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Policy Roundtable

Presenting the views of experts from around the world on policy-making as it relates to health care quality

Implementing culture change in health care: theory and practice

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Abstract

Objectives. To review some of the key debates relating to the nature of organizational culture and culture change in health care organizations and systems.

Methods. A literature review was conducted that covered both theoretical contributions and published studies of the processes and outcomes of culture change programmes across a range of health and non-health care settings.

Results. There is little consensus among scholars over the precise meaning of organizational culture. Competing claims exist concerning whether organizational cultures are capable of being shaped by external manipulation to beneficial effect. A range of culture change models has been developed. A number of underlying factors that commonly attenuate culture change programmes can be identified. Key factors that appear to impede culture change across a range of sectors include: inadequate or inappropriate leadership; constraints imposed by external stakeholders and professional allegiances; perceived lack of ownership; and subcultural diversity within health care organizations and systems.

Conclusions. Managing organizational culture is increasingly viewed as an essential part of health system reform. To transform the culture of a whole health system such as the UK National Health Service would be a complex, multi-level, and uncertain process, comprising a range of interlocking strategies and supporting tactics unfolding over a period of years.

Keywords: change management, leadership, organizational culture, quality improvement

The management of organizational culture is increasingly viewed as a necessary part of health system reform. In the United Kingdom, the latest National Health Service (NHS) reforms are based on the premise that a major cultural transformation of the organization must be secured alongside structural and procedural change to deliver desired improvements in quality and performance [1]. In the United States, in the wake of high profile reports documenting gross medical errors, policy thinking is embracing the notion of culture change as a key element of health system redesign [2], and there is evidence to suggest that many other OECD (Organisation for Economic Cooperation and Development) countries are focusing on cultural renewal as a potential lever for health care improvement [3].

Appeals for culture change in health systems draw upon a belief that culture is related to organizational performance. Some studies have suggested that culture might be an important factor associated with the effectiveness of a wide variety of organizations across a range of sectors [4–6], including health care. For example, health care cultures that emphasize group affiliation, teamwork, and coordination have been associated with greater implementation of continuous quality improvement practices [7] and higher functional health status in coronary artery bypass graft patients [8]. By contrast, organizational cultures that emphasize formal structures, regulations and reporting relationships appear to be negatively associated with quality improvement activity [9]. However, most studies suggesting a link between culture and performance are methodologically weak and their findings should be interpreted with caution [10].

If the nature of the relationship between culture and performance remains to be clarified, is it reasonable to plan

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interventions to instil those cultural attributes thought to underpin continuous performance improvement? This begs other questions, such as what is organizational culture? Are organizational cultures capable of being shaped by external manipulation? If so, what strategies are available to managers wishing to inculcate an appropriate organizational culture? In this article we aim to shed some light on these issues. We review key theoretical debates on the nature of organizational culture(s) and consider what practical strategies are open to health care organizations to implement culture change. The literature discussed formed part of a larger project, including a systematic review of literature on culture and performance in health care and non-health care settings [10–12,32]. The systematic literature search was conducted using Medline, CINAHL, Helmis, PsychLit, DHdata, and the database of the King's Fund in London, using the phrase 'organizational culture'. The information presented in this article is drawn from the systematic review, supplementary reading, and the advice of 30 experts in health services policy and management research in the UK and USA.

Organizational culture

1. Origins and development

There is little consensus among scholars over the precise meaning of 'organizational culture'. The term 'culture' is derived from the Latin, meaning to tend crops or animals [13]. Early in the last century social anthropologists applied a culture metaphor to describe processes of socialization through family, community, educational, religious, and other institutions [14]. The idea that an organization's effectiveness can vary as a function of its culture can be traced back at least as far as the Hawthorne studies [15] and related work. Those studies observed how the informal, social dimension of enterprise mediated between organizational structures and performance, and how those dimensions could be manipulated to affect employee effort and commitment. This interest in the organization as a social institution evolved into their study as microsocieties or -cultures [16]. In the post-war period, a number of researchers, including behavioural economists [17], industrial sociologists [18], and organizational psychologists, emphasized the importance of culture in shaping organizational behaviour. However, it was not until the 1980s that the concept entered mainstream management thinking via the influence of a number of best selling management handbooks, which popularized the notion that culture was a critical determinant of organizational performance [19–21].

