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How difficulties in upward vertical voice lead to lateral voice: a case study of a Chinese hospital.

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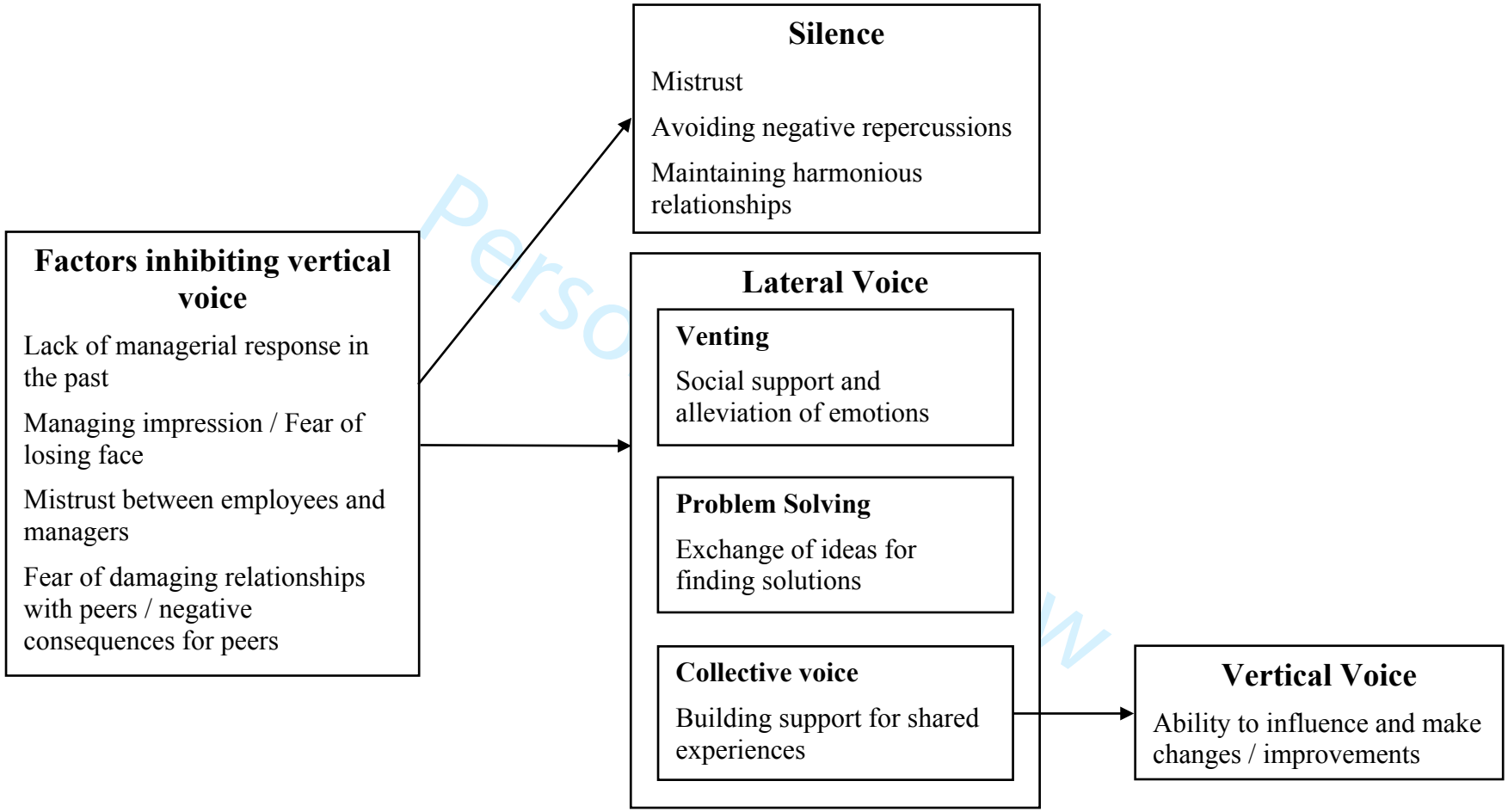
Figure 1


Silence
Mistrust
Avoiding negative repercussions
Maintaining harmonious relationships
Factors inhibiting vertical voice
Lack of managerial response in the past
Managing impression / Fear of losing face
Mistrust between employees and managers
Fear of damaging relationships with peers / negative consequences for peers
Lateral Voice
Venting
Social support and alleviation of emotions
Problem Solving
Exchange of ideas for finding solutions
Collective voice
Building support for shared experiences
Vertical Voice
Ability to influence and make changes / improvements

How difficulties in upward voice lead to lateral voice: a case study of a Chinese hospital.

Keywords: Employee Voice ; Employee participation

Structured Abstract

Design/methodology/approach

A qualitative design was used, involving interviews of 24 medical personnel from a public hospital in mainland China. This included two focus groups (8 participants each) of physicians and nurses, and 8 individual interviews with managers, including a chief nurse and directors of the medical centre.

Purpose

To explore and unpack the notion of lateral voice within the context of a Chinese Hospital

Findings

The findings reveal that in top-down contexts with a respect for hierarchy, direct and vertical voice is discouraged but lateral voice fills this gap and can lead in some circumstances to a pathway to collective vertical voice. Interestingly, we find that fear of damaging relationships with peers may also discourage lateral voice in some cases, leading to silence altogether. Contradictory lateral voice outcomes arising from employees working within this context are discussed.

