



Influence of organizational culture on quality healthcare delivery

Influence of
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Marie Carney

School of Nursing, Royal College of Surgeons in Ireland, Dublin, Ireland

Abstract

Purpose – The purpose of this paper is to identify if aspects of organizational culture may indicate a new terrain in the cultural influences-quality healthcare relationship. This research stems from the author's belief that viewing the role of head of department or directorate as pivotal to health care management is critical to health care planning and quality healthcare delivery.

Design/methodology/approach – Interviews were undertaken among 50 professional clinician and non-clinician managers working in the role of head of department, in acute care hospitals in Ireland. The sample was drawn from the total population of 850 managers, utilized in a previous survey study.

Findings – Organizational culture is more complex than was previously thought. Several cultural influences such as excellence in care delivery, ethical values, involvement, professionalism, value-for-money, cost of care, commitment to quality and strategic thinking were found to be key cultural determinants in quality care delivery.

Research limitations/implications – Health care managers perceive that in order to deliver quality focused care they need to act in a professional, committed manner and to place excellence at the forefront of care delivery, whilst at the same time being capable of managing the tensions that exist between cost effectiveness and quality of care. These tensions require further research in order to determine if quality of care is affected in a negative manner by those tensions.

Originality/value – Originality relates to the new cultural terrain presented in this paper that recognizes the potential of health service managers to influence the organizations' culture and through this influence to take a greater part in ensuring that quality health care is delivered to their patients. It also seems to be important that value-for-money is viewed as an ethical means of delivering healthcare, and not as a conflict between quality and cost.

Keywords Organizational culture, Quality of care, Health services, Managers, Quality costs, Ireland

Paper type Research paper

Literature review

The literature identifies the many and varied relationships between culture and health care. These relationships contribute to the multidisciplinary perspectives that assist us in reaching an understanding of culture and health (MacLachlan, 2006). MacLachlan (2006), in his exploration of the complexities of human experiences of health and illness across different cultures, talks of the need for a global health perspective, although he acknowledges that different cultural positions cloud the simplicity of this idea, thereby contributing to the complexity of providing optimal care to patients from differing cultural and ideological backgrounds. MacLachlan (2004) presents a further view on cultural themes, such as cultural sensitivity, migration and empowerment and he demonstrates how different cultural themes form the interplay between health and culture. This terrain is extensive and emerging and only a small part can be covered in this paper.



What does the word “culture” mean? MacLachlan (2006) says that the word has been so widely used that its meaning will vary from one situation to another. Kroeber and Kluckhohn (1952) in their review of the word “culture” found 150 definitions of the word. It is arguable that little consensus has been reached since then. Allen (1992) described seven ways to use the word “culture” that include generic and expressive uses, as well as holistic and pluralistic and MacLachlan (2006) takes a view that culture presents us with a set of guidelines for living. It is likely that Deal and Kennedy (1982) is taking this approach when they say that the culture of the organization is a critical driver of norms and the “way we do things around here”, that according to Saffold (1988) plays a powerful and pervasive role in shaping the life of the organization. Wickens (1995) believes that culture is constantly being reinforced through employees behaving in a similar manner to their colleagues through a complex communications process.

It is known that certain influences work together to form an organization’s culture. Thorne (2000) and Fasting (2004) argue that whilst divergent cultures work alongside each other in an organization, shared cultural values are often present and have been associated with commitment, self-confidence and ethical behaviour (Carney, 2006b). One such influence is the ethos or values of the organization. Inglehart and Baker (2000), in their study of world values that encompassed 65 societies on six continents, found that even in the presence of strong cultural changes occurring in those continental societies between 1981 and 1998, distinctive traditional values existed. Values are the “explicit and implicit elements of the care culture that serve to determine the individual’s action system” (Sarvimaki and Benko’s (2001), with emphasis being placed on the ethical dimensions of multi-professional health care delivery. These ethical dimensions encompass concepts such as accountability, responsibility, trust, and professional standards of care. Hewison (2001) in his study of National Health Services values writes that “the values of an organization are key factors that influence the way it is managed”, but he also acknowledges that there is not a single moral model or set of guidelines to assist in health care management.

In exploring this dimension of culture further it is evident that a value-laden influence in health care delivery is value-for-money. This demand causes conflict and unrealistic expectations of care delivery among clinicians (Carney, 2004a), and as a result it is likely that some clinicians misunderstand the ethical tension existing between cost efficiencies and quality-of-care. Carney (2004a), in a study of 50 Directors of Nursing, found that the conflict existing between value-for-money and excellence in care delivery was an important barrier to clinical effectiveness. Other identified ideologically based conflicts in health service management include access to services, equity in delivery of care, managing risk, safety and healthcare reliability (Attree and Newbold, 2009; Riley, 2009) and caring approaches to care delivery (Carney, 2002). A compounding factor is that clinician values may be at variance with the perceived values and ethics of senior management in the areas of efficiency and cost effectiveness (Carney, 2004b). It appears that the new health service cost-effectiveness culture has yet to be accepted by some professionals (Thomas and Dunkerley, 1999), although a study undertaken in Finland found that the concepts for efficiency and cost effectiveness have been adopted by health professionals (Viitanen *et al.*, 2007).

