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THE INFORMAL STRUCTURE AND JOB SATISFACTION IN A HOSPITAL ORGANIZATION: A CASE STUDY

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This paper is a sociological analysis of a hospital as a complex organization focusing on such human relational aspects as motivation, leadership, and communication among the various groups of personnel. The question is raised on whether traditional norms and patterns of behavior (termed as familism) in formal organizations have any effect on job satisfaction of organizational members and how much of the differences in informal structure and job satisfaction are attributed to the various group characteristics consisting of the hospital personnel.

The results show that there are both modern, rational and traditional, personal elements in the informal structure of the organization and that traditional values of familism largely shared by the organizational members affect patterns of organizational behaviors and job satisfaction. The various occupational groups become an important factor affecting the differentials in informal structure. The hospital organizations dealing with high task uncertainty need to rely more on mutual negotiation to coordinate and control action. The traditional value of familism in this study turns out to play a key role in the hierarchical structure of hospital organization.

INTRODUCTION

Hospitals are typically large institutions with a diversity of activities and personnel within them. While the hospital is chiefly a setting for medical practice, it has, by virtue of being an organization, many characteristics of its own. Hospitals have been analyzed from a variety of perspectives, but sociological work has focused on the hospital as a social organization, drawing on general sociological work on organizations, and on the experiences of patients and staff (Morgan *et al.* 1985). This study is also a sociological analysis of a hospital as a formal organization.

As other work organizations in modern society, the hospital displays many of the attributes of bureaucracy that were delineated by Max Weber (Gerth and Mills 1946). It is a rational organization with an elaborate, systematic division of labor and a high degree of specialization of expertise, responsibilities, rights and authority, whose manifold statuses, roles, and offices are structured according to a principle of hierarchy, and governed by impersonal rules and norms.

The hospital, however, differs from the Weberian paradigam in several

aspects which causes conflicts and further limits the efficiency of the hospital's performance as organization. One of these aspects is attributed to the fact that the functioning and governance of the hospital is premised on a number of parallel lines of professional authority (Perrow 1965).

Each of the numerous professional groups in the hospital has its own department and set of services, with varying amounts and styles of control over its specialized work. There are also paramedical professionals and nonprofessionals under its supervision. These include physicians, nurses, technicians, social workers, orderlies, clerks, just to name a few. An organization with such weak internal structures and high complexity are hypothesized to be more informal than bureaucratic, rely more on mutual negotiations than on administrative fiats to coordinate and control action, and have a more pluralistic symbolic culture (March and Olsen 1979).

This paper begins to explore the hospital as a complex organization focusing on such human relational aspects as motivation, leadership, and communication among the various groups of personnel. In addition, the question is raised on whether traditional norms and patterns of behavior (termed as familism) in formal organization have any effect on job satisfaction of organizational members and how much of the difference in job satisfaction within these groups is attributed to the various group characteristics consisting of hospital personnel.

THE COMPLEXITY OF HOSPITAL ORGANIZATION

Hospitals have changed more dramatically than any other kind of corporation, from small philanthropic endeavors to the center of complex health services. They have grown in size, complexity, and technology and are even considered as big business (Rakich and Darr 1978). However, hospitals are different from other complex organizations due to the nature of their work, which requires more emphasis on human relations.

First, the goal is different from other complex organizations, where patient care, not corporate profit, is the primary objective of organizational behavior. Availability of care has become the right of every citizen which assumes that the private interest of organization, such as profit-making or employee satisfaction, must be superseded by the public interest and, thus, more responsibility for society is expected. There is, however, a wide diversity of objectives and goals for different personnel and subsystems within hospital organizations. Various segments of the hospital are involved in patient care, education, and research (Perrow 1961). These various activities are sometimes contradictory and are therefore often in conflict.

Second, the hospital organizational structure is highly formal and quasi-bureaucratic. The hospital operation is carried on by the formal written rules and regularities, and there are formal procedures for controlling its members. For instance, "charting" is mandatory for every practice; written informed consent has to be signed by patients before an operation; a medication is not released without written orders, etc. Paradoxically, the hospital is in continuous operation (Fox 1989). This requires high standby costs which limit the efficiency of the bureaucratic system. This work depends on day-to-day adjustment and heavy reliance upon the employees to coordinate their activities on a voluntary, informal and expedient basis.

