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ORIGINAL RESEARCH

Assessing the cultural character of an academic department of family medicine

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KEYWORDS:
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Abstract
OBJECTIVE: The purpose of this study, conducted in 2007, was to assess and explore the applicability and usefulness of the organizational culture of a Department of Family Medicine.
MATERIALS: As part of a faculty development exercise, we administered a 14-item survey developed by Goffee and Jones to 51 individuals within the Department of Family Medicine. The instrument assesses four aspects of organizational culture: Networked, Communal, Fragmented, and Mercenary.
RESULTS: Respondents tended to align mostly within the Communal and Fragmented quadrants. Clinical faculty members showed a much higher degree of Fragmented and Mercenary cultural characteristics compared with the nonclinical faculty. Nonclinical faculty plotted in a distribution along the Communal and Networked cultures, with a single respondent in the Mercenary quadrant. Residents from group A plotted mostly in the Networked and Communal cultures quadrants, with three members in the Fragmented culture position and one member in the Mercenary culture position. Residents from group B plotted in the Communal culture quadrant, with one individual falling in the Networked culture quadrant and one individual in the Fragmented culture quadrant.
CONCLUSIONS: The higher degree of Fragmented and Mercenary cultural characteristics of the clinical faculty compared with the nonclinical faculty was hypothesized to be related to the general disenchantment resulting from the sum of specific extrinsic and intrinsic factors described in this article. Traits characterized by low sociability and solidarity will be detrimental to both patient care and the development of well-rounded competencies in learners. Sociability is an essential attribute of the human condition, and its presence in any community of employees will only enhance feelings of security, attitudes toward the support of higher performance levels, and overall happiness. Given that, it is likely that Departments with Communal cultures are best suited to perform at a higher level of productivity and dynamics, thus driving them closer to excellence.
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Attaining the goal of improving the quality of medical care for the public logically begins with providing high-quality medical education to today's medical students, our future physicians. Medical educators confront numerous challenges as they strive for excellence in the education and training of the physicians of tomorrow.[1] These challenges are multifaceted, containing elements of institutional, economical, and social factors, thus mandating faculty to find effective and novel ways of developing strong organizational and leadership skills. To help faculty members overcome these challenges, they need to come together as a team. It appears, though, that at times they lack the skills or knowledge necessary to engage in teamwork, including

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striving toward a shared vision and mission. This paper will examine an attempt to help achieve these goals by assessing the cultural ambiance and providing feedback to the faculty within a Department of Family Medicine on the nature or character of its organizational culture.

In this study, an instrument designed to measure organizational culture was used to assess the cultural characteristics of a family medicine department to provide both leadership and faculty members' critical information needed to facilitate the changes for the achievement of a more effective and efficiently functioning academic department.

Background

Defining culture

Several definitions of culture have been offered in the literature. Hofstede[2] stated: "Culture is the collective programming of the human mind that distinguishes the members of one human group from those of another." Culture in this sense is a system of collectively held values." As quoted by Brown,[3] Edgar Schein defined culture as " . . . the deeper level of basic assumptions and beliefs that are shared by members of an organization that operate unconsciously and define in a basic 'taken for granted' fashion an organization's view of its self and its environment."

For this study, culture may be viewed as the "group personality" resulting from people's interactions over time. Culture takes on a persona—a "life of its own"—in that it guides behavior and generates agreements surrounding confrontations. Leaders must recognize the characteristics of their organizational culture before embarking on the complex task of leading change. To interact successfully and promote changes within a defined group, leaders must identify these elements of culture and understand the dynamics they exert within a culture.

To further understand culture, we need to depart from the notion that culture is determined collectivity *via* an intrinsic need to communicate at different levels. It should be understood that communication can have mere superficial meaning or entail a deeper connotation where words, actions, and expectations become part of a specific meaning for the group such as rituals for meetings, greetings, reprimands, and other group processes. Symbols are created playing a role to remind the group of their culture, helping them to distinguish their group from others. Specific behavioral rules evolve that serve to propagate and explain the shared meanings within the group.

Culture in medicine

Identifying the cultural characteristics of an organization is an essential component of the preparation for the change process. Academic departments are known to resist change and Family Medicine is not exempt from this resistance.[4,5]

A study published in 2004 identified positive organizational culture characteristics within a community health center medical practice environment.[6] These characteristics were indicated to be substantially cultivated by specific values, attitudes, behaviors, and relationships among employees in the environment. The categories of culture in the practice environments studied included: (1) Community mission and values, (2) leadership and organizational dynamics, (3) workplace relationships, and (4) physical space. The culture in the practices studied proved essential for the promotion of employees' spirit, the quality of patient care, and enhancement of the overall process of clinical care.