Warburton (2009) acknowledges that tough decisions need to be made with limited resources, but equally so that applying strict cost effectiveness measures mean that

interventions such as safety and quality may not be implemented or may be compromised. In Britain a seven-step process is being taken to create a safety culture (NPSA, 2004) thus encouraging staff to report when things go wrong by looking at “what” went wrong rather than “who” did it. Attributing causation to systems is far more time consuming than blaming individuals and less costly than blaming the system, and consequently inappropriate blame culture results (Merry and Peck, 1995; Reason, 2004). Armitage (2009) puts forward the view that as the dominant health care culture remains predominately grounded in medicine, healthcare remains reluctant to feeling comfortable in acknowledging practitioners’ infallibility. Safety culture refers to a commitment to safety that should pervade the entire organization where risk is managed more effectively (Attree and Newbold, 2009). These authors also report that risk, error, adverse events and critical incidents are ever present in health care delivery and serve to undermine safety and quality and also that quality, safety and reliability levels in health care are not as high as they should be (Attree and Newbold, 2009). Therefore, understanding the bias resulting from values conflict such as cost versus quality is required by health care managers (Hoffman and Ventresca, 1999; Wade-Benzoni *et al.*, 2002).

Healthcare organizations are values driven and consequently strive for excellence in meeting the needs of their patients in a caring, healing, quality focused and safe environment (Carney, 2002). Developing a culture of healthcare safety is a global priority whereby open reporting where adverse events are reported, analyzed and learned is needed (NPSA, 2004). Kearsey (2003) found that a correlation existed between healthy workplace environments and healthy patients. Miller *et al.* (2009) say that technical and team competence are both necessary competencies needed to achieve high reliability in order to ensure safe patient care. Thus, clinical managers are well placed to deliver ethical health care, due to their professional background, that is firmly grounded in ethics and values and safe care, and because of their understanding of the ethical conflicts that can occur in health care delivery (Hewison, 2001; Thorne, 2000; Pulce, 2002; Carney, 2006b).

A further factor, highlighted in the literature, is on how culture influences involvement in planning care delivery. A study by Floyd and Wooldridge (1992a) of 259 managers, in 25 mainly for-profit organizations, found that middle managers were involved in strategic planning. Strategic thinking is an important component of professionals’ work so that they can respond to the challenging trends occurring in health service delivery. Carney (2002, Carney, 2006a, 2007) supports the importance of professionals becoming strategic thinkers and in proposing and developing new strategic initiatives for the organization, thereby assisting in shaping organizational culture. There is a requirement for professional clinicians and non-clinicians to know and understand the mission of the organization, and to have clear and focused strategic direction. Thus, senior managers need to invest time and effort to ensure that middle manager strategic thinking is developed and that organizational strategy is known and understood by them, thereby ensuring strategic planning occurs at this level (Ferlie and Pettigrew, 1996).

Aim of study

To identify if aspects of organizational culture may indicate a new terrain in the cultural influences-quality healthcare relationship.

Method

Sample

A sample of 50 health care professional managers, working in the role of head of department in Ireland, was undertaken. The sample was drawn from the total population of 850 managers working in acute care hospitals, utilized in a previous survey study (Carney, 2002). The random selection procedure in SPSS was utilized to select the sample of 50 respondents for interview. The sample was drawn from both clinicians and non-clinicians. Clinicians included nurses, radiographers, physiotherapists, social workers and doctors and non-clinicians were heads of finance, pathology, accounts, human resources and service delivery.

Data collection

Data were collected during the period May – July 2005 through telephone interviews that ranged from 0.45-0.60 minutes in duration. Questions asked during the interviews were identified from the literature as contributing to organizational culture and quality of care. Questions were broadly related to the perceptions of respondents in relation to:

- cultural influences within the organization;
- involvement in strategy development;
- value systems in place in the organization;
- influence of commitment;
- the meaning of quality to individuals;
- linkages between cost containment and quality in service delivery; and
- linkages between culture and quality.

Data analysis

Data analyses were completed in September 2005. Qualitative methods of analysis, that focused on attempting to understand the complexity of respondents and that attempted to build a picture of a phenomenon of interest within the context of their work in the healthcare environment, were undertaken. This qualitative exploratory study relied upon individual interviews to obtain information and perceptions not accessible to the same depth through the quantitative survey method previously undertaken amongst the population of 850 health care managers in Ireland. The study was designed to obtain the participant's views on the cultural influences contributing to quality health care delivery. All interviews relied upon a topic guide, comprising open questions that allowed for comparable information to be obtained from all participants and which allowed sufficient flexibility to capture context and every-day differences and therefore the locus of control lay with participants. The literature review and previous research in the areas informed the type of questions posed.

Content analysis enabled systematic, objective exploration of the material and identification of relevant themes. All interviews were tape-recorded and transcribed verbatim. Themes, underlying ideas behind the words spoken, or concepts implicit in and recurring throughout the data were extracted, and units of analysis were identified (Wilkinson, 1995). Thematic analysis summarized and synthesized discrete ideas to create a picture from the words collected in the study, thus allowing sense to be made

of complex material (Weber, 2004). Categories were established by examining the data for recurrent words, concepts, themes and patterns (Huberman and Miles, 2002). Themes were then grouped into constructs thus clarifying and finally forming the main themes (LoBindo-Wood and Haber, 2002). Data saturation occurred when no new information was being generated. Two independent university lecturers were asked to examine the coded interviews and to relate themes to findings and to confirm that they were able to follow the decision trail of the researcher. Agreement was high with convergence on overall coding categories. This process ensured conformability.

Ethical dimensions

Ethical approval was obtained from the university where the researcher was based during the study. Respondents gave their approval to participate in the study. Other considerations included confidentiality, transcribing, rigor, audibility and credibility. To achieve rigor a homogenous sample was sought in order to establish applicability in overcoming bias in sample selection. Thus, the sample was made up of equal numbers of clinicians and non-clinicians.

