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Organizational Energy and Its Influence on Quiet Quitting and Service Quality in Hospitals

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Abstract

Worldwide healthcare institutes face a huge pressure to maintain service excellence amid resource constraints and workforce challenges. This study explores how organizational energy affects quiet quitting behaviours, and service quality in hospital settings, focusing to address a critical gap in understanding how employee psychological states influence patient care outcomes. A quantitative cross-sectional study was conducted across 72 hospital departments/ units. Organizational energy was measured using the OEQ 12 questionnaire assessing four energy states (productive, comfortable, resigned, and corrosive energy). Quiet quitting was evaluated through a 9-item scale measuring disengagement behaviours and withdrawal of discretionary effort. Service quality was assessed using the SERVPERF instrument, capturing patient perceptions across five dimensions (tangibles, reliability, responsiveness, assurance, and empathy). Data were collected from healthcare professionals (3-4 per unit) for energy and engagement measures, and from patients/attendants (3-4 per unit) for service quality assessments, then aggregated at the departmental level. Strong correlations emerged between all variables: organizational energy positively correlated with service quality and negatively with quiet quitting, while quiet quitting showed a strong negative association with service quality. Regression showed that organizational energy significantly predicted higher service quality and lower quiet quitting, and multiple regression indicated that organizational energy and quiet quitting jointly explained about 53.5% of the variance in service quality at the departmental level, with organizational energy emerging as the stronger predictor. The findings confirm that organizational energy and quiet quitting are significant determinants of patient-perceived service quality in hospital departments. Units with higher energy demonstrate superior service outcomes, while disengagement behaviours substantially undermine care quality. These findings suggest that healthcare leaders should prioritize interventions to enhance organizational energy through supportive leadership and recognition while addressing factors contributing to employee disengagement to improve patient care experiences.

Keywords: organizational energy, quiet quitting, service quality, hospital departments, employee disengagement

1. Introduction

1.1 Background and Context

Healthcare systems worldwide face growing pressure to deliver high-quality patient care amid workforce shortages, rising service expectations, and increasing emotional demands on healthcare professionals (World Health Organization [WHO], 2020). Hospitals function not only as clinical institutions but also as service organizations in which patient perceptions of quality depend strongly on staff behavior, communication, and emotional engagement (Cronin & Taylor, 1992; Parasuraman et al., 1988).

Prolonged workload, emotional strain, and resource constraints have contributed to widespread burnout and disengagement among healthcare workers (Maslach & Leiter, 2016; West et al., 2014). Recent studies highlight a shift from overt turnover to more subtle forms of withdrawal, where employees remain physically present but psychologically disengaged from their work (Harris, 2024; Geng et al., 2026). Understanding these collective psychological conditions is critical because they directly shape patient experiences and service outcomes in hospital departments.

1.2 Organizational Energy in Healthcare

Organizational energy refers to the shared emotional, cognitive, and behavioral activation of employees within a work unit (Bruch & Ghoshal, 2003). It captures whether members feel enthusiastic and action-oriented (productive energy) or emotionally depleted and withdrawn (resigned or corrosive energy). Unlike individual burnout or job satisfaction, organizational energy reflects a collective climate that influences coordination, responsiveness, and service behavior at the unit level (Bruch & Vogel, 2011).

In healthcare, where teamwork and emotional labor are essential, collective energy states shape how staff interact with patients and manage clinical demands. Research on engagement and work climate shows that energized units demonstrate better communication, empathy, and performance (Bakker & Demerouti, 2007; West et al., 2014). However, empirical work directly linking organizational energy to patient-perceived service quality remains scarce, particularly in hospital settings in developing economies.

1.3 Quiet Quitting and Healthcare Disengagement

Quiet quitting describes a form of psychological withdrawal in which employees meet formal job requirements but deliberately reduce discretionary effort and emotional involvement (Harter, 2022; Galanis et al., 2023). In healthcare, this phenomenon is especially consequential because patient care relies heavily on compassion, initiative, and teamwork.

Recent evidence demonstrates that quiet quitting is widespread among healthcare professionals. Harris (2024) showed that declining organizational commitment and unmet psychological contracts drive disengagement over time, while Geng et al. (2026), in a meta-analytic review of nurses, identified burnout, workplace injustice, and lack of organizational support as key antecedents of quiet quitting. These findings suggest that quiet quitting reflects deeper organizational and emotional conditions rather than individual laziness or low work ethic.

From an organizational energy perspective, quiet quitting aligns with resigned inertia and corrosive energy states, in which employees remain active but emotionally disconnected from organizational goals (Bruch & Vogel, 2011). Yet, few studies have examined quiet quitting together with collective energy states and service outcomes within a unified framework.

1.4 Service Quality in Hospitals

Service quality in healthcare refers to patients' evaluations of reliability, responsiveness, assurance, empathy, and tangibles in care delivery (Parasuraman et al., 1988; Cronin & Taylor, 1992). Patient perceptions are shaped not only by technical competence but also by staff attitudes, emotional availability, and communication quality (Donabedian, 1988; Andaleeb, 2001).

