The Perceptions and Expectations Toward the Social Responsibility of Hospitals and Organizational Commitment of Nursing Staff

Sheng-Che Hsieh[1] • Herng-Chia Chiu[2] • Ya-Hui Hsieh[3] • Pei-Shen Ho[4]
Li-Chin Chen[5] • Wei-Chou Chang[6]*

[1]PhD, Associate Professor, Department of Social Work, Chia Nan University of Pharmacy and Science • [2]PhD, Professor, Department of Healthcare Administration and Medical Informatics, Kaohsiung Medical University and Investigator, Research Education and Epidemiology Center, Changhua Christian Hospital • [3]PhD, Assistant Professor, Department of Healthcare Information and Management, Ming Chuan University • [4]PhD, Associate Professor, Department of Oral Hygiene, Kaohsiung Medical University • [5]MS, Director, Nursing Department, Kaohsiung Municipal Ta-Tung Hospital, Kaohsiung Medical University • [6]MS, Senior Executive Officer, Superintendent Office, Kaohsiung Municipal Hsiao-Kang Hospital, Kaohsiung Medical University Hospital, Kaohsiung Medical University.

ABSTRACT

Background: The labor rights of medical workers in hospitals in Taiwan have been a key issue of discussion and controversy in recent years. Generally, poor work conditions and manpower shortages in hospitals have resulted in a vicious circle of severely overworked medical and healthcare staff and chronically low staffing and retention rates.

Purpose: This study employed corporate social responsibility as the conceptual framework of the social responsibility of hospitals to examine the perceptions and expectations of nurses toward the social responsibility practices of the hospital where they serve and to explore the relationship between these perceptions and organizational commitment (OC).

Methods: The participants were all nurses who were employed by one medical group in southern Taiwan. Two hundred forty anonymous questionnaires, which included scales that were designed to measure the social responsibility of hospitals and OC, were distributed. Two hundred twenty-seven valid questionnaires were returned. Exploratory factor analysis was used to validate the dimension of the social responsibility of hospitals, and hierarchical multiregression analyses were used to verify the relationship between the perceptions of nurses with regard to the social responsibility practices of the hospital where nurses serve and OC.

Results: There were considerable differences between participants' perceptions and expectations toward the social responsibility of hospitals. The nurses with high perceptions toward the social responsibility practices of the hospital where they serve tended to have relatively high OC. Senior nurses who had high perceptions of the legal and rational, ethical, and economic dimensions of the social responsibility practices of the hospital where they serve exhibited relatively strong affective commitment. Nurses in junior positions who had high perceptions of the practices of ethical responsibilities exhibited relatively strong continuance commitment. Senior nurses who had high perceptions of the legal and rational, ethical, and discretionary dimensions of the social responsibility practices of the hospital where they serve exhibited relatively strong normative commitment.

Conclusions/Implications for Practice: A friendly and humane work environment in hospital settings facilitates the implementation of social responsibility, which has been shown to foster higher levels of organizational identification and job performance among nurses and other hospital employees.

KEY WORDS:
social responsibility, hospital, nurse, organizational commitment.

Introduction

Background

Most hospitals in Taiwan are nonprofit public or corporate hospitals. Tax regulations in Taiwan exempt hospitals from paying business and corporate taxes. Therefore, hospitals are broadly categorized in the "third sector" (i.e., the nonprofit or "not-for-profit" sector). However, social and political struggles

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*Address correspondence to: Wei-Chou Chang, No.100, TzYou 1st Rd., San-Ming District, Kaohsiung City 806, Taiwan, ROC.
Tel: 886 (07) 3121101; E-mail: 0870500@gmail.com
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in recent years have impeded much-needed reforms to the domestic national health insurance (NHI) system. Hospital accreditations are frequently conducted, and medical disputes arise regularly, which increasingly strain doctor–patient relationships. The percentage of personnel expenditure in more than 80% of nonprofit corporate hospitals has decreased even when they have surplus revenues (Chang, 2014). Public hospitals have even become "sweat hospitals," where the working and welfare conditions fall short of Labor Standards Act requirements (Huang & Lee, 2013). Moreover, the average nursing job-vacancy rate in Taiwan is 5.57% (Taiwan Union of Nurses Association, 2014), the rate of employment among registered nurses is only 60.20% (Taiwan Union of Nurses Association, 2015), and the average professional career of nurses currently lasts an average of only 6–7 years (International Council of Nurses, 2014). When nurses leave the workplace, the workload of those who stay increases. This situation creates a vicious circle marked by reduced care quality and deteriorating patient rights.

Objectives

Corporate social responsibility (CSR) was originally used to examine the nonoperating profit-related influences and contributions of for-profit corporations on their stakeholders. In the present environment marked by the increasing commercialization of medical services and the increasingly profit-based motivations of hospitals that have become for-profit, using a CSR framework to assess the social responsibility of hospitals is crucial and necessary to sustain and improve the quality of healthcare resources (Abreu, David, & Crowther, 2005). The two objectives of this study were to (a) investigate the perceptions and expectations of nurses toward the social responsibility practices of the hospital where they serve and (b) explore the relationship between the perceptions of the social responsibility practices of the hospital where nurses serve and organizational commitment (OC). Furthermore, most previous studies of nurse-related human resources management (HRM) have adopted a micro-level approach that addressed nurses' workload and job satisfaction and/or explored nurses' attitudes and behaviors in the realms of OC, organizational citizenship behavior, and turnover. This study works to develop a framework that bridges the macro (organizational) and micro (individual) levels of analysis and to explain how the macro-level construct of the social responsibility of hospitals influences the OC of nurses on the micro level. In light of the current difficult circumstances faced by nurses in the current healthcare environment, the authors hope to provide a valuable new perspective on nursing resources and contribute positively to improving the HRM treatment of nurses.