Third, the hospital is a "people industry". Unlike other large-scale industrial organizations, the development of technology cannot always replace what people do in the hospital. As discussions on our information society becomes reality, we expect a work organization where work is performed not by people with direct face-to-face interaction, but through the newly developed electronically mediated means of communication (Nohria and Eccles 1992).

Despite this drastic change in modern complex organizations and the development of even more technological medical practices, there is hardly a possibility of a hospital without "people" working in it. In other words, the attainment of a hospital's goal is still largely based on the integrity, skills, motivations, and behaviors of its members. As mentioned earlier, however, the people in hospitals vary from the most highly skilled and educated physicians and administrators to unskilled and uneducated employees (Chung *et al.* 1991). Enabling these various groups of people to work together is a substantial part of hospital management.

The last characteristic of hospital organization is the absence of a single line of authority. Many studies have investigated the power structure of hospitals and found that there are "dual lines of authority" or "power in triad" (Mishler *et al.* 1981; Taylor 1975). Administrators are responsible for solving a wide variety of management problems, physicians for patient care, education, and research, and the board of trustees for capital investment, etc. Each group of personnel has its own norms, communication networks, and hierarchies. Moreover, most of them are professionals who possess a certain degree of independence and autonomy over their own work. We often witness the conflict between the head nurse and the first-year intern on the matter of who follows whose orders.

In addition to the conflict among professionals, the administrative part rests its work on relatively strict bureaucratic rules. The hospital shows a typical example of the well-known conflict between line and staff in a

professional organization (Dalton 1950). Theoretically, this arrangement permits a sharing of power among the groups, but one of them may dominate the organization depending on particular problems or tasks that the hospital must emphasize at any given time (Perrow 1986).

The attributes of the hospital discussed so far assume the presence of generic conflicts in hospital organizations. The conflicts sometimes can contribute to the organization's development by solving potential problems in advance. However, hospitals need more efforts to keep the integrity of the personnel in order to maintain efficiency in their performance. Furthermore, hospitals deal with the problem of life and death which cannot allow for minor mistakes to occur in their work. The conflicts among personnel can cause consumers to be overly critical. This puts a special psychological and physical stress on hospital personnel (Rakich and Darr 1978). In this context, there is a relevance in recent discussions on "corporate culture" in hospital organizations.

CORPORATE CULTURE AND FAMILISM

The emphasis on "corporate culture"[1] in the hospital derives not only from the practical demand for better performance, but from new theoretical perspectives in the study of complex organizations as well. What distinguished this line of research from previous approaches (i.e. rational-choice approach, micro-economic approach) is its specifically normative element, that is, standards of behavior that are defined in terms of customs, obligations and cultures (Powell and DiMaggio 1991). This approach highlights the "shadowland of informal interaction" (Selznick 1949); both illustrate how the informal structures deviate from constrained aspects of formal structure and demonstrate the subversion of the organization's intended, rational mission by parochial interests. Moreover, it locates irrationality in the formal structure itself, attributing the diffusion of certain operating procedures to conformity and the persuasiveness of cultural accounts rather than the function it is intended to perform (Meyer and Rowan 1991).

Then, the following research questions are raised to analyze hospital organization. What elements of corporate culture affect the organizational behavior in the rational, complex hospital organizations? What is most

[1]The definition of corporate culture is diverse, but it is defined as "patterns of belief or shared meaning, fragmented or integrated, and supported by various operating norms and rituals, which exert a decisive influence on the overall ability of the organization to deal with the challenges that it faces (Morgan 1986)."

important in regulating the personal relations within organizations? What tensions lie between the tradition-based personal relations and the formal structure of westernized, modern, rational hospitals in general? How is familism, in particular, as a typical relational characteristic of Korean society, reflected in our hospital organizations as symbolic culture of their own, and finally, is it different among various occupational groups?

The concept of "familism" used in this study refers to several distinctive properties of behavioral patterns of Korean people, which are 1) strict role division, 2) hierarchy by sex and age, 3) patriarchy, 4) authoritarianism, and 5) group orientation.[2] Most of the earlier studies concentrate on the role of traditional and rational values in the changes of families, organizations, or a whole society. The results are, however, inconclusive and there is still a debate over the positive or negative impact of traditional values on intensive social change in our society.

