

CLEAR, STRONG, AND BALANCED LINKS AMONG ENVIRONMENT, CULTURE AND STRATEGY: THE CASE OF A SUCCESSFUL NONPROFIT COMMUNITY HOSPITAL

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Abstract

We set out to write an in-depth case study of Doctors Community Hospital (DCH), a not-for-profit organization located in Landham, Maryland. Given our initial findings, we tried to explain the success of DCH in terms of established theory. We turned first to Michael Porter (1996), but did not find in his model adequate emphasis on the role of organizational culture, an element we believed was central to understanding the performance of DCH. Thus, we subsequently turned to the work of Edgar Schein (1985, 1992) and of John Kotter and James Heskett (1992). We gradually realized that while the respective models described relations between culture and strategy, culture and environment, or strategy and environment, none among them provided an articulation of the clear, strong, and balanced links among the three elements that we perceived to be central to the case of DCH. Thus, we constructed a simple framework that synthesized the insights of the three approaches. Our framework permitted us to posit that in successful organizations, four conditions will hold. Although our framework is based on inductive reasoning and evidence from one organization, we believe and hope our insights will be helpful to others.

INTRODUCTION

When pursuing the same objectives, why are some organizations successful and others not? Why do some organizations vary in performance over time? Several analysts have attempted to answer these questions and to provide recommendations on ways to reach and sustain superior performance (Thompson, 1967; Ouchi, 1981; Peters and Waterman, 1982; Pasmore, 1988, 1994; Senge, 1990; Collins and Porras, 1994; Drucker, 1999). Some authors have linked good performance in competitive markets to strong organizational culture or to coherent and well executed strategy (Ouchi, 1981; Pascale & Athos, 1981; Deal & Kennedy, 1981; Peters & Waterman, 1982; Kotter & Heskett, 1992; Osborne & Gaebler, 1992). A handful of experts in the health care industry have embraced the role of culture in improving performance and managing change within turbulent operating environments (Hupfield, 1997; Vestal et al, 1997; Umiker, 1999; Smith et al, 2000; Degling et al, 2001; Helms and Stern, 2001; Crow and Hartman, 2002; Larson, 2002; Fassel, 2002)

We had an opportunity to address these questions when Mr. Phillip Down, Chairman of the Board and CEO of Doctors Community Hospital (DCH), permitted us to write a case study about his organization. DCH, a nonprofit community hospital located in Lanham, Maryland, has an especially provocative history. Once poised on the brink of bankruptcy, during the 1990's DCH completed a financial turnaround and achieved national acclaim, a successful set of outcomes that we attribute to the proper alignment of the hospital's culture and strategy with its operating environment.

While our findings are generally consistent with conclusions previously voiced in the literature, we attempt to do more in this paper than simply concur with existing views. Our first objective is to describe the evolution that occurred in our own thinking. That is, as we attempted to make sense of our field observations about DCH, we were gradually led to integrate into one framework ideas originally stated between fifteen and twenty five years ago—but nonetheless still relevant to the management field—by culture studies scholar Edgar Schein, strategy theorist Michael Porter, and researchers John Kotter and James Heskett. Drawing upon their respective contributions, we developed a Proposition we had not seen neatly articulated in the literature: a successful organization will exhibit four conditions that collectively imply clear, strong, and balanced links among environment, organizational culture, and strategy. Our second objective is to describe the organization's history, environment,

culture, and strategy in order to demonstrate that DCH did indeed exhibit the four important conditions we identified. Since our insights emerged from an inductive and dialectical process and our findings are based on the experience of one organization, our third objective is to offer some final commentary about the possible relevance of our insights for other hospitals or more generally for the management literature.

The remainder of our paper is organized in the following way. In Section I, we first place the work of Schein, Porter, and Kotter and Heskett in context and distill major ideas from each, and then describe the inductive process that led us to our theoretical framework and to the articulation of our Proposition. In Section II, we sketch the history of DCH and the environment that confronted the hospital. In Section III, we describe the relationship between culture and strategy at DCH and the reasons why we believe they were particularly appropriate to the environment. In the process, we illustrate the conditions associated with our Proposition. (We note in advance that our treatment is brief, but refer the interested reader to our case study “**” recently published in “**”, which provides a more detailed description.) In Section IV, we offer commentary about the applications and limitations of our results, and suggest some directions for further research, all for the purpose of stimulating further conversation relevant to the field of strategic management.

ANALYTICAL FRAMEWORK

The Complexities of Organizational Culture

Scholars and practitioners offer numerous interpretations of organizational culture. For example, A. Wilkins and W. Ouchi (1983) say that culture may be considered a social control system, Howard Davis and Stanley Schultz (1981) describe culture as a ritualized pattern of beliefs, values and behaviors, and O’Reilly (1989) suggests that within an accepted range of conduct, individual behavior is not driven as much by personal needs as it is by the influence of others, particularly those in power.

A consistent idea in these and other definitions is that members of an organization share something in common. Edgar Schein (1985, 1992) also builds his definition on the idea of something that is shared, but he goes much further in capturing the complexity of organizational culture. He defines culture as a

. . . pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems (1992, p.12).