Corporate Social Responsibility

The concept of CSR first appeared in the early 20th century, and the controversies surrounding the conceptualization of CSR have existed since the 1950s. During the divergent conceptualization of CSR, the economic, legal, ethical, and discretionary responsibilities in the CSR conceptual framework proposed by Carroll (1979, 1991, 1998) were frequently employed for the empirical measures of CSR. Economic responsibilities indicate that business organizations provide goods and services based on the motivation of profit maximization and that economic responsibilities are the primary objectives of businesses. Legal responsibilities are the second type of responsibilities of businesses, which are based on the partial actualization of the social contract. Businesses are expected to pursue economic goals within the frame of regulatory compliance. Consequently, economic and legal responsibilities are the fundamental regulations with which businesses must comply. Ethical responsibilities address the nonlegally mandated standards and values that a society expects a business to meet. Discretionary responsibilities refer to the actions of a business in response to the social expectations of a corporate citizen. The major difference between discretionary and ethical responsibilities is that discretionary responsibilities do not rely on ethical sentiments or a sense of right and wrong. Although society expects businesses to provide philanthropic services, the provision of these services remains at the discretion of the business. Carroll's CSR conceptual framework is similar to Maslow's hierarchy of needs (Tuzzolino & Armandi, 1981), with responsibilities organized from bottom (fundamental) to top (selective) as economic, legal, ethical, and discretionary. In other words, lower responsibilities must be accomplished before higher responsibilities.

The Social Responsibility of Hospitals and Its Employees

CSR benefits hospitals in terms of obtaining greater recognition of its operations from crucial stakeholders, enhancing its reputation, improving the efficiency with which resources are used, increasing patient loyalty, generating incentives for attracting and retaining capable employees, attaining competitive advantages as an industry leader, gaining government support, and enhancing overall financial performance (Tehemar, 2012). Healthcare organizations are required to provide high-quality clinical services, high-quality services, and cost-effective patient care under conditions of limited resources (Fottler, Blair, Whitehead, Laus, & Savage, 1989). Therefore, to meet the pressure to increase returns on public investment and to enhance financial performance, hospitals in the public sector must shift their primary focus from providing services to managing limited resources (Kakabadse & Rozuel, 2006). The social responsibilities of a hospital may be defined as effectively using limited medical resources, focusing on providing efficient services, and properly managing the interests of stakeholders. Employees, the major stakeholders and the crucial assets of an organization, must be treated with esteem and respect. Employee rights in the realm of procedural propriety, privacy, freedom of speech, and safety must be considered during the decision-making process, and the objective of management should be to pursue a "fair trade" with

employees (Carroll, 1991). The implementation of social responsibility at a hospital thus offers the potential to not only enhance the external reputation and evaluation of that hospital but also enhance employee identification and service efficiency. Considering the labor rights of employees and satisfying their specific requirements enhances and stabilizes medical service quality, ensures patient safety and health, supports the further development of hospital operations, and conserves valuable medical resources.

Organizational Commitment

Porter, Steers, Mowday, and Boulian (1974) defined OC as an individual's identification with and participation in an organization and wrote that OC exhibits the following three features: accepting organizational goals and values, possessing strong beliefs, and being willing to devote oneself to the organization, specifically showing the desire to remain a member of the organization. Allen and Meyer (1990) interpreted OC as the psychological attachment of employees to their organizations, reflected in their desire to stay in the organization, their need for the organization, and their self-perceived obligation to stay in the organization, which corresponded to affective, continuance, and normative commitments, respectively. Numerous studies have shown the shared relationship between CSR and OC. Peterson (2004) found that the ethical dimension of corporate citizenship predicted OC more accurately than the other three dimensions. When using the four types of CSR responsibilities to predict affective, continuance, and normative commitments, Rego, Leal, Cunha, and Faria (2008) found that the perceptions of employees related to legal, ethical, and discretionary responsibilities most accurately predicted affective commitment and that continuance commitment increased when employees perceived corporate legal and ethical responsibilities. However, the perceptions of employees of their economic responsibilities did not correlate with any OC dimension because, from the perspective of employees, economic responsibilities lay primarily in the context of the relationship between clients and shareholders (Rego, Leal, & Cunha, 2011). Rego, Leal, Cunha, Faria, and Pinho (2010) categorized CSR into economic, legal, ethical, and two types of discretionary dimensions (one toward employees and the other toward the community) and used these categories to predict employee OC. They found that discretionary responsibilities toward employees most accurately predicted affective commitment. Al-bdour, Ellisha, and Lin (2010) and Turker (2009) found that internal CSR that related closely to employee welfare correlated significantly and positively with affective and normative commitments. Consequently, for businesses, communicating with employees regarding CSR strategies and actions increases employee OC and enhances organizational effectiveness. Chang and Chang (2007) found that the perceptions of nurses toward the internal marketing of hospitals (i.e., the degree to which hospitals treat their employees as internal customers) affect both job satisfaction and OC positively.

Methods

The study employed a prospective cross-sectional research design and applied Carroll's CSR framework to examine the OC of nurses.

