

The Effect of Toxic Workplace Environment on Work Engagement (Study at ENT X Special Hospital, Jakarta)

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ABSTRACT

A toxic workplace environment has become a critical issue in healthcare organizations because negative workplace behaviors can reduce employees' psychological well-being and work engagement, ultimately affecting service quality. This study aimed to analyze the level of toxic workplace environment, identify the dominant dimensions contributing to workplace toxicity, measure employee work engagement, and examine the effect of a toxic workplace environment on work engagement among employees at ENT X Special Hospital, Jakarta. This research employed a quantitative approach with a descriptive-verification design. Data were collected from 50 employees using questionnaires based on toxic workplace environment and work engagement indicators, supported by interviews and organizational document analysis. Data were analyzed using descriptive analysis, validity and reliability tests, classical assumption tests, Pearson correlation analysis, and simple linear regression using SPSS. The findings revealed that the toxic workplace environment was categorized as high, with bullying identified as the most dominant dimension, followed by harassment and abusive supervision. Employee work engagement was categorized as moderate, with absorption identified as the strongest dimension. Statistical analysis showed that a toxic workplace environment had a significant negative effect on work engagement, indicated by a very strong negative relationship between the variables. Despite experiencing a highly toxic work environment, employees maintained moderate levels of engagement due to professional commitment and ethical values in providing healthcare services. This study concludes that organizational efforts to reduce workplace toxicity through anti-bullying policies, effective leadership practices, improved communication, and employee protection mechanisms are essential for establishing a healthier and more sustainable healthcare work environment.

INTRODUCTION

Attention to the quality of the work environment has developed into a global issue that extends beyond academic discussions and has become a concern for business practitioners and policymakers. Increasingly intense competition encourages organizations to pursue high performance targets, which may sometimes occur at the expense of employee well-being, resulting in work conditions characterized by pressure, conflict, and unethical behavior. The concept of toxicity, which originally emerged from the field of chemistry, was adopted in management studies during the 1980s to describe harmful organizational conditions. In the management context, a toxic workplace environment refers to conditions that cause employee distress and reduce work enthusiasm through negative effects on morale and motivation

(Taştan, 2023). This phenomenon has been identified across countries and sectors, including organizations in Pakistan (Anjum & Ming, 2018), China (Zhenjing et al., 2022), and Indonesia (Larasati & Prajogo, 2022). The healthcare sector is particularly vulnerable due to job characteristics requiring high accuracy, extended working hours, and intensive emotional interactions. The World Health Organization (2020) has placed the quality of healthcare workers' work environments as a global strategic priority, considering that poor working conditions contribute to the global health workforce crisis and threaten the sustainability of healthcare systems (Figuerola et al., 2019).

The development of a toxic work environment in hospitals is influenced by several interconnected factors. Structural factors include excessive workload, limited staffing, and rigid hierarchical organizational structures, which may create opportunities for power abuse between supervisors and subordinates as well as between senior and junior employees (Matthiesen & Einarsen, 2007). Leadership factors also contribute through abusive supervision, ineffective leadership practices, and limited career development opportunities that reduce employee job satisfaction (Yastin & Suwarsi, 2023). Interpersonal factors appear in forms such as workplace gossip, unhealthy competition, ineffective communication, and disrespectful behaviors that spread within work units (Andersson, 1999). Employment-related factors also play an important role, particularly the use of short-term employment contracts that create job insecurity among healthcare workers (Thirikwa et al., 2024). In Indonesia, although Law No. 13 of 2003 concerning Manpower and Government Regulation No. 50 of 2012 concerning Occupational Safety and Health Management Systems regulate worker protection and psychosocial risk management, their implementation in hospital environments remains challenging. This implementation gap may provide opportunities for toxic behaviors to emerge in healthcare workplaces.

The accumulation of these factors has serious consequences at both individual and organizational levels. At the individual level, repeated exposure to toxic workplace behaviors is associated with increased work stress, anxiety, emotional exhaustion, and reduced psychological well-being, which may subsequently decrease employee performance (Wright & Cropanzano, 2000; Larasati & Prajogo, 2022). At the organizational level, toxic work environments contribute to weakened teamwork, increased absenteeism, and higher intentions to leave as well as actual employee turnover (Khan, 2016; Al Yahyaei et al., 2022). Kurniawan et al. (2023) found that toxic work environments positively influenced work stress and negatively affected employee engagement among workers in Jakarta, while Augustine et al. (2025) demonstrated that toxic workplaces influenced employees' intention to leave through reduced employee engagement. These impacts are particularly critical in hospitals because decreased healthcare worker engagement directly affects patient interactions, clinical accuracy, and patient safety. Therefore, a toxic work environment is not merely an organizational climate issue but also a concern related to public healthcare service quality (Al Yahyaei et al., 2022).

Conceptually, a toxic workplace environment refers to unfavorable working conditions in which the workplace atmosphere, organizational climate, work systems, and interpersonal interactions negatively affect employees' comfort and psychological well-being. This construct is measured through five dimensions: bullying, defined as repeated hostile behavior directed toward individuals (Einarsen, 2003); harassment, referring to unwanted behaviors related to personal characteristics such as gender, race, or physical appearance (Fitzgerald, 1995); ostracism, referring to intentional exclusion from social interactions (Ferris, 2008); incivility, referring to low-intensity disrespectful behavior with ambiguous intent (Blau, 2005); and abusive supervision, referring to hostile verbal and nonverbal behaviors by supervisors. Work engagement refers to a positive work-related psychological state reflected through three dimensions: vigor, characterized by energy and mental resilience; dedication, characterized by involvement, enthusiasm, and pride; and absorption, characterized by deep concentration and

immersion in work activities (Schaufeli et al., 2002; Bakker, 2018). The relationship between these variables can be explained through the Job Demands–Resources model, which positions toxic workplace behaviors as job demands that consume employee energy and reduce work engagement (Demerouti et al., 2001; Bakker et al., 2007).