He says that organizational culture has three major components that lie at different “levels of awareness” for both employees and outsiders. The first, “Artifacts and Creations,” are the most superficial component and are reflected in an organization’s physical attributes and control mechanisms. The second, “Organizational Values,” are more deeply embedded; nonetheless, they are articulated by senior management, provide the rationale for the artifacts, motivate the operating philosophy of the organization, and on occasion are subject to debate. The third, “Basic Assumptions,” the foundation of organizational culture, are “invisible,” “taken for granted,” “preconscious,” and “not debatable.” They take shape as leaders form fundamental views about the nature of reality and truth, human nature, human activity, human relationships, and the relationship of the organization to the environment. Basic assumptions gain increased validity when they consistently serve as the basis for successful problem solving and risk avoidance. Over time, group members incorporate assumptions into daily activity without question.

To be effective, leaders must recognize that organizational cultures are dynamic and will evolve as the organization expands and or diversifies, meets new challenges, and welcomes new leaders and members. Furthermore, they must also actively shape culture to environmental conditions. In an effort to maintain the dominant culture, senior leadership utilize numerous methods to instill their underlying assumptions and beliefs into the thinking, feeling, and actions of the group. Primary methods include what leaders measure and control; leaders’ reactions to critical organizational incidents; role modeling; allocation of rewards; and criteria for selections,

promotion and punishment. Secondary methods of reinforcements include: organizational designs; systems and procedures; facility design; and formal philosophical statements (Schein, 1985, p.225). If senior leaders effectively use those methods, then an organization will be perceived as having a “strong” culture, as measured by the awareness of values by members of the organization and, perhaps more importantly, by the intensity with which members approve of those values.

This management responsibility is difficult, however. One reason is that multiple cultures routinely exist within a single organization. Subcultures, which arise as an organization grows in size and complexity, can lead to conflict within the organization (Schein, 1992), especially if members of some subgroups come to disapprove of emerging values.

What is Strategy?

When people discuss organizational performance, they sometimes use the terms “culture” and “strategy” interchangeably. The terms, however, have distinct meanings. While culture represents a shared set of values, strategy is a logic that is applied by leaders to move an organization in a particular direction (Vestal et al, 1997). John M. Bryson for example defines strategy as “a pattern of purposes, policies, programs, actions, decisions, and/or resource allocations” that define “what an organization is, what it does, and why it does it.” In this light, strategy becomes the “extension of an organization’s mission” and a “bridge between the organization and its environment (p.130)”.

In early work, Michael Porter (1985) identifies a set of competitive strategic positions available to individual firms, namely cost leadership, differentiation, and focus. Although Porter regards those generic strategies as mutually exclusive, other researchers employ hybrid versions of those strategies to explain the success of organizations (Kumar, 1997). Porter (1996, p. 68) subsequently concurs that an organization might indeed employ a combination of the categories he originally identified. This refinement is evident in his argument that both “operational effectiveness” and “strategy” are essential to a firm’s superior performance and sustainable competitive advantage.

Operational effectiveness refers to the ability to perform activities “better” than rivals in order to reduce cost (which suggests an element of cost leadership) and improve quality. However, operational effectiveness cannot be the basis of sustainable competitive advantage, since relevant processes will become commonplace. Therefore, in order to thrive, organizations must formulate and execute a strategy: they must either perform “different activities from rivals” or “similar activities in different ways (Porter, 1996, p.62)” (all of which brings to mind the idea of differentiation).

In turn, activities must exhibit three attributes. First, activities must be consistent with a position in the external environment; that is, the company must decide what range of products or services they will provide to which group of customers or clients (which implies the relevance of focus, and is essentially consistent with Bryson’s definition of strategy). Second, the activities undertaken by the company in support of an established strategic position entail “tradeoffs.” Tradeoffs arise because the value of products and services being provided must conform to the company’s image and reputation; because resources and processes must be specialized; and because management has finite coordination and control abilities. An awareness of tradeoffs shapes decisions by managers about what activities the company should pursue as well as which it should avoid. Third, the activities must “fit” with one another. Taken separately, each activity must be consistent with the company’s overall strategic position. Furthermore, each activity must reinforce others. Finally, the activities must be holistically coherent. This coherence contributes to system wide efficiency and also serves as a defense mechanism from potential rivals. Porter illustrates his ideas regarding fit through the use of molecule-like activity-system maps, with each map a schematic representation of a company’s “strategic position.” A map includes both a handful of high-order “strategic themes” that summarize the distinctive attributes of the company’s product or service and a

larger number of clustered, linked “activities” undertaken to implement the themes.

Culture, Strategy, Environment, and Performance

John Kotter and James Heskett (1992) provide an empirically based book-length study of the relationship between culture and economic performance. At the outset, the authors review the work of other organizational theorists about the importance of culture to organizational success. In particular, they acknowledge the contributions of Edgar Schein.

They start off with what they label Theory I: organizations with strong culture will have good economic performance. The authors’ initial efforts to test this claim involved a study of 207 publicly traded firms representing a range of U. S. industries. They administered a survey, collected data, constructed a “culture strength” index for each firm, and used the index number as an explanatory variable for average yearly increases in net income, return on investments, and stock price of each firm. They found positive, albeit modest, correlations between strong organizational cultures and economic performances in both the aggregate data and subsets of the data organized by industry. Of note, they found examples of firms with strong cultures and weak economic performances. However, they quickly point out that the “strong culture” viewpoint associated with Theory I is too simplistic.

That observation leads them to Theory II: strong economic performance is associated with an organizational culture that fits context. To explore this relationship, they perform a more in-depth analysis of 22 of the 207 firms in their original sample. They note that a positive relationship exists between firm performance and organizational culture when the content of the culture as defined by its beliefs and values “fit” its competitive environment.