Data Collection

The study population was composed of nurses from three hospitals of one medical group. These hospitals included one medical center and two regional hospitals. Considering the professional workload of participants and the accessibility of administrative support, a convenience sampling method was adopted to recruit nurses as participants. Eighty questionnaires were distributed at an on-the-job training lecture at one of the target hospitals that was attended by 250 nurses. Seventy-two valid questionnaires were collected (response rate: 90%). In the other two regional hospitals, a simple random sampling method was adopted using nurses' employee numbers. Eighty questionnaires were distributed at each hospital, with 76 and 79 valid questionnaires returned (response rates: 95% and 98.75%, respectively). In summary, 240 anonymous questionnaires were distributed from March 2013 to October 2013, of which 227 were successfully completed and returned, giving a response rate of 94.6%. Before conducting the survey, the questionnaires were tested for validity by experts and reviewed and approved by an institutional review board (No. KMUH-IRB-20130011).

Measures

For the purposes of this study, the awareness and psychological responses of nurses toward the social responsibility practices of the hospital where they serve were termed "perceptions," and their beliefs regarding the social responsibility of hospitals were termed "expectations." A questionnaire that used Carroll's four-dimensional responsibility conceptual framework to measure corporate citizenship was administered. The original questionnaire was designed by Maignan, Ferrell, and Hult (1999) and has since been modified and used in numerous studies (Maignan & Ferrell, 2000; Peterson, 2004; Rego et al., 2008, 2010, 2011). The current study adapted the modified questionnaires and revised the items on these questionnaires into two types to ascertain the perceptions and expectations of respondents toward the social responsibility practices of the hospital where they serve. Each item was measured using a 5-point Likert scale, with scores interpreted as 5 = *strongly agree*, 4 = *agree*, 3 = *acceptable*, 2 = *disagree*, and 1 = *strongly disagree*. However, the use of the items formulated by Maignan et al. for corporate citizenship to measure the social responsibility of hospitals raises concerns regarding trans-sector validity. This study thus conducted a principal component analysis to construct the dimensions of the social responsibility of hospitals for nurses. Table 1 presents the four factors that were extracted from the principal component analysis. The Kaiser–Meyer–Olkin value was 0.89, and the

TABLE 1.
Principal Component Analysis: Perceptions of the Social Responsibility of Hospitals

Item No.	Factor 1	2	3	4
LR1	.750	.236	.176	.094
LR2	.725	.088	.372	.138
LR3	.695	.264	−.031	.153
LR4	.680	.178	.021	.295
LR5	.650	.259	.264	−.037
LR6	.611	.231	.274	.063
LR7	.549	.331	.330	−.022
EtR1	.246	.743	.313	.128
EtR2	.275	.732	.252	.071
EtR3	.219	.578	.001	.135
EtR4	.304	.570	.247	.226
DR1	.297	.113	.711	.073
DR2	.024	.426	.673	.036
DR3	.175	.129	.609	.247
DR4	.219	.424	.594	.045
ER1	−.004	.278	.069	.773
ER2	.445	.352	.093	.566
ER3	.208	−.105	.507	.549
Explained variance (%)	21.33	14.45	14.21	9.10
Cronbach's α	.87	.76	.75	.61

Note. LR = legal responsibility; EtR = ethical responsibility; DR = discretionary responsibility; ER = economic responsibility.

Bartlett's test of sphericity was 1873.58 ($p < .000$), which explained 59.1% of the total variance. One of the items in the original scale was deleted because of cross-loading and of its factor loading of <0.5. Therefore, this study defined Factor 1 as the dimension of legal and rational responsibility, Factor 2 as the dimension of ethical responsibility, Factor 3 as the dimension of discretionary responsibility, and Factor 4 as the dimension of economic responsibility. After deleting the one item noted above, the scores for all items were totaled according to their dimensions. Except for the dimension of economic responsibilities, which exhibited a relatively lower reliability because of its inclusion of only three items, all dimensions had a reliability value that was greater than 0.7.

This study adopted the revised OC scale of Meyer and Allen (1991), which uses 10 items to measure the dimensions of affective commitment (three items), continuance commitment (three items), and normative commitment (four items). Each item is scored using a 5-point Likert scale that ranges from "strongly agree" to "strongly disagree." The scores in each dimension are totaled to generate the related dimension score. Table 2 presents the results of the confirmatory factor analysis. All of the items had a factor loading higher than 0.5. All of the three commitment dimensions had a reliability higher than 0.7.

Analysis

This study used IBM SPSS V21 (IBM, Armonk, NY, USA) for the data analysis. A paired t test was applied to detect the presence of significant differences between nurses' perceptions and expectations toward the social responsibility practices of the hospital where they serve. Next, a multiple hierarchical regression analysis was conducted to determine the influences of the predictor variables such as perceptions toward the various dimensions of responsibility practices on OC. For the multiple hierarchical regression analyses, socioeconomic variables (including age, education, job level, and the employer hospital) were placed into Model 1, and the regional hospitals were adopted as the reference group for the hospital variable. Subsequently, the perceptions of participants toward the four dimensions of the social responsibility practices of the hospital where they serve were placed into Model 2 to determine the explanatory power of each predictor variable for the variance of criterion variables.

Results

Table 3 presents the perceptions and expectations toward the various dimensions of the social responsibility practices of the hospital where respondents serve and the significance of the differences between the two. A score of more than 4 indicates that the average perception or expectation for that item exceeds the level of "agree"; a score of between 3 and 4 indicates that the average perception or expectation for that item exceeds the level of "acceptable" but falls below the level of "agree."

