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Staying Despite Strain: A Systematic Grounded Theory Study Of Human-Centered HRM And Healthcare Worker Retention

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Abstract

Healthcare organizations face a retention problem that conventional turnover metrics cannot fully diagnose. Workers may stay because they remain committed, because they need income or career credentials, or because secure employment traps them in defensive compliance. This study develops a grounded theory of how healthcare workers construct decisions to stay amid clinical, emotional, administrative, digital, and employment-status pressures. The study applies systematic grounded theory in the Strauss and Corbin tradition. Data were collected through three iterative rounds of semi-structured interviews with clinical workers, support personnel, unit managers, and HR-level informants. Round 1 opened the category, round 2 deepened it through theoretical sampling, and Round 3 tested the emerging model. The analysis used open, axial, and selective coding; constant comparison across professions, employment statuses, units, and two interviewer datasets; memo writing; negative-case attention; and audit-trail procedures. The core category is Conditional Staying. Healthcare workers stay not because strain disappears, but because they reinterpret layered strain through professional calling, employment security, peer solidarity, economic necessity, career aspirations, and perceived organizational care. The resulting typology distinguishes Committed Staying, Pragmatic Staying, and Defensive Staying. The model shows how Layered Strain activates a Perceived Organizational Care Gap, which triggers Retention Reframing and produces qualitatively different forms of staying. The study shifts

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healthcare retention theory from a binary stay-or-leave logic toward the quality of staying. It demarcates the perceived organizational care gap from perceived organizational support, psychological contract breach, and perceived organizational obstruction. It also reframes technostrain as a strategic HRM issue rather than a merely technical information-systems problem.

Keywords: healthcare worker retention; human-centered HRM; systematic grounded theory; technostrain; psychological contract breach; perceived organizational support; organizational justice; conditional staying

INTRODUCTION

Healthcare workforce retention has become a strategic concern for health systems, not only because organizations lose workers but also because many who remain do so with declining commitment. Global workforce debates frequently begin with shortages, vacancy rates, and turnover. That emphasis matters. The World Health Organization continues to warn that the world faces a major health-worker shortfall by 2030, with low- and lower-middle-income countries bearing the heaviest burden (World Health Organization, 2024). Nevertheless, turnover alone provides an incomplete diagnosis. A hospital can report stable headcount while its nurses, doctors, midwives, pharmacists, laboratory staff, and digital support workers quietly shift from committed service to a defensive presence.

This distinction matters for HRM theory and practice. Most retention models explain why workers intend to stay or leave. They identify job satisfaction, leadership, organizational commitment, workload, burnout, workplace climate, autonomy, and career opportunities as determinants of retention (de Vries et al., 2023; Pressley & Garside, 2023). These models remain valuable, but they often treat staying as an outcome whose internal quality requires little scrutiny. A healthcare worker who stays with curiosity, empathy, and initiative differs fundamentally from one who stays because of status security, economic constraint, contract anxiety, or fear of losing benefits. Both appear in the same workforce dashboard. The organizational consequences differ sharply.

Digital transformation deepens the problem. Electronic health records (EHRs), hospital information systems, online referrals, e-claims, telemedicine platforms, digital dashboards, and messaging groups promise coordination and transparency. Yet digital systems can also redistribute work toward clinicians and support staff, intensify documentation pressure, expand surveillance, and erode recovery time. Information-

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systems research has long described technostress creators such as techno-overload, techno-invasion, techno-complexity, techno-insecurity, and techno-uncertainty (Tarafdar et al., 2007; Ragu-Nathan et al., 2008). Healthcare research adds evidence that EHR stress, documentation burden, and poor usability contribute to burnout and strain (Alobayli et al., 2023; Murad et al., 2024; Wu et al., 2024). The present study asks a sharper HRM question: when digital systems intensify work without an equivalent level of organizational care, how do workers reinterpret staying?

The empirical setting gives this question institutional texture. Participants worked within Indonesian healthcare organizations characterized by the coexistence of ASN (state-secure) employment, contract and honorary work, professional hierarchies, SIMRS/RME implementation, claims administration, and unit-specific clinical risk. This setting does not provide a universal template for all health systems. It offers an analytically useful case for theorizing how retention changes when high public-sector security coexists with heavy bureaucratic control, fragile digital infrastructure, and unequal employment statuses. The article, therefore, advances a middle-range grounded theory rather than a context-free law.

The study develops the concept of Conditional Staying. Conditional Staying refers to a quality of retention in which healthcare workers remain in an organization not because strain disappears, but because they reinterpret layered strain through professional calling, employment security, peer support, economic need, career aspirations, and perceived organizational care. The study also introduces the Perceived Organizational Care Gap, defined as workers' felt mismatch between the intensity of organizational demands and the concrete care, protection, recognition, and enabling resources returned by the organization. The research question is: How do healthcare workers construct decisions to stay amid layered work strain and human-centered HRM deficits in digitally transforming healthcare environments?

