblings	0.294**	0.288**	0.108**	0.198**	0.172**	0.025	-0.047**	-0.018	0.086**	0.145**	-				
12. Number of children	0.658**	0.650**	0.015	0.554**	0.312**	0.291**	-0.264**	-0.115**	0.248**	0.730**	0.182**	-			
13. WFC	0.020	0.015	0.060*	0.096***	0.003	0.080**	-0.088***	0.035	0.030	0.103***	0.011	0.105***	-		
14. OS	0.038*	-0.042**	0.045**	-0.019**	-0.127**	0.031	-0.063**	0.088**	-0.021	0.003	-0.023	-0.016	0.448***	-	

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
15. PS	0.072 **	0.064 **	-0.074 **	0.066 **	0.149 **	0.014	-0.031	-0.116 **	0.067 **	0.027	-0.006	0.019	-0.292 ***	-0.430 **	-
16. TI	-0.175 **	-0.167 **	0.071 **	-0.125 **	0.185 **	-0.044 **	0.078 **	0.152 **	-0.130 **	-0.071 **	-0.074 **	-0.077 **	0.483 ***	0.493 **	-0.348 **

Note: a. The values at the lower left part are the *r* values of Pearson or Spearman correlation coefficients; and the values on the upper right part are the corresponding *p* values; **. indicates a significant correlation at the 0.01 level (two-tailed); *. indicates a significant correlation at the 0.05 level (two-tailed). WFC: Work-family conflict; OS: Organizational silence; PS: Peer support; TI: Turnover intention

4.9 Confirmatory Factor Analysis (CFA), reliability and validity of the survey scales

The analyses conducted so, far comparing differences in the four scales (Work-Family Conflict, Organizational Silence, Peer support and Turnover Intention) by sociodemographic characteristics, work attitudes, work requirements, income levels, family situation and number of children of the nurses, have been based on score variables, computed as means of the nurses' responses to the various items of each scale. The current section investigates the measurement properties of each scale, namely its reliability and validity.

4.9.1 CFA, reliability and validity of the Work-Family Conflict Scale

The 10 items of the Work-Family Conflict scale were used to conduct exploratory factor analysis (KMO=0.834＞0.70, and Bartlett's test of sphericity shows $p<0.001$), and two factors were obtained: One corresponding to the work-family conflict subscale, the other associated with the family-work conflict subscale. Cronbach's α coefficients were computed for each subscale: a value of 0.927 was obtained for the work-family conflict dimension; and the Cronbach's α of the family-work conflict scale is 0.876.

A confirmatory factor analysis model with two factors was then estimated to validate the 2 factors structure. Obtained factor loadings are presented in Table 4.15.

Table 4.15 Confirmatory factor analysis of the Work-Family Conflict Scale

Dimension	Item	Standardized factor loading
Work-Family Conflict	1. My job requirements have affected my family life;	0.85
	2. My work schedule makes it difficult for me to fulfil my family responsibilities;	0.951
	3. I did not complete what I wanted to do because of the work that I had to do;	0.796
	4. Work stress made it difficult for me to flexibly arrange my family activity plan;	0.862
	5. I had to change my family activity plan due to my job responsibilities;	0.773
Family-Work Conflict	6. The requirements from my family members have affected my normal work;	0.729
	7. I have to delay work due to family reasons;	0.785
	8. Sometimes I am unable to complete planned work, such as going to work on time, finishing daily tasks, and working overtime;	0.654
	9. My family has affected my work, such as working on time, finishing daily tasks, and working overtime;	0.863
	10. Family stress has affected my work performance.	0.827

4.9.2 CFA, reliability and validity of the Organizational Silence Scale

The 12 items of the Organizational Silence scale were used to conduct exploratory factor analysis (KMO=0.926＞0.70, and Bartlett's test of sphericity shows p＜0.001), and three factors were obtained: One corresponding to the acquiescent silence subscale, another to the Defensive silence subscale, and the third one to the Indifferent silence subscale. Cronbach's α coefficients were computed for each subscale: a value of 0.927 was obtained for the acquiescent silence dimension; a value of 0.899 was obtained for the defensive silence dimension; and the Cronbach's α of the indifferent silence dimension equals 0.894.

A confirmatory factor analysis model with three factors was then estimated to validate the 3 factors structure. Obtained factor loadings for the Organizational Silence scale are presented in Table 4.16.

Table 4.16 Confirmatory factor analysis of the Organizational Silence Scale

Dimension	Item	Standardized factor loading
Acquiescent silence	1. Leaders have almost made decisions, and my opinions will not make a big difference;	0.872
	2. My opinions will not affect the current situation;	0.832
	3. It is nearly impossible for leaders to adopt my suggestions;	0.885
	4. Leaders will not change some decisions, and it makes little difference for me to speak out my views;	0.902
Defensive silence	5. I choose to remain silent about others' deficiencies and negligence in work to avoid affecting my relationships with peers;	0.764
	6. I might as well withhold my views in order not to become the target of criticism;	0.905
	7. There is no need for me to offend leaders or peers;	0.819
	8. I get along well with everyone. So, it is better for me to withhold my own opinions;	0.847
	9. Other people's affairs are not my business, and there is no need for me to talk about them;	0.688
Indifferent silence	10. I do not care about the affairs of the hospital;	0.899
	11. As the Doctrine of the Mean suggests, less talking means fewer responsibilities;	0.822
	12. I do not have a strong attachment with the hospital. So, there is no need for me to give any comments.	0.881

4.9.3 CFA, reliability and validity of the Peer Support Scale

The 30 items of the Peer Support Scale were used to conduct exploratory factor analysis (KMO=0.977＞0.70, and Bartlett's test of sphericity shows p＜0.001), and eight factors were obtained: Specifically, the Cronbach's α of Subscale A, the Head Nurse Support Scale, is 0.969, that of the subjective support dimension is 0.918, cooperation dimension 0.912,

empathy dimension is 0.954, awareness raising dimension 0.946, goal setting dimension 0.958, action plan dimension 0.959, and process management dimension 0.946. Obtained factor loadings for the Peer Support Silence scale are presented in Table 4.17.

Table 4.17 Confirmatory factor analysis results of the Peer Support Scale

Dimension	Item	Standardized factor loading
Head Nurse Support	1. The head nurse spends time understanding my goals and expectations;	0.823
	2. The head nurse cares whether I have achieved my goals;	0.867
	3. The head nurse has been paying attention to various opportunities beneficial to my career development in the hospital;	0.892
	4. The head nurse always praises me after I complete important tasks;	0.890
	5. The head nurse can provide me with effective feedback on my work;	0.897
	6. The head nurse gives me suggestions on how to improve my work when I need such suggestions;	0.875
	7. The head nurse supports my desire for additional training or education for better development in the future;	0.914
	8. The head nurse provides me with work tasks that could help me develop new skills;	0.918
	9. The head nurse assigns to me special tasks which can promote my development in the hospital;	0.852
Subjective support	10. The help provided by my peers is effective in reducing my work stress;	0.836
	11. I value my time spent in building up a peer support system;	0.892
	12. The peer support system has significantly relieved my work stress;	0.940
Cooperation	13. Peers respect my choice and encourage rather than force me to participate in department activities;	0.772
	14. Peers provide me with a supportive environment where I feel safe to talk about my feelings;	0.947
	15. Peers give me various kinds of support, especially the support I need;	0.929
Empathy	16. Peers always seem to understand my views;	0.900
	17. Peers always recognize my feelings and show that they understand my feelings;	0.967
	18. Peers allow me enough time to express my feelings before giving advice;	0.937
Awareness raising	19. I have a clearer understanding of the problems I face after communicating with peers;	0.956
	20. Questions from peers can help me think better about my problems;	0.966
	21. Peers use detailed examples to provide me with feedback and suggestions;	0.854
Goal setting	22. Communication with peers makes me realize that the goals I have set can be achieved despite the difficulties;	0.909
	23. Communication with peers makes me aware of the importance of having clear goals;	0.950
	24. Communication with peers makes me realize that any goals I have set can be quantified;	0.961

Dimension	Item	Standardized factor loading
Action plan	25. Peers can help me make clear, simple, and feasible plans;	0.947
	26. Peers help me focus on how to succeed instead of studying old problems;	0.962
	27. Peers always take my action plan seriously;	0.916
Process management	28. Peers always ask me about the progress of my goals;	0.894
	29. Peers always help me make up for the deficiencies in my work;	0.948
	30. Peers always acknowledge my progress and success and give me encouragement.	0.931

4.9.4 CFA, reliability and validity of the Turnover Intention Scale

The 4 items of the Turnover Intention scale were used to conduct exploratory factor analysis (KMO=0.821＞0.70, and Bartlett's test of sphericity shows p＜0.001), and a single factor was obtained. A reliability analysis of the Turnover Intention Scale shows that the Cronbach's α of the scale is 0.881.

A confirmatory factor analysis model was then estimated to validate the single-factor model structure. Obtained factor loadings for the Turnover Intention scale are presented in Table 4.18.

Table 4.18 Confirmatory factor analysis results of the Turnover Intention Scale

Dimension	Item	Standardized factor loading
Turnover intention	1. I often have the idea of leaving the nursing profession;	0.854
	2. I think I will submit resignation in the near future and look for another job;	0.884
	3. I believe that with my professional skills, I can easily find a job that gives full play to my skills in other hospitals;	0.643
	4. I will choose to leave the hospital if I am given the chance.	0.842

4.10 Structural equation model of nurses' work-family conflict, organizational silence, peer support, and turnover intention

Based on the turnover intention decision model proposed in this study (recall Figure 2.1), and in order to validate the nine research hypotheses proposed in Section 2.6, a structural equation model was constructed: The two measurement indicators of the endogenous latent variable work-family conflict are "WFC" (work-family conflict dimension score) and "FWC" (family-work conflict dimension score). The eight measurement indicators of the latent variable peer support are the scores of "PS1" (head nurse support dimension), "PS2"

(subjective support dimension), “PS3” (cooperation dimension), “PS4” (empathy dimension), “PS5” (awareness raising dimension), “PS6” (goal setting dimension), “PS7” (action plan dimension), and “PS8” (process management dimension). The three measurement indicators of the latent variable organizational silence are “OS1” (acquiescent silence), “OS2” (defensive silence) and “OS3” (indifferent silence). All the four items of the Turnover Intention Scale were used to measure turnover intention (See Figure B.1 in Annex B for details).