The perceptions and expectations and the differences between these two for each dimension of the social responsibility practices of the hospital where respondents serve are comprehensively compared and presented in the following. The overall perceptions for each dimension failed to reach the level of "agree." The average score for perception toward ethical responsibilities was the highest (3.99), followed by the perceptions toward the legal and rational (3.97), economic (3.94), and discretionary (3.67) responsibilities. The overall expectations toward each dimension in descending order were the legal and rational (4.19), ethical (4.12), discretionary (4.00), and economic (3.98) responsibilities. The overall differences in each dimension were greatest in the discretionary domain ($t = -7.994$, $p < .001$), followed by legal and rational ($t = -6.745$, $p < .001$), ethical ($t = -3.871$, $p < .001$), and economic ($t = -1.203$, $p = .230$) responsibilities. The overall difference in the economic dimension did not reach significance because the expectation that hospitals strive to lower operating costs was significantly lower than the perception, which caused the differences to offset each other. The overall perception and expectation toward the social

TABLE 2.
Confirmatory Factor Analysis: Organizational Commitment[a]

Scale Item	Factor Loading
Affective commitment	.901
I do not feel a strong sense of belonging to this hospital.	.897
I do not feel emotionally attached to this hospital.	.915
I do not feel like part of the family at this hospital.	.795
Continuance commitment	.776
Too much of my life would be disrupted if I decided I wanted to leave this hospital now.	.628
I feel that I have too few options to consider leaving this hospital.	.908
One of the few negative consequences of leaving this hospital would be the scarcity of available alternatives.	.698
Normative commitment	.740
Even if it were to my advantage, I do not feel it would be right to leave this hospital now.	.541
I would feel guilty if I left this hospital now.	.546
This hospital deserves my loyalty.	.760
I would not leave this hospital right now because I have a sense of obligation to the people in it.	.753
Fit indices	
Chi-square/degrees of freedom	143.245/32
Root mean square error of approximation	0.124
Goodness-of-fit index	0.880
Adjusted goodness-of-fit index	0.793
Comparative fit index	0.896
Incremental fit index	0.898
Relative fit index	0.820

Note. In parentheses: Cronbach's alphas.
[a]Completely standardized solution.

responsibility practices of the hospital where respondents serve differed significantly in all dimensions ($t = -6.785$, $p < .001$). The next paragraph addresses the major item-based differences between the perceptions and expectations for each dimension.

All of the perception and expectation scores in the economic dimension differed significantly with the exception of the item "*hospitals closely monitor employee productivity.*" However, the perception (3.83) that "*hospitals steadily make profits*" was significantly lower than the expectation (4.12) and the perception (3.97) that "*hospitals strive to lower operating costs*" was significantly higher than the expectation (3.76). All of the perception and expectation scores in the legal and rational dimensions differed significantly with the exception of the item "*hospitals encourage diversity in the workforce*" ($t = -1.224$, $p = .222$). Both the perception (4.17) and the expectation (4.26) toward "*hospital managers' compliance with the law*" scored the highest among all items. The difference between the perception and the expectation toward "*the internal policies of hospitals for preventing discrimination in employees' compensation and promotion*" was the second highest ($t = -7.271$, $p < .001$). In the ethical dimension, except for the item "*hospitals require employees to acquire additional certifications and skills*" ($t = -1.464$, $p = .145$), the perceptions and the expectations for all of the other three items differed significantly. Only the perception (3.85) regarding "*the confidential procedure for employees to report any misconduct at work*" fell below the level of "agree." All of the perception and expectation scores in the discretionary dimension differed significantly, with the highest score earned by the difference in the item "*hospital's policies for employees to balance work and life*" ($t = -8.949$, $p < .001$), with the lowest perception score of 3.49.

Table 4 presents the means, standard deviations, and intercorrelations for the study variables. The perceptions toward the social responsibility practices of the hospital where respondents serve and the OC in each dimension reached a moderate level or above, with continuance commitment earning the lowest score and the largest variance. One benefit of using intercorrelations is their ability to provide a general picture of the relationships among the study variables. Age correlated significantly and positively with the perceptions toward ethical and economic responsibilities as well as with affective and normative commitments. Education correlated significantly and positively with the perceptions toward economic responsibility practices and affective commitment and correlated significantly and negatively with continuance commitment. Job level correlated significantly and positively with the perceptions toward ethical and economic responsibility practices and affective commitment and correlated significantly and negatively with continuance commitment. Both affective and normative commitments correlated significantly and positively with the perceptions toward every dimension of the social responsibility practices of the hospital where respondents serve. Continuance commitment correlated only with the perceptions toward the ethical responsibility practices. The

TABLE 3.

Descriptive Statistics and Paired Sample t Test of Employee's Perceptions and Expectations of the Social Responsibility of Hospitals Measure