Originality/value

The study makes an original contribution to voice literature through exploring an understudied voice target i.e., voicing to peers. In doing so, the study demonstrates the importance of lateral voice as an important component of voice behavior.

Introduction

Employee voice, or employees' *'attempt to have a say'* (Dundon, Wilkinson, Marchington, & Ackers, 2004, p. 5;) may facilitate better decision making by leaders (Detert & Trevino, 2010; Morrison, Wheeler-Smith, & Kamdar, 2011) and better organisational outcomes, whether it be preventing unethical practices or adopting better practices to increase productivity (Holland, Pyman, Cooper, & Teicher, 2011; Selvaraj & Joseph, 2020). However, employee voice can also involve the expression of employees' own interests and opinions that may be separate from the organisation (Mowbray, Wilkinson, & Tse, 2019; Wilkinson, Gollan, Kalfa, & Xu, 2018). Given the value of voice to employees and the organisation, it is important to understand how different factors may affect how voice takes place, especially in terms of the targets of voice (Kalfa & Budd, 2020; Liu, Tangirala, & Ramanujam, 2013) and the context in which it occurs. Voice scholars have tended to consider voice as the vertical and upward expression of voice, whether it be the collective expression of concerns and issues indirectly targeted toward the organisation through a union or representative (Freeman & Medoff, 1984; Klaas, 1989) or targeted toward a supervisor or leaders within the organisation (Morrison, 2011). This stems from how voice has been viewed historically i.e. to change unfavourable circumstances by voicing to those who have the power to remedy unfavourable circumstances (Hirschman, 1970). As such, relatively little attention has been given to lateral voice i.e. voice flows between peers and colleagues, despite some recognition that in practice, voice through this route might be favoured or be the only option (Loudoun et al., 2020).

In addition, the majority of theorisation on employee voice has been carried out from a Western perspective and this is partly responsible for the narrow conceptualization of the voice construct from an assertiveness-centered perspective; failing to recognize more subtle, nonconfrontational voice behaviors found in other cultures (Matsunaga, 2015). While existing studies tend to focus on "speaking up" as the only form of voice, there is little theorizing about the complexity of voice enactment patterns (Morrison et al., 2011). In non-western cultures where authoritative leadership styles and formality are more common, voice may be influenced not only by fear of retaliation, but by norms that only authority figures have the right to power and voice (Emelifeonwu & Valk, 2019;

Huang, Vliert, & Vegt, 2005; Kwon & Farndale, 2020; Wu, Liu, Hua, Lo, & Yeh, 2020; Y. Zhang, Huai, & Xie, 2015).

However, in such circumstances where authoritarian beliefs discourage voice, vertical voice to supervisors/authority figures is not always a viable option. Despite this, driven by pro-social motives or the need to improve their conditions and raise their concerns (Wilkinson et al 2020) , employees may still want to voice and may find other avenues and targets to do so outside of the formal, upward channels. In such situations, these employees may be more likely to voice to their colleagues, in the first instance, to garner support and to improve their chances of successfully voicing (Subhakaran, Dyaram, Dayaram, Ayentimi, and Khan (2020), such that individual voice then takes a more collective form. This paper explores how and why lateral voice develops in the context of a case study of a hospital in China. The study contributes to voice literature through exploring an understudied voice target i.e. voicing to peers (Kalfa & Budd, 2020) and identifying the different forms that lateral voice may take and its relationship to vertical and collective voice. Contributions to voice scholarship and practical outcomes are discussed as well as future directions to the exploration of lateral voice.

Literature

Employee voice may be characterised by various types including task-based, problem-solving, grievances, suggestions or opinions and in turn may be expressed to different targets such as leaders/managers (vertical voice), unions, or peers/colleagues (lateral voice) (Mowbray, Wilkinson, & Tse, 2015; Mowbray et al., 2019) depending on the organisational context in which it occurs (Kaufman 2015 ; Kwon & Farndale, 2020; Morrison, 2011, 2014). Research shows that various target-related factors affect voice, such as leader openness towards voice (Detert & Burris, 2007), quality of relationships (Davidson, Van Dyne, & Lin, 2017; Duan, Lapointe, Xu, & Brooks, 2019) individual personalities (Harlos, 2010), type of leadership (Li & Sun, 2015; Y. Zhang et al., 2015), and level of power and influence of target (Detert, Burris, Harrison, & Martin, 2013; Detert & Trevino, 2010). Most of these factors are related to management factors, which is to be expected as it

is generally assumed that direct supervisors/line managers or senior management are the main voice-targets given they have the power and authority to respond to and shape the voice system.

In contrast to the plethora of research on vertical voice which is seen as the norm, the extant voice literature does not fully explain why, how, and what employees choose to voice to peers, especially given these targets usually do not have the same formal authority or power to be able to address voice issues (Detert *et al*., 2013). A starting point might be that not all leadership accommodates voice (Li & Sun, 2015; Wei, Zhang, & Chen, 2015). A study by Jia, Zhou, Zhang, and Jiang (2020) of employees in China found that authoritarian leaders play a negative role in voice behavior such that employees fear speaking up. Equally, Y. Zhang *et al*. (2015) study of employees and their supervisors in the Chinese context found that authoritative/paternalistic leaders tend to reduce voice by lowering employees' perceptions about their status and consequently, the importance of their voice. While this research shows how and why traditional vertical voice might be muted, they do not explain whether employees express their voice elsewhere and in other ways or whether they opt for silence? What is also unclear in the literature is whether lateral voice even has positive or tangible outcomes. In fact, one of the few studies considering lateral voice only found negative outcomes. Examining improvement-oriented voice flows to the direct boss, other managers, and co-workers, Detert *et al.* (2013) argued that lateral voice to co-workers to evaluate consensus on an issue, to vent, or to receive social support, will have a harmful effect on unit performance. However, they did not consider that collective voice may be more powerful than direct individual voice and nor did they consider employee interests.