The parameter values of the proposed structural equation model were estimated, and an acceptable model-data fit was achieved: $\chi 2/df=68.257$, RMSEA=0.130, NFI=0.902>0.90, RFI=0.876, IFI=0.903>0.90, TLI=0.878, CFI=0.903>0.90, and PNFI=0.714>0.50. Figure 4.2 displays the path diagram of the structural model, with the estimates that were obtained in a standardized solution. For a more detailed figure with the measurement model estimates see Figure B.1 in Annex B.

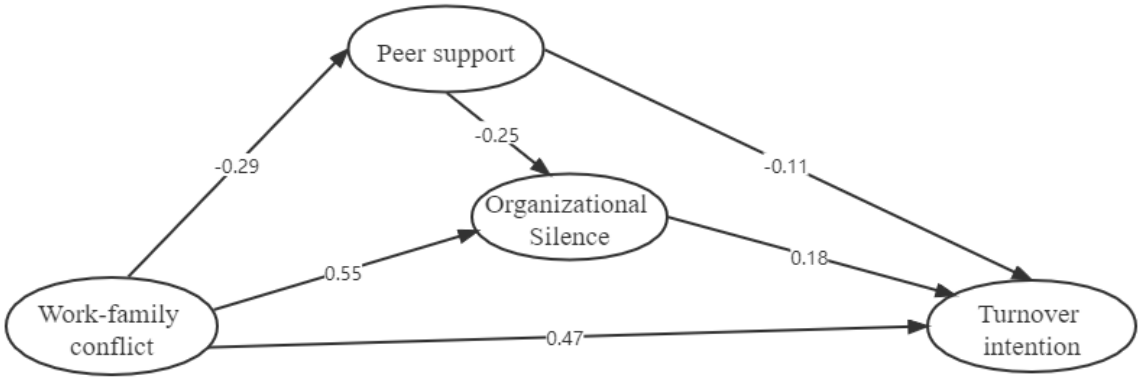

Figure 4.2 Path diagram of the structural model with standardized estimates

It can be seen from Table 4.19 that the six path coefficients, including the path coefficients from peer support to organizational silence and turnover intention, as well as the path coefficients from work-family conflict to peer support, organizational silence, and turnover intention are all statistically significant (p<0.001). Thus, it is possible to conclude that research hypotheses H1 to H6 are validated.

Table 4.19 The estimates and test values for the structural model

Path	S-Coefficient	NS-Coefficient	S.E.	C.R.	*p*
PS←WFC	-0.289	-0.535	0.037	-14.324	<0.001
OS ←WFC	0.551	0.545	0.023	24.159	<0.001
OS←PS	-0.252	-0.134	0.009	-14.855	<0.001
TI←WFC	0.470	0.647	0.035	18.702	<0.001
TI←PS	-0.107	-0.079	0.011	-7.119	<0.001
TI←OS	0.182	0.253	0.032	7.909	<0.001

Note: PS: Peer support; OS: Organizational silence; WFC: Work-family conflict; TI: Turnover intention; S-coefficient: Standard coefficient; NS-Coefficient: None-standard coefficient.

In order to validate hypotheses H7 to H9 involving mediation effects, indirect effects were computed.

Table 4.20 shows the obtained estimates for the effects of each variable on turnover intention. Work-family conflict has both direct and indirect effects on turnover intention, and the overall effect is 0.614, and $p<0.001$; peer support has both direct and indirect effects on turnover intention, and the overall effect is -0.153, and $p<0.001$; organizational silence has a direct effect on turnover intention, with the overall effect being 0.182 and $p<0.001$.

Table 4.20 Standardized direct and indirect effects from WFC, OS and PS on TI

Latent variable	Direct effect on turnover intention	Indirect effect on turnover intention		Overall effect on turnover intention
		Chain of indirect effect	Indirect effect value	
PS	-0.107*	PS→OS→TI	-0.046*	-0.164*
OS	0.182*	-	-	0.189*
WFC	0.470*	WFC→PS→TI	0.032*	0.614*
		WFC→OS→TI	0.099*	
		WFC→PS→OS →TI	0.013*	

Note: PS: Peer support; OS: Organizational silence; WFC: Work-family conflict; TI: Turnover intention. * $p<0.001$.

The indirect effect from WFC on TI via OS (WFC→OS→TI) equals 0.099 and is significant, and so are the direct effects, suggesting OS mediates the effect from WFC on TI, as postulated in H7.

The indirect effect from WFC on TI via PS (WFC→PS→TI) equals 0.032 and is significant, suggesting PS mediates the effect from WFC on TI, as proposed in H8.

Also, indirect effect from PS on TI via OS equals -0.046 and is significant, suggesting OS mediates the effect from PS on TI, as postulated in H9.

In brief, based on the above analysis, the nine research hypotheses proposed in the current study are validated, as shown in Table 4.21.

Table 4.21 Validation of the proposed research hypotheses

No.	Hypothesis content	Result
H1	Work-family conflict positively influences nurses' turnover intention.	Validated
H2	Work-family conflict positively influences organizational silence among nurses.	Validated
H3	Work-family conflict negatively influences peer support for nurses.	Validated
H4	Peer support negatively influences nurses' turnover intention.	Validated
H5	Peer support negative influences organizational silence among nurses.	Validated
H6	Organizational silence positively influences nurses' turnover intention.	Validated
H7	Organizational silence mediates the effect from work-family conflict on nurses' turnover intention.	Validated
H8	Peer support mediates the effect from work-family conflict on nurses' turnover intention.	Validated
H9	Organizational silence mediates the effect from peer support on nurses' turnover intention.	Validated

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Chapter 5: Discussion

This chapter provides a discussion of the research findings, including: (1) *status quo* of Chinese nurses' turnover intention; (2) *status quo* of Chinese nurses' work-family conflict, organizational silence and peer support; (3) influence of having a second child on nurses' work-family conflict, organizational silence, peer support and turnover intention; (4) influences of work-family conflict, organizational silence and peer support on nurses' turnover intention; (5) implications; and (6) limitations and suggestions for further research.

5.1 Status quo of nurses' turnover intention in China

The mean score of nurses' turnover intention in China was 2.73 points out of 5.00 points, which indicated that the turnover intention of Chinese nurses was relatively low and that the nursing team in China was relatively flexible. This is in line with the results of the studies carried out by such scholars as Su et al. (2019), Zhong et al. (2019), Wang and Zhai (2019) and Zhao et al. (2020). A high turnover rate is a common challenge for many countries across the globe. Despite so, the results of the present study indicated that the turnover intention of Chinese nurses was relatively low, which might be related to the narrow scope of employment, as well as to the high requirements for professionalism, technical skills and knowledge in the nursing industry. Besides, nurses have generally received years of nursing education. They tend not to easily give up their profession despite turnover intention.

5.1.1 Influence of socio-demographic characteristics on nurses' turnover intention

Nurses aged under 30 years had the highest levels of turnover intention, and the older the nurses, the lower the turnover intention. This is in line with the results of the studies carried out by Feng (2011), Chen (2012), Pan (2013) as well as Zheng, Wei, and Wang (2017). The possible reasons are as follows. First, most of the less experienced nurses are single children, used to be taken care of by their parents since childhood. The high level of pressure and heavy workload of nursing work are too much for them to handle. Second, most young nurses are contract-based employees, whose job stability and compensation package are not as good as those of permanent employees. Yet, in clinical care practice, they need to undertake more

nursing tasks, such as working night shifts and working overtime. Apart from work, they also need to cope with various kinds of trainings and exams. All these factors may cause them to be physically and mentally exhausted and thus develop higher levels of turnover intention.

Nurses in Zhejiang Province, nurses working in non-Grade A tertiary hospitals, and nurses who were temporary employees had higher levels of turnover intention than their counterparts in places other than Zhejiang Province, those working in Grade A tertiary hospitals and those who were permanent or contract-based employees. According to the statistics jointly released by Zhejiang Nursing Association, Zhejiang Medical Quality Control and Evaluation Office and Zhejiang Nursing Quality Control Center (Ge, 2014), among the main reasons for nurses' turnover intention, individual or family reasons accounted for 41.3%, salary reasons 29%, and work stress reasons 24.7%. Zhejiang Province, located in the coastal area, has a developed economy and a high level of consumption. Therefore, the low income of nurses working in non-Grade A tertiary hospitals and those employed on a temporary basis would directly affect their quality of life.

Nurses of ENT departments and other departments (anesthesiology, reproductive medicine, imaging, traditional Chinese medicine and administrative departments) had the lowest levels of turnover intention. This might be because nurses in these departments have to work fewer night shifts than their counterparts in such departments as internal medicine, surgery as well as gynecology and pediatrics and thus experience less work stress.

Nurses with senior titles, senior positions and higher levels of education had lower levels of turnover intention. This might be because nurses with senior titles and senior positions have higher levels of income and work less night shifts, and nurses with higher levels of education tend to cherish their jobs more due to their years of nursing education.

5.1.2 Influence of work and family situation on nurses' turnover intention

Nurses' turnover intention increased with the increase in the number of night shifts per month, which is in line with the results of the study by Tang and Liu (2019). The number of night shifts is an important measurement indicator of nurses' workload. A higher number of night shifts means a heavier workload, which tends to cause a stronger sense of burnout and helplessness among nurses, leading to increased turnover intention.