LITERATURE REVIEW AND SENSITIZING CONCEPTS

Retention beyond the stay-or-leave binary

Healthcare retention studies have generated a strong evidence base. Reviews identify job satisfaction, leadership quality, professional autonomy, staffing conditions, career development, organizational commitment, and workplace climate as predictors of intention to stay or leave (de Vries et al., 2023; Pressley & Garside, 2023). Burnout research adds that emotional exhaustion, depersonalization, moral distress, and workload impair retention by draining workers' capacity to continue caring (Galanis et al.,

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2021; Woo et al., 2020). This literature explains retention pressures well, but it often leaves the internal quality of staying underdeveloped. The worker who remains with intact commitment and the worker who remains with depleted commitment are analytically collapsed into the same category of retention.

This article treats retention as a qualitative state. It asks how staying is organized internally as a form of commitment, pragmatism, or defensive compliance. This turn matters because HR dashboards usually register resignation, absenteeism, and vacancy, but they miss quieter forms of retreat: reduced initiative, emotional detachment, minimal compliance, silent job search, or withdrawal from innovation. In healthcare, where quality depends on attention, empathy, timely judgment, and interprofessional coordination, defensive staying may damage service quality long before turnover occurs.

Organizational support, justice, psychological contract, and organizational obstruction

Perceived organizational support (POS) theory argues that employees form global beliefs about whether the organization values their contribution and cares about their well-being (Eisenberger et al., 1986; Rhoades & Eisenberger, 2002). Social exchange theory explains why such support can produce felt obligation, commitment, and discretionary effort (Blau, 1964). Organizational justice research further clarifies how distributive, procedural, and interactional fairness shape employees' evaluation of schedules, rewards, voice, promotion, and managerial treatment (Colquitt, 2001). These concepts sensitized this study, yet the data required a more precise construct.

Reviewer-level skepticism about the Perceived Organizational Care Gap is warranted because it is closely related to psychological contract breach and perceived organizational obstruction. Psychological contracts concern an individual's belief in reciprocal obligations between employee and organization (Rousseau, 1989). A breach occurs when employees perceive that promised obligations have not been fulfilled. Perceived organizational obstruction describes employees' belief that the organization hinders, interferes with, or damages their goal attainment and well-being (Gibney et al., 2011; Mackey et al., 2018). The construct proposed here does not replace these theories. It demarcates a healthcare-specific relational imbalance: the gap between the magnitude of clinical, emotional, digital, legal, and administrative demands and the concrete care architecture that workers feel the organization provides in return.

Table 1 makes this demarcation explicit. The table is not a definitional appendix; it functions as the theoretical boundary work for the article. It shows why the proposed

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construct does not merely rename existing support, contract, or obstruction concepts. Perceived Organizational Care Gap concerns proportionality under sector-specific strain: workers ask whether the organization provides sufficient care, protection, recognition, and enabling resources relative to the risks and demands it imposes.

Table 1. Demarcating Perceived Organizational Care Gap from adjacent constructs

Construct	Primary question	Analytic center	How does this study use or extend it
Perceived Organizational Support	Does the organization value me and care about my well-being?	Global belief about support and valuation	Used as a sensitizing base, the study specifies the felt adequacy of care relative to healthcare-specific demands.
Psychological Contract Breach	Has the organization failed to fulfill perceived promises or obligations?	Violation of expected reciprocal obligations	In contrast to the care gap, participants often described no explicit promise but a perceived moral imbalance between demanded sacrifice and returned care.
Perceived Organizational Obstruction	Does the organization hinder my goals and well-being?	Organization as an obstacle or detriment	In contrast to the care gap, obstruction captures hindrance; the care gap captures insufficient reciprocal care under layered strain, even when the organization also provides some support.
Perceived Organizational Care Gap	Are organizational demands proportionate to the care, protection, recognition, and resources	Felt a mismatch between the demanded strain and the returned care architecture	Proposed construct explaining why strain is reframed into committed, pragmatic, or defensive staying.

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	workers actually experience?		

Job demands, emotional labor, and healthcare strain

The job demands-resources model explains strain as a function of high demands and insufficient resources (Bakker & Demerouti, 2007, 2017). Healthcare work contains demands by design: uncertain patient flow, acuity, shift work, emotional exposure, interprofessional coordination, and clinical risk. Emotional labor further intensifies strain because healthcare workers must regulate fear, grief, empathy, and professionalism while responding to patients and families. Nurses absorb anger in crowded wards. Midwives carry responsibility for maternal and infant outcomes. Doctors negotiate diagnostic uncertainty and legal exposure. Pharmacists and laboratory personnel work under zero-error expectations. The medical records, claims, and IT staff maintain the data infrastructure that keeps hospitals financially and administratively viable.

The study extends JD-R by showing that digital documentation has become a demand, not simply a tool. When RME, SIMRS, e-claims, dashboard reporting, telemedicine, and WhatsApp coordination expand without an equivalent design of resources, digital work consumes cognitive and emotional energy. Technological strain then interacts with workload, justice, status insecurity, and professional risk. The empirical question becomes how workers stay when resources do not merely buffer demands, but appear structurally misaligned with them.

