CHAPTER-II
REVIEW OF LITERATURE - TOWARDS A
THEORETICAL MODEL OF THE STUDY
In this chapter, the researcher has arranged all relevant literature and empirical studies reviewed under the following schemes:

1) A review of empirical studies in the area of hospital administration arranged chronologically
2) Hospital described as a formal organization
3) Hospital explained as a psycho-social system.
4) A summary is made of the literature search with regard to the concept and importance of organisational climate, in different disciplines.
5) The structural and functional variables presented in terms of two structural models- Bureaucratic Model and Human Relations model which forms the basis of the study.
6) The theoretical and empirical literature available in explaining the structural and functional variables selected in this study.
7) The theoretical model of the present study.

**Review of Empirical studies in the Area of Hospital Administration**

Medical sociology a good part of which is devoted to studies of, or in hospitals, is the fastest growing section of American Sociological Association. The National Institute of Health, as well as many other foundations, have distributed unusual largess in this research area.

Friedson(1963) noted in his preface to a group of studies on the hospital that the virtues of the hospital for social scientists are that it is ubiquitous, varies widely and significantly in its characteristics. “Since they are generally identified with the universal of science, they cannot easily excuse themselves from study by reference to competitive trade secrets,”. Friedson noted further more, they presumably are oriented toward treatment and welcome studies which may improve their effectiveness. Hospital also have captive audiences of patients who are in a dependent positions and are vulnerable to research. The status of social scientists vis-a-vis organisation personnel is probably higher in hospitals than in business and industrial settings. This is less true with regard to doctors, but it is indeed the doctors who are most infrequently studied.(A report of the
Health Information Foundation noted that working with doctors is the biggest single problem in medical sociology, Anderson and Seacat 1957). Finally as noted above, the variations in hospitals should provide an attractive impetus to comparative studies, although in fact there have been very few of these. Most studies are case studies and the phrases “explanatory” needs replication in other studies.

The earlier hospital studies were concerned with theoretical issues. The distinctive character of the hospital highlighted certain social processes, and even gave some suggestion of models of the future. With increasing professionalization in all formal organisations, the hospitals offered a close relationship between professionals and non-professionals. Also hospitals like other non-profit organisations such as schools and prisons, were of interest because of their social-service goals. In an organisational society which is moving towards welfare goals, such analysis would be most instructive. Finally, of course the preoccupation with health, physical and mental, in our society would be enough to move social scientists in the direction of hospital studies: they, after all, are members of society themselves.

The researcher in the first part has reviewed the studies mainly in Hospital Administration done in western countries and then proceeds to those hospital studies done in India.

A hospital is an extremely complex system consisting of a large number of physical, human and technical elements all of which are devoted to providing an output which is difficult, if not impossible to measure in purely quantitative terms. In fact any hospital may be visualised as a macro-system comprising a large number of sub-systems which are quite complex both within themselves and in their interactions with each other. These interactions occur in a wide variety of ways but the net result is that the totality of a hospital is greater than the sum of its individual parts. This is one factor which makes a study of hospital system so difficult.

Review of studies in Western Countries

Coghill and Revans (1968) found there was significant difference in the employees perception of certain aspects of the hospital. Both personal and organisational
factors were included mainly pertaining to relations with nurses, and with technicians in the hospital.

Bellerby and Goslin (1981) provide guidelines which permit mental health managers to determine the current stage of growth of the macro dimensions of their MIS environment. These macro dimensions are representative of the technical, managerial and organisational behaviour aspects of system development.

Matteson and Ivancevich (1982) describes a preliminary investigation of the proposition that organisations as well as people can be classified along a Type A and B behaviour pattern dimensions and that the resulting match or lack there of between individual and organisational behaviour patterns were related to various health indices. A sample of 315 medical technologists were classified as either type A’s or B’s and as working in either type A or B environments. Results supported the hypothesis that 1) Type B’s in B organisation report the fewest negative health symptoms. b) Type A’s in A organisation report the most and 3) Type B’s in A organisation and type A’s in B organisation report an intermediate level of symptoms.

Micheal S.R (1982) was of the opinion that to help carry out their responsibility of managing rapid and often unexpected change, managers in the hospitals must have a available set of techniques of change. Such as MOB, OB modification, organisation development, management auditing etc. He concludes that newer breed of managers who are versed in the social sciences, mathematics, and the computer are likely to spread new techniques in the organisational world.

Duxbury M.L, Henley G.A and Amstrong G.D(1982) investigated nurse perception of the organisational climate of NICU’s in a sample of 18 hospitals. The organisational climate description questionnaire was modified for use in the NICU setting. There were six subscales of different organisational climate dimensions. Nurse satisfaction was also measured by the Minnesota satisfaction questionnaire. Massholder, Kevin et al(1982) in their study on “Group process work outcome relationships: A note on the moderating impact of self- esteem” found that self-esteem would moderate relationships between peer group interaction and two work-related variables such as job performance and job strain on 164 nursing employees at a multiservice hospital.
Eberhardt, Bruce et al (1984) examined the perceptions of 68 part-time employees in a medical rehabilitation hospital toward specific organisational characteristics and compared these attitudes and feelings of overall job satisfaction with those of 182 full-time employees. The completed questionnaires assessed three group processes (trust, cooperation and power), job satisfaction, and organisational climate. Anova revealed that part-time employees had more favourable attitudes toward the organisational structure, policies and reward systems, the level of trust among organisation members and the distribution of power than did full time employees. Part-time employees also reported higher levels of overall job satisfaction.

Jones and Allan (1984) investigated the role of organisational reward structures on individual perception of the reward climate. 73 military nurses and 50 civilian nurses in a naval hospital worked for the same supervisors but were subject to either tenure-contingent or Behaviour-contingent reward systems. No differences in perceived reward climate were found between the two groups. Job attitudes among the tenure-contingent group reflected individual characteristics rather than perceived climate. The opposite relationship was found for the behaviour-contingent group.

McClure (1984) in his article “Managing the professional nurse. Part-1. The organisational theories” asks the question: How do employment organisations outside the hospital field deal with issues such as staff productivity, motivation, burnout, and high turnover? In Part-1 of this two part article, the author presents an overview of modern management theory and practice, drawn from the literature on organisational behaviour. She shows how nursing administrators can use this scholarly foundation to better understand the organizing principles and problems of their departments, In part-II, the author applies these classic and relevant theories to the specific challenges that face the manager of professional nurses.

Mckinney M.M(1984) saw that a number of hospitals throughout United States have been exploring the use of Japanese style quality circles to reduce their operating expenses, improve productivity, and enhance the quality of work life for hospital employees. This article examined the organisational climate necessary for quality circles, methods used to implement quality circles. His findings pointed out that quality circles
are most successful in hospitals where they are part of larger organisational development effort. When administrators believe in their employees ability to contribute to the Institution and are willing to invest necessary time and resources in employee education and the measurement of quality circle achievements, quality circles can produce creative solutions to perplexing institutional problems.

Podasakoff, Todor, Grover and Huber (1984), reported here was to increase our understanding of the relationships between leader contingent and non-contingent reward and punishment behaviours and subordinate responses in hospitals. Contingent reward behaviour was found to have the most pronounced relationship with subordinate performance and satisfaction, followed by non-contingent punishment behaviour and the vice versa. The second goal of research was to examine the effects of a variety of potential moderators on the relationship between leader reward and punishment behaviors and subordinate responses. The result of this study suggest that the relationships between leader reward and punishment behaviours and subordinates performance are relatively free of moderating effects.

Madsen and Harper (1985) discussed on what steps can one take in hospital setting to create an organisational climate conducive to implementing cost containment activities? One of the solution in the hospitals was to broaden the role of its nurse managers, strengthen unit level problem solving and more creative use of existing resources.

Gray-Toft and Anderson (1935) developed and tested a model of organisational stress in the hospital. The model utilised measures of organisational climate, supervisory practices and work group relations as supervisory practice and work group relations as predictors of the amount of role conflict and ambiguity that nurses perceived in providing patient care. Role conflict and ambiguity were treated as variables that intervene between organisational variables, and the level of stress that the nursing staff experienced. Nursing stress was viewed as a direct cause of dissatisfaction. The findings suggest that, as predicted, supervisory practices that led to more open expression of views and joint problem solving resulted in reduced role conflict, ambiguity and stress, increased job satisfaction and lower levels of absenteeism among the nursing staff.
Dillard, James et al (1986) reviewed the literature of the variable communication climate, identifying a series of relationships regarding two measures of the construct communication climate, three aspects of job satisfaction and the variable organisational climate. This formed the basis for a causal model that was tested using data gathered at a state supported hospital with 103 employees. Two variables, satisfaction with supervision and one measure of communication climate (ie, perceived upward openness) exhibited predictive power for the criterion variable organisational climate, eventhough the model as a whole did not fit as hypothesised.

Rudnick, Doherty and Draper (1987) found that in the midst of the many changes that are occurring in the health industry, the pursuit of quality remains a constant. In the past, efforts at quality control have largely focused on the provision of quality care beyond the clinical environment in the area of guest services. Additionally they reviewed how to improve the organisational climate in which services are provided and measure the results.

Fahrenfort (1987) speaks of how the development of patient education in hospitals received its first impetus in the U.S. For this reason, countries like Netherlands where these developments tend to lag behind a bit look to U.S hospitals and literature for guidance on how to proceed in this matter. Given this context, the difference in social, political and organisational climate between the Netherlands and the U.S, provides unique opportunities for classifying some of the issues that characterize the development of patient education.

Seim, Lerner (1988) presented a useful overview of the planning, design and construction process, emphasizing the importance of the practical application of management skills in the hospital.

Driscoll, Micheal et al (1988) assessed the relationships of perceived organisational structure, leader behaviours and communication processes with perceptions of the work environment and ward atmosphere by 58 staff members and 42 patients in three psychiatric units. Satisfaction with communication and participation in decision-making emerged as the most consistent correlates of staff views about their work environment, while dimensions of ward atmosphere were most frequently related to
work environment, while dimensions of ward atmosphere were most frequently related to satisfaction with communication. Patient scores on the ward atmosphere scales were most closely associated with receptiveness and interest, along with patient involvement in decisions and satisfaction with the degree of patient staff communication. Findings highlight the salience of organisational climate variables and illustrate the utility of ward atmosphere and work environment perceptions as components of a multi-dimensional climate construct.

Contel and Onildo (1988) compares physician patient interaction in a Brazilian general hospital to the dyadic, transference-counter transference physician patient relationship at an output facility, where psycho-therapies are frequently creative and successful because of the independence and mutual respect of two parties involved. At large hospitals, patients are depersonalized, infantilised and tyrannized. They are not informed of their real condition, are passed from one medical members to another, and are administered painful and intrusive treatments without warning or explanation. The authors suggest a democratization of Brazilian hospitals effected through community-elected watch dog boards of directors.

Hildebrand, Joan et al (1988) explored the relationship between person environment congruence and perceived social climate work environment. Using data from 133 registered nurses in staff or management positions. Employees completed the self-directed search and the work environment scale. There were no significant difference between congruent and incongruent groups. Employees represented a homogeneous personality group in an explicitly defined environment. However, management employees perceived the work setting as more positive, rewarding, friendly, supportive and relationship-oriented, and viewed their work as more valued than staff employees.

Dastmalchian, Blyton et al (1989) validated a measure of industrial relations climate, using the concept of organisational climate. Industrial relations climate is defined as a subset of organisational climate. Industrial relations climate is defined as a subset of organisational climate that pertains to the norms and attitudes reflecting union management relationships in an organisation. Data were collected by means of interviews with management and union representatives and by distributing a questionnaire to 729
Canada. Results show the validity and the reliability of 5 scales measuring in industrial relations climate. Four of the climate scales also demonstrated strong within organisation and within group agreement.

Pineault, Raynald et al (1989) examined the extend to which health counselling practices in 3 hospitals were influenced by patient characteristics, medical care processes and organisational factors. It was seen organisational factors were more important than the patient characteristics in determining health counseling.

Fallon (1989) says that organisation is technology in the broadest sense: processes, procedures, policies, controls, formal authority structures and techniques. Among groups or organisations, it is unusual for changes in sentiment to precede action or organisational rearrangement. Technology and structure must be changed first. The components of each organisational theory and structure were identified and discussed. In addition to understanding one’s subordinate and peers, the effective manager understands the organisational forces that exist in the work place. A willingness to listen, communicate, innovate, and lead should result in both effectiveness and rewarding experiences for a manager in the hospital too.