We focus here on the implications of using culture change as a lever for performance improvement. However, we are aware of the limitations of the managerialist perspective and refer interested readers to a number of excellent scholarly publications that explore in-depth a range of theoretical stances and epistemological positions on the nature of organizational culture and the feasibility of managed culture change [22–24].

2. Conceptual frameworks

Organizational culture has been described as perhaps the most difficult of organizational concepts to define [25]. The management literature is replete with overlapping and competing definitions, a situation that has been referred to as 'an embarrassment of definitional riches' [22].

Conventionally the culture literature is divided into two broad streams [26]. One stream approaches culture as an 'attribute', something an organization 'has', along with other attributes such as structure and strategy. Another stream of literature regards culture more globally as defining the whole character and experience of organizational life, i.e. what the organization 'is'. Here organizations are construed as cultures existing in, and reproduced through, the social interaction of participants. Some scholars view the 'organization as culture' approach as but one of a range of paradigms used in organizational analysis. From that relativist perspective, a global definition of organizational culture may be termed as the 'culture as metaphor' approach.

The distinction between viewing culture as either an attribute, a defining quality, or a metaphor has important policy implications. The view of culture as an attribute has been instrumentally interpreted as an independent variable capable of manipulation to satisfy organizational objectives. From that perspective, culture change is viewed as a means to commercial or other technical ends and comprises a range of activities directed at 'overhauling' or 're-engineering' an organization's value system (Table 1). Much popular management literature adopts this approach. If, by contrast, organizations are approached as cultural systems, culture becomes the defining context by which the meaning of organizational attributes is revealed. Then, change agents are offered fewer levers to influence the formation of desirable cultures. Indeed the whole emphasis shifts from what organizations accomplish to a cultural anthropological understanding of how organizations are socially accomplished and reproduced.

These different conceptualizations generate rival claims as to the nature and feasibility of planned culture change. For the purposes of this paper we tread a middle path between the two dominant approaches by treating an organization's culture is an emergent property, concomitant with its status as a social institution [27]. By this definition, culture is not assumed *a priori* to be controllable. Instead we assume that its main characteristics can at least be described and assessed in terms of their functional contribution to broader managerial and organizational objectives.

3. Subcultures

The management literature on organizational culture has tended to assert a relationship between 'strong', unified cultures and commercial success. Yet observation suggests that few large, complex organizations are likely to be characterized by a single dominant culture. Moreover, there is no convincing evidence that a unitary culture yields higher performance than a pluralistic one. Where organizations are differentiated along clear occupational lines, as health care

Table 1 Key differences between approaches based on culture as an 'attribute' and culture as a 'metaphor'

	Culture as an attribute	Culture as a metaphor
Epistemological assumptions	Positivist	Phenomenological
Disciplinary base	Anthropology/biology	Social psychology
Theory of cultural cohesion	Single, coherent culture	Coexisting subcultures
Theory of organizational order	Provides an adaptive regulating mechanism to maintain status quo	Cultural conflicts can engender change
Creation and transmission of culture	Directed by actions of senior staff to change artefacts and espoused ideology	Reproduced by all culture members through their ongoing negotiation of symbols and artefacts
Culture change agents	Senior management only manipulate culture to meet corporate objectives	Managers, as well as other organization members, all seek to influence the cultural direction of the organization