There is a significant body of research that shows high power-distance and collectivist cultures often have a negative affect over voice, especially if it is challenging in nature (Kassing, 1997), or is expressed beyond the immediate supervisor to skip-leaders, as it may be perceived as disrespectful or a threat to the immediate supervisors' own power (Dorfman, Javidan, Hanges, Dastmalchian, & House, 2012; Yang, Li, & Sekiguchi, 2019). Furthermore, it should be noted that while dissent literature demonstrates the value of such voice may result in improved organisational and employee outcomes (Croucher, Zeng, & Kassing, 2019; Kassing & Armstrong, 2002), the extant literature

shows that such challenging voice will not occur if the voice environment is unfavourable, because voice carries a degree of risk (Burris, 2012). This is particularly important when dissenting voice is expressed to supervisory figures, because these employees may be seen as rocking the boat and damaging relationships (Garner, 2012) and/or diminishing their employee impression to management (Kassing & Armstrong, 2002).

Nevertheless, some recent studies have tried to shed some light on lateral voice to explore its value to individuals and organisations alike. A study of paramedics in Australia by Loudoun *et al.* (2020) found peer-to-peer voice to be a source of informal communication and support for the well-being for employees, especially in high stress situations. Similarly, a study on coping strategies for shift-working nurses in Australia (Gifkins, Loudoun, and Johnston (2017) found that sharing concerns with peers is an important source of support. These studies emphasise the need for further deliberate focus on lateral voice, especially in the health professions where employees may experience frequent stress. Equally, we note that in the health sector there is often strong support for hierarchy.

In some cultures, employees more readily see unequal distribution of power and status as normal (Huang *et al*., 2005) which makes the decision to voice either vertically or laterally more complex. Croucher, Zeng, Rahmani, and Cui (2018) in their study of immigrants in Singapore found a positive correlation between workplace freedom of speech with latent dissent, such that '*expressing latent dissent is not the result of the suppression of upward dissent, but rather is crucial by its very nature in collectivistic and hierarchical cultures*' (p. 802). This was the case especially for Chinese migrants. In addition, Subhakaran *et al.* (2020) showed that senior managers across various industries in India reported that employees often voiced laterally first in order to filter/refine voice before voicing vertically.

While this research illustrates that in non-Western cultures lateral voice may be a common form of voice, it is still unclear why, how and what employees choose to voice to peers rather than vertically (Kalfa & Budd, 2020), and how this issue may be particularly salient in high-power distance and collectivist cultures (Chan, 2020). This is where this study makes a key contribution and in doing so

we draw on the work of Kalfa and Budd (2020) who have highlighted the need to conduct research on lateral voice as:

traditional categories of employee voice seemingly overlook employee-to-employee interactions such as voicing concerns with each other, acting on a colleague's behalf, sharing common experiences, griping, supporting each other, and exchanging tips and techniques. Indeed, while overlooked in research, this form of voice has likely been occurring for centuries in guildhalls, union halls, pubs, bowling alleys, company cafeterias, and other venues where workers gather to socialize and "talk shop." It seems that our conceptual as well as empirical research on voice should pay more attention to various forms of peer-to-peer or sideways voice (p. 567)

Our case study of hospital workers in a Chinese hospital explores how lateral voice was used by nurses and doctors within the hospital when vertical voice became difficult, and we present findings on the different forms of lateral voice used. We also illustrate how this lateral voice can improve the power and influence of these workers to generate positive and tangible outcomes when it is used to garner the support of co-workers and then expressed in collective form. However, we also find that in this specific context, fear of disrupting harmonious relationships with peers also meant that silence was sometimes the preferred choice. In the remainder of the paper, we discuss our methodology, findings, and discussion, before presenting future research directions and practical recommendations on the basis of our findings.

Methods

Design

This study adopted a qualitative research design using a focus group and individual interviews. Qualitative research methods allow a higher degree of flexibility in data collection and a full range of responses, without being driven by pre-defined quantitative measures (Bryman, 2016). Hence, given the limited evidence available on the topic of employee voice in Chinese hospitals, qualitative methods are considered well suited to understand the experiences of how employees speak up (or not) and whether the system of employee voice works.

We used focus group interviews to stimulate broad discussion of the experiences of the voice system. The focus group dynamics can generate new thinking about a topic which may result in a more in-depth discussion as compared with individual interviews. Hence, the presence of several informants participating in open, spontaneous conversations may enhance richness of data (Krueger & Casey, 2009; Rice & Ezzy, 1999). Additionally, focus group interviews can create a more active environment than one-on-one interviews because the researcher takes a moderator, rather than an investigator role in the discussion (Bloor, Frankland, Thomas, & Robson, 2001). Hence, discussions take place among participants rather than just between researcher and participants and in an atmosphere of heuristic discussion, participants can provide more information sought through such dynamic interaction. In addition to the focus groups, we also employed the use of one-on-one interviews with managers and stakeholders. When conducting focus groups, we felt it best to exclude senior management from the groups to improve the psychological safety of the more junior staff. Hence, individual interviews with these managerial participants was deemed most appropriate to ensure that the focus group participants felt safe to speak up in the group (Kitzinger, 1995).

