

Hospital culture, organizational climate, and goal acceptance: Deconstructing the influence path on Chinese medical staff's control at work

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Abstract

Against the policy background of the in-depth advancement of the 'Healthy China 2030' strategy and the high-quality development of hospitals, hospital culture construction—as a key measure to enhance the core competitiveness of medical institutions—has become an important research topic in the field of management. Although studies have begun to explore the influence models of hospital culture in China, there is currently a lack of relevant research on how hospital culture affects medical staff's control at work. Based on Process Macro Model 7, this study integrates social identity theory, social exchange theory, and self-determination theory to build a moderated mediating model to explore the mediating psychological mechanisms and boundary conditions through which hospital culture affects medical staff's control at work. This study proposes that hospital culture will have an indirect positive impact on medical staff's control at work through the mediating role of goal acceptance; this indirect impact process will be moderated by the organizational climate. The study included 289 China medical staff and analyzed data through IBM® SPSS® 26.0, IBM® SPSS® AMOS 23.0, and PROCESS Macro 3.4.1. The results indicate that, except for Hypothesis 2 (hospital culture has a positive impact on control at work)—all other hypotheses proposed in this study are supported. This study explores the role of hospital culture in improving control at work through a moderated mediation model, which provides a theoretical basis for related research. It clearly reveals the role mechanism of improving control at work among medical staff in China, showing differences from previous research and explains how organizational climate regulates the mediating impact of goal acceptance. Finally, this study pioneered the motivation and further optimization paths for medical institutions in China to improve the control of medical staff's work, providing theoretical guidance and practical reference for academic research and management practices.

I. Introduction

Since the 1990s, major countries, including China, Japan, Germany, and the United States, have gradually accelerated the pace of medical system reforms (Luo et al., 2024). In 2009, the Chinese government launched significant healthcare reforms (the 'Opinions on Deepening the Reform of the Medical and Health System'), aiming to provide equitable basic medical services to all citizens (Zhao et al., 2024). Recognizing the challenges facing population health, the Chinese government promulgated the 'Healthy China 2030' Strategy in 2016, setting quantitative goals to be achieved by 2030, providing an important platform for promoting universal health coverage in China (Yip et al., 2023). In June 2019, the State Council of China issued the 'Opinions on Implementing the Healthy China Action'. Subsequently, in July 2019, the Healthy China Action Promotion Committee was established and the 'Healthy China Action (2019–2030)' was launched (Haibin, 2021). However, as the soul of medical institutions, hospital culture is deeply integrated with the 'Healthy China 2030' strategy; it will become the core driving force for accelerating the implementation of policies through concept penetration, mechanism reshaping, and service upgrading (Ma et al., 2021).

This study posits that hospital culture is a key factor in enhancing control at work among medical staff in China. From the perspective of China's economic development and national cultural identity, patients now have increasing expectations for health and quality of life, which often places tremendous pressure on medical staff, leading to communication barriers and the collapse of the ecosystem chain (Kang and Ding, 2024). The development of hospital culture consolidates unity within the hospital, stimulates innovation, and cultivates employees' ability to think independently and creatively, thereby improving the hospital's overall competitiveness (Wang and Wen, 2025). For medical staff, a good hospital culture helps enhance their sense of control at work, gives them a sense of autonomy, and forms a positive internal psychological state (Butcher et al., 2022). Examples of mental health outcomes include self-reported stress, burnout, and depressive symptoms. When a sense of control at work is increased, all measures improve (Balogh et al., 2025). Additionally, improving the control of medical staff at work effectively reduces intentional violations and other unsafe behaviors (Liu et al., 2022). Therefore, it is important to explore the level of hospital culture within Chinese medical institutions and reveal the causal relationship between hospital culture and control at work.

In addition to the belief that hospital culture improves medical staff's control at work, this study attempts to determine the variables that mediate the impact of hospital culture on control at work. Specifically, this study assumes that goal acceptance is a mediating variable between hospital culture and control at work. Goal acceptance refers to goals that have been assigned, while the scope of goal commitment is broader, including both the assigned goals and those set by the individual (Nyaga, 2015). Hospital culture fosters interdisciplinary leadership teams, enables teams to establish common goals with senior management, and effectively uses data to drive change—ways of working that experts have identified as key elements for improvement (Curry et al., 2018). Goal acceptance is an important feature; when assigned goals are consistent with personal aspirations, this acceptance is most easily formed and leads to greater control at work (Orimus, 2016). Therefore, in hospital culture promotion, organizational goals (such as 'building a research hospital') are tied to medical staff's career development (such as scientific research awards and promotion opportunities) and medical staff are encouraged to actively pursue control at work by improving goal acceptance (such as independent design research topics).

Additionally, the study posits that changes in the goal acceptance of medical staff will be affected by the interaction between hospital culture and organizational climate. Organizational climate is regarded as a dynamic shaper of hospital culture that has a systematic impact on work-related output by optimizing the information interaction mechanism of medical staff, cultivating innovation soil, and providing higher levels of work autonomy (Moreno-Domínguez et al., 2024). From the perspective of medical institution governance, hospital culture facilitates the systematic improvement of goal acceptance levels during conflicts between performance management models and cultural values, through management's strengthening of a trust-based governance system (Christensen et al., 2006). Therefore, in a positive climate (such as transparent resource allocation), the goals advocated by hospital culture (such as discipline construction) are quickly implemented through the training resources and equipment support provided by the organization. This helps employees perceive the goals as attainable, thereby increasing their willingness to accept them.

While emphasizing that organizational climate moderates' hospital culture and control at work, this study also suggests that it moderates the mediating effect of goal acceptance. Therefore, this study aimed to investigate how the organizational climate enhances the impact of goal acceptance using research models. This study shows that the organizational climate, as a moderated variable, dynamically interferes in this transmission process: when the organizational climate is positive, such as filled with an open communication climate, mutual trust, and collaboration, it strengthens the connection between hospital culture and goal acceptance, making it easier for medical staff to understand and identify with the goals rooted in hospital culture and accelerating the transformation of hospital culture into goal acceptance. Simultaneously, in advancing the translation of goal acceptance into control at work, a positive culture in healthcare fosters confidence to innovate and act independently, enabling goal acceptance to more efficiently convert into workplace control actions. Based on these perspectives, this study aims to examine the impact of hospital culture on medical staff's control at work through a moderated mediation model involving organizational climate and goal acceptance.

To understand the mechanism by which hospital culture affects medical staff's control at work, this study integrates social identity theory, social exchange theory, and self-determination theory. With the help of social identity theory, we explain how hospital culture shapes medical staff's sense of belonging and identity to the organization, so that they more actively accept the goals contained in culture based on group identity, and then pursue control of processes and decision-making in their work. Social exchange theory is be used to analyses the atmosphere of trust and support fostered by hospital culture, and how it enables medical staff to reasonably reciprocate organizational expectations (such as career development and emotional recognition), actively maintaining exchange balance by improving control at work. Self-determination theory focuses on how hospital culture satisfies medical staff's needs for autonomy, competence, and belonging. When culture provides them independent decision-making power, it assists in professional growth, creates a harmonious atmosphere, activates intrinsic motivation, drives them to accept goals, and realizes self-worth with stronger control at work. Simultaneously, the organizational climate serves as a key link that regulates the connection between hospital culture and goal acceptance and the mediating role of goal acceptance. When a positive climate (such as open communication and full authorization) is present, it will strengthen the positive impact of culture on goal acceptance, allowing medical personnel to be more motivated when pursuing control at work. If the climate is negative, cultural transmission is blocked, and the construction of goal acceptance and control at work will also encounter obstacles. Together, these theories lay a solid foundation for understanding how hospital culture affects medical staff's control at work.

Based on the above research and theory, the application of hospital culture has become a problem that must be resolved by medical institutions in China. Overall, this study's innovation is summarized as follows. First, through a review of previous research, it is found that there is a lack of empirical research on the relationship between hospital culture and medical staff's control at work. Therefore, this study clarifies how hospital culture enhances medical staff's control at work, which will assist in expanding the research field of hospital culture and control at work.

Second, most studies have investigated the antecedent variables of control at work (Waldenström et al., 2003; Ashraf and Siddiqui, 2020), affirming their mediating and moderating impacts on stimulating control at work (Loudoun et al., 2014; B Butler et al., 2005). However, this study expands the scope of control at work research. Additionally, this study introduced and verified a moderated mediation model.

Third, although academic research on hospital culture has been ongoing, there are still few studies on how hospital culture affects medical staff's control at work. Therefore, this study identifies the role of hospital culture and control at work in medical institutions and explains its significance in organizations. Furthermore, it clarifies the interaction between hospital culture and organizational climate and their impact on the goal acceptance of medical staff.

Fourth, although most studies position hospital culture as a moderating variable, this study sets it as an independent variable and examines its impact. Specifically, this study investigates the interaction between hospital culture and organizational climate and how this interaction affects the mediating role of goal acceptance, thereby improving medical staff's control at work.

In summary, this study suggests that there is currently a lack of in-depth research on hospital culture in medical institutions in China; therefore, we seek to clarify and investigate this topic. This will help expand research areas based on hospital culture. Specifically, this study proposes a new research model to test hospital culture and reveal the process by which it improves medical staff's control at work. Additionally, this study makes significant contributions to the field of hospital culture and control at work. Moreover, it highlights the organizational climate within China's medical institutions and enhances our understanding of the role of goal acceptance and control at work in medical institutions through interaction with hospital culture.

Ⅱ. Theoretical background and hypotheses

2.1 Hospital culture

Hospital culture refers to the ideals, values, and behavioral norms formed by hospital employees through unconscious optimization in the long-term process of hospital management and medical services (Rong, 2014). It denotes the unified cognition, understanding, pursuit, and behavior gradually formed by hospital staff, along with the development of society and the economy (Zhao, 2021). Additionally, it is defined as the aggregate of material and spiritual assets created by hospital personnel and resources through long-term medical practices (Jian, 2020).