Nurses earning over RMB 200,000 per year had the lowest levels of turnover intention, which is in line with the findings by Shang et al. (2014), Shen (2014), as well as Zhou and Wang (2015). Salary and benefits provide the basic guarantee for clinical nurses. According

to Maslow's hierarchy of needs theory and Herzberg's two-factor theory, no incentive mechanism can increase nurses' job engagement and job satisfaction if their basic needs are not met (Zheng, Wei, & Wang, 2017). The mismatch between "a heavy workload and a high number of night shifts" and "low salaries" tends to cause negative emotions among nurses, leading to increased turnover intention. Similarly, the financial burden caused by the family can also lead to nurses' increased turnover intention.

Nurses who felt poor health had higher levels of turnover intention. Nurses work in a tense environment, with a heavy workload. If their physical and mental health is not good, it would be difficult for them to undertake a heavy workload and work night shifts. As a result, they might fail to adapt to their job needs and have increased turnover intention.

Unmarried nurses had the highest levels of turnover intention. Such factors as social customs, habits and cultural traditions tend to prompt unmarried nurses to choose a spouse as soon as possible, marry out or marry abroad, or seek better employment opportunities in big cities. All these factors would lead to increased turnover intention among unmarried nurses.

5.2 Status quo of work-family conflict, organizational silence and peer support of Chinese nurses

The Work-Family Conflict Scale results showed that the mean score of Chinese nurses' work-family conflict was 2.71 points out of 5.00 points, which indicated that the work-family conflict of Chinese nurses was at a medium-to-high level. This is in line with the results of the studies carried out by Wan et al. (2017), as well as Wang, Ma, and Wei (2018). Nurses need to deal with a heavy workload and work at a fast pace for a long time. Besides, nursing is a profession that requires both mental and physical effort. Nurses need to shoulder heavy responsibilities, which causes them to experience a high level of mental stress, unable to develop a regular work and life routine, and unable to strike a balance between work and family, ultimately leading to work-family conflict.

The Organizational Silence Scale results showed that the mean score of Chinese nurses' organizational silence was 2.91 points out of 5.00 points, which indicated that the organizational silence of Chinese nurses was at a medium-to-high level, slightly higher than the results of the research carried out by Zhong et al. (2016), Hu and Ma (2016), as well as Wang and Yang (2016), but similar to the results of the study done by Gillet et al. (2013). In terms of the silence behavior, most people choose to be silent because they lack self-confidence and worry that their suggestions would not be adopted or that "they might say

something wrong" to the detriment of their own interests. When nurses' initiative gets frustrated, they would intuitively choose to remain silent so as to avoid disadvantages. Besides, a small number of people are indifferent to organizational affairs. They completely ignore such affairs and choose to remain silent. This phenomenon is related to the sense of burnout and boredom nurses feel after a long time of tedious work, which causes them to lack passion for organizational affairs.

The Peer Support Scale results showed that the mean score of Chinese nurses' peer support was 3.59 points out of 5.00 points, which indicated that the peer support of Chinese nurses was at medium-to-high level. This is in line with the results of the studies conducted by Tang and Ye (2007) as well as Liu, Zhu, and Wang (2015). This might be because nursing work is of high intensity and tends to cause physical and mental exhaustion among nurses. Nurses tend to seek advice and support from peers who understand them when they encounter failures or setbacks. Besides, mutual trust and solidarity can also improve the coordination among nurses, as well as the efficiency and quality of nursing care.

5.2.1 Influence of socio-demographic characteristics on nurses' work-family conflict, organizational silence and peer support

Nurses aged under 40 years and those with no more than 15 years of work experience had lower levels of peer support, as well as higher levels of work-family conflict and organizational silence. There are multiple reasons for this. First, individuals tend to get married between 18 and 35 years old. Nurses aged under 40 years and those with no more than 15 years of work experience are either unmarried or in the early years of marriage. Their children are still young and require long-term company and care from them. Second, nurses at this stage are the emerging forces at work. Apart from daily care of patients, they also suffer pressure from such aspects of work as promotion, business learning, continuing education, subject research and teaching activities, leading to increased work-family conflict. Third, due to the lack of work and life experiences, this group of nurses tends to be aggressive and not good at words, which tends to cause stress in interpersonal relationships (doctor-nurse relationships, nurse-patient relationships and nurse-to-nurse relationships), leading to lower levels of peer support among them. Fourth, young nurses or nurses with less years of experience may experience increased negative emotions due to various reasons such as the conflict in work schedule and the strong hierarchy in the nursing system. As a result, they

tend to be unwilling to offer advice and suggestions for the organization. In other words, they tend to have higher levels of organizational silence.

Nurses in Zhejiang Province had higher levels of work-family conflict, organizational silence and peer support. Zhejiang Province is a leading coastal province in economic development. It is characterized by a fast pace of life, a high level of pressure and constant introduction of talents. Therefore, competition in the nursing industry is fierce. Nurses often opt for "less talk or no talk" to avoid their own interests being harmed due to "saying the wrong words". Emotional depression in the workplace and the financial burden of the family (house mortgage and car loans) can easily become the cause of work-family conflict. In such cases, peers can often help each other because they are in similar situations and understand each other.

Nurses in Grade A tertiary hospitals had lower levels of work-family conflict and organizational silence, as well as higher levels of peer support. The large number of patients and heavy conditions in Grade A tertiary hospitals result in a heavy nursing workload. Despite so, due to the reasonable scheduling and clear division of labor, the nurses in these hospitals all do their own work, and there are fewer cases of overtime work or delayed shifts. As a result, nurses in these hospitals can better balance their work and family, hence their lower levels of work-family conflict. In addition, the heavy workload and stressful nursing work in Grade A tertiary hospitals also require nurses to cooperate with and support each other, work as a team, express their opinions and put forward suggestions, so as to jointly provide the best quality nursing care to patients. Therefore, nurses in Grade A tertiary hospitals had higher levels of peer support and lower levels of organizational silence.

Nurses in internal medicine departments, surgery departments and intensive care units had higher levels of work-family conflict and organizational silence as well as lower levels of peer support. Clark (2000)'s work-family theory suggests that conflict occurs if elements of work (or family) permeate family (or work). First, the above-mentioned departments are characterized by special working environments. Nurses working in these departments need to deal with a high level of stress, a high level of risk, a heavy workload and a large number of emergencies. As a result, they tend to suffer from a lack of energy, relatively less time for family activities and the inability to take on family responsibilities well, leading to higher levels of work-family conflict. This is consistent with the findings of Jiang, Chen, and Wang (2020). Second, the busy and stressful clinical work (shifts and overtime work) also tends to cause nurses to experience burnout, emotional instability and tension among peers, resulting in lower levels of peer support. Third, due to the large number of nurses in the internal

medicine departments, surgery departments and ICUs, nurses often choose to be submissive and remain silent when participating in organizational activities because their opinions could not change organizational decisions. In comparison, nurses in ENT departments and other departments (such as anesthesiology, reproductive medicine and imaging) had lower levels of work-family conflict and organizational silence as well as higher levels of peer support. Patients in ENT departments and other departments tend to have milder and simpler conditions, less intense and stressful work, as well as lower rates of overtime work and night shifts, resulting in their lower levels of work-family conflict. In addition, nurses in ENT departments and other departments tend to have more positive emotions, work in a relaxed and harmonious atmosphere, are more likely to express their views and suggestions and help colleagues to contribute to the better development of the departments. Therefore, these nurses had lower levels of organizational silence and higher levels of peer support.

Nurses with senior titles and senior positions had lower levels of work-family conflict and organizational silence as well as higher levels of peer support. Nurses with senior titles and senior positions are older and more experienced. They know how to allocate their time and energy rationally, strike a balance between work and family, and integrate personal career development with family cycle planning (Han et al., 2021). Therefore, they had lower levels of work-family conflict. Besides, nurses with more experience have rich clinical experience. They dare to speak their minds and put forward constructive suggestions to the organization. Therefore, they had lower levels of organizational silence and higher levels of peer support.

The higher the education level, the higher the work-family conflict for nurses. Highly educated nurses have high requirements and standards for themselves, higher levels of work engagement and intrinsic motivation, as well as higher levels of after-hours work involvement (such as research and class preparation) (Van Bogaert et al., 2017). Sometimes, they may focus too much on their work, leading to imbalance between work and family, hence their higher levels of work-family conflict.

Nurses who were permanent employees had higher levels of work-family conflict, organizational silence and peer support. Permanently-employed nurses had higher salaries and higher job stability, but the pressure caused by title and promotion, business learning and teaching remain, resulting in their higher levels of work-family conflict. When the organization seeks opinions from nurses, nurses who are permanent employees tend to withhold their opinions due to the fear for their own interests being harmed or contentment with the *status quo*, hence their higher levels of organizational silence. Besides,

permanently-employed nurses tend to be close and get along with each other harmoniously due to the need to work together for a long time, hence their higher levels of peer support.

5.2.2 Influence of work factors on work-family conflict, organizational silence and peer support

With the increase in the number of night shifts per month, nurses had higher levels of work-family conflict and organizational silence yet lower levels of peer support, which is consistent with the findings of D. H. Wang et al. (2018). Too frequent night shifts may be related to factors such as insufficient nursing human resources and unreasonable scheduling by head nurses. Frequent night shifts lead to physical and mental exhaustion, which further leads to occupational burnout. Feng et al. (2018) and Yuan et al. (2017) found in their studies that nursing staff on day and night shift rotations had poorer mental health as well as significantly higher levels of anxiety, depression and sleep disturbances than people with other occupations, which further increased nurses' workload and emotional dysregulation, leading to work-family conflict, reduced communication and cooperation among peers at work and reduced peer support. Besides, due to the difficulty to express their views clearly and fully in the organization, their levels of organizational silence also tend to gradually increase.