However, since Theory II cannot explain “differential success at adapting to change,” they test Theory III: only cultures that can help organizations anticipate and adapt to environmental change will be associated with superior performance. They evaluate the lower performing firms in their second study. They concluded that each of these firms demonstrated a deep rooted resistance to change. This resistance was often reflected in organizational cultures characterized by insular and bureaucratic managerial behavior. The authors surmise that a lack of leadership initiative in these organizations resulted in a failure to adjust strategies to a changing environment and an eventual deterioration in performance.

Developing Our Framework of Analysis

Our first encounter with Phil Down came in autumn of 2002, when he visited our college as a guest in one of our courses and delivered a two hour presentation about DCH. Following his visit, he welcomed our interest in writing a case study of the hospital that we hoped would explore the competitive and regulatory environment, the hospital’s organization and its history, the reasons for the hospital’s success, and the challenges faced by DCH.

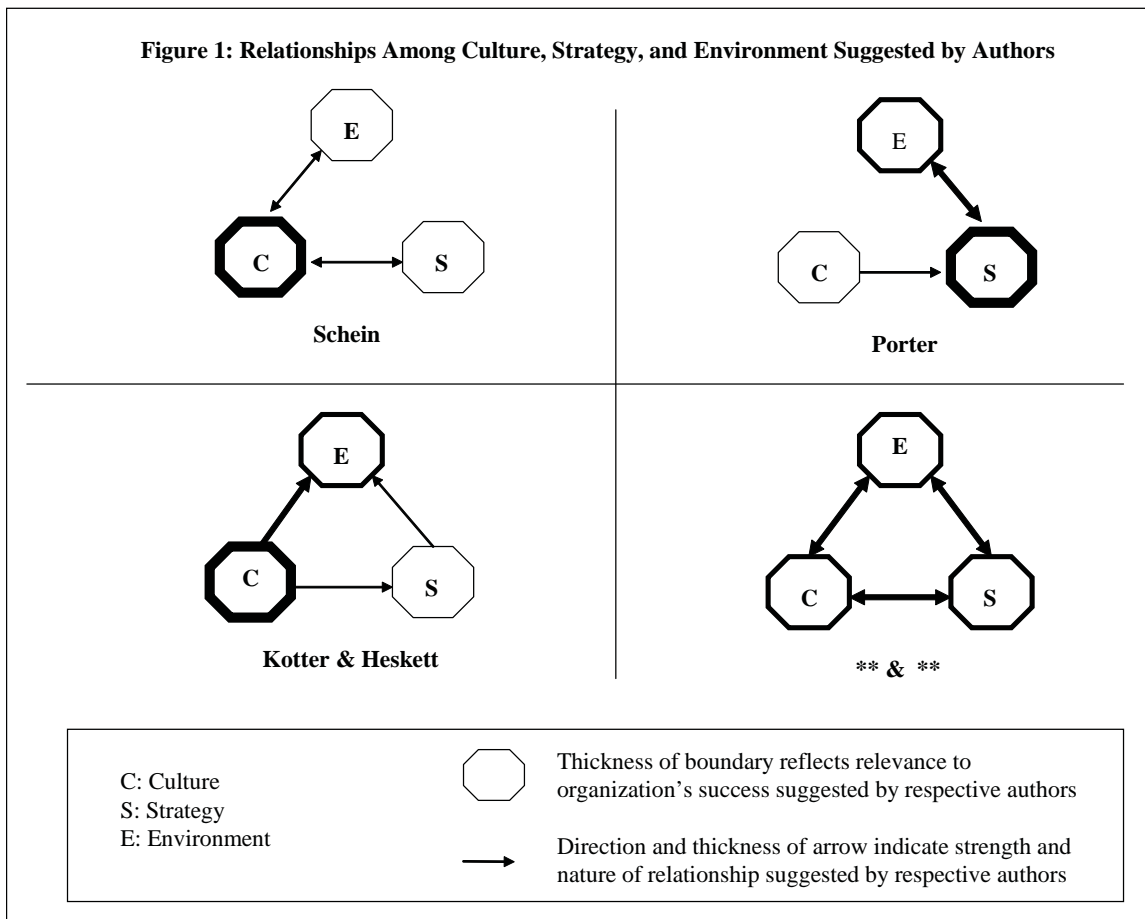
We subsequently traveled to the hospital for a four hour interview and a tour of the facility with him. Prior to our visit, we read material posted on the hospital web site. Following our visit, we typed up our notes, discussed what we observed and heard, read company and industry related documents provided to us by Phil Down, and went so far as to draft a Michel Porter like activity system that reflected our interpretation of the success of DCH. We sent our findings to Phil Down. During an hour long phone interview, he validated some of our insights but questioned others. He also suggested we speak with the Director of Strategic Planning for DCH.

Based on our conversation with Phil Down, we modified our draft activity system and forwarded our material to the Director. In our conference call with her, we were surprised when she quickly downplayed the relevance of our activity system and instead insisted that the real key to the success of DCH was the leadership of Phil Down and the very strong culture of the organization, which he helped foster. That conversation prompted us to revisit literature about organizational culture, with special emphasis on the work of Edgar Schein.