Findings

The themes and sub-themes identified in the research are presented in Table I.

Theme 1: excellence in care delivery

The highest ranking and most consistent theme identified as a key determinant of the organizations' culture was excellence in care delivery. This was perceived as resulting in patient safety, low risk, high standards, and commitment to quality-focussed excellence. Excellence in health care delivery was perceived:

- as an ethical issue that health care professionals were directly responsible for providing;
- the care they delivered impacted on their patients in a positive or negative manner; and
- failure to provide service of the highest quality of excellence resulted in patient dissatisfaction with the services they provided and lack of trust in them as professionals.

A typical remark made to identify excellence was the importance of:

[...] commitment to patients, quality improvements based on evidence [and] respect for staff and colleagues and the importance of providing quality patient care through shared governance and respect for all staff members (Nurse manager).

[...] we need to be aware that our clients will very quickly become very dissatisfied with the service we offer if it is not of the high standard that they expect from us (Nurse manager).

Theme 2: ethical values

The second-highest ranked theme identified as a key determinant of culture, was ethical values; indicated by trust, integrity, caring, loyalty, compassion, justice, quality, advocacy and dignity. Participants believed that they delivered, and are

Themes	Sub-themes
Theme 1: excellence in care delivery	Patient safety High standards Commitment to quality
Theme 2: ethical values	Trust Integrity Caring Loyalty Compassion Justice Quality Advocacy Dignity
Theme 3: strategic involvement	Involvement Access for managers Collaboration Lack of trust Roles and responsibilities Teamwork
Theme 4: cost versus quality	Budget conscious Cost effectiveness Ideology differences
Theme 5: professionalism and commitment	Expertise Appreciation Respect Recognition Role commitment Organizational commitment
Theme 6: strategic planning and thinking	Political awareness Professional roles Socialization into role Big picture approach Learning pathways Multidisciplinary team approaches Education

Table I.

responsible for healthcare management, that is based upon values already existing within the professions, and which has emanated from their sense of professionalism and desire to deliver care to the highest standard possible. This sense of ethical moral and self was found to be present in both professional clinicians and non-clinicians. Some believed that a sense of cognitive dissonance existed between their value system and that of their organization's culture that may be focused on value-for-money and efficiencies. This was evident by the following typical remarks:

We strive for excellence in meeting the holistic needs of our patients in a caring healing environment in which the contribution of each staff member is valued. The values of human dignity, compassion, justice, quality [and] advocacy guide us in our work (Nurse manager).

[. . .] sometimes our patients expect more of us and do not tolerate sloppy work or when we forget to do what they ask . . . that is not excellence (Physiotherapist).

Theme 3: strategic involvement

Strategic involvement, identified as a key determinant of culture, highlighted the fact that clinicians strive for involvement. A sense that they were being excluded from the strategic decision-making process was perceived as leading to isolation and lack of strategic involvement in decisions being made at the higher levels within their organizations. Some perceived that clinicians deliberately excluded themselves from the decision-making process due to perceived time constraints on their time, shortage of staff and a lack of trust in senior managers. Participants talked about:

[...] our role in client advocacy is a professional role, but because of our lack of strategic involvement in this role we are not adequately addressing this, as our professional and clinical responsibilities very often take precedence over our strategic management roles. We often opt out as a result and this cannot be good for our patients. We are letting them down (Medical administrator).

Clinicians recognized the need to avoid making excuses for non-involvement in the strategic process, and talked about the need to become more involved, particularly in decisions concerning care delivery. There was the sense that this level of strategic involvement could be enhanced and developed further and that managers often felt isolated in their work and from the decision-making process. A typical comment highlights this lack of involvement:

We think we are not involved. But why is this? We should stop the learned helplessness mode that some professional clinicians adopt. I think this is an excuse for not wanting to get involvement in strategy development (Nurse manager).

Theme 4: costs versus quality

The fourth most common theme, identified as a key determinant of their organizations culture, was that of cost versus quality in healthcare delivery. Participants believed that difficulty did exist in relation to measuring costs, efficiencies, effectiveness, and of the best and most efficient way of doing. Because of the difficulty in measuring and valuing health care output tensions exist between cost of care and quality of care delivered. Differing ideology amongst professionals in relation to cost of care is an ongoing debate even though all managers involved in the delivery of care have the same aim. Differences in ideology regarding care delivery, responsibility for budgets and how clinicians perceive their role in management is evident from the comments printed below:

Clinicians see their role as taking care of the patients and not managing, and expect the budget to be there for what they want (Head of finance).

[...] all that senior managers think about is budgets and saving money. How can we ever reach consensus when this attitude is there (Medical administrator).

[...] clinicians, particularly medical staff, very often do not consult with us in the delivery of services (Head of service delivery).

Theme 5: professionalism

Professionalism and recognition of expertise were identified as key determinants of culture. Respondents agreed that there was a requirement to identify their areas of

expertise, and to have an appreciation that this expertise provided them with a critical asset in seeking strategic involvement from senior managers and from non-clinician managers. Professionalism was also perceived as conferring benefits on patients in relation to the quality of care delivered. Commitment to the role and to the organization was found to be important aspects of professionalism. Professional clinicians said that they need recognition from senior managers that they possess expertise, that their work is meaningful and that they are working in an effective manner. A lack of trust by clinicians in the non-clinician's role contributed to this view.

Professionals frequently expressed the view that:

Our commitment to our work and to our patients could be appreciated more sometimes (Social worker).

I think that respect for our management work is accepted by senior managers, but I also think that our professional expertise and experience are not always appreciated and we are not involved when strategic decisions are being made. I do not believe we are even invited to meetings where strategy is being developed (Pathologist).