Some emphasize that the tension between these values intensifies the stresses in society, whereas some contend that the selective affinity among these values actually eases the conflicts (Lee and Ham 1992). The study by Lee and Ham (1992) also deals with this problem. They chose four different types of work organizations and examined the effects of familism on personal relations. They found that familism played a contradictory role to the behavioral norms set up in a work organization. But, the type of organizations reported were not significantly different from each other.

DATA, METHOD, AND VARIABLES

Data and Method

Data was collected from a questionnaire survey[3] conducted in a general hospital located in Seoul, in 1992. The sample hospital is a general, teaching, but unaffiliated with a medical school, profit-making hospital.[4] While it has a branch hospital in a south-eastern city, the survey was conducted only in Seoul. As of April 1992, there were 510 beds and 801 organizational members in Seoul which were divided into 8 different occupational groups as shown in Table 1. A random sample of 200 people was drawn and the return rate was 86.5%.

The total sample consisted of 158 cases after compiling the data while 121

[2]See Lee and Ham (1992) for the discussion on familism in detail.

[3]The survey was also conducted in four different types of work organizations and analyzed by Lee and Ham (1992).

[4]See Chung *et al.*(1991, pp.152-56) for more details.

TABLE 1. NUMBER OF PERSONNEL BY OCCUPATION IN SAMPLE HOSPITAL

Category	Staff	Resident	Nurse	Pharmacist	Technician	Nutritionist	Administrator	Others	Total
Headquarter	2						14	16	
Seoul	69	100	301	17	60	4	101	149	801
Branch	49	69	317	12	50	3	94	141	735
Total	120	169	618	29	110	7	209	290	1,552

cases were analyzed whenever the occupational group was considered as an independent variable. This was due to the fact that the occupational groups other than doctors, nurses, and administrators, consisted of a relatively small portion of the organizational personnel, and thus, of the whole sample. Crosstabulations, mean differences, and multiple regression analysis were used in the analysis according to the nature of the variables in question.

Variables

Work motives: The fact that the hospital is a service organization (Scott 1981) emphasizes motive and morale of the people working in it. As indicators of work motives, the respondents were asked about the meaning of work for them and on specific aspects of the work they gave first priority.

Leadership: One of the important properties of familism is its acceptance of the hierarchical order within the group. This is expected to play an important role in the organizational bahavior in terms of leadership and compliance of group members. The questions were made to explore the quality of leadership that hospital members stress and their actual evaluation of the top management leadership.

Communication: The indicators of hospital communication are two-fold: distance and openness. First, for distance measure, the question was asked if they felt a communication gap between members in their twenties or thirties and those over forty. This question was intended to explore the presence of a generation gap as one source of conflict derived from familism within the organization. The second question measured the cognitive openness of the communication channel from bottom to top in vertical communication process.

Familism: There are two different variables to measure the degree of familism in work organizations. One is the familism considered as an ideological value and the other, as an actual behavioral pattern. The connection between values or beliefs and behaviors has been an important subject of concern to social psychologists as early as the 1930s, but as yet a

limited amount of research on these psychological constructs has been proved effective on the predictability of the beliefs for the actual behaviors (DiMatteo and DiNicola 1982). This study attempts to differentiate the values and behaviors hypothesizing that there would be a gap between traditional values and actual organizational behaviors. The variable was measured by 13 value-related and 8 behavior-related questions which would represent the properties of traditional familism. Four scores of Likert Scale for each item were adopted to measure the degree of familism.

Job Satisfaction: The respondents were asked how satisfied they are with their hospital work in several areas including overall organization, department, and their relationship with leaders, colleagues, and subordinates. Separate questions were asked concerning personal relations with male or female employees since a basic facet of familism is gender role division.

ANALYSIS

Work Motives

Considering the hospital as a service organization, workers are often expected to sacrifice their individual interests for the public welfare. With a rapid change toward individualistic society, however, work tends to become a mere means of economic earning that leads to instrumental personal relations in the work organization. In order to examine work motives in the sample hospital, seven items of work motives were rated by the respondents.

As presented in Table 2, 31.4% of the respondents answered that they work to be acknowledged by others in society. There were also many respondents who emphasized working for belongingness, economic rewards, and future success which are rather personal reasons to work. This can be interpreted as reflecting an individualistic tendency to take work as a mere means of life in our society. The result that only 5.8% of the respondents consider social contribution as a reason to work also confirms this tendency despite the fact that social service is a hospital's primary goal.