organizations have traditionally been, a number of coexisting subcultures are likely to be identified. Subcultures may share a common orientation and similar espoused values, but there may also be disparate subcultures that clash or maintain an uneasy symbiosis [28]. Researchers have adopted two broad frameworks for studying organizational subcultures. The first defines subcultures relative to an organization's overall cultural patterns, especially its dominant values [28]. From this perspective, subcultures are classified in terms of whether they support, deny, or simply coexist alongside the values of the dominant culture (Figure 1). The second framework acknowledges that subcultures relate to occupational, departmental, ward, speciality, clinical network, and other affiliations. Arguably, these two perspectives need to be synthesized, as elements of both are likely to be found within an organization. For example, the NHS is a distinctly British institution with a recognizable overall identity and certain apparent core values. Within that overall 'NHS culture', a number of distinct subcultures can be discerned whose relationship to the overall organizational culture is hard to disentangle. These subcultures can be divided into a number of non-mutually exclusive categories (Figure 2).

Managing culture change

1. Reform or transformation

Culture change strategies may be targeted at either first order or second order change [29]. During first order change the objective is to 'do what you do better'. According to Deal and Kennedy [20] many commercial organizations have maintained a competitive advantage by pursuing a policy of 'cultural continuity', capitalizing on the lessons, traditions, and working practices that have served the organizational well over a period of time. There the focus is on evolutionary growth or quantitative reproduction and repetition (more of the same). In contrast, second order, qualitative growth (something different) is more appropriate if an existing culture has begun to stagnate and its complete overhaul is required [30]. Second order change is often invoked in response to a growing crisis or deficiency in the existing culture, which cannot be addressed adequately by a change *in* culture but rather demands a fundamental change *of* culture. If politicians and management gurus are to be believed, health systems in many countries stand perennially on the threshold of such fundamental change.

2. Developing strategies for cultural change

Various models to understand and guide culture change have been developed [22]. Bate highlights the key dimensions to be targeted in a culture change strategy, as follows [30].

The structural dimension. To be successful a culture change programme must take account of the nature of the culture to be changed. Only after an effective diagnosis or cultural audit has revealed how the current order is sustained can effective change management strategies be deployed. As Brooks and Bate maintain, many attempts at changing organizational cultures are strong on prescription but lamentably weak on diagnosis [31]. Such a diagnosis would proceed by first acquiring an appreciation of the currently prevailing culture. A range of quantitative and qualitative assessment tools have been developed to help decipher an organization's culture. These have been used extensively across different industries and settings, including health care organizations. However, these instruments should be used cautiously as there is wide variance in their established validity and reliability [32].

The process dimension. If cultures develop spontaneously, as an emergent model suggests, how they change is a key question. Bate [30] applies a sailing metaphor based on wave momenta to illustrate spontaneous change. If the latest cultural wave appears to be going in the right direction (a virtuous momentum) then it may be possible to ride the wave using its own energy to deliver the organization to its desired destination.

Complex organisations such as hospitals can be characterised as comprising a variety of co-existing subcultures. Three types of sub-culture can be identified vis a vis their organisational functionality.

i) *enhancing cultures*: these represent an organisational enclave in which members hold core values that are more fervent than and amplify the dominant culture. For example special hospital units which constitute centres of excellence.

ii) *orthogonal* cultures: an organisational enclave which tacitly accepts the dominant culture of the organisation whilst simultaneously espousing its own professional values. For example in the NHS clinicians allegiance to the Royal Colleges.

iii) *counter cultures*: an organisational enclave that espouses values which directly challenge the dominant culture. For example, clinical resistance to management diktat or the new contractual obligations and limitations on clinical freedom wrought by the rise of managed care in the US.

Figure 1 Classification of subcultures.

If the prevailing wave is not going in the desired direction, at least three alternative strategies are possible. First, to deflect waves using their own momenta (re-framing strategies). Secondly, to wait until the most powerful waves have subsided and then create new ones (new-wave strategies). And thirdly, to wait until a new wave is going in the desired direction and 'hitch a ride' (opportunistic strategies).

