



Conceptualizing the Relationships between Organizational Cultures, Nurse Leaders and the Nurse Practice Environments: A Historical Perspective

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Abstract

This paper explores the relationship between organizational cultures, nurse leaders and nurse practice environments from a historical perspective.

Introduction

In an article entitled, *From Tall Poppies to Squashed Weeds: Why Don't Nurses Pull Together More*, Farrell [1] concluded that it was not only the alleged misogyny intrinsic to oppression or feminist theory that shackled and impeded nurses, but nurses themselves who in their everyday work and interpersonal interactions, act as insidious gatekeepers to an iniquitous status quo [1]. Nursing shortages are created by these external as well as internal barriers, and cannot be stopped by either viewing them as merely 'endemic to modern organizational life' or by blaming all of the discipline's schisms upon its outside forces [2,3].

Nurses should recognize that historically; the continual recruitment, retention, work environment and image concerns that the discipline has faced are not caused solely by those barriers copiously identified in the available literature which exist external to the profession, such as a lack of political power, funding, sexism or even the institutionalization of health care. They also are being created by the inability of Nursing's leadership to deal with the barriers within the profession and to some extent by embracing the existing institutional culture.

Modern Problem or Status Quo

A poll of 5,679 senior leaders from 77 US based companies revealed that the reason they determined to join, stay with or leave a company was: *values and culture* [Italics added] (fifty-eight percent), freedom and autonomy (fifty-six percent), exciting job challenges (fifty-one percent), well managed (fifty percent) and career advancement (thirty-nine percent) [4,5]. For nurses in practice today the major reason cited for dissatisfaction was a lack of autonomy and poor management. *Oddly enough, culture and values often were either not identified as a factor or not addressed.* The responses generated from both older as well as younger nurses in this study validate what

is happening nationwide. According to the US Department of Health and Human Services, nurses may constitute the most dissatisfied profession in the US today [6]. Slightly more than two-thirds of registered nurses (sixty-nine point five percent) reported being even "moderately satisfied" with their jobs [6]. Reporting recent changes in the *industry* [italics added], a survey done by the Nursing Executive Centre reported that fifty-one percent of all registered nurses stated that they were less satisfied with their jobs than they had been just two years earlier [7].

Hospital staff nurses had the lowest satisfaction (sixty-six percent) than any other type of nurse when analyzed by place of work. Numerous studies by those within as well as without the profession have focused on the multiple frustrations facing nurses such as, "feeling exhausted and discouraged, powerless to affect the change necessary for safe, quality patient care and feeling frightened for themselves or their patients" [8-10]. Yet while nurse dissatisfaction is endemic, survey after survey also reports that nurses would like to continue working as nurses if job conditions were improved, many stating that they would stay, and many others who have left nursing altogether stating that they would consider returning if certain conditions were met. Among these conditions are better compensation, an improved work environment, better hours and more respect from management; nurses with no plans to leave also echo many of these same sentiments [11,12]. What is perhaps most telling about this condition is that the business issues of compensation and better work hours have been repeatedly cited and addressed since 1948, to positive effect, at least in the short term. However, though the 'humanization' of the institutional setting has also been cited since before 1948, little or no sustained positive change has been forthcoming in regards to the cultural issues of respect and a morally inhabitable work environment [13,14].

Nursing's crisis issues, namely recruitment, retention and public image, cannot be halted solely by gaining political knowledge, socio-economic clout or by embracing science and technology over humanitarian aims. Unfortunately, some nurse administrators within the system have bought into the ethos of the existing 'crisis-prone' management style of the establishment. They manage in the belief that a crisis can be handled by increasing power or technology, denying the possibility of a crisis or involving fate as an excuse to do

Citation: West EA (2016) Conceptualizing the Relationships between Organizational Cultures, Nurse Leaders and the Nurse Practice Environments: A Historical Perspective. *Int Arch Nurs Health Care* 2:042

Received: November 24, 2015; **Accepted:** March 27, 2016; **Published:** March 31, 2016

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nothing about it. Trapped by the same structural and bureaucratic rigidity as their employees within these organizations, they often end-up trying to survive within the system instead of serving as leaders, movers and shakers for constructive transformation [15,16]. Further, the profession's attempts at change, which focus on issues surrounding 'Nightingalism' (that is viewing the 'art' of nursing as a liability to modern nursing's evidence based 'scientific' ambitions and public image) and that attempts at professional recognition that solely focus on salary increases or hours of work decreases are really just treatment of the symptoms and not the root causes of the profession's main problem; namely, its cultural identity crisis and need for core belief clarification.