Although this attitude is largely shared by three occupational groups in the hospital, there are interesting group differences in Table 2. For doctors, the successful future is considered more important than any other social reward. Since doctors include staff and residents who are in training, we can understand their positive future orientation compared to other groups of personnel. Nurses, on the other hand, emphasize social acknowledgement

TABLE 2. PERCENT DISTRIBUTION OF WORK MOTIVES BY OCCUPATIONAL GROUP

Work Motives	Occupational Groups (%)			All	χ^2
	Doctors	Nurses	Administrators		
Acknowledgement by others	23.1	40.0	25.0	31.4	25.0*
Belongingness	19.2	25.5	12.5	19.8	
Economic rewards	11.5	14.5	15.0	14.0	
Future success	26.9	5.5	7.5	10.7	
Social contribution	3.8	1.8	12.8	5.8	
Status quo	0.0	1.8	10.0	4.1	
Social respect	0.0	0.0	2.5	0.8	
Others	15.4	10.9	15.0	13.2	
Total (N)	100.0 (26)	100.0 (55)	100.0 (40)	100.0 (121)	

* $p < .05$.

and do not expect much in the way of future success. This may be attributed to the nature of nursing which is considered inferior than to that of the counterpart professional in hospitals (Navarro 1975; Brown 1975) and because of this, much effort is now being put forth to establish more academic and professional nursing (Chung *et al.* 1991).

Among those in the administrative group, the economic reward is considered important in addition to social acknowledgement, whereas compared to doctors and nurses, a larger portion of administrators identify social contribution as their motives for work. To summarize, the primary goal of hospital organizations as a provision of health services is not deeply internalized by the members of the organization, but rather individualistic motive is predominent.

Respondents in our sample chose as their most important activity the achievement of creative work and maintenance of good personal relations with others as shown in Table 3. This result shows that hospital personnel pay attention to both formal and informal components of their work. They seem to recognize the need for personal relations in rational and bureaucratic organization. It supports the theoretically derived notion that uncertainty of hospital work needs more human relational orientation among the personnel.

Despite its statistical insignificance, the comparison between doctors and the rest of the groups needs to be mentioned. The relatively low percentage of doctors to consider personal relations as an important aspect of work may come from a more instrumental attitude among residents due to their short length of stay in this hospital.

Leadership

The human relations perspective provides two branches of a relations theory in organizational studies. One is the importance of leadership and the other is the horizontal interaction of groups. Among that which concerns leadership, research has been accumulated specifically on leadership and productivity models, which claims that good leadership will lead to increased productivity on the part of employees (Perrow 1986). Leadership is crucial in defining the organizational mission and role, leading to a high morale, reducing turnover and absenteeism, and defending the organization's integrity (Selznick 1957; Hall 1991), all of which bring about better performance of the organization.

This study attempts to focus on leadership traits and leadership style rather than its effects on productivity since the purpose of this study is to investigate personal relations and, thus, pays more attention to the processes than consequences.

First, the respondents were asked to list three leadership traits in order of preference. Table 4 presents percent distribution of the top three answers. The results show that 60% of the respondents prefer leaders who have a rational and efficient working style and 12% chose consideration for subordinates as the most important leadership trait. Here again, hospital personnel expect both rational and humanistic elements of leadership. In addition, they seem to like democratic leadership by emphasizing the consultative decision-making style as a leadership trait.

The second question on leadership attempts to examine the evaluation of actual leadership style in our sample hospital. The respondents were asked to give subjective opinions about their top management leaders. Evenly split, 68.4% of the respondents describe their top leaders as "authoritarian but warm" or "rational and calculative", followed by "authoritarian and autocratic", "democratic", and "warm and protective". This implies that top

TABLE 3. PERCENT DISTRIBUTION OF PRIORITY OF ORGANIZATIONAL WORK BY OCCUPATIONAL GROUP

Priority of Hospital Work	Occupational Groups (%)			Total	χ^2
	Doctors	Nurses	Administrators		
Achievement of creative work	65.4	49.1	40.0	49.6	7.8
Good personal relations	23.1	40.0	45.0	38.0	p = n.s.
Performance of one's own work	0.0	3.6	5.0	3.3	
Good relations with leader	0.0	0.0	2.5	0.8	
Others	11.5	7.3	7.5	8.3	
Total (N)	100.0 (26)	100.0 (55)	100.0 (40)	100.0 (121)	