Sample and participants

The focus groups and interviews were conducted in a public hospital in mainland China and were undertaken by one of the researchers of the project, who is a Mandarin-speaking native Chinese. The hospital, one of the first Western medicine hospitals established in China in the 1800s, is comprised of four branches and a Cancer Research Institute, with 55 clinical and technical departments. It is a comprehensive tertiary class A hospital (the top level of hospital ranking in China) with a complete range of disciplines, integrating medical treatment, teaching and scientific research. The hospital has approximately 3,500 staff members.

To gain a wide range of views, we aimed to recruit a suitable sample and employed a mixture of purposive and convenience sampling. We aimed to conduct two focus groups and a sample size of between eight to ten respondents in each focus group. The process of recruiting focus group participants was organised by a contact person who is a senior administrator in the hospital. The contact person first informed the heads of various departments through the WeChat working group

within the hospital, who further informed the staff and asked them to participate in the study. Following this promotion of the study, the employees and managers of the outpatient nursing department and neurology department were more willing to share their information related to employee voice and to participate in our study; hence these two departments were selected. These two departments comprise the front-line core work departments of the hospital, they have the largest staff number of nurses and doctors, and they have the highest workload. Our criteria for selecting focus group interviewees were employees who were working in these two departments on the day of the focus group and who were willing to participate in our focus group during their noon break time. The focus group participants covered a wide range of employee positions and status. A total of 16 staff were allocated into two focus groups. Thus, our sample comes from different levels, status, professions and so while they may not be necessarily representative of the whole hospital, we have been able to obtain a broad cross-section of views and experiences within the 2 depts.

In order to obtain the employee voice information from the perspective of management the contact person also helped to identify suitable management respondents from the two departments for individual interviews. A total of 8 interviews with managers were conducted.

Data collection

Two focus groups were conducted with staff from two different departments, comprised of 8 participants each, with 3 males and 13 females. Participants in the focus groups included physicians and nurses, ranging from assistant nurse to senior nurse roles, and resident physicians to physician in charge. It is recognised that the focus groups were comprised of employees of different status and power which may have influenced our findings and caused those more junior staff to be reluctant to speak up during the focus group. However, as our findings indicate, the junior nurses were happy to discuss with us their challenges associated with voicing. The average tenure of the first focus group was 4.6 years (ranging from 2-16 years), while the average tenure for focus group 2 was 6.75 years (ranging from 3-17 years).

The focus groups followed a structured interview guide. We began each focus group or interview by providing a brief description of the study, backgrounds of the researchers and our aim to explore how employees speak up (or not) and whether the system of employee voice at this hospital supports this. The interview questions were designed for participants to share their experience with the researcher in an open and supportive way, leaving them free to unfold their story as they prefer. The researcher followed the development of the discussion using prompts when necessary, ensuring a sensitive and empathetic approach. We assured respondents that all information would be kept confidential. Both focus groups were conducted on-site in the quiet conference rooms of the two departments. The focus groups lasted 1.5-2 hours, during which time participants were asked by one of the researchers set questions, such as "What are the main avenues you use to speak up about errors, concerns for your well-being or improvements?" and "Can anyone think of a specific instance in their current job where they have felt they could not or should not speak openly or honestly about a certain issue or issues?" The focus groups were audio recorded and later transcribed. The researcher and participants spoke in Mandarin in interviews, and this was later translated by the research assistant into English and then these were checked by the researcher for accuracy.

Several months after the focus groups, the individual interviews were undertaken at the manager participants' offices during their working time. The purposive sample of 8 managers from the two departments included senior managers at the hospital, such as chief nurse and directors of the medical centre. Many of these participants had been employed at the hospital for a significant period of time, with the average tenure 17.5 years (ranging from 5-24 years), and, comprised of 2 males and 6 females. The interviews lasted around one hour and were audio recorded and later transcribed and translated into English. The interviews were structured and included questions associated with voice mechanisms, their response to voice and their perceptions of how employees were speaking up. Example questions include "What are some of the main issues with employee voice (generally) at the hospital?" and "Can you tell us any more about the structures by which staff can express voice to management and the effectiveness of these?".

Data analysis

The interview data was manually coded by two of the other researchers to identify key themes emerging from the data. Using an inductive method, the data was analysed by reading and re-reading the transcripts and the assignment of keywords to phrases or chunks of text, which resulted in numerous child codes in this open coding phase. During the coding process, meetings between the researchers took place to ensure internal reliability i.e., consistency and agreement on the coding. During the axial coding process, connections between the codes were identified, and then through selective coding these child codes were aggregated to parent codes, resulting in three key themes which we discuss below (Williams & Moser, 2019).

Findings

The findings of the research reveal several important insights into lateral voice in a context where authoritative leadership is embedded. This feature limits direct and vertical voice, while at times stimulating lateral voice. Coincidentally, we find these factors also have the potential to limit lateral voice between peers, thus leading to silence. Hence, we find contradictory lateral voice outcomes arising from employees working within this context. Figure 1 illustrates the dynamics of voice.