The contextual dimension. It is important to assess the 'fit' or alignment between a culture and the wider environment. As the external environment changes so must the internal culture to avoid obsolescence. This adaptive approach involves an assessment of 'cultural lag' or 'strategic drift' [33] to gauge the gap between the culture in use and the required culture. A number of highly critical reports on quality failings within the NHS have highlighted the need to reduce the dissonance between the prevailing culture of the NHS and broader societal changes occurring since its inception over 50 years ago [34].

3. Overcoming resistance to planned culture change

All strategies of culture change need to be mindful of the possible barriers that serve to block or attenuate purposeful change. Key sources of organizational inertia and resistance include:

Lack of ownership. As change often evokes a sense of loss [35], reactions to change by individuals or professional groups can be negative and unpredictable. Even a few disaffected individuals can cause disruption, whilst a disaffected workforce or professional grouping is a recipe for organizational disaster. The implication is that unless a critical mass of employees 'buy into' a culture change programme, such initiatives are likely to fail.

Complexity. Organization culture is transmitted and embedded via a wide range of media, including established working procedures and practices (e.g. rewards ceremonies, exemplary individuals, written documentation, physical spaces, professional demarcations, shift patterns). It is unrealistic to expect culture change strategies to be effective on all these fronts simultaneously. Successful strategies require realistic time frames to implement the types of complex and multi-level changes required. It would appear that the UK government's 10-year programme of reform for the NHS is a tacit acknowledgement that cultural transformation cannot be wrought overnight on an organization with such well established practices and values [36].

External influence. The influence of outside interests may cut across and sometimes work against efforts towards internal reform. Culture change strategies need to heed the constraints posed by external stakeholders in determining the values and behaviour of health professionals [37]. In the UK it is accepted that attempts to change the culture of the NHS may also need to target external bodies such as the Royal Medical Colleges, which exert control over training and influence the internalization of professional core values [38]. Similarly, research in Australian hospitals has shown that profession-based attitudes and beliefs have hampered the efforts of health authorities to promote more outcome-focused approaches to health care organization and management [37]. More widely, the Romanow Commission acknowledges the crucial importance for successful health care reform of working with, not against, core public values [39].

The United Kingdom National Health Service[1] comprises a rich mix of co-existing sub-cultures that may be structured by, occupation, department, speciality, ethnic and religious group, social class and other affiliations.

Ethnic

A significant proportion of NHS practitioners and patients are members of ethnic cultural groups and may bring distinctive values and expectations to the scene. These influences may lead to a different emphasis in the care delivered by different teams or individual staff to different patients, and to different expectations on behalf of patients.

Religious

Differing religious beliefs can also affect preferences about the kinds of health care offered and received. For example, some Catholics believe strongly in the sanctity of life of an unborn foetus, whilst Jehovah's Witnesses do not believe in accepting blood transfusions.

Class

Social class has long been recognised as a determinant of occupational culture. In the UK there is a strong relationship between entry into professions like medicine and socio-economic class. This may be an important factor in mediating relationship between doctors and nurses and doctors and patients.

Gender

The likelihood that masculine and feminine subcultures exist within NHS organisational culture is in part related to the distribution of the sexes within and between occupational sub-groups. That the medical profession is dominated by men and the nursing profession by women is well known. If the dominant values and aspirations held by a particular occupation are 'masculine' or 'feminine', it might be expected that those who are highly successful in that occupation would generally need to have internalised its dominant values, irrespective of their sex.

Occupational

Although they are associated in the common enterprise of delivery health care, NHS managers, doctors, nurses, therapists, clerks, porters, cleaners and other occupational groups each has a distinctive sense of identity and purpose. This arises from their specialised training and education, interaction with peers and other occupational groups, and the attitudes, beliefs and assumptions thus engendered.

Divisional/Specialism

The occupational groups comprising NHS organisations are sub-divided into services and specialisms: cardiology, oncology, gynaecology and obstetrics etc overlaid on the basic occupational culture, therefore we might expect each specialism to elaborate its own distinctive subculture based on the anatomic functions, diseases, procedures, complications and therapies which they customarily treat and apply.