Previous studies examining the relationship between toxic workplace environments and work engagement have produced varying findings. Several studies confirmed a strong negative relationship between these variables (Rasool et al., 2021; Kurniawan et al., 2023), while another study found that toxic workplace environments did not significantly affect employee engagement when mediated by organizational culture and support (Cherlyn & Sentoso, 2022). In Indonesia's healthcare sector, previous research has generally examined the work environment as a broad predictor of performance rather than focusing specifically on workplace toxicity as a predictor of work engagement (Burhannudin et al., 2019). The novelty of this research lies in two aspects. First, the study was conducted in a specialized private hospital with a relatively small organizational scale, a context that has received limited attention despite its unique characteristics, including limited resources, overlapping job responsibilities, and contractual or partnership-based employment relationships. Second, this study identified a pattern in which moderate work engagement persisted despite a high level of workplace toxicity. Based on interview findings, this pattern was associated with strong professional ethics and healthcare workers' professional values. These findings highlight professional values as a potential protective factor that remains underexplored in toxic workplace environment research.

The urgency of this research is strengthened by conditions identified at ENT X Special Hospital, Jakarta. Personnel records from October 2024 to October 2025 indicated that ten employees resigned from various work units, including medical and non-medical staff. These resignations were accompanied by absenteeism and work delays managed through task backup mechanisms, increasing workloads among remaining employees. Preliminary reviews of standard operating procedures and employment agreements identified the use of fixed-term employment agreements lasting twelve months, wage withholding during the initial three months, multiple job responsibilities, sudden changes in work regulations, and salary deduction policies as disciplinary measures. Preliminary interviews indicated experiences of intimidation related to supervisor behavior, limited recognition, and ineffective team communication. In addition, the hospital did not yet have a systematic workplace toxicity prevention program, behavioral ethics education materials for patients and families, or comprehensive behavioral standards accompanied by clear sanctions. These conditions highlight the need for empirical research as a basis for developing effective managerial policies.

Based on this background, this study aimed to analyze three aspects. First, it examined the level of toxic workplace environment at ENT X Special Hospital, Jakarta, and identified the dominant dimensions contributing to workplace toxicity. Second, it assessed the level of employee work engagement and determined the most prominent dimensions. Third, it examined the magnitude and direction of the influence of toxic workplace environment on employee work engagement among both medical and non-medical personnel, providing insight into how workplace toxicity explains variations in employee engagement within a specialized hospital context.

The results of this study are expected to provide theoretical and practical contributions. Theoretically, this research contributes to organizational behavior and healthcare human resource management literature by expanding the application of the Job Demands–Resources model within specialized hospital settings and highlighting the potential role of professional values and ethics as protective factors for work engagement. Practically, the findings may support hospital management in developing anti-bullying and anti-harassment procedures, improving complaint management systems, clarifying job descriptions, and strengthening

internal communication to establish a healthier work environment (Ulrich & Dulebohn, 2015; Anjani et al., 2024). For future researchers, this study may serve as a reference for developing models incorporating additional variables, such as leadership, organizational support, and organizational culture, as well as applying qualitative and comparative approaches across healthcare facilities.

METHOD

Research Design and Strategy

This study employed a quantitative research method with a descriptive-verification approach. This approach was selected because the research aimed to describe the level of toxic workplace environment and work engagement experienced by employees and empirically examine the relationship between the two variables. The descriptive approach was used to identify the levels and dimensions of toxic workplace environment and work engagement, while the verification approach was applied to test the hypothesis regarding the negative effect of toxic workplace environment on work engagement (Sugiyono, 2021). The combination of these approaches enabled the study to provide both descriptive findings and statistical evidence to support managerial recommendations (Hardani, 2020).

Location, Time, and Scope of Research

This research was conducted at ENT X Special Hospital, a private specialized hospital located in Jakarta. The research site was selected because it represented the characteristics relevant to the research problem, including limited workforce capacity, overlapping job responsibilities, contractual and partnership-based employment relationships, and the absence of a structured toxic workplace environment prevention program. The observation period covered personnel data from October 2024 to October 2025, while primary data collection was conducted at the end of the observation period. The research scope was limited to a single hospital to analyze employee perceptions within the same management system, organizational policies, and workplace culture rather than variations between different institutions (Robbins & Judge, 2017). The study examined employee perceptions of negative workplace behaviors, work engagement levels, and organizational conditions related to standard operating procedures, employment agreements, and conflict management mechanisms.

The research population consisted of all 50 employees of ENT X Special Hospital, including medical and non-medical personnel such as specialists, general practitioners, nurses, pharmacists, radiographers, medical record officers, receptionists, cashiers, administrative staff, financial staff, technicians, cleaners, and security personnel. Since the population size was relatively small, all employees were included as respondents using a total sampling technique (Sugiyono, 2021). The inclusion criteria included employees with formal employment relationships, employees directly involved in hospital operations, employees aged at least 18 years, and employees willing to participate by providing informed consent. The exclusion criteria included third-party vendor employees, employees not directly involved in hospital operations, and employees on extended leave or those who submitted incomplete questionnaires.