Disengaged or emotionally depleted staff may perform core tasks while withholding relational and discretionary behaviours essential for high-quality care. Prior research has linked staff burnout and engagement to patient satisfaction and safety outcomes (Aiken et al., 2018; West et al., 2014). However, the role of organizational energy and quiet quitting as collective departmental conditions influencing service quality remains underexplored.

1.5 Research Gap and Contribution

Although prior studies have examined burnout, engagement, and quiet quitting in healthcare, three key gaps remain. First, most research focuses on individual-level attitudes rather than collective unit-level psychological states. Second, quiet quitting has rarely been examined alongside organizational energy as a shared departmental phenomenon. Third, limited empirical evidence links these internal workforce conditions with patient-perceived service quality, particularly in public hospital contexts in developing countries.

Responding to recent calls for more integrative and contextualized research on workforce disengagement in healthcare (Harris, 2024; Geng et al., 2026), this study examines hospital departments as the unit of analysis and connects organizational energy and quiet quitting with service quality outcomes. By integrating employee and patient data at the departmental level, the study provides new evidence on how internal psychological climates translate into external service experiences.

The objective of this study is to examine the relationships among organizational energy, quiet quitting, and service quality in hospital departments.

1.6 Contribution of the Study

This study makes three key contributions to the literature on healthcare workforce dynamics and service quality. First, while prior research on quiet quitting has focused mainly on individual-level attitudes and turnover intentions (Harris, 2024; Geng et al., 2026), this study conceptualizes quiet quitting as a collective, department-level phenomenon, capturing shared patterns of disengagement within hospital units (Kozlowski & Klein, 2000).

Second, the study extends organizational energy theory to the healthcare service context by empirically linking collective energy states with patient-perceived service quality. Whereas earlier research has primarily examined organizational energy in relation to internal outcomes such as engagement and performance (Bruch & Ghoshal, 2003; Bruch & Vogel, 2011), this study demonstrates how organizational energy and quiet quitting jointly shape service quality outcomes.

Third, the study provides empirical evidence from a public hospital in a developing country, a context that remains underrepresented in existing quiet quitting and organizational energy research. By integrating multisource data from healthcare professionals and patients at the departmental level, the study offers a more holistic understanding of how internal psychological climates translate into external service experiences in hospital settings.

2. Materials and Methods

2.1 Research Design

This study adopted a quantitative, cross-sectional research design to examine the relationships among organizational energy, quiet quitting, and service quality in hospital departments. A cross-sectional design is appropriate when data are collected at a single point in time to analyze relationships among variables (Creswell, 2014). This approach allows the comparison of employee-related psychological and behavioural factors with patient-perceived service quality across different hospital units.

The unit of analysis in this study was the hospital department or unit rather than individual employees or patients. Organizational energy and quiet quitting are conceptualized as collective states reflecting shared perceptions and behaviors within work units, while service quality represents a unit-level service climate experienced by patients. Aggregating responses at the departmental level therefore provides a theoretically meaningful representation of these collective constructs (Kozlowski & Klein, 2000; Bliese, 2000).

The study employed a multisource design, collecting data from healthcare professionals for organizational energy and quiet quitting and from patients for service quality. This design reduces common method bias by separating predictor and outcome measures across different respondent groups (Podsakoff et al., 2003).

2.2 Study Setting and Sample

The study was conducted in a public multispeciality hospital of national importance. A total of 72 hospital departments or units participated in the study, including general medicine, surgery, emergency care, intensive care, outpatient services, and diagnostic units.

From each department, three to four healthcare professionals (doctors, nurses, and allied health staff) provided responses on organizational energy and quiet quitting. At the same time, three to four patients or patient attendants provided responses on service quality. The final sample consisted of 233 healthcare professionals and 247 patients or attendants.

Department-level scores were calculated by averaging individual responses within each unit. Thus, the final dataset consisted of 72 aggregated unit-level observations for organizational energy, quiet quitting, and service quality.

2.3 Sampling Technique

A purposive sampling method was used to select hospital departments that met the following criteria:

1. Departments with regular patient interaction.
2. Departments with stable staff strength.
3. Willingness of hospital management to participate.

Within each department, respondents were selected using convenience sampling based on availability and informed consent. This approach is commonly used in healthcare organizational research where access to respondents is constrained by work schedules and patient conditions (Polit & Beck, 2017).

2.4 Measurement Instruments

Organizational Energy

Organizational energy was measured using the Organizational Energy Questionnaire (OEQ-12) developed by Bruch and Ghoshal (2003). The instrument assesses four energy states:

- Productive energy (enthusiasm, focus, action orientation)
- Comfortable energy (positive affect with low urgency for change)
- Resigned inertia (low motivation and helplessness)
- Corrosive energy (negative emotions and interpersonal conflict)

Responses were recorded on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Prior research has demonstrated acceptable reliability and construct validity for the OEQ across organizational contexts (Bruch & Ghoshal, 2003; Cole et al., 2012).

Although the OEQ conceptualizes four distinct energy states, the present study adopts a higher-order composite approach consistent with prior research (Cole et al., 2012; Bruch & Vogel, 2011), where the focus lies on the overall energetic climate rather than typological classification. The four dimensions, productive energy, comfortable energy, resigned inertia, and corrosive energy, represent complementary manifestations of a shared underlying construct. Negatively valenced dimensions (resigned inertia and corrosive energy) were reverse-coded prior to aggregation to ensure conceptual alignment.

