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All Eyes on Me: The Impact of Individualism vs. Collectivism Orientations on Justice Perceptions and Mistreatment of Frontline Staff in Emergency Departments

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Abstract

Mistreatment of frontline staff is a widespread issue across all industries, but is particularly prevalent in Emergency Departments (EDs). This paper examines how the orientation toward individualism vs. collectivism of outsiders—namely, patients and their escorts—affects their perceptions of justice within EDs and subsequent mistreatment of frontline staff. We conducted two field studies in major hospitals to test our hypotheses. The first study validated our model, and revealed that mistreatment was particularly likely by outsiders oriented toward individualism. The second study replicated our findings and implemented an intervention that significantly enhanced justice perceptions among these outsiders, subsequently reducing their propensity to mistreat ED staff. Our results offer new insights into the dynamics of mistreatment within EDs, emphasizing the impact of outsider expectations on their perceptions of justice and subsequent behavior.

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Introduction

Workplace mistreatment is a significant and widespread issue that disproportionately affects frontline staff (Yuan et al., 2021). While mistreatment is present in all industries where employees interact with the public, healthcare staff account for roughly 75% of all workplace injuries caused by violent conflicts in the United States (Bureau of Labor Statistics, 2018). Emergency Departments (EDs) are particularly volatile environments where heightened emotions can lead to tense interactions. ED outsiders, such as patients and their escorts, often experience anxiety while waiting for treatment (Nairn et al., 2004), which can manifest as frustration and contribute to mistreatment directed at healthcare providers (Akerstrom, 1997; Reyt et al., 2022). In fact, research finds that outsiders are responsible for most of the violence in EDs (Ori et al., 2014; Taylor & Rew, 2011).

Mistreatment, which often begins with negative comments or disparaging gestures, holds the potential to spiral into more severe conflict and violent acts, such as physical assaults (Baron & Neuman, 1996). Importantly, any form of mistreatment, regardless of its intensity, poses significant risks to the mental health of staff (Hershcovis & Barling, 2010), with consequences including burnout, anxiety, and depression (Schonfeld et al., 2019). The cumulative effect of ongoing exposure to conflict and mistreatment can lead to increased absenteeism, elevated staff turnover, and diminished productivity (Nahrgang et al., 2011), which are estimated to cost the global economy between hundreds of billions and over a trillion dollars annually (Dhanani et al., 2021). Taken together, these factors underscore the importance of addressing all forms of conflict that can lead to mistreatment—not just the overtly violent ones—in healthcare settings.

Regrettably, healthcare institutions frequently address mistreatment only after it escalates into physical violence, relying on reactive measures such as security guards, duress buttons, de-escalation protocols, and staff self-defense training (Pich et al., 2011; Wiksow, 2003). This reactive approach has normalized abuse in the eyes of many medical professionals, leading them to perceive outsider mistreatment as an intrinsic aspect of their roles (Jones & Lyneham, 2001; Gates et al., 2006). Recently, organizational research has been advocating for a more *proactive* approach, stressing the need to understand the antecedents of mistreatment in order to preemptively counteract them (Hershcovis et al., 2020). Our paper falls within this context, exploring (1) the underlying contextual and psychological triggers that prompt outsiders to mistreat staff, and (2) actionable strategies enabling healthcare organizations to curtail such conflicts, fostering a culture of safety that safeguards employee well-being.

We take inspiration from the General Aggression Model (Anderson & Bushman, 2001) to argue that both situational and personal factors contribute to mistreatment. First, regarding the situation, ED resources are allocated based on triage, whereby medical staff determine the urgency of patients' treatment needs and the order in which they are seen (Robertson-Steel, 2006; Lauridsen, 2020). This process magnifies the significance of procedural justice in deciding who receives immediate care and who must wait (Zhu et al., 2022). Situations such as witnessing perceived preferential treatment can trigger feelings of injustice from outsiders, leading those who feel unfairly treated by the ED to

manifest their frustrations through mistreatment, targeting staff members seen as organizational representatives (Naumann & Bennett, 2000).

Further complicating matters are individual perceptions. Central to understanding perceptions of justice within EDs are individuals' expectations about the importance of their personal needs relative to collective needs. This dynamic can be examined through the lens of orientation toward individualism vs. collectivism (I/C orientation)—a cultural dimension widely applied to understand personal perceptions and responses in various situations (Hofstede, 1984; Triandis, 1995; Liu, 2011). For instance, people oriented toward individualism may perceive a long wait or the prioritization of others' needs over their own as a violation of what they consider to be legitimate expectations. Conversely, individuals oriented toward collectivism might react negatively to policies that they perceive as undermining group welfare, such as restrictions on escorts accompanying patients into treatment areas. Such violations of expectations can lead to perceived injustice and, consequently, contribute to mistreatment (Ramirez Martin et al., 2019).

To test our model, we conducted two field studies in major hospital EDs. In Study 1, we established that outsiders' I/C orientation influenced their justice perceptions in EDs, which in turn affected their intentions to mistreat staff. Further, we found that the effect was predominantly driven by outsiders oriented toward individualism, who showed significant sensitivity to violations of their personal needs. In Study 2, conducted in a different hospital, we replicated our initial findings and implemented an intervention which provided individualized attention to ED outsiders. Our intervention successfully enhanced perceptions of justice among outsiders oriented toward individualism regarding the triage process, thereby reducing their intentions to mistreat staff. Our research offers new insights into how I/C orientation can influence perceptions of justice and mistreatment, and proposes effective measures to mitigate such issues in ED settings.

Our research contributes to the literatures on workplace mistreatment, cultural values in organizational settings, organizational justice and conflict theory. First, we contribute to the literature on workplace mistreatment by addressing the antecedents of mistreatment and highlighting strategies for healthcare organizations to preemptively address abusive behaviors, potentially preventing escalation into severe aggression and violence. Second, we contribute to the literature on cultural values by challenging the assumption that all individuals react similarly to potential transgressions. We propose that an individual's I/C orientation is a crucial determinant in how they perceive and respond to mistreatment of frontline staff, refining previous insights about sensitivity to perceived transgressions. Third, we contribute to the justice literature by examining how perceived justice influences aggressive behaviors and mistreatment. Last, we contribute to the literature on conflict theory by highlighting that not all people perceive conflicts equally, rather, the conflict is perceived through the cultural lens of the parties involved. Therefore, by understanding their cultural orientations, one can predict how the conflict will develop, whether it will escalate into mistreatment, and how to ease the conflict by being sensitive to what is important to people from various cultural orientations.

Our findings suggest that an individual's I/C orientation significantly influences their perception of fairness, affecting their reactions to perceived transgressions and their subsequent mistreatment of those they see as responsible.

Theory and Hypotheses

Outsider Mistreatment of Employees

Workplace mistreatment refers to a range of harmful social behaviors that vary in severity (Hershcovis et al., 2020) and are studied under different labels, including incivility (Mao et al., 2019; Montgomery et al., 2004; Paulin, & Griffin, 2017; Walker et al., 2017), aggression (Bowler et al., 2011; Hershcovis et al., 2007; Lisak et al., 2021), deviance (Bennett & Robinson, 2000), and violence (Efrat-Treister et al., 2019; Van Emmerik, et al., 2007). On the proximal end of the mistreatment continuum, incivility might involve disparaging comments and negative gestures (Walker et al., 2017; Pearson et al., 2000), while on the distal end, violence may involve physical assaults (Neuman & Baron, 1998).

Research on workplace mistreatment is largely focused on how coworkers mistreat each other (Hershcovis, 2011; Hershcovis et al., 2007). Although coworker dynamics can be a breeding ground for mistreatment, it is essential to note that a significant portion also arises from people who are not members of the organization (Karaeminogullar et al., 2018). Thus, following the distinction made by Grandey et al. (2004), we contrast *insider* mistreatment, which comes from organizational members, and *outsider* mistreatment, which is perpetrated by customers and visitors. Outsider mistreatment is typically directed toward frontline staff—employees who form the link between the organization and the public (Bettencourt & Brown, 2003). The term "outsider" reflects that mistreatment comes not only from customers or patients; it can also originate from other external sources, like visitors, family members, or others. For example, a restaurant host might experience noise complaints from a displeased neighbor, a security guard might endure aggressive behavior from an intoxicated visitor, and a nurse might face negative remarks from a patient's relative.