The need for clinicians to be able to merge their professional and management roles was seen as a priority by them. They explained that both elements of the role, the management and the professional, are now required and that there is a great need for professional development in order to be able to achieve the resources that clients need and deserve. There was also recognition that professional clinicians need to justify service delivery outcomes, yet the mechanism for achieving these outcomes remains unclear. They talked about the need for teamwork:

In order to be more involved in the strategic direction of the organization we need to join together with other groups and set up multidisciplinary teams but we don't know how to set about this or what the composition of those teams should be (Senior social worker).

Theme 6: strategic planning and thinking

The need for strategic planning and strategic thinking were identified as key determinants of culture. The importance of multidisciplinary cohesion and the need for development and educational programmes in the areas of strategy development, budgeting and leadership were identified. Political awareness was recognized as important in cultural development. Respondents perceived that there is a need for political awareness and astuteness in policy matters and recognition that the professional role and the socialization process into the profession that professional clinicians have undergone does not adequately prepare them from a political or strategic perspective. This was placed within the context of the changing, and cost focused nature of health service delivery: comments related to the socialization process undergone by professionals. Typical comments were:

[...] we are not ready for the roles we have to undertake. Our socialization process during our training did not prepare us well enough [and therefore] we know very little about strategy, budgeting or finance (Nurse manager).

[...] we need help to understand the cost focused nature of health service delivery (Medical doctor).

[...] the need to understand the mission of the organization, and to be able to incorporate this into the planning of services [this] must be seen as a priority (for clinicians) (Service manager).

The need for the development of professional networks, preferably of a multidisciplinary nature, in order to disseminate information regarding strategic thinking within various healthcare organizations, was recognized:

[...] the strategic process requires greater transparency and fairness, and if this were to be put in place, it would contribute to both groups [clinicians and non-clinicians] seeking greater involvement, and would result a higher level of strategic consensus all round (Social worker).

The need for development and educational programs in the areas of strategy development, budgeting and leadership were identified by clinicians in order to provide them with a more confident and assertive approach to the strategic issues affecting the delivery of services. Typical comments were:

[...] we need learning pathways so that the expectations of all health care professionals are met. Things that could help are net working and professional groupings. We also need to do more reflection on practice (Nurse manager).

[...] discussion between different professional groupings on multi and interdisciplinary working and how to have more innovative approaches to care delivery would be good learning pathways (Physiotherapy manager).

[...] we need more education programmes that teach us about budgets, strategy and working together. Clinicians are not good at this (Nurse manager).

There was discussion on the importance and need for cohesion between professionals. Typical comments focused on:

[...] work outcomes and outputs are perceived as resulting in sound interpersonal relationships, empowerment and broad consensus (Occupational therapist).

[...] discussion and challenge are welcomed, and partnership in decision-making is very often present, although not always (Pathologist).

Discussion

Several cultural influences were identified that appear to indicate new cultural aspects that have the potential to influence the delivery of quality health care. The first cultural determinant identified was excellence in care delivery.

Theme 1: excellence in care delivery

Excellence in care delivery was the primary focus of participants, as signified by the importance to them of delivering high quality care in a safe environment, and of maintaining their patients' trust. This theme is highlighted by Magill and Prybil (2004) who say that health care professionals need to demonstrate to the public the importance to them of ensuring that the highest standard of care is delivered to their patients, as failure to provide service of the highest quality will result in consumer dissatisfaction with the services provided. Cooper *et al.* (2004), in two studies undertaken in 2002 among 2,000 members of the American Nurses Association (ANA) and in 2000 with the American Organization of Nurse

Executives (AONE) members, identified “quality of service” or “failure to provide service of the highest quality owing to economic constraints determined by the organization”, and “failure to provide service of the highest quality consistent with the standards of the nursing profession” as the two most important ethical issues encountered during the course of their work.

According to Magill and Prybil (2004), healthcare organizations need to work harder at regaining the respect, confidence and trust of disheartened patients, diminishing over a period of years through unsafe practices. Safety in care delivery is an important cultural determinant. Riley (2009) says that healthcare is not a safe industry and unintended patient injury in health care is high and quality is low, and he recommends that interdisciplinary teamwork training will ensure greater patient safety. Simpson and Knox (2000) concur saying that increased patient safety would result if basic principles of teamwork and high reliability systems; this is an organization that has measurable-near-perfect-performance for quality and safety (Riley, 2009), were more widely introduced into clinical units. Reason (2000) recommends that models to reduce human error are needed. Theme 2 is presented below.

Theme 2: ethical values

Several cultural values were identified as contributing to the delivery of high quality care. These are trust, integrity, caring, loyalty, compassion, justice, quality, advocacy and dignity. Fasting (2004) argues that organizations should “build on the moral fabric of the health professions, stimulate the ethical knowledge that resides within them [...] [and that] this is not value-based management from above, but management based on, and developed from the values already existing within the professions”. Bishop and Scudder (1987, 2001) say that because all healthcare team members have the same moral commitment to patients they promote co-operative moral decisions in healthcare delivery. Hartrick Doane (2002) views ethics as a personal process that is lived in the complexity and ambiguity of everyday nursing work, yet Redman and Fry (2000) argue that little is known about nurses’ ethical conflicts.