Data Collection Instruments and Techniques

The primary instrument used in this study was a closed-ended questionnaire developed based on indicators of the research variables and measured using a five-point Likert scale ranging from strongly disagree to strongly agree (Bodur et al., 2025). The toxic workplace environment variable was measured using 23 statements representing five dimensions: bullying (Einarsen, 2003), harassment (Fitzgerald, 1995), ostracism (Ferris, 2008), incivility (Blau, 2005), and abusive supervision. These items assessed employees' experiences of negative workplace behaviors during the previous six months from three sources: interactions among employees, supervisor-subordinate relationships, and interactions with patients or patients'

families. The work engagement variable was measured using 21 statements representing the dimensions of vigor, dedication, and absorption (Schaufeli et al., 2002; Bakker, 2018). To provide additional contextual understanding of the quantitative findings, semi-structured interviews were conducted with selected employees (Arianto & Rani, 2024). Secondary data were obtained from internal hospital documents, including standard operating procedures, workplace behavior guidelines, employment agreements, personnel records, relevant scientific literature, and labor regulations (Sugiyono, 2021).

Instrument Feasibility Test

Before hypothesis testing, the research instruments were evaluated to ensure validity and reliability. Validity testing was conducted using Pearson product-moment correlation with an r -table value of 0.2759 for 50 respondents. All questionnaire items were declared valid because their calculated r -values exceeded the required threshold. Reliability testing was performed using Cronbach's alpha, producing values of 0.944 for toxic workplace environment and 0.769 for work engagement, indicating that both instruments were reliable (Ghozali, 2018).

Data Analysis Techniques

Data analysis was conducted using SPSS software through descriptive and verification analyses. Descriptive analysis was performed by calculating mean scores for each item and dimension and categorizing responses into five levels ranging from "very low" to "very high." The results were used to identify dominant dimensions and determine priority areas for managerial improvement (Siregar, 2021).

Verification analysis was conducted through several statistical tests. Classical assumption tests included the Kolmogorov–Smirnov normality test and the Glejser heteroscedasticity test using a significance level greater than 0.05 as the criterion (Iba & Wardhana, 2024; Ghozali, 2018). Pearson correlation analysis was then conducted to determine the direction and strength of the relationship between variables. Simple linear regression analysis was applied to measure the effect of toxic workplace environment as the independent variable on work engagement as the dependent variable (Agus & Nano, 2016; Nurhaswinda et al., 2025). Hypothesis testing was performed using a partial t -test at a significance level of 0.05, accompanied by the coefficient of determination to determine the proportion of variance in work engagement explained by toxic workplace environment. Interview findings were used to support the interpretation of statistical results, particularly in explaining patterns that differed from theoretical expectations and developing practical recommendations based on organizational conditions.

RESULTS AND DISCUSSION

The study was conducted with 50 respondents, comprising the entire staff of the X Specialized ENT Hospital in Jakarta. The findings are presented in six sections: respondent profiles, instrument validity test results, an overview of the toxic workplace environment level, an overview of the work engagement level, classical assumption test results, and the results of the analysis regarding the influence between variables. This presentation follows the structure of the problem statement, ensuring that the connection between each finding and the research questions can be clearly traced.

Respondent Profiles

All participating respondents worked at ENT-Specialized Hospital X; thus, there was full alignment between the respondents and the established inclusion criteria. This institutional uniformity is significant because it allows any observed variations in perception to be more accurately attributed to the hospital's internal conditions rather than to policy differences across institutions (Robbins & Judge, 2017). Detailed respondent characteristics are presented in Table 1.

Table 1. Respondent Characteristics (n = 50)

Characteristics	Category	Quantity	Percentage
Gender	Male	21	42%
	Female	29	58%
Age	15–24 years	4	8%
	25–44 years	31	62%
	45–60 years	8	16%
	> 60 years	7	14%
Employment status	PKWT	35	70%
Characteristics	Partner	15	30%

In terms of gender, female respondents outnumbered males. This proportion aligns with literature indicating that the health sector has historically undergone feminization where caregiving and patient-service professions are constructed in line with female gender roles (George, 2008) and reflects the high demand for frontline care personnel, a workforce predominantly composed of women (WHO, 2022; Kuhlmann et al., 2018). Regarding age, the majority of respondents fell within the 25–44 age bracket, representing the prime productive years a group characterized by optimal competence, high adaptability, and strong work commitment (Buchan et al., 2019). The 45–60 age group represents the mid-career workforce with deeper experience, whereas respondents over the age of 60 generally serve in supervisory, educational, and administrative roles (WHO, 2020).

Regarding employment status, the predominance of fixed-term contract (PKWT) employees reflects the hospital's strategy of managing its workforce flexibly to adjust to workloads and maintain service continuity (Thirikwa et al., 2024), while partnership schemes are applied to general practitioners and specialists. This composition is relevant to the research problem, as the majority of respondents hold positions where the continuity of employment depends on management assessment.

Instrument Feasibility Test Results

Prior to analysis, the suitability of all instrument items was tested. The validity test results indicated that all 23 statement items for the "toxic workplace environment" variable and all 21 statement items for the "work engagement" variable yielded calculated r-values exceeding the r-table value of 0.2759; thus, they were deemed valid. The reliability test results are presented in Table 2.