Figure 1 about here.

Stifling of vertical voice due to leadership behaviors and norms

To understand why and how lateral peer-to-peer voice arose within this hospital, we first unpack the issues and sentiments concerning the use of vertical voice directed toward management. We find that the organisational climate for voice stifled vertical voice. Our findings show that a strong hierarchical system within the hospital, where authoritative leadership was prevalent, led to many employees being reluctant and fearful to voice to management:

> *A great deal of employees' ideas and their views on work service improvement are extremely difficult to be heard by the management. This is because of the stereotyped organizational structure that hinders the expression of employees' voice.* (SM1)

Participants spoke about how the respect for authority had an influence over norms such that employee voice was not even considered an acceptable behavior:

> *When the manager shows a paternalistic leadership style, the employee's voice is regarded as an inappropriate behavior. It is accepted that managers do not like to be instructed by subordinates to solve problems. (JN3)*

For others, the reluctance to voice was related to impression management motives, whereby employees were concerned that by raising challenging voice to management, they would be looked upon less favourably. This perspective contrasts with the notion that employees will be encouraged to voice due to impression management motives, which has been found as a positive predictor of voice in other voice studies (Zhou, Mao, Liu, & Ning, 2021) and which has also been identified as a means to enhance guanxi i.e., to improve human relationships (Xue, Song, & Tang, 2015). Therefore, rather than seeing voice as a means to improve their relationship with their leader, it was instead seen as jeopardising that relationship. Here, a junior nurse discusses her concerns that she would be overlooked for development opportunities:

> *It is not an easy task for employees to point out the mistakes of the organisation or [point out] the lack of leadership openly and boldly…I think that even if we [point] out the defects of managers' leadership, they are unwilling to adopt the corresponding changes. Instead, they may regard my suggestions as dissatisfaction with themselves, which hinders my future career development and promotion. (JN7)*

Even a more senior physician noted their reluctance to raise issues with their managers, for fear of damaging their manager's impression of them:

> *I don't [want to express] complaints [to] managers, [as it] might cause a negative effect on my working attitude from the perspective of managers. (SP)*

Despite working long hours and having concerns associated with their own wellbeing, employees felt they could not raise these issues with their managers, as this would be seen as complaining and

demonstrate that they were not capable workers, as illustrated in these comments expressed by these senior employees:

> *I felt that some of my tasks had exceeded my personal and professional levels, but I still couldn't refuse my supervisors and kept silent. I feel that the tasks for me is a sense of trust exerted by my superior...Even if the task is a little difficult, I still don't want to disappoint my supervisors...If I expressed a view that I needed help in the assigned job tasks, managers will underrate my own abilities and feel that I can't take on essential tasks. (SN2)*

And:

> *As an attending physician, in addition to the treatment of patients, I need to work overtime as well sometimes when the hospital is busy. I feel great working stress. [If I don't do overtime] it will leave a bad impression in front of the superior. (SP)*

The way in which voice had been dealt with historically at the hospital also led to norms and expectations associated with voice. For some, a lack of response from management led them to perceive that it was futile to voice, given the hospital leaders were reluctant to listen or act upon voice, as mentioned by two junior nurses:

> *Managers have a weak responsiveness [on] WeChat communication. In the past, I sent a few messages to managers in order to reveal the problems in the hospital. But I didn't receive any reply. So, I felt that I was not fully respected ... (JN6)*

And:

> *Some of the suggestions have not been implemented or responded to by the relevant [authorities] after being put forward. As a consequence, we may feel depressed and disappointed about the results of the proposal, which weakens the significance of our voices. (JN7)*

More concerning, was the fear of retaliation for voicing upward to their manager, as discussed by this assistant nurse, who indicated that it would negatively impact their psychological safety and wellbeing if they were to actually voice upwards:

> *I need to worry about whether or not I will be criticized or picked on by the manager after making suggestions , which will reduce my sense of safety . If I have been in a state of anxiety and always been frightened at work, it will increase my sense of tension and reduce my work efficiency. (AN2)*

Providing credence to this fear of retribution, one of the line managers interviewed reiterates this perception that employees may hold:

> *Employees' willingness to speak is not strong, [they are] afraid of expressing personal views...general staff are worried of vengeful actions from their line mangers after expressing concerns. Leaders may give negative feedback to employees' suggestions and ask them to [retract] these comments. (LM)*

Consequently, there was a sense of underlying mistrust between managers and employees, with employees generally hesitant to engage in voice which might be seen as challenging voice:

> *Once I put forward several questions concerning interests such as rest, vacation, and bonuses with managers, they did not respond positively and clearly but with the tone of an official reply to me. This left me feeling a bit confused and resulted in a sense of mistrust. (P3)*

As a result of these factors that inhibited vertical voice, we see that silence was one potential outcome:

> *I usually keep silent and refuse to talk to anyone. For example, I found that my supervisors would take responsibility for the good working results for themselves but attribute the job mistakes and defects to the employees. In most cases, they*

refuse to assume responsibility. Although I have realised this problem, but I choose to be silent. (JN8)