Frontline staff face a considerable amount of outsider mistreatment for various reasons, the main one being that their work involves interacting with many individuals daily (Emanuel et al., 2020). Furthermore, unlike insiders who might moderate their behavior due to the expectation of future interactions with colleagues, outsiders often lack such constraints (Grandey et al., 2007). The fact that no ongoing relationship is expected can diminish inhibitions, potentially leading to more frequent and intense confrontations (Kiesler et al., 1984). Finally, members of certain professions are required to frequently interact with individuals in pain, under the influence of illicit or abuse-prone substances, or experiencing mental health crises, increasing the risks of mistreatment (Blanchard & Curtis, 1999).

Outsider mistreatment is widespread across all service sectors, yet it is particularly acute in EDs. Research highlights that a majority of ED staff in North America consider outsider mistreatment an expected part of their job (Copeland & Henry, 2017; Stene et al., 2015; Hesketh et al., 2003). Similar issues were documented in Europe (e.g., Winstanley & Whittington, 2004; Vezyridis et al., 2015), Asia (e.g., Alyaemni & Alhudaithi, 2016; Sachdeva et al., 2019), Oceania (e.g., Lyneham, 2000; Pich et al., 2017), and Africa (e.g., Adeniyi & Puzi, 2021). These widespread reports from different continents underline the global scale of this issue, leading researchers to describe outsider mistreatment in EDs as an "epidemic" (Chapman & Styles, 2006; Gates, 2004; Quintal, 2002; Reddy et al., 2019).

EDs typically have protocols in place to repress mistreatment *after* it has escalated into aggression and violence, including hiring security personnel, installing duress buttons, and teaching staff de-escalation techniques and self-defense (Pich et al., 2011; Wiksow, 2003). However, addressing milder forms of mistreatment, such as cursing, yelling, or offensive language, can be challenging (Barling et al., 2009; Grandey et al., 2007; Efrat-Treister et al., 2020a; Reyt et al., 2022). These more subtle acts of mistreatment are more difficult to quantify and prove, and often slip through policy gaps (Scholz, 2024). As frontline workers are often required to remain composed under provocation,

this dynamic effectively allows such mistreatment to occur without significant consequences for the aggressor (Hochschild, 1983, Rafaeli, 1989; Rafaeli & Sutton, 1990).

Yet mild forms of mistreatment are not harmless. Not only can they escalate into physical violence, they can also have severe psychological impacts on employees, such as depression, anxiety, and stress, as well as cognitive repercussions, such as reduced working memory capacity and impaired creative problem-solving (Miron-Spektor et al., 2011; Rafaeli et al., 2012; Zhou et al., 2019). In addition, the financial repercussions of outsider mistreatment can be crippling for organizations. The cumulative effect of ongoing exposure to mistreatment often results in increased absenteeism, elevated staff turnover, and diminished productivity, which together have been estimated to cost between $691.70 billion and $1.97 trillion globally every year (Dhanani et al., 2021). The debilitating consequences of mistreatment on employees, combined with the sheer magnitude of these costs, underscore the importance of addressing and curtailing such behaviors.

Organizational Justice and Outsider Mistreatment

To effectively address outsider mistreatment of frontline staff in EDs, it is essential to understand the core concepts influencing these settings. EDs face the challenge of having a fixed number of caregivers while dealing with variable demand that often exceeds their capacity (Van De Ruit & Wallis, 2020). Consequently, outsiders seeking care gather in waiting areas until called for treatment by clinicians. EDs worldwide struggle with overcrowded waiting areas, with research reviews on ED crowding calling the situation an “international crisis” (Hoot & Aronsky, 2008), a “global problem” (Carter et al., 2014), and a “major global healthcare issue” (Morley et al., 2018). Several factors have been identified as contributing to overcrowding in EDs, including poor access to primary care, ED nursing staff shortages, and an increase in the complexity and acuity of patient needs (Morley et al., 2018).

Unlike other organizations facing high demand relative to supply, EDs do not operate on a first-come, first-served basis. Instead of an *egalitarian* approach that gives everyone an equal opportunity to access care, EDs use a *utilitarian* approach that aims to maximize the common good (Greenacre & Fleshner, 2017). This is where the concept of triage comes into play. Originating from the French word “trier,” meaning to sort, triage systems prioritize patients based on the severity of their health conditions (Yancey & O’Rourke, 2022). Upon arrival, patients are evaluated by a medical professional, typically a nurse, and categorized according to the urgency of their situation using various systems such as numbers, labels or colors (Yancey & O’Rourke, 2020). Highly urgent cases receive priority care, while lower-priority patients wait until resources become available. This method aims to ensure that those in greatest need receive care promptly, with the ultimate goal of maximizing collective well-being over individual convenience when resources are limited (Möller et al., 2010; Robertson-Steel, 2006; Bazyar et al., 2020).

The triage process is a crucial aspect of the patient experience in EDs, and often a major point of contention between staff and outsiders (Janerka et al., 2024). For example, in a study on patients’ perception of an ED triage process, half the participants disagreed with the category they were assigned at triage and believed they deserved to be given higher priority (Toloo et al., 2016). For low-priority patients, the situation is even more challenging, as they frequently wait more than four hours to receive medical care (Al Nhdi et al., 2021; Paling et al., 2020). Low-priority patients often feel “powerless, insulted, and humiliated” when their care is delayed for reasons they do not fully understand (Dahlen et al., 2012). The result is that the ED visit, already stressful, becomes a highly negative experience, with patients left feeling undervalued and neglected (Shah et al., 2015).

In the chaotic and overcrowded environments of EDs, outsiders are acutely aware of the limited availability of resources (Lauridsen, 2020). Instead of fostering understanding and acceptance of treatment delays, this awareness often heightens their sensitivity to perceived disparities in care. Outsiders may feel particularly aggrieved when they perceive that the attention they receive deviates from what they consider "fair," "deserved," or "just" (Adeniji & Mash, 2016; Reblora et al., 2020; Möller et al., 2010). For instance, seeing another patient receive priority treatment without understanding the criteria underlying the decision can trigger feelings of injustice and suspicion about ED procedures. Consequently, outsiders' perception of procedural justice—concerning the fairness of the processes used to decide who receives resources (Colquitt et al., 2001; Greenberg, 1990)—becomes particularly central to their experience while waiting in an ED (Effrat-Treister et al., 2020b; Miles & Naumann, 2004)

Extensive research has documented the role of perceived justice in interpersonal mistreatment between organizational insiders. Employees' perceptions of injustice in the workplace are associated with negative reactions such as retaliation, aggression, sabotage, and other forms of counterproductive work behavior (e.g. Greenberg, 1990; Skarlicki & Folger, 1997; Aquino & Lamertz, 2004; Robinson & Bennett, 1995). Some studies suggest that this relationship exists with outsiders as well. In various service settings, Clemmer and Schneider (1996) showed that outsiders' perceptions of justice crucially impacted their satisfaction and the likelihood of revisiting a service provider, whether in banks, doctor's offices, or restaurants. Additionally, research in healthcare settings has found that patients' perceptions of organizational justice are positively related to their satisfaction, trust in clinicians, and overall justice evaluations (Pérez-Arechaederra et al., 2014). Finally, a study by Efrat-Treister et al. (2020b) on emergency department waiting times demonstrates how perceived justice—or its absence—can provoke aggression.

Several theories support an association between perceived injustice and outsider mistreatment in EDs. First, the frustration–aggression hypothesis suggests that when individuals feel frustrated due to perceived injustices, their frustration can escalate into aggression (Berkowitz, 1989). This aggression is often directed towards those immediately available, such as frontline staff, regardless of their direct involvement in the injustice. Second, a perceived lack of justice can also lead outsiders to feel a loss of control, which may heighten their propensity to restore control through confrontational or aggressive behaviors (Tyler, 2006; Tyler & Blader, 2003). Finally, the concept of restorative justice suggests that individuals may engage in mistreatment as a means of seeking retribution and rebalancing the scales of justice in their favor (Wenzel et al., 2008). This approach is seen as a way to punish the perceived source of injustice and deter future unfair treatment. Together, these mechanisms suggest a clear pathway from outsiders' injustice perceptions to their mistreatment of frontline staff in EDs.