Table 2. Reliability Test Results

Variabel	Cronbach's Alpha	Number of Items	Information
<i>Toxic workplace environment</i>	0,944	23	Reliable
<i>Work engagement</i>	0,769	21	Reliable

Both variables yielded Cronbach's alpha values above 0.7; thus, the instrument was deemed to possess adequate internal consistency and to be suitable for further testing (Ghozali, 2018).

Toxic Workplace Environment Level

Measurement was conducted using a five-point Likert scale, interpreted through five categories with an interval of 0.8: very low (1.00–1.80), low (1.81–2.60), moderate (2.61–3.40), high (3.41–4.20), and very high (4.21–5.00). This variable was measured using 23 statements designed to capture employees' experiences over the past six months regarding behaviors originating from three sources: among employees, from superiors to subordinates, and from patients and their families toward employees. The mean scores for all items ranged from 2.84 to 4.74, indicating that no form of negative behavior fell into the low or very low

categories. A summary of the measurement results for each item across the five dimensions is presented in Table 3.

Table 3. Distribution of Item Scores for the Toxic Workplace Environment Variable (n = 50)

Dimensions	Statement Item	Average	Category
Bullying	Discomfort due to harsh treatment, mockery, or intimidation	4,68	Very High
	Work disruption due to rumors, negative gossip, or work sabotage	4,74	Very High
	Distress due to threats, psychological manipulation, or a supervisor ignoring complaints	3,96	High
	Anxiety due to unaddressed verbal or physical threats from patients	3,58	High
	Distress due to pressure to serve patients beyond the scope of duties	3,48	High
Harassment	Anxiety due to verbal abuse or identity-based discrimination	4,26	Very High
	Distress due to sexual harassment or power-based threats	3,80	High
	Anxiety due to harassment not being adequately addressed	4,04	High
	Anxiety due to delays in handling harassment complaints	3,70	High
	Anxiety due to demeaning comments and inappropriate jokes	4,14	High
Ostracism	Discomfort due to exclusion from important discussions and decisions	3,94	High
	Anxiety due to being treated as invisible or being withheld from work-related information	4,04	High
	Discomfort due to achievements and contributions being	4,28	Very High

	overlooked in performance evaluations		
	Distress due to rejection or discrimination by patients	4,14	High
Incivility	Discomfort due to colleagues' cynicism, indifference, or interruptions	2,84	Moderate
	Anxiety due to demeaning communication in front of others	2,84	Moderate
	Anxiety due to disrespectful behavior from patients or their families	2,90	Moderate
	Anxiety due to a lack of respect for professional advice	2,98	Moderate
Abusive supervision	Distress due to the use of authority to intimidate or humiliate	3,72	High
Dimensions	Anxiety due to excessive and non-constructive criticism	3,96	High
Bullying	Anxiety due to pressure to perform tasks outside of one's responsibilities	3,88	High
	Anxiety due to employee input and complaints being ignored	3,88	High
	Distress due to unfair treatment or favoritism by a supervisor	3,94	High

The bullying dimension recorded the highest mean score (4.08), placing it in the "high" category. The two highest-scoring items across the entire instrument belonged to this dimension: distress caused by the spreading of rumors and work sabotage, and discomfort resulting from harsh treatment and intimidation. Interview findings corroborated these results; several employees reported being subjected to demeaning remarks and harsh criticism in front of others, as well as a culture of blame-shifting following incidents within their work units. Employees were also assigned workloads beyond their primary responsibilities without additional compensation or other forms of recognition, while the hospital remained reluctant to hire more staff due to cost-efficiency concerns. Consequently, some new employees resigned before their probationary periods had even ended. This pattern underscores that bullying within the hospital is not merely an isolated, individual occurrence but is instead embedded in the workplace dynamics consistent with Einarsen's (2003) assertion that recurring hostile behavior is rooted in power relations and organizational structures.

The harassment dimension scored an average of 3.98, placing it in the high category. The highest scores were associated with anxiety stemming from verbal abuse and discrimination based on physical appearance, race, gender, religion, or personal preferences. Interview results revealed that harassment occurred horizontally among colleagues, vertically from superiors, and externally from patients and their families. Reported behaviors included shouting, pointing fingers, slamming tables, and threats to photograph and report staff members. Negative comments on social media and online reviews that misrepresented actual conditions further strained the psychological well-being of healthcare workers, particularly when management blamed employees without allowing them an opportunity to clarify the situation. These findings indicate that harassment stems not only from internal workplace relationships but also from interactions with service recipients, aligning with the conceptualization of harassment as unwanted behavior linked to the victim's personal attributes (Fitzgerald, 1995).

The ostracism dimension yielded a mean score of 3.28, placing it in the moderate category, even though all its constituent items fell within the high to very high ranges. The highest-scoring item related to the disregard for achievements and contributions during performance evaluations. Interviews revealed that this disregard was evident in the lack of employee involvement in critical decision-making such as the unilateral decision to switch to an electronic medical record system without consulting those directly affected. The absence of measurable performance metrics, such as Key Performance Indicators (KPIs), meant that evaluations relied on supervisors' subjective perceptions, thereby fostering a sense of unfairness. Some employees noted that efforts to compensate for operational shortcomings went unappreciated, whereas minor errors were quickly highlighted. These conditions fostered feelings of alienation and demotivation, consistent with Ferris's (2008) explanation that workplace ostracism operates through forms of disregard that, while not always explicit, have a cumulative impact.