Reivicki (1989) developed and tested model of occupational stress in hospital nurses. The model used measures organisational climate, supervisor behaviour, and work group relations as predictors of the quantity of role ambiguity perceived by nurses. Data were collected on 232 hospital nurses working in a rural community hospital affiliated with a medical model. Results confirmed the hypothesized structural model. Organisational climate, supervisor behaviour and work group relations directly influenced role perception. Increased role ambiguity led to decreased job satisfaction and increases perceived stress. The organisational environment directly influenced job stress. Occupational stress exerted a strong direct influence on the development of depressive symptoms in nurses.

James, Milne and Firth (1990) pointed that efficacy of therapeutic programs depends on several characteristics of the treatment environment. For this reason therapists are increasingly directing their effect towards changing the social characteristics of treatment units. This study aimed to promote change in social climate by providing
treatment units. This study aimed to promote change in social climate by providing nursing staff with structured information about their unit. The real and ideal social climate of the unit was defined and assessed using the ward atmosphere scale. Feedback about their perception of the unit was provided to staff in two ways. The effect of the feedback on the social climate of the unit was ascertained by further assessment using the ward atmosphere scale and from interviews with all staff. The evaluation suggested that the feedback had contributed to changes in several procedures in the unit and to the reduction with real-ideal discrepancies for the system maintenance elements. The effect was greater for the group of staff who had the opportunity to discuss the feedback in a formal setting.

Mcginnis, Sheila et al (1990) examined whether part-time workers demonstrate different job attitudes than full-time workers, using 350 hospital employees. Employees completed measures of job satisfaction, work commitment and perceived organisational climate. Employment status did not have a significant effect on the majority of employees job attitudes. Findings suggest that employment status may not be a useful predictor of work related attitudes and that future investigation of potential differences between full and part-time workers should include a wider variety of variables of the practical application of management skills to that process.

Kenney (1990) presented an overview of the health care industry's trend toward multihealth system and specific adaptive strategies for social work managers in health care are suggested. Doctors of social work departments in multihealth corporations will need to resolve issues of institutional versus corporate versus professional identity. The emergence of multi health systems possesses major challenges and unique opportunities to the social work profession. Awareness of managerial strategies and critical content areas can help social work leaders enhance the role and contribution of social work in these existing and complex health care delivery systems.

Burke (1991) explained the relations of the way minority managers and professionals described their treatments within their organisations and their organisations acceptance and opinions to minorities within measures of satisfaction, commitment, skill utilization and integration. Data were collected from 81 minority managers and
Minority managers experiencing more positive treatment in their organisation, and employed in organisations more accepting of minorities, were more satisfied, committed and integrated.

George and Brief (1992) described five forms of organisational spontaneity (helping co-workers, protecting the organisation, and spreading good will). They found that primary work group, affective disposition life event history and contextual characteristics are proposed to have direct and indirect effects or both, on positive mood at work. Motivational basis of organisational sympathy also are described. The model and its implications were discussed in the hospital setting.

Count, Glandon, Oleske and Hill (1992) examined the effects of one such TQM program on employee job program on employee job satisfaction, perception of organisational climate and general opinions concerning the work situation. Two years after the TQM program had been introduced, responses of participants and non-participants were compared. Participants in the program exhibited a higher level of job satisfaction and more regarding both the organisation and their work.

Shelledy, Mikies, May and Yousefey (1992) found that the predictors of work satisfaction level were recognition by physicians and nursing, age, burn-out level, absenteeism and intent to leave the field. Predictors of level of satisfaction with pay were actual salary, job independence, organisational climate, case of obtaining time off, job stress, absenteeism, intent to leave the field, and number of independent children. Predictors of level of satisfaction with promotions were recognition by nursing, participation in decision making, job stress, intent to leave the field, past turnover rates and absenteeism. Predictors of level of satisfaction with supervisor included supervisor support, role clarity, independence and case of obtaining time off.

Hern-Underwood M. J. and Workman (1993) saw that in today's technical and demanding patient care system within the hospital organisation, there is a need for head nurses as nurse managers to be ever more attuned to the climate of their staff. In this study of 34 nurse managers in seven paediatric hospital organisations across a midwestern portion of the united states, an analysis of fielder leader match scales showed the significance of group climate on retention.
portion of the united states, an analysis of fielder leader match scales showed the significance of group climate on retention.

Hetherington and Angela (1993) examined the context and sources of stress, sources of satisfaction and organisational climate of the accident and emergency units of 19 major UK hospitals. The use of copying strategies and the receptivity were also assessed. Surveys were completed by 316 accident and emergency personnel. Major copying strategies included dealing with the problem directly and talking to colleagues, senior staff, counselors and friends and family. Sources of satisfaction were working as part of a team, use of skills, the emergency environment, a part of a team, use of skills, the emergency environment, a feeling of competency and challenge within the job, and the rewards of direct patient care. Major sources of stress were inadequate communications, interpersonal conflicts and divisions between staff. 40% of the staff felt the level of stress to be sufficiently high to detract from job satisfaction. 51% of the staff did not see themselves working in an accident and emergency unit in 5 years.

Lowzy and Mousa (1994) explained job satisfaction concerning organisational climate among working members that the public hospitals in Jordan by answering what the relationships between gender, social status, academic rank, age, job classification, place of work and organisational climate satisfaction are. A total of 545 members participated in this study. The research instrument consisted of 2 parts-personnel information and job satisfaction with organisational climate. Findings indicate that there were no significant differences in organisational climate satisfaction between females and males or on the basis of social status, academic rank and age. Significant differences were found regarding job classification and place of work. The source of major satisfaction for employees was in the areas of performance, standards, conflict structure and identity.

Berg, Hansson, Hallberg (1994) studied nursing care: intervention was evaluated by means of the creative climate questionnaire, Burnout Measure and Mastach Burnout inventory. The findings of this study point to the necessary for a support system that focuses on the work itself, the nursing care. Individualised planned care and systematic clinical supervision may offer this kind of support.
included system maintenance, relationship and treatment aspects. There were suggested trends between assault frequency and a low score on autonomy and a high score on staff control.

Meighan (1994) found that the current turmoil and uncertainty in the health care industry are causing increasing tension and conflict among the groups responsible for rendering and managing care (physicians, nurses, hospital executives and board members). Different ways to recognise and manage conflict or situations of potential conflict were examined here.

Judge, Boudreau, Bretz (1994) found that despite executives important positions in organisations, their attitudes have not received much research attention. To remedy this deficiency, the authors tested a hypothesised model of executive attitudes involving job satisfaction, life satisfaction, job stress, and work-family conflict. Using data from a large, representative sample of male executives, the authors obtained LISREL results indicating support for the overall model and the specific relationships within the model. The results were, first to simultaneously consider job satisfaction, life satisfaction, job stress and work-family conflict which constitute the most comprehensive evidence to date on executive attitudes.

Gelinas, Manthey (1995) reported on a project that studied the impact of work redesign on the roles of hospital executives. The report represented a broad multidisciplinary perspective reflecting the ideas of members of the health care management team.

Kralewski, Wingert and Barbouche (1996) identified the relevant components of the organisational culture of medical group practices and developed an instrument to measure those cultures.

Seago, Jean et al (1997) reviewed selected empirical studies of organisational and work group culture in hospitals and critique the two measurement instruments - Organisational Culture Inventory and the Nursing Unit Cultural Assessment Tool. The paper discusses the issues of unit of analysis/aggregation bias and sample size when using these two instruments. It was concluded that the OCI has been widely used in many types
two instruments. It was concluded that the OCI has been widely used in many types of organisations and has substantial data supporting the reliability and validity. However, the instrument does not always capture variation in nursing units.

All the above studies in the area of hospital administration and management done in western countries pin points to various organisational dimensions. Avery few studies of organisational climate has been seen, also very limited studies pertaining to various structural and functional aspects of organisational climate. Most of the studies done are on physicians, nurses and hospital executives ignoring the other categories of staff working in the hospital. The review of this study enabled the research to understand the prominent areas where research could be done as well as the lacunae existing in those areas.

Review of Studies in India

In India researches conducted in hospital situation are of recent origin, more so when the government as a policy started fostering local experimentation with the new ways of organising and providing health care for disadvantage sectors of population. If the hospitals have to be responsive to the needs and demands of the community, it is important that they develop a linkage to alter its structure and functioning based on the felt needs of the communities. Social scientists, Psychologists, Medical Professionals, Management specialists have been responsible for providing a lead towards developing and designing studies on hospital situations. The schools of social work, Department of sociology in various universities, the National Institute of Health and Family Welfare, All India Institute of Medical Sciences, Post Graduate Institute, Chandigarh and the rest while NIHAE were among the first few institutions where studies were undertaken to understand the existing structure and functioning of the hospitals. In some cases, these studies were in the form of dissertations towards partial fulfillment of masters of social work, sociology, diploma in health administration or PH.D. Only in a few cases independent research reports have been carried out as specific projects on hospitals. The universities where such studies have been carried out are Delhi, Udaipur, Chandigarh, Sagam, Patna, Jaipur and Mumbai. Medical institutions of national importance such as
AIIMS, NIHEN, Institute of Management at Bangalore, Ahmedabad and Calcutta, The Institute of management studies at Bombay and PGI at Chandigarh and some other medical Institutions in Vellore, Pondicherry and Ranchi have also been responsible for conducting number of studies having either behaviour as a major focus or the management oriented research studies. Here an attempt has been made to classify the studies in some meaningful categories.

National Institute Of Health and Family Welfare has made a broad classification of “Behaviour Studies” and “Organisational studies” for purposes of convenience. Behavioural studies consist of studies where attempts have been made to develop theoretical framework of understanding the hospital or highlight the sociology of professionals in hospital situation or assess the socio-economic characteristics of different types of patients reaction towards hospital and its services. The organisational studies cover very wide area in which the management of the services, evaluation, monitoring, application of modern management techniques have been taken into consideration.

Behavioural Studies

The following type of studies have been conducted with a view to develop theoretical framework for understanding the hospital as a system and the inter-personnel relations within the hospital situation. Examples of such studies are as follows:

Human relations in a hospital, Inter personnel relationship in a professional setting., Human relations as a element of hospital system - A study in a hospital ,Some aspects of social systems of an Indian Hospital and Hospital- a study of interaction pattern.

Most of these studies have attempted to enlist and provide insight into the hospital as human system demanding a realistic appraisal not only of its physical working but understanding subjective orientation of the patients, the diseases and the providers of services.

There are a set of studies which highlight the sociology of profession in hospital situation. These studies have focused their attention on doctors, para-medical staff and
nurses. Some of them even focus on the problem of interaction between two or more professionals. Examples of such studies are:

Role perception and role conflict - A study of professional nurses, Inter-personnel relationship in professional setting - A study of nurses in hospital in Delhi, A study of behavioural pattern of doctors and nurses in a casualty department, Inter-personnel relationship in a medical setting - A study of doctors in Delhi hospitals, Study of doctors: Perception, Performance and conflict, Professional relationship among Doctors and Professional commitment of doctors.

A number of studies in hospital situations was also conducted with a view to assess the socio-economic and personality characteristics of the patient suffering from different types of diseases. Another area relates to patients reaction towards hospital as an organisation and its services. This area has attracted the attention of sociologists, psychologists and social work scholars. Most of these studies have assessed the level of satisfaction towards service and or the reasons for dissatisfaction. Some of these studies have focused only on a single department such as Casualty, Emergency, Food etc.

Examples of such studies are:
1. Patients signing against our medical advice
2. Patients resisting hospitalisation
3. A sociological study of patients hospitalisation.
4. Hospital and its peoples "A Sociological Exploration".
5. Patients satisfaction and ward social system
6. Attitude of patients towards surgery in hospitals.
7. Patients and hospital
8. Study of impact of hospital on women patients and their families.
9. Study of paediatric patients leaving hospital against medical advice.
10. Hospital food - how patients like it

Organisational studies

A series of organisational studies in hospital situation have been undertaken with a purpose of understanding its internal structure and functioning. Most of the application
the stores department are the commonest areas where such studies have been undertaken. However, the other sectors of the hospital such as operation theatre, dietary services pharmacy department, blood bank, wards have been studied in great detail. A number of studies have also been undertaken with a main purpose of assessing the levels of satisfaction particularly among the nurses, class II and class IV employees, doctors and other such categories. In many cases the findings of these studies have been accepted by the hospital authorities with a purpose of improving the existing situation. They have in some case been able to bring improvement in the working of hospitals without involving much of the resources of the hospital. An important dimension of these studies have been that almost all such studies are applied in nature and have given suitable recommendations for implementation. The studies of this type are useful in so far as they are able to suggest methodology for improving the utilisation of existing facilities without involving additional resources. It is this aspect that makes the studies important for having the potential of showing a direction to the hospital administrators for improving the existing situation in their respective hospitals.