Change in organizations

Other research has explored the tensions resulting from cultural change implemented by organizational leaders. A 1991 report identified successful strategies used by departments of family medicine.[7] This study also identified the methods and skills considered to be important by the leaders of these departments. The authors of this study discussed the problematic issue of change relating to cultural conflict between the worlds of clinical care and organizational leadership. A case study was provided of organizational cultural change, facilitated through a physician leadership development program. Common themes among the successful departments of family medicine studied were: (1) Recruiting and mentoring the best faculty, (2) building a reputation for clinical excellence of faculty and residents, (3) becoming part of institution-wide curriculum activities, (4) establishing a scholarly presence, and (5) developing networks of support. The authors concluded that their locally developed physician leadership program can be extremely effective at both improving physicians' leadership skills and increasing understanding of the strategic goals and direction of the organization.

Swick recommends embracing change and molding academic medicine to intertwine with the business orientation of health care.[8] To achieve this synthesis, Swick suggests that an open dialogue should be established between academia, government, the health care industry, and the public. The dialogue must emphasize: (1) managing change rather than resisting it by focusing on the positive aspects of change, while reaffirming fundamental professional values of medicine and medical education; (2) making it clear to all stakeholders the need to balance all of the various roles required of them; and (3) fostering professionalism by increasing medical schools' emphasis on faculty development by ensuring that schools keep an appropriate balance between the science and the art of medicine, and by faculty who model appropriate professional values for their students. These three factors point to the need of developing new ways to better evaluate and, when needed, intervene in the organizational culture of medical settings. Based on these recommendations, this study applied a model of organizational culture as described by Goffee and Jones.[9]

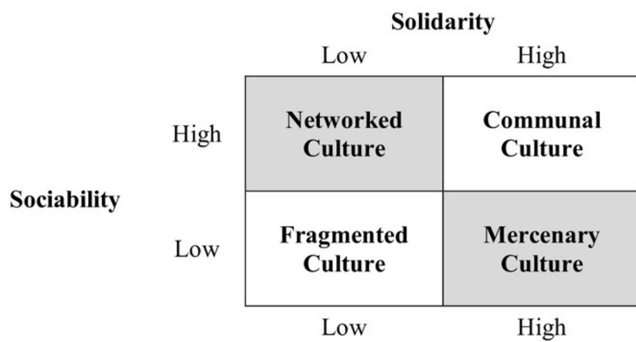


Figure 1 Double-S Model.

The Goffee and Jones Cultural Model

In this approach, Goffee and Jones[9] have reduced culture to two dimensions—sociability and solidarity. They define solidarity as the degree to which people share tasks and mutual interests and think similarly. In solidarity, logic is the main driving force behind decisions made by individuals. Esteem and mutual concern for others are the main forces motivating their performance in sociability. The main driving forces in decision-making processes are emotion and social concerns.

High sociability is considered "people-based," whereas low sociability places a greater emphasis on the focus of accomplishing tasks.

They note that there are negative and positive forms of each element. Positive solidarity results in a job done efficiently and effectively. Negative solidarity, which does not value other people, can produce high levels of internal conflict or excessive/inappropriate self-interest. Positive sociability is a condition where people help one another to be successful. Negative sociability is characterized by the covering up of other people's errors, and it tolerates poor performance in the name of friendship or "saving face."

These factors are graphically described by the Goffee and Jones Double-S Model (Fig. 1). It is a two-by-two matrix identifying four distinct cultures that are dependent on levels of solidarity and sociability.

Communal culture

The communal culture is characterized by both high sociability and solidarity, leading to open spaces, highly visible corporate symbols, a focus on face-to-face communications, and situations in which persuasion is often used. People who value both high levels of sociability and solidarity typically identify with company values.

Networked culture

The networked culture is one identified by high sociability and low solidarity. Physical spaces are open, including social areas with wall decorations such as photos that are typically separated into marked spaces to identify individual territories, especially in negative forms. Members prefer to engage each other at informal meetings and make great use of e-mail and telephone communications. Particular attention to communicating the "right" way is emphasized. Socializing occurs during work hours as people identify with one another.