The incivility dimension obtained a mean score of 3.37, placing it in the moderate category, and represented the dimension with the lowest item scores within this variable. Reported behaviors included sarcasm, a demeaning tone, and the dismissal of opinions during meetings originating from colleagues, superiors, and patients alike. Although the intensity of these behaviors was lower than that of other dimensions, they occurred repeatedly and undermined interpersonal harmony among staff; this aligns with Andersson's (1999) findings that low-intensity incivility tends to be contagious and can escalate into more serious conflict if left unchecked.

The abusive supervision dimension obtained a mean score of 3.87 categorized as high and showed a relatively even distribution of scores across all its items. Excessive, non-constructive criticism received the highest score, followed by unfair treatment and favoritism by superiors. Interviews revealed excessive interference by the foundation in operational matters including the direct evaluation and criticism of employee performance which was deemed inconsistent with structural roles and reinforced an intimidating atmosphere. A summary of the five dimensions is presented in Table 4.

Table 4. Summary of Toxic Workplace Environment Levels

Dimensions	Average	Category
Bullying	4,08	High
Harassment	3,98	High
Ostracism	3,28	Medium
Incivility	3,37	Medium
Abusive supervision	3,87	High
Total average	4,04	High

An overall average score of 4.04 was obtained by dividing the total score of 93.02 by the 23 statement items; on the continuum scale, this falls within the 3.41–4.20 range, which is categorized as high. These findings indicate that employees at ENT Specialty Hospital X perceive their work environment as uncondusive, with bullying identified as the most dominant form of negative behavior.

Work Engagement Level

The work engagement variable was measured using 21 statements representing the dimensions of vigor, dedication, and absorption, all utilizing the same rating scale. Unlike the previous variable, which exhibited a wide score range, all items for this variable fell within the moderate category, with a narrow range of 2.80 to 3.08. This homogeneous distribution pattern indicates that perceptions of work engagement were relatively uniform among respondents, with no aspects standing out at extreme levels in either a positive or negative direction. A summary of the items with the highest and lowest scores for each dimension is presented in Table 5.

Table 5. Distribution of Item Scores for the Work Engagement Variable (n = 50)

Dimensions	Highest-Scoring Items	Avirage	Lowest-Scoring Items	Avirage
<i>Vigor</i>	Able to work for long periods without feeling tired	2,98	Feeling full of energy while working	2,84
<i>Dedication</i>	Work that is meaningful and benefits others	2,94	Work provides deep personal satisfaction	2,80
<i>Absorption</i>	Full concentration on the work	3,08	Time seems to fly while working	2,86

The vigor dimension scored an average of 2.89, placing it in the moderate category. This result indicates that employees maintain relatively stable energy levels and mental resilience when facing job demands. Observations in the field show that employees continue to carry out their duties despite limited staffing, increased workloads, and the necessity of working overtime. The dedication dimension also scored an average of 2.89, falling into the moderate category. The highest-scoring item relates to the meaningfulness of the work and its benefit to others, while the lowest-scoring item relates to personal fulfillment. This pattern suggests that employee engagement stems more from the value of the service provided than from satisfaction derived from the organization itself. Some employees perceive their work as routine and repetitive, with limited opportunities for training and competency development.

The absorption dimension recorded the highest mean score at 2.94, with the item regarding "full concentration on the job" achieving the highest score across the entire instrument for this variable. These findings are reflected in daily work practices such as nurses remaining with patients in the outpatient clinic while a doctor is still attending to them or assisting with surgeries outside their scheduled shifts, cleaning staff ensuring rooms remain sterile after working hours, cashiers seeing transactions through to completion, and pharmacists fulfilling urgent medication requests outside of standard service hours. Erwina (2020) explains that absorption tends to score higher in jobs requiring precision, as focus is essential to avoid work-related errors. A summary of the three dimensions is presented in Table 6.

Table 6. Summary of Work Engagement Levels

Dimensions	Average	Category
<i>Vigor</i>	2,89	Medium
<i>Dedication</i>	2,89	Medium

<i>Absorption</i>	2,94	Medium
Overall Average	2,90	Medium

An average total score of 2.90 derived by dividing the total score of 61.10 by the 21 statement items falls within the 2.61–3.40 range, classifying it as the moderate category. Thus, employee work engagement remains at a relatively stable level despite the highly toxic work environment.

Classical Assumption Test Results

Prior to hypothesis testing, the regression model was subjected to normality and heteroscedasticity tests, with the results presented in Table 7.

Table 7. Classical Assumption Test Results

Testing	Method	Sig. value	Conclusion
Normality	Kolmogorov-Smirnov	0,200	The data is normally distributed.
Heteroskedasticity	Glejser	0,607	No heteroscedasticity is present.

The significance value of the normality test (0.200) exceeds 0.05, indicating that the residuals are normally distributed; furthermore, the normality plot displays a balanced curve pattern without any tendency to skew toward one side. The significance value of the Glejser test (0.607) also exceeds 0.05, confirming that the model is free from heteroscedasticity. Thus, the regression model meets the statistical requirements for interpretation (Ghozali, 2018; Iba & Wardhana, 2024).