From the review of the research studies in the area of hospital administration conducted in India there is only on Ph.D study entitled “A study of planned organisational change in the structure and functioning of Indian hospitals” by Carol Huss (1975), where organisational climate in hospital has been studied. Individual research work is very scanty and studies done only by National Institutes were seen mainly in the areas of personnel working, satisfaction of the patient’s and staff as well as some of the topics related to the structure and functioning of hospitals. No study on organisational climate was seen.

To sum up the researcher has attempted to make a thorough search of empirical studies in the area of hospital administration. More of studies were seen in western countries. In India the studies are scanty. Moreover the studies are mainly concerned independently with organisational characteristics about patient’s and personnel of the hospital. Only few studies speak of organisational climate and social climate in hospitals and their relationship with other variables. In Kerala no such study on organisational climate
and their relationship with other variables. In Kerala no such study on organisational climate in hospitals has been done so far. This motivated the researcher to take up the present study.

**Hospital as a formal organisation**

In old traditional society man's needs were taken care of within the family or community - the small informal group around him. He was born, educated, worked and died in the informal circle. But as his needs increased and became more complex, a more rationalistic approach to meet the needs of man was needed. So in a rational society of today, everything is done within the organisation.

Organisations are social groupings formed consciously or unconsciously to carry out certain tasks so as to reach a goal or goals, while informal organizations are formed unconsciously, formal organizations are formed consciously.

Formal organisations are social units deliberately constructed and reconstructed to seek specific goals e.g. corporations, armies, schools, hospitals, churches and prisons. Organisations are established to coordinate the activities of the group in the interest of achieving specified goals. They are characterised by

a) existence of procedures for mobilizing individuals (qualification, experience etc.) and activities (rules and constitution to proceed to achieve the goals)

b) division of labor, power and communication responsibilities. It is deliberately planned to achieve the goals.

c) presence of one or more power centres to control the activities and direct them to achieve the goals. They review the performance bring about changes in the structure to increase efficiency.

d) personnel may be removed or transferred or reassigned tasks or promoted to increase the efficiency.

**Hospital Goal**

Hospital goals may be broadly classified into three types. They are

1) central goal
2) supportive goals
3) extended goals

Central goal is the ultimate goal of a hospital, i.e., care of patients which we may call therapy. Supportive goals are care and custody. These two goals provide support to achieve the therapeutic goal. The extended goals are education and research which we may find predominant in teaching hospitals.

Supportive Goals
- Custody
- Care

Therapy (Central Goal)

Extended Goals
- Education
- Research

Figure :1
To create an ideal hospital situation we need a suitable mix of custody, care, education and research to facilitate therapy.

Hospital Structure  Mary Goss(1969) had studied the bureaucratic patterns in hospitals. According to her, advisory bureaucracy is observed among professionals. In this type of structured pattern supervisors only advice the subordinates. The subordinate has the right to accept or reject the advice of the supervisor. The superior must have
1) better qualifications
2) higher ranks in the hospital and
3) necessary information about the case, about whom advice is rendered.

Hospitals deviate very much from the ideal bureaucracy due to its multiple authority or multiple subordinate system e.g., nurses are subordinated to doctors,
administrators and their own ranks. Rules, hierarchy, impersonality are less applicable to doctors because

1) they deal with life and death situations
2) they are highly independent
3) doctors emphasize self-governance and autonomy rather than hierarchy and rules
4) and he cannot be impersonal, as he has to take into account the needs of individual patients.

The structure of the hospital consists of positions with varied training, education, skills and functions. To carry out the goals of the hospital, all these people need collaboration, coordination, support and assistance from one another. In other formal organizations there is a system or mechanism of collaboration, coordination, support and assistance. However in hospital structure, these processes cannot be standardised or mechanized. Unlike other formal organizations the raw material in the hospital is human being with health problem. Every patient is unique in himself and his needs are different. Hence hospital personnel have to adapt different skills for each patient. Hence standardization of activities are not possible. Under such circumstances, the structure mainly function based on the skills, motivations and behaviour of individual workers. Paradoxical to the above mentioned structure of the hospital, a hospital is also highly formal, within quasi-bureaucratic organizations, formal policies, rules and regulations. All these sometimes portray hospitals as a kind of authoritarian organizations.

**Hospital viewed as a psycho social system**

The hospital makes use of sophisticated technology and has a complex structure. However, one of its fundamental characteristics is the importance of the psycho social system. “A hospital is basically, fundamentally and above all, a man system. It is a complex, human-social system. It raw material is human, its product is human, its work is mainly done by human hands; and its objective is human-direct service to people, service that is individualised and personalised. (Basil Georgopolous 1964) In this context, hospitals definitely fall in the category of human service organisation.
Hospitals have clearly defined status and role systems. Status symbols are an important part of the social system. Different types of caps, white and colored uniforms, and various titles are used to emphasize status positions. Many of the official and unofficial norms in the hospital are geared to the implementation and maintenance of status identification.

The roles of the various participants—the physicians, the administrators, the nurses and the paramedical personnel are rather well-defined. This role definition stem from professionalization. The long process of education and training emphasizes certain role precepts which delineate the individual's actions. However, many role conflicts occur for individual participants when they are cast in two different roles with incongruent demands. For example, the doctor frequently faces a conflict between his professional role as an independent practitioner and his institutional role as a participating member of the hospital. The nursing supervisor may continually find herself in conflicting roles as a member of the nursing group with an orientation towards her professional colleagues and as a member of the administrative hierarchy. Although organizational positions are delineated, shaded areas remain and there are many possibilities for conflict. In this discussion of psychological system, the human groups in the hospital organisation includes the patient, as well as the medical nursing, paramedical and administrative staff.

Organisational analysis is the first necessary part of the total approach. It is concerned with the environment of the organisational system in which work is accomplished, management programs are designed and implemented, patient services are modified and developed, and personnel policies and practices are introduced. In analysing and evaluating the organisational environment, it is necessary to consider two sets of characteristics that has impact on the environment: formal structural characteristics and climate characteristics. In this study emphasis has been on climate characteristics which includes the structural factors. Structural characteristics are highly rigid and fragmented structure of the organisation brings with it strong pressure and forces for stability and often causes insurmountable obstacles to introducing change, what occurs too often is that a concept of system is not perceived. There is always harmful absence of vertical and
horizontal teamwork, interdepartmental coordination, communication deficiencies and division of labour among staff with line and staff functions.

**Climate characteristics:** which are defined as “The subjective perception and orientation that has developed among the individuals about their organisational setting” (James and Jones, 1974). Hospitals are described as a deeply human organism in which people make the difference when this type of service organisation is compared with all other areas of commercial and industrial efforts. Beyond this fundamental quality, each hospital has its own unique characteristics, and in developing and maintaining change for improvement it is important that the manager understand the nature of the enterprise. “This is true because every (organisation) has a nature unique to itself, a set essential characteristics and patterns of behaviour that determines its present performance and its future prospects”(Ansari, 1980).

It is essential, that the hospital administrator first understand the climate characteristics, or personality of the hospital in which he manages before moving on to subsequent levels of consideration, in the introduction of change, whether it be the introduction of new training programs, new or different demands or requests for management or non management participation in decision-making, solicitation of employee involvement in problem-solving situations or the development and declaration of unprecedented dimensions in policies and procedures.

The objective of the initial stage of organisational analysis is to gain an overview and understanding of the total internal environment of the hospital, not only in terms of what, in fact, it really is and how administrators see it but, more important in terms of how employees perceive it.

The importance of this broad conceptual view can be expressed this way. Everything is known in its detail but largely unknown in its totality. We have the dimensions of every brick, but we don’t see the cathedral. Work is being done, but the conceptual framework for that work has not been built. It is this broad conceptual view which is called organisational climate in hospitals.
Since organisational climate is a multidimensional concept various authors have selected different dimensions. In this study structural and functional dimensions are included as perceived by the staff and patients of the hospitals.

In conclusion, in this study hospitals can be visualised as a formal quasi-bureaucratic and quasi-authoritarian organisation which heavily relies on conventional hierarchical work arrangements rather than on rigid impersonal rules, regulations and procedures. It is highly departmentalised, highly specialised, high professionalised organisation that cannot function effectively without internal coordination among the staff. In this study hospital is viewed as a psycho-social system, where human groups in the organisation included are the patients, as well as the administrative, medical, nursing, paramedical and unskilled staff who constitute the employees of the hospital setting except the patient who are the beneficiaries. In organisational studies in order to gain an overview and understanding of the organisation it is the employees perception of the internal environment factors. Structural and functional characteristics (organisational climate) that is to be studied. In this study it is the hospital staff perception of organisational climate that is studied in three types of hospital settings-government, private and voluntary. Patient’s perception of ward atmosphere is also considered as a dimension that parallels the concept of organisational climate in the present study. The structural and functional variables of organisational climate studied here are formalisation, centralisation, leadership, communication, interpersonal relations and working conditions.

The largest set of variables put to test in this study includes a number of bio-social variables of the employees under study. The presumption here is that the bio-social variables and job satisfaction of the employees are likely to have a influence on their perception towards organisational climate in the hospital setting. Variables included here are age, education, years of experience and marital status along with it job satisfaction is also taken and whether these variables influence the staff perception of organisational climate dimensions at different hierarchal levels in the three types of hospital settings are also found out.
Concept of Organisational Climate

Organisational climate is a management concept and it was seen that literature and research studies in the area of organisational climate was more in other disciplines rather than in the area of hospital administration. Few of the studies of organisational climate seen in hospitals were conducted in western countries. In India, there is only one Ph.D. study entitled “Planned organisational change in the structure and functioning of Indian hospitals” by Carol Huss (1975), where organisational climate has been studied incorporating various structural and functional dimensions of the hospitals. In Kerala, no study on organisational climate in hospital setting has been done so far. The researcher was able to arrive both at the clarity of the concept of organisational concept and in the identification of the four theoretical premises selected for the present study through the review of literature and research studies conducted in different disciplines such as industrial sector, banks, schools, hospitals and welfare agencies.

Organisational climate refers to a collective description of the organisation most often assessed through the average perception of organisation members. Climate is thought of as perception of the characteristics of the organisation. The structure, process and values are the major identifiable dimensions of the organisational climate. Every organisation has a personality, uniqueness or climate of its own. Organisational climate is the feel, personality or the character of the firm’s internal environment. More precisely organisational climate is a person’s perception of a host of interacting variables that results in judgment about the climate.

Organisational climate is a molar concept and illustrates a common dilemma in efforts to describe and understand human behaviour in organisations. Since approximately 1964, a substantial amount of organisational behaviour research has been concerned with the subject of organisational climate which means

1) global impressions of the organisation which members form as a consequence of interacting with other members policies, structure and processes.
2) these climate perceptions are descriptions of environmental events and conditions rather than evaluation of them i.e. climate is logically and empirically distinct from such evaluative constructs as job satisfaction and
3) the climate construct is multidimensional (e.g. Hellriegel and Slocum, 1974, Schneider and Synder 1975)

Organisational climate results from the behaviour and policies of the members of the organisation, it is perceived by the members of the organisation, it serves as a basis for interpreting the situation, and it acts as a source of pressure for directing activity. Organisational climate is the perceived aspects of an organization's internal environment, but within the same organisation there may be many different organisational climates. This might happen because people with different length of experience or at different levels of organisation’s hierarchy, may perceive internal environment of an organisation differently. Personal characteristics such as values, needs, attitudes and expectations determine the manner in which an individual is likely to perceive the various aspects of the internal working environment of the organisation. (Study on organisational climate in Banking industry by V.S.P. Rao1985).

Thus organisational climate is the perceptions of organisational practices and procedures. Individuals develop a global or summary perception of their organisation, (James and Jones, 1974, Schneider, 1973, Tagiuri, 1968) is organisational climate.