As annual income increased, nurses' work-family conflict and peer support increased while their organizational silence deceased. Nurses with higher incomes tend to be those with senior positions and have more tasks. They tend to devote more time to work, have to work overtime or continue thinking about their work after hours. The time given to the family will be reduced accordingly, and it becomes hard for them to take a break from work, leading to work-family conflict. In addition, these nurses have more say and are willing to express their views as they are in senior positions; they can also give more support and help to general nurses, hence their increased levels of peer support and organizational silence. By the same token, the financial burden caused to nurses by their family members/family also leads to increased organizational silence and decreased peer support.

Nurses who felt they were in poor health had higher levels of work-family conflict and organizational silence, as well as lower levels of peer support. If nurses are in poor health, it is difficult for them to adapt to the intensive and stressful nursing work. In turn, intense nursing work and working three shifts will also aggravate their conditions. These two continue to interact with each other and form a vicious circle, causing nurses to gradually experience the

lack of energy, accumulated negative emotions, lower quality of work, the difficulty to balance work and family, increased conflict among peers and the lack of time to pay attention to the organization's development and change, ultimately leading to higher levels of work-family conflict and organizational silence as well as lower levels of peer support.

5.2.3 Influence of family factors on nurses' work-family conflict, organizational silence and peer support

Other (divorced/separated/widowed) nurses had the highest levels of work-family conflict, followed by married nurses, and unmarried nurses had the lowest levels of work-family conflict. Work-family conflict is closely related to family satisfaction, family well-being and life satisfaction. Other (divorced/separated/widowed) nurses tend to have heavier responsibilities in both family and work due to unfortunate marriage. Besides, they are not able to resolve various negative emotions and lack support from their husbands, leading to increased work-family conflict. Married nurses play dual roles in work and family, and professional women tend to have the perfectionism tendency of aspiring for success in both career and family. On the one hand, they have to face the heavy and fast-paced nursing work to realize their self-worth; on the other hand, they have to take up the burden of tedious and complicated household work, give birth, raise and educate children, as well as support parents. Once their ability to play certain roles conflicts the society's expectations for them to play dual roles, it will be difficult for nurses to weigh the relationship between the two, eventually leading to work-family conflict.

Nurses who were not the only children of their families had higher levels of work-family conflict than those who were the only children of their families. Nurses with a larger family size need to take on more family responsibilities and take care of their siblings. Apart from playing the roles of father/mother, son/daughter and husband/wife, they also need to play additional roles such as brother/sister and sibling, which requires nurses to devote more time and energy and cause them pressure from various aspects, resulting in their higher levels of work-family conflict.

Nurses who felt financial burden and those whose family caused them financial burden had significantly higher levels of work-family conflict and organizational silence as well as significantly lower levels of peer support. These nurses tend to work several jobs, feel weighed down by work and save money in order to reduce expenditure and support the family financially. In addition, they are also the main bearers of household chores (such as raising

children, caring for the elderly, cleaning, laundry and cooking), which take up a lot of their time and energy and also render them unable to have enough time to complete their nursing duties. Consequently, they are prone to such negative emotions as fatigue, irritability, agitation and tension, which influence each other and lead to work-family conflict. The lack of excellent and responsible nursing care can also lead to increased conflict between peers, complaints against each other and a corresponding decline in peer support. Nurses suffering physical and mental fatigue are no longer able to share the burdens of the organization or give advice or suggestions, hence their higher levels of organizational silence.

5.3 Influence of having a second child on nurses' work-family conflict, organizational silence, peer support and turnover intention

Childbirth is not only a physiological activity but also a social behavior, and most of its direct and indirect cost is borne by women. Thus, it has become one of the important events leading to work-family conflict among professional women (Chen & Chen, 2011). Work and family are two core domains of people's lives. Incompatibility between the role requirements of these two domains can lead to work-family conflict. The results of the research by Zhang, Duffy, and De Castillero (2017), as well as Grzywacz et al. (2006), showed that due to the special requirements of working hours (such as shifts, night shifts and long working hours), as well as the characteristics of high pressure and a heavy workload, nurses had high levels of work-family conflict. Specifically, 50% of nurses experienced long-term work interference in their families, and 11% of nurses experienced interference from family life in their work. The Work Family Conflict Scale results in the present study showed that among nurses with three different types of child conditions, the total score of work-family conflict of the 1,427 nurses without children was 25.80 points, with a standard deviation of 7.94 points; the total score of work-family conflict of the 1,646 nurses with one child was 27.05 points, with a standard deviation of 7.78 points; and the total score of work-family conflict of the 901 nurses with two or more children was 28.99 points, with a standard deviation of 7.93, which was above average. The total score of work-family conflict of nurses with two or more children was the highest, followed by those with one child, and the total score of work-family conflict of nurses without children was the lowest. The results are consistent with the research findings by Xu et al. (2019). After a stratified analysis of factors such as hospital level (tertiary/secondary), type of employment (permanent employees/contract-based employees /temporary employees), annual income (no more than RMB 100,000 per year/over RMB

100,000 per year), and whether there is financial burden in the family, it was similarly found that nurses with two or more children had higher levels of work-family conflict than nurses with one child, which had higher levels of work-family conflict than nurses without children. As the number of children increases, nurses are likely to fulfill family responsibilities; due to limited time resources and social resources, they need to sacrifice some work time to deal with family matters, which may cause them to be absent from work, come to work late and leave early, and work with low efficiency, eventually leading to work-family conflict.

Organizational silence among nurses refers to nurses' choice to withhold their views or to refine and filter their views for a variety of reasons. For nurses themselves, organizational silence can reduce job satisfaction, increase burnout, reduce their interest in and initiative for nursing work, increase resistance to nursing work, increase turnover rates, and be detrimental to their psychological health; for the organization, nurses, as front-line clinical workers, are able to identify problems and deficiencies in clinic practice at the earliest. However, due to nurses' choice to remain silent, managers of the organization are unable to receive information feedback and thus lose the opportunity to correct mistakes. This hinders the development of nursing; for patients, organizational silence poses a threat to patient safety. The Organizational Silence Scale results in this study showed that among nurses with the three types of child status, the total score of organizational silence of the 1,427 nurses without children was 35.10 points, with a standard deviation of 10.36 points; the total score of organizational silence of the 1,646 nurses with one child was 34.87 points, with a standard deviation of 10.03 points; and the total score of organizational silence of the 901 nurses with two or more children was 34.94 points, with a standard deviation of 9.59 points, and the overall score was above average. There were no significant differences in the total scores of organizational silence among nurses with the three different types of child status. After a stratified analysis of factors such as hospital level (tertiary/secondary), type of employment (permanent employees/contract-based employees/temporary employees), annual income (no more than RMB 100,000 per year/over RMB 100,000 per year) and whether there is financial burden in the family, it was still found that there were no significant differences in the total scores of organizational silence among nurses with the three different types of child status.

Nurses' peer support refers to the phenomenon where individuals in the same position and at the same level provide emotional, instrumental and informational support and assistance to each other. Peer support can help nurses improve the nurse-patient relationship and motivate nurses to help patients solve their problems. Because most nurses are women, they are more able to understand, support, show tolerance towards, and give assistance to each other, hence

their higher levels of peer support. The Peer Support Scale results in this study showed that among nurses with the three types of child status, the total score of peer support of the 1,427 nurses without children was 106.83 points, with a standard deviation of 20.97 points; the total score of peer support of the 1,646 nurses with one child was 108.79 points, with a standard deviation of 21.41 points; and the total score of peer support of the 901 nurses with two or more children was 107.16 points, with a standard deviation of 20.91 points, and the overall score was above average. There were significant differences in the total scores of peer support among nurses with the three different types of child status. Besides, nurses with one child and those with two or more children had significantly higher levels of peer support than those with no children. After a stratified analysis of factors such as hospital level (tertiary/secondary), type of employment (permanent employees/contract-based employees/temporary employees), annual income (no more than RMB 100,000 per year/over RMB 100,000 per year) and whether there is financial burden in the family, it was found that among nurses in secondary hospitals or nurses with no financial burden in the family, nurses with one child had significantly higher levels of peer support than nurses with no children and nurses with two or more children. This may be because nurses with two or more children often have to devote more time to their families, which would affect nursing work to a certain extent. Besides, being late for work or leaving early from work and making mistakes or omissions would negatively affect normal nursing work, lead to increased conflict among peers, and tend to result in decreased peer support. In contrast, nurses without children generally do not have family burdens, are young and have strong work initiative, have a shorter period of time of getting along with senior colleagues in the department, and are not yet familiar with each other, hence the lower levels of peer support.

The Turnover Intention Scale results of this study showed that the total score of turnover intention of the 1,427 nurses with no children was 12.00 points, with a standard deviation of 5.00 points; the total score of turnover intention of the 1,646 nurses with one child was 11.00 points, with a standard deviation of 5.00 points; and the total score of turnover intention of the 901 nurses with two or more children was 11.00 points, with a standard deviation of 5.00 points, and the overall score was low, which was similar to the results of the study by Lai (2019). The total score of the turnover intention scale of the nurses with no children was significantly higher than that of the nurses with children. After a stratified analysis of factors such as hospital level (tertiary/secondary), type of employment (permanent employees/contract-based employees/temporary employees), annual income (no more than RMB 100,000 per year/over RMB 100,000 per year) and whether there is financial burden in

the family, it was found that apart from the group of contract-based nurses, the above trend existed among all other groups. This indicates that from the perspective of the number of children, nurses with children had lower levels of turnover intention than nurses without children. In other words, nurses with children were more willing to stick to their current jobs. However, the results of the survey conducted by Li (2018) suggested that the turnover intention of nurses with two or more children was significantly higher than that of nurses without children and nurses with one child, which is inconsistent with the findings of the current study. The reason may be that nurses with two or more children need to undertake heavier financial burden for raising children, making them cherish their current jobs more. In comparison, nurses without children are relatively young and have more career development opportunities and choices. Therefore, nurses with children are more willing to stay in their current hospital than their counterparts without children.