Mercenary culture

In the mercenary culture type, there is low sociability and high solidarity, leading to functional work spaces that are designed to do the job and little more. Displays of awards and recognitions are rare, yet the concept of winning is valued. Talk is short and focused, argument is confrontational, and long hours are spent working.

Fragmented culture

The fragmented culture has low sociability and low solidarity in which people have private offices or work from home. There is little interpersonal talk or communication, and when it occurs, it is focused on specific topics. Most communications are directed to people outside of the organization. Members prize individualism and freedom.

Methodology

The purpose of this current study was to assess the organizational culture of a medical school Department of Family Medicine using a survey (Appendix) developed by Goffee and Jones.[10] Furthermore, this study explored the applicability and usefulness in analyzing the cultural dynamics of an academic department. This study obtained approval from the university's institutional review board for human subject use within the context of faculty development.

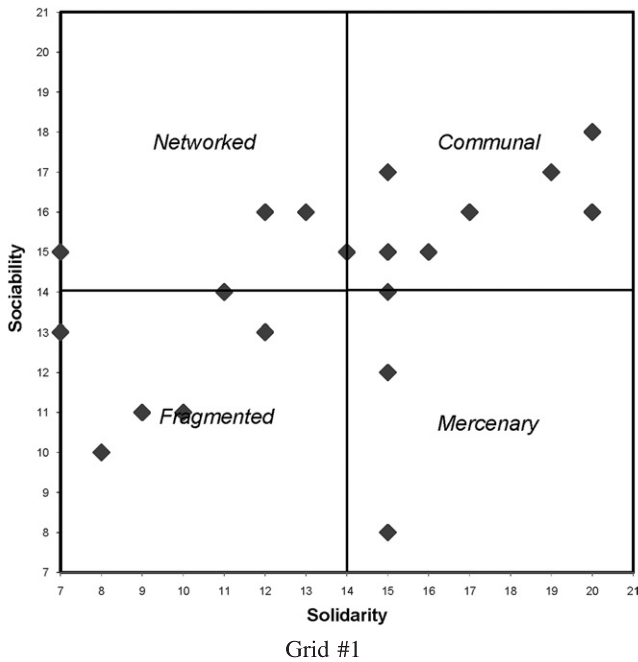
To assess the cultural characteristics of individuals within organizational groups, Goffee and Jones developed a 14-item survey (Appendix) based on their Double S Model. The instrument was distributed to all faculty members at a departmental meeting and the completed surveys were collected a week later.

Subjects

The subjects included clinical faculty (physicians) and nonclinical faculty (medical educators and behavioralists) and resident physicians from two different hospital-based family medicine residency programs.

Data analysis

A total of 51 individuals completed the instrument. This comprised of 9 clinical faculty, 12 nonclinical faculty, and 30 resident physicians from two different programs (Residency A: n = 18, Residency B: n = 12). The



Grid #1

individual answers to each of the 14 survey questions determines the level of endorsement for each of the two cultural dimensions. This endorsement is further identified as belonging to one of the four cultural characteristics previously described. For each question, the respondent answers by selecting one of three choices: low, medium or high. Values are: 1 = low, 2 = medium, and 3 = high. Questions 1 to 7 measure the concept of *sociability*; its score is the sum of the value for each of the choices answered. The same process is repeated for questions 8 through 14, which measure the concept of *solidarity*.

Each respondent's score for solidarity and sociability is plotted on a two-by-two grid shown in Fig. 1. To examine group culture, all respondent scores are plotted on a single grid. With our group, scores were calculated from the 51 subjects and illustrated on the following grids.

The values that plotted equally between the cultural quadrants were considered to represent traits of two or more cultures and therefore were counted as belonging to two or more cultures.