TABLE 4. IDEAL LEADERSHIP TRAITS IN ORDER

Rank	Leadership Traits	%
First choice	1) rational working orientation	59.7
	2) consideration for subordinates	12.3
	3) consultative decision-making	8.4
Second choice	1) consultative decision-making	26.8
	2) consideration for subordinates	15.7
	3) rational working orientation	11.1
Third choice	1) impartial evaluation	17.0
	2) consideration for subordinates	14.4
	3) consultative decision-making	13.7

leaders in the sample hospital are regarded as having both rational and personal leadership styles.

Three occupational groups, however, show differences in the evaluation of the top leaders, where a larger number of doctors and administrators perceive them as "authoritarian and warm", while nurses tend to evaluate them as "rational and calculative". There are, however, differences between doctors and administrators, too. Whereas the opinions among the administrators are widely dispersed, nearly half of the doctors consider the leaders as "authoritarian but warm". This may result from the characteristics of professionals who share the claims to an esoteric, complex body of knowledge and the autonomy to choose and train its own members which allows them to establish hierarchy among themselves (Light 1980; Freidson 1988). In other words, there is a certain degree of personal intimacy despite the strict and authoritarian hierarchy among doctors.

Communication

The importance of the communication process in organizational research varies according to where one is looking within an organization and what kind of organization is being studied (Hall 1991). Some analysts place communications at the heart of the organization whereas others pay little attention to the importance of communications in an organization (Kats and Kahn 1978; Clegg and Dunkerley 1980). But they tend to agree that communication is important in organizations that must deal with uncertainty, and which have a technology which does not permit easy routinization. In this context, communications in a hospital organization seem critical to maintain successful performance. In particular, vertical communication is the best place to start in order to examine the communication related to familism in the organization.

TABLE 5. PERCENT DISTRIBUTION OF THE LEADERSHIP STYLES BY OCCUPATIONAL GROUP

Leadership Traits	Occupational Groups (%)			Total	χ^2
	Doctors	Nurses	Administrators		
Authoritarian but warm	46.2	31.5	29.7	34.2	22.6**
Rational and calculative	26.9	46.3	21.6	34.2	
Authoritarian and autocratic	7.7	18.5	16.2	15.4	
Democratic	7.7	3.7	18.9	9.4	
Warm and protective	11.5	-	13.5	6.8	
Total (N)	100.0 (26)	100.0 (55)	100.0 (40)	100.0 (121)	

**$p < .01$.

Looking at the first factor of communication in the closeness of members among generations, Table 6 summarizes the responses by sex, age, and occupational groups. The result shows that only 18% of the respondents feel that there is close communication between generations within the organization. This implies the existence of potential conflicts among members due to the generation gap, which is considered to be one of the most common sources of social conflict in our society. The degree of communication distance between the generations, however, varies along the lines of sex, age, and occupational groups. More female members tend to feel distance in communication than male, although it is not statistically significant. Of the young generation, below 30 years old, 58.9% feel distance, whereas the middle generation seems to have better communication with older people in the organization.

An interesting finding is the contrasting perception of communication distance between doctors and administrators. The former seem to suffer from the communication gap between generations, whereas the latter tend to have better communication with others. This could be another example of professional characteristics of doctors as discussed above. The authoritarian hierarchy in the medical profession turns out to share many characteristics of traditional familism.

Vertical communication has received much attention since it is crucial in organizational operations. Concerning upward communication, in particular, Katz and Kahn (1978) gave a good list of messages that it can provide. These messages range from the most personal gripe to the most loyal suggestion for improvement of the organization. An important fact is, however, that the consequences of upward communication can be either positive or negative for those who send it, and often the negative consequences are vital to the individual. Thus, if the members perceive the