Subscale reliabilities at the individual level were satisfactory: productive energy ($\alpha = .78$), comfortable energy ($\alpha = .75$), resigned inertia ($\alpha = .76$), and corrosive energy ($\alpha = .77$). A composite index of organizational energy was then computed to provide a parsimonious and theoretically meaningful indicator of collective organizational energy suitable for relational analysis. To assess robustness, supplementary regression analyses were conducted using the four energy dimensions separately. Productive energy exhibited a positive association with service quality and a negative association with quiet quitting, whereas resigned inertia and corrosive energy showed the opposite pattern; comfortable energy demonstrated weaker but directionally consistent effects. Overall, the pattern of relationships remained substantively consistent with the composite model, supporting the use of the aggregated measure.

Quiet Quitting

Quiet quitting was measured using a 9-item scale developed and validated by Galanis et al. (2023). The scale captures behavioral disengagement characterized by minimal task performance, reduced initiative, and psychological withdrawal while remaining formally employed. Responses were recorded on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree).

The original validation study established a three-factor structure (detachment, lack of initiative, and lack of motivation) with good internal consistency (Cronbach's $\alpha = .80$; McDonald's $\omega = .81$) and acceptable model fit using exploratory and confirmatory factor analysis (Galanis et al., 2023).

In the present study, the quiet quitting scale was administered to 233 healthcare professionals nested within 72 hospital departments. Because the theoretical focus of this study was on departmental-level disengagement rather than individual differences, item responses were aggregated to compute unit-level quiet quitting scores following the assessment of within-group agreement and reliability (Bliese, 2000; Chan, 1998). The previously validated factor structure was retained, and reliability was evaluated at the individual level prior to aggregation.

Service Quality

Service quality was measured using the SERVPERF scale developed by Cronin and Taylor (1992), which focuses on perceived service performance rather than expectations. The scale includes five dimensions:

1. Tangibles
2. Reliability
3. Responsiveness
4. Assurance
5. Empathy

Patients and attendants rated service quality on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). SERVPERF has been widely applied in healthcare research and has demonstrated strong reliability and validity (Cronin & Taylor, 1992; Andaleeb, 2001; Schneider et al., 1998). Service quality scores were aggregated to the department level to represent shared patient perceptions of service performance within each hospital unit.

2.5 Data Collection Procedure

Data were collected through institutional collaboration with the participating hospital after obtaining formal permission from hospital authorities and relevant departmental heads. During designated data collection periods, eligible respondents were approached directly by the research team/institutional coordinators within participating departments. Respondents were informed about the purpose of the study and assured that participation was voluntary and confidential. Healthcare professionals completed questionnaires assessing organizational energy and quiet quitting during work breaks or other designated times, while patients and attendants completed the service quality questionnaire after receiving services in the respective departments. No personal identifiers were collected, and participation remained anonymous to encourage honest responses and reduce social desirability bias. Of the 109 hospital departments/units approached, 72 agreed to participate, yielding a departmental participation rate of 66.1%. Because questionnaires were administered in person within participating departments during designated collection periods, formal invitation-to-response tracking was not maintained at the individual level; however, efforts were made to obtain broad participation across all eligible respondent groups and departments included in the sampling frame. Given the in-person administration of questionnaires within participating departments, nonresponse at the individual level was minimal among approached respondents. However, formal nonresponse bias testing (e.g., early versus late respondent comparison) was not feasible due to the absence of systematic response tracking.

The study employed a purposive sampling approach through institutional collaboration, which may limit the generalizability of the findings beyond the study context. While department type was included as a structural control variable, other contextual factors such as staffing ratios, workload intensity, and patient acuity, were not systematically measured and may influence the observed relationships. These factors represent important avenues for future research.

2.6 Data Aggregation and Justification

Individual responses were aggregated at the departmental level by calculating the mean score for each variable within each department. Aggregation is appropriate when studying collective constructs such as organizational energy and service quality climate (Kozlowski & Klein, 2000). This method ensured that each department was treated as a single analytical unit, representing the shared perceptions of employees and patients. Internal consistency reliability of all study scales was assessed using Cronbach's alpha prior to aggregation. All constructs demonstrated satisfactory internal consistency, exceeding the recommended threshold of .70 for research purposes (Nunnally & Bernstein, 1994).

To justify aggregation of individual responses to the departmental level, within-group agreement and intraclass correlation coefficients were calculated. Specifically, r_{wg} indices were computed to assess the degree of consensus among respondents within each hospital department (James et al., 1984). Intraclass correlation coefficients ICC(1) and ICC(2) were estimated following the procedures outlined by Bliese (2000). ICC(1) represents the proportion of variance in responses attributable to unit membership, whereas ICC(2) reflects the reliability of unit-level means.

Aggregation was considered theoretically and empirically defensible given acceptable r_{wg}(>.60) and ICC(1) [>.05] values, while ICC(2) values were modest due to small group sizes, consistent with established guidelines in organizational and healthcare research (Bliese, 2000; Kozlowski & Klein, 2000; LeBreton & Senter, 2008).