The trend of hospital cultural construction in China originated in the late 1990s and has developed in the early 21st century (Jian, 2020). For a hospital, aspects such as quality management, scientific research and teaching, high-quality services, the medical environment, and rules and regulations are all closely related to hospital culture (Zhao, 2021). It enables its members to priorities not only the individual interests but also the collective interests of the hospital (Rong, 2014).

With the deepening of the healthcare system reform, the state has successively issued a series of guiding documents to promote the high-quality development of China's public hospitals. Previous research has positively (+) associated hospital culture with hospital performance (Zhou et al., 2011), physicians' job satisfaction (Zhao, 2021), and service quality (Wu, 2022). It has also been shown to have a positive impact on physicians' professional behavior (Chen et al., 2023) and knowledge management (Moreno-Domínguez et al., 2024). Therefore, this study defines hospital culture as a value ecosystem jointly constructed by all stakeholders (medical staff, patients, technology developers, communities, etc.) in the dynamic interaction of technological iteration, humanistic care, and social health governance of medical organizations.

2.2 Goal acceptance

Goal acceptance refers to team members' willingness to accept team goals (Saenz, 2003). It reflects the idea that, to motivate an individual, a goal must first be accepted by that person (Serhan, 2018). Furthermore, goal acceptance implies that employees must 'accept' the goal and commit to achieving it (Sulu Babaita et al., 2016).

Goal acceptance, even if imposed externally, must receive internal recognition to be truly effective (Umo, 2025). Employees who personalize organizational goals align themselves with the organization's policies, processes, and the achievement of established goals (Ordua and Mebom, 2025). Developing goal acceptance is associated with behaviors that promote cooperation and teamwork among team members and encourage healthy partnerships between colleagues and organizational stakeholders (Khumalo and Jackson, 2024).

According to the theory of goal setting, participatory goal setting (where individuals participate in setting goals) stimulates motivation, which better aligns with their needs. Previous research has positively (+) associated goal acceptance with uncovering motivation (Hendriks et al., 2020), employee performance (Domeh, 2020), and employee engagement (Tyagi et al., 2023). It has also been shown to positively impact innovative work behavior (Anindita and Lestari, 2024) and goal commitment (Ali et al., 2022). Based on these theories, this study defines goal acceptance as the psychological state and behavioral tendency of an individual or group to recognize, accept, and be willing to work hard for the set goals.

2.3 Organizational climate

Organizational climate refers to employees' perceptions of the work environment and the cultural characteristics of an organization (Alwaheeb, 2020). It also denotes employees' perceptions of policies and management practices applied by the organization (Laurențiu, 2016). Furthermore, organizational climate signifies a set of measurable attributes of the work environment perceived by the people who work in it and the impact of these attributes on their motivations and behaviors (Bhutto and Laghari, 2012).

Organizational climate stems from social information processing, which involves the meaning employees attach to the policies, practices, and procedures they are exposed to and the behaviors they observe being rewarded, supported, and expected (Mohanta et al., 2023). A good organizational climate has many characteristics, including an atmosphere of fairness where everyone has full opportunity to participate, and the principle of justice: whether to guide employees or empower them (Nabella et al., 2022). It also requires addressing individual autonomy, health, and stress management, which will enhance individual and collective productivity in the long term (Khan and Sharma, 2020).

A relaxed and harmonious organizational climate may foster an effective communication environment, alleviate work stress, and stimulate strong internal motivation among organizational members. Previous research positively (+) associates organizational climate with creative performance (Mutonyi et al., 2020), employee performance (Pradoto et al., 2022), and organizational effectiveness (Lannes, 2021). It has also been shown to positively affect job satisfaction (Ozsoy, 2022) and organizational citizenship behavior (Al Shbail and Al Shbail, 2020). Therefore, in this study, organizational climate is defined as the collective perception of employees towards policies, operational practices, behavioral norms, and interpersonal dynamics within a work setting.

2.4 Control at work

Control at work is defined as the level of employees' belief in their capacity to exercise agency over work activities by freely articulating viewpoints and contributing to work-related decisions, a definition rooted in self-determination theory (Parameswari and Kadiravan, 2011). It refers to employees' perceived capacity to regulate, direct, and exercise agency over work tasks, together with their involvement in workplace decision-making (Stomlien et al., 2023). Furthermore, control at work implies how much room employees must have when performing their duties (Sarno and Nabe, 2023).

In recent years, with the continuous emergence of powerful political and economic discourses surrounding the 'digital/artificial intelligence revolution' (or, alternatively, the popular term 'Industry 4.0'), the debate over control at work has resurfaced (Dupuis, 2025). This may also be termed workplace autonomy, which denotes employees' discretionary power to determine work tasks and execution methods freely (Ashraf and Siddiqui, 2020). It increases workplace vitality and control through employee autonomy and skill development to reduce stress levels, thereby improving physical and mental health (Cortés-Denia et al., 2022).

When employees have high levels of control at work, they usually make their own judgements, choose valuable new tasks, and have greater autonomy in working method innovation and work process improvements. Previous research has positively associated control at work with creativity (Santoro, 2023), caring behavior (Shakeri et al., 2021), and quality of work life (Li et al., 2023). It has also been shown to positively impact happiness at work (Dharani and April, 2022) and performance appraisal (Sy et al., 2023). Therefore, based on the above theories, this study defines control at work as the ability to autonomously determine how work tasks are structured and executed based on professional judgement.

2.5 Hospital culture and goal acceptance

Culture serves as the collective accumulation of values, principles, and beliefs shared by employees in an organization, and organizations that incorporate staff ideas and aspirations into their cultural framework typically involve employees in both goal-setting and task-allocation processes based on individual responsibilities (Khan et al., 2024). Owing to financial scandals and other issues, many companies in developing countries are prone to corporate culture degradation, which not only makes it difficult for employees to align with the company's objectives but also causes companies to lose credibility (Umo, 2022). As a more inclusive community of values, hospital culture embodies the consensus of patients, medical staff, and other stakeholders, which not only drives the setting of goals (including self-setting, participatory setting, or allocation goals) but also promotes all parties' recognition of goals (Locke et al., 1988). Therefore, based on social identity theory, this study proposes that hospital culture usually enhances medical staff's consensus on organizational goals, combine their own goals with organizational goals, and improve their level of goal acceptance.

Hypothesis 1. Hospital culture has a positive impact on goal acceptance.

2.6 Hospital culture and control at work

Hospital culture is work-oriented, and in this environment, employees' personal abilities and skills are continuously emphasized, thus providing the necessary conditions for the development of autonomy and freedom at work (Rocha et al., 2016). A hospital culture that underscores patient safety is increasingly recognized as the key to improving patient safety; that is, when emergencies occur, medical staff promptly structure new work processes based on their professionalism and skills (Nuntawinit et al., 2009). However, due to the nature of doctors' work, when hospitals have an intolerant hospital culture, it may make them a special group for studying work conditions because, in this case, their work control will be at a lower level (Lee, 2016). Therefore, based on social exchange theory, when medical staff and hospitals are in a mutually beneficial relationship, hospital culture creates an atmosphere of 'trust and respect'; in return, medical staff will proactively assume more work responsibilities in this atmosphere.

Hypothesis 2. Hospital culture has a positive impact on control at work.

2.7 Goal acceptance and control at work

When an organization provides a large amount of task information, employees are more receptive to assigned and personal goals. The more detailed the information, the more control employees have over their work by understanding the overall task (Jimmieson and Terry, 1999). As a group more inclined to actively control work processes and goals, medical staff will transform the information shared by the organization into a basis for decision-making, thereby meeting their control needs more efficiently (Ng and Butts, 2009). According to goal-setting theory, when goals are both difficult and concrete and employees form a commitment to them, their continuous efforts to achieve the goals will gradually be transformed into strategic optimization and experience accumulation under the influence of feedback

mechanisms and resource support, which accumulate over time, thereby improving their abilities and perceived control over work (Moodley, 2011). Therefore, based on self-determination theory, this study posits that when goal acceptance is based on intrinsic motivations (such as self-identified goals), medical staff will perceive that the behavior stems from self-will rather than external coercion, and this 'sense of autonomy' directly corresponds to an improved sense of control at work.

Hypothesis 3. Goal acceptance has a positive impact on control at work.

2.8 The mediating effect of goal acceptance

When the medical staff's own development goals align with the hospital culture, on the premise that the goals are feasible, organizational support and the external load are reasonable, their acceptance of the goals will direct their efforts towards achieving the goals and then improve the level of control at work through continuous practice (Renn, 1998). By motivating employees, hospital culture usually inspires their drive to complete challenging goals, and through sustained practice and experience accumulation, their business capabilities are ultimately enhanced (Liang et al., 2011). A healthy hospital culture aligned with medical staff's goals usually fosters spiritual bonds with the organization, thereby creating a positive working atmosphere and enhancing practitioners' control over their work through increased motivation and focused practices (Arokiasamy, 2017). Therefore, based on self-determination theory, this study proposes that when hospital culture provides employees with opportunities to participate in decision-making, recognizes the value of work, and creates a supportive environment, employees are more likely to actively accept organizational goals and internalize them into personal goals. When employees accept goals, they will actively devote energy and creativity to achieve the goals and ultimately, employees will be encouraged to understand the work process more deeply and accumulate experience in solving problems, thereby enhancing their sense of control over the work.

Hypothesis 4. Goal acceptance mediates the relationship between hospital culture and control at work.