In circumstances where employees are unable to voice to their direct supervisors, studies have shown that it is sometimes the case that they may seek out other targets in authority positions such as skip-leaders (Detert & Trevino, 2010). However, in our case at the hospital, skip-leaders did not seem to be an option for voice as employees took the view that voicing to skip-leaders was considered an even more undesirable behavior. The nursing staff commented:

Overstepped voice is not allowed for common employees, which has hindered the voice initiative of ordinary staffs. (JN5)

And:

Once a nurse went over the regular ranks to speak up to the senior management personnel directly, yet the hospital considered such behavior (making suggestions) inappropriate and suggested the nurse speak up and express voice "appeals " [step-by-step] through the ranks. Such s response from the hospital management has tremendously discouraged their desire to speak up. (CN3)

Even a senior manager added:

"The method of overstepped voice is not advocated by our hospital" (SM3)

This is consistent with the findings of Yang *et al.* (2019) whose study of Chinese and Japanese employees found that speaking up to skip-level leaders rather than immediate supervisors was negatively related to evaluations of voicing. If speaking up to your boss is frowned upon, going higher can be perceived as even more disrespectful (Huang et al., 2005).

Stifling of vertical voice to preserve relationships with peers

Employees were also concerned not only about the feelings of their superiors but that they could jeopardise their relationships with their colleagues if they spoke up about individual concerns. Given the importance of guanxi within this setting, it was important to the employees that they maintained a

harmonious atmosphere. Hence, they would often remain silent on matters, such as changes to scheduling and the errors of their colleagues:

> *We have built favourable interpersonal relationships with colleagues in our daily life, but suggestions may affect the harmonious atmosphere between us and lead to a tense organisational climate...Employees worry about the impact of suggestions on arranging schedules or colleagues' work defects on the relationship between colleagues,. In order to maintain group cohesion and a harmonious organisational atmosphere, we will give up some of the suggestions. (JN7)*

An assistant nurse also noted:

> *When my supervisor arranged a schedule of work, I felt there was a conflict between work and family. But I could not talk openly even though I did not agree with the schedule...schedule rearrangements will affect the relationship with colleagues. So, I have not publicly put forward [my]suggestion...it will bring inconvenience to the work schedule arrangement of the colleagues. (AN1)*

This was also the case with more senior employees, who reiterated that they would choose to remain silent in the interest of maintaining harmonious relationships with their colleagues:

> *Although I don't agree with my supervisors [when they give preferential treatment to some colleagues], I have a relatively harmonious relationship with my colleagues. If I put forward the recommendation, it will destroy the organisational interpersonal atmosphere. (SN1)*

Hence, what has become evident throughout our study, is that the use of vertical voice to management is stifled due to leadership behaviors, norms and expectations within the hospital, and concerns for maintaining the status quo and harmony between co-workers. Consequently, this limits the ability of employees to voice on issues concerning their own interests or to offer suggestions or identify problems that could have the potential to improve organisational functioning at the hospital.

Shifting to Lateral Voice

With our findings indicating the hesitancy of employees in expressing voice vertically, we found that as an alternative to silence, employees could instead consider lateral voice to their peers and colleagues. Our data indicates that this voice could be used for a variety of ways for purposes that were beneficial for the employees and was a way to raise and might also resolve concerns and issues. As we discuss in the following section, this ranged from (i) venting, which did not necessarily resolve issues but was an important means to gain social support and ameliorate the employees' emotions concerning workplace issues; (ii) problem-solving, through exchanging ideas between themselves and subsequently finding their own solutions; and (iii) developing collective support, by using lateral voice to garner peer support that then creates momentum and a pathway for collective, vertical voice.

Venting

We find that in certain cases, while employees acknowledged the importance of voicing vertically to be able to influence decision making and to obtain solutions, on some occasions they just wanted to discuss the issue sharing their frustrations with colleagues but were not always thinking of escalation:

> *It depends on the detailed situation. If I just want to complain these problems merely, then I would talk to my colleagues. But if I would like to solve the relevant issues, suggesting with superior may be an ideal method. (JN1)*

For some employees, lateral voice provided an opportunity to express their feelings and seek the support of their peers, enabling them to discuss some of their workload pressures:

> *I will tell the trusted colleagues in my innermost thoughts to seek mutual support and understanding so that I can obtain emotional satisfaction. (JN2)*

And:

> *I have more contact with assistant nurses and junior nurses. We mainly concern about work and family topics. [When] there is too much stress in my work and too*

many problems in my family, such as duty on weekends, salary reduction and parents' illness, I will talk with my colleagues to seek consolation. (SN2)

In contrast to the mistrust and distance felt toward the managers, there was typically a strong sense of collegiality between the colleagues and peers, creating a context of trust where lateral voice was able to flourish:

I have intimate communication with my colleagues in the same working room. We mainly focus on the coordination of mutual daily work...I would talk with my colleagues [regarding any issues]. (AN2)

As Loudoun et al. (2020) identified, this form of peer-to-peer voice is particularly important in high stress work environments to help cope with workplace demands and to buffer against the stresses they experience at work. Given that employees at this hospital did not feel comfortable expressing their frustrations to their leaders, this venting is important for these employees:

I am able to share my troubles with my colleagues at the appointed occasion. Thus, releasing the emotional tension caused by the pressure in busy work...I would raise these problems with my colleagues in the same department. I would discuss with my colleagues if there are existing several unreasonable management institutions in our hospital. (P3)