A separate analysis of second child nurses showed that second child nurses in Zhejiang Province had higher levels of work-family conflict, organizational silence and turnover intention than those outside Zhejiang Province. Zhejiang Province has a developed economy, high living costs and housing prices, advanced medical technologies, a large number of patients, many types of diseases, complicated conditions, a fast pace of work and life, as well as a high level of pressure. Having a second child undoubtedly increases the burden on nurses' shoulders and breaks the balance between family and work, leading to increased levels of work-family conflict and organizational silence and even resignation among second child nurses in Zhejiang Province. The results also showed that second child nurses in tertiary hospitals had higher levels of peer support than those in secondary hospitals. Due to the heavy nursing workload, nurses in tertiary hospitals often need to cooperate and coordinate with each other with strong cohesion. Besides, managers can well consider the career development needs as well as time and energy needs of second child nurses. Therefore, the nursing team has a good atmosphere and a high level of peer pressure. Furthermore, the second child nurses who were permanent employees had the highest levels of work-family conflict. Although nurses who were permanent employees had substantial benefits and less competition, they were also faced with the pressure of promotion. A rigorous work attitude is necessary for permanently-employed nurses. Strictly following the work schedule and volunteering to work at the front line during special periods (such as epidemic and influenza) would affect their time devotion to their family roles, leading to work-family conflict. Second child nurses who were permanent employees had higher levels of organizational silence than those who were contract-based employees, who had higher levels of organizational silence than those who

were temporary employees. Second child nurses have higher job stability, are more content with the current life, feel reluctant to make their own suggestions and hesitate to break the existing rules of regulations of the organization, hence their higher levels of organizational silence. Second child nurses who needed to work night shifts, those who felt they were in poor health and those whose family/family members had caused them financial burden had higher levels of work-family conflict, organizational silence and turnover intention, as well as lower levels of peer support. Good health and a harmonious family atmosphere are solid guarantees for the work of second child nurses. Once they are in poor health, the financial pressure their family/family members caused them would increase their physical and mental pressure, cause them to experience more negative emotions, get along poorly with their peers, ignore organizational matters and even hand in their resignation. Second child nurses with an annual income of no more than RMB 100,000 had lower levels of peer support. Second child nurses have a greater financial burden due to the fact that they have more children. Nurses with an annual income of no more than RMB 100,000 struggle to afford the cost of their children's life and pay for their tuitions and fees. In addition, due to limited time, energy and wealth, second child nurses tend not to participate in the team building and collective outings of their departments, which is also one of the influencing factors of their low levels of peer support.

5.4 Influence of work-family conflict, organizational silence and peer support on nurses' turnover intention

5.4.1 Organizational silence directly influences nurses' turnover intention

The results of this study suggested a significantly positive influence from organizational silence on turnover intention, which is in line with the results of studies by such researchers as Alparslan, Can, and Erdem (2015), as well as Yang (2017). The possible reason is that passively remaining silent would make nurses feel undervalued, cause them to lack control over their work, and lead to cognitive dissonance. As a result, nurses might have decreased job satisfaction and feel estranged from their work, which in turn undermines their organizational identification and leads to or increases their turnover intention.

5.4.2 Peer support and organizational silence mediate the relationship between nurses' work-family conflict and turnover intention

The results of this study suggested a significantly positive influence from work-family conflict on turnover intention, as well as a significantly negative impact from peer support on turnover intention. Amstad et al. (2011) held that work-family conflict was one of the key factors leading to employees' turnover intention. Jiang, Wu, and Wang (2019) found in their study that work-family conflict was positively related to employees' turnover intention. Larrabee et al. (2003) argued that positive peer relationships are an important influencing factor of retention intention. Zhang et al. (2014) found in their study that building up a peer support system increased nurses' retention intention and reduced their turnover rate (Zhang et al., 2014).

The structural equation model proposed that work-family conflict directly influenced peer support, organizational silence and turnover intention. Besides, work-family conflict indirectly influenced turnover intention through the mediating effects of peer support and organizational silence. The study by Jin, Li, and Sun (2017) indicated that only when nurses fully devoted themselves to work could they identify problems in clinical practice and deficiencies in the department system, in which case they were also willing to break the silence and put forward suggestions to the organization. In addition, most nurses are women. They have to not only sacrifice more time and energy to cope with the high pressure, high requirements and high risks at work but also play multiple roles in family and undertake family responsibilities and obligations. To resolve or reduce work-family conflict, nurses have to devote some energy to family, which leads to their lack of job engagement, hence organizational silence and increased turnover intention. Furthermore, as work-family conflict increases, nurses communicate less with their peers at work, leading to reduced peer support and hence increased turnover intention.

5.5 Implications

The implications of the present study are as follows:

First, implementation of the "universal two-child" policy in China was put forward in response to population aging. This study focuses on the nursing management challenges caused by nurses' work-family conflict since the implementation of the "universal two-child" policy. And such conflict is attributable to the special characteristics of nursing work such as

"huge responsibilities, a heavy workload, a tight schedule and the shift system" as well as the increase in the number of children.

Second, based on an analysis of the turnover intention of 3,974 nurses in 216 hospitals, this study explored the suggestions for developing incentive management strategies to increase the stability of the nursing staff in secondary hospitals and above, making positive contributions to stabilizing the nursing team in China. Besides, this study established a research model and conducted a large sample survey among nurses from 216 hospitals in China. It enriched the literature on turnover and health management.

Third, this study enables peers in the nursing industry to understand the factors influencing Chinese nurses' turnover intention and the relationships among those factors. In particular, it shows that the number of children of nurses is related to nurses' work-family conflict, organizational silence, peer support and turnover intention. Specifically, nurses with a child or children have lower turnover intention.

Fourth, this study proposed a structural equation model of work-family conflict, organizational silence, peer support and turnover intention. It postulated that both work-family conflict and organizational silence had a positive influence on turnover intention; peer support had a negative influence on turnover intention; organizational silence and peer support mediated the relationship between work-family conflict and turnover intention. All these results provide insights for nursing managers in the improvement of nursing management models and the development of health policies.

5.6 Limitations and suggestions for further research

The present study has the following limitations:

(1) This study was only based on an empirical survey among 3,974 nurses in 216 hospitals in China. The chosen sample cannot represent the situation of nurses in all parts of China. Give China's vast territory and diverse culture, this study is not universally representative.

(2) This study explored the influences of nurses' work-family conflict, organizational silence and peer support on their turnover intention through such factors as age, location, hospital level, title, position, level of education, number of night shifts per month, department, marital status, annual income and self-perceived health status. However, turnover intention may also be affected by other external factors, such as temptation from a large number of external employment opportunities.

(1) In the future, focus can be given to the following aspects to further the research on this topic:

(2) Carry out in-depth research of relevant external factors influencing nurses' turnover intention;

(3) Explore the differences in second child nurses' turnover intention during different periods, such as pregnancy period, perinatal period and their children's different age periods;

(4) Identify the factors influencing the turnover intention of nurses and second child nurses born after the 1970s, the 1980s and the 1990s, and analyze the differences among such influencing factors;

(1) Conduct multi-method research. For example, qualitative research can be carried out to develop an all-round understanding of the topic through in-depth interviews, observations, and interactions with the research population.

Chapter 6: Conclusion and Suggestions

6.1 Research conclusions

Based on the analyses conducted and presented in Chapters 4 and 5, this thesis has led to the following conclusions:

First, the turnover intention of the Chinese nurses surveyed in this study was relatively low. Socio-demographic characteristics, work requirements and income levels, as well as family situation, all had influences on nurses' turnover intention.

Second, work-family conflict, organizational silence and peer support of nurses surveyed in this study were all at medium to high levels in China; work-family conflict, organizational silence and peer support differed significantly for nurses with different ages, located in different areas, working in different levels of hospitals, and having different titles and positions; peer support and organizational silence differed significantly for nurses working different numbers of night shifts per month, earning different annual incomes, and having different self-perceived health status; and work-family conflict differed significantly for nurses working in different departments, of different marital status, and having different child status.

Third, nurses who did not have children in this study had significantly lower levels of work-family conflict than those who had children, and nurses with one child had significantly lower levels of work-family conflict than nurses with two or more children; nurses with one child or children had lower levels of turnover intention compared to nurses without children.

Fourth, work-family conflict positively influenced turnover intention; peer support negatively influenced both organizational silence and turnover intention; and organizational silence positively influenced turnover intention. Nurses' work-family conflict, organizational silence and peer support all had a direct effect on turnover intention; peer support and organizational silence mediated the relationship between work-family conflict and turnover intention.

Fifth, nurses with two or more children had significantly higher levels of work-family conflict than those with one child and nurses without children regardless of hospital level, type of employment, annual income, and whether or not the family had financial burden.

6.2 Suggestions for nursing management

6.2.1 Paying attention to what nurses have to say to reduce organizational silence

When making decisions, nursing managers should not only listen to the opinions of senior nurses but also value communication with nurses working at the front line, especially those with certain work experience. Managers should also encourage all organization members to actively express their views and suggestions, give their views serious consideration, and adopt suggestions based on merit. Besides, managers should be brave enough to accept different opinions from nurses, communicate with them with a tolerant and open attitude, and let them realize that their suggestions will not have a negative impact on their own interests, to eliminate their concerns when making suggestions and establish a smooth hierarchical feedback mechanism of information. These efforts will be conducive to the emotional communication between nurses and the organization, enhance their trust in and reliance on the organization, and reduce organizational silence among nurses.