Results

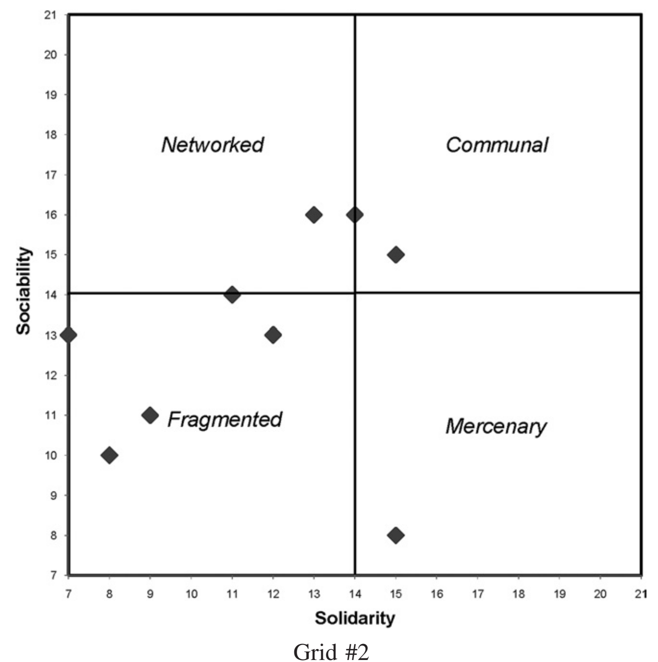
As shown in Grid #1, all faculty members tended to align mostly within the communal and fragmented quadrants. Clinical faculty (Grid #2) showed a much higher degree of Fragmented and Mercenary cultural characteristics compared with the nonclinical faculty (Grid #3). Nonclinical faculty plotted in a distribution along the Communal and Networked cultures, with a single respondent in the Mercenary quadrant.

Residency A (Grid #4) plotted mostly in the Networked and Communal cultures quadrants, with three members in the Fragmented culture position and one member in the Mercenary culture position. Residency B (Grid #5) mostly plotted in the Communal culture quadrant, with one individual falling in the Networked culture quadrant and one individual in the Fragmented culture quadrant.

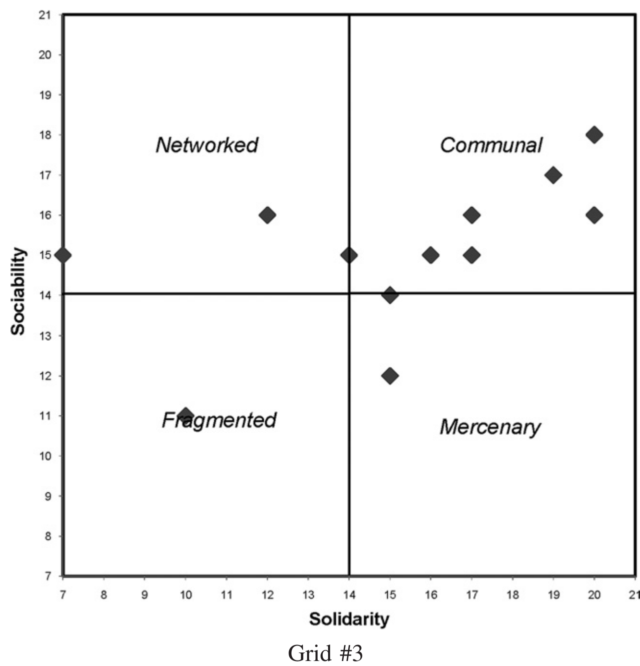
Discussion

The higher degree of fragmented and mercenary cultural characteristics of the clinical faculty compared with the nonclinical faculty was hypothesized to be related to the general disenchantment resulting from the sum of extrinsic and intrinsic factors. External factors of importance are the lack of control on decision making when caring for patients, the inability to provide prompt access to specialty care, fragmented continuity of care, perceived lack of prestige among other specialties, poor reimbursement, and overall feeling of belonging to a specialty whose viability is seriously threatened. Internal factors include cultural factors like uncertainty in the future role and identity as clinical teachers, lack of common values and bonding as a community of educators with common goals, and attitudinal and affective needs that remain unmet.

Most of the nonclinical faculty members are educators and behavioralists by training who specialize in adult medical education. Their responsibilities are framed into the design of educational tools and strategies for curricular improvement and in the evaluation of competencies in both medical students and residents, which may account for their majority plotting in the Communal and Networked culture quadrants.