Therefore, we propose:

H1. Outsiders' perceptions of justice are negatively related to mistreatment of frontline staff.

I/C Orientation and Justice Perceptions

Perceptions of justice are complex and inherently subjective. Different outsiders may perceive the same situation as either fair or unfair, a fact which explains why the same situation may escalate into mistreatment among some individuals but not others. Research also suggests that the interplay between individuals and their environment significantly influences the likelihood and severity of mistreatment behavior (Hershcovis et al., 2020). This idea aligns with Anderson and Bushman's (2001) General Aggression Model, according to which aggression results from the interaction between personal characteristics and contextual factors.

While outsiders are not formal members of the organization, they engage in a transactional relationship with the organization during their visit. This relationship establishes expectations similar to those experienced by insiders regarding the fairness and quality of treatment they receive. In fact, a great deal of research has focused on understanding and managing outsider expectations regarding ED triage processes (e.g. Watt et al., 2005; Cooke et al., 2006; Shah et al., 2016; Alnaeem et al., 2024). When these expectations are not met, outsiders, much like employees, may perceive an injustice. The formation and nature of outsider expectations can vary significantly based on broader societal contexts and personality factors. Therefore, it is crucial to identify the factors among outsiders that can shape their expectations and, subsequently, their perception of justice in EDs.

In modern society, humans face a complex paradox: while we rely on large groups for collective survival and well-being, our individual access to resources is often determined on a personal basis. This inherent tension between group reliance and individual achievement underscores the diverse expectations people develop regarding how they should be treated. For example, individuals who prioritize their personal needs may expect EDs to treat them swiftly, considering this as a measure of fairness and respect. Conversely, those who prioritize the collective might expect the ED to focus on group needs, such as letting patient escorts come into treatment areas for moral support. Variations in expectations can lead to markedly different perceptions of the same situation: what one person views as just, and an efficient use of resources, another might perceive as an unjust violation of their expectations. Therefore, we propose that the extent to which outsiders prioritize personal versus collective needs, or their orientation toward individualism vs. collectivism (I/C orientation), significantly influences their perceptions of justice in ED operations.

According to Hofstede (1980), individualism and collectivism represent two ends of a cultural continuum influencing perceptions, societal expectations, and behavior. On the individualism side, Hofstede describes a cultural orientation that prioritizes personal rights over duties. People in individualistic societies are encouraged to express and assert themselves, and their social behavior is largely shaped by their personal goals and the direct benefits to themselves. Conversely, in collectivistic societies, priorities shift significantly toward the interests of the group rather than the individual. Relationships are characterized by a deep sense of interconnectedness, with identity often rooted in group affiliations and communal achievements. Loyalty to the group and conformity to societal norms are paramount, with personal sacrifices frequently seen as necessary for the greater good of the community. This cultural orientation emphasizes the importance of maintaining harmony and providing support within social networks, thus influencing how justice, responsibilities, and rewards are perceived and distributed among group members.

Since Hofstede's (1980) work, the constructs of individualism and collectivism have become prominent in management and other fields, although their conceptualization remains controversial and subject to debate. Some researchers view individualism and collectivism as opposite ends of a single continuum, while others consider them as two (or more) independent constructs (Taras et al., 2014; Wong et al., 2018; Fatehi et al., 2020). Moreover, how individuals conceptualize and apply these constructs seems to be highly context-dependent (Taras et al., 2014). For instance, an individual might prioritize collectivist values within family settings but adopt individualist behaviors in the workplace. In this paper, we specifically examine how individuals prioritize different needs while awaiting treatment in an ED. We propose that in this context, one cannot simultaneously prioritize personal needs and collective needs. Thus, despite the ongoing debates surrounding their conceptualization, we believe that in our study's context, it is appropriate to view individualism and collectivism as existing on a continuum.

People oriented more toward individualism and those oriented more toward collectivism may perceive justice based on different factors. For example, Tata (2005) shows that the perceived fairness

of grading procedures among students in the United States and China reflects cultural values of individualism and collectivism, respectively. In that research, American students valued having a voice in the grading process by being able to discuss and appeal grades. This is in keeping with their individualistic orientation, with personal rights and individual agency paramount. Conversely, Chinese students, coming from a more collectivistic culture, valued being treated with dignity and respect and appreciated clear explanations about grading procedures, indicating higher sensitivity to the communal aspects of justice.

I/C orientation is not just a macro-cultural phenomenon, but also operates within sub-groups and individuals, as demonstrated by Oyserman et al. (2002). They found considerable variability in individualism within the same cultural group, underscoring the complexity of predicting justice perceptions based solely on cultural background. Therefore, when examining the relationship between cultural values and perceived justice, it is crucial to consider not only overarching cultural norms but also the individual's personal alignment with these values.

In ED environments, where quick decision-making is essential, cultural and personal perspectives on justice influence how outsiders perceive and respond to the prioritization of care. Outsiders oriented toward individualism may expect immediate and personalized attention to their needs. They may be particularly sensitive to instances where they perceive their needs as not being addressed promptly enough, as when they witness others receiving attention ahead of them. Conversely, outsiders oriented toward collectivism may be more sensitive to situations that violate communal needs. For instance, if an ED policy forbids companions in treatment areas, outsiders oriented toward collectivism may perceive the policy as disregarding the familial or community support essential in times of crisis. In both cases, the result for the outsider is a sense of injustice, either in policy or practice.

In short, we expect an outsider's personal I/C orientation to interact with specific situational factors, and specifically the types of needs that they perceive as being violated. This in turn shapes their perceptions of justice and, consequently, their likelihood of mistreating frontline staff. Thus, we predict (see Figure 1):

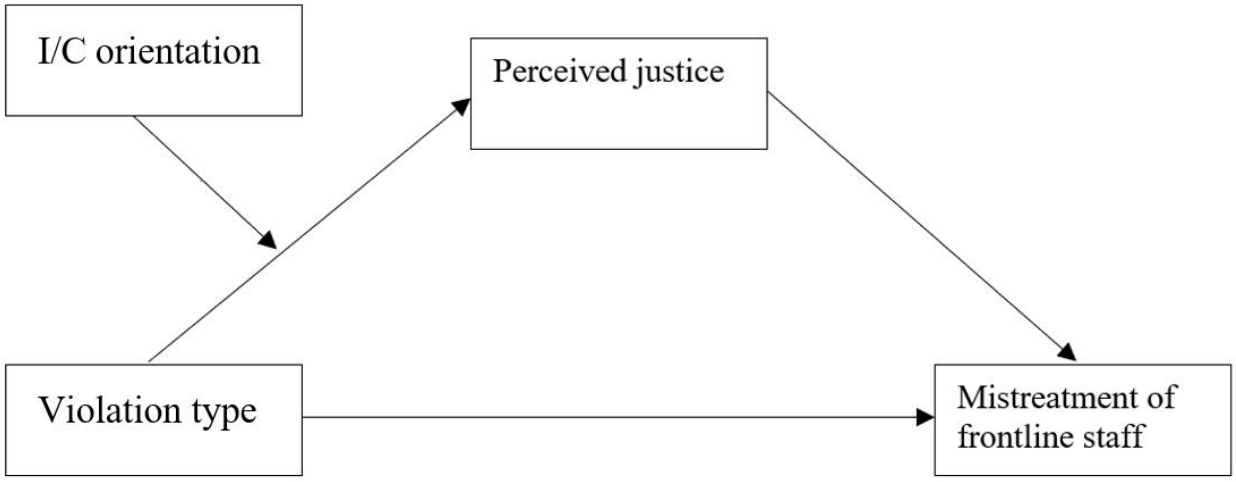
H2. Outsiders' I/C orientation moderates the relationship between violation type (violation of individual needs vs. group needs) and justice perceptions. Outsiders oriented toward individualism will perceive violations of their individual needs as less just, while outsiders oriented toward collectivism will perceive violations of the group's needs as less just.

H3. Outsiders' I/C orientation moderates the relationship between violation type (violation of individual vs. group needs) and mistreatment of frontline staff via perceived justice (moderated mediation).