Friss noted that as early as 1915, leaders in the nursing profession were concerned with the "image problem of nurses," which they saw as needing improvement [17]. She stated that since then, countless studies, reports, and commissions have attempted to explain and solve perceived shortages of registered nurses, which have always occurred regularly after brief periods of quiescence or oversupply. Usually their recommendations have not dealt with the real issues of nursing work but rather on the 'image' of the profession [17]. These studies and commissions do little more than recycle data and obscure the profession's fundamental problems which in turn create role and identity confusion within its ranks. Their ineffectiveness to bring about sustained positive change suggests the need for less "image enhancement" and more actual leadership and effort to garner support from physicians, hospital administrators, the government and the public to bring about institutional reform instead of continuing the cycle of investing in recruitment in times of perceived 'shortage' while simultaneously doing nothing to foster retention within the institutional setting [18].

The reality is that only top organizational managers have the power to bring about major organization cultural change within these environments, and these managers must also be professional leaders. Leaders like Florence Nightingale, who set an excellent ethical example and removed or reprimanded those lax in monitoring ethical compliance; encouraged fresh ideas and suggestions; tolerated mavericks with creative ideas, giving them room to operate; and who were willing to tolerate failures and reward success, while encouraging people who championed unsuccessful ideas to try again [19]. Nurse leaders can be a catalyst for change but this can only be achieved by impacting a society or organization's core beliefs. Values, fears, behaviors and infrastructure all flow from core beliefs. Therefore, attempts at changing culture by changing these elements are doomed to failure until the core beliefs are changed [20].

Culture Theory and Cultures in Organizations

Though there is no standard definition of culture, most alternatives incorporate the work of Franz Boas, one of the pioneers of modern anthropology who was famed for applying the scientific method to the study of human cultures and societies, a field which was previously based on the formulation of grand theories around anecdotal knowledge. Boas believed in historical and cultural relativism, which points out that the differences between people, were the result of historical, social and geographic conditions and that all populations had a complete and equally developed culture [21]. For the purpose of this study, Boas' approach was adopted whereby culture was defined as 'the system of shared beliefs, values, customs, behaviors and artefacts that the members of a society use to cope with their world and with one another, and that are transmitted from generation to generation through learning' [21]. Moreover, with the evolution of institutions within cultures come more rigidity and resistance to these natural impulses. Indeed, these organizations and institutions themselves can be viewed as cultures within cultures [21-23].

Organization or 'corporate' culture research draws heavily upon anthropological theory with regard to culture and is defined as 'the attitudes, experiences, beliefs and views of an organization,' the elements of which describe or influence its paradigm, control system,

organization and power structures, symbols, rituals, routines, stories and myths [24]. Unlike other traditions of organizational inquiry cultural research offers an unprecedented understanding of interplay, homogeneity, conflict and ambiguity within organizations. It also unveils the working of power in organizations, acknowledges conflict of interest between groups and attends to differences of opinion [25]. When 'culture' is used as a root metaphor for organizational life, organizations can be analyzed and understood in expressive, ideational and symbolic terms [25,26].

Managers, Leaders and Visionaries: Strong versus Weak Cultures

Organizational culture is a system of shared meaning and beliefs held by members that determine, in large degree, how they act. They represent a common perception held by the organization's members. The more employees accept the organization's key values and the greater their commitment to those values, the stronger the culture tends to be [27]. Strong cultures in which the key values are deeply held and widely shared have a greater influence on employees than do weak cultures [24].

In regards to organizational cultures, managers are concerned with the problem at hand; they focus on what has to be done. Leaders on the other hand, notice what has to be done, but spend their time figuring out how to get it done [28]. Sanborn suggested leadership was all about taking an organization to a place it would not have otherwise gone without you, in a value-adding, measurable way (p. 86) [28]. When you 'vision,' you think your way into a situation and it is the approach in visioning that separates managers from leaders. The problem is that health systems use a business model that is focused on management, which in essence is a process of resource allocation. Indeed, every business model cites the necessity of a 'results-oriented culture' in building a 'spirit of high performance into an organization' [29].