2.9 The moderated mediation effects of organizational climate

This study emphasizes the moderating role of organizational climate and proposes that it usually enhances the hospital culture's role in goal acceptance. Therefore, the goal acceptance level of medical staff in China will be determined by the interaction between hospital culture and the organizational climate. Organizational climate refers to the collective behavioral tendencies of members within an organization, and it is a key factor in determining the success of an organization because the behavior of members within the organization affects various interactions (Deciu, 2022). Additionally, in a broader sense, organizational climate is usually regarded as a social environment and a social psychological environment characterized by a specific organization (Jokanović et al., 2020). The level of organizational climate within medical institutions in China is relatively high, and owing to the positive impact of the organizational climate, the goal acceptance of medical staff will also increase accordingly. A strong organizational climate allows employees to form a clear sense of direction and mission, which in turn encourages the organization and employees to jointly define success standards; when employees agree

with these standards, they actively increase participation and optimize work efficiency (Kim and Jung, 2022). Leaders who 'actively listen to concerns and acknowledge shortcomings' usually make employees feel respected and believe that the organization has the attitude of 'facing problems frankly', thereby creating a 'safe and open' organizational climate and ultimately promoting the formation of a positive hospital culture (Moreno-Domínguez et al., 2024). This suggests that organizational climate positively impacts goal acceptance (Sabbah et al., 2024). Based on this theory, the staff within medical institutions must communicate frequently because of the nature of their work. If such exchanges are characterized by equality and openness, a more inclusive organizational climate may be formed. When problems arise, various departments usually reach a consensus through timely communication. This collaboration model usually not only solve specific problems but also allow individuals to understand organizational goals more clearly during communication, thereby improving the acceptance of goals.

Additionally, in environments with a strong organizational climate, it is easier for medical institutions to build a good hospital culture. Only when the organizational climate matches employees' experiences organizations usually gain the support and commitment of employees and promote the healthy development of hospital culture (Levine et al., 2020). Therefore, this study believes that the organizational climate within medical institutions is related to hospital culture. Moreover, because the hospital culture of medical institutions promotes communication among members, this will enhance the development of the organizational climate. A major goal of hospital culture is to cultivate the adaptability, flexibility, and creativity of medical staff, which enables organizations to quickly develop a high-level organizational climate when faced with challenges (technological and service innovation) (Mesfin et al., 2020). Medical services require the cooperation of multiple departments (such as surgical teams and multidisciplinary consultations), which then forms a 'team first' collaboration culture, giving the hospital culture the cultural characteristics of interdisciplinary collaboration. Therefore, this study emphasizes that hospital culture improves organizational climate; the higher the level of hospital culture, the higher the level of organizational climate. Furthermore, when a hospital culture of high mutual trust develops between an organization's political leadership and management executives and subunit members, goal acceptance among the subunit or individual organizational members increases (Christensen et al., 2006). Hospital culture plays an important role in promoting goal acceptance among medical staff. Similarly, when the level of organizational climate within medical institutions is high, the goal acceptance level of the medical staff remains high. Moreover, when there is a high level of hospital culture within medical institutions, medical staff will think that the organizational goals are highly consistent with their own career value pursuits, and the organization provides sufficient resource support and institutional guarantees for the realization of the goals; thus, the goal acceptance level will also increase. Therefore, with the healthy development of hospital culture in China, the level of organizational climate will also improve, and to achieve the unity of personal values and organizational goals in cultural identity, or overcome professional challenges under the guarantee of resources provided by high-quality culture, the level of goal acceptance will also increase. This emphasizes that the interaction between organizational climate and hospital culture determines the goal acceptance level of medical staff in China. In summary, the higher the level of organizational climate, the greater the impact

of hospital culture on the goal acceptance of medical staff. This explains why the organizational climate moderates the impact of hospital culture on goal acceptance among medical staff. Employees assigned to the 'high control-high information' condition reported higher levels of goal acceptance and demonstrated higher levels of control at work than employees who only received control or only received information (Jimmieson and Terry, 1999). Therefore, the level of control at work of medical staff depends on the level of their goal acceptance.

Therefore, this study considers goal acceptance as a mediator between hospital culture and control at work. Moreover, organizational climate was set as the moderating variable between hospital culture and goal acceptance. Therefore, this study emphasizes that the organizational climate plays a moderating role in mediating medical staff's goal acceptance. Based on this theory, this study proposes the following assumptions:

Hypothesis 5. Organizational climate moderates the relationship between hospital culture and goal acceptance.

Hypothesis 6. The mediating influence of goal acceptance on the relationship between hospital culture and control at work is moderated by organizational climate.

Ⅹ. Methods

3.1. Sample characteristics

This study focused on medical staff in China and collected online samples via SoJump. In compliance with the principles of informed consent and data confidentiality, each participant read a statement at the beginning of the questionnaire before engaging in the study. The statement explicitly informed participants that the research would be conducted anonymously and would not affect their work units. To maintain data integrity and ensure cooperation, we guaranteed the confidentiality of all participants. The data collected will be used exclusively for this study, and we strictly pledge not to share it with any external parties.

In this study, we employed a snowball sampling method to collect data, distributing research questionnaires to medical staff within our professional networks—primarily to individuals with whom we had pre-established professional relationships. We relied on colleagues in these hospitals to conduct the research among medical staff, encouraging their participation and facilitating further dissemination. The study was conducted from May 7 to May 11, 2025, recruiting a total of 374 participants from 29 provinces, cities, and regions across China.

In this study, we performed a retrospective analysis to identify and remove consistent response patterns from survey data. When participants responded in fixed, repetitive patterns (e.g., "11111" or "12345"), these responses emerged as potential indicators of thoughtless or inauthentic answers. To minimize data contamination and ensure the reliability of our findings, we adopted various strategies (Peterson &

Griffith, 2006). After excluding 85 samples with suspiciously similar responses or abnormally short completion times, the final dataset for analysis comprised 289 questionnaires. In questionnaire-based research, a valid response rate of at least 70% is generally expected for robust conclusions; here, we achieved a valid response rate of 77.27%, indicating a satisfactory response rate.

G*Power 3.1 software (Faul et al., 2007) was used to conduct power analyses for this study. The significance level was set at $\alpha=0.05$, and the calculated effect size was $f=0.15$. This analysis concentrated on a single unidirectional predictor, specifically the control at work variable (Y). Three predictors were included: independent variable (X, hospital culture), mediating variable (M, goal acceptance), and moderating variable (Z, organizational climate). Power analysis indicated that at least 85 participants were required to achieve 95% statistical power. To ensure an adequate sample size, the study ultimately enrolled 289 participants, far exceeding the 89 participants recommended by the power analysis. Thus, the sample size was deemed sufficiently large to meet the standards for thorough analysis.

The demographic characteristics of this study cover dimensions such as gender, age, education, marital status, and length of service, systematically presenting the structure and occupational features of the medical staff group (see Table 1 for data). In terms of gender distribution, there were more females, with 158 people (54.7%), and 131 males (45.3%), reflecting the gender differences in the medical system. The age gradient is dominated by young and middle-aged people: the group aged 20-29 accounts for 29.4% (85 people), those aged 30-39 account for 36.6% (106 people), those aged 40-49 account for 15.6% (45 people), while the proportions of those under 20 (8.0%, 23 people) and those aged 50 and above (10.4%, 30 people) are relatively low, reflecting the coverage of the backbone of the industry in the sample. The education level shows a diverse and concentrated trend of high education: 9 people have a technical secondary school or high school education, accounting for 3.1%; 42 people have a junior college education, accounting for 14.5%; 99 people have an undergraduate degree, accounting for 34.3%; 128 people have a master's degree, accounting for 44.3%; and 11 people have a doctor's degree or above, accounting for 3.8%, reflecting the high requirements for educational background in the medical industry. Among the marital statuses, the unmarried group has 81 people, accounting for 28.0%; the married and cohabiting group has the highest proportion, with 135 people (46.7%); 45 people are married and separated, accounting for 15.6%; 21 people are divorced, accounting for 7.3%; and 7 people are widowed, accounting for 2.4%. The diverse marital statuses constitute the sample characteristics. The length of service ranges from less than 1 year to 15 years and above. The group with less than 5 years of service has 91 people, accounting for 31.5%; the group with 5 years to less than 10 years of service has 100 people, accounting for 34.6%; the group with 10 years to less than 15 years of service has 18 people, accounting for 6.2%; and the group with 15 years and above of service has 80 people, accounting for 27.7%. The group with 5-10 years of service has a prominent proportion, and the groups with less than 5 years and 15 years and above of service form two extremes in terms of experience, covering both newcomers to the industry and senior practitioners. In terms of employment relationship, the established-post staff are in the majority, with 241 people, accounting for 83.4%; the non-established-post staff have 48 people, accounting for 16.6%, which is in line with the actual characteristics of staffing

management within China's medical system. The distribution of professional titles covers from junior to senior levels: 74 people have junior-level titles (technician/nurse practitioner), accounting for 25.6%; 64 people have intermediate-level titles (attending physician/charge nurse, etc.), accounting for 22.1%; 84 people have associate senior-level titles (associate chief physician/associate chief nurse, etc.), accounting for 29.1%; and 67 people (23.2%) have full senior-level titles (chief physician/chief nurse, etc.), reflecting that the sample is dominated by experienced medical workers. The department distribution focuses on core clinical fields: 110 people are in internal medicine, accounting for 38.1%; 84 people are in surgery, accounting for 29.1%; 24 people are in obstetrics and gynecology (Ob/Gyn), accounting for 8.3%; 37 people are in pediatrics, accounting for 12.8%; and 34 people are in other departments, accounting for 11.8%, reflecting the research focus on the front-line of clinical work. Among the job types, 181 people are clinicians (physicians), accounting for 62.6%; 51 people are clinical nurses, accounting for 17.6%; 33 people are medical technologists/technicians, accounting for 11.4%; and 24 people have an administrative - clinical dual role, accounting for 8.3%, covering diverse roles. The average weekly working hours show a medium-to-high intensity characteristic: 29 people work less than 40 hours per week, accounting for 10.0%; 150 people work 40-50 hours per week, accounting for 51.9%; 78 people work 51-60 hours per week, accounting for 27.0%; and 32 people work more than 60 hours per week, accounting for 11.1%. More than 80% of the samples have a weekly working hour of ≥ 40 hours. The overtime frequency further verifies the work load: 159 people always need to work overtime, accounting for 55.0%; 113 people frequently need to work overtime, accounting for 39.1%; 5 people occasionally need to work overtime, accounting for 1.7%; and 12 people never need to work overtime, accounting for 4.2%, highlighting the work intensity in the medical industry.