2.7 Data Analysis Techniques

Data were analyzed using IBM SPSS Statistics Version 29.0.0.0 (241). Prior to hypothesis testing, data were screened for accuracy and completeness. Missing data were minimal (<2%) and handled using mean substitution at the individual level before aggregation, as recommended for small group datasets (Hair et al., 2019). Given the minimal extent of missing data (<2%), mean substitution was applied at the individual level prior to aggregation, a procedure unlikely to materially affect parameter estimates. Outliers were assessed using standardized z-scores (±3.29) (Tabachnick & Fidell, 2019) and Mahalanobis distance; no influential multivariate outliers were detected. Normality assumptions were examined through skewness and kurtosis values, which fell within acceptable ranges (±2), indicating approximate normal distribution. Linearity and homoscedasticity were also verified. Pearson's product–moment correlation analysis (two-tailed) was first conducted to examine the bivariate relationships among Organizational Energy, Quiet Quitting, and Service Quality. To address the study objective of examining how organizational energy and quiet quitting are associated with service quality in hospital departments, a series of linear regression analyses was performed.

First, simple linear regression analyses were conducted to assess (a) the association between Organizational Energy and Quiet Quitting and (b) the association between Organizational Energy and Service Quality. Subsequently, a multiple linear regression analysis was carried out with Service Quality as the dependent variable and Organizational Energy and Quiet Quitting as independent variables to examine their joint contribution to explaining variance in service quality.

Prior to interpretation, key regression assumptions were evaluated. Multicollinearity was assessed using tolerance values, Variance Inflation Factors (VIF), eigenvalues, and condition indices. All VIF values were below the commonly accepted threshold (VIF < 5), tolerance values exceeded 0.20, and condition indices were below 30, indicating no serious multicollinearity concerns. Regression coefficients were reported with unstandardized coefficients (B), standard errors (SE), standardized coefficients (β), and 95% confidence intervals (CI). Model fit was evaluated using R^2, adjusted R^2, and F-statistics. Department type was included as a control variable to account for structural differences across hospital units. Departments were categorized by functional area and dummy-coded for regression analysis.

2.8 Ethical Considerations

Ethical approval was obtained from the Institutional Ethics Committee of IIT Kharagpur (Approval No. IITKharagpur/EC/20BM92R04/01, dated 04.06.2024). Participants were informed of the study's purpose and their right to withdraw at any time. Confidentiality and

anonymity were strictly maintained. No sensitive personal data were collected. The study followed standard ethical guidelines for research involving human participants (American Psychological Association, 2020).

3. Results

3.1 Reliability and Aggregation Statistics

Internal consistency reliability was first assessed at the individual respondent level prior to aggregation, as recommended in multilevel research (Bliese, 2000). Cronbach's alpha values indicated satisfactory reliability for Organizational Energy (α = .773), Quiet Quitting (α = .785), and Service Quality (α = .793). McDonald's omega coefficients showed comparable results (Organizational Energy: ω = .78; Quiet Quitting: ω = .80; Service Quality: ω = .81), further supporting internal consistency.

Reliability was also assessed at the unit level following aggregation. All study constructs demonstrated acceptable reliability, exceeding the recommended threshold of .70 for research purposes (Nunnally & Bernstein, 1994). Specifically, Cronbach's alpha values were .735 for Organizational Energy, .749 for Quiet Quitting, and .761 for Service Quality.

Although confirmatory factor analysis (CFA) would provide additional evidence of construct validity, the present study relied on previously validated instruments with established factor structures in prior research. Given the study's focus on aggregated departmental-level constructs and sample size constraints at the unit level, CFA was not conducted. This represents a limitation, and future research may employ CFA or structural equation modelling to further validate the measurement structure.

Following confirmation of scale reliability, aggregation to the departmental level was evaluated through within-group agreement and intraclass correlation coefficients. Within-group agreement (r_{wg}) ranged from .673 to .709 (M = .691), indicating moderate to acceptable consensus among respondents within hospital departments (James et al., 1984). Approximate 95% confidence intervals, inferred from the observed distribution, ranged from .65 to .73, suggesting relatively stable agreement across units.

Intraclass correlation coefficients further informed aggregation decisions. ICC(1) values ranged from .098 to .127, indicating that approximately 9.8% to 12.7% of the variance in the study constructs was attributable to departmental membership, exceeding the commonly accepted minimum threshold of .05 for meaningful group-level variance (Bliese, 2000). With average group sizes of 3.23 respondents for Organizational Energy and Quiet Quitting and 3.43 respondents for Service Quality, ICC(2) values were .283, .260, and .332, respectively, as shown in Table 1. These ICC(2) values indicate modest reliability of group means, which is expected in field-based healthcare research involving relatively small workgroup sizes, as ICC(2) is sensitive to the number of raters per unit (LeBreton & Senter, 2008).

Despite modest ICC(2), aggregation was considered theoretically and empirically defensible given acceptable r_{wg} and ICC(1) values, consistent with prior multilevel research (Kozlowski & Klein, 2000). To further address concerns regarding modest ICC(2) values and small group sizes, robustness analyses were conducted using bootstrapped regression estimates (2,000 resamples) as well as alternative aggregation checks. Bootstrapping, which does not rely on strict distributional assumptions, provides more stable estimates in small samples. Across all models, coefficient directions, statistical significance, and substantive effect sizes remained consistent with the original results. In addition, supplementary analyses using the four OE subdimensions separately yielded convergent results supporting the use of the higher-order

composite. Taken together, these findings indicate that the results are robust and not unduly influenced by aggregation limitations or sampling variability.