Technostrain and the rejection of technological determinism

Information systems literature prevents a simplistic reading of digitalization. Tarafdar et al. (2007) identified technostress creators through which ICTs intensify role stress and productivity pressures. Later work elaborated techno-overload, techno-invasion, techno-complexity, techno-insecurity, and techno-uncertainty (Ragu-Nathan et al., 2008). In healthcare, EHR research similarly links usability, after-hours documentation, cognitive burden, and workflow disruption with burnout and stress (Alobayli et al., 2023; Murad et al., 2024; Wu et al., 2024).

This study does not adopt technological determinism. Participants did not claim that digital systems are inherently harmful. They described digital systems as ambivalent infrastructures: helpful when stable, integrated, clinically meaningful, and supported; parasitic when they duplicate manual work, invade rest time, intensify surveillance, or require clinicians to become data clerks during care. This distinction matters. The

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managerial problem is not the presence of technology. It is the HRM's failure to design adoption around cognitive limits, staffing realities, role boundaries, and recovery rights.

Human-centered HRM as a retention repair logic

Human-centered HRM in this article means more than supportive supervision or generic well-being programming. It names a configuration of HR practices that treats workers as clinical, emotional, digital, moral, and social actors. In healthcare, this requires fair workload distribution, transparent status and career pathways, recognition of emotional and professional labor, psychological and legal protections, digital boundary rules, meaningful training, and unit-level managerial autonomy. Human-centered HRM becomes a retention-repair logic when it reduces the care gap sufficiently to prevent committed staying from deteriorating into pragmatic or defensive staying.

Methodology

Design

The study used systematic grounded theory in the Strauss and Corbin tradition (Corbin & Strauss, 2015; Strauss & Corbin, 1998). The design was appropriate because the research aimed to explain a social process rather than merely describe themes. Open coding identified actions and incidents. Axial coding organized categories through conditions, context, action/interaction strategies, and consequences. Selective coding integrated the core category and theoretical model.

Table 2 is cited here because it anchors the sampling architecture of the study. It shows how each round contributed to theory development and how returning and new informants supported theoretical sampling rather than simple repetition.

Table 2. Participant configuration across interview rounds

Round	Sampling logic	Participants / sessions	Analytic purpose
Round 1	Purposive variation	18 participants / 18 sessions	Open broad categories: daily work, strain, digitalization, HRM support, career, and retention.
Round 2	Theoretical sampling	14 participants / 14 sessions; 8	Deepen categories including technostrain, employment status, care

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		returning and 6 new	gap, unit-level justice, and pragmatic staying.
Round 3	Model and typology validation	8 participants / 8 sessions; 7 returning and 1 new comparative case	Confirm and refine model, identify boundary conditions, and test the tripartite typology of staying.

Participants and theoretical sampling

The study involved 34 unique participants and 40 interview sessions. Participants represented clinical workers, support personnel, unit-level managers, and macro-HRM informants. Sampling began purposively to ensure variation across profession, employment status, unit risk, digital exposure, and managerial position. It then became theoretical. After Round 1 showed strong categories around RME, WhatsApp work, status insecurity, workload, and ignored complaints, Round 2 added informants from IT/RME, rekam medis, unit management, and non-ASN professions. After Round 2 clarified the four-part model, Round 3 selected informants able to validate, contest, or refine the emerging model. Table 3 specifies the analytic role of each group, so the reader can see why no group was included in the study as a decorative demographic category.

Table 3. Informant groups and analytic roles

Informant group	Analytic role in theoretical sampling
Nurses: ASN, contract, honorary, senior, junior, critical-unit, and ward roles	Core variation for workload strain, emotional labor, shift justice, status security, mentoring, and defensive staying.
Midwives in VK/KIA	Variation for maternal emotional strain, spiritual-professional calling, post-trauma support, and the risk of exploiting vocation.
Doctors: IGD, primary care, telemedicine	Variation for clinical autonomy, legal risk, digital overload, portfolio-based staying, and platform-mediated HRM.
Pharmacy and laboratory staff	Variation for zero-error work, invisible risk, stock/data pressure, professional recognition, and non-ward forms of strain.

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Rekam medis, claims, IT/RME personnel	Theoretical extension for documentation burden, system integration failure, technostrain, invisible digital labour, and non-clinical marginalization.
Head nurses/unit coordinators	Midline managerial view of two-directional pressure, constrained autonomy, unit justice, and translation of macro-HRM into daily care.
HRD / director/head of facility	Macro view of turnover data, fiscal constraints, status policy, retention programmes, and limits of bureaucratic control.

Data collection and interviewer management

Interviews were semi-structured and narrative-oriented. Round 1 asked broad questions about daily work, strain, digital systems, support, recognition, career prospects, and reasons for staying. Round 2 used the categories emerging from Round 1 to deepen technostrain, organizational justice, status insecurity, support gaps, and retention motives. Round 3 presented the provisional model and asked participants to confirm, qualify, or reject its components. Two interviewers conducted the interviews using shared guides.

The two interviewer datasets differed in texture. One produced more pattern-confirming accounts, while the other generated more elaborated, unit-specific narratives. Rather than treating this difference as noise, the analysis turned it into a dependability challenge. Table 4 documents the formal reconciliation protocol. This protocol is essential because interviewer style can shape the interactional production of qualitative data.