Table1. Data characteristics

		Number of Respondents	Percentage of Respondents (%)
	Total respondents	289	100
Gender	Male	131	45.3
	Female	158	54.7
Age	Under 20	23	8.0
	20-29	85	29.4
	30-39	106	36.6
	40-49	45	15.6
	50 or over	30	10.4
Education	Technical secondary school or high school	9	3.1
	Junior college	42	14.5
	Undergraduate degrees	99	34.3
	Master's degrees	128	44.3
	Doctor's degrees or over	11	3.8
Marriage	Unmarried	81	28.0
	Married and Cohabiting	135	46.7
	Married and Separated	45	15.6
	Divorced	21	7.3
	Widowed	7	2.4
Service Year	Less than 5 years	91	31.5
	5 years to less than 10 years	100	34.6
	10 years to less than 15 years	18	6.2
	15 years and above	80	27.7
Employment Relationship	Established-post Staff	241	83.4
	Non-established-post Staff	48	16.6
Professional Title	Junior-level (Technician/Nurse Practitioner)	74	25.6
	Intermediate-level	64	22.1

	(Attending Physician/Charge Nurse, etc.)		
	Associate Senior-level	84	29.1
	(Associate Chief Physician/Associate Chief Nurse, etc.)		
	Full Senior-level	67	23.2
	(Chief Physician/Chief Nurse, etc.)		
Department	Internal Medicine	110	38.1
	Surgery	84	29.1
	Obstetrics and Gynecology (Ob/Gyn)	24	8.3
	Pediatrics	37	12.8
	Other	34	11.8
Job Type	Clinician (Physician)	181	62.6
	Clinical Nurse	51	17.6
	Medical Technologist/Technician	33	11.4
	Administrative-Clinical Dual Role	24	8.3
Working Hours/Weekly	Less than 40 hours	29	10.0
	40–50 hours	150	51.9
	51–60 hours	78	27.0
	More than 60 hours	32	11.1
Work Overtime	Always	159	55.0
	Frequently	113	39.1
	Occasionally	5	1.7
	Never	12	4.2

3.2. Measurement

This study utilizes measurement tools for which reliability has already been established in previous research.

Hospital culture refers to the value-centered group consciousness formed and internalized by hospitals during their long-term self-development, as well as the overall social perception of the hospital (He,

2019). To quantify the hospital culture of China's medical system, this study used the nine question scales proposed by Wang et al. (2023) in their study. During the investigation period, we did not modify the scale and retained it in its original form to the greatest extent; the questions in the scale included "Colleagues get along well and help each other." or "I'm satisfied with my salary and performance awards."

Goal acceptance refers to the process by which a person must accept the goals assigned to him/her in order to be able to influence motivation (Smith, 2011). To quantify the goal acceptance of medical staff in China, this study used the four-question scale proposed by Shalley et al. (1987) in their research. During the investigation period, we did not modify the scale and retained it in its original form to the greatest extent; the questions in the scale included "I was committed to attaining the performance goal." or "I had a production goal to meet on this task."

Organizational climate refers to the atmosphere or environment within an organization created by the attitudes, behaviors and values of employees and management (Arage, 2024). To quantify the organizational climate within China's healthcare institutions, this study used the five-question scale proposed by Mohamad et al. (2020) in their study. During the investigation period, we did not modify the scale and retained it in its original form to the greatest extent; the questions in the scale included "Innovation is highly rewarded in our organization." or "Our organization's culture allows people to be creative."

Control at work refers to the perceived freedom or ability to control, regulate, guide, and make decisions about the work (Stomlien et al., 2023). To quantify the control at work of medical staff in China, this study used the three-question scale proposed by Easton and Van Laar (2013) in their study. During the investigation period, we did not modify the scale and retained it in its original form to the greatest extent; the questions in the scale included "I feel able to voice opinions and influence changes in my area of work." or "I am involved in decisions that affect me in my own area of work."

3.3. Statistical Analysis

The statistical analysis steps of this study are as follows: First, power analysis and demographic analysis were conducted. Subsequently, summary of structural model fit results, exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) were sequentially performed, followed by reliability analysis. Based on descriptive statistics, the correlations among variables and discriminant validity were further tested, and hypothesis testing was finally completed. In terms of specific tool applications: SPSS 26.0 was used for demographic analysis, EFA, reliability testing, descriptive statistics, correlation analysis, and moderation effect analysis. AMOS 23.0 was employed to execute CFA, discriminant validity testing, path testing, and summary of structural model fit results. The moderated mediation model analysis was conducted using Model 7 of SPSS PROCESS Macro 3.4.1. HTMT and HTMT inference were completed via Smart PLS 4. Interaction plots for moderation effects were generated using Interaction v.1.7 and origin 2024. The figure 1 is the research model.

Ⅹ. Results

4.1. Exploratory Factor Analysis

EFA refers to a statistical approach where researchers have no prior expectations or preconceptions about the factor structure of the data, instead, they use statistical methods to uncover and analyze the underlying factor structure (Jia, 2020). As shown in Table 2, the EFA in this study identified four different factors, each of which had significant loadings on its respective constituent elements and all exceeded the 0.5 threshold: hospital culture containing nine items showed high loadings of 0.846 to 0.877 on Component 1; goal acceptance containing four items was strongly correlated with Component 3, with load values ranging from 0.837 to 0.868; organizational culture composed of five items was mainly related to Component 2, with a load range of 0.827 to 0.874; the control at work with three items corresponding to Component 4, and the load values were between 0.911 and 0.932.

Table 2
The result of Exploratory Factor Analysis

Variable	Item	Component			
		1	2	3	4
Hospital Culture	1	0.859	0.160	0.188	0.074
	2	0.874	0.137	0.158	0.031
	3	0.854	0.191	0.154	0.038
	4	0.852	0.174	0.134	0.013
	5	0.857	0.147	0.128	0.093
	6	0.860	0.150	0.146	0.037
	7	0.863	0.116	0.183	0.016
	8	0.877	0.113	0.152	0.050
	9	0.846	0.181	0.139	0.045
Goal Acceptance	1	0.211	0.223	0.868	0.083
	2	0.191	0.250	0.853	0.051
	3	0.231	0.266	0.844	0.044
	4	0.290	0.269	0.837	0.076
Organizational Climate	1	0.199	0.861	0.267	0.052
	2	0.191	0.874	0.158	0.098
	3	0.198	0.827	0.220	0.116
	4	0.195	0.858	0.235	0.058
	5	0.169	0.869	0.183	0.095
Control at Work	1	0.045	0.137	0.056	0.911
	2	0.059	0.084	0.058	0.915
	3	0.077	0.077	0.072	0.932
Eigenvalues		9.792	9.792	3.379	2.349
Dispersion (%)		46.627	46.627	16.090	11.185
Cumulative (%)		46.627	46.627	62.718	73.902
KMO=.941 (sig=.000)					

4.2. Confirmatory Factor Analysis

CFA refers to the process of assessing the convergence validity of measured variables and the discrimination validity of latent variables (Kim & Lee, 2015). The study employed AMOS version 23.0 to conduct CFA on six distinct models (Table 3). First was the hypothesized model, in which four variables were independently and concurrently evaluated. The statistical results for this model were as follows: $\chi^2(p) = 396.444$ ($p < 0.000$), $\chi^2/df = 2.178$, RMSEA = 0.064, IFI = 0.964, CFI = 0.964, PNFI = 0.811, PGFI = 0.691. Model 2, however, proposed a unidimensional structure encompassing all items, yielding poorer results: $\chi^2(p) = 2889.629$ ($p < 0.000$), $\chi^2/df = 15.209$, RMSEA = 0.222, IFI = 0.547, CFI = 0.545, PNFI = 0.479, PGFI = 0.352. Model 3 integrated hospital culture and goal acceptance as Factor 1, and organizational climate and control at work as Factor 2, with the following statistics: $\chi^2(p) = 1802.008$ ($p < 0.000$), $\chi^2/df = 9.484$, RMSEA = 0.172, IFI = 0.729, CFI = 0.728, PNFI = 0.639, PGFI = 0.501. Model 4 grouped hospital culture and organizational climate into Factor 1, and goal acceptance and control at work into Factor 2, presenting: $\chi^2(p) = 2174.631$ ($p < 0.000$), $\chi^2/df = 11.445$, RMSEA = 0.19, IFI = 0.667, CFI = 0.666, PNFI = 0.585, PGFI = 0.438. Model 5 divided the variables into three factors: hospital culture, organizational climate, and a combined factor of goal acceptance and control at work, showing improved fit indices: $\chi^2(p) = 1092.083$ ($p < 0.000$), $\chi^2/df = 5.778$, RMSEA = 0.129, IFI = 0.848, CFI = 0.848, PNFI = 0.740, PGFI = 0.569. Conversely, Model 6 integrated hospital culture and organizational climate into Factor 1, designated goal acceptance as Factor 2, and classified control at work as Factor 3, resulting in: $\chi^2(p) = 1237.034$ ($p < 0.000$), $\chi^2/df = 6.545$, RMSEA = 0.139, IFI = 0.824, CFI = 0.823, PNFI = 0.719, PGFI = 0.551. A comprehensive examination of these results led to the conclusion that Model 1 exhibited the best alignment with the data, indicating a significant fit.

Table 3
Summary of structural model fit results.

Model	$\chi^2(p)$	χ^2/df	RMSEA	IFI	CFI	PNFI	PGFI
Model 1 (Expected Model of four-factor a)	396.444 (0.000)	2.178	0.064	0.964	0.964	0.811	0.691
Model 2 (one-factor b)	2889.629 (0.000)	15.209	0.222	0.547	0.545	0.479	0.352
Model 3 (two-factor c)	1802.008 (0.000)	9.484	0.172	0.729	0.728	0.639	0.501
Model 4 (two-factor d)	2174.631 (0.000)	11.445	0.190	0.667	0.666	0.585	0.438
Model 5 (three-factor e)	1092.083 (0.000)	5.778	0.129	0.848	0.848	0.740	0.569
Model 6 (three-factor f)	1237.034 (0.000)	6.545	0.139	0.824	0.823	0.719	0.551
Note: a=hospital culture, goal acceptance, organizational climate, and control at work. b = All items were loaded on a single factor. c=hospital culture and goal acceptance, organizational climate and control at work. d=hospital culture and organizational climate, goal acceptance and control at work. e=hospital culture, goal acceptance and organizational climate, control at work. f=hospital culture and organizational climate, goal acceptance, control at work.							