[1] NHS, National Health System

Figure 2 Varieties of subculture in the UK National Health Service.

Lack of appropriate leadership. Leadership plays a central role in any cultural transformation. Inadequate or inappropriate leadership has been identified as a key factor when attempts to change culture fail [40]. Two main styles of leadership are widely recognized: 'transactional' leadership, based around securing organizational compliance and control by using material motivational factors like reward systems; and 'transformational' leadership processes, which inspire cognitive change by redefining the meaning of information to which organizational members are exposed (but not necessarily sensitized). Integrating these two styles is a necessary and challenging project. For example, it may be possible to

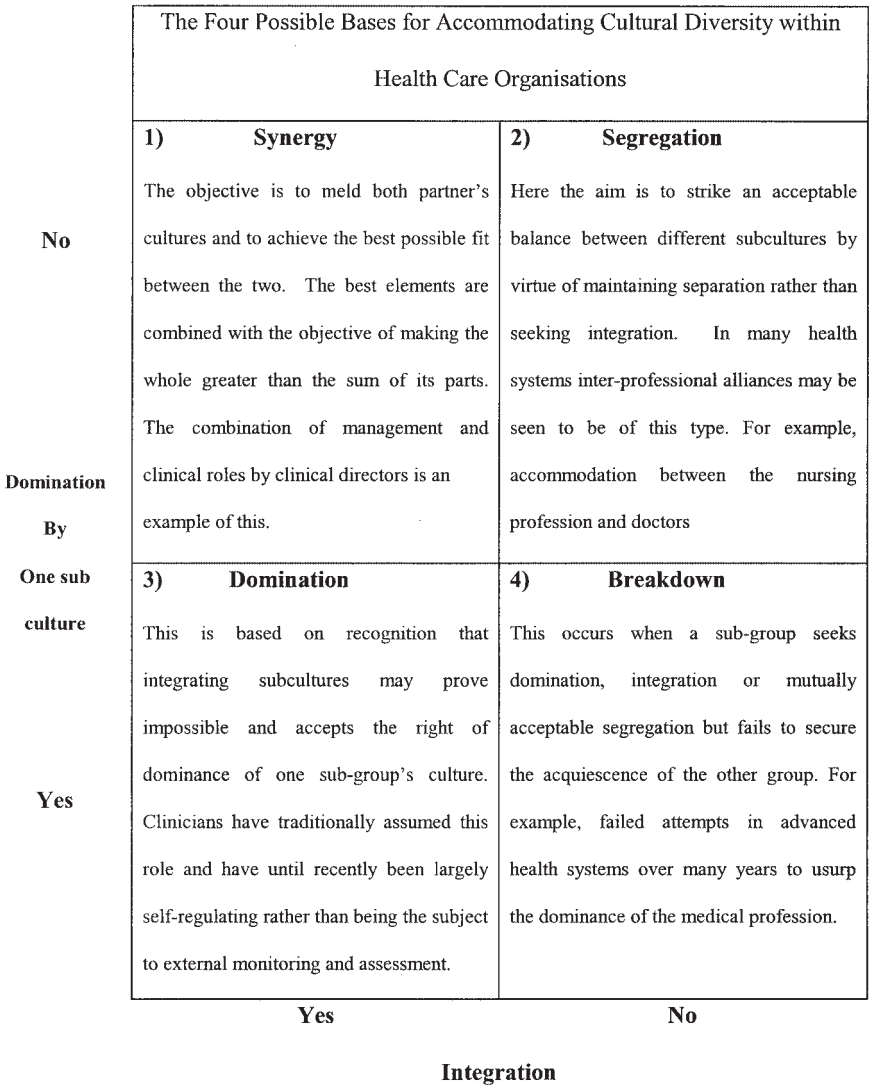

Figure 3 The meeting of cultures: achieving a cultural fit. Derived and expanded from a classificatory scheme on strategic alliances developed by Child and Faulkner [42] and based on original work by Tung [43]. Figure reproduced with permission.