Grid #2



Grid #3

The Goffee and Jones Cultural Model identifies cultural attributes that contribute to the effectiveness of a team as proportional to the degree of Solidarity and Sociability characterized by the team. Solidarity cultural attributes will determine the reliability of the team. Medical care and medical education are strongly based in team efforts. Traits characterized by low sociability and solidarity will be detrimental to both patient care and the development of well-rounded competencies in learners. Sociability is an essential attribute of the human condition, and its presence in any community of employees will only enhance feelings of security, attitudes toward the support of higher performance levels, and overall happiness. Given that, it is likely that Departments with Communal cultures are best suited to perform at a higher level of productivity and dynamics, thus driving them closer to excellence. According to Goffee and Jones,[9] the presence of Networked and Mercenary individuals yields a balanced distribution on the overall cultural traits, given that these two cultural types offer positive values: Networked individuals are rich in sociability but deficient in solidarity traits and are therefore more emotional supporters than collaborators, whereas Mercenary individuals are high in solidarity and less in sociability and are therefore the opposite of Networked individuals. Fragmented individuals are at a higher risk of not contributing at all to the dynamics and productivity of the department because they lack both solidarity and sociability. Fragmented cultural traits isolate and disengage individuals from a team.

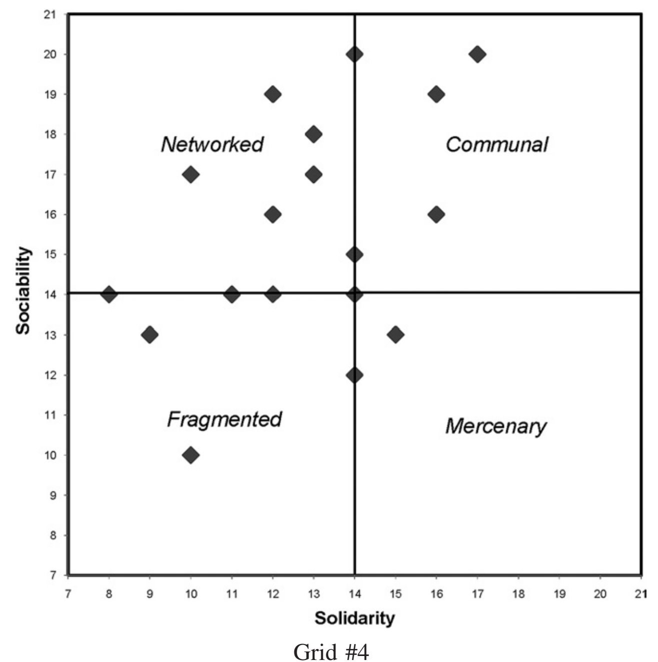
The evaluation of organizational culture traits gained in this study was used in defining and implementing change within this academic department. The following guidelines will be considered in the planning and implementation of departmental change:

- Department's culture should be encouraged within the Communal (positive solidarity and positive sociability) frame of culture.
- Culture should be continuously assessed, analyzed, and communicated to all members.
- A continuum of processes should be developed that encourage the culture's positive solidarity and sociability traits.
- Cultural values identified as deviations from the promoted ones should be redirected before they become a permanent feature of the culture.

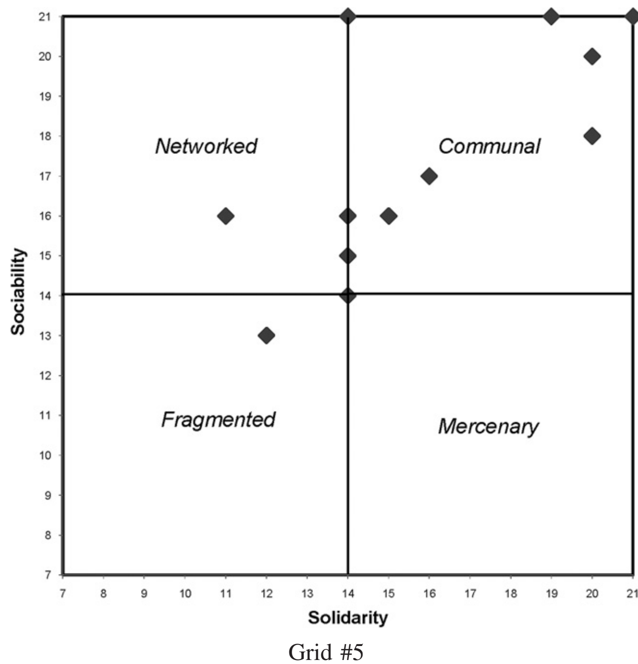
Conclusions

Departments of family medicine in academic centers must continue to ensure the future scope and quality of family practice patient care and general medical education, the ongoing evolution of family medicine as a scholarly discipline, and a continued flow of qualified medical school graduates into family practice residency programs and eventually into practice.