TABLE 6. PERCENT DISTRIBUTION OF COMMUNICATION DISTANCE WITH OTHER GENERATIONS BY SEX, AGE, AND OCCUPATIONAL GROUPS

Category	Close(%)	Distant(%)	Total	χ^2
All	18.1	81.9	100.0	
Sex				
Male	42.9	27.6	30.3	2.3
Female	57.1	72.4	69.7	
Age				
Under 30	29.6	58.9	53.6	8.0**
30 - 39	59.3	32.3	37.1	
Over 40	11.1	8.9	9.3	
Total (N)	100.0 (47)	100.0 (108)	100.0 (158)	
Occupational groups				
Doctors	9.1	24.7	21.8	8.0**
Nurses	31.8	47.4	44.5	
Administrators	59.1	27.8	33.6	
Total (N)	100.0 (24)	100.0 (97)	100.0 (121)	

** $p < .01$.

presence of an upward communication channel, it indicates the organization has a more open communication structure and possibly a less centralized decision-making process.

In order to examine vertical communication, the respondents were asked whether they perceive an open upward communication channel through which they can express their opinions and complaints. In the sample hospital, the communication channel is found to be closed-off as shown in Table 7. Almost three-quarters of the members perceived that the upward communication channel is very limited. This negative perception is stronger among females and nurses. On the other hand, doctors show contradictory attitudes in two communication indicators. In the earlier question, they report their distance from the older generations, but here they do not complain much about the channel through which they can express their opinions. This contradictory result is very consistent with the theory of the medical profession and professional organizations (Freidson 1988). While doctors have a strict and authoritarian hierarchy in their own professional community which I already pointed out, at the same time they are able to exercise an extensive autonomy over their own work (Starr 1983, Park 1993). This enables doctors to exert more power and to speak out about their problems more easily than any other occupational groups within the hospital.

TABLE 7. PERCENT DISTRIBUTION OF PERCEPTIONS OF OPEN UPWARD COMMUNICATION CHANNEL BY SEX, AGE, AND OCCUPATIONAL GROUP

Category	Open(%)	Closed(%)	Total(%)	χ^2
All	26.6	73.4	100.0	
Sex				
Male	45.2	24.1	26.6	6.3*
Female	4.8	75.9	73.4	
Age				
Under 30	40.0	57.9	53.2	3.9
30–39	47.5	34.2	37.7	
Over 40	12.5	7.9	9.1	
Total (N)	100.0 (47)	100.0 (111)	100.0 (158)	
Occupational groups				
Doctors	26.7	19.8	21.5	8.0**
Nurses	33.3	49.5	45.5	
Administrators	40.0	30.8	33.1	
Total (N)	100.0 (30)	100.0 (91)	100.0 (121)	

*$p < .05$, **$p < .01$.

However, the responses of the personnel in the administrative part are notable here. As found in the case of communication distance mentioned above, they tend to be satisfied with the availability of the upward communication channel as well. This result is inconsistent with the proposition that the subordinate status of lines to professional staff causes more complaints and dissatisfactions among those in the administration of professional organizations.

It is speculated that the relatively strong administrative sector in the sample hospital is attributed to the history of this hospital. The sample hospital belongs to one of the largest corporate groups in Korea, and most of the personnel in the administrative part moved from the corporate headquarters when the hospital opened. Their close networking with management headquarters enables them to monitor the performance of the professionals and render more power than the administrative lines in other organizations. According to Perrow (1965), the power structure of the organization is closely related with the operative goals of a complex organization. The historical development of the sample hospital needs to be analyzed further in order for thorough investigation of this aspect.

Familism and Job Satisfaction

The degree of familism in work organizations is measured by 13 items of

traditional values and 8 actual behavioral patterns, which represent the traditional values in our society (see Appendices A and B). The mean score of familism as traditional value is 2.35, whereas familism as an organizational behavioral pattern is higher with a mean of 2.85. That is, personnel in the sample hospital tend to have more traditional tendencies in their behavior than values, which has also been found in other work organizations (Lee and Ham 1992).

This study is more concerned about the effects of familism on job satisfaction. The famous study on job satisfaction by Herzberg differentiated between factors for job satisfaction and dissatisfaction (Herzberg 1959). This two-factor theory claims that job satisfaction largely depends on social and psychological rewards, but job dissatisfaction depends more on physical and economic rewards.

The last analysis of this study attempts to find out the relative importance of the factors determining job satisfaction of organization personnel. As mentioned earlier, familism is hypothesized to have effects on job satisfaction as a dominant corporate culture, but the direction was not definite. The independent variables include two indicators of familism and occupational group controlling sex and age.