Watley and May (2004), in their study of 314 professional managers, found that it was individual managers and not the organization that determined the organization’s ethical direction, and that health care organizations require a moral or ethical code of practice. Cooper *et al.* (2004) argue that health care organizations have become more accountable to the expectations of stakeholders such as Trust Managers in Britain and the Health Service Executive in Ireland. This accountability raises ethical issues for health professionals resulting in the collision of “clinical ethics and organizational ethics” (Carney, 2006b). Hemingway and Maclagan (2004) argue that there are difficulties in establishing if values held are personal or organizational, and they question whether both merge in time through rational choice.

Carney (2002) in a study of 860 professional healthcare managers in Ireland found that health care clinicians and non-clinicians demonstrate a range of values in the delivery of health care that are often at odds, thus demonstrating lack of trust in each other’s moral and ethical value system and she asks if this merging occurs in order to achieve compromise or consensus. Healthcare professionals have a moral code, or tacit ethical sense embedded in their psyche through their education and training into their discipline (Fasting, 2004; Carney, 2004b, 2007). However, this value system requires refinement to include thinking in a strategic manner. This means incorporating into

their knowledge base values-laden, financial, economic and quality focused initiatives, thereby contributing to a safe environment for patients. Involvement and commitment were identified as influencing culture.

Theme 3: strategic involvement and commitment

Strategic involvement and commitment were identified as important cultural determinants in delivering high quality care. Participants expressed the view that strategic involvement would only be achieved if there were access to senior management; as a result collaboration and participation in strategic decision-making would be encouraged and fostered. Teamwork was identified as being important to achieve this aim. Comments indicate that participants often lacked a sense of collaboration and trust in each others' roles and responsibilities. Meehan (2003) recommends trustworthy collaboration between nurses and doctors in service delivery, but this is not happening according to Norris (2009) who says that healthcare professionals are very well practiced at working together but have rarely been trained in teamwork or given the tools to develop as a team. Respondents recognized this dichotomy. There are a number of approaches available to help develop team-working skills that Healey *et al.* (2006), Mishra *et al.* (2007) and Lingard *et al.* (2005) say will help to improve the areas of team climate and team culture.

The process of strategic involvement requires commitment to implementing the goals of the organization. Commitment to the organization influences strategic involvement (Carney, 2002; Dooley and Fryxell, 1999). If professionals are initially involved in the development of strategy they will direct their efforts and exercise a higher level of commitment to the strategy (Floyd and Wooldridge, 1992a, 1992b; Carney, 2004a). This commitment leads to understanding of, and acceptance of strategy, and to more effective and efficient delivery of services to consumers (Dutton *et al.*, 1997; Carney, 2002) in addition to a culture where health care managers are routinely involved in decision-making regarding health care choices. The fourth theme relates to cost and quality.

Theme 4: cost versus quality

Participants recognized cost versus quality issues in delivering high quality care as important cultural determinants. It was also noted that differing ideology existing between clinical and non-clinicians in relation to approaches to cost effectiveness, resulted in conflicting approaches to care. The importance of being budget conscious and having a cost effectiveness approach to care delivery were emphasized. Current health care changes require all managers to be aware of senior manager expectations in relation to cost versus quality. This challenge is mainly due to the inherent difficulties in determining with any degree of accuracy the outputs from healthcare (Badger, 1999; Tod *et al.*, 2002; Meulenbergs and Schotsmans, 2004; Carney, 2006b). Outputs of healthcare can be defined either as the amount of care provided or the health that results from it (Wells, 1999; Morris *et al.*, 2007). However, even the most carefully considered, strategically planned and prioritized healthcare "will buckle when confronted with certain ethical imperatives" (Morris *et al.*, 2007, p. 358). For example the rule of rescue will inevitably be dominated by the need for cost-effectiveness

(Hadorn, 1991). This example highlights the ethical tensions that may face professionals in the future.

Conflict may arise in health care management as a result of differing ideology amongst professionals relating to how care should be delivered and the costs incurred as a result of such types of care (Carney, 2006b, 2007). Resolution of such differences requires professionalism in approach as well as knowledge of the areas of negotiation, conflict resolution, financial management and cost effectiveness. Some divergence of strategic opinion does exist in relation to ethical values held by professional clinicians and it appears to be important to ensure that ethical dilemmas such as cost of care versus quality of care delivery and cost cutting are resolved through dialogue, thus supporting the notion that it is the cultural environment that influences quality of care delivered (Leino-Kilpi, 1990; Sarvimaki and Sandelin Benko, 2001; Carney, 2004a). It therefore seems to be important that value-for-money is viewed as an ethical means of delivering healthcare, and not as a conflict between quality and cost.

Theme 5: professionalism

Professionalism was identified as a cultural determinant to high quality care delivery. The main cultural influences identified were political awareness, professional roles and socialization into the role. The need for appreciation, recognition and respect for the professionals' level of expertise in delivering care was highlighted and conversely the perception that lack of appreciation leads to dissatisfaction and low morale. This latter response is supported by Kuokkanen and Leino-Kilpi (2000), Kuokkanen *et al.* (2007) and Corbally *et al.* (2007) who identified the moral principles of shared values and shared care philosophy as promoting high morale and staff empowerment. Carney (2002) found that if shared strong ethical values are absent within an organization this absence will contribute to dissatisfaction and poor morale amongst healthcare workers. Maxwell (2007) says that the key to improving nurses' satisfaction is to mentor them (Bally, 2007), help them to recognize that they possess expertise, that their work is meaningful and that they are working in an effective manner. McNicholl *et al.* (2008) in exploring a Culture Index in the UK, identified the importance of staff having knowledge and skills bases to improve clinical practice. Parahoo (2000) said that a fundamental premise is that nurses feel they have autonomy and ownership of their practice.