Some researchers have conceptualised climate as a dependent variable where the focus has been on understanding of the causes of climate perceptions (Dieterly and Schneider 1972; Litwin and Stringer 1968; George and Bishop 1971; Lawler, Hall, Oldham 1974; Payne and Mansfield 1973; Payne, Phyezy and Pugh 1971) and was measured through questionnaires.

Others (Frederikson, et al. 1972; Pritchard and Karasick 1973) conceptualised climate as an independent variable, a cause of attitudes or behaviour. Still others (Hall and Schneider 1972; Likert 1967) conceptualize climate as a mediating variable, a variable whose existence is thought to serve as a cognition mediating organisational behaviour and individual behaviour.

In this study organisational climate is conceptualised as a dependent variable where the focus is on understanding the causes of climate perceptions of individuals of different hierarchical positions with regard to different organisational climate dimensions.
The main confusion lies in the unit of analysis, that is whether one is measuring psychological climate (the perceived world of individual member) or studying the organisational climate (attributes of the organisation as a whole). If we regard climate as an organisational attribute, the term ‘organisational climate’ seems appropriate, when regarded as an individual attribute a new designation such as ‘psychological climate’, may be employed (James and Jones 1974). The present research deals with ‘organisational climate’ and not with ‘psychological climate’. With this end in view, organisational climate may be defined as the “sum total of particular attributes of the organisation as a whole as well as those values and norms which symbolize the on-going pattern of the organisation and its sub-units” (Ansari, 1980).

**Importance of organisational climate**

All organisational theoreticians and researchers unanimously agree that a sound organisational climate is extremely important for the ultimate achievement of organisational objectives. It affects the behaviour of people in many ways. Organisational climate provides a useful platform for understanding such characteristics of organisations as stability, creativity, innovation, communication and effectiveness. Organisational climate is the manifestation of the attitudes of organisational members toward the organisation itself. An organisation tends to attract and keep people who fit its climate, so that its patterns are perpetuated at least to some extent.

In order to bring about change in the behaviour pattern of people in the organisation, a change in the organisational climate will be enough. If the change in the organisational climate is incongruent with the perceptual system of the individual in the organisation, there may arise resistance from the part of the people in the organisation first, and if the changed climate continues in the organisations, in order to maintain homeostatic condition people will start to change according to the changed climate. But when change in procedures & practices is such that it cannot be incorporated into the perception of the individual in the organisation, resistance may continue and finally that may lead to distress and dissatisfaction among employees. It is easy to bring about change in the climate of the organisation. But we cannot aspire for a change in the
behaviour of the employees as speedily as that of the organisational change. This lag occurs because people first have to form new climate perceptions which serve as a frame of reference for coherent set of adaptive behaviour. This observation is very much important for those who are concerned to bring about change in a work setting. So from the forgoing description, it is not wrong if one infer that situational characteristics rather than individual attributes are the main cause of behaviourism in organisation. This is more true when the range of individual difference is relatively narrow.

The extent of the importance of this concept is evidenced by no fewer than 8 major reviews discussing over 25 years of climate literature (Campbell, Dunnette, Lawler and Weick 1970; Forehand and Gilmer 1964; Hellriegel and Slocum 1974; James and Jones 1974; Litwin & Stringer 1968; Payne and Pugh 1967; Tagiuri and Litwin 1964; Woodman and King 1978)

While organisational climate is an important construct it is also the subject of considerable controversy. Eight reviews in 15 years have not served to completely clarify it. In fact, the latest review by Woodman and King concluded that “Until these issues of validity can be resolved, much speculation about organisational climate is likely to elude science and remain in the realm of organisational folklore (1978).

Climate should be seen as a system variable, which can permit the analysis and understanding of individual and group behaviour in actual, complex social situations (Litwin and Stringer, 1968, Tagiuri, 1968, Schneider 1975) concluded that people perceive a work climate in their work world and behave in ways that fit that perception. In summary, climate is an important construct to be integrated into organisational behaviour systems theory. There is a great deal of research which supports the importance of climate within the nomological net.

Dimensions of climate have been determined through the measurement of the individual perceptions of employees within organisations. Most questionnaires were developed by aggregating the scores of all organisational participants who responded to questionnaire survey. These aggregate scores were then considered indicators of the degree a particular dimension was experienced in the climate by everyone in the organisation.
From the above discussion it can be said that the term organisational climate used in this present study includes the following five qualities or elements:

a) Organisational climate is a molar concept;
b) Is enduring over time;
c) Though differences may arise in individual perceptions, there can be broad over all agreement in describing organisational climate;
d) When used in the form of summated, averaged perceptions of individuals, organisational climate is characteristic of the organisation instead of the individual and;
e) Organisational climate influences the behaviour of members of the organisation.

In practice different researchers have employed different combinations and permutations with the result that everyone has ended up studying organisational climate somewhat differently from all others.

Thus the wide range of performance and effectiveness-related factors included within, organisational climate is of considerable importance to health care administrators.

Having discussed on the importance of the concept of organisational climate, the researcher has concentrated to identify some of the theoretical schemes by which organisational climate has been studied by earlier researchers. There are studies which show organisational variables affect climate directly or indirectly (Field and Abelson 1982). Some studies have concentrated on identifying organisational climate concept as sufficiently complex and as a multidimensional construct (Pritchard and Karasick 1973; Litwin and Stringer 1968). There are few researchers who have selected organisational climate as an interaction between environmental variables and personal variables (Forehand and Gilmer 1968; Johnston 1976). Some have centered their studies on finding organisational climate in relation to its effect on individual behaviour, attitude, motivation, performance and job satisfaction and sometimes vice-versa (Lewin 1936; Meyer 1968; Litwin and Stringer 1968; Kaczka and Kirk 1968; James and Jones 1974, 1979; Batlis 1980; Sharma and Kumpar 1981; Sinha 1983). While another group of researchers have been concerned with organisational climate influencing organisation.
process variables (Lawler 1974; Blau 1968; LaFolette and Sim 1975) as well as structural variables (Allen and Lafolette 1977).

From the ongoing discussion of the various theoretical schemes under which organisational climate has been studied, it can be inferred that organisational climate is a useful construct in the study of organisation because it aids in the prediction of organisational phenomena and it is a link with other organisational constructs forming a nomological net. The present research work on organisational climate in hospital settings has been studied under four theoretical premises.

The foremost premise taken here is that organisational climate concept is sufficiently complex and it is a multidimensional construct. Organisational characteristics both structural and functional has effect on the organisational climate. Various authors have studied organisational climate including different organisational characteristics with the assumption that improvement or purposeful changes in these aspects would be reflected in organisational climate. The characteristics included are structure, size, leadership, responsibility, rewards and benefits, accuracy, acceptance, risk, warmth and support, standards, conflicts, supervision, identity, autonomy, formalisation, communication, flexibility, supportiveness, centralisation, teamwork, intergroup cooperation, interpersonal relations and decision-making (Forchand and Gilmer 1964; Payne and Pugh 1967; Taguiiri and Litwin 1968; Litwin and Stringer 1968; Schneider and Barlett 1968; Meyer 1968; Campbell 1970; House and Rizzo 1972; Pritchard and Karasick 1973; James and Jones 1974; Lawler 1974; LaFollette 1977; Steers 1977; Muchinsky 1977; Joyce and Slocum 1979, 82, 84; Field and Abelson 1982; Baldev Sharma 1988; David Turnipseed 1990).

The second theoretical premise taken in this study is that organisational characteristics are perceived and interpreted by organisation members and that organisational climate are usually seen as an interaction between environmental variables and personal variables. The employees when they are subgrouped by organisational characteristics such as hierarchial level, department or work group, or by personal characteristics such as age, education, sex and other socio-demographic dimensions, they were found to report different perceived organisational climate. The researchers who have
done studies in this direction are (Astin 1963; Forehand 1968; Friedlander and Margulies 1969; Payne and Pugh 1967; Lawler, Hall and Oldham 1974; James and Jones 1974; Payne and Mansfield 1973; Waters et al 1974; Downey 1975; Schneider 1975; Hellriegel and Slocum 1974; Allen and La Follette 1977).

The third theoretical premise of the study is concerned with organisational climate's effect on other organisational variables such as motivation, performance, attitude, behaviour and job satisfaction of the employees and sometimes vice-versa. This premise has been studied with the assumption that job performance and effectiveness would increase in organisation through improvement of organisational climate. Various authors have done researches with regard to these aspects (Forehand and Gilmer 1964; Litwin and Stringer 1968; Forehand 1968; Kaczka and Kirk 1968; Meyer 1968; Lawler 1974, Payne, Fineman and Wall 1976; Steers 1977; Muchinsky 1977; Ford and Jackofsky 1978; Woodman and King 1978; Batjis 1980; Sinha 1980). In the present study, the influence of job satisfaction on organisational climate perception is found out.

The fourth theoretical premise is that patient's perception of ward atmosphere has been considered important dimension of organisational climate. Researchers in this regard includes (Rudolf Moos 1974, 86; James, Milne and Firth 1990; Lanza, Kayne, Hicks and Milner 1994; Contel and Onildo 1998).

In the present study only few of the structural and functional variables are included for studying organisational climate. First these variables are discussed in terms of the two models- Bureaucratic Model and Human Relations Model.

**Structural - Functional Factors**

The next step in this analysis is to identify and discuss those structural and functional factors that are most crucial to the behaviour of the organisation and its members. Viewing broadly, the function of structure in any kind of entity is to hold the things together, to give it a form rather than randomness, to give it consistency and stability, to relates its parts to one anoher, and to delineate its operations. So also in the context of organisations too, structure helps to delineate and regulate the work, actions, and behaviour of the people in a consistent way. Without an organisational support and
control staff behaviour and the organisational objectives are not met. In essence, as most of the writers perceive the concept of structures implies the mode of arrangements done among people to get the work done (Zald 1962; Perrow 1967, 1951; Newman 1973). Presumably the structural and functional factors are intimately intertwined so much so that the pattern of structure tend to influence the various administrative processes. In short, structure is considered as a crucial factor in determining what actually happens to an organisation including the process within the organisation.

A question which arises at this juncture is: what are the relevant factors to be taken up under the structural and functional factors? An overview of the empirical literature on structure suggests an exhaustive range of possible factors. While one group of researchers have selected specialisation, standardisation, formalisation, centralisation and flexibility as the major factors (Pugh et al 1963; Aiken and Hage 1966), another group of researchers have been concerned with hierarchial patterns such as span of control, levels of hierarchy, size of the organisation etc. (Blau et al 1966; Triandis 1971). Review of the studies on organisational climate done earlier shows a list of structural factors taken differently by the researchers. In this study the perception of staff pertaining to the structural components such as formalisation, centralisation and working conditions are covered.

Similarly the determination of crucial functional factors also appears to be a difficult task, as some of the authors provide a very comprehensive list of possible variables. For example, Triandis (1971) suggests at least about 25 variables under functional factors of which planning, organizing, co-ordinating, participation in decision-making etc. are a few to be mentioned here. However, previous empirical analysis have only dealt with the key variables such as decision-making, co-ordination and communication because of the practical difficulties involved in measurement (Murdia 1979). As is the case in any such endeavour a choice is made in the present study to the most pertinent assets of the managerial functions such as leadership styles, communication and interpersonal relations.

Nevertheless, before the selected factors are presented it seems appropriate to refer to some of the theoretical models relevant to the present discussion. Organisational
theorists have proposed a number of theoretical models to analyse the industrial, governmental, political and other such complex organisations (Champion 1975; Hasenfeld and English 1978). Among these bureaucratic and human relations models are found to be more applicable in human service organisations. Therefore a discussion of these models appear to be useful as a basis for the structural and functional analysis of hospital settings.

**Bureaucratic Model**

The most popular theory among bureaucratic model is the one proposed by Weber (1947). It prescribes the following essential dimensions inorder to obtain maximum efficiency in the organisation

1) the hierarchial authority structure
2) the high degree of specialization and division of labour
3) recruitment and promotion on the basis of merit and technical knowledge
4) impersonal relations

In the bureaucratic organisation, the administrative processes such as decision-making, communication and leadership style follow a specific pattern. The decision-making situation tend to be treated either as

1) occasional or superior or non-programmed or
2) routine or habitual or programmed.