We then returned to DCH, had an initial one hour interview with Phil Down, this time talking more about

the culture of the hospital. We then conducted eight detailed, semi-structured interviews with key hospital participants representing senior management, middle management and the medical staff. The interviews averaged sixty minutes in length. In those conversations, we tried to discover from each person what they regarded as the behaviors and activities most important to the organization’s success. During those sessions and later when we analyzed our notes, we recognized a general consistency in “cultural” factors listed by the participants for the success of DCH. At the same time, the interviews provided us with numerous examples of “activities” performed by DCH that distinguished the organization from other hospitals.

Following our second visit, as we again attempted to explain the reasons for the success of DCH, we tried to reconcile our initial activities system interpretation of DCH with our new insights about the culture of the organization. We thought again about the relative strengths and weaknesses of the approaches taken by Schein and Porter. At about that time, we also began to consider the contributions of Kotter and Heskett, and realized that although they helped round out our understanding of matters, their analysis also did not offer a complete framework. As suggested by Figure 1, we began to think in schematic terms about what the respective authors had to say regarding relationships among culture, strategy, and environment.



Schein suggests connections between culture, strategy and environment. He says that one of the most important functions of leadership is the creation and management of a culture that motivates and creates social meaning for members of the organization and fits the environment. Schein also suggests that cultures are validated by experience. Nonetheless, while Schein provides insight about what makes an organization “tick,” he does not investigate the way an organization selects a competitive focus or sustains a competitive advantage. Porter

argues that to achieve competitive advantage, senior managers must first define the organization's core purpose relative to its primary external constituencies. Based on this assessment, they formulate a strategy characterized by a few general strategic themes and perform activities that support those themes. However, Porter does not explicitly discuss the influence of organizational culture on strategy development or implementation.

Kotter and Heskett find positive links among culture, strategy, and firm performance in a competitive environment, and assert that on-going success requires organizations to proactively adapt cultures and strategies to meet changes in the environment. While we find their exposition very helpful, their framework has a few shortcomings for our purposes. First, and most significant, while they place great emphasis on culture, they do not elaborate the concept of business strategy and throughout their analysis tend to treat strategy in a rather cursory way. This tendency is reflected in the minimalist treatment of strategy in various schematic diagrams throughout their presentation, which stands in contrast to their detailed representations of culture and environment. Second, and of less consequence, at a few points, their articulation contains some ambiguity regarding relationships. For example, in their final chapter, when summarizing the importance of culture, they very clearly say that

“... alignment, motivation, organization, and control can help performance, but only if the resulting actions fit an intelligent business strategy for the specific environment in which a firm operates.”

That statement suggests a clear link between culture and strategy and then strategy and environment. Yet, in the very next paragraph, when they point to the importance of adaptive cultures, they say

“... even contextually or strategically appropriate cultures will not promote excellent performance over long periods unless they contain norms and values that can help firms adapt to a changing environment (Kotter & Heskett, 1992, p.142)”

In the second instance, the authors seem to be implying that at any point in time, success depends on *either* a good fit between the organizational culture and the environment *or* between the organizational culture and the business strategy, a statement that strikes us as somewhat imprecise. Finally, since their findings are solely based on data gathered about publicly traded firms, the question remains open as to how links among culture, strategy, and environment play-out for a not-for-profit organization in a regulated industry setting.

In retrospect, we came to see that none of the authors had explicitly connected all three elements and began to synthesize the ideas embedded in the three perspectives. Taken together, Schein and Porter suggest that an organization's values and themes should consistently serve as the basis for day-to-day decisions and actions across the organization. To us, this suggested that members of the organization must sense a fit between the organization's culture, strategic plan, and operational actions; that failure to align beliefs with required actions across the organization will result in underperformance and eventual operational decline; and that culture circumscribes the set of actions that will be undertaken by the firm. Kotter and Heskett caution that culture linked to strategy is not a sufficient condition for success: culture and related strategy must also be contextually appropriate.

Finally, we reached a point when we were able to say with confidence that leaders of successful organizations must purposely manage their organization's culture; that in a successful organization each member must not only know *what* has to be done (activities are informed by strategy) but also *how* to do things (activities are enabled by culture); and that an organization's culture and strategy must satisfy the interests of its internal and external constituencies—customers, employees, owners, and so forth. Our reflections, in conjunction with our insights about DCH, led us to the following statement.

Proposition: An organization that has been successful—that is has managed to fulfill its mission in the eyes of relevant stakeholders and to achieve sound financial results—will exhibit all four of the following conditions.

1. The organization's values are purposefully cultivated by leadership and resonate with members

of the enterprise.

2. The organization's culture serves as the foundation for its competitive strategic themes and associated activity systems.
3. The organization's culture and related strategy fit its competitive environment.
4. The organization's activities reinforce organizational values.

The final panel of Figure 1 illustrates the equal importance we assign to culture, strategy, and environment in explaining organizational success and the two-way interdependence we see among each pair of elements.

EVOLUTION OF DCH IN THE COMPLEX HEALTH CARE ENVIRONMENT

A Brief History of Doctors Community Hospital

Doctors Hospital was founded in 1975, in Lanham, Maryland by a group of local physicians, in response to their collective dissatisfaction with existing community inpatient institutions. Doctors Hospital experienced early operational and financial success. However, the owners failed to reinvest in the facility on a consistent basis and by the early 1980s, the hospital had experienced a sharp decline in community reputation and in operational and financial performance. The final blow came when Doctors Hospital was the subject of an unfavorable court settlement.