Table 8 presents the results of regression equations with four different dependent variables of job satisfaction. The most powerful factor to determine job satisfaction in the sample organization turns out to be the degree of traditional values of familism. Those who are more traditional-value oriented tend to be more satisfied with work in general and with supervisors in particular. This result implies that those with a higher degree of familism value are better adjusted in the hospital organization which largely relies upon an authoritarian professional hierarchy for the most crucial part of organizational performance. This confirms the hypothesis that the nature of hospital work requires bureaucratic and complex hospital organization to depend largely on personal relations. Moreover, traditional values of familism as distinctive characteristics of such personal relations in our society are consistent with a symbolic culture of the dominant occupational group and, therefore, play a positive function in the sample hospital.

TABLE 8. MULTIPLE REGRESSIONS OF JOB SATISFACTION ON INDEPENDENT VARIABLES

Independent variables	Equations			
	(1)+	(2)	(3)	(4)
Familism				
in value	.500**	.684**	1.270***	.602*
	(.418)++	(.301)	(.621)	(.249)
in actual behavior	−.160	.126	−.231	−.166
	(−.124)	(.052)	(−.122)	(−.044)
Occupational group				
doctors	−.050	−.280	.267	.095
	(−.063)	(−.180)	(.184)	(.062)
administrators	−.012	−.257	.258	−.060
	(−.017)	(−.193)	(.195)	(−.044)
Sex	−.020	−.007	.419*	−.158
(male = 0, female = 1)	(−.026)	(−.005)	(.304)	(−.115)
Age	.001	.013	.001	−.007
	(.020)	(.149)	(.017)	(−.081)
Intercept	1.963	.424	−.089	1.845
Adjusted R	.092	.082	.294	.014

+(1) Overall, (2) Department, (3) Relations with female supervisor, (4) Relations with male supervisor.

++Standardized regression coefficients in parentheses.

*p < .05, ** p < .01, *** p < .001.

SUMMARY AND DISCUSSION

This study attempted to analyze a hospital as a complex organization focusing on its informal structure in relation to corporate culture. It began with the assumption that a hospital organization is bureaucratic, but the nature of work that a hospital has to provide does not allow for strictly rational behavior. It was, therefore, hypothesized that the traditional value of familism in a corporate culture would have large effects on the personal relations and job satisfaction of the organizational personnel. Moreover, these relationships were hypothesized to vary amongst the diverse occupational groups within the hospital organization.

The results show that there are both modern, rational and traditional, personal elements in the informal structure of an organization in terms of work motives, communication, and leadership. Moreover, the traditional value of familism, largely shared by the organizational members, affects patterns of organizational behavior and job satisfaction. Those with more traditional values tend to be more satisfied with the hospital organization which has a hierarchical structure of authority. This is even more convincing

when the various occupational groups become an important factor because they affect the differences in informal structure. Hospital organizations dealing with high task uncertainty need to rely more on mutual negotiation than on administrative fiats to coordinate and control action. This study demonstrates that the traditional value of familism plays a very key role in the hierarchical structure of a hospital organization.

This stuy, however, has several limitations. First, since it is based on a case study of a hospital, the implication of the findings cannot simply be generalized to other organizations. Future researches on various types of hospitals need to be done to clarify the inconclusive results. Second, it has to be pointed out that the quantitative analysis has limitation in investigating the informal structure of the organization. The qualitative research method would be useful to explore the human relations aspect of organizaitons in depth.

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APPENDIX A. FAMILISM AS TRADITIONAL VALUES BY SELECTED INDEPENDENT VARIABLES