Table 4. Audit protocol for managing dual-interviewer data

Analytic risk	Audit response	Decision rule
Patterned answers produced by repeated guides	Flag repeated phrasing and avoid over-reliance on templated excerpts	Use patterned data for cross-case confirmation, not as primary conceptual evidence.
Richer narratives from one interviewer could dominate findings	Compare every major category across both interviewer datasets	Retain a category only if it appears across datasets or is theoretically justified as a boundary case.

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Interviewer interaction may shape emphasis	Maintain separate memos for each interviewer dataset before integration	Integrate only after the memo comparison identifies convergent and divergent incidents.
Possible profession/status over-generalization	Compare categories across profession, unit, status, and managerial level	Specify contextual boundaries whenever a mechanism is tied to ASN, contract, unit risk, or digital-role conditions.
Premature sufficiency claim	Track whether new incidents change properties, dimensions, or relationships among categories	Declare sufficiency only when Round 3 refines labels but does not alter the model structure.

Analysis and theoretical sufficiency

The analysis moved through three coding stages. Open coding generated action-oriented codes such as enduring unstable shifts, duplicating manual and digital work, silencing complaints, mentoring juniors, detaching emotionally, waiting for an appointment, protecting clinical autonomy, and treating digital failure as human workload. Axial coding connected these codes into categories: Layered Strain, Perceived Organizational Care Gap, Retention Reframing, and forms of Conditional Staying. Selective coding integrated these categories around the core category of Conditional Staying.

Table 5 is placed in the methodology because it provides a transparent bridge from data incidents to theoretical integration. This prevents the coding tables from functioning as ornamental evidence. Theoretical sufficiency was reached in Round 3 when no new incidents altered the model's core sequence. New material refined boundaries, such as the distinction between ASN defensive staying and contract pragmatic staying, but it did not generate a new major category or break the Layered Strain-Care Gap-Reframing-Staying sequence.

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Table 5. Coding trajectory from incidents to grounded theory

Analytic stage	Illustrative incidents or codes	Theoretical move
Open coding	Server down during clinical work; WhatsApp instructions after hours; ignored shift complaints; status anxiety; emotional detachment after trauma; portfolio-based staying	Identify repeated actions and meanings in participants' accounts.
Axial coding	Workload, emotional, digital, justice, status, and professional strains cluster into Layered Strain; support failures cluster into Care Gap; staying motives cluster into reframing logics	Connect categories through conditions, context, strategies, and consequences.
Selective coding	Participants stay through committed, pragmatic, or defensive forms depending on how care, security, calling, and opportunity reshape strain	Integrate Conditional Staying as the core category.

Context and transferability

The study's setting carries institutional particularity. The ASN/non-ASN divide, SIMRS/RME implementation, bureaucratic reporting, and public-sector employment security shaped several mechanisms. The model, therefore, should not be read as a universal claim that all health systems produce the same form of staying. Instead, it offers a transferable process explanation: where layered demands exceed felt care, workers reinterpret staying; the form of staying then depends on employment security, professional opportunity, labor-market alternatives, and local HRM architecture. In market-flexible systems, defensive staying may emerge from fear of income loss rather than from state-secure status. In public bureaucratic systems, it may hide behind low turnover and formal job security.

Ethics

Participants were anonymized using role-based codes. Direct quotations were edited lightly for readability without changing meaning. Ethical approval details, consent procedures, and data storage information should be included in accordance with the actual institutional approval before submission.

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Findings

The findings are organized around the final grounded theory model. Figure 1 summarizes the process after the components have been introduced in the text. The model is not a linear stress-outcome diagram. It shows how workers reinterpret strain through organizational care, employment status, professional meaning, and future opportunities.

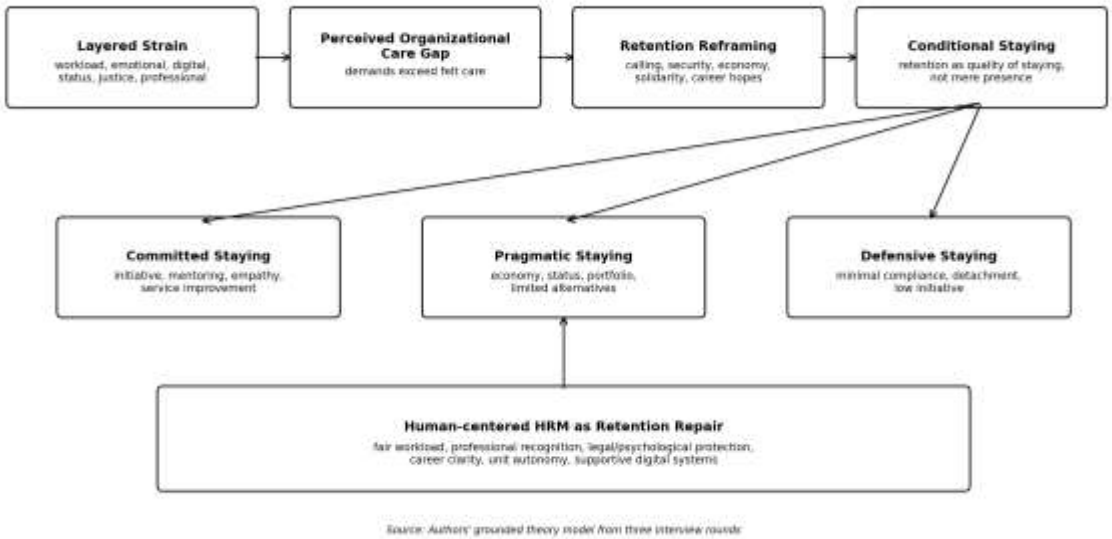


Figure 1. Conditional Staying Model of Healthcare Worker Retention

Layered Strain: pressure that accumulates across clinical, emotional, digital, and status domains