The Effect of a Toxic Workplace Environment on Work Engagement

The results of the Pearson correlation test and simple linear regression analysis are presented in Table 8.

Table 8. Results of Correlation Test, Simple Linear Regression, and Coefficient of Determination

Testing	T-value	Coefficient	Sig	Description
Correlation	-0,992	–	< 0,001	Very strong
<i>Pearson</i> (r)				negative
Constant	178,067	80,066	< 0,001	relationship
<i>Toxic workplace</i>				Significant
<i>environmt</i> (B)	-1,257	-53,060	< 0,001	Significant
				negative effect
R-Squared	0,983	–	–	98.3%
				contribution

The correlation test results yielded an r-value of -0.992 with a significance level of less than 0.001, indicating a very strong negative relationship between the two variables. Regression analysis produced the equation $Y = 178.067 - 1.257X$. The constant value of 178.067 represents the level of work engagement when the toxic workplace environment is held constant, while the regression coefficient of -1.257 indicates that for every one-unit increase in workplace environment toxicity, work engagement decreases by 1.257 units. The partial test yielded a calculated t-value of -53.060 with a significance level of less than 0.001; thus, the research hypothesis stating that a toxic workplace environment negatively affects work engagement was accepted. The coefficient of determination of 0.983 indicates that 98.3% of the variation in work engagement can be explained by the toxic workplace environment variable, while the remaining 1.7% is influenced by variables outside the model, such as organizational support, leadership, workload, resilience, and the meaningfulness of work (Schaufeli & Bakker, 2004).

Overall, the three research questions were addressed through these findings. The level of workplace toxicity fell into the high category, with bullying as the most dominant dimension; the level of work engagement fell into the moderate category, with absorption as the most prominent dimension; and a significant negative influence was observed between the two. However, an interesting and not entirely linear pattern emerged. Despite the high level of workplace toxicity, employee work engagement did not drop to the low category but remained in the moderate category, with a very narrow spread of scores across dimensions ranging from 2.89 to 2.94. Interview-based analysis revealed that this resilience stemmed from strong work ethics and professional values rooted in the professional oath, professional training, and the workplace orientation process. These findings were tangibly reflected in employee behavior, specifically the continued completion of patient care duties beyond formal working hours, as evidenced by

the highest score was in the 'absorption' dimension. Thus, work engagement within this organization appears to be driven more by individuals' professional commitment than by organizational support systems; consequently, this situation cannot be interpreted as an indicator of a healthy work environment.

Workplace Toxicity as a Structural Issue

The finding that the toxic workplace environment at ENT-Specialized Hospital X falls into the high category with a mean score of 4.04 directly addresses the urgency behind this study: the high resignation rate (ten employees within a year) and recurring complaints regarding intimidation and excessive workloads. The data indicate that not a single statement item fell into the low category, implying that negative behaviors are not sporadic incidents but rather conditions experienced widely. The causes can be traced to three mutually reinforcing layers. The first layer is structural, involving limited staffing that leads to overlapping job descriptions and role overload; interviews confirmed that management was reluctant to hire additional staff due to cost-efficiency concerns. The second layer is contractual, involving the use of twelve-month fixed-term employment contracts coupled with the withholding of wages for the first three months practices that create job insecurity and weaken employees' bargaining power to resist unfair treatment (Thirikwa et al., 2024). The third layer is institutional, characterized by the absence of anti-bullying standard operating procedures (SOPs) with strict sanctions and the lack of a structured reporting mechanism. Taştan (2023) refers to this type of situation as "contextual toxicity" toxicity stemming from socio-structural factors and the work climate, rather than solely from individual behaviors. Consequently, the issues at this hospital cannot be reduced to mere interpersonal conflicts resolvable through informal dialogue, as has been the prevailing practice.

Bullying as a Dominant Dimension and Its Underlying Power Relations

The bullying dimension recorded the highest score at 4.08; the two highest-scoring items across the entire instrument related to the spreading of rumors and work sabotage (4.74) and to harsh treatment and intimidation (4.68). The dominance of this dimension is significant because bullying represents a form of negative behavior that is highly repetitive and specifically targeted at certain individuals (Einarsen, 2003). Matthiesen and Einarsen (2007) explain that such behavior thrives in organizations characterized by high role ambiguity and rigid hierarchical structures conditions both present at the research site, evidenced by overlapping tasks and foundation interference in operational matters. Interview findings regarding a culture of blame-shifting following incidents suggest that bullying here serves as a self-preservation mechanism within a system lacking objective performance assessments. This situation is reinforced by findings in the ostracism dimension specifically the item regarding the disregard of achievements and contributions during work evaluations (scoring 4.28) and complaints about the absence of Key Performance Indicators. Ferris (2008) asserts that ostracism operates through forms of neglect that, while not always explicit, have a cumulative

impact on employees' sense of connectedness. When contributions are not objectively measured yet minor errors are quickly highlighted, employees are incentivized to shift blame rather than collaborate. The abusive supervision dimension, scoring 3.87, completes this picture, aligning with findings by Yastin and Suwarsi (2023) that ineffective and unfair leadership reduces job satisfaction and potentially fosters an uncondusive work environment.