The need for political awareness and astuteness in policy matters by health service professionals were also recognized. It appears that the professional role and the socialization process into-the-profession that professional clinicians undergo did not adequately prepare them from a political or strategic perspective. Clinicians should promote their strengths and capitalize on these strengths and this means becoming more politically aware and coming forward with their opinions and views on how health care should be delivered (Carney, 2006b, 2007).

There appears to be conflict of opinion in relation to the role of the clinician and non-clinician by each other in relation to strategy development. Participants agreed that a greater level of multidisciplinary working as well as greater openness and transparency in the workings of each group would enhance decision making and care delivery. Trust in each other's capabilities, respect for the expertise and professionalism of both groups, and the acceptance that the aim of both is the delivery of excellence in patient care, is recognized by them. Inter-professional

education and learning will promote those relationships. There is need for learning pathways for health care professionals in order that the expectations of all concerned in care delivery are met. Pathways such as net working and professional groupings where reflection on practice is undertaken are needed. Multi and interdisciplinary discussion and collaboration on new and innovative approaches to care delivery may prove to be effective learning pathways.

Theme 6: strategic planning and thinking

Strategic planning and thinking were identified as cultural determinants in quality care delivery. The importance of health professional adopting a multi-disciplinary approach to the “big picture” in the delivery of health care was highlighted. This view is endorsed by Currie (1999), when in researching the planning process of a 3,000-bed acute general hospital in Great Britain, concluded that middle managers, through involvement in the strategic process that incorporated strategic thinking, enjoyed an enhanced role and added value to the organization in terms of quality care delivery. Carney (2002) in her study of consensus in health service management concurs. However, Fyffe (2009) argues that even though much has been achieved in positioning nurses as an influencer of policy, there is need for greater co-ordination of actions to ensure that nursing is actively supported in influencing and shaping health care policy. Findings from this study indicate that all healthcare professionals will benefit from such support.

Limitations to study

Due to the subjective nature of the concepts identified findings may vary across healthcare managers depending on their orientation and discipline. However, themes extracted were consistent across all respondents and are more likely to be generalizable across the healthcare sector, than not. Replication in other areas would be useful. Limitation of qualitative analysis is that errors of judgment in over representing or under representing elements of the population in the sample can occur, but it will tend to balance out, as with any non-probability sample, the ability to generalize is very limited (LoBindo-Wood and Haber, 2002). The sample size was 50. If a larger sample size was utilized this could result in stronger findings to back up themes or it could result in additional themes being generated.

Conclusion

The aim of this study was to identify if aspects of organizational culture may indicate a new terrain in the cultural influences-quality healthcare relationship. This was found to be the case. Excellence in patient care delivery that is allied to positive value systems delivered through a multi-disciplinary team approach and utilizing strategic involvement, were the most important organizational cultural influences reported for optimum effectiveness in quality care delivery. The cultural aspects identified are well known themes in care delivery as stand-alone concepts. When these aspects are found collectively within an organization it appears that they have the potential to influence the quality of care delivered.

References

- Allen, T. (1992), "Taking culture seriously", in Allen, T. and Thomas, A. (Eds), *Poverty and Development in the 1990s*, Oxford University Press, Oxford.
- Armitage, G. (2009), "Human error theory: relevance to nurse management", *Journal of Nursing Management*, Vol. 17 No. 2, pp. 212-7.
- Attree, M. and Newbold, D. (2009), "Risk, safety and reliability. From cult to culture?", *Journal of Nursing Management*, Vol. 17 No. 2, pp. 145-50.
- Badger, T.G. (1999), "Quality management within a cost constrained service", *Journal of Nursing Management*, Vol. 7, pp. 323-9.
- Bally, J.M.G. (2007), "The role of nursing leadership in creating a mentoring culture in acute care environments", *Nursing Economics*, Vol. 25 No. 3, pp. 143-57.
- Bishop, A. and Scudder, J. (1987), "Nursing ethics in an age of controversy", *Advances in Nursing Science*, Vol. 9 No. 3, pp. 34-43.
- Bishop, A. and Scudder, J. (2001), *Nursing Ethics: Therapeutic Caring Presence*, 2nd ed., Jones and Bartlett Publishers, Boston, MA.
- Carney, M. (2002), "A strategic consensus model for not-for-profit organizations", unpublished PhD thesis, Smurfit Graduate School, University College: Dublin.
- Carney, M. (2004a), "Middle manager involvement in strategy development in not-for-profit organisations: the director of nursing perspective – how organisational structure impacts on the role", *Journal of Nursing Management*, Vol. 12 No. 1, pp. 13-21.
- Carney, M. (2004b), "Perceptions of professional clinicians and non-clinicians on their involvement in strategic planning in health care management: implications for interdisciplinary involvement", *Nursing and Health Sciences*, Vol. 6 No. 4, pp. 321-8.
- Carney, M. (2006a), "Understanding organisational culture: the key to successful middle manager strategic involvement in health care delivery?", *Journal of Nursing Management*, Vol. 14, pp. 23-33.
- Carney, M. (2006b), "Positive and negative outcomes from values and beliefs held by health care clinician and non-clinician managers", *Journal of Advanced Nursing*, Vol. 54 No. 1, pp. 1-9.
- Carney, M. (2007), "Developing strategic consensus amongst clinician and non-clinician managers in health service organizations", *Journal of Nursing Management*, Vol. 15, pp. 649-58.
- Cooper, R.W., Frank, G.L., Hansen, M.M. and Gouty, C.A. (2004), "Key ethical issues encountered in healthcare organisations", *JONA*, Vol. 34 No. 3, p. 149.
- Corbally, M.A., Scott, A.P., Matthews, A., MacGabhann, L. and Murphy, C. (2007), "Irish nurses' and midwives' understanding and experiences of empowerment", *Journal of Nursing Management*, Vol. 15 No. 2, pp. 169-79.
- Currie, G. (1999), "The influence of middle managers in the business planning process: a case study in the UK NHS", *British Journal of Management*, Vol. 10, pp. 141-55.
- Deal, T.E. and Kennedy, A.A. (1982), *Corporate Cultures: The Rites and Rituals of Corporate Life*, Addison-Wesley, Reading, MA.
- Dooley, R.S. and Fryxell, G.E. (1999), "Attaining decision quality and commitment from dissent: the moderating effects of loyalty and competence in strategic decision-making teams", *Academy of Management Journal*, Vol. 42 No. 4, pp. 389-402.
- Dutton, J.E., Ashford, S.J., O'Neill, R.M., Hayes, E. and Wierba, E.E. (1997), "Reading the wind: how middle managers assess the context for selling issues to top managers", *Strategic Management Journal*, Vol. 18 No. 5, pp. 407-25.