Usually, the occasional or non-programmed decisions are made by the higher echelon, while the routine or programmed ones are by the lower echelon in the organisation. Thus at the lower level the areas of decision-making are limited, but moving up to the top level, areas are broad. Moreover the decisions made by lower levels are always subjected to the approval or disapproval of the higher level (Dill 1962). Besides, in the hierarchical structure of bureaucracy, communication system is structured along the line of authority relations. The functional framework of hierarchy insists on a unity of command reinforces authority and maintains a formal system of communication. In other words, in the communication process, the primary emphasis on the downward flow of orders and influences. There is no corresponding emphasis on upward communication,
individual initiation, participation and creative activities. The leadership style followed in the bureaucratic organisation is often the authoritarian one and some of the writers consider it as a 'job-oriented' one (Likert 1961). In this form of leadership there is no concern for people, the only responsibility of the leader is to ensure whether the subordinates are performing their assigned duties within the specified rules and procedures. The measures the leader uses to obtain the work done are the authority derived from his specific position in an organisation or coercive measures (Etzioni 1965).

Most of the complex organisations such as industrial, governmental, educational, religious etc. are following bureaucratic model in varying degrees. The reason perhaps would be that the hierarchical structure, the chain of command, rigid rules etc. can maintain a certain degree of order, discipline and efficiency in the running of the organisation. Weber believed that, this model is an ideal one for organisational structure, for its emphasize on specialization and the pyramidal form of administration would lead to maximum efficiency. Unfortunately this model has been subjected to the criticism of other organisational theorists for its over emphasis on specialisation, hierarchy, rigid rules and impersonal relationships. Some of the limitations pointed out by Bennis (1965) could be summarised as:

1) it does not adequately allow for the growth and development of mature personalities,

2) it does not take into account the "informal organisation" and the emerging needs of people and unanticipated problems

3) its emphasize is on control and hence it blocks upward, downward and sideways communication and

4) it cannot assimilate the inflow of new technology and thus impedes the development of innovative ideas.

Thus most of the critics contend that, this model completely lacks flexibility, adaptability and above all the human touch. Moreover, the high degree of specialisation, instead of leading to efficiency, sometimes leads to internal conflicts and blocks in communication.
In conclusion to the discussion on bureaucratic model, Dubey (1973) states that it is not a suitable model for the organisations engaged in creating new ideas or problem solving (research organisations) or in changing people's habits, attitudes, behaviour or in socialisation functions (institutions for juvenile delinquents, prostitutes and youth) or in distribution of services directly to the consumers.

**Human Relations Model**

The unique recognition of the principle of the motivation for work as an important variable in an organisation to increase productivity has set forward a new dimension to organisational analysis. The perspective takes into account the premise that, human beings could be motivated to work more productively if their social - psychological needs are fulfilled. The contemporary social scientists view this human relations model as a social psychological approach which gives due emphasis to psycho - social nature of human beings. Thus the human relations theorists argue that man is not only an income - earning organism who has got feelings, motivation, goals, attributes etc. which need to be taken into consideration.

Admittedly, human relations model is a sharp reaction to the negation of ‘human - relational’ aspects in the bureaucratic approach. While bureaucratic theorists consider impersonal relationship, specialization, hierarchial structure, rigid rules etc. as the means to increase efficiency, human relation theorists suggest inter - personal relationship, participation, cohesive group work activity and coordinative leadership as the effective means to increase productivity in work organizations. Thus one could observe a distinctive shift in focus from “structure” to “individuals and their sentiments” and “single” administration to “group” administration. This new perspective of human relation theory has influenced the administrative processes of work organisations as well as social welfare organisations. Some of the writers suggest this model as more appropriate to the social welfare and child welfare organisations, though it has not been fully developed and used in these fields (Sohini 1979).

The structural models presented here provides a conceptual overview of two important approaches in organisational theory. This discussion suggest that human-
relation model seems more suitable for organisations which are engaged in the tasks of “socialisation” or “resocialisation”. A combination of both bureaucrat and human-relations model seems more suitable for hospital settings. Bureacrat model finds importance due to the specialisation, heirarchial structure and differentiation of activities seen in the hospitals. The leadership style in the bureacratic model is often authoritarian which is considered as job oriented and helps in achievement of objectives. Human relations model seems more applicable in terms of staff-patient relationship, since the staff deals with human beings. Today in hospitals the administrators implement human relations approach mainly concerning doctors who are considered to uphold the hospital reputation.

Given this perspective, a question arises here what should be the nature of structural and functional factors in hospital setting in order to influence organisational climate? As noted earlier, formalisation, centralisation and working conditions are the three factors identified under structural variables. leadership, communication and interpersonal relations are considered as functional variables. Fig 2, gives the theoretical model of the study.

The researcher now moves on to discuss both theoretical and empirical literature based on each of the structural and functional variables included in the present study. It has been seen that structural and functional factors are intertwined so much so that the pattern of structure tend to influence the various administrative process. So the structural factors are discussed first followed by the functional factors. Both structural and functional factors of the hospital are included in this study as dependent variables (organisational climate), whereas bio-social factors and job satisfaction are included as independent variables.

Formalisation

The concept of formalisation has also received wide acceptance among the organisational researchers (Aiken and Hage 1966; Hall et al 1967; Inkson et al 1970; Hall 1972; Kakabadse 1979). To begin with a simple definition given by Hall (1972) may be considered: formalisation is the organisational technique of prescribing how, when and by whom tasks are to be performed. While some organisations rigorously prescribe the
responsibilities, duties and procedures to be followed by its members, some other organisations have loosely defined jobs and do not control the behaviour of its members. As noted in the review of studies, Aiken and Hage (1966,1967,1971) have done an extensive research on organisational formalisation. According to these social scientists, formalisation is measured by the proportion of codified jobs and the range of variation that is tolerated within the rules defining the jobs. The higher the proportion of codified jobs and less the range of variation allowed, the more formalized organisation is. To measure the degree of formalisation, 5 indicators have been suggested by them: Job codification, rule observation, rule manual, job descriptions and specificity of job descriptions.

It is noted that there is often a link between the degree of formalisation and the size of the organisation. As size increases there is a likely hood of increase in formalized structure too. Similarly, formalisation is positively related to other dimensions of organisational behaviour. This rigidity in structure leads to alienation from work and greater dissatisfaction in work. Hall (1972) strongly feels that the degree of formalisation as important consequences for the individual behaviour, either he becomes a silent follower of rules or a constant rebel who fights against rules. Moreover instead of creating an informal atmosphere, the high degree of formalisation leads to a formal and imposed organisational situation. And one could expect only a minimal participation from its members in the various administrative processes and sometimes vice-versa.

However the importance of formalisation has to be viewed from the nature of the organisation. The nature of members involved and the techniques used in the organisation determine to a large extent the degree of formalisation. In an autocratic or military type of organisation, where everything is controlled from the top level, perhaps, a high degree of formalisation may lead to the achievement of the goal. On the contrary, in human service organisations, particularly in people-changing organisations where individuals are the targets of change, rigidity in rules and structure may yield to negative results. As noted earlier, it leads to alienation from work and consequent non-identification with organisation. It precludes the members from using individual freedom, creativity, informal and personalized approach. Most of the writers are of the view that the people-
changing organisations use a variety of human relations techniques in achieving its qualitative changes (Street et al., 1960; Hasenfeld and English, 1978). High degree of formalisation minimises the use of human relations techniques.

In hospitals which seeks to provide various treatment modalities which varies from individual to individual and the approach also varies, such a setting cannot function meaningfully in a strictly induced organisational atmosphere. No assumption is made here that hospitals should not have any rules and regulations. Certainly, for the successful functioning of the institution, certain amount of formalisation is desirable but it should allow some degree of leniency which permits the use of individual freedom and the creativity of its member as long as it helps in the achievement of the stipulated goals.

Centralisation

The issue of centralisation has been another major variable incorporated in the organisational analysis. While the centralisation refers to the locus of control and decision-making at the higher level of the organisation, decentralisation refers to the diffusion of authority to the different departmental heads (Aiken and Hage 1966; Hall 1972; Newman 1973). Aiken and Hage furnishes a more precise dimension to this concept by defining centralisation as the degree to which members participate in decision-making. The component of power is an important factor in every type of organization as it is one of the determinant factors affecting the behaviour of the organisational members. The maximum degree of centralisation would exist if the entire power is being exercised by a single individual and the minimum degree of centralisation (i.e. decentralisation) would exist if the entire power is being exercised by all the members of the organisation. Generally, most of the organisation reflect a mixture of these tendencies, falling somewhere between the extremes.

Aiken and Hage (1966, 1967, 1969) are the two popular researchers who have done a serious study on this issue of centralisation too. The two dimension of centralisation have been measured by them:

1) the degree to which occupants of various positions participate in decisions regarding the organisational policies
2) the extent to which members are assigned tasks and then provided with the freedom to
implement them without any interruption from superiors

Coming to the findings of various studies, it has been noted that there is a
correlation between the degree of centralisation and other organisational processes such
as a adoption of innovative ideas, expressive relations, interdepartmental communications
and routines of work. Highly centralized organisations impedes the adoption of new ideas
(Moch and Morse 1977), frequent communication process (Hage et al 1971), expressive
relations (Aiken and Hage 1966) and promotes a routine nature of work (Hage and Aiken
1969). In essence, centralised authority structure does not promote participation in
management, group decision-making which are essential for the development of human
resources. Human service organizations which are essentially functioning on human
relations model would prefer decentralized structure rather than centralized structure.

Dubey points out that, in people-changing organisations, vertical hierarchy based
on a single line is ineffective. This vertical structure hampers individual motivation,
innovative planning and creativity. On the contrary, decentralisation of authority through
distribution to heads of each functional unit will provide opportunities for them to make
decisions in the appropriate context. Thus delegation of authority facilitates innovation,
creativity, flexibility and freedom in dealing with the organisational tasks (1981).

In hospitals the treatment of patients involves a complex set of skills-technical,
professional and administrative. The staff employed in hospitals consists of personnel at
different levels. Administrative personnel such as superintendent, resident medical
officer, sergeant, lay secretary, nursing superintendent etc. Professionals are mainly
doctors. Nursing care personnel includes nurses, housewives and nursing aids. Technical
and paramedical staff includes x-ray technicians, laboratory technicians, radiologist,
pharmacist. Apart from the above mentioned there is a lower level of staff comprising
mainly of peons, drivers, sweepers, attenders and canteen staff. It is the co-ordinated
functioning of staff from all levels that can contribute to better treatment of the patient. At
the operational level in providing better treatment both decentralised system as well as
some extent of centralisation also to be made use of in the hospital. A single line, rigid
and inflexible administrative structure alone would appear to be ineffective and
impractical. As it has been pointed out earlier, in a bureaucratic set-up, the lower the hierarchical level, the lesser the authority. Less authority does not always imply less responsibility. Staff at the lower levels are also contributing to providing better care and treatment of the patients. Lack of cooperation from them always creates problems for the patient. Lack of authority to them impedes the motivation, freedom and creative planning of lower level staff members which are very essential in achieving the goals. Then there is a great need for decentralisation of authority to lower level staff members particularly to the lower level personnel who have the responsibility of looking after the day to day needs of patients. In this context, a collegial relationship which can obtain compliance from all levels of staff is suggested. It is a structure which fosters a participative mode of decision-making which takes into account the suggestions and opinions of lower level staff members.

**Working Conditions**

In a cash-nexus economy, the importance of monetary compensation cannot be over emphasised. What happens to wages and salaries is of crucial concern to employees. To the employee salaries represent incomes, to the employer they represent cost and to the government they signify potential taxes. Salaries constitute the largest source of purchasing power; hence, changes in labour income have an important bearing on the level of economic activity. Moreover, wages constitute one of the important factors around which most of the labour problems revolve. In the hospitals, whether it be government, private or voluntary, majority of the employees are not satisfied with the salaries they receive. They expect to be protected against the galloping inflation. They want to improve their standard of living by sharing in the gains of economic progress in the country. Litwin and Stringer (1968) studied reward (positive inducements for jobs well done) as one of the elements while measuring organisational climate. Campbell et al (1970) also included reward (degree to which there is a promotion-achievement orientation in the organisation) as one of the elements while measuring organisational climate. Similarly Pritchard and Karasick (1973) included reward as one of the dimension of organisational climate.
Herman (1976) identified six dimensions for studying psychological climate such as rewards, autonomy, motivation to achieve centrality, closeness of supervision and peer relations. Rewards which was included as a dimension of organisational climate measured the extent to which adequate rewards are available within the organisation and are contingent upon performance.