Research Overview

We conducted two studies to examine our predictions. In both studies, all participants were escorts of patients approached in the ED waiting area while the patient was within the ED. This decision was made at the request of the EDs to ensure that our research did not obstruct the critical processes and care provided to the patients themselves. Our research assistants invited the escorts to complete a brief survey in exchange for a small, sugar-free snack. In both studies, we first asked participants to complete a measure eliciting their I/C orientation. Then, they were presented with a vignette describing an ED-related scenario that violated either individual or group needs, employing a between-subjects design. Subsequently, participants indicated how they perceived the justice of the scenario, reported their inclinations towards mistreatment, and provided demographic information.

Figure 1. *Research Model, Study 1*



Study 1 was conducted to test the interaction between participants' I/C orientation and the violation type to predict their justice perceptions and their inclination towards mistreatment. Study 2 replicated Study 1's procedures in a different hospital, and included an intervention to increase perceptions of justice and reduce mistreatment of staff among outsiders.

The research was approved by the following Helsinki committees: Carmel Medical Center Helsinki Committee, approval number: CMC-0073-13; Soroka Medical Center Helsinki Committee, approval number: 0126-16-SOR.

Study 1: Individualism/Collectivism Orientation, Perceived Justice, and Mistreatment of Frontline Staff

Methods

Sample & Procedure

Study 1 was conducted in the EDs of two large public hospitals: a city hospital (500 beds, average of 200 patients a day) and a suburban hospital (700 beds, average of 350 patients per day). The sample size for this study was determined using G*Power V.3.1.9.4. The calculation was based on a linear multiple regression with a fixed model and regression coefficients, aiming for 80% power and a 5% significance level (α), with an anticipated medium effect size (Cohen's d=.06). To account for potential non-responses, we increased the sample size by 10%. As a result, our target sample size was at least 141 participants. Ultimately, we gathered data from 151 individuals who met the Helsinki Committee's inclusion criteria, which are (1) participated voluntarily and (2) were aged 18 or older, were mentally stable, understood the survey, and provided informed consent (Hospital A: N= 97; average age = 47.32; 47.2% female; Hospital B: N=54, average age = 44.81; 44% female).

The study employed a between-subjects design, where participants were randomly assigned to read one of two different vignettes. Then, they were asked to complete a survey that assessed their perceptions of justice related to the scenario described in the vignette, their I/C orientation, and their inclinations toward mistreatment. To ensure inclusivity, the vignettes and surveys were translated into all languages spoken by the patient population, following the approach utilized by Cha et al. (2007). The surveys were administered by research assistants who were fluent speakers of the various

languages spoken in the ED, and were kept unaware of the study's hypotheses, aligning with the methodology employed by Hulin and Mayer (1986). Each survey took approximately 10 minutes to complete, and participants were subsequently thanked and given a sugar-free snack as a token of appreciation.

Violation Manipulation

We adapted vignettes from Efrat-Treister's 2014 study, which identified ED scenarios that can be perceived as violations and, at times, escalate into mistreatment. From this pool, we selected two specific violations of different expectations. The first portrayed a situation where staff cared for a recently arrived patient ahead of someone who had been waiting for a long time. This situation implies a prioritization of the group's need over individual needs, and we hypothesized that it would be judged as less just by participants oriented toward individualism. The second scenario involved ED staff forbidding a group of family members and friends from accompanying a patient into the ED treatment areas, thus appearing to violate group needs. We anticipated that this scenario would be judged as less just by people oriented toward collectivism. For the full text of the vignettes and the expectations they violate, see Table 1.

Table 1. *Vignettes Depicting Violation Types (Violation of Individual vs Communal Needs)*

Violation type	Expectation violated
1. ***Individual needs:*** The emergency room is very crowded. A staff member allows someone who came in after the patient to see the doctor first.	Self, personal goals
2. ***Collective needs:*** A patient arrives at the ED accompanied by several escorts, but hospital staff allow only one family member into the emergency room.	Community, in-group goals

Meaures

I/C Orientation was obtained using the individualism–collectivism subscale of Dorfman and Howell's (1988) measure. To calculate our I/C orientation variable, we reverse-coded the measure so that higher I/C scores represented an orientation toward individualism, and lower I/C scores represented an orientation toward collectivism. Sample items include "Group success is more important than individual success" and "Individuals may be expected to give up their goals in order to benefit group success." Cronbach's alpha was .77, and McDonald's omega was .78.

Perceived Justice was measured using a three-item scale based on Colquitt et al. (2001): "The ED is managed fairly"; "The procedures in the ED are fair"; "The procedures in the ED are medically correct." Participants responded using a Likert-type scale ranging from 1 (*strongly disagree)* to 7 (*strongly agree*). Cronbach's alpha was .92; McDonald's omega was .89.

Mistreatment of Frontline Staff was assessed using six items developed by Efrat-Treister et al. (2020b). Items include: "What are the chances that the patient's son [in the vignette] will use an aggressive tone of voice toward a staff member / yell / curse / bang on a table / slam a door / interrupt a staff member." Participants responded using a 7-point Likert-type scale ranging from 1 (*very low*) to 7 (*very high*). Cronbach's alpha was .93; McDonald's omega was .90. This scale measures the likelihood of engaging in mistreatment, rather than actual mistreatment, since people who have already

engaged in mistreatment are removed from the ED and are not available to answer surveys. People who are about to mistreat staff can be surveyed, but are unlikely to truthfully report their desire to mistreat staff in the first person, because of social desirability concerns and fear of being removed from the ED. Therefore, asking in the third person has been found to be most useful to capture inclinations toward mistreatment. In a pretest, this measure was found to significantly predict actual violence of ED outsiders towards frontline staff (Efrat-Treister et al., 2019).

Control Variables. Several variables offered a theoretical basis to assume their influence on perceived justice and mistreatment (Carlson & Wu, 2012). These variables included gender, age (with younger people tending to engage in more mistreatment), hospital (as procedures might be perceived differently across hospitals), education, and ethnic group affiliation.

Results

Descriptive statistics (means, standard deviations, and intercorrelations) for the Study 1 variables are presented in Table 2.

Table 2. *Means, Standard Deviations, and Intercorrelations of Study 1 Variables*

	M	SD	1	2	3	4	5	6	7	8
1. Gender	.46	.50	-							
2. Age	46.93	17.36	-.02	-						
3. Hospital	.35	.48	-.03	-.09	-					
4. Education	13.58	3.23	-.05	.28**	-.12	-				
5. Ethnic group	.71	.46	.08	.06	-.19*	.11	-			
6. Violation type	.52	.50	.12	.06	.04	-.02	-.08	-		
7. Perceived justice	4.93	1.65	-.05	.12	.12	.09	-.07	.11	-	
8. I/C orientation	1.80	1.09	-.05	.01	-.03	.01	.10	.02	-.21*	-
9. Mistreatment	2.56	1.55	.02	-.28**	.09	-.15	-.12	-.18*	-.28**	-.12

Note. †p<.1; *p <.05; **p <.01; two-tailed. Violation type was coded as 1—violating individual needs; 2—violating group needs; Higher I/C scores represented a greater orientation toward individualism, and lower I/C scores represented a greater orientation toward collectivism.

We tested our research model with a latent moderated structural equation model (LMS). First, we ran a confirmatory factor analysis (CFA) to verify that the indicators indeed reflected the intended latent variables. We compared the fit of a three-factor (I/C orientation, perceived justice, and mistreatment) with all possible two-factor models and a one-factor model using two relative fit indices, the comparative fit index (CFI) and the Tucker–Lewis Index (TLI), and an absolute measure of fit, the standardized root mean square residual (SRMR; Hu & Bentler, 1999). We evaluated these fit indices using the traditional cutoff values of .90 for the CFI and TLI and less than .08 for the SRMR. As presented in Table 3, the three factors model reproduced the observed covariance matrix ($\chi^2_{(74)}$ = 148.41, p < .01; CFI = .94; TLI = .92; SRMR = .054), and all standardized factor loadings of the latent variables on their indicators were significant (p < .01). Analyses of the other possible two-factor and one-factor models show a substantial loss of fit relative to the three-factor model (e.g., CFI and TLI < .90 and SRMR > .08 in all these models). A comparison between the models' chi-squared scores confirmed the fit of the three-factor model as better than all other models (p < .01).