- Fasting, U. (2004), "Editorial comment", *Nursing Ethics*, Vol. 11 No. 1, p. 4.
- Ferlie, E. and Pettigrew, A. (1996), "Managing through networks: some issues and implications for the NHS", *British Journal of Management*, Vol. 7, Special Issue, pp. S81-S99.
- Floyd, S.W. and Wooldridge, B. (1992a), "Middle management involvement in strategy and its association with strategic type: a research note", *Strategic Management Journal*, Vol. 13, Special Issue, pp. 153-67.
- Floyd, S.W. and Wooldridge, B. (1992b), "Managing strategic consensus: the foundation of effective implementation", *Academy of Management Executive*, Vol. 6 No. 4, pp. 27-39.
- Fyffe, T. (2009), "Nursing shaping and influencing health and social care policy", *Journal of Nursing Management*, Vol. 17 No. 6, pp. 698-717.
- Hadorn, D. (1991), "Setting healthcare priorities in Oregon: cost effectiveness meets the rule of rescue", *Journal of the American Medical Association*, Vol. 265 No. 17, pp. 2218-25.
- Hartrick Doane, G. (2002), "In the spirit of creativity: the learning and teaching of ethics in nursing", *Journal of Advanced Nursing*, Vol. 39 No. 6, p. 521.
- Healey, A.N., Undre, S. and Vincent, C.A. (2006), "Defining the technical skills of teamwork in surgery", *Quality and Safety in Health Care*, Vol. 15 No. 4, pp. 231-4.
- Hemingway, C.A. and MacLagan, P.W. (2004), "Managers' personal values as drivers of corporate social responsibility", *Journal of Business Ethics*, Vol. 50 No. 1, pp. 33-44.
- Hewison, A. (2001), "Values in the National Health Service: implications for nurse managers", *Journal of Nursing Management*, Vol. 9 No. 253, pp. 253-8.
- Hoffman, A.J. and Ventresca, M.J. (1999), "The institutional framing of policy debates: economics versus the environment", *American Behavioural Scientist*, Vol. 42, pp. 1368-92.
- Huberman, M.B. and Miles, A.M. (2002), *The Qualitative Researcher's Companion*, Sage, Newbury Park, CA.
- Inglehart, R. and Baker, W.E. (2000), "Modernization, cultural change and the persistence of traditional values", *American Sociology Review*, Vol. 65, pp. 19-51.
- Kearsey, K. (2003), "Your work your health: whether patient or health care provider: a healthy workplace is key to well being", *Registered Nurse Journal*, Vol. 15 No. 1, pp. 16-19.
- Kroeber, A.L. and Kluckhohn, C. (1952), "Culture: a critical review of concepts and definitions", Harvard University Peabody Museum of American Archaeology and Ethnology Papers 47, Cambridge, MA.
- Kuokkanen, L. and Leino-Kilpi, H. (2000), "Power and empowerment in nursing: three theoretical approaches", *Journal of Advanced Nursing*, Vol. 31, pp. 235-41.
- Kuokkanen, L., Suominen, T., Rankinen, S., Kukkurainen, M-L., Savikko, N. and Doran, D. (2007), "Organizational change and work-related empowerment", *Journal of Nursing Management*, Vol. 15 No. 5, pp. 500-7.
- Leino-Kilpi, H. (1990), "Good nursing care: on what basis?" *Annales Universitates Turkuensis, Series D*, 49, Turun yliopisto, Turku.
- Lingard, L., Espin, S. and Rubin, B. (2005), "Getting teams to talk: development and pilot implementation of a checklist to promote inter-professional communication in the OR", *Quality and Safety in Health Care*, Vol. 14 No. 5, pp. 340-6.
- LoBindo-Wood, G. and Haber, J. (2002), *Nursing Research: Methods, Critical Appraisal and Utilization*, Mosby, St Louis, MO.
- McNicholl, M.P., Coates, V. and Dunne, K. (2008), "Driving towards an improved research and development culture", *Journal of Nursing Management*, Vol. 16, pp. 344-51.