Scale Item	Mean	*SD*	*t* Value	*p*
Perception of economic responsibility	3.94	0.497	−1.203	.230
Expectation of economic responsibility	3.98	0.510		
ER1P. This hospital has made profits steadily.	3.83	0.679	−6.456	<.001
ER1E. This hospital must make profits steadily.	4.12	0.619		
ER2P. This hospital strives to lower operating costs.	3.97	0.710	3.860	<.001
ER2E. This hospital must strive to lower operating costs.	3.76	0.769		
ER3P. This hospital closely monitors employees' productivity.	4.03	0.583	−0.970	.333
ER3E. This hospital must closely monitor employees' productivity.	4.07	0.624		
Perception of legal/rational responsibility	3.97	0.486	−6.745	<.001
Expectation of legal/rational responsibility	4.19	0.506		
LR1P. This hospital has a comprehensive code of conduct.	4.02	0.641	−4.856	<.001
LR1E. This hospital must have a comprehensive code of conduct.	4.23	0.617		
LR2P. This hospital was recognized as a trustworthy one.	3.95	0.629	−6.473	<.001
LR2E. This hospital must be recognized as a trustworthy one.	4.23	0.654		
LR3P. The managers of this hospital try to comply with the law.	4.17	0.581	−2.639	.009
LR3E. The managers of this hospital must comply with the law.	4.26	0.610		
LR4P. This hospital complies with all laws regulating hiring and employee benefits.	3.98	0.638	−5.392	<.001
LR4E. This hospital must comply with all laws regulating hiring and employee benefits.	4.24	0.642		
LR5P. This hospital has programs that encourage the diversity of workforce.	4.04	0.623	−1.224	.222
LR5E. This hospital must have programs that encourage the diversity of workforce.	4.08	0.643		
LR6P. Fairness toward coworkers and business partners is an integral part of the employee evaluation process.	3.85	0.698	−5.528	<.001
LR6E. Fairness toward coworkers and business partners must be an integral part of the employee evaluation process.	4.10	0.647		
LR7P. This hospital has internal policies to prevent discrimination in employees' compensation and promotion.	3.77	0.766	−7.271	<.001
LR7E. This hospital must have internal policies to prevent discrimination in employees' compensation and promotion.	4.18	0.675		
Perception of ethical responsibility	3.99	0.513	−3.871	<.001
Expectation of ethical responsibility	4.12	0.555		
ER1P. This hospital supports employees who acquire extra licenses and skills.	4.02	0.675	−1.464	.145
ER1E. This hospital must support employees who acquire extra licenses and skills.	4.09	0.649		
ER2P. This hospital supports employees who acquire additional education.	4.05	0.647	−2.013	.045
ER2E. This hospital must support employees who acquire additional education.	4.14	0.641		
ER3P. A confidential procedure is in place for employees to report any misconduct at work.	3.83	0.763	−2.747	.007
ER3E. A confidential procedure must be in place for employees to report any misconduct at work.	4.08	0.791		
ER4P. This hospital's employees are required to provide full and accurate information to all patients.	4.07	0.595	−6.483	<.001
ER4E. This hospital's employees must be required to provide full and accurate information to all patients.	4.16	0.627		
Perception of discretionary responsibility	3.67	0.544	−7.994	<.001
Expectation of discretionary responsibility	4.00	0.554		
DR1P. This hospital encourages partnerships with local businesses and schools.	3.86	0.598	−4.154	<.001
DR1E. This hospital must encourage partnerships with local businesses and schools.	4.03	0.630		
DR2P. This hospital gives adequate contributions to charities.	3.66	0.701	−4.735	<.001
DR2E. This hospital must give adequate contributions to charities.	3.89	0.688		
DR3P. This hospital has programs to reduce the amount of energy and materials wasted.	3.68	0.732	−5.661	<.001
DR3E. This hospital must have programs to reduce the amount of energy and materials wasted.	3.98	0.685		
DR4P. This hospital has flexible policies to enable employees to better coordinate work and personal life.	3.49	0.833	−8.949	<.001
DR4E. This hospital must have flexible policies to enable employees to better coordinate work and personal life.	4.11	0.696		

Note. The paired *t* test significance of difference between perception item and expectation item.

TABLE 4.
Correlations Matrix

	Mean	*SD*	1	2	3	4	5	6	7	8	9	10
1. Age	37.85	8.52	–									
2. Education	–	–	.325**	–								
3. Job level	–	–	.571**	.468**	–							
4. Legal/rational responsibility	3.97	.49	.090	.077	.068	–						
5. Ethical responsibility	3.99	.51	.131*	.121	.167*	.639**	–					
6. Discretionary responsibility	3.67	.54	.129	.089	.096	.573**	.606**	–				
7. Economic responsibility	3.94	.49	.280**	.152*	.244**	.515**	.495**	.483**	–			
8. Affective commitment	3.37	.63	.394**	.146*	.274**	.365**	.336**	.272**	.335**	–		
9. Continuance commitment	3.06	.85	−.043	−.140*	−.195**	.146*	.126	.067	−.026	.051	–	
10. Normative commitment	3.87	.66	.181**	−.022	.092	.418**	.368**	.353**	.231**	.498**	.432**	–

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

perceptions toward each dimension of the social responsibility practices of the hospital where respondents serve correlated significantly and positively. Normative commitments correlated significantly and positively with both affective and continuance commitments, whereas affective commitment correlated weakly with continuance commitment. Another benefit of the correlation matrix was its ability to identify multicollinearity among the study variables. All of the coefficients were less than 0.75, which is a common threshold used to detect multicollinearity (Tabachnick & Fidell, 1996). Therefore, multicollinearity was not an issue of concern in this study.

Table 5 presents the results of hierarchical regression analysis. The criterion variables were analyzed individually using affective, continuance, and normative commitments. The factors that significantly influenced affective commitment included variables such as age and the perceptions toward the legal and rational, ethical, and economic dimensions of the social responsibility practices of the hospital where respondents serve. In other words, senior nurses who had high perceptions of the legal and rational, ethical, and economic responsibilities of their hospital exhibited significantly strong affective commitment to that hospital. The variance explained by the regression equation increased from 15.2% to 26.4% after the perceptions toward the social responsibility practices of the hospital where respondents serve were placed into Model 2, indicating that perceptions toward the social responsibility practices of the hospital where respondents serve predicted and explained up to 11.2% of affective commitment. Subsequently, only the job level variable and the perception toward ethical responsibility practices were found to significantly influence continuance commitment. In other words, participants who held junior jobs and who held high perceptions with regard to the ethical dimension showed significantly stronger continuance commitment to their hospital. The explained variance of the regression equation increased slightly from 5.3% to 7.9% after the perceptions toward the social responsibility practices of the hospital where respondents serve were placed into Model 2, showing that the perceptions toward the social responsibility practices of the hospital where respondents serve predicted and explained only 2.6% of continuance commitment. Finally, variables such as age and perceptions toward the legal and rational, ethical, and discretionary dimensions were the factors that were found to influence normative commitment significantly. In other words, senior nurses who held high perceptions toward the legal and rational, ethical, and discretionary dimensions showed significantly stronger normative commitment to their hospital. The explained variance for the regression equation increased considerably from 2.3% to 21.7% after the perceptions toward the social responsibility practices of the hospital where respondents serve were placed into Model 2, indicating that these perceptions predicted and explained 19.4% of normative commitment.