Problem-solving

We also found that lateral voice could be used to solve employee concerns amongst themselves. Through a regular exchange of ideas, we see that employees are able to explore solutions to everyday problems related to patient care as well as how work is organised. This is exemplified in these comments from junior nurses who sought solutions to problems through talking with their peers, rather than approaching managers:

I feel it is necessary for me to consult with colleagues and deal with the solution together. For example, the problem of too many patients and the shortage of our medical staffs in the hospital can only be discussed among colleagues [because]

> *there have been employees who [voiced] the problem to the hospital leaders, [but] the leaders replied that they can't change the current situation [and are only] arranging more employees to work overtime, so we often talk about it privately. (JN5)*

And in this instance, where the junior nurse spoke to colleagues at a similar level who were outside of her department:

> *I have more communication with colleagues in the other department...if I am faced with some difficult issues or vague questions, I choose to share problems with colleagues and ask for recommendations from them. (JN6)*

The voice literature assumes issues must go to superiors as they have the authority and resources to solve problems, but this ignores worker agency and how they can combine to solve problems themselves.

Developing collective support

Aside from using lateral voice to vent and to find their own solutions, we found that employees were voicing to their peers and that this sometimes transitioned to collective vertical voice. Shared experiences whereby employees were faced with similar issues and difficulties were often discussed among peers. Over time, these peer conversations between each other meant that there was increased support from their peers to voice these shared issues together and vertically up the management chain. Hence, employees could use lateral voice to garner support and the confidence to build a coalition and to then voice to managers as a group. For example, one physician discussed how they were able to use this tactic to then collectively approach their leaders to resolve issues related to staff housing:

> *There [was not] any housing or dormitory provided for us [earlier], so we had to assume the expensive costs of renting [accommodation]. Later, we obtained an opportunity to talk about this problem together with the Dean and the hospital leaders and they promised to arrange accommodations for us. (P2)*

Similarly, a nurse explained how lateral, peer-to-peer discussions on issues related to scheduling which was affecting their staff work-load and their ability to effectively manage their patients during weekends, was eventually collectively voiced vertically to improve overall individual and organisational outcomes:

> *We [together] proposed that the number of doctors and nurses should be increased during the busy weekend. At last, the hospital leaders arranged doctors to work overtime according to the number of specific visitors. (JN3)*

A recurring issue of car-parking space was also solved through lateral voice moving to a collective form. The issue concerned new parking regulations allowing senior managers to pay less for parking than other employees who had problems in accessing car parks in busy visitor times. A chief nurse elaborated:

> *In the past, everyone in the hospital could enjoy free parking. However, after the [new regulations], the hospital staff are graded in accordance with their respective job titles. Senior directors such as the Dean, the Department Chiefs and Directors can park in the underground parking lot with only 200RMB a month; and the general staff have to pay 15 RMB a day for the ground parking lot. It is unfair. (CN2)*

Employees discussed this matter individually with their peers before the issue was escalated to the management through the Worker's Representative Congress, a formal, representative organisational level forum for employee voice in the organisation. Below we see a junior nurse discussing how this issue was voiced laterally, in the first instance:

> *[My colleagues and I] even discuss[ed] the relevant institutional measures like parking reform schedule which is formulated by the management. Through these discussions, we are able to reach an agreement [with each other] easily. (JN7)*

Their Congress Representative then put forward suggestions to management:

> *I am also a representative of the staff congress; the previous problem of parking lot charging was solved through the channel of Congress. This [new car parking] system is not very reasonable, because the staff on the night shift needs to pay twice. Everyone put forward their personal opinions and the hospital eventually decide to stop charging workers who have overtime on weekends. So, this problem has been partly solved. (LM)*

Our findings suggest that for lateral voice to gain legitimacy and be taken seriously by authority figures, it needed to represent the collective voice of employees. A junior nurse said:

> *It may be that our [joint] proposal represents the voice of the vast number of front-line employees and obtains the support and understanding of our colleagues. Thus, [positively] affecting managers' attitude towards the problem. (JN7)*

A senior nurse emphasised the importance of the role of lateral voice being used first before using a representative to voice on behalf of the collective:

> *I think the [junior] staffs should choose representatives to reflect issues, this is due to their blind, radical, and even irrational views on some problems in several cases, so there should be representatives with perfect morality and behavior integrating the contents of employee voice and improve the quality of the content. (SN2)*

So here, we see the importance of informal lateral voice used to discuss issues, garner support, and then be collectively raised to management in order to achieve positive outcomes for employees. Therefore, the role of lateral voice is augmented where voicing vertically is not deemed safe or considered unlikely to bring about any suitable outcomes. In voicing laterally to peers, we find that not only are they able to find solutions, but in sharing concerns regarding employee interests and experiences, they are able on occasion to influence decision making and bring about change.

Discussion

Our findings demonstrate that in our case context including authoritarian leadership, collectivism, and the need to maintain guanxi i.e., harmonious relationships in the workplace, shaped how employees in our hospital case study chose to voice vertically and laterally. While the restriction of vertical voice in the context of authoritative leadership in this sample reinforces the findings of Wei et al. (2015), Jia *et al.* (2020) and Y. Zhang *et al.* (2015), we observed that lateral voice might be a more viable path in such contexts.