Table 1: Validation of aggregation

Construct	r_{wg}	ICC(1)	ICC(2)
Organizational Energy (OE)	0.697	0.109	0.283
Quiet Quitting (QQ)	0.673	0.098	0.260
Service Quality (SQ)	0.709	0.127	0.332

Taken together, the reliability estimates, r_{wg}, ICC(1), and ICC(2) statistics provide sufficient justification for aggregating individual-level responses to the departmental level for subsequent analyses (Kozlowski & Klein, 2000).

3.2 Correlation Analysis

Pearson's product–moment correlation analysis (two-tailed) was conducted to examine the relationships among Organizational Energy, Quiet Quitting, and Service Quality. This analysis directly addresses the study's objective of exploring how collective organizational energy and employee disengagement are associated with service quality outcomes in hospital settings.

As shown in Tab. 2, Organizational Energy was strongly and positively correlated with Service Quality ($r = .686$, $p < .001$), indicating that hospital units characterized by higher levels of shared energy, enthusiasm, and constructive engagement tended to report superior levels of perceived service quality. This finding is consistent with prior research suggesting that positive collective affective and motivational states contribute to enhanced performance and service delivery in healthcare organizations (Bruch & Vogel, 2011; Salanova et al., 2011).

Table 2: Correlation analysis

Correlations				
		OE Score	**QQ Score**	**SQ Score**
OE Score	**Pearson Correlation**	1	-.585**	.686**
	Sig. (2-tailed)		<.001	<.001
	N	72	72	72
QQ Score	**Pearson Correlation**	-.585**	1	-.606**
	Sig. (2-tailed)	<.001		<.001
	N	72	72	72
SQ Score	**Pearson Correlation**	.686**	-.606**	1
	Sig. (2-tailed)	<.001	<.001	
	N	72	72	72
**. Correlation is significant at the 0.01 level (2-tailed).				

Quiet Quitting demonstrated a strong negative association with Service Quality ($r = –.606$, $p < .001$), suggesting that withdrawal-oriented work behavior and psychological disengagement may undermine the quality of care and services delivered to patients. This result aligns with the broader literature on employee disengagement and burnout in healthcare, which links reduced work involvement to declines in patient-centered outcomes and service effectiveness (Maslach & Leiter, 2016; Shanafelt et al., 2015).

Furthermore, Organizational Energy was negatively correlated with Quiet Quitting ($r = –.585$, $p < .001$), indicating that units exhibiting higher collective energy levels also reported lower tendencies toward quiet quitting. This relationship highlights the potential protective

role of organizational energy in buffering against disengagement and passive withdrawal behaviors, particularly in high-demand healthcare environments (Schaufeli, 2017).

All observed correlations were statistically significant at the .01 level (two-tailed) and were of moderate to large magnitude based on established effect size benchmarks (Cohen, 1988). Importantly, none of the correlation coefficients exceeded .80, suggesting that the constructs, while related, remained empirically distinct and that multicollinearity was not a concern for subsequent multivariate analyses (Tabachnick & Fidell, 2019). Together, these results offer an integrated picture of how organizational energy, disengagement in the form of quiet quitting, and service quality are interrelated at the unit level in hospital contexts, thereby fulfilling the study's objective of examining their associative patterns rather than causal relationships.

3.2 Multiple Regression Analysis

Regression Model 1: Organizational Energy Predicting Quiet Quitting

A simple linear regression analysis was conducted to examine the association between Organizational Energy (OE) and Quiet Quitting (QQ) at the unit level (N = 72). Descriptive statistics indicated a moderate level of Quiet Quitting (M = 2.53, SD = 0.79) and relatively higher Organizational Energy (M = 3.48, SD = 0.62). The model was significant, explaining 34% of the variance in quiet quitting ($R^2 = .34$, $p < .001$), represented in Tab. 3.

Organizational Energy was a strong negative predictor of Quiet Quitting ($\beta = –.59$, $p < .001$), indicating that departments with higher collective energy reported substantially lower disengagement. This result demonstrates a robust inverse association between organizational energy and quiet quitting across hospital units.

Table 3: Regression table for Model 1

Simple Linear Regression Predicting Quiet Quitting from Organizational Energy (N = 72)						
Predictor	**B**	**SE**	**β**	**t**	**p**	**95% CI for B**
Constant	5.138	0.439	—	11.694	< .001	[4.262, 6.015]
Organizational Energy (OE)	–0.750	0.124	–.585	–6.027	< .001	[–0.998, –0.502]
Model Fit Statistics						
Statistic			**Value**			
R			0.585			
R^2			0.342			
Adjusted R^2			0.332			
F(df)			36.326 (1, 70)			
p			< .001			
Standard Error of Estimate (SEE)			0.646			
VIF (OE)			1			
Tolerance (OE)			1			
Condition Index (max)			11.46			

B = unstandardized regression coefficient; SE = standard error; β = standardized coefficient; CI = confidence interval; OE = Organizational Energy; QQ = Quiet Quitting. Dependent variable: Quiet Quitting.