Participants rarely described one isolated source of strain. Workload strain came from patient volume, unstable shifts, simultaneous patient deterioration, crowded outpatient units, and insufficient staffing. Emotional strain emerged through death, family anger, maternal and infant risk, legal threat, and compassion fatigue. Digital strain was evident in RME/SIMRS failures, duplicate data entry, e-claims, telemedicine targets, dashboards, and WhatsApp work. Status strain came from differences between ASN, contract, honorary, employee, and platform-based arrangements. Professional strain appeared when administrative or fiscal control interfered with clinical judgment.

Round 3 confirmed that these layers interact rather than merely add up. A senior nurse explained that workers stay by raising their tolerance threshold, but the body and mind continue to absorb the cost. A critical-unit participant described the limit as the

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moment fast clinical action collides with documentation and no legal or psychological protection appears. A midwife added that maternal cases carry a form of emotional exposure that becomes intolerable after death or complications if the organization provides no post-case recovery. The category of Layered Strain therefore rejects a single-cause explanation of retention risk.

"The pressure does not disappear. We survive it by raising our tolerance, but the body and mind still pay the cost." (NUR-SEN, Round 3)

"In the critical unit, the problem is not only the number of patients. The limit breaks when fast clinical action collides with documentation, and there is no legal or psychological protection." (ICU/IGD, Round 3)

Technostrain as redistributed care work

Digital systems entered every round of data. Participants acknowledged digital benefits: integrated laboratory results, reduced handwriting errors, automated stock updates, faster claims tracking, and searchable patient histories. Their criticism targeted implementation design. Digital work became strained when the system failed, duplicated manual entry, invaded rest time, or demanded documentation during clinical urgency. The data, therefore, challenge technological determinism. RME is not inherently harmful. It becomes harmful when organizations treat digital implementation as a technical rollout while ignoring the cognitive, temporal, and emotional labor of users.

A rekam medis/IT informant stated that digitalization had created a new concentration of invisible labor: workers were expected to maintain data accuracy, handle server failure, reconcile platforms, and absorb complaints while receiving little recognition. A doctor in telemedicine described flexibility as attractive but undermined by rating systems and rapid-response targets. These accounts align with technostress research on techno-overload and techno-invasion, but they extend it by showing how digital strain shifts the quality of staying. Digital overload does not merely make work uncomfortable; it can convert committed staying into pragmatic or defensive staying.

"Digitalization helps if it is stable. When the server collapses, or the same data must be entered again manually, the burden simply moves to us." (REC/DGT, Round 3)

"In telemedicine, flexibility helps, but the rating system and response targets can make the work feel like constant digital surveillance." (DOC, Round 3)

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Perceived Organizational Care Gap: demands exceed felt care

Perceived Organizational Care Gap became the second major category. Participants did not evaluate organizational support by policy presence alone. They evaluated whether the organization provided enough care relative to the demands it imposed. Demands included patient load, legal risk, documentation, emotional exposure, digital responsiveness, and loyalty. Care included fair staffing, schedule justice, incentive fairness, recognition, professional autonomy, digital infrastructure, psychological recovery, legal protection, and career clarity.

The gap differed by status and profession. ASN workers had job security but could slide into defensive staying when security replaced commitment. Contract and honorary workers felt exposed to economic uncertainty and reduced voice. Doctors linked care to clinical autonomy and legal protection. Midwives linked care to recognition of maternal emotional labor. IT, claims, and rekam medis workers linked care to recognition of digital and administrative work that remained invisible until something failed.

“Management reads low turnover among ASN as retention success, but some of us are only physically present. Innovation dies quietly.” (NUR-SEN, round 3)

“For non-ASN staff, the problem is not only workload. The future is unclear, but the rights are unequal, and speaking up feels risky.” (NUR-KON/HON, round 3)

“We are treated as technical support, but the hospital's money depends on our data and claims accuracy. That work is invisible until something goes wrong.” (REC/DGT, round 3)

Retention Reframing: workers reinterpret why they stay

Retention Reframing describes the interpretive process between care gap and staying. Participants did not describe staying as a single, stable decision. They recalibrated it through professional calling, economic need, employment security, family location, portfolio building, peer solidarity, fear of contract non-renewal, or moral responsibility. Reframing explains why high strain does not always produce immediate exit. It also explains why staying can lose quality even without resignation.

Bidan informants demonstrated the complexity of calling. Spiritual and professional values helped them remain committed despite emotional strain. Yet they warned that organizations can exploit calling by using vocation to compensate for poor staffing, weak post-trauma support, or unequal professional recognition. Doctors and contract workers

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demonstrated a different reframing: staying as portfolio accumulation, economic survival, or waiting for a better offer.