The CFA for Model 1, which comprised a four-factor structure, demonstrated good model fit, thus confirming the validity of the constructs. To evaluate convergent validity, the standardized regression coefficients for hospital culture ranged from 0.748 to 0.850; those for goal acceptance varied between 0.711 and 0.846; organizational climate showed coefficients from 0.603 to 0.887; and control at work showed coefficients ranging from 0.716 to 0.920. These coefficients exhibited significant correspondence with the theoretical model. The assessment of AVE and CR further confirmed the reliability of the measurements. Specifically, the AVE values for hospital culture, goal acceptance, organizational climate, and control at work exceeded the 0.5 threshold, with values of 0.682, 0.646, 0.656, and 0.682, respectively. The CR values also surpassed the 0.7 threshold, standing at 0.899, 0.759, 0.801, and 0.751, respectively, indicating a high level of reliability. The evaluation of the model fit involved the analysis of three categories of indices: absolute fit, incremental fit, and parsimonious adjusted fit.

The absolute fit indices were $\chi^2(p) = 396.444$ ($p < 0.000$), $\chi^2/df = 2.178$, and RMSEA = 0.064. The incremental fit indices were IFI = 0.964 and CFI = 0.964. The parsimonious adjusted fit indices were PGFI = 0.691 and PNFI = 0.811. Collectively, these indices supported the acceptability of the CFA model. Therefore, the structural equation model was considered reasonable, and Table 4 details the analysis results.

Table 4
The Result of Confirmatory Factor Analysis

Variables		Estimate	S.E.	C.R.	p	Standardized Regression Weights	AVE	C.R
Hospital Culture (A)	A9	1				.748	.682	.899
	A8	1.242	.054	23.071	***	.847		
	A7	1.261	.056	22.329	***	.833		
	A6	1.225	.055	22.213	***	.830		
	A5	1.173	.054	21.843	***	.822		
	A4	1.209	.056	21.678	***	.819		
	A3	1.235	.055	22.420	***	.834		
	A2	1.287	.055	23.220	***	.850		
	A1	1.325	.057	23.046	***	.846		
Goal Acceptance (B)	B4	1				.711	.646	.759
	B3	1.358	.062	21.782	***	.835		
	B2	1.274	.060	21.076	***	.817		
	B1	1.306	.058	22.350	***	.846		
Organizational Climate (C)	C5	1				.603	.656	.801
	C4	1.465	.065	22.400	***	.859		
	C3	1.324	.065	20.336	***	.812		
	C2	1.398	.063	22.195	***	.856		
	C1	1.503	.063	23.727	***	.887		
Control at Work (D)	D1	1				.716	.682	.751
	D2	1.251	.062	20.089	***	.830		
	D3	1.397	.062	22.375	***	.920		
Model Fit Index		X ² (p) = 396.444(.000), X ² /df = 2.178, RMSEA=.064, IFI=.964, CFI=.964, PGFI=.691, PNFI=.811						

4.3. Reliability Analysis

Reliability analysis refers to the assessment of a questionnaire's consistency and stability, which reflects whether the measurements (i.e. responses) are reliable and free from random errors (Shao et al., 2022). Cronbach's α coefficient was used to conduct a reliability analysis of the relevant variables (Table 5). The results of the reliability analysis are summarized as follows: First, hospital culture (A) was evaluated through a 9-item scale to assess participants' engagement and experience with aspects related to hospital culture in the work environment, yielding a Cronbach's α of 0.966. Second, goal acceptance (B) was measured using a 4-item scale to gauge participants' perceptions of tasks at work, with a Cronbach's α of 0.938. Third, organizational climate (C) was assessed using a 5-item scale to evaluate participants' perceptions of cultural aspects in medical institutions, resulting in a Cronbach's α of 0.947. Finally, control at work (D) was measured using a 3-item scale to gauge participants' feelings of mastery in the workplace, with a Cronbach's α of 0.920. All calculated Cronbach's α coefficients exceeded the benchmark of 0.7, confirming that the variables have high reliability and validity.

Table 5
Reliability analysis results

Variables	Item	Cronbach's Alpha
Hospital Culture (A)	1. The hospital has a harmonious working atmosphere and a good culture.	.966
	2. Colleagues get along well and help each other.	
	3. The smooth coordination between hospital departments can effectively solve problems for patients.	
	4. Leaders have strong leadership and decision-making abilities.	
	5. Hospital functional departments have strong executive abilities.	
	6. The hospital provides a good opportunity for my promotion to a professional title.	
	7. The hospital does its best to provide me with training and exchange opportunities.	
	8. I'm satisfied with my salary and performance awards.	
	9. The working environment of the hospital is clean and comfortable.	
Goal Acceptance (B)	1. I felt I had a high degree of personal investment in completing the performance goal.	.938
	2. I was committed to attaining the performance goal.	
	3. I had a production goal to meet on this task.	
	4. Attaining the performance goal was important to my feelings of achievement and accomplishment.	
Organizational Climate (C)	1. The people in my organization are encouraged to try new and better ways of doing their jobs.	.947
	2. Innovation is highly rewarded in our organization.	
	3. Trying new ways of solving problems is encouraged in our organization.	
	4. Our organization's culture allows people to be creative.	
	5. In our organization, change is viewed as a positive factor, which brings new opportunities.	
Control at Work (D)	1. I feel able to voice opinions and influence changes in my area of work.	.920

Variables	Item	Cronbach's Alpha
	2.I am involved in decisions that affect me in my own area of work.	
	3.I am involved in decisions that affect members of the public in my own area of work.	

4.4 Descriptive Statistics and Correlation Analysis

The results of descriptive statistics and correlation analysis are presented in Table 6. The mean values of hospital culture, goal acceptance, organizational climate, and control at work were 5.2053, 4.8322, 4.9322, and 5.1742, respectively, with standard deviations of 1.5027, 1.7365, 1.6925, and 1.6068, respectively.

The correlation analysis revealed that hospital culture was significantly correlated with goal acceptance ($r=.454^{***}$, $p<.001$), positively correlated with organizational climate ($r=.410^{***}$, $p<.001$), and positively correlated with control at work ($r=.142^*$, $p < 0.05$). Goal acceptance showed a strong positive correlation with organizational climate ($r=.535^{***}$, $p<.001$) and a weak positive correlation with control at work ($r=.176^{**}$, $p < 0.01$). Organizational climate was positively correlated with control at work ($r=.221^{***}$, $p<.001$), indicating different degrees of association among the variables.

Hospital culture conveys the core ideas and values of medical institutions. It drives the medical staff to recognize goal acceptance, thereby fostering a positive organizational climate and indirectly enhancing their control at work. These four variables (hospital culture, goal acceptance, organizational climate, and control at work) jointly promote the positive development of medical institutions through mutual reinforcement and cyclic interaction.

Table 6
The Results of Descriptive Statistics and Correlation Analysis

Variables	Mean	SD	Hospital Culture	Goal Acceptance	Organizational Climate	Control at Work
Hospital Culture	5.2053	1.5027	-			
Goal Acceptance	4.8322	1.7365	.454 ^{***}	-		
Organizational Climate	4.9322	1.6925	.410 ^{***}	.535 ^{***}	-	
Control at Work	5.1742	1.6068	.142 [*]	.176 ^{**}	.221 ^{***}	-
***: $p<.001$, **: $p<.01$, *: $p<.05$						

4.5 Discriminant Validity Assessment Methods

As shown in Table 7, the AVE of hospital culture was 0.682, exceeding its squared correlation coefficients (r^2) with other variables: 0.140, 0.099, and 0.012, respectively. The AVE for goal acceptance was 0.646, which was higher than its r^2 values with other dimensions: 0.140, 0.198, and 0.019. The AVE of organizational climate was 0.656, which was greater than its r^2 values with other dimensions: 0.099, 0.198, and 0.019. Similarly, the AVE for control at work was 0.682, exceeding its r^2 values with other dimensions: 0.012, 0.019, and 0.019. Given that the AVE of each variable exceeded the corresponding r^2 values with other variables, discriminant validity analysis in this study was confirmed.

Table 7
The Results of Discriminant Validity

Variables	Hospital Culture	Goal Acceptance	Organizational Climate	Control at Work
Hospital Culture	(.682)			
Goal Acceptance	.375(.140)	(.646)		
Organizational Climate	.315(.099)	.446(.198)	(.656)	
Control at Work	.110(.012)	.140(.019)	.139(.019)	(.682)

This study evaluated the discriminant validity of hospital culture, goal acceptance, organizational climate, and control at work using the Heterotrait-Monotrait ratio (HTMT). According to Henseler et al. (2015), discriminant validity is confirmed if the HTMT value is below the threshold of 0.85. The HTMT results in Table 8 show that all the variables' HTMT values are below this threshold, confirming the discriminant validity among these constructs. Table 9 provides the HTMT inference results derived from bootstrapping with 5,000 subsamples. Discriminant validity is further confirmed as all 95% confidence intervals are below 1.

Table 8
The Results of HTMT

Variables	Hospital Culture	Goal Acceptance	Organizational Climate	Control at Work
Hospital Culture	-			
Goal Acceptance	.476	-		
Organizational Climate	.428	.567	-	
Control at Work	.151	.189	.238	-

Table 9
The Results of HTMT inference

Goal Acceptance → Control at Work	Original data (O)	Data average (M)	5.0%	95.0%	Data average (M)	Bias	5.0%	95.0%
	.189	.190	.072	.310	.190	0	.070	.308
Hospital Culture → Control at Work	.151	.154	.051	.278	.154	.003	.051	.278
Hospital Culture → Goal Acceptance	.476	.476	.361	.590	.476	0	.360	.588
Organizational Climate → Control at Work	.238	.239	.117	.361	.239	.001	.115	.357
Organizational Climate → Goal Acceptance	.567	.568	.463	.670	.568	.001	.460	.667
Organizational Climate → Hospital Culture	.428	.427	.308	.542	.427	– .001	.308	.541

4.6 Hypothesis Test

Six hypotheses were proposed in this study. It first verified the impact of hospital culture on the goal acceptance of medical staff, then examined the relationship between hospital culture and control at work, and finally evaluated the role of goal acceptance in improving the control at work of medical staff. Additionally, it analyzed the mediating effect of goal acceptance on the relationship between hospital culture and control at work. To test the above hypotheses, AMOS 23.0 was used for the path analysis, and the results are shown in Table 10.