The different strategies used by managers and leaders in terms of their use of human resources can also differentiate for us the major factors that influence each position. Managers are required to monitor, supervise, and get tasks done in a certain amount of time. Managers have to be efficient, and thus time is the most important human resource for them. By improving their efficiency, managers can improve their managerial success. Leaders, on the other hand, must strategically use not only their time, but energy as well. Thus, leaders should use their energy efficiently because there is only a certain amount of tasks that can be done in one day. By using these resources strategically, leaders can also efficiently use the time and energy of others. Sanborn stated "Managers try to put more time into life, whereas leaders try to put more life into their time" (p. 11) [28].

Leaders must carefully plan out strategies they will use to accomplish given tasks because strategy is not the consequence of planning, but the opposite- its starting point. Managers and leaders have different strategic approaches in utilizing their human resources. It is the approach that separates the one from the other. It is evident that by 'visioning' the appropriate outcome and by using human resources purposefully, goals can be met efficiently as well. As mentioned earlier, time is the most valuable resource for managers because they must be efficient, therefore it is can be said that the managers are focused on time. The prime focus in a managerial position is the speed at which tasks are completed. Leaders conversely are and should be more focused on being effective, that is their intentions are on doing the right thing. Managerial power is positional power; it is power *over* people whereas leadership is supportive power, and it is power *with* people.

Strong cultures are said to exist where staff respond to stimuli because of their alignment to organizational values. Where cultures are strong, people do things because they believe it is the right thing to do [30]. Salary, staffing, autonomy and respect remain key issues with the understanding that nursing has achieved much by way of the more tangible rewards, while either not having or in some

cases losing those less tangible rewards, such as autonomy, respect and professional 'stimulation'. Indeed, nurses surveyed have stated repeatedly that they feel like 'factory' workers [19]. Since the 1940s nurses have also been reporting that the 'priority' in patient care has actually been being given to the 'paper work'. Words used to illustrate the change to nurses institutional settings have also historically included, 'business,' or 'corporate' culture; over-regulation; a focus on 'the bottom line' and the prioritization of the paperwork it generated, which created a "factory-like experience" that proved detrimental to quality patient care [13,19,31].

Some characteristics of low performance cultures are a politicized internal environment, hostility to change, promotion of managers who understand structures, systems and controls better than vision, strategies and culture-building and have an aversion to looking outside the organization for superior practices. Conversely, high performance cultures emphasize achievement and excellence, produce extraordinary results with ordinary people and emphasize an intense people orientation [32]. A low-performance culture may be strong or weak and a strong low-performance culture may actively inhibit necessary competitive re-alignment [32]. Hospitals are certainly described by nurses today as strong, low-performance cultures where managers as well as nurses are actively discouraged from exercising initiative to alter status quo and where avoiding risks and not screwing-up are deemed more important than innovativeness. They are also entrenched, multi-layered bureaucracies where people are promoted who understand structures, systems and controls better than vision, strategies and culture building.

Corporate Culture versus Nursing Culture

Nurses have not fared well in institutional environments with centralized power structures that adhere to the business model in the delivery of care. They have struggled to secure adequate hours of work, wages, professional autonomy, respect and a 'voice' on the health care team; all key elements inherent within the cultural value one has inside an organization.

Nurse leaders have long felt that a clean break from its vocational roots is essential for professional advancement and have blamed much of its failure to achieve it on nursing's historically uneasy relationship with feminism, the prevailing gender role stereotypes and institutional oppression [33]. In truth, the contributions that prominent nurses and the profession of nursing have made for equal rights, not only for women but also for humanity have remained hidden from the collective consciousness of the general public. Indeed, it was feminism that abandoned nursing in its zeal to move into male-dominated professions. As one writer noted:

'For in the eagerness of some women to embrace new roles has come a denigration of old ones. No one, these women say, should want to be just a housewife; no one with brains should want to be just a nurse. Have a career! Be a doctor!' [34].

Nursing has long struggled with feminist ideology and the aspects therein which could adversely affect its ability to provide public service, while feminists have grappled with the nurture and care aspects inherent to the work of nursing, which they sought to emancipate themselves from and that modern society continues to devalue. It has been suggested that had nursing joined forces with feminists sooner it would not be in the situation it is in today [33]. It could also be argued that had it done so it would have also had to embrace the values and ideals of one of its oppressors. Equality could hardly be gained by devaluing oneself and one's chosen work. The reality is that nursing was the only bastion for women that offered adventure, freedom, self-sufficiency and significant work well into the 1960s. It is also a reality that modern feminists would prefer to overlook.