As nurses' length of service and age increase, their work initiative and organizational engagement gradually decrease, and their organizational silence increases. And they would develop a certain level of turnover intention. However, these nurses, with certain work experience and technical expertise, are generally the core members of the nursing team. Thus, nursing managers should pay more attention to mobilizing the initiative of this group of nurses and enable them to contribute to the organization.

To prevent the silent behavior of young nurses due to environmental discomfort, lack of knowledge and mismatch with other senior nurses in medical and nursing knowledge structure, managers should strengthen organizational culture education among nurses and create opportunities for joint learning among medical and nursing staff in the department. This will not only facilitate knowledge progress but also contribute to good interpersonal relationships and a higher level of organizational identification. By creating a good organizational climate, work alienation can be reduced, and silent behavior will occur less among nurses. The study carried out by Jiang (2009) showed that head nurses could create a good organizational climate and improve nurses' work enthusiasm through their own qualities and management skills. Managers should create an organizational climate of trust and encourage nurses to actively participate in all hospital affairs and express their views in different ways.

6.2.2 Providing humanistic care; developing department culture; and increasing peer support among nurses

The hospital human resources department should not only strictly comply with the basic management principles but also provide humanistic care to hospital staff in the process of management. First, nursing managers should strictly comply with the principle of putting people first in the process of hospital human resources management. Based on the special nature of human resource management, nursing managers should effectively provide humanistic care to nurses, protect employees' legitimate rights and interests according to the law, and realize the people-oriented management of the hospital. The principle of distribution according to labor should be implemented to protect the material interests of employees. Fairness and impartiality should be guaranteed in the distribution of wages. Although it is unlikely to achieve absolute fairness and impartiality, improvement should be made through gradual exploration to establish an assessment mechanism in line with the development of the hospital and the needs of employees. Second, nursing managers should focus on the cultivation and use of talents, improve the quality of staff comprehensively, and pay attention to staff training. The all-round development of staff requires frequent training. In particular, strengthening the training of new nurses can enable new nurses to better adapt to the hospital environment, thus reducing the turnover rate. Wen (2019) put forward that the establishment of a humanistic care-based growth mentor program for new nurses could enable new nurses to emotionally accept and discover the charm of the profession, embrace the career, and establish good professional values. It improved the professional competence of new nurses and perfected the hospital's such policies and rules as the Measures for Training and Managing New Nurses, Manual of Standardized Training for New Nurses and Comprehensive Ability Assessment Form for Hospital Rotating Nurses. Finally, nursing mangers should attach importance to employees' career planning, utilize talents reasonably, and expand the room for development of employees. The purpose of training talents is to use them. Thus, managers must make good career planning for employees and constantly give them opportunities for practice and self-realization.

Zhang et al. (2015) put forward that measures should be taken to optimize post management, improve nurses' identification with their own values, and provide them with emotional support to eliminate workplace ostracism. Dåderman and Basinska (2016) held that to reduce employee turnover, managers' primary goal is to improve the work environment

and strengthen the culture of the hospital. The so-called hospital culture refers to the group consciousness and the overall public understanding of the hospital created collectively by the hospital in the course of the long-term medical service operation activities and gradually formed and recognized by the staff. It is a stable cultural tradition formed by the hospital over a long period and can unify various forces within the hospital under a common guiding ideology and management philosophy and motivate them towards a common goal and direction, thus significantly contributing to the promotion of the all-round development of the hospital. The development of hospital culture mainly includes material culture development, institutional culture development, behavior culture development and spiritual culture development. Material culture development encompasses such aspects as hospital environment, medical equipment, hospital appearance and service facilities. Material culture is the concrete embodiment of a hospital's strength and guarantees a good image of the hospital. It can enable the staff to feel beauty amidst their busy work and rest in the spiritual sense, which will stimulate their work enthusiasm and creativity. Institutional culture development consists of such aspects as a management system, policies and regulations, rules and regulations, codes of work and management objectives. Behavior culture includes the level of medical expertise, speech and behavior, dressing attire as well as spirit and temperament of all staff. Spiritual culture development is the core and soul of the hospital culture development, the group consciousness of all hospital staff established in long-term practice and the driving force of hospital development. It encompasses such aspects as the hospital spirit, objective of the struggle, value orientation, ideals and beliefs as well as service philosophy. Once the spiritual culture is formed and recognized by the staff, it will regulate staff to exercise self-discipline and build their morale, so that the staff's thinking and hospital development will be unified on the same track.

Nursing managers should also organize cultural education and create opportunities for medical staff in the department to learn and communicate together. These measures can help nurses build good interpersonal relationships and increase peer support. They will also enable nurses to have a high level of organizational identification so that they will feel proud to be part of the hospital and thus reduce their turnover intention. This requires hospitals to create conditions that allow those with ambitions in life to realize their ideals and life values, provide a positive and cooperative work environment for front-line nurses. Bringing into play and enhancing nursing leadership is the key to building hospital culture. Rich cultural activities should be carried out to nurture the souls of the staff. Staff activities can not only contribute to the cultural development of the hospital well, but also strengthen the ties among

the staff and the connections among departments. Such activities play a highly constructive role in increasing the unity among the staff. Hospitals can also organize corresponding quality training through staff activities so that employees can enhance their professional quality in the activities. Besides, nursing managers should also pay attention to the psychological health of employees and communicate with and guide employees well. H. Wang et al. (2018) put forward the practice and effect of nursing management based on magnetic hospital culture. They held that the use of the magnetic concept can enhance the professional achievement of nurses and reduce the turnover rate. With the continuous development of China's nursing and the continuous transformation of the nursing model, it is necessary to accept and absorb good management concepts to improve service quality, control service costs, develop convenient measures, simplify the workflow, and provide patients with "high-quality, efficient, low-consumption, satisfactory and reassuring" medical services. According to the actual situation of the hospital, we can refer to the management model of the magnetic hospital, strengthen the management of nursing human resources, reduce the loss of talents, and form a people-oriented and highly satisfactory management mode, thereby making up for the shortage of nurses in China, improving the quality of nursing services, and contributing to the better development of the nursing profession. In short, regardless of what measures, only when nursing managers truly care about nurses from their heart can nurses be more willing to dedicate their values.

6.2.3 Personalized management

Personalized management is a management model that emphasizes full attention to people's personality traits in the entire management process to fully unleash people's potential, such as respect for people, adequate material and spiritual incentives, provision of a variety of growth and development opportunities, emphasis on win-win and the development of career planning for employees. It highlights the development of human potential and use of people according to their talents, and enables people to learn from each other and make up for each other's deficiencies. Focus on the inner world and manage nurses according to the characteristics of the plasticity, tendency and stability of emotions, the core of which is to stimulate the initiative of employees and eliminate their negative emotions. First, nursing managers should establish a relationship of equality and mutual trust with nurses, communicate well at work, give nurses enough care and understanding from language and action, identify nurses' emotional problems in time, give them support and guidance, and win nurses' trust with

sincerity and a trustworthy attitude. Second, nursing managers should have good communication and coordination skills, and strengthen their own character, morality and emotional management, be good at self-reflection, pay attention to developing a positive leadership style, and work in a style of adherence to principles and a strong sense of responsibility in department management. Nursing managers should be reasonable, people-oriented, fair and just in the management process to reduce negative emotions, increase job satisfaction, and reduce turnover intention among nurses. Third, exercise self-management. Nurses should make their own plans, implement control, and achieve their goals independently according to the development goals of the hospital in their work. They should also combine their personal development goals with those of the hospital and associate their mood comfort with the development of the hospital.

6.3 Attention to second child nurses from the whole society

Fertility, which is very important to individuals, families and society, is the basis for the existence and continuity of a country and nation. China's current fertility rate is about 1.5%. If the fertility rate drops below 1.5%, it will fall into the "low fertility trap", meaning that the fertility rate will continue to drop.

The present study found that nurses with two or more children had significantly higher levels of work-family conflict than nurses with one child and nurses without children despite their difference in hospital rank, type of employment, annual income, and whether the family had financial burden. Society as a whole should pay more attention to the nursing team, especially second child nurses, to help them balance work and family in order to reduce their turnover intention and achieve nursing team stability.

The state and the government should introduce some policies to effectively protect the rights and interests of nurses, improve the performance appraisal system of hospitals at all levels, and implement various preferential policies to improve the income and social status of nurses, especially for nurses with two or more children.

In fact, some countries other than China have introduced some policies to guarantee fertility. For example, Hungary introduced a policy according to which a woman of the first marriage who has the first child under 40 years is eligible for an interest-free loan of about 239,000 yuan; she will not need to pay back a third of the loan if she has the second child; and she will not need to pay for the entire loan if she gives birth to the third child. Germany has introduced various birth subsidies. Women who give birth to a child can directly receive a

subsidy of 600,000 yuan and the parents can enjoy parental leave. The more children a family has, the higher the monthly subsidy the family is entitled to. Back in 1939, France put forward that mothers be given paid (partial) leave before the child turns three, that the government provide free weight loss training, that kindergarten services and free day care be provided for young children of the right age. Later on, it put forward that women be given a maternity checkup, that all the medical expenses for delivery and hospitalization be covered by the government, and that mothers can apply for a maternity allowance equivalent to more than 7,000 yuan. In 2013, Russia introduced a three-and-a-half-year maternity leave and allowance for families with three or more children and a medal and cash incentive for families with four or more children. In 2018, it introduced a monthly allowance of about RMB 1,188 for families with a child up to 18 months of age. Japan proposed in 2019 that all fees for children who are three to five years old attending nursery schools and kindergartens shall be exempted, and children shall be exempt from tuition and medical care until they graduated from junior high school. In addition, the government shall pay children a monthly child wage. Countries such as Sweden and Finland promote active employment for women while also providing a wide range of public services for children. Singapore encourages three-generational families, with grandparents taking on some of the childcare responsibilities, increasing the labor force participation rate of adult women, which is quite beneficial to the environment in which children grow up. Taiwan has also introduced fertility incentives across the island. Specifically, Taipei City, New Taipei City and Keelung City have an incentive of 20,000 yuan for each child and 40,000 yuan for twins. Taiwan's health department invested nearly one billion yuan to subsidize artificial reproduction, and infertile couples receiving artificial reproductive technology can apply for grants and subsidies. In addition, Taiwan has begun to foster a culture of fertility, such as holding a slogan contest to encourage fertility, with the first prize of up to one million yuan. To this end, China can learn from the welfare policies of other countries regarding fertility incentives such as childbirth subsidies, parental leave, child care and education.