Hypothesis 1

proposed that hospital culture positively impacts goal acceptance. The analysis showed that hospital culture had a significant positive impact on goal acceptance (estimate=.529, $p < .001$), supporting Hypothesis 1 and indicating that hospital culture improves the goal acceptance level of medical staff. Hypothesis 2 proposed that hospital culture positively impacts medical staff's control at work. The results showed that hospital culture did not have a significant positive effect on medical staff's control at work (estimate=.078, $p > .05$). Thus, Hypothesis 2 was rejected. This may be because work scenarios are complex and changeable, relying more on immediate decision-making and autonomous control. If hospital culture is biased towards 'administrative and standardised', culture and control at work will easily be disconnected. Hypothesis 3 proposed that goal acceptance positively impacts medical staff's control at work. The analysis showed a significant positive association between goal acceptance and

medical staff's control at work (estimate=.144, $p<.05$), supporting Hypothesis 3, which suggests that goal acceptance promotes medical staff's control at work. Hypothesis 4 tested the mediating role of goal acceptance in the relationship between hospital culture and control at work. The analysis yielded an indirect effect value of 0.013, LLCI of 0.015, and ULCI of 0.164. Since the bootstrap confidence interval does not contain zero, the mediation effect is statistically significant, and the mediation effect is a complete mediation effect, supporting Hypothesis 4.

Table 10
The results of path analysis

Path			Estimate	S.E.	C.R.	p
Hospital Culture	→	Goal Acceptance	.592	.072	8.187	***
Hospital Culture	→	Control at Work	.078	.076	1.021	.307
Goal Acceptance	→	Control at Work	.144	.063	2.279	.023
Indirect Effect			Effect	Boot LLCI	Boot ULCI	
Hospital Culture → Goal Acceptance → Control at Work			.013	.015	.164	
Model Fit Index		X ² (p) = 81.685(.000), X ² /df = 1.317, RMSEA=.033, IFI=.996, CFI=.996, AGFI=.928, PNFI=.507				
***:p<.001, **:p<.01, *:p<.05						

Hypothesis 5

explored the moderating role of organizational climate in the relationship between hospital culture and goal acceptance. This study used SPSS (version 26.0) to perform multiple regression analysis to verify the hypothesis. The multiple regression results in Table 11 show that the interaction term between hospital culture and organizational climate is statistically significant ($\beta = 0.723$, $p < 0.01$). Therefore, Hypothesis 5 is supported, indicating that organizational climate moderates the relationship between hospital culture and goal acceptance.

Figure 2 (Moderated effect plot) visually illustrates this mechanism, with hospital culture plotted on the horizontal axis and goal acceptance on the vertical axis. The three lines represent scenarios where organizational climate is at + 1 standard deviation (high-level climate, red line), mean level (moderate climate, green line), and - 1 standard deviation (low-level climate, blue dotted line). Evidently, the positive impact of hospital culture on goal acceptance strengthens as organizational climate increases; the steeper slope of the red line (high organizational climate) indicates a more pronounced promotion effect, while the gentler slope of the blue dotted line (low organizational climate) reflects a weaker influence.

Table 11
The result of the moderating effect of Organizational Culture

Dependent Variable: Control at Work							
	Model 1		Model 2		Model 3		VIF
	β	t	β	t	β	t	
Hospital Culture (A)	.454***	8.643	.283***	5.420	– .079	– .587	1.341
Organizational Culture (B)			.419***	8.040	– .061	– .353	1.207
Interaction (A*B)					.723**	2.915	1.167
R^2 (Adjusted R^2)	.207 (.204)		.353 (.348)		.372 (.365)		
ΔR^2 (Δ Adjusted R^2)	-		.146 (.144)		.019 (.017)		
F	74.703***		77.952***		56.164***		
***: $p < .001$, **: $p < .01$, *: $p < .05$							

Table 12 presents the results of a moderated mediation analysis of organizational climate. At one standard deviation below the mean (–1 SD), the conditional indirect effect was calculated as 0.0288, with a bootstrap SE of 0.0162, and the confidence interval ranged from 0.0027 to 0.0660. At the mean level, the conditional indirect effect increased to 0.0501, with a bootstrap SE of 0.0231 and a confidence interval of 0.0085–0.0989. At one standard deviation above the mean (+ 1 SD), the conditional indirect effect further increased to 0.0713, with a bootstrap SE of 0.0338, and the confidence interval ranging from 0.0110 to 0.1455. As none of the confidence intervals contained zero at the – 1 SD, mean, and + 1 SD levels, the results were statistically significant. Additionally, the index of moderated mediation was calculated to be 0.0126, with a bootstrap SE of 0.0078, and the confidence interval ranged from 0.0003 to 0.0304 (with no zero within the interval), further confirming the statistical significance of the results. Overall, these findings indicate that the moderated mediating effect of organizational climate is statistically significant, thus supporting Hypothesis 6.

Table 12
The moderated mediation effect of Organizational Climate

Dependent Variable: Control at Work					
Moderator	Level	Conditional Indirect Effect	Boot SE	Boot LLCI	Boot ULCI
Organizational Climate	-1 SD (- 1.6926)	.0288	.0162	.0027	.0660
	M	.0501	.0231	.0085	.0989
	+ 1 SD (+ 1.6926)	.0713	.0338	.0110	.1455
Index of moderated mediation					
	Index		Boot SE	Boot LLCI	Boot ULCI
		.0126	.0078	.0003	.0304

8. Discussion

This study explored the connection between hospital culture and control at work by assessing the impact of hospital culture on the behavior and psychology of medical staff. Research has focused on the mediating role of goal acceptance in the relationship between hospital culture and control at work. This study used a moderated mediation framework to determine whether the impact of hospital culture on control at work was indirectly influenced by goal acceptance and whether organizational climate could moderate the mediating effect of goal acceptance. The results of this study provide reference insights for future research, emphasize the strategic importance of hospital culture in China's medical institutions, and provide a valuable way to implement national policies. The main findings of this study are summarized as follows:

5.1. Theoretical Implications

First, hospital culture positively impacts the goal acceptance of medical staff. This implies that as the level of hospital cultural construction improves, the medical staff's acceptance of goals will also increase. Hospital culture effectively stimulates medical staff's willingness to express themselves and a sense of mutual respect, meet the self-realization needs of organization members, and bring about higher goal acceptance (Chou et al., 2011). Simultaneously, the main goal of hospital culture is to strengthen the coordination and efficient utilization of resources and improve overall performance and operational efficiency, which will also promote an improved level of goal acceptance among members (Christensen et al., 2006). Therefore, when hospital culture builds value consensus, gathers team

strength, and optimizes resource operation while meeting individual spiritual needs, the process from recognition to acceptance of goals becomes smoother for medical staff.

Second, hospital culture has no significant positive impact on medical staff's control at work. This implies that as the hospital's cultural level improves, the degree of control of medical staff over their work will not increase. Although it is seen based on Hypothesis 2 and the literature that hospital culture depends on managers, many hospital managements need to be upgraded to improve personal skills and professionalism, drive cultural change, make the workplace healthier, and ensure that medical staff's control over their work remains central (Cleary et al., 2013). Additionally, institutions with an employee-oriented hospital culture value competencies and personal skills that provide conditions for the development of autonomy and freedom at work, resulting in greater control at work (Rocha et al., 2016). However, this study suggests that the reason for this result may be the short observation period, which has not yet been able to capture the positive effect of cultural construction on control at work after long-term accumulation.

Third, goal acceptance has a significant influence on medical staff's control at work. This indicates that an increase in goal acceptance enhances the medical staff's control at work. In work scenarios, the level of goal acceptance determines the extent to which employees believe they have the opportunity to take action to control the quality, occurrence, and duration of major work-related events (Jimmieson and Terry, 1998). Therefore, when higher goal acceptance and a higher degree of organization-related information sharing coexist, employees with internal control are more likely to meet their needs to exercise control at work (Ng and Butts, 2009). Therefore, the higher the medical staff's acceptance of the goals, the more they will actively understand the meaning and requirements behind the goals, and then they will be more willing to invest in exploring ways to achieve the goals, coordinating the resources required, and flexibly adjusting the pace and strategies during implementation, ultimately strengthening control over the work process and results. In contrast, if the goals are not accepted, medical staff will easily have a passive coping mentality and lack the motivation to proactively plan and adjust, and control at work will weaken.

Fourth, goal acceptance fully mediates the relationship between hospital culture and medical staff's control at work. This suggests that hospital culture lacks the direct effect on medical staff's control at work, but exerts an indirect effect on it through the fully mediating effect of goal acceptance. When hospital culture is integrated into human resource management, it unites medical professionals, enhances their sense of belonging, and encourages them to work together for institutional development (Wang and Wen, 2025). To some extent, goal acceptance is based on relatively objective and quantitative information rather than ambiguous standards and subjective interpretation of performance levels; the resulting interactions should be less acute and allow participants to develop a higher level of control at work (Tziner and Kopelman, 2002). Therefore, the penetration of hospital culture into the values and behavioral orientation of medical staff transforms them from 'passively implementing goals' to 'actively identifying and pursuing goals', thereby gaining a stronger sense of autonomy, direction and accomplishment in their work, and ultimately improving control over their work.