"Calling still matters, but it cannot be used by the organization to replace fairness." (MID, Round 3)

"For some of us, staying is simply portfolio building. Once another institution offers better autonomy or remuneration, the reason to stay disappears." (DOC, Round 3)

Conditional Staying: a typology of the quality of staying

The selective coding stage produced three forms of Conditional Staying. Table 6 is introduced here because it is the central findings table, not a summary afterthought. It links the model to observable signs and HRM risks. The table also clarifies why retention quality matters more than turnover quantity.

Table 6. Typology of Conditional Staying

Type of staying	Core logic	Typical signs	Main HRM risk
Committed Staying	Staying remains meaningful and supported despite strain	Initiative, mentoring, empathy, learning, service improvement, advocacy for patients and unit	Calling can be exploited if fairness, recovery, and recognition are absent.
Pragmatic Staying	Staying is driven by economic need, status hope, portfolio value, location, or limited alternatives	Silent job search, waiting for appointment, transactional effort, dependence on external opportunities	Retention remains fragile; workers leave as soon as a better option appears.
Defensive Staying	Staying becomes protective compliance under the accumulated care gap	Minimal SOP compliance, reduced initiative, emotional detachment, resistance to change, and low innovation	Low turnover hides erosion of commitment and service quality.

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Committed Staying occurred when strain remained meaningful, and workers felt enough support from peers, unit leaders, or professional identity to keep investing effort. Pragmatic Staying occurred when workers stayed for economic or career reasons without strong affective commitment. Defensive Staying occurred when workers stayed because leaving felt impractical or status security made remaining easier, but commitment eroded. The last category is analytically important because it exposes a false positive in HR dashboards: low turnover can coexist with declining care quality and innovation.

DISCUSSION

From retention quantity to quality of staying

The first contribution is to shift retention theory from whether workers stay to how they stay. Existing retention research identifies predictors of intention to stay, but it often treats retention as a desirable endpoint. The findings complicate that assumption. Retention can be committed, pragmatic, or defensive. A stable workforce can therefore contain hidden fragility. This distinction is especially important in public or semi-public healthcare systems where job security, pension expectations, or rigid employment rules can suppress turnover while allowing commitment to decline.

This contribution does not reject turnover research. It argues that turnover indicators must be complemented by qualitative indicators of staying: initiative, mentoring, empathy, willingness to learn, voice behavior, emotional availability, and participation in service improvement. Human-centered HRM cannot celebrate low resignation rates unless it can also demonstrate that workers remain psychologically, professionally, and ethically engaged.

Perceived Organizational Care Gap and its theoretical boundary

The second contribution is the Perceived Organizational Care Gap. The construct adds value only if it remains theoretically disciplined. It should not be used as a loose synonym for support, breach of contract, or obstruction. POS explains beliefs about support and valuation. Psychological contract breach explains perceived failure to fulfill obligations. Perceived organizational obstruction explains the organization as a hindrance. Perceived Organizational Care Gap explains a proportionality judgment under layered strain: workers compare what the organization demands with what it returns as care, protection, recognition, and enabling infrastructure.

The construct, therefore, has three boundary conditions. First, it becomes visible under high-demand work where the organization asks for sacrifice, risk-bearing,

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availability, and emotional regulation. Second, it concerns the adequacy of returned care relative to those demands, not merely whether a promise was broken. Third, it affects the form of staying by shaping whether workers interpret continued employment as meaningful, necessary, or defensive. In this sense, the construct extends social exchange theory into a sector-specific account of healthcare labor.

Technostrain as HRM, not merely IT

The third contribution is the repositioning of technostrain. Information systems research has long shown that technology can create stress through overload, invasion, complexity, insecurity, and uncertainty. The present study shows how those mechanisms enter HRM. Digital systems reshape staffing, documentation, rest, voice, surveillance, and professional identity. When RME, SIMRS, e-claims, telemedicine, dashboards, or WhatsApp work increase cognitive load without staffing or recovery design, technostrain becomes a retention mechanism.

The findings directly challenge the assumption that digital adoption naturally improves efficiency. Participants described digital systems as useful when stable and integrated, but parasitic when they extracted time, multiplied documentation, or shifted accountability downward. This does not support anti-technology nostalgia. It supports human-centered digital HRM: co-design with users, realistic workload accounting, digital boundary rules, IT staffing, an after-hours communication policy, and recognition of digital support labor.

Institutional specificity and transferability

The study's model emerged from an Indonesian healthcare context where ASN security, non-ASN precarity, SIMRS/RME implementation, and bureaucratic reporting shaped the form of staying. This specificity strengthens rather than weakens the analysis when stated clearly. Defensive Staying among ASN workers reflects a public-sector mechanism: secure employment can preserve presence while eroding innovation. Pragmatic staying among contract, honorary, and platform-based workers reflects a different mechanism: insecurity can preserve presence through economic necessity while weakening voice and commitment.