Regression Model 2: Organizational Energy Predicting Service Quality

A simple linear regression analysis was conducted to examine the association between Organizational Energy (OE) and Service Quality (SQ) at the unit level (N = 72). Descriptive statistics indicated moderate levels of Service Quality (M = 3.41, SD = 0.58) and relatively higher levels of Organizational Energy (M = 3.48, SD = 0.62). Tab. 4 shows that the model is significant, explaining 47% of the variance in service quality (R^2 = .47, p < .001). Organizational Energy was a strong positive predictor of Service Quality (β = .69, p < .001), indicating that departments with higher collective energy reported better patient-perceived service quality.

Table 4: Regression table for Model 2

Simple Linear Regression Predicting Service Quality from Organizational Energy (N = 72)						
Predictor	**B**	**SE**	**β**	**t**	**p**	**95% CI for B**
Constant	1.154	0.290	—	3.977	< .001	[0.575, 1.733]
Organizational Energy (OE)	0.648	0.082	0.686	7.890	< .001	[0.485, 0.812]
Model Fit Statistics						
Statistic			**Value**			
R			0.686			
R^2			0.471			
Adjusted R^2			0.463			
F(df)			62.257 (1, 70)			
p			< .001			
Standard Error of Estimate (SEE)			0.427			
VIF (OE)			1			
Tolerance (OE)			1			
Condition Index (max)			11.46			

B = unstandardized regression coefficient; SE = standard error; β = standardized coefficient; CI = confidence interval; OE = Organizational Energy; SQ = Service Quality. Dependent variable: Service Quality.

Overall, this model demonstrates a strong positive association between Organizational Energy and Service Quality at the departmental level. Hospital units characterized by higher levels of shared energy, enthusiasm, and engagement reported significantly better service quality outcomes. This result directly addresses the study's objective of examining how organizational energy is related to service quality in hospital departments.

Regression Model 3: Organizational Energy and Quiet Quitting Predicting Service Quality

A multiple linear regression analysis was conducted to examine the joint association of Organizational Energy (OE) and Quiet Quitting (QQ) with Service Quality (SQ) at the unit level (N = 72). Descriptive statistics indicated moderate levels of Service Quality (M = 3.41, SD = 0.58), relatively higher levels of Organizational Energy (M = 3.48, SD = 0.62), and comparatively lower levels of Quiet Quitting (M = 2.53, SD = 0.79). Bivariate correlations showed that Service Quality was positively correlated with Organizational Energy (r = .686, p < .001) and negatively correlated with Quiet Quitting (r = –.606, p < .001).

Table 5: Regression table for Model 3

Multiple Linear Regression Predicting Service Quality from Organizational Energy and Quiet Quitting (N = 72)						
Predictor	**B**	**SE**	**β**	**t**	**p**	**95% CI for B**
Constant	2.334	0.471	—	4.956	< .001	[1.394, 3.273]
Organizational Energy (OE)	0.476	0.096	0.504	4.979	< .001	[0.285, 0.667]
Quiet Quitting (QQ)	-0.230	0.075	-0.312	-3.080	0.003	[-0.378, -0.081]

Model Fit Statistics	
Statistic	**Value**
R	0.731
R^2	0.535
Adjusted R^2	0.521
F(df)	39.648 (2, 69)
p	< .001
Standard Error of Estimate (SEE)	0.403
VIF (OE)	1.52
VIF (QQ)	1.52
Tolerance (OE)	0.658
Tolerance (QQ)	0.658
Condition Index (max)	21.22

B = unstandardized regression coefficient; SE = standard error; β = standardized coefficient; CI = confidence interval; OE = Organizational Energy; QQ = Quiet Quitting; SQ = Service Quality. Dependent variable: Service Quality.

The overall regression model, shown in Tab. 5, was statistically significant, $F(2, 69) = 39.648$, $p < .001$, explaining a substantial proportion of variance in Service Quality ($R^2 = .535$; Adjusted $R^2 = .521$). This indicates that Organizational Energy and Quiet Quitting together accounted for approximately 53.5% of the variability in service quality across hospital departments.

Examination of the individual regression coefficients revealed that Organizational Energy was a strong positive predictor of Service Quality ($B = 0.476$, $SE = 0.096$, $\beta = .504$, $t = 4.979$, $p < .001$, 95% CI [0.285, 0.667]). This suggests that departments characterized by higher collective energy, enthusiasm, and engagement tended to report significantly higher service quality.

Quiet Quitting also emerged as a significant predictor of Service Quality, but in the opposite direction ($B = –0.230$, $SE = 0.075$, $\beta = –.312$, $t = –3.080$, $p = .003$, 95% CI [–0.378, –0.081]). This finding indicates that higher levels of disengagement and withdrawal-oriented work behavior were associated with significantly lower service quality outcomes, even after accounting for the effect of Organizational Energy.