Familism+	Sex			Age				Occupational groups				All
	male	female	F	under 30	30-39	over 40	F	doctors	nurses	admini.	F	
Subordinates have to follow supervisor's order	2.23	2.08	2.7	2.09	2.23	2.07	1.3	2.12	2.13	2.23	.5	2.16
Subordinates have to respect supervisor	3.06	2.97	1.8	2.98	3.07	2.93	1.3	2.89	3.04	3.05	1.6	3.01
Manager is responsible for subordinates' finance	2.98	2.94	.2	3.01	2.91	2.71	1.6	2.69	2.96	3.03	2.6	2.93
Manager is a moral supporter	2.53	2.61	.4	2.56	2.58	2.57	.0	2.35	2.55	2.65	1.5	2.54
Supervisor is an expert to control and organize subordinates	2.85	2.89	.1	2.91	2.84	2.7	.8	2.92	2.85	2.78	.5	2.84
The final decision of organization belongs to the manager (or department head in case of department)	3.13	2.75	12.8**	2.74	2.95	2.93	2.0	3.00	2.71	3.18	7.1**	2.93
Subordinates have to leave after supervisor	2.02	1.94	.6	1.94	1.91	2.14	.9	1.96	1.98	2.00	.0	1.98
Subordinates' morale can vary with supervisor's personal emotion	2.11	2.06	.2	2.05	2.12	2.00	.2	1.81	2.09	2.30	3.6*	2.10
Subordinates' basic need must be repressed in front of supervior	2.06	2.05	.0	2.09	1.96	2.07	.6	1.92	2.00	2.20	1.6	2.05
Personal interest is more important than organizational objectives	2.66	2.43	5.2*	2.43	2.61	2.36	2.0	2.39	2.35	2.77	6.1**	2.50

(continued)

APPENDIX A. (Continued)

Familism+	Sex			Age				Occupational groups				All
	male	female	F	under 30	30-39	over 40	F	doctors	nurses	admini.	F	
Males and females must be treated equally in work organization	2.26	1.59	56.4***	1.63	1.93	2.21	8.8***	1.92	1.65	2.03	5.1**	1.83
Roles of male and female in work organization must be equal	2.34	1.92	16.5***	1.87	2.26	2.29	8.6***	2.00	2.04	2.13	.4	2.06
Married woman must quit working	2.13	1.49	46.8***	1.49	1.93	1.93	11.3***	1.73	1.56	1.95	4.7*	1.73
Mean of All	2.49	2.78	22.7***	2.29	2.41	2.38	3.0*	2.28	2.30	2.47	5.9**	2.35

+The items are recorded with higher score representing higher degree of familism.

*p < .05, **p < .01, ***p < .001.

APPENDIX B. FAMILISM AS PATTERNS OF BEHAVIOR BY SELECTED INDEPENDENT VARIABLES

Familism+	Sex			Age				Occupational groups				All
	male	female	F	under 30	30-39	over 40	F	doctors	nurses	admini.	F	
Wait until supervisor starts eating at dinner meeting	3.00	3.00	.0	3.01	2.98	2.93	.2	3.19	3.04	2.95	2.3	3.04
Wait until supervisor eaves despite nothing to work	2.15	2.51	8.6**	2.51	2.33	2.14	2.2	2.35	2.75	2.10	10.1***	2.45
Pay respect to supervisor in the mornings and evenings	3.04	2.99	.4	3.01	3.02	2.86	.8	2.92	3.02	3.08	.9	3.02
Offices are arranged by organizational rank	2.71	2.50	2.8	2.55	2.64	2.58	.3	2.58	2.63	2.73	.3	2.66
Ask female workers to take care of their attire	2.28	2.72	15.6***	2.70	2.49	2.43	2.0	2.19	2.87	2.50	11.0***	2.60
Female workers are treated equally	2.48	2.96	20.2***	2.82	2.79	2.69	.2	2.48	2.96	2.80	6.0**	2.80
Married woman was forced to quit working	2.02	2.39	10.3**	2.42	2.14	1.93	5.2*	2.04	2.26	2.33	1.7	2.23
Manager (department head) generally makes decision alone and makes orders	2.67	2.74	.3	2.74	2.77	2.29	3.5*	2.81	2.75	2.69	.3	2.74
Communication flows from top to bottom not from bottom to top	2.72	2.94	5.1*	2.90	2.83	2.79	.5	2.73	2.96	2.80	2.0	2.86
Workers know each other's personal affairs	2.43	2.23	4.2*	2.21	2.40	2.14	2.4	2.23	2.15	2.50	5.6**	2.28
Manager is eager to help workers' personal problems	2.06	1.86	3.8**	1.90	1.86	2.36	3.9*	2.08	1.86	2.03	1.4***	1.96
Mean of All	2.76	2.85	3.3	2.84	2.81	2.74	.8	2.77	2.89	2.84	1.6	2.85

+The items are recorded with higher score representing higher degree of familism.

* $p < .05$, ** $p < .01$, *** $p < .001$.