Toxicity Originating from Outside the Organization

The dimension of incivility that received the lowest score on this variable actually warrants specific attention. A low score does not imply the absence of such behavior; rather, it indicates that low-intensity forms of incivility such as sarcasm, a demeaning tone, and the dismissal of opinions during meetings have come to be viewed as a normal part of the workday. Andersson (1999) explains that incivility is contagious and escalates in a spiral; minor behaviors that go unchecked are met with similar responses, eventually intensifying into open conflict. This pattern helps explain why other dimensions register at much higher levels. When incivility goes uncorrected because it is deemed trivial, the boundary between assertive communication and demeaning treatment blurs, paving the way for more severe behaviors such as bullying and abusive supervision. Consequently, even the lowest-scoring dimension remains a relevant entry point for intervention, as it represents the initial stage of the toxicity spiral.

One finding that distinguishes the hospital context from other sectors is the presence of sources of toxic behavior originating outside the organization specifically, patients and their families. The item regarding anxiety caused by unaddressed verbal or physical threats from patients scored 3.58, while distress resulting from rejection or discrimination by patients reached 4.14. Interview findings clarified the nature of these behaviors, ranging from shouting, pointing fingers, and slamming tables to threats of photographing staff and posting negative online reviews that misrepresented the actual situation. While Fitzgerald (1995) linked harassment to the victim's personal attributes, in the healthcare context, such pressure is also inherent in the professional role being performed. The situation is exacerbated when management blames employees without allowing them to provide an explanation, subjecting them to dual pressure from both service users and their own organization. This situation explains why improvement efforts focused solely on the internal organization are insufficient. The absence of educational materials for patients and their families regarding behavioral ethics within the hospital environment as identified in the preliminary study represents a gap that directly contributes to the scores in this dimension.

Sustained Work Engagement and the Role of Professional Values

The most intriguing finding of this study is that work engagement remained at a moderate level with a score of 2.90 despite high levels of toxicity. The distribution of scores across dimensions was remarkably tight 2.89 for vigor and dedication, and 2.94 for absorption indicating that work engagement did not collapse in any single specific aspect. Absorption emerged as the highest-scoring dimension, with the item regarding full concentration on the job reaching 3.08. Erwina (2020) explains that absorption tends to be higher in jobs requiring precision, as focus is essential to avoid errors; however, this explanation alone does not fully account for why work engagement was sustained when all dimensions of toxicity were high. Interview findings point to a more fundamental explanation: a strong work ethic and professional values rooted in the professional oath, professional education, and the workplace orientation process. The principles of beneficence and non-maleficence compel employees to provide excellent care and exercise due diligence, while the professional oath establishes a moral compass that prioritizes patient safety over personal interests or organizational pressures. Beauchamp and Childress (2019) emphasize that ethical principles and professional commitment often serve as the primary foundation for the behavior of healthcare workers, even when organizational systems fail to support worker well-being. This constitutes the study's novel contribution: identifying professional values as a protective factor that prevents a decline

in work engagement within a toxic environment. Concrete examples of this behavior are evident in nurses who attend to patients outside their scheduled shifts, cleaning staff who ensure rooms are sterile after working hours, and pharmacists who fulfill urgent medication requests outside of standard service hours.

An Engagement Requiring Critical Reading

However, sustained work engagement cannot be interpreted as an indicator of a healthy organization. The pattern of scores reveals a concerning trend: the highest-rated item within the "dedication" dimension relates to the meaningfulness of the work and its benefit to others (2.94), whereas the lowest-rated item relates to personal fulfillment (2.80). This implies that engagement stems from the service values held by the individuals rather than from satisfaction derived from the organization. Within the Job Demands-Resources framework, this situation reflects high job demands unaccompanied by adequate job resources a scenario that theoretically leads to exhaustion rather than sustainable engagement (Demerouti et al., 2001; Bakker et al., 2007). Professional resilience in a toxic environment is often merely adaptive in the short term, serving as a coping mechanism that masks the negative impact on psychological well-being (McCann et al., 2013). Furthermore, engagement maintained not through organizational support but through pressure, a culture of blame, and fear of sanctions is known as "fear-based engagement"; this causes employees to appear highly engaged behaviorally while remaining vulnerable to psychological fatigue and burnout (Einarsen et al., 2020). Evidence of this vulnerability is found in field data showing new employees resigning before the end of their two-week probationary period and a turnover of ten employees within a single year findings that align with Al Yahyaei et al. (2022) regarding the link between the work environment and the retention intentions of healthcare workers.

Comparison with Previous Studies

The statistical test results of this study reveal a very strong negative relationship, with an r-value of -0.992, and a significant negative influence, indicated by a regression coefficient of -1.257 ($p < 0.001$). The direction of these findings aligns with Rasool et al. (2021) who found that toxic work environments spread negative sentiments among colleagues and reduce employee engagement and with Kurniawan et al. (2023), who demonstrated the negative impact of toxic work environments on employee engagement within Jakarta's service sector. These findings also reinforce the work of Augustine et al. (2025), showing that a toxic workplace influences the intention to leave an organization by diminishing work engagement. However, this study offers a different perspective from Cherlyn and Sentoso (2022), who found that toxic work environments did not significantly impact certain employee engagement variables. This discrepancy can be explained by sectoral characteristics: in the hospitality sector, employee engagement relies heavily on organizational culture and support, whereas the healthcare sector involves a layer of professional commitment that operates independently of organizational conditions. Furthermore, this study extends the findings of Burhannudin et al. (2019) who identified the work environment as a performance predictor in Indonesian hospitals by demonstrating that the focus should be specifically on toxicity rather than the work environment in general. Additionally, these results complement Khan et al. (2020) who noted that appropriate human resource practices can mitigate the impact of toxic work environments by adding that in hospitals, such mitigation can also stem from the internalization of professional values, rather than solely from managerial practices.