Discussion

There are currently few articles in the nursing literature that either address the issue of the social responsibility of hospitals or report on empirical surveys done to assess the relationship between the social responsibility of hospitals and OC. The following section provides preliminary inferences and explanations for the perceptions and expectations of the social responsibility of hospitals among nurses and discusses the relationship between the social responsibility of

TABLE 5.
Hierarchical Regression Analyses for Predicting Commitment

	Affective Commitment		Continuance Commitment		Normative Commitment	
	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2
Age	.334***	.292***	.077	.099	.201*	.190*
Education	−.024	−.045	−.102	−.105	−.095	−.116
Job level	.096	.080	−.190*	−.207*	.021	.009
Hospital (medical center)	.094	.095	.150*	.116	−.013	−.042
Legal/rational responsibility		.265***		.112		.291***
Ethical responsibility		.176**		.148*		.265***
Discretionary responsibility		.103		.045		.225***
Economic responsibility		.123*		−.080		−.030
F	11.149***	11.15***	4.171**	3.412**	2.333	8.817***
Adjusted R^2	.152	.264	.053	.079	.023	.217
Adjusted R^2 Change		.112		.026		.194

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

hospitals and OC in the context of the current literature on CSR and OC. The insights offered in this article are preliminary, and more research and investigation is recommended in the future.

Nurses' Perceptions and Expectations Toward the Social Responsibility of Hospitals

Ditlev-Simonsen and Midttun (2011) identified a large discrepancy between what managers think motivates and what should motivate their employees to pursue CSR. Employees use positive and negative emotions to construct different views of CSR (Onkila, 2013). Similarly, this study found that the average perceptions of participants toward the social responsibility practices of the hospital where they serve were significantly lower than the related expectations. This result indicates that nurses not only do not accept the content and degree of social responsibility practices of these hospitals but also perceive significant differences between their expectations and hospital practices. The following paragraphs discuss the results by dimension.

First, the differences between participant perceptions and expectations in the economic dimension were not significant. Nevertheless, for personal income and career sustainability, participants expected that their hospital employer would pursue steady growth in profits and financial well-being. Given this situation, a natural follow-up question is: why did participants not expect their hospital to reduce operating costs? A plausible explanation may be that, despite the rise in healthcare costs of NHI relative to the GDP and price index through the past decades (Wen, Huang, & Chiang, 2012) and the rising cost of healthcare payments, hospitals have not been allowed to focus their practices on niches that are the most profitable or to focus on financial growth because of various control measures such as centralized management, the continuous expansion of coverage, and reductions in the prices of pharmaceuticals. Therefore, hospitals may have turned to reducing staff, increasing workloads, and/or reducing benefits and salaries to decrease operating costs. Thus, although participants perceived the conditions of insufficient workforce and increased workload, they did not expect hospitals to reduce operating costs continuously.

Second, this study found significant differences between the expectations and perceptions of participants regarding the legal and rational dimensions of the social responsibility practices of their employers, although participants expressed no specific opinions regarding hospital programs that were designed to encourage workforce diversity. This was probably because women comprise most nurses. The healthcare industry is defined by characteristics such as public goods, externalities, merit goods, and information asymmetry. Therefore, most countries worldwide have always been highly stringent and conservative in managing and regulating this industry. Both the NHI and the Ministry of Health and Welfare in Taiwan use policies such as accreditation to regulate hospitals and institute various management and control mechanisms to maintain controls over hospital operations. Violating relevant regulations not only damages a medical institution's reputation but also influences accreditation and health insurance reimbursements, which further threatens overall operations. Consequently, hospitals comply with relevant laws in the interest of sustainable development. Furthermore, the results of this study showed that the participants exhibited the highest expectations toward hospital compliance with the law and the regulations related to employment benefits. In addition, employees often rely on perceptions of fairness to decide whether management is trustworthy, nonbiased, and willing to treat employees as legitimate members of the organization

(Rupp, Ganapathi, Aguilera, & Williams, 2006). In this study, the participants expressed a generally unfavorable perception toward hospital policies for promoting fairness in employee evaluation, salaries, and promotion and expected relevant improvement.

In the ethical dimension, no significant differences were detected between the perceptions and expectations of the participants toward the support of their hospital for further academic qualifications, professional certifications, and skills. Moreover, their perceptions and expectations were all in the realm of "agree." A possible explanation for this result is that nurses must acquire national certification to practice nursing, and hospitals or relevant professional nursing education associations already provide complete on-the-job educational training and skill specialization courses. Nevertheless, the nurses showed significantly different perceptions and expectations toward hospital requirements that employees provide complete and accurate information for patients and family members. It could be that nurses, who are at the forefront of hospital interactions with patients and their families, deeply identify with patients' doubts and fears regarding unknown diseases and therefore expect to strengthen patient–physician communications further.