The model can travel analytically, but not mechanically. In flexible labor markets, defensive staying may arise through fear of unemployment or loss of health benefits rather than ASN security. In platform-mediated healthcare, pragmatic staying may arise from rating algorithms and income instability. In well-resourced systems, the care gap

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may narrow through staffing and legal protection but widen through digital surveillance or loss of professional autonomy. The theory is therefore transferable as a process model, not as a claim that every health system shares the same institutional drivers.

Paradigm model and propositions

Because the study uses systematic grounded theory, the final model can be expressed through the Strauss and Corbin paradigm. Table 7 integrates the categories into conditions, context, strategies, and consequences. The table is placed in the discussion because it translates findings into a theoretical structure that readers can evaluate.

Table 7. Grounded theory paradigm model

Paradigm element	Grounded content in this study
Causal conditions	Patient overload, staffing shortage, emotional events, digital overload, unstable schedules, employment-status insecurity, and clinical/legal risk.
Central phenomenon	Conditional Staying: staying whose quality depends on how workers reinterpret strain under perceived care conditions.
Context	Profession, unit risk, ASN/non-ASN status, public/private or platform arrangement, digital exposure, local labor market, and managerial autonomy.
Intervening conditions	Peer solidarity, unit leadership, professional calling, legal/psychological protection, fair workload, career clarity, digital infrastructure, HR responsiveness.
Action/interaction strategies	Raising tolerance thresholds, seeking peer support, detaching emotionally, mentoring, innovating, complying minimally, and waiting for alternatives.
Consequences	Committed Staying, Pragmatic Staying, Defensive Staying, low-turnover illusion, eroded innovation, delayed exit, or renewed commitment.

The model yields five theoretical propositions for future work. First, healthcare workers remain because strain is not absent but because they reinterpret layered strain through professional, economic, relational, and organizational meanings. Second, the

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Perceived Organizational Care Gap shapes the quality of staying by affecting whether strain is interpreted as bearable, unjust, or exploitative. Third, human-centered HRM shifts toward commitment when it supplies a fair workload, recognition, psychological safety, legal protection, and supportive digital systems. Fourth, technostrain accelerates movement from committed to pragmatic or defensive staying when technology increases the administrative burden without adequate resources. Fifth, low turnover among secure-status workers can conceal defensive staying rather than successful retention.

Practical Implications

The findings demand practical reorientation. HR units should stop treating turnover rates as sufficient evidence of retention health. They need diagnostic tools that identify committed, pragmatic, and defensive staying. Table 8 translates the grounded theory into actionable HRM interventions and should be read as the applied counterpart of the theoretical model.

Table 8. Human-centered HRM implications by retention risk

Retention risk	Human-centered HRM action
Committed to staying at risk of erosion	Protect professional meaning with fair workload, visible recognition, recovery time, and professional autonomy.
Pragmatic Staying among contract/honorary workers	Create transparent appointment pathways, equitable incentives, voice safety, access to development, and predictable contract rules.
Defensive Staying among secure workers	Measure initiative, innovation, mentoring, and emotional availability, not only attendance and turnover.
Technostrain-driven withdrawal	Integrate systems, reduce duplicate entry, regulate after-hours messaging, fund IT staffing, and involve end users in design.
Unit-critical exhaustion	Use acuity-based staffing and incentives, post-trauma debriefing, legal protection, and rotation or recovery policies.

For healthcare managers, the central lesson is uncomfortable. Organizations cannot rely indefinitely on professional calling, ASN security, or economic necessity to retain workers. Those mechanisms preserve presence, but they do not guarantee

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commitment. Human-centered HRM must treat workers with care as part of the quality of care for patients.

Limitations and Future Research

The study has limitations. First, its institutional context matters. The ASN/non-ASN divide and Indonesian public-sector bureaucracy shaped several mechanisms, especially Defensive Staying. Future studies should test the model in private hospitals, faith-based facilities, platform-based telemedicine, and health systems with more flexible labor markets. Second, the study used interviews rather than direct ethnographic observation. Future work could examine whether defensive staying appears in clinical handover, documentation practices, or patient communication. Third, the data were collected by two interviewers whose interactional styles differed. The study addressed this through audit protocols and constant comparison, but future studies could use paired interviewing or inter-interviewer calibration sessions from the outset. Fourth, the proposed construct of Perceived Organizational Care Gap requires further theoretical and empirical development. Quantitative scale development could assess its discriminant validity relative to POS, psychological contract breach, and perceived organizational obstruction.

CONCLUSION

This study developed a systematic grounded theory of healthcare worker retention as Conditional Staying. Healthcare workers stay not because strain disappears, but because they reinterpret layered clinical, emotional, digital, administrative, and status pressures through professional calling, peer solidarity, economic necessity, employment security, career aspirations, and perceived organizational care. When care matches demand, staying committed remains. When care is weak but practical constraints remain strong, staying becomes pragmatic. When secure employment meets a persistent care gap, staying becomes defensive.

The article contributes to HRM theory by showing that retention must be judged by quality, not only by continuity. It demarcates Perceived Organizational Care Gap from adjacent constructs, repositions technostrain as an HRM problem, and demonstrates how public-sector employment security can conceal eroding commitment. For healthcare organizations, the implication is clear: retaining bodies is not the same as retaining commitment. Human-centered HRM must repair the care gap before staying becomes merely an administrative presence.