Singh et al (1980) and Sharma (1987) says that whenever the problem of motivation is faced within the organisation, by and large they tend to rely more on economic rewards. This is so because of their belief system—that people in this country work primarily for money. Similarly Sinha (1980) and Pestonjee (1980) included rewards and benefits as a measure of organisational climate.

Sharma and Venkata Ratnam (1982, 87 and 88) in their study on organisational climate included monetary benefits as one of the dimensions. They studied the salary, dearness allowances, house rent allowances and city compensatory allowances of the employees of Bharat electrical company. Monetary benefits was the highest rated dimension of climate in BEC. They also studied on special schemes for giving recognition and appreciation to employees whose work was found to be exceptionally good. These included promotions, giving cash awards to those who acquire additional qualifications. This dimension was also included in organisational climate.

Welfare facilities was also taken as a dimension to study organisational climate. They studied various welfare activities provided to the employees such as provident fund, family pension, transport, canteen, medical, uniform, leave travel allowance, group insurance and benevolent fund. In this present study working conditions included salary, allowances, promotions, security, Appreciation and recognition for work, power and respect and development of personal worth. All the above studies pinpoint that this variable is important in the study of the organisation. For this is the basic urge or motivation to the employees. Naturally if they are satisfied in this area, their behaviour would be better and better performance can be expected out of them. Dissatisfaction of this basic structural dimension has led to numerous problems in the organisations. The researcher felt strongly that working condition should be included while measuring organisational climate of the hospital setting.
Leadership

For many years the analysis of organisation was largely guided by a set of basic assumptions, most effectively stated by Weber (1947) in his discussion of “bureaucracy”. Theorists writing in this tradition assume that an organisation has a primary objective (also referred to as purpose, goal, task, function or mission). To reach this objective, subgoals must be established and specific means chosen for their attainment. This in turn, requires a differentiation into specialised tasks which must be carried out dependably in co-ordinated manner. Tasks are combined into positions (or offices or jobs) and individuals are assigned to these. Each position has a formal or informal job description which specifies what the occupant of the position is supposed to do it and how he is supposed to do it. To give further assurance that the system will work properly, rules, regulations and policies are promulgated as guidance to the behavior of the participants. Finally a control mechanism is established whereby the various positions are linked together by a chain of command so that the authority and responsibility of each position is unambiguous. Nevertheless, the view prevents that every organisation has a basic objective and to be viable it must have some control system to guarantee accomplishment of this objective. As Gilman (1962) puts it “positive control of performance down the time is possible only because one can influence, when and if necessary, the behavior of the subordinate in such a way that he acts on the basis of his supervisors judgment rather than his own.

Russell (1938) in his analysis of power in society, asserts that there are three principal ways in which an agent may exert influence over a person a) by physical power his body, e.g.: - by imposing or killing him. b) by rewards and punishments employed as inducements, e.g.: - by giving or withholding employment and c) by influence on opinion e.g.: - through education or propaganda. Gilman (1962) who is concerned with the problem of accomplishing control in hierarchical organisations, identifies four methods: a) coercion b) manipulation c) authority and d) persuasion

An empirical study of how the effectiveness of a reward system affects the amount of influence exerted by a supervisor is provided by Bennis and his associates (1958). The results of this study indicate two major limitations on the effectiveness of a supervisors
influence a) an incorrect perception on the part of a supervisors of what rewards the subordinates desire and b) an inability to increase or withhold these rewards. In hospitals where it is less extreme, the supervisors were found to exert greater influence over the activities of the subordinates.

In choosing a means of influence an agent is guided by a theory of human nature and constrained by legal prescriptions deriving from the larger social environment. A rather different set of determinants are indicated by Rosenberg and Pearlin (1962) in their study of types of influence used by the members of the nursing staff of a mental hospital. Types of influences used are persuasion, manipulation, legitimate authority, coercion and contractual power. Analysis of the reason given for preferring a particular means reveals a number of factors: a) the value system of the nursing profession, b) the predicted effectiveness of the means, c) the immediate costs or work for the nurse, d) delayed consequences that might be expected e) consequences for relationships with other patients f) the nurses orientation to work.

The foregoing discussion on the nature of authority structure and communication system also pinpoints the leadership style required in hospitals. In people-changing organisations, Dubey (1981) recommends a 'co-ordinative' leadership rather than 'directive' leadership. In the former style of leadership, the leader's role is explained as a promoter who fosters congruence between the individuals and organisational goals. In the latter style of leadership, the leader is an agent of power whose responsibility is to see whether his subordinates have performed their assigned tasks in the specified manner. Dubey feels that this second style of leadership will not be an appropriate one in organisation which values individual freedom and autonomy. Hospitals, which are operated by a band of technical staff, professionals, administrative and unskilled staff will have to ensure effective co-ordination and teamwork. This is achieved mainly through a co-ordinative leadership which facilitates a supportive rather than a competitive relationship among the members. Collegiate relationship and feedback systems would promote effective co-ordination.

Meyer (1968) found that differences in perceived climate seemed to be due to different leadership styles of the managers. Garlie Forchand and Gilmer (1964), Litwin
and Stringer (1968) and Schneider and Bartlett (1970) hold the view that the managerial personnel in most organisations contribute more to what the climate is than do others in that system. Blau (1954) and La Folette and Sim (1975) argues that different styles of leadership could be associated with different organisational climate. Lawler et al. (1974) conclude that the difference in leadership styles is caused by organisational norms and climate. Similarly Ansari (1980) and Sharma (1987) have grouped leadership function as one of the dimensions of organisational climate. In this present study on organisational climate in hospital setting leadership is included as one of the dimensions while measuring organisational climate.

**Communication**

Communication is not a tool of organisation, something to be grated on those thriving organisations able to afford this rather expensive luxury. Instead, it is the very essence of all organisation, for without the sharing of information, an organisation could not be formed or survive for very long. In a narrow sense, communication involves skills such as reading, writing, listening and speaking. In larger sense, it involves attitudes, psychology, environment, and perhaps the entire range of business and personal relationships. It involves the sending and receiving not only of information, but of attitudes and feelings as well. When effective, it helps an organisation reach its goals. When ineffective, it does the opposite.

To get feedback is of course, to learn how effective communication has been. It is knowledge of results, and it tells management (1) whether employees have understood and acted upon a message; (2) what employees can contribute to the solution of a problem; and (3) what remains to be said to reconcile the needs of management, employees and the organisation.

Without feedback, managers tend to overrate the effectiveness of their communication. They are often too remote from employees to directly observe the frustrations, tensions and inefficiency resulting from poor communication and consequently may often be unaware of the relationship between communication, morale, turnover, and so forth. Through effective feedback, evaluation can be more objective and
realistic. Problem areas can be more easily and accurately detected. In addition, proper emphasis on feedback can conceive employees of management’s interest in their ideas and attitudes, with consequent positive effects on morale, as well as communication and job performance.

Employees attitude surveys provide administration with an analysis and evaluation of employees options, attitudes and morale as obtained from formal questionnaires. Through this information, management can hope to discover what different groups of employees—a section, a department, or perhaps the entire organisation—think about job satisfaction, supervision and the hospitals effectiveness.

The task of improving media is also affected by an organisational characteristic of the hospital environment, namely the hierarchical ordering of health workers, where staff stratification is high. Communication to and about the patient is decreased and vice versa. This hierarchical barrier to communication along with others, gives credence to the general rule that the more important the message, the more often it should be repeated—in a different media, at different times, in different contexts. Although many managers feel that a message need be transmitted only once to be effective (one memorandum one notice, one bulletin, and so forth), specialists insist that repetition is important. Many employees, often because of the existing stratification, miss a message the first time around. And the techniques of newspaper, radio and television advertising may have caused people to associate repetition with importance.

Thus it can be said that an important component in the effective running of an organization is the communication system which is clearly connected with the authority pattern. Katz (1957) notice four main channels of communication by which members of an organisation receive and relay information: the upward communication, travels from subordinates to superior. The most common purpose of their information flow is to provide feedback on how well things are going. Downward communication, travels from the superior to the subordinate. The most common purpose of this communication flow are to transmit information and instruct employees in the performance of their jobs. For human relation study, downward communication is important because it provides direction and control for the employees. Lateral and diagonal communication takes place
between people on the same level of the hierarchy. The most common reason for this communication flow is to promote co-ordination and team work. There is a greater need for communication in all directions in an organisation when the task involved is interdisciplinary and when there is the division of work and delegation of authority.

House and Rizzo (1972) included upward communication requirement, as one of the dimension for measuring organisational climate. Sinha and Pestonjee (1980) has included communication as one of the elements of organisational climate. Similarly Baldev R. Sharma (1988), House and Rizzo (1972), Schneider and Hall (1972) discussed communication flow, accuracy and acceptance as elements of climate. Gibson and Hodgetts (1986) points out numerous demonstration of the effects of communication processes on individual and group performance as well as job attitudes and organisational commitment.

Therefore communication represents not only one of the important aspects of all human interaction but as one of the important organisational climate dimension. In the present study communication is taken as organisational climate dimension because all programmes in hospital setting revolve around a wide range of medical, physical, psychological and rehabilitation needs of patients. Hence a 'holistic approach' is essential towards the achievement of the task. The holistic approach also necessitates the organisation to function in synchronization with other governmental and non-governmental organisations in the community. Hage and his associates pointed out that, "as organisations become more diversified, more specified and more differentiated, they have to rely more on a system of reciprocal information (feedback) to achieve co-ordination (1971)". Thus a network of three dimensional communication system is essential in hospitals to achieve the necessary linkages. That is, instead of a single line Communication (vertical), an increased flow of communication between superiors and subordinates, across the departments and among the peers would appear to be effective in hospitals.

Frequent consultation, and group meetings are the techniques suggested to create an effective communication system in human service organisation (Dubey, 1981). Admittedly these techniques would be most desirable in generating an effective
communication system in hospitals which is vital for providing better care to the patients through the multidisciplinary approach practised in hospitals.

**Interpersonal relations**

The study of interpersonal relations as an aspect of organisational behavior provides a remarkable meeting ground for diverse points of view, both scientific and practical. Since the basic data of interpersonal relations are the face to face interaction and the related attitudes of men in purposive settings, one of necessity approaches this work within an interdisciplinary framework. While much of the motivation underlying the interest in interpersonal relations is scientific, a good part is practical.

This is reflective of general good fellowship that prevails in the organisation; the emphasis on being liked by colleagues, peer groups and trust reflecting managerial concern for employee interests. Interpersonal relation processes are reflected in the manner in which informal associations are formed inside an organisation. If such associations emerged to protect their own sectional interests, there may be cliques, creating a specific control-oriented climate, as contrasted with another situation where people nurture informal relations with their superiors/supervisors reflecting a dependent relationship. Informal associations also reflect the manner in which people look at each other—with trust, confidence and warmth reflecting a friendly and mutually-supportive climate. Where people lack trust and confidence in each other, the climate may not be congenial for better organisational performance. It is with this view that the researcher has included interpersonal relations as a dimension while measuring organisational climate in hospital setting.

Litwin and Stringer (1968) included warmth (prevalence of friendly relations among work groups), support (availability of mutual help from above and below when necessary) and identity (the feeling of belongingness with the company) as the elements while measuring organisational climate.

Studies by Kaczka and Kirk (1968), Friedlander and Margulies (1969), Hall and Lawler (1969), Schneider (1972, 1973) and Pritchard and Karasick (1973) clearly indicate that organisational climate is related to job satisfaction in terms of interpersonal relation,
group cohesiveness, task involvement and the like. Campbell et al (1970) studied warmth (managerial support to subordinates) as one of the elements while measuring organisational climate.

Rudolph Moos (1974) included three clusters to find staff perception of their work environment in hospitals. The three clusters are

1) relationships (staff involvement, peer cohesion and staff support)
2) personal growth (autonomy and task orientation)
3) system maintenance and change (work pressure, clarity, control, innovation and physical comfort)

Staff perception of their work environment was taken as a dimension of organisational climate in hospitals, where importance has been given to relationship between superior staff, peer group and subordinates. The same variable has been studied by Driscoll and Evan (1988), where relationship has been taken as a dimension to study organisational climate in three psychiatric units.

Herman (1976) identified six dimensions to study the climate of an organisation as rewards, autonomy, motivation to achieve, centrality, closeness of supervision and peer relations (which is the degree to which supervisors at equivalent organisational levels maintain warm and friendly relation). Sinha and Pestonjee (1980) has also included interpersonal help and trust as one of the element while measuring organisational climate.