Table 3. *Fitness Indices for Measurement Model Analyses*

Factor and model	χ^2	df	CFI	TLI	SRMR
Equal form models					
Model 1: Three factors (PJ+IC+MIS)	148.41**	74	.94	.92	.054
Model 2: Two factors (PJ+MIS)	454.91**	76	.68	.62	.140
Model 3: Two factors (IC+MIS)	318.90**	76	.80	.76	.139
Model 4: Two factors (IC+PJ)	307.70**	76	.81	.77	.137
Model 5: One factor	617.52**	77	.55	.46	.181

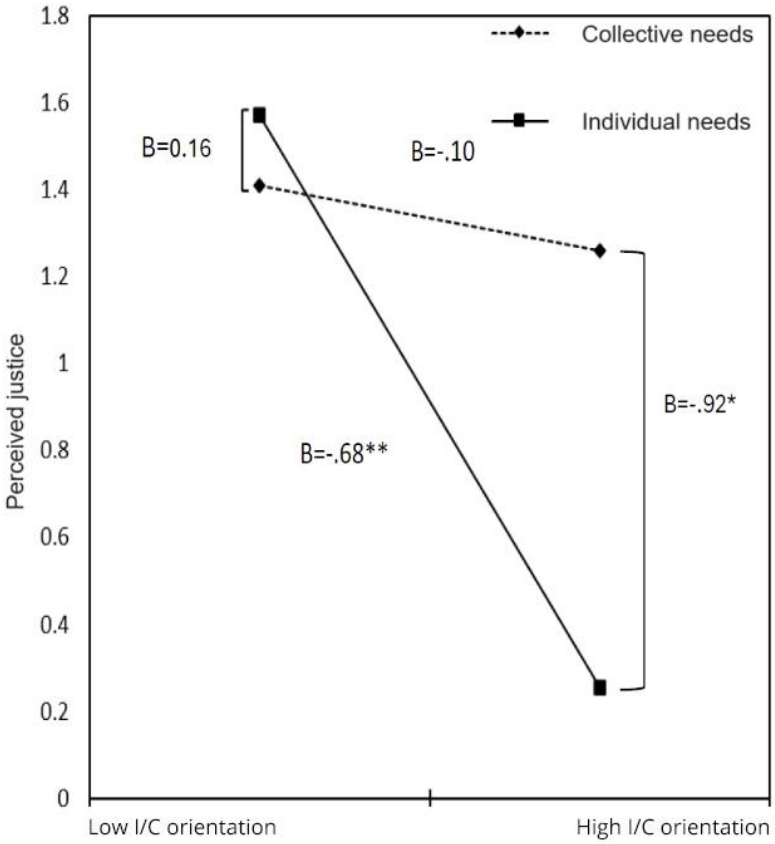
Note. * P < .05, ** P < .01. PJ = Perceived justice; IC = *Outsiders' I/C orientation*; MIS = Mistreatment. Comparisons of Model 1 and Models 2–5 revealed a better fit for Model 1 (p<.01).

Next, in the second step of the LMS, we tested relationships between the variables in the structural models. We used maximum likelihood estimation to assess the overall fit of each LMS model, following Klein and Moosbrugger (2000). To test Hypotheses 1 and 2, we first compared the linear null model (with violation type, perceived justice, mistreatment, and the control variables; $\chi^2_{(150)}$ = 248.76, p < .01; CFI = .92; TLI = .91; SRMR = .058; log likelihood= -3200.48) with a model that also included the two latent interactions of violation type and I/C orientation predicting both perceived justice and mistreatment. The comparison revealed a better fit of the data for the model with the interactions (-2 log-likelihood = 7.38; $\chi^2_{(2)}$ = 7.38, p < .05). A significant interaction was found between violation type and I/C orientation on perceived justice (B = -.59, p < .05). However, the interaction between violation type and I/C orientation on mistreatment was non-significant (B = -.60, n.s.). These results indicate that the moderation effect of I/C orientation on the relationship between violation type and mistreatment can be explained by the interaction of violation type and I/C orientation on perceived justice.

We found a negative relationship between perceived justice and mistreatment (B = -.26, p < .01), supporting Hypothesis 1. Simple slope analysis revealed a significant relationship between violation type and perceived justice for outsiders with higher I/C scores (i.e., oriented toward individualism; B= -0.92 p <.05), but not for outsiders with lower I/C scores (i.e., oriented toward collectivism; B=0.16, n.s.). Participants with higher I/C scores perceived the individual needs violation as less just than the group needs violation. Moreover, participants with lower I/C scores perceived the individual needs violation as more just than did participants oriented toward individualism (B= -.68, p<.01), while no similar relationship was found for the scenario describing a group needs violation (B= -.10, n.s.; see Figure 2). These results support Hypothesis 2.

To test Hypothesis 3, we first compared the null model (the relationship between violation type and mistreatment in the presence of the control variables: hospital, age, education, and socioeconomic status) with the model that includes the latent interaction between violation type and I/C orientation. The null model demonstrated reasonable fit ($\chi^2_{(93)}$ = 178.49, p < .01; CFI = .89; TLI = .88; SRMR = .061, log-likelihood= -2577.32). Nevertheless, the model with the latent interaction terms fit the data significantly better than the model without the latent interaction terms (-2 log-likelihood = 5.23; $\chi^2_{(1)}$ = 5.23, p < .01), and a significant interaction was revealed (B=-.75, p<.05).

Figure 2. *Interaction between Violation Type and I/C Orientation, Predicting Perceived Justice*

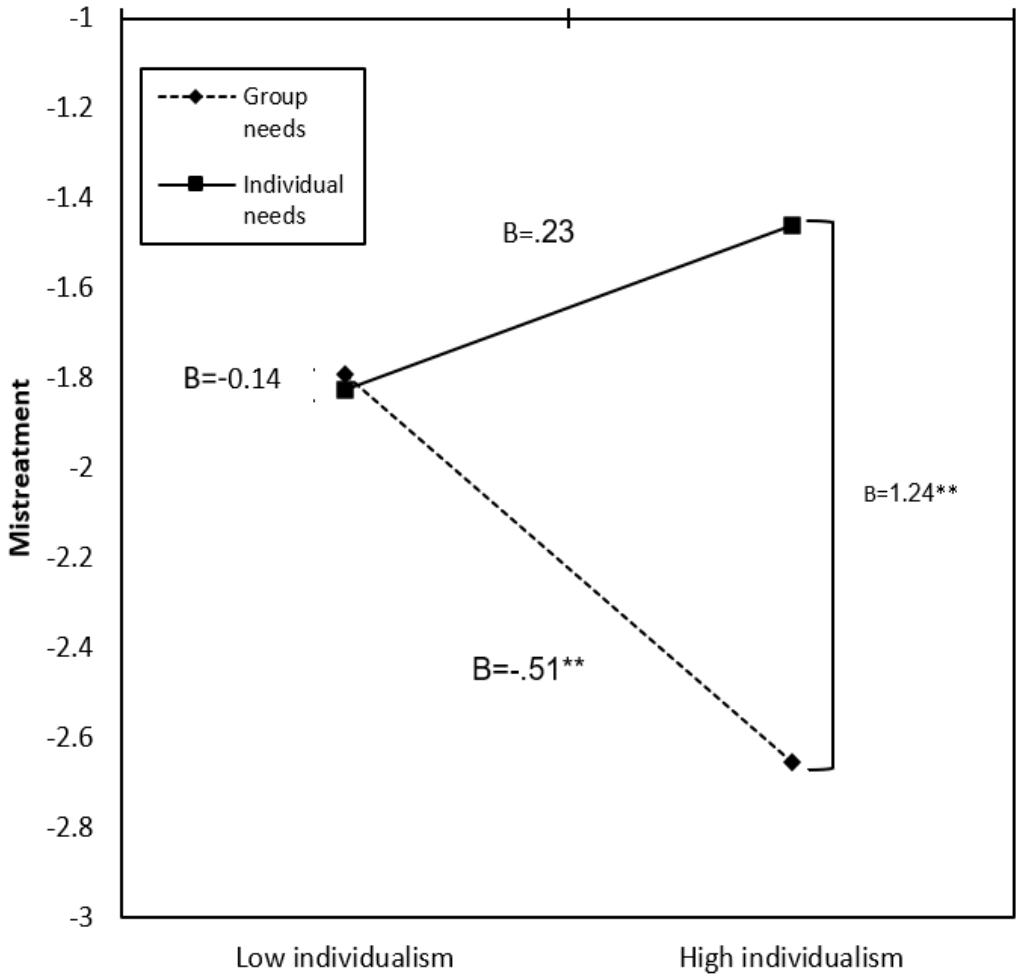


Note: ** p < .01. The procedural justice scale reflects the expected latent score (μ=0; σ=1); Higher I/C scores represented a greater orientation toward individualism, and lower I/C scores represented a greater orientation toward collectivism.