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REFERENCES

Alobayli, F., O'Connor, S., Holloway, A., & Cresswell, K. (2023). Electronic health record stress and burnout among clinicians in hospital settings: A systematic review. Digital Health, 9, 20552076231220241. https://doi.org/10.1177/20552076231220241

Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State of the art. Journal of Managerial Psychology, 22(3), 309-328. https://doi.org/10.1108/02683940710733115

Bakker, A. B., & Demerouti, E. (2017). Job demands-resources theory: Taking stock and looking forward. Journal of Occupational Health Psychology, 22(3), 273-285. https://doi.org/10.1037/ocp0000056

Blau, P. M. (1964). Exchange and power in social life. Wiley.

Colquitt, J. A. (2001). On the dimensionality of organizational justice: A construct validation of a measure. Journal of Applied Psychology, 86(3), 386-400. https://doi.org/10.1037/0021-9010.86.3.386

Corbin, J., & Strauss, A. (2015). Basics of qualitative research: Techniques and procedures for developing grounded theory (4th ed.). SAGE.

de Vries, N., Boone, A., Godderis, L., Bouman, J., Szemik, S., Matranga, D., & de Winter, P. (2023). The race to retain healthcare workers: A systematic review on factors that impact retention of nurses and physicians in hospitals. Inquiry, 60, 1-21. https://doi.org/10.1177/00469580231159318

Eisenberger, R., Huntington, R., Hutchison, S., & Sowa, D. (1986). Perceived organizational support. Journal of Applied Psychology, 71(3), 500-507. https://doi.org/10.1037/0021-9010.71.3.500

Galanis, P., Vraka, I., Fragkou, D., Bilali, A., & Kaitelidou, D. (2021). Nurses' burnout and associated risk factors during the COVID-19 pandemic: A systematic review and meta-analysis. Journal of Advanced Nursing, 77(8), 3286-3302. https://doi.org/10.1111/jan.14839

Gibney, R., Zagenczyk, T. J., Fuller, J. B., Hester, K., & Caner, T. (2011). Exploring organizational obstruction and the expanded model of organizational identification. Journal of Applied Social Psychology, 41(5), 1083-1109. https://doi.org/10.1111/j.1559-1816.2011.00748.x

Mackey, J. D., McAllister, C. P., Brees, J. R., Huang, L., & Carson, J. E. (2018). Perceived organizational obstruction: A mediator that addresses source-target misalignment

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between abusive supervision and OCBs. Journal of Organizational Behavior, 39(10), 1283-1295. https://doi.org/10.1002/job.2293

Muhamad, R., et al. (2025). Technostress, burnout and fatigue among healthcare workers: Evidence from digital health work. PLOS ONE, 20(2), e0319506. https://doi.org/10.1371/journal.pone.0319506

Murad, M. H., Vaa Stelling, B. E., West, C. P., Hasan, B., Simha, S., Saadi, S., Firwana, M., Viola, K. E., Prokop, L. J., Nayfeh, T., & Wang, Z. (2024). Measuring documentation burden in healthcare. Journal of General Internal Medicine, 39(14), 2837-2848. https://doi.org/10.1007/s11606-024-08956-8

Pressley, C., & Garside, J. (2023). Safeguarding the retention of nurses: A systematic review on determinants of nurse's intentions to stay. Nursing Open, 10(2), 284-303. https://doi.org/10.1002/nop2.1361

Ragu-Nathan, T. S., Tarafdar, M., Ragu-Nathan, B. S., & Tu, Q. (2008). The consequences of technostress for end users in organizations: Conceptual development and empirical validation. Information Systems Research, 19(4), 417-433. https://doi.org/10.1287/isre.1070.0165

Rhoades, L., & Eisenberger, R. (2002). Perceived organizational support: A review of the literature. Journal of Applied Psychology, 87(4), 698-714. https://doi.org/10.1037/0021-9010.87.4.698

Rousseau, D. M. (1989). Psychological and implied contracts in organizations. Employee Responsibilities and Rights Journal, 2(2), 121-139. https://doi.org/10.1007/BF01384942

Strauss, A., & Corbin, J. (1998). Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.). SAGE.

Tarafdar, M., Tu, Q., Ragu-Nathan, B. S., & Ragu-Nathan, T. S. (2007). The impact of technostress on role stress and productivity. Journal of Management Information Systems, 24(1), 301-328. https://doi.org/10.2753/MIS0742-1222240109

Woo, T., Ho, R., Tang, A., & Tam, W. (2020). Global prevalence of burnout symptoms among nurses: A systematic review and meta-analysis. Journal of Psychiatric Research, 123, 9-20. https://doi.org/10.1016/j.jpsychires.2019.12.015

World Health Organization. (2024). Health workforce. https://www.who.int/health-topics/health-workforce

Wu, Y., Wu, M., Wang, C., Lin, J., Liu, J., & Liu, S. (2024). Evaluating the prevalence of burnout among health care professionals related to electronic health record use:

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Systematic review and meta-analysis. JMIR Medical Informatics, 12, e54811. https://doi.org/10.2196/54811

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