In people-changing organisations interpersonal relations are very vital and should be existing between all levels of staff in the hierarchy. In the hospital people from different disciplines are working together. The effectiveness of delivery of better patient care can be ensured only if the personnel at all levels work cooperatively as a unit. This cooperation can be established only through meaningful and positive interpersonal relations among the personnel (Croog 1953). This is very vital in hospital where the life of the individuals are in the hands of the personnel working there. Existence of good interpersonal relations would definitely enhance the performance of the staff.
Bio-Social factors

The researcher identified bio-social factors and job satisfaction of the staff as independent variables of the study and has attempted to find the influence of these independent variables on organisational climate dimensions such as formalisation, centralisation, leadership, communication, interpersonal relations and working conditions.

There are number of studies reporting a difference in perceived climate between different employee groups (Astin 1963; Curtis 1975; Payne and Mansfield 1973; Waters et al 1974). The social and economic background of the employees may also have a big effect on organisational climate perception.

Schneider and Hall (1972) argue that organisational climate is the perception by individuals of their organisational environment. They state that individual acts as an information processor when forming climate perceptions using data from the organisation and personnel characteristics of the perceiver such as values and needs.

Johnston (1976) emphasised that concept of organisational climate as a joint function of situational and personality variables, so that the researchers must also try to identify/specify personality and other socio-demographic dimensions that give rise to differential effects of similar perceptions of organisational climate on the psychological well being.

Forehand (1982) identified three main classes of variables which influences organisational climate. External influences of the physical and socio-cultural factors affect the climate of an organisation. Rao (1985) in his study found that socio-economic profile of the employees has influence on their perception of organisational climate. George and Brief (1992) also found that the primary work-group, affective disposition, life-event history and contextual characteristics are proposed to have direct or indirect effects, or both on positive mood at work.

El-lowzy and Mousa (1994) explained job satisfaction concerning organisational climate among working members at the public hospitals in Jordan, by answering what the relationships between gender, social status, academic rank, age, job classification, place of work and organisational climate satisfaction are. Total of 545 members (20%)
participated in this study. The research instrument consisted of two parts—personnel information and job satisfaction with organisational climate. Findings indicate that there were no significant differences in organisational climate satisfaction between females and males or on the basis of social status, academic rank and age. Significant differences were found regarding job classification and place of work. While organisational climate as an important construct, it is also the subject of considerable controversy. Some researchers have stated that climates measured by the perception of individuals seem to duplicate the construct of job satisfaction.

Bednar, Marshall and Babouth (1995) studied the effects of various demographic and socio-economic variables on perceived stress among employees in bank and found significant differences between genders, among management levels and age groups.

In conclusion it can be said that literature in regard to the inclusions of bio-social factors in the study of organisational climate is limited. However few studies pointed out the influence of bio-social variables on the perception of employees about the organisational climate (Johnston 1976; Rao 1985; El. Lowzy and Mousa 1994).

**Job satisfaction**

Job satisfaction is surprisingly difficult to define. It is to do with psychological well-being at work and that in turn is related to general psychological well-being. Most people would continue working even if they could afford not to and it is said that the most important overall predictor of living to ripe old age is to be satisfied with work.

Studying job satisfaction of the employees of the organisation is important for improving the psychological well-being based on its findings. The beginnings of research into job satisfaction and work motivation date back more than forty years to the pioneering studies of Hoppock. Since that time interest has been sporadic until the last ten to fifteen years. When a recent upsurge of interest in the area has been taken it to a position of prominence and controversy within the behavioural sciences. Among many practitioners and researchers there has been a tendency to place high intrinsic value on job satisfaction, the experience of which is taken to be evidence of a satisfactory adjustment between a person and his job. Unrest and low productivity however manifested are
thought to be caused in part through the failure of society to provide a satisfying work environment. Vroom (1946) pointed out, the relationships between expressed job satisfaction and overt behaviour seem neither to be uniform nor direct.

Job satisfaction is usually described as a relative enduring attitude of an individual towards his or her job. It depends on the presence or absence of certain key features of the task, job or working environment and reflects on the mental health of the individual. To promote job satisfaction we have to remedy environmental deficiencies but we must also extend people and allow them to use some of the special skills which are uniquely human and give them the capacity for "psychological growth".

Forehand (1968) said organisational climate can be seen as an interaction between environment variables and person variables. Organisational characteristics are perceived, selected and interpreted by organisational members along with individual motive and abilities, the outcome variables of job satisfaction, productivity and motivation.

In two separate studies (Lewin et al, 1969; Litwin and Stringer, 1968) three climates of democratic, authoritarian, laissez-faire leadership were experimentally created. These climates were found to have differential effects on motivation, performance and job satisfaction. Frieclander and Margulies (1969) have found that the personalities of the individual moderate the climate-satisfaction relationship. There have been a number of studies that have found an influence of climate on other organisational variables, such as motivation, performance and job satisfaction (Kaczka and Kirk 1968; Lawler et al 1974; Lewin et al 1969; Litwin and Stringer 1968). Schneider and Synder (1975) reported that when respondents to a climate questionnaire were grouped by position level within an organisation they tend to agree more on the climate of their job satisfaction.

Johannesson (1973) Guion (1973) considered perceived organisational climate as an attribute of the individual and not that of the organisation. Their reasoning is that an individual's feelings influence the description of perceptions or the perception themselves. Therefore, climate reported by perceptions is not differed from construct like job satisfaction or a more general term job attitudes. Further evidence show, however, that while climate and job satisfaction are related, they are not the same construct. Several
authors (Payne, Finneman and Wall, 1976) have noted that climate is a perceptual description of the work environment whereas job satisfaction is a person's affective evaluative response to aspects of their job. In a review Field and Abelson (1982) conclude that climate measures correlate with satisfaction score because of the inclusion of evaluative items in climate measures where only descriptive items are expected.

Joyce and Slocum (1982, 1984) examined the performance and satisfaction correlates of discrepancies between individuals psychological climates and the multiple aggregate organisational climate's present in their work settings. It was reported that climate discrepancy was significantly related to job satisfaction. Climate discrepancy appears to be an important predictor of job satisfaction. They also examined the hypothesis that climate discrepancy should be related to measures of individuals job satisfaction than of job performance.

Duxburg, Henly, Armstrong (1982) found that there was significant relationship between organisational climate dimensions and nurse satisfaction. The favourable perceptions of organisational climate were associated with greater job satisfaction supplements. The conclusion of earlier studies agrees to the above (Batlis 1980; James and Jones 1979; Kumar and Bohra 1979; Prakashan, Deshpande and Kshir sagar 1979; Pradap and Srivastava 1985; Sharma and Kumar 1981). In addition it was revealed that favourable perception of organisational climate was also reflected in greater satisfaction, personnel adjustment and social relations outside job.

Eberhardt, Bruce etal (1984) in their study on "The effects of full-time versus part-time employment status on attitudes toward specific organisational characteristics and overall job satisfaction", examined the perceptions of 68 part-time employees in a medical rehabilitation hospital toward specific organisational characteristics and compared these attitudes and feelings of overall job satisfaction with those of 182 full-time employees. The questionnaires used assessed three group processes (trust, corporation and power), job satisfaction and organisational climate. Anova revealed that part-time employees had more favorable attitudes in terms of the above variables studied.

Dillard, James etal (1986) in their study "Communication climate and its role in organisations" found that two variables satisfaction with supervision and one measure of
communication climate (i.e., Perceived upward opinions openers), exhibited predicative power for the criterion variables organisational climate.

Ford and Jackofsky (1978) reported that majority of climate dimensions examined in their study were significantly correlated with job satisfaction. Woodman and King (1978) concluded that the climate and job satisfaction measures are correlated for people in some positions and not others.

Numerous studies have demonstrated a consistent and impressive relationship between various measures of organisational climate and job satisfaction in different organisational settings (Batlis 1980; James and Jones 1980; Kumar and Bohra 1979; Pratab and Srivastava 1985; Pritchard and Karasick 1973).

Mcginnis, Sheila et al (1990) studied on "Job attitudes among full and part-time employees", they measured employees job satisfaction, work commitment and perceived organisational climate. It was found that employment status did not have a significant effect on the majority of employees job attitudes.

Gilluies, Franklin and Child (1990) found that there was relationship between organisational climate and job satisfaction in their study of nursing personnel. Job satisfaction was found to influence the perception of organisational climate.

Counte, Glandon, Oleske, Hill (1992) examined the effect of total quality management program on employee job satisfaction, perceptions of organisational climate and general opinions concerning the work situation in a Health care organisation and found that the participants in the program exhibited a higher level of job satisfaction and more favorable opinions regarding both the organisational climate and their work.

Shelledy, Mikles, Youtsey (1992) had analysed job and found that job satisfaction and perception of organisational climate among the respiratory care practitioners are related.

Richardsen (1993) found that there was relationships among occupational stress, job satisfaction and various individual characteristics among women physicians. It was seen that over-all satisfaction was related to satisfaction with both professional and social aspects of the job.
Researchers have studied the dimension of job satisfaction as either influencing organisational climate perception (independent variable) or perceived as one of the dimension of organisational climate. In this study job satisfaction of employees is taken as an independent variable whereby influencing the perception of organisational climate dimensions in the hospital settings.

**Patient’s perception of ward atmosphere**

The study on organisational climate in hospital settings would remain incomplete, if the beneficiaries or patient’s perception of the hospital is not taken into consideration. The researcher keeping this fact in mind through both literature search and discussion with experts in the health care, identified ward atmosphere as one of the dimensions of organisational climate. This was measured through patient’s perception.

The researcher has included patient’s perception of ward atmosphere as one of the dimension of organisational climate. A study was undertaken in 1970-71, with Indian Council of Medical Research support, to identify important hospital variables, influencing the three indices of hospital performance: length of stay, bed occupancy rate and patient satisfaction: to study the extent to which the in-hospital variables influence the indices of hospital performance and to develop and standardise instruments to measure patients satisfaction and several inter-organisational variables. An explanatory study was carried out in two hospitals, the results of which were utilised for preparing a hypothetical model concerning hospital performance. This model hypothesised a relationship among the patient satisfaction, hospital status, employee satisfaction and service leading to patient satisfaction and forming a vicious circle.

With the exception of research reported by Moos (1974) who examined contextual and personal correlates of patients perceptions of ward atmosphere, no previous evidence was available on organisational predictors of ward atmosphere for the patients. These findings highlight the salience of organisational climate variables and illustrate the utility of ward atmosphere and work environment perceptions as components of a multi-dimensional climate construct. Regarding patients the ward atmosphere has a direct influence on them. Based on the assumption that when patients
perceptions about the ward atmosphere is positive it is very much related to their well-being both physically and mentally. In this study in order to study patients perception of ward atmosphere, the ward atmosphere scale developed by Rudolph H. Moos (1974), with necessary modification was made use of. It consisted of 30 item measure focusing on three dimensions of ward atmosphere:

1) relationships (patient involvement, support and spontaneity)
2) treatment programme (autonomy, practical orientation, personal problem orientation and anger and aggression) and
3) system maintenance (order and organisation, program clarity and staff control)

Agarwal and Anand (1985) who studied on “Essential intervention to improve the quality of patients care in our hospitals” had taken into consideration patient’s perception of the hospital ward situation.

Micheal P.O. Driscoll and Rosalind Evans in their study organisational factors and perceptions of climate in three psychiatric units (1988) hypothesized that patient involvement in decision-making, the degree of responsibility accorded to patients for their own-behaviour and decisions, the extent of patient-staff communication, staff receptiveness, commitment and interest in patients would be the salient factors related to positive perceptions of climate by patients, whereas staff authoritarianism would be linked with negative evaluation of ward atmosphere.