At present, China has also introduced some welfare policies for the second child. In terms of maternity leave, as China continues to develop, many policies have been introduced to protect women's rights and interests at work for them to work better. With the implementation of the second child policy, China has also made clear instructions on this issue, adjusting the calculation of maternity leave to "98 days of national leave + maternity bonus leave". Some regions have increased the length of maternity leave to 128 days or 158 days. In some regions, women can take maternity leave after childbirth until the child reaches

one year of age. In terms of benefits, allowance benefits and some maternity examinations are free of charge, and the main benefits for the second child are the maternity allowance and the second child benefit. The maternity allowance is calculated by dividing the average monthly salary of employees in the previous year at the pregnant woman's current employer by thirty days and multiplying by the number of days of leave. The second-child benefit includes a one-time nutrition allowance and a one-time allowance of 25% of the average monthly salary of the employee at the location in the previous year for normal deliveries, and 50% of the nutrition allowance for multiple births and difficult deliveries. Some of the maternity tests such as amniocentesis or Down's screening can be done for free with ID card or temporary residence permit. In terms of entitlements, the state has also introduced many welfare policies. For example, China's Jiangsu Province stipulates that for those who are less than three months pregnant and more than seven months pregnant and have difficulties in going to work, a break should be arranged according to the certificate of the medical institution, and the treatment during the break should not be less than 80% of the local minimum wage; China's Xianning City, Hubei Province supports pregnant mothers and mothers with children less than three years old to apply for flexible working hours and working locations from the company. In terms of parental leave, employers are encouraged to adopt a flexible work system. Due to the difficulty for women to balance family and work at the same time, some women choose to leave their jobs, leading to "parental leave" in many regions. "Parental leave" is only available to couples of childbearing ages who have worked for more than one year, and the leave is about one year, connecting with maternity leave until the child reaches one-year-old. For example, in China's Fujian Province, the policy specifies that couples who have children under the age of three will each have ten days of parental leave per year.

Based on the above context and the results of this study, the researcher would like to put forward the following policy recommendations: First, introduce the "parental leave" policy. Childbirth and housework are inextricably linked. And after the introduction of the universal two-child policy, women who give birth to a second child will face even heavier housework, and the burden of childcare will also cause some women to give up their previous jobs and devote themselves to housework full-time. Yang (2018) suggested increasing paternity and parental leave, which would allow fathers to take a few weeks off to stay home to care for their wives and children after women give birth to children. China has always provided maternity leave for women only, without paternity leave. This policy has some drawbacks. In the long run, it will intensify women's employment discrimination. Besides, lack of care from fathers will lead to children's blurred understanding of their father's role, which is detrimental

to their growth. China can also learn from this way of paternity leave. In particular, for a family with two children, the mother will be weak after delivery. If she still has to take care of the newborn child, she will inevitably end up exhausted both physically and mentally. However, if the father can help take care of the child this time, the mother's pressure will be relieved.

Second, increase the birth allowance for the second child. The birth of a second child is important for coping with China's aging population, and to a certain extent, relieves the pressure of senior care. However, given China's rapid economic development, accelerated pace of life and tremendous pressure of life today, many families will consider the costs and risks associated with the birth of a second child. Yet this aspect of social security for women in China is not perfect. If China also has a series of generous maternity subsidy systems like Sweden and other welfare countries, citizens will have fewer concerns when having children (Yang, 2018). Chen (2019) suggests that many families face childcare problems during the period between the end of maternity leave and the child's entry into kindergarten, so the government can provide a certain family care allowance for double-income families until the child goes to kindergarten, and develop childcare services for preschool-age children, strengthen market regulation, and transfer some of the childcare tasks to the market. The government should also enhance the social and public welfare nature of kindergarten services to cope with the pressure of kindergarten enrollment brought by the two-child policy, balance the relationship between women's families and work, and reduce women's burden of childbirth.

At the hospital level, they should follow the Chinese government's policy and pay attention to the nursing community, especially nurses with two or more children. Hospital managers should effectively protect the rights and interests of nurses, provide various welfare policies, and reduce work pressure so that nurses can better balance family and work.

Lin et al. (2020) found in their study that nurse group support, return time, whether they work night shifts or not and average weekly working hours were the main factors affecting the job stress of nurses returning to work after giving birth to the second child. And work stress may also lead to a decrease in work quality. The nurses without children in this study had significantly lower levels of work-family conflict than those who had a child or children, and work-family conflict positively influenced turnover intention; peer support negatively influenced both organizational silence and turnover intention; and organizational silence positively influenced turnover intention. Nurses' work-family conflict, organizational silence and peer support all directly influenced their turnover intention, whereas peer support and

organizational silence mediated the influence from work-family conflict on turnover intention.

Hospitals should pay attention to optimizing the allocation of human resources, match resources according to the number of patients, their conditions and nurses' abilities and energies, reasonably allocate staff's workload to avoid overload, introduce advanced equipment to reduce nurses' labor intensity, establish good logistic support and set up relevant supporting posts to reduce nurses' non-nursing workload and save nursing human resources, give full play to nurses' potential and enable them to be fully devoted to their nursing career to improve their job satisfaction and stabilize the nursing team. Besides, hospitals should also pay attention to the work pressure state of nurses returning to work after the birth of a second child and their support needs, such as appropriately reducing the number of night shifts, providing some subsidies to second child nurses, giving nurses forms of work that can give them a greater sense of professional accomplishment, giving full play to nurses' strengths and satisfying their needs for self-fulfillment, and building a communication platform for second child nurses to liaise, communicate and share experiences with each other, and reducing nurses' work pressure through scientific and people-oriented management, to facilitate nurses' physical and mental regulation and the improvement of work quality.

From the individual perspective, nurses should strengthen their capacity building and improve their work competence so that they can work with ease, actively communicate with their peers, actively integrate into the group after returning to work, establish good interpersonal relationships, enhance their relationship with peers, and gain better support from peers. They should also give feedback to their managers in time if they have any opinions or suggestions so that the organization can develop in a better direction. Nurses, especially second child nurses, should be encouraged to maintain a good state of mind and actively seek help from others when they encounter difficulties or stressful events and confide in their families, colleagues, friends and other associations to gain understanding and recognition, thus reducing their turnover intention. Besides, nurses should take an initiative to do exercise to maintain a healthy body. Health is the prerequisite for good work. Nursing work is cumbersome and heavy. Only nurses with good physical and mental health can dedicate themselves to the heavy and difficult work with a high spirit.

In conclusion, the state, government, hospitals and individuals should jointly pay attention to nurses. In particular, after the implementation of the "universal two-child" policy, the number of second child nurses has been increasing. The government and hospitals should adopt policies and measures to reduce nurses' work-family conflict and organizational silence

while increasing peer support, thereby reducing their turnover intention, and stabilizing the nursing workforce.

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Annex A: Questionnaire

Prevalence survey on Work-family conflict, organizational silence, peer support, and turnover intention of second child nurses in China

Dear nursing colleagues，

Thank you very much for taking time out of your busy schedule to participate in our survey! The purpose of this survey is to understand whether the increase in the number of children has bothered nursing staff in work and family after the introduction of China's "two-child policy" and to improve related policies, provide management methods and suggestions.

This survey strictly complies with the requirements of the "Statistics Law" and is filled out anonymously. There is not a so-called right or wrong answer, and we will keep the survey information confidential. We hope you can answer objectively. Thank you for your support and cooperation!

1. Basic information

1) Which city do you live: ____

2) Which level is the hospital you served at?

A. Grade III Level A Hospital

B. Grade III Level B Hospital

C. Grade II Level A Hospital

D. Grade II Level B Hospital

3) Department:

4) Length of service at current department: _____ years

5) Age: ___ Number of children: ____

6) Length of service as a nurse: ____ year

7) Please select your title:

A. Nurse

B. Senior nurse

C. Supervisor nurse

D. Co-chief nurse

E. Chief nurse

8) Please select your position:

A. General nurse

B. Clinical teacher

C. Head nurse and deputy head nurse

D. Director of nursing

E. Administrative staff or others

9) Please select your first educational degree:

A. High school/technical secondary school graduates

B. Junior college graduates

C. College graduates

D. Postgraduates or above

10) Please select your highest educational degree:

A. High school/technical secondary school graduates

B. Junior college graduates

C. College graduates

D. Postgraduates or above

11) Please select your type of employment:

A. Permanent employees

B. Contract-based employees

C. Temporary contractors

12) Please select your marital status:

A. Unmarried

B. Married

C. Others: Divorced/separated/widowed

13) How many children do you have?