The introduction of the medical model in nursing at the turn of the century invariably changed the trajectory of the profession from one of purely vocation, which essentially constituted providing comfort to dying, hopeless cases, to one of a trained, highly skilled

professional [35,36]. The evolution of medicine also brought in its wake a host of ancillary occupations which included therapists, pharmacists, X-ray and lab technicians to name a few. Nursing, which was never really highly prized to begin with as a direct result of being deemed a female vocation, came to be viewed as just another ancillary skill. Yet as medical mastery of technique in the cure and treatment of disease progressed in the burgeoning fields of medical/surgical study, and an ever increasing array of specialty areas arose, much of what was once considered exclusively medical practice became a routine part of nursing practice. With this increase in clinical responsibility nursing has in turn given up much of the custodial patient care that was once considered exclusively nursing practice by Florence Nightingale to unlicensed nursing assistants, domestic and housekeeping staff [35,37]. Nurses have attributed the discipline's lack of complete professional emancipation to the prevailing Victorian image of servanthood associated with nursing [35]. Some nurses have attempted an approach to professionalism that challenges and purges all association with humanitarianism in efforts to realign the discipline's focus purely on intellectual and technological savvy. This is much more highly valued by the dominant culture, and in its adoption lays the hope of securing nursing's rightful place in the health care environment as a true professional. Economists and institutional administrators use the opposing side of this debate to keep nurses from earning the wages they deserve and thereby can lower health care operating costs. Neither extreme is an accurate rendering of nursing's roots nor can fully embracing or eradicating either of them achieve for the discipline the status it desires.

Conclusion

Daiski in a Canadian study which examined the views of hospital staff nurses about their relationships with nursing colleagues and other health care professionals and their ideas for change concluded that change for the better needed to come from within the nursing profession [38]. Yet is this really possible if nurses become embedded within the establishment and embrace the values that are keeping sustained positive change from occurring? Within any organizational culture there are deeper elements that are unseen and not consciously identified in everyday interactions between its members. Additionally, these are the elements of culture which are often taboo to discuss inside the organization. Many of these 'unspoken rules' exist without the conscious knowledge of the membership. Those with sufficient experience to understand this level of organizational culture usually become acclimatized to its attributes over time, thus reinforcing the invisibility of their existence. Schein called this paradoxical organizational behavior [39]. It explains why an organization can profess highly aesthetic and moral standards in its slogans, mission statement and other operational creeds while simultaneously displaying curiously opposing behavior at the deepest level of the culture. Indeed, merely understanding culture at the deepest level may be insufficient to institute cultural change because the dynamics of interpersonal relationships (often under threatening conditions) are added to the dynamics of organizational culture while attempts are made to institute desired change (p 87).

The discipline of nursing has always had to change and evolve while maintaining commitment to its 'care' roots. Adaptive cultures are said to have a strong commitment to timeless principles; a sense of confidence among all employees to do what is needed to ensure long-term success and to be proactive in implementing workable solutions. In addition, adaptive cultures are supportive of people proposing useful change, adept at changing the right things in the right way and genuinely concerned about the well-being of others [29]. These traits are all hallmarks of nursing and decidedly stem from a 'people focused' perspective. All of the traits associated with strong and high performance cultures are people oriented, emphasizing achievement and excellence and producing extraordinary results with ordinary people [32]. Naranjo-Valencia, Jiménez-Jiménez and Sanz-Valle found that an organizational innovative orientation is crucial for any organization's effectiveness and that organizational culture is a clear determinant of innovation strategy [40]. Moreover, they found that

adhocracy cultures foster innovation strategies while hierarchical cultures promote imitation cultures.

What is necessary to heal nursing's identity crisis is for the profession to embrace the changes wrought by science, technology and global economics while simultaneously recommitting itself to the community-based and service (or people) oriented vision of its founders. These are not mutually exclusive concepts and either concept should not be embraced as of superior value to the other. What can be gained from this historical analysis is the needed for nursing to rediscover its core values and beliefs and begin to use them to shape the social context of our times, instead of vice versa. Though this has been happening as evidenced by the rise of nurse led clinics, services and in consulting and advanced practitioner roles, there is much that still needs done within the profession. The far-reaching and empowering value inherent within a morally inhabitable environment made so by strong nurse leaders, who embrace, value and seek to perpetuate their profession's identity in the marketplace; who are ready, willing and able to take a seat at the negotiating table with institutional administrators and physicians to push for sustained positive change for nurses and their patients cannot be underestimated.

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