In 1985, American Medical International (AMI), Inc. purchased Doctors Hospital and established a new, wholly-owned subsidiary in the state of Maryland, AMISUB Inc., to run the institution. In early 1986, Phil Down was named the Executive Director of AMI Doctors' Hospital. He initially faced the challenges of investing in the facility and restoring trust between the medical staff and the hospital's management team.

With the approval of AMI, Phil Down directed the expenditure of approximately \$4.3 million toward hospital improvements. Despite his efforts, AMI corporate management began to reevaluate their acquisition of the hospital. While several factors influenced their thinking, primary among those was the fact that AMI Doctors Hospital reported annual losses of \$434 thousand, \$2.96 million, and \$2.37 million for the 1987, 1988, and 1989 fiscal years.

In 1988, Phil and other members of his management team began negotiations with AMI to purchase Doctors Hospital and convert it from a for-profit to a not-for-profit community based institution. They were ultimately successful: in early autumn of 1990, Doctors Community Hospital (DCH) was registered as a non-stock corporation in the State of Maryland. The acquisition was financed by \$51 million in bonds issued by the Maryland Health and Higher Educational Facilities Authority. Those funds were used to pay for the hospital building and movable equipment, renovations, startup costs, financing fees, and to set up a working capital fund. At that point, DCH was fully leveraged, with a debt to equity ratio of 110 percent.

Over the next 10 years, DCH experienced both operational and financial successes. It became a valued asset in Lanham, a racially diverse and primarily working class community. Despite the presence of eight other hospitals within a ten-mile radius, it managed an 85 percent occupancy rate for its 176 beds. It had solid financial performance in 1991 and 1992 with operating margins of 3.8 percent and 2.1 percent, respectively; and from 1993 to 1999, far exceeded the national profile, with operating margins that averaged 7 percent per year. It successfully engaged in two rounds of refinancing, took on \$10 million in new debt obligations, and in the three years to 2003 made several capital improvements, including the addition of the best critical care unit in the region, a state of the art emergency room, a cardiac catheterization unit, and several new nursing stations. It was recognized as one of the best hospitals in the Washington DC area by HCIA in 1997 and 1998; was rated by the Jackson Organization in the top 5 percent nationally for emergency room patient satisfaction in 2001; received a five star rating by Health Grades for heart and pulmonary related treatment in 2001; earned very high marks by the Joint Commission on Accreditation of Healthcare Organizations in 2001; and perhaps most notable, was named one of America's Best Hospitals by *U.S. News and World Report* in 2000, 2001, and 2002.

Health Care Industry Environment

The environment confronting Phil Down and his management team was complex and posed challenges on many levels. First, over the decades, the U.S. healthcare industry had undergone a significant transformation. Through the 1970s, third party payers, including the government and private insurers, reimbursed hospitals for services provided to patients on a “cost plus” basis. This scheme, along with various government subsidies (Long, 1988; Barton, 1999), resulted in a substantial expansion of hospital facilities and arguably excess in-patient capacity on a regional basis. During the 1980’s, both the government and private sector took steps to reduce costs. The federal government rolled out the Medicare Prospective Payment System (PPS) in 1983. The private sector embraced the concept of managed care—a reimbursement model which significantly shifted financial risk from the payers to health care providers. Hospitals were particularly hard hit by changing reimbursement methodologies, which tended to reduce both the number of inpatient admissions and average length of inpatient stays. To reduce cost, they first experimented with horizontal networks and then proceeded in significant numbers to create wholly-owned vertically-integrated health care networks (Long, 1988; Shortell, 1988; Dowling, 1995). But due to the changing range and level of quality of health care services, the difficulty in measuring output, and traditionally weak control over physicians, the chief decision makers in provision of service (Goldsmith, 1994; Walston, 1996; Spang et al, 2001; Sinay & Cambell, 2002), savings never materialized. Unable to improve declining profit margins, the rate of investment in new hospitals declined. In the first decade of the twenty-first century, hospitals experienced “profitless growth” (Health Care Advisory Board, 2001) due to a range of factors, including resurgent demand for inpatient care, shortages of key health care professionals, and current short-run under-capacity at existing hospitals.

Second, the regulatory regime in Maryland was unique. In 1971, the Maryland legislature created the Maryland Health Services Cost Review Commission (HSCRC) in response to public concern over escalating hospital costs. Starting in 1980, Maryland was granted an exemption from Medicare and Medicaid legislation by the Federal government and the HSCRC was permitted to experiment with methods of controlling health care cost. By 2002, Maryland was the only state with rate regulation in place. Each year, the HSCRC approved rates for each Maryland hospital and established a “corridor” around those rates. If overcharges fell inside the corridor, the hospital had to repay the overcharges plus interest in the form of approved rates in the next fiscal year; if the overcharges fell outside the corridor, then the hospital had to repay 140 percent of the overcharges, plus interest. In contrast, if undercharges fell inside the corridor, then the hospital would be able to recoup 100 percent of the undercharges in the following year, via a premium on approved rates; but the hospital would not be able to recoup undercharges that fell outside the corridor.