Collinearity diagnostics demonstrated that multicollinearity was not a concern in this model. Tolerance values for both predictors were .658 and corresponding Variance Inflation Factor (VIF) values were 1.519, which fall well below commonly accepted thresholds (VIF < 5). Condition indices did not exceed 21.22, further confirming the stability and independence of the predictors. These diagnostics support the reliability and interpretability of the regression estimates.

Bootstrapped confidence intervals (2,000 resamples) further confirmed the stability of all regression coefficients, with all key predictors remaining statistically significant and confidence intervals not crossing zero. Robustness analyses controlling for department type yielded substantively similar results (Tab. 6). Inclusion of department type produced only minor reductions in coefficient magnitudes, with all hypothesized relationships remaining statistically significant, thereby supporting the stability of the findings across departmental contexts.

Table 6: Robustness analysis controlling for department type

Model	Dependent Variable	Predictors	Base β	Controlled β	p
1	Quiet Quitting	Organizational Energy	−.585	−.561	<0.001
2	Service Quality	Organizational Energy	0.686	0.654	<0.001
3	Service Quality	Organizational Energy	0.504	0.471	<0.001
3	Service Quality	Quiet Quitting	−.312	−.287	0.006

Taken together, the results show that both Organizational Energy and Quiet Quitting make independent and statistically significant contributions to explaining variations in Service Quality at the departmental level. Organizational Energy emerged as the stronger predictor, while Quiet Quitting exerted a meaningful negative influence even after controlling for Organizational Energy. These findings fulfil the study's objective of examining how collective energetic states and disengagement behaviours are associated with service quality in hospital departments and underscore the importance of addressing both positive and negative workforce dynamics in healthcare service delivery.

4. Discussion

This study examined the influence of organizational energy on quiet quitting and service quality in hospital departments. The findings provide strong empirical evidence that collective emotional and motivational states of healthcare employees significantly shape disengagement behaviours and patient-perceived service quality.

4.1 Interpretation of Key Findings

This study examined the relationships among organizational energy, quiet quitting, and service quality at the departmental level in a hospital setting. The findings demonstrate that collective psychological and behavioural states of healthcare professionals are strongly associated with patient-perceived service outcomes.

Organizational energy was positively related to service quality and negatively related to quiet quitting. Departments with higher shared enthusiasm and action orientation reported better service quality and lower disengagement, supporting the view that organizational energy reflects a collective climate shaping employee behavior rather than merely individual motivation (Bruch & Ghoshal, 2003; Cole et al., 2012). In emotionally demanding healthcare environments, such shared energy appears critical for sustaining high-quality care.

Quiet quitting showed a strong negative association with service quality. Departments characterized by withdrawal and reduced discretionary effort reported poorer patient-rated service quality, consistent with engagement theory which links psychological disengagement to lower emotional, cognitive, and behavioral investment in service encounters (Kahn, 1990; Schaufeli et al., 2002). Given the importance of empathy and responsiveness in hospitals, even subtle disengagement may undermine patient experiences (Maslach & Leiter, 2016; Shanafelt et al., 2015).

Regression results further indicated that organizational energy and quiet quitting independently predicted service quality, with organizational energy emerging as the stronger predictor. Together, these variables explained a substantial proportion of variance in service quality across departments, suggesting that both positive collective resources and disengagement processes simultaneously shape service outcomes.

Overall, the findings highlight the importance of unit-level emotional and behavioral climates in hospitals, reinforcing the view that service quality is not only a technical outcome but also a psychological and social phenomenon embedded in how healthcare teams collectively experience their work environment (West et al., 2014; Schneider et al., 1998).

4.2 Theoretical Implications

This study contributes to theory in several ways. First, it extends organizational energy theory into the healthcare context. While earlier research linked organizational energy to performance and innovation in corporate settings (Bruch & Vogel, 2011; Cole et al., 2012), evidence from hospitals has been limited. By showing that organizational energy predicts both quiet quitting and service quality, this study positions energy as a meso-level construct connecting employee psychology with patient outcomes.

Second, the findings integrate quiet quitting into engagement and burnout frameworks. Quiet quitting reflects low-energy states such as resigned inertia and corrosive energy (Bruch & Ghoshal, 2003) and is shaped by the collective energetic climate of work units rather than individual choice alone. This advances understanding of disengagement as a socially embedded and context-driven phenomenon (Kahn, 1990; Bakker & Demerouti, 2007).

Third, the study contributes to service climate theory by demonstrating that internal psychological states of staff are systematically linked to patient perceptions. Building on prior work linking service climate to customer outcomes (Schneider et al., 1998; Salanova et al., 2011), the present findings identify organizational energy and quiet quitting as antecedent conditions explaining variation in service quality across departments, supporting multilevel models of collective processes (Kozlowski & Klein, 2000).

Finally, the study enriches healthcare management research in developing-country contexts. By examining a public hospital under resource constraints, it provides context-sensitive evidence that emotional and psychological dynamics remain central even in high-pressure environments, responding to calls for more non-Western organizational research (WHO, 2020; West et al., 2014).

4.3 Practical Implications for Hospital Management

The findings offer several implications for hospital administrators and policymakers. First, organizational energy should be recognized as a strategic resource. Improvements in infrastructure and procedures alone may not enhance service quality if departments operate in low-energy or disengaged climates. Leadership practices that promote meaning, recognition, and participation can strengthen productive energy and collective motivation (Bakker & Demerouti, 2007; West et al., 2014).