manipulate employment to reward behaviour patterns appropriate to patient-centred care. But such a naive behaviourist (transactional) approach would be insufficient. Leadership is also required to help transform practitioners' cognitive apprehension of the status and relationships of participants in care-giving situations. In this way practitioners will not only be rewarded for appropriate behaviour, they will view their roles relative both to one another and to patients and their families in a different light. Thus, the patient-centred model of care is not just about modifying familiar behaviour, it is also about radically redefining participants' interpretations and experiences of health care. This cognitive behavioural or transformational approach to leadership defines cultural as opposed to structural organizational change [41].

Cultural diversity. As we have noted, health care organizations are likely to comprise competing and overlapping professional subgroups. Thus, a key challenge to culture change programmes is to consider carefully the impact of change on specific groups (e.g. doctors, nurses and other health professionals, and managers) and to design appropriate policies to accommodate this. Building on the work of Tung [43], Child and Faulkner [42] have developed a useful typology to assess approaches to managing organizational change in the face of cultural diversity. Their analysis is structured according to two fundamental choices. The first concerns whether one subgroup's culture should dominate. The second relates to the decision either to integrate different subcultures (in order to derive synergy between them) or to segregate the various subcultures (with the aim of avoiding conflict or efforts devoted to culture management). These strategic choices give rise to four possible bases for accommodating cultural diversity (Figure 3). The first three offer some scope for establishing

a cultural fit, whilst the fourth may give rise to serious dysfunctional consequences.

Dysfunctional consequences. In addition to, or instead of, driving beneficial outcomes, culture change policies may induce a range of unintended and dysfunctional consequences [44]. This is seen, for example, in the range of adverse behaviours generated by the rise of a performance management culture in the UK NHS [45]. For example, qualitative case study research has revealed that in addition to promoting constructive change, the increased emphasis on performance targets has resulted in: a concentration on areas that are measured to the detriment of other important areas, especially qualitative aspects of care that defy quantification (tunnel vision); the deliberate misrepresentation of data, including creative accounting and fraud (misrepresentation); a lack of ambition for quality and performance improvement brought about by a perceived 'satisfactory' league table ranking (complacency); and the concentration on short-term issues, to the exclusion of long-term criteria that may only show up in performance measures in many years' time (myopia). There are also fears that similar problems are emerging because of the culture of public reporting that has grown in the US [46]. Therefore, it is imperative that culture change policies are not monitored only in terms of the extent to which they foster constructive change, but also in terms of the perverse side effects that they inadvertently generate.

Concluding remarks

There is increasing international interest in managing organizational culture as a lever for health care improvement. Changing the organizational culture along with its structure has become a familiar prescription in health system reform. Nowhere is this more apparent than in the UK, where the centralized administration of the NHS has allowed opportunities for the national government to experiment with a 'top down' approach to instilling new values, beliefs, and working relationships. Yet planned culture change is a difficult, uncertain, and risky enterprise. Professional values, affirmed over centuries and woven into the fabric of health care organizations, are resilient enough to frustrate many attempts to 'engineer' change from above.

In this article we have sought to sharpen thinking around the theory and feasibility of culture change in health care. We have: (1) argued that organizational culture is a complex and contested terrain; (2) emphasized the importance of distinguishing between different types of subcultures; (3) highlighted the crucial role of leadership; and (4) outlined common barriers to culture change and suggested a variety of approaches to surmounting these. We end on a note of caution for those planning cultural reform: efforts targeted at culture change may not always generate the anticipated organizational outcomes. Indeed, experience in health care and other sectors suggests that such attempts have the potential to induce seriously dysfunctional as well as functional consequences.

Contributions

R.M. devised the study in conjunction with H.D. and M.M. T.S. conducted the literature review and wrote the first draft of the findings of the review. R.M. wrote the first draft of this paper and all authors contributed to subsequent drafts.

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