Third, physicians were arguably the most important stakeholder group for managers of any hospital. Physicians who treated patients in hospitals were either “general staff,” who had their own practices, or “hospitalists,” who were directly employed by the hospital. General staff were paid for their services either by patients or by health insurance plans and did not receive a salary from the hospital; they were much like “free agents” in that they were often affiliated with two or more hospitals and would admit their patients to the one from which they received the most in terms of professional courtesies and amenities and in which they—based on their assessment of the quality and efficiency of clinical services, the nursing staff, and the facility—had the most confidence. Furthermore, the set of physicians practicing at a hospital had both a direct and indirect impact on the financial performance of the hospital. When working with staff physicians, hospitals earned revenues by providing ancillary services, such as lab tests; equipment and facilities, such as those in surgical suites; and care associated with overnight stays. In contrast, if care was provided by a hospitalist, then the hospital would be able to charge the patient or the insurer for physician services. Other factors were also at play. Some physicians, due to the nature of their practice and the number of their patients, contributed proportionately more to the bottom line of the hospital

than others. Net operating margins on medical patients were less on average than margins with surgical patients. Additionally, if a patient was receiving care from an “in-patient” team of hospitalists it was more likely that the team could choose the most efficient route to testing, diagnosing, and treating a patient having problems with multiple systems and thereby help the hospital to control costs, than if the patient were to receive treatment from staff physician who made cross referrals to other specialists.

Fourth, most hospitals comprised numerous stakeholders, which meant that managers had to juggle competing and at times conflicting claims for access, quality, and cost of providing health care. Hospitals were also administratively complex and hard to manage, for several reasons. The sources of formal and informal power within a hospital were typically diffused throughout a tripartite governance structure composed of the board of trustees, administration, and the medical staff. Strategic and operational actions were executed by parallel management structures respectively consisting of separate administrative and medical staff members. The actions of physicians and other hospital based care providers were driven more by their respective professional belief systems than by traditional economic incentives (Shi & Singh, 2004). Finally, as provision of health care became more complex, numerous specialized professions emerged, each with rich traditions of professionalism and strong membership loyalty (Walston, 1996).

In the 1990s, the American health system was considered one of the best in the world, as it fostered breakthroughs in new knowledge and technology and dramatic advances in medical care. On a day-to-day basis however, the system was much less spectacular, characterized by uncertainty of purpose, inequities and inefficiencies, and a diffusion of professional and political power, all of which were reflected in the system’s fragmented financing and service delivery mechanisms. Despite those challenges, regulators, payers, and consumers constantly called upon health care businesses to reduce costs, improve quality, and broaden access to services, objectives that were at times in conflict.

EXPLAINING THE SUCCESS OF DOCTORS COMMUNITY HOSPITAL

The Culture of Doctors Community Hospital

Schein argues that organizational culture rests on a shared system of assumptions, is multilayered, and evolves over time. We had those characterizations in mind by the time of our second trip to DCH. In retrospect, we encountered during our visits were what we later came to articulate as the *first* and *fourth* conditions associated with our Proposition: *The organization’s values are purposefully cultivated by leadership and resonate with members of the enterprise; and the organization’s activities reinforce organizational values.*

During both our visits to the hospital, Phil Down and others pointed out several suggestive artifacts. The executive offices had been relocated so that they were immediately adjacent to main entrance to the hospital. A physician’s dining room, which provided free-meals from early morning till late evening and served as a place where physicians and management could routinely interact, had been installed very near the executive office suite. To ensure patient privacy, special hallways had been constructed and were only used to transport patients to and from surgery suites or treatment rooms. To promote efficiency and a sense of urgency and professionalism, in the emergency room the status of each patient, including stage of treatment and elapsed time from when the patient was admitted, was digitally posted for all parties to see. Encased posters based on the vertically arranged letters of the word SERVICE—Service, Excellence, Respect, Vision, Innovation, Compassion, Everyone—were prominently displayed throughout hospital corridors. The vision statement (“Continuously strive for excellence in service and clinical quality to distinguish us with our patients and other customers.”) and mission statement (“Dedicated to Caring for your Health”) were featured in hospital literature. The organizational chart indicated that DCH had a very lean staff and a rather flat chain of command. While special committees had been established to gather broad based input for the design of the emergency room and the critical care unit, there were standing committees for information technology and for the review of new clinical products, services, and technologies.

During interviews, members of the management team talked about important values. Some values were mentioned by more than one person. Collectively, they provided a consistent picture. In retrospect, perhaps this was to be expected: among the then current members, the shortest tenure was 10 years; several department directors had been with DCH for 15 to 20 years; and from 2000 to 2003, DCH had experienced turnover in only 2 of 45 management positions. Clearly, shared experience had reinforced culture.

Members valued competence. They respected Phil Down because he had detailed knowledge of the health care industry, had vision, and had earned their confidence via his previous decisions. They were proud of the hospital's record in providing both clinical and support services and in earning accolades. They celebrated the professional accomplishments of their colleagues.

They enjoyed an environment in which there was individual responsibility and accountability. Different team members described themselves as "serious-minded," "self-managing," and "self-critical." Executives and directors felt they had to "be nimble" and had to engage in analysis and "proactive problem solving." They said the organizational structure was consistent with a situation in which there was empowerment and autonomy of workers, expectations of high performance, and above average compensation.

The people we spoke with had an appreciation for collaboration among individuals with different skills and attributes, based on open communications and inclusive decision making, in an atmosphere of mutual respect, patience and trust, and an ability to live with "honest differences of opinion." As noted by some, at DCH, all executives and directors were visible and accessible, there were no "turf wars," and communication lines were relatively informal.