In the study ‘A Systematic Comparison of Feedback and Staff Discussion in changing the Ward Atmosphere’ (James, Milne and Firth 1990) claimed to promote change in social climate by providing nursing staff with structured information about their unit. The ‘real’ and ‘ideal’ social climate of the unit was defined and assessed using the ward atmosphere scale administered to patient’s. In the study ‘Environmental characteristics related to patient assault’ (Lanza, Kayne, Hicks and Milner 1994). The concepts of ward conditions (degree of patients illness, number of patients and staff) and ward climate were the focus of the study. Participants were patients and nursing staff on two acute and four long-term psychiatric units in a large neuropsychiatric hospital. Patients and staff were asked to complete the ward atmosphere scale to assess ward mood and climate.
Contel and Onildo (1998) in their study on “Institutional authoritarianism and its implications for the doctor patient relationship in a university general hospital”, compares physician patient interaction in a Brazilian general hospital to the dyadic, transferential-counter transferential. Physician patient relationship at an outpatient facility. At large hospitals patients are depersonalized, infantilized and tyrannized. They are not informed of their real condition, are passed from one medical staff member to another and are administered painful and intrusive treatments without warning or explanation. The authors suggest a democratization of Brazilian hospitals effected through community-elected watch dog boards of directors. All the above studies suggest the importance of patients perception in understanding the ward climate. In this study patient’s perception of ward atmosphere is considered as a component of hospital climate construct. If their perception is positive it is indicator of a good climate and if it is negative as an indicator of bad climate.

In conclusion, an attempt is made in this chapter to develop a conceptual framework for analysing the organisational climate dimensions in hospital setting. As Kulkarni (1980) writes “Conceptual framework implies a set of principles or some basic thought, perhaps a theory which provides a rationale for a practical programme.

Theoretical Model of the present study.

Based on the literature reviewed, researcher came to the conclusion that hospital has to be viewed as a psycho-social system. “A hospital is basically, fundamentally and above all, a man system. Its raw material is human, its product is human, it work is done by human hands, and its objective is human direct service to the people that is individualised and personalised (Basil Georgopolous, 1964). In this context, hospitals definitely fall in the category of human service organisations.

Hospitals are influenced by three factors: the cultural system which sets legitimate goals, the technology which determines the means available for reaching these goals, and the social structure of the hospital in which specific techniques are embedded in such a way as to permit goal achievement. These three factors are found interdependent (Charles Perrow 1961). Structure can operate in an autonomous fashion, resisting or bringing
about change in technology and in goals. In this present study this perception is adhered to. The social structure here includes both structural and functional dimensions, both these dimensions are intertwined and that the pattern of structure tend to influence the functional aspects. A probe into the organisational characteristics-both structural and functional aspects seems to be imperative at this juncture based on the assumption that apparent changes in structural and functional aspects would reflect in the functioning of the hospital. In the present study, two structural models - Bureaucratic model and Human Relations model are taken as the basis for discussion pertaining to both structural and functional dimensions of the hospitals.

The study of organisational characteristics is often done through the average perception of organisation members which is called organisational climate. Organisational climate is the collective description of the organisation. In order to study organisation climate, the hospital staff and patient perception of a host of interacting variables that results in the judgment about the climate has to be studied.

Since organisational climate is a multidimensional concept various authors have studied different dimensions(Litwin and Stringer 1968; Pritchard and Karasick 1973; Joyce and Slocum 1979; Field and Abelson 1982). The staff perception which is his/her view of the organisation derives from a multitude stimuli within themselves and their environment. In hospital, the staff of course is exposed to various types of stimuli which have either a positive impact or a negative impact on the members. The effect of this stimuli naturally shapes views of the members. It is with this contention that the researcher is going to find out what is the staff perception about various dimensions of organisational climate and how the various stimuli to which they are exposed are related.

Review of the studies pertaining to the concept of organisational climate pinpoints that common to those researchers is the basic proposition that organisational climate is the characteristics of the organisation as perceived by its members. As Schneider(1975) rightly argues that individuals interact with their organisation and develop a global or summary perception of their organisation which is termed as organisational climate.

In this study organisational climate as been conceptualised as a dependent variable where the focus has been on understanding of the causes of climate perception (Dieterly
**THEORETICAL MODEL OF THE STUDY**

Figure 2
and Schneider 1973) and was measured through questionnaires. The independent variables conceptualised in this study are the bio-social factors namely age, education, years of experience and marital status of the staff which can be a cause of the perception (Johnston 1976; Newman 1977; Forehand 1982).

The extent of the importance of this concept is evident by no fewer than 8 major reviews discussing over 25 years of climate literature (Campbell, Dunnette, Lawler and Weick 1970; Forehand and Gilmer 1964; Hellriegel and Slocum 1974; James and Jones 1974; Litwin and stringer 1968; Payne and Pugh 1976; Taguiri and Litwin 1964; Woodman and King 1978).

In summary organisational climate is seen as a very useful construct. First it has been found to be a necessary link in the nomological net, second, there exists evidence of the links between climate and other variables and third climate may be useful for organisational development efforts.

In the present study the dimensions conceptualised for measuring organisational climate comprises structural dimensions - formalisation, centralisation and working conditions whereas functional dimensions includes, leadership, communication and interpersonal relations. This is measured through staff perception. The dimension ward atmosphere which parallels the concept of organisational climate is measured through patient’s perception. The influence of bio-social factors and job satisfaction of staff on their perception of organisational climate dimensions has also been conceptualised here.

The present study was an attempt to find out organisational climate in the three types of hospitals- government, private and voluntary. It is theoretised that improvement of the dimensions of organisational climate would improve the organisational climate which inturn would influence the behaviour of the staff towards the patient, enhance their performance and lead to better hospital functioning. This rationalisation coupled with the necessity of the organisational climate studies in Kerala motivated the researcher to take up an investigation in this area of hospital administration. Moreover the research studies in the area of organisational climate in India is scanty and no study of this kind done in Kerala.
Hospitals can be classified based on their objectives, types of patients treated according to the ownership and control, size, duration of stay in the hospital, and on system of medicine. Whatever be the classification the prime function of hospital is the provision of health care services to the people. The present trend seen in our society is the commercialisation of medical care and its cultural product has contributed to a situation where medical service is alienated from human relationship, but measured in terms of the purchasing power of the patient, cost of drugs and number of investigations done. This commercialisation has been extended to government sector also, since private practice is allowed. This is an appalling situation of medical care. Present society comprise of people belonging to high class, middle class and low class based mainly on their socio-economic condition. Private owned hospitals are usually the refugee for high class. Whereas middle class go both to private and voluntary hospitals. Government general hospitals are the sole refugee for the lower class people, where small percentage of middle class too visit for availing medical care services. In the government sector, the medical college hospitals with specialities and super specialities, the people from all socio-economic classes avail the services. It is seen that economic constraint stands no barrier for middle class or lower class people to approach private hospital if there is a ray of hope in the patient’s life. It is these premises that prompted the researcher in studying government, private and voluntary hospitals. The hospital staff behaviour and attitude towards patient in these different settings are also assumed to vary. The organisational characteristics and staff perception about the organisations are closely related. If the organisational characteristics are conducive to the staff that would be reflected in their perception towards it. The researcher presumes that there is difference in organisational characteristics seen in three types of hospitals-government, private and voluntary which the researcher intended to study. In the present study the researcher intends to measure the variation in the three types of hospitals with regard to organisational climate.

In the hospital the staff comprise of different categories. There exists variation based on the cadre, knowledge, professional and non-professional skills and the type of service delivered by them. This factor definitely creates differences in their perception of the organisation. What a doctor or nurse perceives varies with that of a sweeper’s or
attender’s perception. It is this premise that prompted the researcher to include in this study the perception of staff of different hierarchical levels namely category I which includes the administrative staff mainly concerned with policy making, implementation and also those who have a say in policy decisions. Category II includes those providing direct service to the patient namely doctors, nurses and paramedical staff and category III are those providing indirect service to the patient namely clerks, peons, attenders, drivers, cook and sweepers.

The study of organisational climate would be incomplete if the patient’s perception of ward atmosphere, which is one of the dimension of organisational climate, is not included. In the present study the researcher has also studied on this important dimension as perceived by the patient in the three types of hospitals.

This research work on organisational climate in hospital settings has been studied under four theoretical premises. The foremost premise is that organisational climate concept is sufficiently complex and it is a multidimensional construct. Organisational characteristics both structural and functional has effect on the organisational climate. (Litwin and Stringer 1968; Pritchard and Karasick 1973; Joyce and Slocum 1979; Field and Abelson 1982). The first set of variables identified here includes both structural and functional dimensions, since both are intertwined and that the pattern of structure tend to influence the functional aspects. The structural dimensions comprises formalisation, centralisation and working conditions, whereas the functional dimensions includes leadership, communication and interpersonal relations. These variables were measured through perception of staff belonging to different hierarchical levels in the hospital. The researcher hypothesised that the variation in these dimensions may contribute to the variation in organisational climate in the three types of hospitals comparatively. Further the outcome of the study would reveal what should be the extent of formalisation, the type of leadership style, the extent of centralisation, the extent of communication and interpersonal relations to be allowed inorder to enable the staff to perceive good organisational climate. The researcher is also interested in finding out whether staff of different hierarchical levels perceived organisational climate differently or not. This is based on the premise that staff perception varies with different positions, knowledge,
skills and expertise. Improvement of structural and functional variables lead to improvement of organisational climate. Better organisational climate fosters better attitude and behaviour which in turn can enhance effectiveness of hospital functioning.

The second theoretical premise is that organisational characteristics are perceived and interpreted by organisation members and organisational climate are usually seen as an interaction between environmental variables and personal variables. It is assumed that employees when subgrouped based on organisational characteristics such as age, education, sex or other socio-demographic factors, they reported different perceived organisational climate. (Schneider and Hall 1972; Johnston 1976; Newman 1977, Allen and Lafollette 1972, Forehand 1982, Rees 1985). The second set of variables studied here is the influence of bio-social factors of staff on their perception of organisational climate dimensions. The bio-social factors included are age, education, years of experience and marital status. The bio-social factors are taken as independent variables.

The third theoretical premise included here is that organisational climate is found to have effect on other organisational variables such as motivation, performance, attitude, behaviour and job satisfaction of the employees and sometimes vice-versa (Forehand and Glimer 1964; Kacza and Kirk 1968; Ford and Jackofsky 1978; Sinha 1980). In this study the influence of job satisfaction on organisational climate in the three types of hospitals are also found out. The variation of job satisfaction will show variation of organisational climate.

The study on organisational climate in hospitals would remain incomplete if patient’s perception is not taken into consideration. The researcher identified variables such as relationship, treatment and system maintenance to study ward atmosphere which is considered one of the important dimensions of organisational climate. (Rudolph Moos 1974; James, Milne and Firth 1990; Lanza, Kayne Hicks and Milner 1994). This is the fourth theoretical premise of the present study. These variables were measured through patient’s perception in the three types of hospitals. The researcher hypothesised that the variation in these dimensions would reflect the variation in ward atmosphere. The result would reveal whether relationship, treatment and system maintenance are good in the three types of hospitals. Further, it would reflect what is the ward atmosphere prevailing
in the three types of hospitals comparatively. The findings would help to suggest what should be relationship, treatment and system maintenance so that good ward atmosphere prevails in the hospital. Good ward atmosphere indicates good organisational climate. Improvement of the variables identified in ward atmosphere brings about improvement in organisational climate, which in turn affect the behaviour of the staff, enhancing the effectiveness of hospital functioning.

To sum up, the present study on "organisational climate in hospital set up", was conducted in three types of hospitals- government, private and voluntary. The perception of the staff belonging to different hierarchial levels in terms of the dimensions of organisational climate are studied. Both structural and functional dimensions of organisational climate are included. The structural dimensions comprises formalisation, centralisation and working conditions and the functional dimensions included are leadership, communication and interpersonal relations. The patients perception of ward atmosphere which is also taken as a dimension of organisational climate has been studied. The variables identified to study ward atmosphere includes relationship, treatment and system-maintenance. It is theorised that improvement in the dimensions of organisational climate would improve organisational climate. Improvement of organisational climate definitely will improve hospital functioning. Further the influence of bio-social factors and job satisfaction on the perception of organisational climate is also studied.

**Scope of the study**

It has been seen from previous studies that organisational climate can influence behaviour, attitude and motivation of the employees. This would produce better performance and better patient care from the part of the hospital employees, thus enhancing hospital effectiveness. Thus the findings of this study would be of immense help to both academicians and hospital administrators since it reveals that through improvement of various dimensions both structural and functional identified and studied here, improvement of organisational climate of the hospital could be brought about.
The findings of the study would widen the scope of social work professionals who are working in the area of hospital administration. Social work professionals specialising in medical and psychiatric social work take up the position of hospital administrators. The outcome of this study would enlighten them about giving importance to the various structural and functional variables of the hospital structure so that the employees' job satisfaction and behaviour can be boosted and that this would lead to better hospital functioning. This would make them effective administrators.