- MacLachlan, M. (2004), *Embodiment: Clinical, Critical and Cultural Perspectives on Health and Illness*, Open University Press, Milton Keynes.
- MacLachlan, M. (2006), *Culture and Health*, 2nd ed., John Wiley & Sons, Chichester.
- Magill, G. and Prybil, L. (2004), "Stewardship and integrity in health care: a role for organisational ethics", *Journal of Business Ethics*, Vol. 50 No. 3, pp. 225-38.
- Maxwell, N.A. (2007), "Shaping humane healthcare systems", *Nursing Administration Quarterly*, Vol. 31 No. 3, pp. 195-201.
- Meehan, T. (2003), "Careful nursing: a model for contemporary nursing practice", *Journal of Advanced Nursing*, Vol. 44 No. 1, pp. 99-107.
- Merry, A.F. and Peck, D.J. (1995), "Anaesthetists, errors in drug administration and the law", *New Zealand Medical Journal*, Vol. 108, pp. 185-7.
- Meulenbergs, T. and Schotsmans, P. (2004), "Ethics committees reform in Belgium", *Nursing Ethics*, Vol. 11 No. 3, pp. 310-2.
- Miller, K., Riley, W. and Davis, S. (2009), "Identifying key nursing and team behaviours to achieve high reliability", *Journal of Nursing Management*, Vol. 17 No. 2, pp. 247-55.
- Mishra, A., Catchpole, K., Dale, T. and McCulloch, P. (2007), "The influence of non-technical performance on technical outcomes in laparoscopic cholecystectomy", *Surgical Endoscopy*, Vol. 22 No. 1, pp. 68-73.
- Morris, S., Delvin, N. and Parkin, D. (2007), *Economic Analysis in Health Care*, John Wiley & Sons, Chichester, p. 358.
- National Patient Safety Agency (NPSA) (2004), *Seven Steps to Patient Safety: A Guide for NHS Staff*, NPSA, London.
- Norris, B. (2009), "Human factors and safe patient care", *Journal of Nursing Management*, Vol. 17 No. 2, pp. 203-11.
- Parahoo, K. (2000), "Barriers and facilitators of, and research utilisation among nurses in Northern Ireland", *Journal of Advanced Nursing*, Vol. 31 No. 1, pp. 89-98.
- Pulce, R. (2002), "Organisational culture", *Seminars for Nurse Managers*, Vol. 10 No. 3, p. 47.
- Reason, J.T. (2000), "Human error, models and management", *British Medical Journal*, Vol. 320 No. 7237, pp. 768-70.
- Reason, J.T. (2004), "Beyond the organizational accident: the need for 'error wisdom', on the frontline", *Quality and Safety in Health Care*, Vol. 13, Supp. II, pp. ii28-ii33.
- Redman, B. and Fry, S. (2000), "Nurses' ethical conflicts: what is really known about them?", *Nursing Ethics*, Vol. 7 No. 4, pp. 360-6.
- Riley, W. (2009), "High reliability and implications for nurse leaders", *Journal of Nursing Management*, Vol. 17 No. 2, pp. 238-46.
- Saffold, G.S. III (1988), "Culture traits, strength, and organizational performance: moving beyond 'strong' culture", *Academy of Management Review*, Vol. 13 No. 4, pp. 546-58.
- Sarvimaki, A. and Sandelin Benko, S. (2001), "Values and evaluation in health care", *Journal of Nursing Management*, Vol. 9 No. 129, pp. 129-37.
- Simpson, K.R. and Knox, G.E. (2000), "Strategies for developing an evidence-based approach to perinatal care", *The American Journal of Maternal and Child Nursing*, Vol. 24 No. 3, pp. 122-31.
- Thomas, R. and Dunkerley, D. (1999), "Careering downwards? Middle managers' experiences in the downsized organization", *British Journal of Management*, Vol. 10 No. 2, pp. 157-69.

-
- Thorne, M.L. (2000), "Cultural chameleons", *British Journal of Management*, Vol. 11 No. 4, pp. 325-39.
- Tod, A.M., Nicolson, P. and Allmark, P. (2002), "Ethical review of health service research in the UK: implications for nursing", *Journal of Advanced Nursing*, Vol. 40 No. 4, pp. 379-86.
- Viitanen, E., Wiili-Peltola, E., Tampusi-Jarvala, T. and Lehto, J. (2007), "First-line nurse managers in university hospitals – captive to their own professional culture?", *Journal of Nursing Management*, Vol. 15 No. 1, pp. 114-22.
- Wade-Benzoni, K.A., Hoffman, A.J., Thompson, L.L., Moore, D.A., Gillespie, J.J. and Bazerman, M.H. (2002), "Barriers to resolution in ideologically based negotiations: the role of values and institutions", *Academy of Management Review*, Vol. 27 No. 1, pp. 41-57.
- Warburton, R. (2009), "Improving patient safety: an economic perspective on the role of nurses", *Journal of Nursing Management*, Vol. 17 No. 2, pp. 223-9.
- Watley, L.D. and May, D.R. (2004), "Enhancing moral intensity: the roles of personal and consequential information in ethical decision-making", *Journal of Business Ethics*, Vol. 50 No. 2, pp. 105-26.
- Weber, R. (2004), *Basic Content Analysis*, 2nd ed., Sage, Newbury Park, CA.
- Wells, J.S.G. (1999), "The growth of managerialism and its impact on nursing and the NHS", in Norman, I.J. and Cowley, S. (Eds), *The Changing Nature of Nursing in a Managerial Age*, Blackwell Science, Oxford, pp. 57-81.
- Wickens, P.D. (1995), *The Ascendant Organisation: Combining Commitment and Control for Long-term, Sustainable Business Success*, Macmillan Business, Basingstoke.
- Wilkinson, J. (1995), "Direct observation", in Breakwell, G.M., Hammond, S. and Fife-Schaw, C. (Eds), *Research Methods in Psychology*, Sage, London.

Corresponding author

Marie Carney can be contacted at: mariecarney@rcsi.ie