The management team seemed to favor what one might call traditionalism. They liked the fact that Phil was a sympathetic leader who had a down to earth style of dealing with people. Some members believed that most people at the hospital had an "old-fashioned" work ethic and deep loyalty to the organization, as exemplified in length of service. Others emphasized honesty and transparency.

Given the intensifying economic pressure in the hospital industry during the 1990s, the economic logic of hospital management in a regulated environment, and the fact that the acquisition of the hospital had been 100 percent financed by debt, the management team of DCH had a permanent and ever-present concern for the bottom-line. They emphasized frugality, as reflected in the quip of the chief financial officer: "No margin, No mission."

Compassion was also an important value at DCH, as reflected in a few organizational stories recounted by the director of patient care services. One in particular stands out. A hospital staff nurse unexpectedly became critically ill. The employee was a single mother living from pay check to pay check. As a result of the illness and recovery period she exhausted her paid time-off benefits but was not yet eligible for short term disability. The nursing staff successfully initiated a donation drive of paid time-off hours from other staff members to build up her paid time-off balance. This allowed the employee to continue to receive her biweekly pay through her recovery.

To stimulate our own thinking, we took all that we had heard one step further and speculated about the set of underlying assumptions that might inform what we had seen and heard at DCH. That is, we created the following list of statements about things Schein might say reflected fundamental views about human nature, activities, and relationships: (1) Organizations and groups work best in collective arrangements bringing to the partnership those skills and resources that contribute to the overall endeavor; (2) People are responsible, motivated and capable of governing themselves; (3) Solutions are best formulated through a participatory process based on procedural justice; (4) Competing ideas are welcomed, and shared leadership is encouraged because of a deep sense of caring and commitment among organizational members; and (5) Clients of a hospital expect and deserve health and social services consistently provided at a high level of quality.

In summary, Phil Down's experiences in the complex health care system strongly influenced his thinking

about “how” to create value. He believed that reaching objectives required the collective and cooperative efforts of hospital employees and medical staff. Given this perspective, Phil and his team took purposeful steps to shape the DCH culture. Values were effectively communicated by management and were gradually accepted by members of the organization for decision-making and operational purposes. Values were articulated in the organization’s vision and mission statements and were reflected in facility design. They guided formal and informal interactions among managers, physicians, and support staff and the roles played by members of those groups in decisions about mundane issues and important initiatives. Those values also came to shape the strategy of DCH, or “what” the organization planned to do to achieve success. Over time, key hospital members came to cite the values of DCH as the central reason for the hospital’s outstanding performance, which suggests that the success enjoyed by DCH as a result of their themes and activities had reinforced basic assumptions.

Culture and Strategy at Doctors Community Hospital

Michael Porter (1996) asserts that successful organizations must decide what activities they will and will not perform. Phil Down and his management team had wonderful clarity on this matter. They decided early on that DCH would remain an independent organization and would not engage in horizontal or vertical integration or become enmeshed in a comprehensive health care system. They chose to not be a teaching or research hospital. They decided they would not run an obstetrics unit, a pediatrics unit, a psychiatric unit, an alcohol rehabilitation center, or a trauma center as part of their emergency room. And they decided they would not support open heart or cranial surgeries. Thus, they developed a sharp focus as a primary-level and secondary-level, adult care, medical and surgical facility that could respond to roughly 95 percent of the inpatient needs of the immediate community.

Digging deeper, we sorted the evidence we encountered at DCH into four strategic themes and thirty-eight supporting activities (See Table 1) and then, following Porter, mapped an activity system for DCH (See Figure 2). Our analysis led us to articulate what we believe is the *second* condition for organizational success: *The organization’s culture serves as the foundation for its strategic themes and associated activity systems.* To say this in another way, in the absence of what we came to identify as central values associated with the DCH culture, strategic themes could not have been actualized—that was precisely the point that the Director of Strategic Planning made when she criticized our first attempt at creating a Porter-like activity system.

Theme 1: Cultivate Personalized Relationships with Physicians Given the central role played by physicians, the management team made symbolic gestures, established structures, and implemented procedures that consistently and effectively conveyed respect and demonstrated the desire of the hospital to provide support for general staff and hospitalists. They did so by engaging in open and honest communication, including physicians in the governance structure of the institution, helping promote the success of the private practices of staff physicians, and introducing several small innovations that created a truly distinctive, physician-friendly environment. Finally, even though technology breakthroughs made it possible for physicians to provide outpatient services in their offices that previously had been performed in hospitals, DCH refrained from engaging in direct competition with physicians’ practices.

Theme 2: Encourage Pro-Active Attitude throughout the Organization Phil Down and his team realized that the difference between average and exceptional performance depended on the daily decisions and actions of the hospital’s employees. Thus, the team encouraged independent thinking, collaboration, and leadership at all levels and cultivated a sense of pride and ownership among members of the organization. They attempted to achieve fair outcomes for all employees and stakeholders when it came to personal and professional concerns.

Theme 3: Shape the “Actual” and “Perceived” Quality of the Patient Experience The DCH management team worked hard to achieve good scores on those objective measures of quality that were recognized by the hospital industry, and were successful in doing so. Nonetheless, throughout their stay, patients and their families

often made judgments about the quality of care that were measured by their satisfaction with support services and facility accommodations. In turn, patients' satisfaction with the hospital stay influenced their overall satisfaction with the surgical/medical procedures and with their physicians. Values such as compassion, cooperation, competence, and empowerment were critical to the actual and perceived quality of the clinical procedures and the hotel and customer-service aspects of the hospital stay.