Discretionary responsibilities indicate that society expects voluntary contributions and provisions from hospitals. The nurses expressed unfavorable perceptions of hospital practices with regard to social actions, community partnerships, and environmental improvement, while exhibiting relatively low expectations of hospitals with regard to support for philanthropic activities. Two possible explanations may account for this result. First, the participants may believe that practicing legal and ethical responsibilities is the duty of hospitals and that discretionary responsibilities are actions performed when additional resources exist. Second, the nurses may consider that the act of operating a hospital is a lifesaving charitable action that fulfills discretionary responsibilities; therefore, additional actions are not necessary. Furthermore, the nurses reported low expectations that their hospitals would implement energy conservation and carbon reduction practices, probably because many items used in the hospital setting are extremely difficult to recycle and reuse. In addition, the cooling and life support equipment in certain places in a hospital must function around the clock. Therefore, rather than being unaware of the significance of energy conservation and carbon reduction, the participants may consider these practices to be impractical in the hospital context. The perceptions toward flexible policies that would allow employees to balance work and life earned the lowest score among all of the items, which reflected a unanimous hope among all medical professionals. Wang and Tsai (2014) found that the degree of family-to-work conflict influenced job performance negatively and suggested that hospitals have a positive role to play in fostering an organizational culture that helps its staff balance work and family responsibilities and strategies of human resource management that are consistent with the demands of nurses to help reduce family–work conflicts.

The Social Responsibility of Hospitals and Organizational Commitment

Employees with high OC are strongly willing to devote themselves to their organizations, thereby generating positive values for that organization. This study found that age significantly and positively influenced affective and normative commitments and that participants with senior jobs and more human capital exhibited significantly lower continuance commitment than those with junior jobs. The perceptions of participants toward the social responsibility practices of the hospital where they serve proved to influence OC significantly and positively.

First, this study found that the perceptions of economic responsibility practices influenced the affective commitment of nurses. This result has not been found in most studies conducted in the West. On the basis of the social exchange theory, we considered that nurses reward hospitals with internal affective commitment when perceiving that the active economic responsibility practices of hospitals could yield them external salary and employment benefits. Several studies (Al-bdour et al., 2010; Rego et al., 2010; Stites & Michael, 2011; Turker, 2009) have indicated that affective commitment is mainly derived from perceptions of internal practices related to employee labor rights and benefits. Whether Chinese cultural characteristics (e.g., sayings such as "receive a favor and you are in debt to the favor giver" or "return a favor with numerous ones") have influence in this regard requires further investigation. However, the perceptions of the economic dimension of social responsibility practices of the hospitals where respondents served, which are fundamental for an organization, were not correlated with the other dimensions of commitment, a finding that echoes those of Rego et al. (2008). This result probably indicates that, even during the current economic downturn, the highly professional skills and certifications of nurses render them independent of a specific hospital employer. With professional skills, nurses may find employment wherever they go. Consequently, the financial performance of a hospital does not influence the continuance and normative commitments of nurses.

Second, the perceptions of participants toward hospital legal practices and rational responsibilities influenced their affective and normative commitments. When participants perceived that the social responsibility practices of the hospital where they served directly influenced their career development (such as regulatory compliance, explicit work rules, and fairness in promotion and employment benefits), hospitals not only gained social trust externally but also fostered employee compliance and identification with organizational values and goals internally. Therefore, employees become increasingly willing to devote themselves to the hospitals, concentrate on their work and tasks, and internalize organizational loyalty as part of their duty. This finding is similar to that of Chang and Chang (2007).

Third, this study found that the perceptions of participants toward the ethical responsibility practices significantly and positively influenced all dimensions of commitment, which

corresponded with the findings of Peterson (2004). According to the social identity theory, social identity denotes an individual's sense of belonging to a social category. An individual acts and behaves based on social recognition. By practicing CSR, a business not only enhances the sustainable development of the organization and fortifies its attitude toward social responsibility but also increases its employees' identification with the organization and their OC (Gond, El-akremi, Igalens, & Swaen, 2010). Peng, Lee, and Tseng (2014) suggested that, when the cognitive values of nurses and the organizational culture fit with hospital value systems, common values may facilitate a higher degree of nurse work engagement and decrease turnover intention. The results of this study indicate that the more hospitals practice actions that are expected by society but not required by law (such as helping employees obtain additional certifications and skills and providing complete and accurate information for patients), the more that nurses will identify with their hospital employer, which is a factor of influence affecting intention to stay.

Finally, although the participants exhibited relatively lower expectations, perceptions of the hospitals' practices of ethical responsibilities did increase normative commitment. The relatively low perceptions toward the discretionary dimension of hospital social responsibility practices were significantly influenced by the normative commitment. This result probably indicates that, for nurses with relatively greater perceptions of discretionary responsibilities, the consistency between hospitals' practices and their own personal values enhance self-loyalty to the organization, which then evolves into normative commitment. Nevertheless, the results of this study differed from those of Rego et al. (2008) in that the practices of ethical responsibilities did not induce affective commitment in the participants. Whether this outcome resulted from the relatively lower perceptions and expectations of the nurses toward discretionary responsibility practices requires further exploration. In general, nurses' perceptions toward hospital social responsibility practices are influenced more by affective and normative commitments than continuance commitment. Two of the aforementioned articles (Al-bdour et al., 2010; Rego et al., 2008) did not report a significant relationship between CSR and continuance commitment. According to Meyer and Allen (1984), continuance commitment is developed on the basis of two factors: (a) the number of investments (side bets) that individuals make on their current organization in terms of time, money, and effort and (b) the employees' perceived lack of alternatives outside the organization, where the perceived costs of leaving will be higher. A plausible explanation for this result was that their professional certifications and expertise kept the participants uncommitted to any specific hospital under current nursing manpower shortage conditions.