An Overview from the Perspective of Islamic Values.

From an Islamic perspective, the prevalence of bullying, harassment, and ostracism reflects a failure to internalize the values of 'iffah and 'izzah within workplace practices. The value of 'iffah requires individuals to refrain from behavior that harms others whether verbal or non-verbal a concept closely linked to self-control within an organizational context. The value of "izzah affirms that every individual possesses a dignity that must be respected, as

enshrined in Surah Al-Munafiqun, verse 8 (Shihab, 2002). Conversely, sustained work engagement amidst pressure can be understood as a manifestation of these values persisting at the individual level: *'iffah* is reflected in the ability to uphold responsibility and professionalism despite an uncondusive environment, while *'izzah* drives individuals to preserve their self-worth through high-quality performance rather than retaliating with negative behavior. Within this framework, work constitutes an act of worship entailing moral responsibility as outlined in Surah At-Taubah, verse 105 meaning that improving the work environment is not merely a managerial necessity but also an ethical imperative.

Managerial Solutions and Expected Impacts

Based on the dimensional mapping, intervention priorities can be sequenced accordingly. The first priority targets bullying and harassment the two highest-ranking dimensions through the development and enforcement of anti-bullying standard operating procedures. These procedures should include operational definitions with concrete behavioral examples, transparent reporting channels, a "no-retaliation" policy, and fair, proportionate sanctions. The second priority addresses abusive supervision by clearly delineating the boundaries of authority between the foundation and operational management, as well as enhancing leadership quality; empowering leadership has been proven to foster a healthy work climate (Izzati & Mulyana, 2020). The third priority targets ostracism through the establishment of measurable performance indicators and the inclusion of employees in operational decision-making. The fourth priority focuses on external sources, involving the provision of educational materials for patients and their families regarding behavioral ethics and the protection of employees against unfounded online reviews. Implementing these measures requires strengthening human resource management functions ranging from job re-analysis and the formal documentation of overtime to the establishment of financial and non-financial reward systems (Nawawi, 2019; Ulrich & Dulebohn, 2015; Anjani et al., 2024). Successful implementation is expected to yield several benefits: reduced psychological stress and burnout risk; improved well-being correlated with performance (Wright & Cropanzano, 2000); enhanced work engagement shifting from mere survival to sustainable engagement (Schaufeli & Bakker, 2004); and reduced turnover, which has previously disrupted operational continuity. Ultimately, improving the work environment translates into better service quality and patient safety, as healthcare worker engagement is directly linked to the precision of clinical actions and the quality of patient interactions (Figueroa et al., 2019).

Limitations of the Study

Several limitations should be noted regarding the interpretation of the results. The coefficient of determination of 0.983 is exceptionally high for organizational behavior research based on perception surveys; this raises the possibility of common method bias, as both variables were measured using the same instrument and respondents simultaneously. This figure should be interpreted as an indication of a strong association within the specific organizational context studied, rather than a claim that toxicity universally explains nearly all variation in work engagement especially given that existing literature identifies organizational support, leadership, and the meaningfulness of work as other critical determinants (Saks, 2006; Bakker, 2018). Furthermore, as this study employed a cross-sectional design involving fifty respondents from a single hospital, the generalizability of the findings is limited, and causal relationships cannot be definitively established. Future research should utilize a longitudinal design, incorporate multiple healthcare facilities, and include mediating variables such as work stress and organizational support to provide a more comprehensive explanation of the underlying influence mechanisms.

CONCLUSION

The results of this study concluded that the toxic workplace environment at ENT X Special Hospital, Jakarta, was categorized as high, with bullying identified as the most dominant dimension, followed by harassment and abusive supervision. These findings indicated that negative workplace behaviors were not merely isolated incidents but represented organizational conditions influenced by structural factors, unclear role boundaries, workload pressure, and limited mechanisms for preventing and addressing workplace toxicity. Meanwhile, employee work engagement remained at a moderate level, with absorption identified as the strongest dimension. This condition demonstrated that employees continued to maintain their involvement and professional commitment despite experiencing an unfavorable work environment. Statistical analysis confirmed that the toxic workplace environment had a significant negative effect on work engagement, as indicated by a very strong negative relationship between the variables. However, the persistence of employee engagement appeared to be supported more by professional values, ethical commitment, and responsibility toward patient care rather than by organizational support systems. Therefore, maintaining employee engagement should not be interpreted as evidence of a healthy workplace climate, as prolonged exposure to workplace toxicity may still increase psychological risks, burnout, and turnover intention.

Future research is recommended to expand the research scope by involving multiple hospitals or healthcare institutions with different organizational characteristics to improve the generalizability of findings. Further studies may also employ longitudinal research designs to examine changes in workplace toxicity and employee engagement over time, as well as investigate the causal mechanisms underlying these relationships. Future researchers are encouraged to incorporate additional variables, such as organizational support, leadership style, psychological safety, resilience, job stress, and organizational culture, as mediating or moderating factors to provide a more comprehensive understanding of how employees maintain engagement in challenging work environments. Qualitative approaches may also be applied to explore healthcare workers' experiences regarding workplace toxicity, professional values, and coping strategies in greater depth.

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