The importance of using lateral voice that transitions to collective vertical voice is reinforced here because not only does it seem to provide a suitable avenue for employees to assess possible outcomes (especially if the issue is collective in nature) of voice itself, but it can also be seen as an essential component of *refining* voice, with this lateral dimension serving as a step towards eventual formal expression of concerns and issues to vertical targets (Subhakaran *et al.* 2020). As Klaas, Olson-Buchanan, and Ward (2012) emphasised, voice expressed through formal mechanisms may lead to actionable outcomes as opposed to non-formal mechanisms. So, while employees may discuss issues together informally first, formalising voice through collective vertical channels seems to be an important part of voice culture in this context.

We can also see that it is possible that voice that initiates as lateral voice and is expressed as a result of frustration and dissatisfaction, may build into a coalition as co-workers see they share interests. Our findings also indicate that lateral voice provides employees an outlet to talk about workplace stress which in turn, makes them feel supported. This is important for professions in healthcare where their inability to raise voice may result in increased apathy, which eventually affects patient care and safety outcomes (Creese et al., 2021). The use of collective voice may also shift the initial motivation of dissatisfaction into a pro-social motivation, as the issue expressed becomes a collective issue that can be packaged or represented by the employees as a means to improve the organisation.

This is an important implication because while some findings from this study do seem to align with previous communication literature about lateral dissent taking place in an overall unfavourable

climate due to individual or organisational issues (Garner, 2012; Goldman & Myers, 2015; Kassing, Fanelli, & Chakravarthy, 2018; Payne, 2007), voice researchers have largely discounted lateral voice in their studies due to the notion that it is the "upward" communication of ideas, suggestions, problems and concerns (Morrison, 2011). Hence, given voice is a construct different to dissent, little is known about how and why lateral voice is used and how it can be beneficial for employee and organizational outcomes. Our study shows that lateral voice can be used for venting and problem-solving but that it can also transition to vertical collective voice. Therefore, by voicing laterally, employees may not only cope with stress and solve everyday issues, but also gather support for their voice in order to better express it to authority targets later on.

Our study reinforce how high-power distance and authoritative leadership can discourage employees from voicing altogether if employees feel that they will have to bear negative consequences from speaking up. However, we see the role of lateral voice as an important step towards allowing employees to not simply exchange ideas or vent, but also gain legitimacy and influence decision making.

Conclusion & Future Directions

This study looks at voice patterns in a Chinese hospital hence answering the call to further explore voice in different cultural and institutional contexts. We note that as in other contexts, authoritative leadership restricts vertical voice due to mistrust and fear of negative consequences such as retaliation by managers, and these fears are accentuated in our context where respect for hierarchy and the need to maintain harmonious relationships are embedded. We observe that lateral voice emerges from this as employees speak to each other about day-to-day issues to provide support, sometimes venting but also to discuss matters they do not feel comfortable speaking about to their superiors. Having said that, the collectivist culture means they are wary of voice if it potentially damages relationships with colleagues, hence diluting lateral opportunities to voice. Nevertheless, we do identify that lateral voice is important in not only allowing employees to have a say when they feel vertical options are not inviting but may also help refine voice.

Our findings showing the importance of lateral voice have practical implications for organisations. Given that venting and the sharing of frustrations between peers may help to reduce stress, providing informal opportunities for co-workers to discuss these issues may be beneficial. For example, providing common staff eating areas and scheduling breaks at the same time to enable peers to discuss these issues amongst themselves. To improve opportunities for co-workers to share ideas and problem-solve together, an anonymous suggestion board could be used where issues are raised and then discussed in team briefings. Our study has shown the value of lateral voice in transitioning to collective vertical voice. To support this, organisations could design worker committees to enable voice to be escalated by a representative and in doing so should provide opportunities for co-workers to meet amongst themselves to discuss issues before being taken up by the representative.

Findings provide further support that lateral voice is an important component of voice behavior and deserves further exploration. While we show that employees seemed to prefer to voice laterally not only for relieving stress but also for solving operational issues, further research is required to understand the intricacies that guide employee's decision to voice laterally as opposed to vertically. This is especially important to understand when employees want to maintain good relationships with their colleagues, however, in doing so, some voice may be lost so as not to damage peer relationships. Therefore, further study on exploring the antecedents of lateral voice may help explain employees' decision process to voice laterally.

We note that our participants were predominantly female and it is possible that females may be more inclined to openly communicate with their peers (Harlos, 2010). Similarly, our study involved participants who are medical professionals and considered high-status workers, where lateral voice, particularly related to patient concerns (Wilkinson *et al*., 2020), may be more expected. Understanding the differences between genders, status and professions and their use of lateral voice are avenues for future research. Given our study focused on one hospital in a Chinese setting, it is possible that different organisational climates, country cultures, and industries may provide different contexts with alternative findings. Therefore, it would be worthwhile to examine lateral voice in these

different contexts or in comparative studies, to elucidate the role these contextual factors play in relation to lateral voice.

Future research could seek to understand the preferred channels adopted for lateral voice. Here we saw that formal channels for collective voice i.e., the Congress, seemed to work well. However, employees mostly seemed to discuss issues amongst themselves informally before simply reaching out to relevant authority figures to voice their concerns. In addition, with technology transforming how communication takes place (Holland & Bardoel, 2016) it would be worth exploring in the future if new communication channels, such as social media, provide better opportunities for lateral voice.

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