Next, we performed a simple slope analysis, which indicated that the relationship between violation type and mistreatment intentions was significant for outsiders with higher I/C scores (i.e., oriented toward individualism; B=1.24, p<.01) but not for those with lower I/C scores (i.e., oriented toward collectivism; B= -.14, n.s.). More precisely, participants with higher I/C scores reported higher mistreatment intentions when exposed to a scenario involving a violation of individual needs as opposed to when they were exposed to a scenario involving a violation of group needs. Moreover, individuals with lower I/C scores reported more mistreatment when exposed to the group-needs violation scenario than those oriented toward individualism (B=-.51, p<.01). The inverse relationship was not found following exposure to the individual-needs violation scenario (B=.23, n.s.). See Figure 3.

Finally, we conducted a conditional indirect effect analysis using the Mplus 8.4. bootstrap method (CI = 95%; boot = 5000). The results revealed that the negative indirect relationship between violation type and mistreatment is mediated by perceived justice, and that this indirect relationship exists only for outsiders with higher I/C orientation scores (i.e. oriented toward individualism; B = -.24; 95% CI [-.63, -.02]; boot = 5000), but not for outsiders with lower I/C orientation scores (i.e., oriented toward collectivism; B = .04; 95% CI [-.19, .29]; IMM =.15; 95% CI [.00,.45]). Altogether, these results support Hypothesis 3.

Figure 3. *Interaction between Violation Type and I/C Orientation, Predicting Mistreatment*



Note: * p < .05; ** p < .01; The mistreatment scale reflects the expected latent score (μ=0; σ=1); Higher I/C scores represented a greater orientation toward individualism, and lower I/C scores represented a greater orientation toward collectivism.

Study 1 Discussion

The results of Study 1 indicate that outsiders' I/C orientation significantly predicts their perceptions of justice and inclinations to engage in mistreatment. Outsiders with higher I/C orientation scores (i.e., those oriented toward individualism) perceived violations of individual needs as less just compared to violations of group needs, and consequently displayed a higher propensity towards mistreatment of hospital staff following such violations. In contrast, outsiders with lower I/C orientation scores (i.e., those oriented toward collectivism) did not differentiate between these violations, reporting a higher degree of perceived justice in both cases and exhibiting lower mistreatment intentions. Therefore, the findings of Study 1 suggest that agitation in ED waiting areas may be particularly likely among outsiders oriented toward individualism, as violations of their personal expectations may lead them to see ED operations as unjust.

Our findings parallel ED research which suggests that outsiders oriented toward individualism may be particularly prone to frustration in such environments. For example, Boudreaux et al. (2000)

found that the extent to which staff show care and concern for patients *as individuals* predicts both patient satisfaction and the likelihood of recommending the facility. Their study underscores that personalized attention remains critical even in settings where collective health outcomes are prioritized. Similarly, Attree (2001) found that outsiders believe high-quality care should be individualized, patient-centered, and marked by nurturing relationships. In contrast, impersonal and routine care often leads to dissatisfaction, emphasizing the importance of staff engagement and empathy. These findings highlight the challenges EDs face in balancing efficient medical triage with the need for personalized care, a balance that is crucial for satisfying outsiders oriented toward individualism.

The observations made in EDs about the value of personalized treatment resonate beyond the healthcare sector and are indicative of a broader shift in organizations. A large body of research emphasizes the profound impact of personalized service on customer satisfaction, and identifies key elements of personalization, such as recognizing a customer's uniqueness, using their name, and addressing their specific needs (Winsted, 1999; Mittal & Lassar, 1996). This is echoed by SERVQUAL, a model capturing customer expectations from providers, and their perceptions of service quality (Coulthard, 2004). According to the model, empathy, or the provision of individualized attention to customers, is one of the main pillars driving customer satisfaction. In the same vein, surveys indicate that customers prefer personalized interactions throughout their dealings with retailers, which includes multiple customized touchpoints, such as receiving compliments on unique aspects of their appearance or behavior (Lindecrantz, 2020).

Building on these findings, we expect that providing individualized attention to outsiders oriented toward individualism may reduce their sense of injustice by affirming their uniqueness, a core concern for this group. Such individual recognition might increase their justice perceptions vis-à-vis the triage process by showing them that their unique needs and status are acknowledged. In turn, this increase in perceived justice is likely to reduce the likelihood of outsiders engaging in mistreatment against staff. However, it is impractical for EDs to differentiate outsiders by their I/C orientation, as such traits are often undisclosed or unknown at the time of encounter. To address this challenge, we propose a universal intervention that emphasizes providing individualized attention to all outsiders, regardless of their cultural and personal values. The intervention involves staff making an active effort to gather information pertinent to the outsider's identity before providing personalized information. By acknowledging each patient's individual identity, we anticipate a reduction in mistreatment of frontline staff.

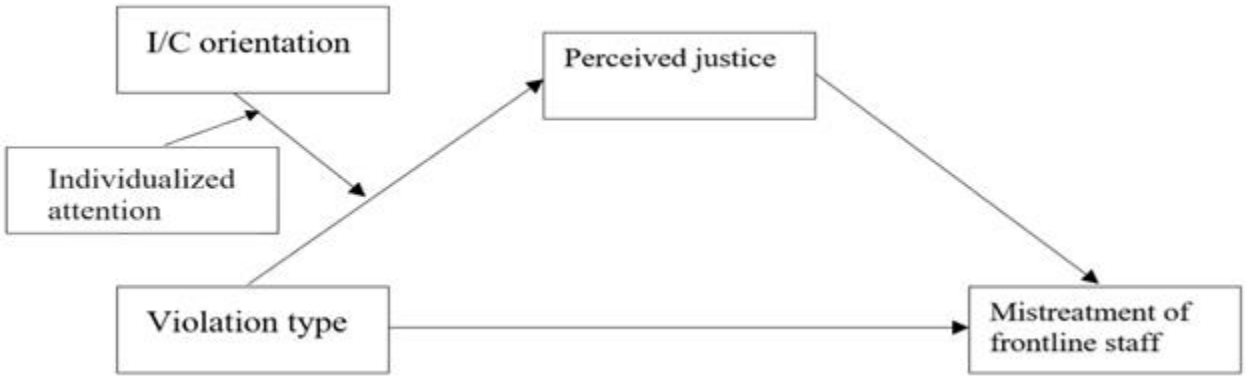
Thus, we predict (see Figure 4):

H4. Providing outsiders with individualized attention will buffer the relationship between violation type and perceived justice. This buffering effect will be stronger for outsiders oriented toward individualism (a three-way interaction).

Taken together, we suggest:

H5. Providing outsiders with individualized attention will increase their justice perceptions in the face of violations, and thus buffer the indirect interactive effect of violation type and I/C orientation on mistreatment via perceived justice (moderated mediation).

Figure 4. *Research Model, Study 2*



Study 2: Individualized Attention, Perceived Justice and Mistreatment

Methods

Study 2 was conducted within a large regional, publicly funded university hospital, which has a total of 1100 beds and serves approximately 400 patients daily in the ED. The primary objective of Study 2 was to expand upon the theoretical framework established in Study 1 and investigate whether mistreatment in EDs could be reduced by providing individualized attention to outsiders.

Sample and Procedure

The design of Study 2 was 2×2 (with/without individualized attention; violation of individual vs. group needs). The sample size for this study was determined using G*Power V.3.1.9.4. The calculation was based on a linear multiple regression with a fixed model and regression coefficients, aiming for 80% power and a 5% significance level (α), with an anticipated medium effect size (Cohen's d=.06). To account for potential non-responses, we increased the sample size by 20%. As a result, our target sample size was at least 153 participants. Ultimately, data was gathered from 224 participants with an average age of 38.75; 49% of whom were female. We controlled for the same variables as in Study 1: age, gender, education, ethnic group affiliation. All participants met the Helsinki Committee's inclusion criteria.