Fifth, organizational climate exerts a positive moderating effect on the impact of hospital culture on the goal acceptance of medical staff. This suggests that the goal acceptance level of medical staff will also increase under the interaction between organizational climate and hospital culture. Healthcare industry leaders need to understand how their actions and behaviors directly shape the work environment (i.e. the organizational climate) and identify the behaviors and initiatives that help to promote a positive organizational climate that leads to a beneficial hospital culture (Moreno-Domínguez et al., 2024). If hospital culture accommodates and adapts to the characteristics and needs of different individuals, medical staff are likely to more effectively understand their cultural environment, accept multicultural differences, and recognize and accept the goals set by the organization (Yawar and Hakimi, 2025). Moreover, it is evident from Table 6 that there is a positive impact among the variables, while Table 11 shows that hospital culture and organizational climate are found to positively promote medical staff's control at work. According to Fig. 2, if the organizational climate is at a higher or lower level, it will increase the level of hospital culture's acceptance of goals, and the slope at a higher level is much higher than the slope at a lower level. This means that when the organizational climate is full of 'respect and support' (such as leaders paying attention to employees' physical and mental health, and the team atmosphere is characterized by mutual assistance and tolerance), medical staff will have a stronger emotional attachment to the organization. At this time, the goals advocated by hospital culture (such as 'building a regional benchmark hospital') will be regarded as 'a common pursuit consistent with one's own interests' rather than as externally imposed tasks—emotional recognition will be transformed into active acceptance of the goal.

Sixth, to verify whether organizational climate is able to moderate the mediating effect of goal acceptance, this study examined the moderated mediation effect of organizational climate. The results show that organizational climate has a significant moderated mediation effect. Goal acceptance is a mediating variable in which hospital culture affects control at work. Its transmission effectiveness is not constant, but is 'context-moderate' by the organizational climate. When organizational climate is positive (such as high support and high transparency), it 'empowers' the connection between hospital culture and goal acceptance—an open communication atmosphere makes cultural concepts (such as 'patient center') easier to understand, and a fair incentive environment makes culturally advocated goals (such as 'quality improvement') more attractive and facilitates the deep transformation of medical staff from 'cultural cognition' to 'goal acceptance'. The strengthening of goal acceptance further provides a 'psychological anchor' for control at work, allowing employees to more clearly perceive work direction and autonomy space, thereby amplifying the mediating effect of 'hospital culture→goal acceptance→control at work'.

In addition to the above theoretical significance, this study found that hospital culture positively impacts goal acceptance, hospital culture positively impacts control at work, and goal acceptance positively impacts control at work. Moreover, this study confirmed that goal acceptance is found to fully mediate the relationship between hospital culture and control at work. It demonstrates that organizational climate is found to serve as a moderating variable between hospital culture and goal acceptance.

Furthermore, this study verified that organizational climate is found to moderate the mediating effect of goal acceptance on hospital culture and control at work.

5.2. Practical Implication

First, based on the hospital culture, the strategic anchoring of goal acceptance should be strengthened. Hospital culture implies that hospitals use the power of culture to promote the management of people by improving people's cultural literacy, creating a good cultural atmosphere, establishing a distinctive hospital spirit, leading correct values, establishing professional standards, and applying mature operating theories (Yan, 2015). Hospital culture should not only be a slogan on the wall, but also a guide to action for medical staff. Therefore, it is crucial to establish a concrete connection between culture and goals. For example, the policy goal of 'reducing the incidence of chronic diseases' is broken down into job-specific indicators such as 'community health education frequency' and 'patient follow-up compliance rate', and case teaching in cultural training, allowing medical staff to clearly perceive the intrinsic consistency of 'organizational goals' and 'personal work'. It is imperative to strengthen the active acceptance of strategic goals from the level of value recognition and avoid the phenomenon of 'passive execution' caused by the disconnect between cultural concepts and policy goals.

Second, actively organizing the climate is able to smooth the transition of culture to goal acceptance. A positive organizational climate is like a 'lubricant' for cultural transmission, which tends to effectively eliminate blocking factors in the process of transforming hospital culture into goal acceptance. Management expert Peter Drucker proposed that 'the atmosphere of an organization determines the efficiency and quality of information transmission' (Uit Beijerse, 1999). This view is particularly obvious in the medical field—when hospitals establish an atmosphere of open communication (for example, regular cross-department goal consensus meetings are held and medical staff opinions are established), a fair and impartial evaluation mechanism (which incorporates cultural practice and goal achievement into same-dimensional assessment), and a supportive fault-tolerant environment (which allows innovative services to be trial-and-error and provide improvement guidance), medical staff will more proactively participate in the interpretation of cultural concepts and goal decomposition.

Third, it is essential to focus on control at work and transform cultural concepts into practical effectiveness. Control at work is a key hub connecting hospital cultural concepts with actual work results. When medical staff have sufficient independent decision-making power, resource allocation power, and process leadership over their work, cultural concepts tend to be truly implemented with quantifiable practical effectiveness. Drawing on the views of scholars at the University of Michigan in Organizational Behavior, when organizations provide individuals with clear work goals, sufficient resources, and moderate space for autonomous decision-making, individuals' control over their work will significantly improve, which in turn will more effectively internalize and externalize organizational culture into work outcomes (Garman, 2006). Hospitals are able to further optimize work processes, introduce digital management systems, monitor work progress in real time, provide medical staff with timely decision-making support, and enhance their control over the pace and quality of work.

Fourth, a 'culture-goal-control' linkage mechanism to adapt to the requirements of 'Healthy China 2030' should be established. The 'Healthy China 2030' strategy adheres to the core essence of 'ensuring people's health in an all-round and full-cycle manner'. This requires medical institutions to build a systematic linkage mechanism among hospital culture, goal acceptance, and control at work to achieve the organic combination of strategic goals and micro practices. Specifically, coordination needs to be achieved through three-level transformation paths: 1) Deeply integrate strategic orientations such as 'prevention first' and 'big health' into the core of hospital culture and form practical orientation such as 'prevention and control integration' and 'health promotion'. The cultural cognitive system provides value anchors for target acceptance; 2) Decompose goals based on cultural cognition and transform macro strategic goals into quantifiable and implementable job goals for medical staff; 3) By clarifying rights and responsibilities, medical staff are given corresponding control over their work, and their decision-making boundaries and resource allocation authority in the entire health management process are clearly defined to provide efficient support for the effective achievement of goals.

Fifth, it is important to rely on digital empowerment to amplify the catalytic effect of organizational climate. Digital tools provide technical support for optimizing the organizational climate and strengthening its catalytic role in 'hospital culture→goal acceptance'. From the perspective of information transmission, by building a digital communication platform within a hospital, hierarchical barriers and departmental barriers tend to be broken down and the openness and transparency characteristics advocated by the active organizational climate tend to be concretized. Medical staff tend to obtain cultural dynamics, goal interpretation, and resource support information in real time, reduce cultural transmission distortion caused by information asymmetry, and thereby improve the efficiency of goal acceptance.

5.3. Limitations and Future Research

Although this study makes valuable contributions in examining the moderating effect of organizational climate on hospital culture and goal acceptance and exploring whether organizational climate has the potential to moderate the mediating effect of goal acceptance between hospital culture and control at work, it is not without limitations. The limitations of this study are as follows:

First, this study focused only on hospital culture as an independent variable. Other independent variables are also worthy of in-depth discussion in future research, such as online collaboration software (Omid and Dal Zotto, 2023), general well-being (Siddiqui et al., 2024), and work engagement (Dehghani Soltani and Joneidi Jafari, 2020). Future research should explore whether different forms of independent variables show different results within the same model and among the same group of medical staff.

Second, in terms of mediating variables, this study selected only goal acceptance. Given the extensive research on control at work, many other mediating variables are able to be studied. For example, psychological capital (Gupta and Shaheen, 2018), generalised self-efficacy (Speier and Frese, 2014), experienced privacy (Laurence et al., 2013), and informal workplace learning strategies (Santoro, 2023) are potential areas that are able to be explored in future research.

Third, regarding moderating variables, this study focused solely on organizational climate. Given the breadth of the research on hospital culture, numerous other moderating variables merit further investigation. For instance, other potential moderating variables include achievement motivation (Huang et al., 2022), transformational leadership (Guan, 2023), leader-member exchange (Shouqiang, 2019), and perceived comfort (Nonnis et al., 2022), which are also worthy of in-depth exploration in future studies.

Fourth, although this study was conducted among medical staff in medical institutions in China, it would be meaningful to expand the study to other countries in the field of Confucian culture. This expansion is able to provide a broader understanding of how cultural nuances affect the relationship among hospital culture, goal acceptance, organizational climate, and control at work. By including different cultural backgrounds, future research could provide more insight into the universality or cultural specificity of the observed effects.

Fifth, the data do not support the assumption that hospital culture is able to improve medical staff's control at work. Future research tends to further explore the potential relationship between hospital culture and medical staff's control at work and whether other factors affect this relationship.

8. Conclusions

This study integrates research results from the limited existing literature on the relationship among hospital culture, goal acceptance, organizational climate, and control at work and explores the impact mechanism of hospital culture on other variables. Its core purpose is to analyse the correlation path between hospital culture and medical staff's control at work, with goal acceptance defined as the mediating variable in this process.

Additionally, this study broadens the research boundaries in the field of hospital culture and medical staff's control at work by assessing the effects of moderating mediation models and the moderating role of organizational climate. The empirical results confirm the moderating function of organizational climate; that is, it is able to moderate the relationship between hospital culture and goal acceptance, a finding that highlights the critical significance of the internal atmosphere of the organization.

Simultaneously, research reveals that improving medical staff's control at work has a positive effect on medical institutions and the exertion of this effect will help promote smooth implementation of the 'Healthy China 2030' strategy. In summary, this study provides a more cutting-edge theoretical explanation for improving the hospital culture and medical staff's sense of control at work. It further condenses the theoretical value and practical enlightenment based on the empirical results.

Declarations

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Data Availability Statement:

The datasets generated and/or analyzed during the current study are available from the corresponding author upon reasonable request.

Conflicts of Interest:

The authors declare no conflict of interest.

Ethical Approval: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of Liaodong University(Ethics Review No. LDU-REC-2025-005).

Informed Consent: Prior consent was obtained from all participants before conducting the survey.