A. 0

B. 1

C. 2

D. 3 or more

14) Age of the Youngest child: _____

Age of the Oldest child: _____

15) Whether health status had influenced the job? A. Yes B. No

16) Whether there is a need to work night shifts? A. Yes B. No

17) Frequency of night shifts (times per month): _____

18) Your annual income after tax in 2019: _____

19) Single child or not: A. Yes B. No

Number of siblings: _____

20) Whether there is financial burden? A. Yes B. No

21) Whether your family members cause you financial burden? A. Yes B. No

2. Select the corresponding options according to your own experience.

Items	Extremely likely	Very likely	Somewhat likely	Not very likely	Not at all likely
1. My job requirements have affected my family life.	5	4	3	2	1
2. My work schedule makes it difficult for me to fulfil my family	5	4	3	2	1

responsibilities.					
3. I didn't complete what I wanted to do because of the work that I had to do.	5	4	3	2	1
4. Work stress makes it difficult for me to flexibly arrange my family activity plan.	5	4	3	2	1
5. I had to change my family activity plan due to my job requirements.	5	4	3	2	1
6. The requirements from my family members have affected my normal work.	5	4	3	2	1
7. I have to delay work due to family reasons.	5	4	3	2	1
8. Sometimes I am unable to complete planned work, such as going to work on time, finishing daily tasks, and working overtime.	5	4	3	2	1
9. My family life has affected my work, such as working on time, finishing daily tasks, and working overtime.	5	4	3	2	1
10. Family stress has affected my work performance.	5	4	3	2	1

3. Select the corresponding options according to your own experience.

Items	Always	Frequently	Sometimes	Seldom	Never
1. Leaders have almost made decisions, and my opinions will not make a big difference.	5	4	3	2	1
2. My opinion will not affect the current situation.	5	4	3	2	1
3. It is nearly impossible for leaders to adopt my suggestions.	5	4	3	2	1
4. Leaders will not change some decisions, and it makes little difference for me to speak out my views.	5	4	3	2	1
5. I choose to remain silent about others' deficiencies and negligence in work to avoid affecting my relationships with peers.	5	4	3	2	1
6. I might as well withhold my views in order not to become the target of criticism.	5	4	3	2	1
7. There is no need for me to offend leaders or peers.	5	4	3	2	1
8. I get along well with everyone. So, it is better for me to withhold my own opinions.	5	4	3	2	1
9. Other people's affairs are not my	5	4	3	2	1

business, and there is no need for me to talk about them.					
10. I do not care about the affairs of the hospital.	5	4	3	2	1
11. As the Doctrine of the Mean suggests, less talking means fewer responsibilities.	5	4	3	2	1
12. I do not have a strong attachment with the hospital. So, there is no need for me to give any comments.	5	4	3	2	1

4. Select the corresponding options according to your own experience.

Items	Very satisfied	Somewhat satisfied	N/A	Somewhat dissatisfied	Very dissatisfied
1. The head nurse spends time understanding my goals and expectations.	5	4	3	2	1
2. The head nurse cares whether I have achieved my goals.	5	4	3	2	1
3. The head nurse has been paying attention to various opportunities beneficial to my career development in the hospital.	5	4	3	2	1
4. The head nurse always praise me after I complete important tasks.	5	4	3	2	1
5. The head nurse can provide me with effective feedback on my work.	5	4	3	2	1
6. The head nurse gives me suggestions on how to improve my work when I need such suggestions.	5	4	3	2	1
7. The head nurse supports my desire for additional training or education for better development in future.	5	4	3	2	1
8. The head nurse provides me with work tasks that could help me develop new skills.	5	4	3	2	1
9. The head nurse assigns to me special tasks which can promote my development in the hospital.	5	4	3	2	1
10. The help provided by my peers is effective in reducing my work stress.	5	4	3	2	1
11. I value my time spent in building up a peer support system.	5	4	3	2	1
12. The peer support system has	5	4	3	2	1

significantly relieved my work stress.					
13. Peers respect my choice and encourage rather than force me to participate in department activities.	5	4	3	2	1
14. Peers provide me with a supportive environment where I feel safe to talk about my feelings.	5	4	3	2	1
15. Peers give me various kinds of support, especially the support I need.	5	4	3	2	1
16. Peers always seem to understand my views.	5	4	3	2	1
17. Peers always recognize my feelings and show that they understand my feelings.	5	4	3	2	1
18. Peers allow me enough time to express my feelings before giving advices.	5	4	3	2	1
19. I have a clearer understanding of the problem I face after communicating with peers.	5	4	3	2	1
20. Questions from peers can help me think better about my problems.	5	4	3	2	1
21. Peers use detailed examples to provide me with feedback and suggestions.	5	4	3	2	1
22. Communication with peers make me realize that goals I have set can be achieved despite the difficulties.	5	4	3	2	1
23. Communication with peers make me aware of the important of having clear goals.	5	4	3	2	1
24. Communication with peers makes me realize that any goals I have set can be quantified.	5	4	3	2	1
25. Peers can help me make clear, simple, and feasible plans.	5	4	3	2	1
26. Peers help me focus on how to succeed instead of studying old problems.	5	4	3	2	1
27. Peers always take my action plan seriously.	5	4	3	2	1
28. Peers always ask me about the progress of my goals.	5	4	3	2	1
29. Peers always help me make up for the deficiencies in my work.	5	4	3	2	1

30. Peers always acknowledge my progress and success and give me encouragement.	5	4	3	2	1

5. Select the corresponding options according to your own experience.

Items	Very satisfied	Somewhat satisfied	N/A	Somewhat dissatisfied	Very dissatisfied
1. I often have the idea of leaving the nursing profession.	5	4	3	2	1
2. I think I will submit resignation in the near future and look for another job.	5	4	3	2	1
3. I believe that with my professional skills, I can easily find a job that gives full play to my skills in other hospitals.	5	4	3	2	1
4. I will choose to leave the hospital if I am given the chance.	5	4	3	2	1

Any other suggestions are welcomed:

Here comes the end of this questionnaire. Thank you again for your cooperation and help! I wish you all the best!

Survey Date:

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Annex B: Tables and Figures

Table B.1 Work-family conflict scale

	Time	Strain	Behavior
WIF	Time-based work-family conflict (TWIF)	Strain-based work-family conflict (SWIF)	Behavior-based work-family conflict (BWIF)
FIW	Time-based family-work conflict (TFIW)	Strain-based family-work conflict (SFIW)	Behavior-based family-work conflict (BFIW)

Source: Gutek, Searle, and Klepa (1991)

Table B.2 Outcomes in work domain

Scholars	Outcomes
Eby et al. (2005)	Individual job satisfaction, organizational commitment, and turnover rate
Boyar, Maertz Jr, and Pearson (2005)	Predictive of individuals' lateness, absence, absenteeism, and turnover
Hoobler, Wayne, and Lemmon (2009)	Chance of career promotion
Frone, Russell, and Cooper (1997)	Low work performance
Bakker, Demerouti, and Dollard (2008)	Related to the risk of occupational burnout and emotional exhaustion

Table B.3 Outcomes in family domain

Scholars	Outcomes
Frone, Russell, and Cooper (1997)	Work-family conflict is related to family satisfaction. It may even lead to low family performance.
	Work-family conflict is negatively correlated with individuals' sense of wellbeing.
	Work-family conflict is related to a higher incidence of such diseases as obesity hypertension.
Crouter et al. (1999)	Work-family conflict is related to awful parent-child relationships and children's problem behaviors.
Grzywacz and Bass (2003)	Work-family conflict is related to such indicators of psychological health as nervousness and anxiety.
Karatepe and Tekinkus (2006)	Work-family conflict is correlated with low satisfaction in marriage and family.
Lallukka et al. (2010)	Work-family conflict is related to such behaviors as smoking, alcoholism, divorce.

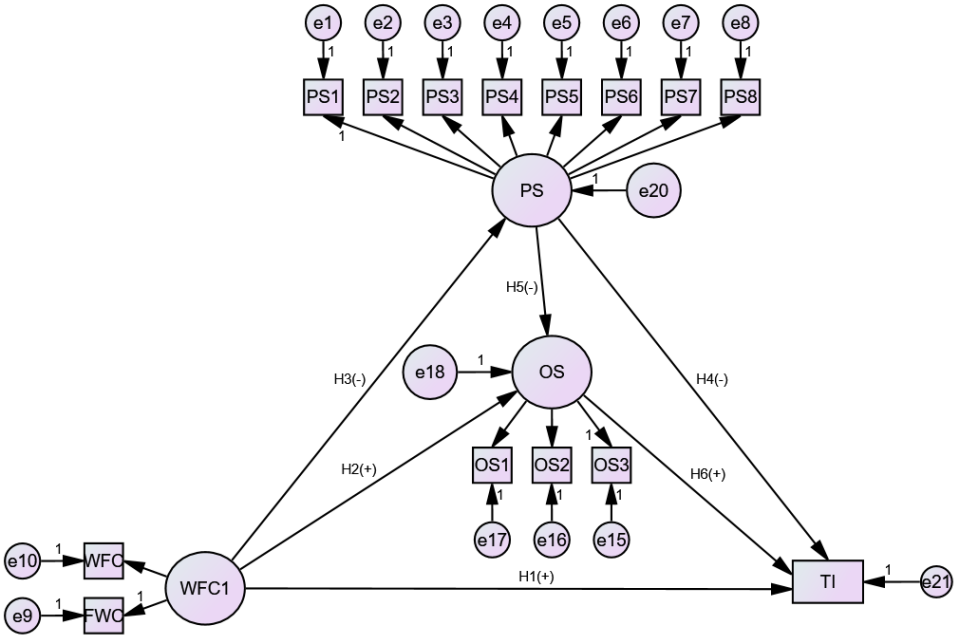

Figure B.1 Diagram of the fitted structural equation model, with standardized estimates

Note: WFC: work-family conflict; PS: Peer support; OS: organizational silence; TI: Turnover intention

Annex C: Ethical Review Process

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School of Ophthalmology & Optometry, WMU
Zhejiang Eye Hospital

The protocol with the title of "Relationship among family-work conflict, organizational silence, peer support and turnover intention of Second-child nurse : A survey of 216 hospitals in China" have obtained approval from the ethics committee of Eye hospital of Wenzhou medical university in Feb.2, 2021. The approval letter number is 2021-028-K-25 and the Chinese approval letter is attached.

Feb.3, 2021

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