Individualized Attention Intervention

We designed an intervention to provide individualized attention to outsiders, aiming to alleviate feelings of injustice among those oriented towards individualism. The experiment spanned five months and took place in a hospital that caters to a diverse population. The intervention and control groups were assigned on different days. On all days, interactions were conducted by a research assistant wearing a name tag with the ED logo to be identified as a representative of the organization. All research assistants were fluent in the primary languages spoken by the patient population.

On control days, research assistants sat at the reception desk and handed out a sheet of paper with information about ED procedures to outsiders (see Appendix A). This information sheet was

provided in the main language of the country where the experiment was conducted, regardless of the cultural identity of the outsider. Outsiders were also handed a survey to fill out, and were then instructed to sit in the waiting area for treatment.

On intervention days, research assistants were instructed to provide a personalized experience to outsiders. After the reception staff directed outsiders to the waiting area, a research assistant approached them for a private conversation. The assistants first asked which language the outsider preferred and then used that language to inquire about their well-being and how the ED could assist them that day. They also provided an instruction sheet translated into the outsider's preferred language, and the survey to complete. After this interaction, the research assistants returned to sit at the reception desk.

Our intervention paralleled recommendations from research on personalization, which emphasize the importance of recognizing a customer's uniqueness, using their name, and addressing their specific needs (Winsted, 1999; Mittal & Lassar, 1996). We anticipated that providing an individualized experience by addressing outsiders in their preferred language and catering the interaction to their needs would reduce their feelings of injustice and decrease their inclination towards mistreatment.

Manipulation Check

To verify that our manipulation indeed provided a sense of individualized attention from the ED staff, we adapted a measure of patient–doctor relational communication, specifically the intimacy subscale (Gallagher et al., 2001). Each outsider was asked, "To what extent do you agree with the following statements about the last ED staff member you spoke to?" Sample items included: "Was interested in talking to me" and "Created a sense of closeness in the conversation." As predicted, outsiders who received individualized attention reported significantly higher perceived levels of intimate communication ($M = 4.4$, $SD = 1.53$) compared to those who did not receive individualized attention ($M = 3.86$, $SD = 1.50$); $T(130) = -2.06$, $p < .05$.

Measures

Study 2 used the same measures as Study 1. Internal consistency values were as follows: I/C orientation—Cronbach's alpha = .86, McDonald's omega = .86; perceived justice—Cronbach's alpha = .97, McDonald's omega = .93; mistreatment of frontline staff—Cronbach's alpha = .97, McDonald's omega = .94.

Results

Table 4 presents means, standard deviations, and intercorrelations for the Study 2 variables.

Table 4. *Means, Standard Deviations, and Intercorrelations of Study 2 Variables*

	M	SD	1	2	3	4	5	6	7	8
1. Gender	.53	.50	-							
2. Age	38.75	15.18	.05	-						
3. Education	13.65	3.57	.04	.32**	-					
4. Ethnic group	1.58	.62	-.02	-.04	-.14*	-				
5. Violation type	1.50	.50	-.20**	.05	.06	.00	-			
6. Perceived justice	5.18	1.78	.03	.12	.03	.17*	.22**	-		
7. I/C orientation	1.84	1.22	.04	-.12	-.01	-.04	-.10	-.16*	-	
8. Individualized attention	.59	.99	-.07	-.03	.01	.12	-.07	.08	-.12	-
9. Mistreatment	2.71	1.63	.02	-.08	-.02	-.19**	-.19**	-.18**	-.01	-.03

Note. †p<.1; *p <.05; **p <.01; two-tailed. Violation type was coded as 1—violating individual needs; 2—violating group needs; Higher I/C scores represented a greater orientation toward individualism, and lower I/C scores represent a greater orientation toward collectivism.

As we predicted, higher perceived justice was associated with lower degrees of mistreatment towards frontline staff (r = -.18; p < .01), supporting H1.

Hypotheses 2–5 were tested using a moderated-mediation three-way interaction model (Model 11; Hayes, 2018; boot=5000), controlling for age, gender, education level, and ethnic group. Outsiders' I/C orientation moderated the relationship between violation type (violation of individual needs vs. group needs) and perceived justice (B = *.63*; p < .05). Outsiders oriented toward individualism perceived violations of individual needs as less just, while outsiders oriented toward collectivism perceived violations of group needs as less just, thus supporting H2. In turn, perceived justice predicted mistreatment intentions, such that higher perceived justice predicted lower mistreatment (B=-.20; p < .01), thus supporting H3.

The three-way interaction between violation type, I/C orientation, and individualized attention significantly predicted perceived justice (B=-1.49; p < .01), indicating that providing outsiders with individualized attention buffered the relationship between violation type and perceived justice, supporting H4. The individualized attention manipulation interacted with I/C orientation and increased the perceived justice of both violations, supporting H5 (B=2.57, p<.01). The index of moderated mediation was .30 (.15); CI [.04;.64]. See Table 5.

Study 2 Discussion

In Study 2, we replicated the research design of Study 1 while introducing an additional condition in which certain participants received individualized attention aimed at increasing their justice perceptions towards ED processes. The results not only replicated those of Study 1 but also supported our subsequent hypotheses.

Our findings suggest that providing individualized attention to ED outsiders effectively neutralizes the impact of violations that infringe upon individual needs for those oriented toward individualism. This results in a consistently high level of perceived justice among all participants, regardless of their I/C orientation and the type of violation they were exposed to. When it comes to violations of group needs, we observed that participants oriented toward individualism perceived such violations as more just when individualized attention was provided.

Table 5. *Moderated Mediation Predicts Mistreatment, Study 2 (Hayes, 2018, Model 11).*

		Perceived justice b (SE)	Mistreatment b (SE)
Constant		4.53 (1.33)	5.36 (.75)
Perceived justice			-.20 (.07)**
Violation type		-.15 (.71)	-.33 (.25)
I/C orientation		-.24 (.50)*	
I/C orientation × Violation type		.63 (.29)*	
Individualized attention		-4.20 (1.68)*	
Violation type × Individualized attention		2.52 (1.01)*	
I/C orientation × Individualized attention		2.57 (.77)**	
Violation type × I/C orientation × Individualized attention		-1.49 (.46)**	
Gender		.12 (.16)	.08 (.24)
Age		.01 (.01)	-.01 (.01)
Education		.00 (.04)	.01 (.03)
Ethnic group		.56 (.22)**	-.54 (.19)**
ΔR^2		.20 (2.64)***	.15 (2.25)**
		Conditional indirect effect	
I/C orientation	Individualized attention	b (boot SE)	% 95 CI
Low (.60)	No	-.05 (.14)	-.35 .25
	Yes	-.38 (.19)	-.79 -.06
Mean (1.9)	No	-.21 (.12)	-.46 -.03
	Yes	-.15 (.09)	-.37 -.01
High (3.0)	No	-.35 (.16)	-.69 -.07
	Yes	.04 (.12)	-.20 .28
Index of moderated mediation		**30 (.15)**	**.04 .64**

Note. *p <.05; **p <.01. Violation type was coded as 1—violating individual needs; 2—violating group needs; Higher I/C scores represented a greater orientation toward individualism, and lower I/C scores represented a greater orientation toward collectivism.

In the absence of individualized attention, outsiders oriented toward individualism tended to view violations of individual needs as less just compared to violations of group needs. Conversely, those oriented toward collectivism displayed consistent levels of perceived justice for both types of violations. This suggests a greater inclination toward conformity, greater acceptance, and fewer questions regarding the fairness of organizational procedures among outsiders oriented toward collectivism. However, when provided with individualized attention, this group perceived violations of group needs as even more just than when such attention was absent.

Our findings highlight the role of I/C orientation in shaping individuals' expectations, perceptions, and reactions to different situations.

General Discussion

In two studies, we explored how the I/C orientation of outsiders influences their perceptions of justice in emergency departments (EDs), subsequently impacting their interactions with frontline staff. The first study confirmed our theoretical model, indicating that individuals with an individualistic orientation were particularly prone to mistreat staff. These individuals demonstrated heightened sensitivity to perceived infringements of their personal needs, leading to increased likelihood of mistreatment. The second study not only replicated these results but also tested an intervention that provided individualized attention to these outsiders. This intervention significantly improved justice perceptions among individuals with an individualistic orientation, which in turn reduced their propensity to mistreat ED staff. Together, these studies provide novel insights into the dynamics of mistreatment in EDs, emphasizing the pivotal role of cultural orientation in shaping both perceptions of justice and behavioral responses, and suggesting that tailored interventions can effectively reduce mistreatment.