Informed Consent Form

This study has not any potentially identifiable images or data are presented directly in this study. Specifically, this study is not a case report on human or animal experiments and does not include any images or data that could potentially identify humans or animals. We promise that this study does not include any experiments that violate ethics, including those involving minors, animals, human experiment, patients, or minors. All survey participants were adults and participated voluntarily. The survey simply includes the company's phenomenon and participants' perceptions of companies so that no experiments exist. In addition, our data used in this study contains no experiments or content related to animals. Furthermore, this study is not a medical study and there is absolutely no animal or human testing or experiments.

1. Survey project name: Hospital culture, organizational climate, and goal acceptance: Deconstructing the influence path on medical staff's control at work.
2. Project background and investigation purpose: This project is initiated by medical staff and investigates Hospital culture, organizational climate, and goal acceptance: Deconstructing the influence path on medical staff's control at work.
3. Confidentiality of personal information: If you decide to participate in this survey, your participation in this survey and your personal information in the course of the survey will be kept strictly confidential. All members of the research team are required to keep your identifying information confidential, and information that identifies you will not be disclosed to members outside the research team.

4. You can voluntarily choose to participate in the survey or withdraw from the survey in the middle: Whether to participate in the survey depends entirely on your wishes. If you have any questions about this survey, you can ask the investigator. You can also refuse to participate in this survey, or in the survey process at any time out of this survey, which will not affect the relationship between you and the investigators, will not affect your rights and interests. As a subject of an investigation, you have a duty to state the facts. If you fail to comply with this duty, the investigator may terminate your continued participation in this investigation and terminate the award.

If there is any important new information in the survey process that may affect your willingness to continue to participate in the survey, the investigator will promptly notify you.

Informed consent page:

I am confident that I am not a minor and agree to provide information.

I have read the above description of this survey and have had the opportunity to discuss and ask questions about this survey with the investigators. All of the questions I asked were answered to my satisfaction. I am not minors and I am over 20 years of age.

I am aware of the risks and benefits that may arise from participating in this survey. I understand that participation in the survey is voluntary, I acknowledge that I have had sufficient time to consider it, and I understand that:

1. I can always ask the investigators for more information.
2. I can withdraw from this survey at any time without discrimination or retaliation.
3. If I do not follow the survey plan, the investigator may terminate my continued participation in this survey.

4. If I participate in this questionnaire, it means I agree to the Informed Consent Form.

5. I confirm that I'm not minors and Informed consent is obtained from all subjects involved in the study.

Author Contribution

Conceptualization, Jiaxing Du and Zhiwei Wang; Methodology, Xiu Jin; validation, Xiu Jin; formal analysis, Xiu Jin; data curation, Jiaxing Du; writing—original draft, Jiaxing Du and Feng Li; writing—review and editing, Xiu Jin; supervision, Xiu Jin. All authors have read and agreed to the published version of the manuscript.

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Figures

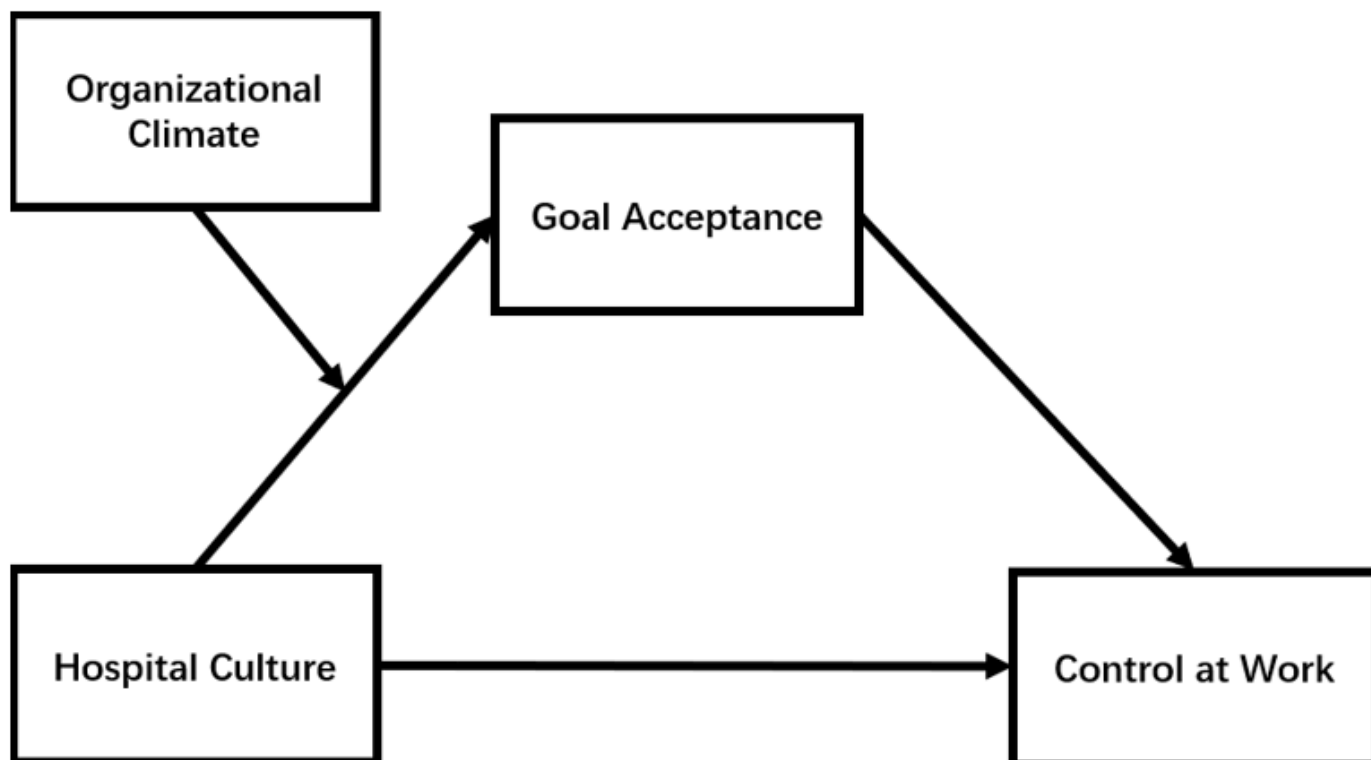


Figure 1. Research Model

Figure 1

See image above for figure legend

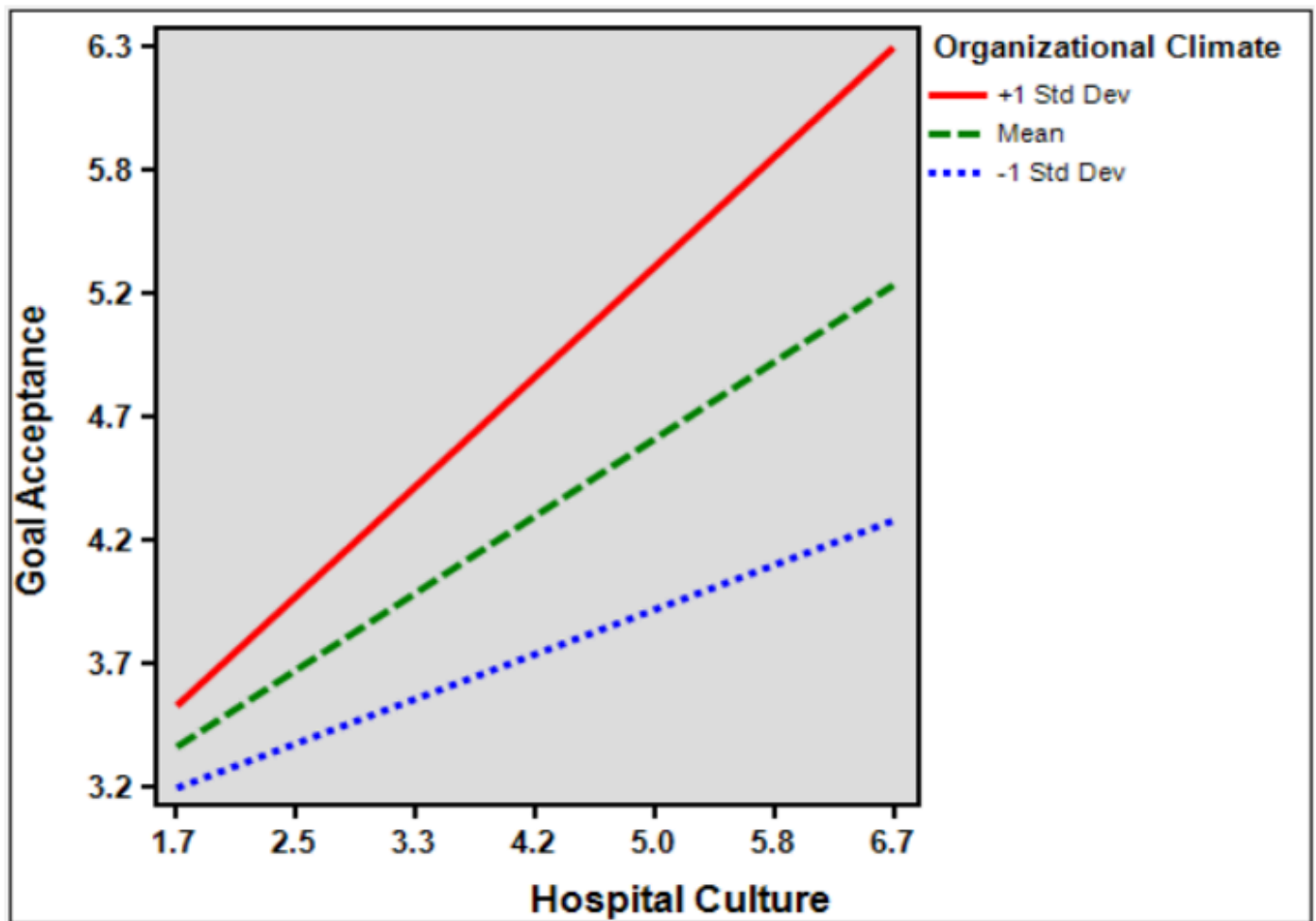


Figure 2

The moderating effect of Organizational Culture (Moderated Effect Plot)