Second, quiet quitting should be viewed as an early warning signal rather than a disciplinary problem. Because it reflects psychological withdrawal, punitive approaches may worsen disengagement. Instead, management should address underlying causes such as workload, limited autonomy, and lack of recognition through job redesign, peer support, and professional development initiatives (Maslach & Leiter, 2016; Shanafelt et al., 2015).

Third, the results emphasize the value of unit-level interventions. Since service quality varies across departments based on shared psychological climates, targeted strategies—such as leadership coaching, team-building, and stress management programs—are likely to be more effective than uniform organizational policies (Schneider et al., 1998; Salanova et al., 2011).

Fourth, workforce well-being should be integrated into quality improvement frameworks. Monitoring organizational energy and disengagement indicators alongside patient satisfaction and safety metrics can provide a more comprehensive view of service performance.

Finally, at the policy level, the findings highlight the importance of sustainable workforce strategies in public hospitals. Investments in staffing stability, mental health support, and participatory governance are essential to prevent corrosive or resigned energy states and to sustain patient-centered care.

4.4 Confounding Variables, Endogeneity and Study Limitations

While the findings demonstrate robust associations among organizational energy, quiet quitting, and service quality, several potential confounding factors must be acknowledged. Departmental characteristics such as clinical specialty, unit size, workload intensity, staffing ratios, and patient mix may independently influence both workforce states and service quality outcomes. For instance, emergency and intensive care units typically experience higher emotional strain and time pressure than outpatient or diagnostic departments, which may shape both disengagement patterns and patient evaluations of care (Aiken et al., 2014; Shanafelt et al., 2015).

Although the study employed a multisource, department-level design and included department type as a basic structural control to mitigate common method and contextual bias, other potentially relevant contextual variables were not explicitly modeled. Consequently, the observed relationships should be interpreted as associative rather than causal. Unobserved structural factors, such as chronic understaffing, workload intensity, or patient acuity, may partially account for the relationships among organizational energy, quiet quitting, and service quality.

The cross-sectional nature of the study further limits causal inference. Because data were collected at a single point in time, the direction of influence cannot be conclusively established. While the results suggest that organizational energy and quiet quitting shape service quality, reverse causality is also plausible: departments with persistently poor service outcomes may experience declining morale and increasing withdrawal behaviors. This potential bidirectionality reflects an endogeneity concern common in organizational and healthcare research (Antonakis et al., 2010).

Additional limitations should be noted. The sample was restricted to 72 departments within a single public hospital, which may limit generalizability to other healthcare systems or regions. Quiet quitting was assessed using self-reported employee data, which may be subject to social desirability bias. Moreover, the analysis focused on departmental aggregates and did not examine individual-level differences such as profession, tenure, or age, which may moderate the observed relationships.

Furthermore, the study did not conduct CFA on the aggregated scales; instead, it relied on previously validated measurement models, which should be verified in future research using CFA or SEM.

4.6 Directions for Future Research

Future research should employ longitudinal designs to examine how changes in organizational energy over time influence quiet quitting and service quality, thereby enabling stronger causal inference. Structural equation modelling (SEM) may be used to test more complex mediation pathways, such as the indirect effect of organizational energy on service quality through quiet quitting. Intervention-based studies could further assess whether leadership development or employee engagement initiatives enhance organizational energy and improve patient outcomes. Researchers may also investigate relevant mediating and moderating mechanisms, including leadership style, job resources, and organizational culture. Additionally, qualitative inquiry could provide deeper insight into how employees experience organizational energy and the factors underlying disengagement behaviors. Comparative studies across diverse healthcare systems and cultural contexts would further enhance the generalizability of these findings.

5. Conclusion

This study examined the influence of organizational energy on quiet quitting and service quality in hospital departments. The findings show that organizational energy plays a critical role in shaping both employee behaviour and patient-perceived service quality. Departments with higher levels of organizational energy demonstrated better service quality, while departments with higher levels of quiet quitting showed poorer service outcomes.

The results confirm that organizational energy is positively associated with service quality and negatively associated with quiet quitting. Quiet quitting, in turn, has a strong negative effect on service quality. These relationships highlight that service quality in hospitals is not only determined by clinical procedures and infrastructure but also by the emotional and motivational climate of healthcare staff. The study contributes to healthcare management literature by linking collective psychological conditions with patient outcomes at the departmental level. It provides empirical evidence that energized and engaged healthcare teams are more likely to deliver responsive, reliable, and empathetic care to patients. At the same time, disengagement and withdrawal behaviours weaken service delivery and reduce patient satisfaction.

From a practical perspective, the findings suggest that hospital leaders should focus on building productive organizational energy through supportive leadership, recognition, and positive work environments. Reducing factors that lead to quiet quitting, such as excessive workload, lack of appreciation, and limited autonomy, is essential for sustaining high service quality. In conclusion, improving service quality in hospitals requires attention not only to technical competence but also to the psychological and emotional conditions of healthcare professionals. Strengthening organizational energy and addressing quiet quitting can help hospitals achieve better patient experiences and more sustainable workforce performance.

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