Theoretical Implications

Our research contributes to the literatures on workplace mistreatment, cultural values in organizational settings, organizational justice and conflict theory. First, we contribute to the literature on workplace mistreatment by addressing a gap identified by Hershcovis et al. (2020) regarding the need for a deeper understanding of mistreatment's antecedents. Our study highlights effective strategies that healthcare organizations can employ to preemptively address abusive behaviors, potentially preventing their escalation into more severe forms of aggression and violence. This builds on findings by Reyt et al. (2022), who demonstrated that reducing outsider frustration through improved management of waiting experiences can diminish the likelihood of staff mistreatment.

Additionally, our findings extend the discussion of mistreatment beyond overt physical violence to include subtler forms of abuse, such as verbal aggression and disparaging gestures, which can then also escalate into more severe acts like physical assaults (Baron & Neuman, 1996; Chris et al., 2022; Yuan et al., 2020). We emphasize that all forms of mistreatment, regardless of their severity, can negatively affect the mental and physical health of healthcare staff, potentially leading to increased absenteeism, high turnover rates, and reduced productivity (Hershcovis & Barling, 2010).

Second, our paper enriches the discourse on cultural values within diverse workplaces. As globalization increases cultural diversity within organizations (Gibson et al., 2014), the risk of misunderstandings that may lead to mistreatment also rises. Challenging the assumption that all individuals react similarly to potential transgressions, we propose that an individual's I/C orientation is a crucial determinant in how they perceive and respond to mistreatment of frontline staff. This assertion is supported by prior research suggesting that individuals oriented towards individualism are more sensitive to perceived transgressions (Brockner et al., 2000, 2001, 2005; Colquitt, 2004; Erdogan & Liden, 2006; Lam et al., 2002; Ramamoorthy & Flood, 2002), but we further refine this insight by suggesting that the alignment between an individual's degree of individualism and the type of violation encountered is critical.

Third, our study contributes to the justice literature by examining how perceived justice influences aggressive behaviors and mistreatment. Established research indicates that perceived injustice is a key predictor of such behaviors (Berry et al., 2007; Colquitt et al., 2001; Ferris et al., 2012), with individuals who perceive the treatment they receive as unfair being more likely to exhibit frustration and mistreat staff, who are often seen as representatives of the organization (Naumann & Bennett, 2000). Our findings suggest that an individual's I/C orientation significantly influences their

perception of fairness, affecting their reactions to perceived transgressions and subsequent tendency toward mistreating staff. The findings thus highlight the role of differentiated justice perceptions as antecedents in diverse workplace environments, responding to calls by Cropanzano et al. (2015) for a more nuanced integration of justice theory and cultural research.

Lastly, we contribute to the literature on conflict theory by emphasizing that conflicts are not perceived equally by everyone; rather, they are viewed through the cultural lens of the parties involved. Understanding these cultural orientations allows us to predict the trajectory of the conflict, assess whether it might escalate into mistreatment, and find ways to alleviate the conflict by being sensitive to the values and priorities of people from diverse cultural backgrounds.

Practical Implications

Understanding the mechanisms that trigger mistreatment in healthcare settings enables the development of targeted interventions to reduce such behaviors. However, segregating outsiders based on personality traits, which are typically unknown, is not a feasible strategy for organizations. To address this challenge, we devised a universal intervention intended to assure all outsiders that their individual needs are being considered. Our intervention has a pronounced positive effect on outsiders oriented toward individualism and a marginal impact on those oriented toward collectivism, aligning with our objectives.

More broadly, our research highlights the need for healthcare organizations, particularly EDs, to adopt a holistic approach to handling mistreatment. This involves recognizing the varied psychological and situational triggers that can lead to such behavior, and implementing tailored strategies to address them.

Limitations and Future Directions

Our studies have several limitations. First, we measured the likelihood of mistreatment rather than actual mistreatment. However, this measure is based on previous research demonstrating a significant correlation between likelihood and actual violence (Efrat-Treister et al., 2019). While future research could supplement our findings with actual behavioral measures of aggression, it is important to note that such measures typically capture only severe aggressive behaviors, which are rare and often addressed too late, after the harm has occurred. We propose that reducing acts of mild mistreatment, which are frequently overlooked, is a valuable strategy for preventing escalation to more severe forms of mistreatment in service industries (Goussinsky, 2012). This proactive approach aligns with recent calls to consider the psychological characteristics of patients (McColl-Kennedy et al., 2017).

Second, our research compared only two scenarios. Future studies should examine a broader range of situations involving different levels of collectivism to enhance our understanding of cultural influences on mistreatment.

Third, we focused on how I/C orientation relates to perceptions of procedural justice. Future research should investigate the effects of other cultural values, such as power distance and uncertainty avoidance (Hofstede, 2001), as well as personal values like self-enhancement and self-transcendence (Schwartz, 2012), on perceived justice and mistreatment.

Last, we did not measure the influence of factors such as level of crowdedness, time of day, and wait duration on perceived justice and mistreatment. Future research should explore these variables to provide a more comprehensive understanding of the dynamics at play.

Conclusion

In conclusion, our research underscores the multifaceted nature of mistreatment of frontline staff, especially in high-stress environments like EDs. Outsider mistreatment, often dismissed as a minor or inevitable aspect of frontline work, can have profound consequences for healthcare staff. Our studies illuminate the complex interplay between outsiders' I/C orientations, their perceptions of justice, and their mistreatment of frontline staff. We demonstrate that I/C orientations significantly influence how individuals perceive and react to situations that violate personal or group needs in resource-constrained settings like EDs.

Our research goes beyond merely identifying the problem of outsider mistreatment. Rather, it offers a proactive approach to mitigating this issue through a theory-based intervention aimed at enhancing justice perceptions, particularly among individuals with high levels of individualism. This strategy represents a shift from traditional reactive responses to a more preventive and inclusive approach, recognizing the diverse value orientations and perceptions of outsiders. By addressing the root causes of mistreatment, our intervention aims to reduce the incidence of these behaviors, leading to a safer work environment for healthcare professionals.

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Arie Eisenman (MD) is the head of the Medical Emergency Department (Emerita) at the Western Galilee Medical Center in Naharia, al general hospital affiliated with the Bar Ilan University Medical School in the Galilee, serving a population of about 500,000 patients. He is also a Clinical Lecturer and in charge of training medical, nursing and paramedic students from Israel and abroad in areas concerning life saving and emergency medicine. He received his MD from Sackler School of Medicine, Tel Aviv University.

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Appendix

Appendix A. Individualized Attention Provided in Study 2

Welcome to the Emergency Department. We are here to help you. On this page, we will explain to you the stages of visiting our department.

1. Please take a number to queue for the reception.
2. When your turn arrives, please give the receptionist your ID (driver's license, passport, or any photo ID).
3. If you don't have a photo ID, the following information must be provided:
    - ID number, first name, last name, parents' names, date of birth, address, and telephone number.
    - Referral from a doctor. If you do not have a doctor's referral, you will explain to the receptionist the reason for arriving at the ED. If you don't have a referral, you will have to pay $300 or sign a promissory note. If, after being checked at the ED, you are hospitalized, this payment debt will be canceled.
4. We will open a visitor's file for you at the reception. Please wait for your name to be announced. When your name is announced, please enter the nurse's room. The nurse will make an initial assessment of your problem. The assessment will include questions, taking vital signs, and providing first aid as needed. Then, the nurse will direct you to a doctor for triage.
5. You will continue your examination and treatment in one of the ED wards.
6. When you arrive at the appropriate ward, you may have to wait for one of the doctors, depending on the load at the ED. The doctors will examine you individually and decide on the necessary treatment and tests.
7. You will have to wait for the test results.
8. After waiting, doctors will update you on the results and decide on hospitalization in one of the hospital wards, or discharge for continuing treatment in community medicine, with recommendations for further treatment.

We wish you good health,

The Emergency Department staff.