Conclusions and Implications

The results of this study indicate that the perceptions and expectations of nurses regarding social responsibility practices of the hospitals where they serve are significantly different. The low expectations of economic responsibilities and the high expectations of legal and rational responsibilities probably showed that the participants were unsatisfied with the reduction of hospital operating costs at the expense of their welfare and that they expected the hospitals to implement medical regulations while protecting their labor rights. High expectations yet low perceptions toward discretionary responsibilities indicate that participants expect hospitals to not merely save lives but also fulfill a responsibility to serve society. Furthermore, all of the nurses with positive perceptions of the social responsibility practices of the hospital where they served had high OC scores. When employees perceive their hospitals' unfavorable performance in a certain dimension of social responsibility practices, OC corresponding with that dimension decreases as well. Senior nurses who had positive perceptions of the legal and rational, ethical, and economic dimensions of the social responsibility practices of their hospitals exhibited strong affective commitment. Nurses who held junior positions and had positive perceptions of the practices of ethical responsibilities displayed significantly strong continuance commitment. Senior nurses who had positive perceptions of the legal and rational, ethical, and discretionary dimensions of hospital social responsibility practices showed significantly strong normative commitment.

At the forefront of healthcare, where they frequently interact with patients and their families, nurses are stakeholders who play multiple roles that hospitals cannot afford to neglect. This study attempted to bridge macro-level social responsibilities of hospitals and micro-level individual attitudes and behaviors. The relationship between CSR and OC was expected to depend on how much employees agree that organizations have social responsibility (Peterson, 2004). The results of the current study contribute to better understanding the benefits of the socially responsible actions of hospitals and make further contribution to the nurse's HRM issue. If nurses have more active and positive perceptions toward hospitals' social responsibility practices, they will have higher levels of identification with that hospital and tend to generate active and significant influences on job satisfaction and even organizational performance. In accordance with the suggestion of Chang, Wang, Huang, and Wang (2014), hospital managers should not only construct a positive and exciting work environment but also work to mitigate the causes of work frustration to promote professional commitment and retention among nurses. If nurses are recognized as crucial capital for hospitals and healthcare, hospital managers and government administrators must do more than merely comply with laws and regulations and make every effort to provide a friendly and humane work environments for nurses.

Research Limitations and Suggestions

This study found that adopting the conceptual framework of CSR to measure the social responsibility of hospitals raised doubts concerning transindustrial and transcultural validity. First, the principal component analysis results of the social

responsibility of hospitals were not consistent with Maignan et al. (1999) and Maignan and Ferrell (2000). Second, dimensions and items such as free medical services for disadvantaged groups in emergency situations, medical service stations in remote areas, and international medical aid should be considered in future research. Third, hospitals exist at various levels and specialties. Whether weights should be assigned to different dimensions of social responsibility according to type of hospital should be considered in future research as well. The findings of this study suggest that the specific demands on hospitals from the various stakeholders should be included to construct a set of comprehensive and appropriate assessment indicators for hospital accreditation. In addition, adopting self-reporting questionnaires in this study to collect the data of the comparative attitudes of the participants (perceptions, expectations, and OC) may incur common method covariance and thus threaten the internal validity of the study (Peng, Kao, & Lin, 2006). This potential problem suggests that future researchers collect attitude data at different times, conceal the meanings of questionnaire items, or randomly arrange items during data collection to minimize relevant risks. Finally, although the participants were selected from the three hospitals, all belonged to the same medical system group and shared a similar organizational culture with regard to promotions and regulations governing salary and employment benefits. Consequently, the homogeneity of the sample limits the generalization of our findings. This suggests that censuses or sample surveys be conducted nationwide to explore the attitudes of nurses toward social responsibility practices in different hospital settings (e.g., public or private, for-profit or religious, and teaching or nonteaching).

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醫院社會責任的感受與期待與護理人員的組織承諾

謝聖哲[1] 邱亨嘉[2] 謝雅惠[3] 何佩珊[4] 陳麗琴[5] 張偉洲[6]*

[1]嘉南藥理大學社會工作系副教授 [2]高雄醫學大學醫務管理暨醫療資訊學系教授暨彰化基督教醫院研究教學與流感中心研究員 [3]銘傳大學醫務資訊與管理學系助理教授 [4]高雄醫學大學口腔衛生學系副教授 [5]高雄醫學大學附設中和紀念醫院護理部副主任 [6]高雄市立小港醫院（委託財團法人私立高雄醫學大學經營）院長室高級專員

背 景 近來台灣面臨醫療勞動人權爭議，勞動環境不佳及人力短缺導致嚴重的照護過勞，惡性循環下使護理人員的執業率及平均年資偏低。

目 的 以企業社會責任作為醫院社會責任的概念架構探究對於護理人員組織承諾（OC）之影響。

方 法 以匿名問卷抽樣調查南台灣某醫療體系240名護理人員，共回收227份。問卷由醫院社會責任及OC兩量表構成，以探索式因素分析確認經濟、法理、道德和慈善等四個社會責任構面，並利用階層迴歸分析各構面責任的感受與情感性、持續性及規範性等三構面OC的關係。

結 果 護理人員對於整體醫院社會責任實踐的感受與期待之間存在顯著落差。對於醫院社會責任感受較佳者發展出較高的組織承諾。年齡愈大及法理、道德和經濟責任等感受愈佳者的情感性承諾明顯愈強。職級愈低且道德責任感受愈佳者的持續性承諾顯著愈強。年齡愈大及法理、道德和慈善責任等感受較佳者的規範性承諾明顯較強。

結 論／實務應用 醫院若能積極提供友善且人性化職場並具體實踐社會責任，將不僅助益護理人員更能提升所有員工的工作績效及組織認同。

關鍵詞：社會責任、醫院、護理人員、組織承諾。

接受刊載：104年5月3日
*通訊作者地址：張偉洲 80756 高雄市三民區自由一路100號
電話：（07）3121101 E-mail: 0870500@gmail.com