Change is rapidly becoming an integral component of health care improvement. To implement change effectively, it is necessary to provide clear vision, leadership, and adequate time to develop followers. Consistent integration of changes in practice to promote positive outcomes is known as an essential continuum for successful and dynamic health care. Change must be, at all times, parallel to quality improvement interventions.[2] The development of primary care depends on high-quality leaders who are able to draw on a range of different management skills and styles. Change leaders are most likely to be effective if they appreciate the



Grid #4



Grid #5

merits and drawbacks of their different styles and are willing to work in partnership.[1]

Implications

Academic physicians can be helped to develop leadership skills to face and embrace transformational change. Studies have supported and encourage the use of leadership development programs that includes the components of careful curriculum design, program monitoring, and opportunities to apply new skills in practice. This organizational transformational change effort can be successfully achieved with faculty development programs oriented to professional growth and organizational leadership.[3]

Academic medicine faces unprecedented challenges, especially the impact of the changing and more business-oriented health care system on medical education. There is an inherent clash of values between business and medicine: among key business values are profit and competition, whereas among the traditional values of the medical profession are service, advocacy, and altruism. Business interests have already gained a central place in medicine, so the challenge has become how to use the positive elements of the entrepreneurial spirit to enhance professional values and advance academic medicine's central enterprise. In 1998, Swick concluded that although change inevitably brings challenge and a sense of loss, it also brings the opportunity to help reshape medical education to meet the needs of society.[8]

To be truly effective, academic family physicians must possess skills as both educators and as leaders. Effective curriculums result in educational programs that are likely to be successful, achieve established goals, and meet expectations of the learners. Establishing effective leadership results in individuals who feel valued for their opinions, empowered to act independently, and accountable for setting and achieving personal goals. The academic environment provides an excellent framework for the development of approaches and strategies to task change and to lead in a rapidly changing, challenging health care environment. Family physicians training students and residents have the great responsibility of perfecting and using educational and leadership skills to positively contribute to the organizational effectiveness of their departments.

In today's health care environment, a number of organizational, economic, and social factors are presenting new challenges to primary care medicine. How those changes are addressed relates proportionally to the degree of positive solidarity and sociability found in the culture of the specific department. A culture characterized by negative solidarity and sociability traits will eventually become a culture of fragmentation.

In large part, the future of primary care departments resides in the strength and knowledge of their faculty. Encouraging faculty interactions conducive to a higher degree of functionality is of paramount importance. Leaders of change should constantly assess the status of their organization's culture and develop ideas and strategies to enrich their departmental culture, perhaps through the quest to enhance solidarity and sociability.

Organizational and leadership development occur in the context of both academic and clinical teaching domains. In this case, the use of faculty development programs could serve as an effective vehicle to provide the backbone for faculty professional development, which in the long term could provide faculty with the framework to interact successfully at a higher level of performance. The reshaping of a department's culture can only take place when problems and deficits are seen as opportunities, and when faculty members, including leaders, can accept those deficiencies and embrace renewal.

Once faculty members have introspectively analyzed their department's culture, and once the tools to think strategically are in place, the organization values will start moving toward the direction of positive solidarity and sociability. The culture can then emerge to a stronger position, ready to face the challenges of change.

Overall, the result suggests that how cultural changes are addressed could be directly proportional to the degree of positive solidarity and sociability found in the culture of the specific department. A culture characterized by negative solidarity and sociability traits will eventually become a culture of fragmentation.

Appendix

WHAT IS YOUR ORGANIZATION'S CULTURE?
Goffee and Jones (1996)[10]

	LOW	MEDIUM	HIGH
Please answer these questions based on your perception of your organization. Check the box that best reflects your view.			
1. People here try to make friends and to keep their relationships strong.			
2. People here get along very well.			
3. People in our group often socialize outside the office.			
4. People here really like one another.			
5. When people leave our group, we stay in touch.			
6. People here do favors for others because they like one another.			
7. People here often confide in one another about personal matters.			
8. Our group (organization, division, unit, team) understands and shares the same business objectives.			
9. Work gets done effectively and productively.			
10. Our group takes strong action to address poor performance.			
11. Our collective will to win is high.			
12. When opportunities for competitive advantage arise, we move quickly to capitalize on them.			
13. We share the same strategic goals.			
14. We know who the competition is.			

SCORING: Low = 1 Medium = 2 High = 3

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