Theme 4: Maintain a Judicious Attitude about Decisions and a Systems Engineering Approach to Operations. Their concern for frugality had helped the team maintain their strategic focus and not too thinly spread resources. It prompted them to pursue a decision making process that invited input from all key participants, created consensus, and thereby reduced risk. It also led them to take what we term a "systems engineering approach" to operating the hospital as reflected in several measures, such as trying to take a second mover approach to adopting new technology and software systems.

Fit between Culture, Strategy, and Environment

Finally, based on our analysis of DCH, we came to recognize the *third* condition for success we identified in our proposition: *The organization's culture and related strategy fit its competitive environment.*

TABLE 1
DCH: STRATEGIC THEMES AND ACTIVITIES

Theme 1: Cultivate Personalized Relationships with Physicians

- Activity 1:** Construct a Physician's Dining Room, proximate to the executive office suite, which provides free-meals from early morning till late evening; creates goodwill, a place where physicians and management interact, and takes on symbolic importance.
- Activity 2:** Refrain from providing outpatient or clinic services that directly compete with services physicians are providing in their individual practices.
- Activity 3:** Hold bi-annual, expenses-paid retreats for management and physicians to strengthen informal communication channels and relationships.
- Activity 4:** Provide proactive administrative support to help physician's navigate the credentialing requirements of the hospital and other organizations.
- Activity 5:** Employ Executive-Level Physician's Liaison responsible for attracting new physician practices and ensuring physicians' concerns and needs are addressed.
- Activity 6:** Invite physician input on facility renovation thereby giving physicians a voice in the planning process.
- Activity 7:** Include physicians in governance at the Board of Directors level.
- Activity 8:** Eliminate the language from DCH bylaws that mandated all physicians must serve "on-call" hours; instead, provide monetary incentives to encourage self-selection.
- Activity 9:** Give physicians' responsibility for monitoring the quality of professional services and participating in the hospital's risk management.
- Activity 10:** Designate qualified nurses as case managers for patients "by doctor," rather than "by-floor" basis, to streamline communication about patients' status with physicians.
- Activity 11:** Provide each on-duty nurse with a cell-phone, with number registered at the front desk and in nurses' stations, to reduce inefficiency and physicians' "on-hold" time.
- Activity 12:** Create an in-house, for-fee, answering service so physicians can have timely access to professional and personal messages.
- Activity 13:** Invest in the newest technology requested by physicians when consistent with the range of services DCH seeks to provide.
- Activity 14:** Provide Doctors equitable access to most desired times for surgeries and procedures; try to give individual physician's clusters of time to promote efficiency.

Theme 2: Encourage Pro-Active Attitude Throughout Organization

- Activity 15:** Use a 360-degree interview process, involving superiors, peers, and subordinates, before hiring new managers.

Activity 16: Seek fair outcomes when addressing employees' personal and workplace concerns; for example, avoid downsizing staff during stressful times.

Activity 17: Publicize individual contributions to team success via monthly in-house publications.

Activity 18: Celebrate organizational milestones and recognize important staff accomplishments in regular hospital-wide forums.

Activity 19: Ensure visible and accessible executive leadership, by locating office suite near main entrance and having management present during second and third shifts.

Activity 20: Empower managers with responsibilities for critical operational decisions.

Activity 21: Maintain standing, inter-departmental collaborative teams to share knowledge, anticipate problems, and come to solutions on routine operational issues.

Activity 22: Use monetary incentives, not directives, to achieve results, including wage-differentials for nurses to staff the 2nd and 3rd shifts and weekend slots.

Activity 23: Keep the senior management staff and other departments lean and flat and delegate authority throughout the organization.

Activity 24: Establish inter-departmental collaborative teams for planning of major projects, such as renovations to the emergency room and critical care units.

Theme 3: Shape "Actual" and "Perceived" Quality of Patient Experience

Activity 25: Monitor and Manage Patient Perceptions of Nursing Staff:

Activity 26: Retain a highly skilled and experienced infection control coordinator.

Activity 27: Create special hallways that are only used to transporting patients to and from surgery suites or treatment rooms, to promote patient privacy.

Activity 28: Provide high-quality "hotel services," including quality of meals; of telephone and television services; appearance and cleanliness of rooms; quality of cafeteria, of newspaper/gift shop; and of family waiting rooms.

Activity 29: Provide digital posting in ER of patient status, including stage of treatment and elapsed time from when the patient was admitted, to provide all ER personnel an overview of conditions on the floor, to sensitize them to progress with particular patients, and to cultivate a sense of urgency and professionalism.

Activity 30: Provide patient services at bedside, when feasible, via transportable equipment, to reduce patient discomfort and enhance productivity.

Theme 4: Maintain Judicious Attitude toward Initiatives and "Systems Engineering" Approach to Operations

Activity 31: Use old emergency room as a holding area for patients recovering from procedures or awaiting clearance, which enables new emergency room to be used more efficiently.

Activity 32: Limit scope of support to providing primary-level and secondary-level medical and surgical services.

Activity 33: Maintain disciplined, conservative attitude towards financial resources to manage the acquisition-related debt burden; avoid further financial risk; and effectively refinance debt to fund renovations and expansions.

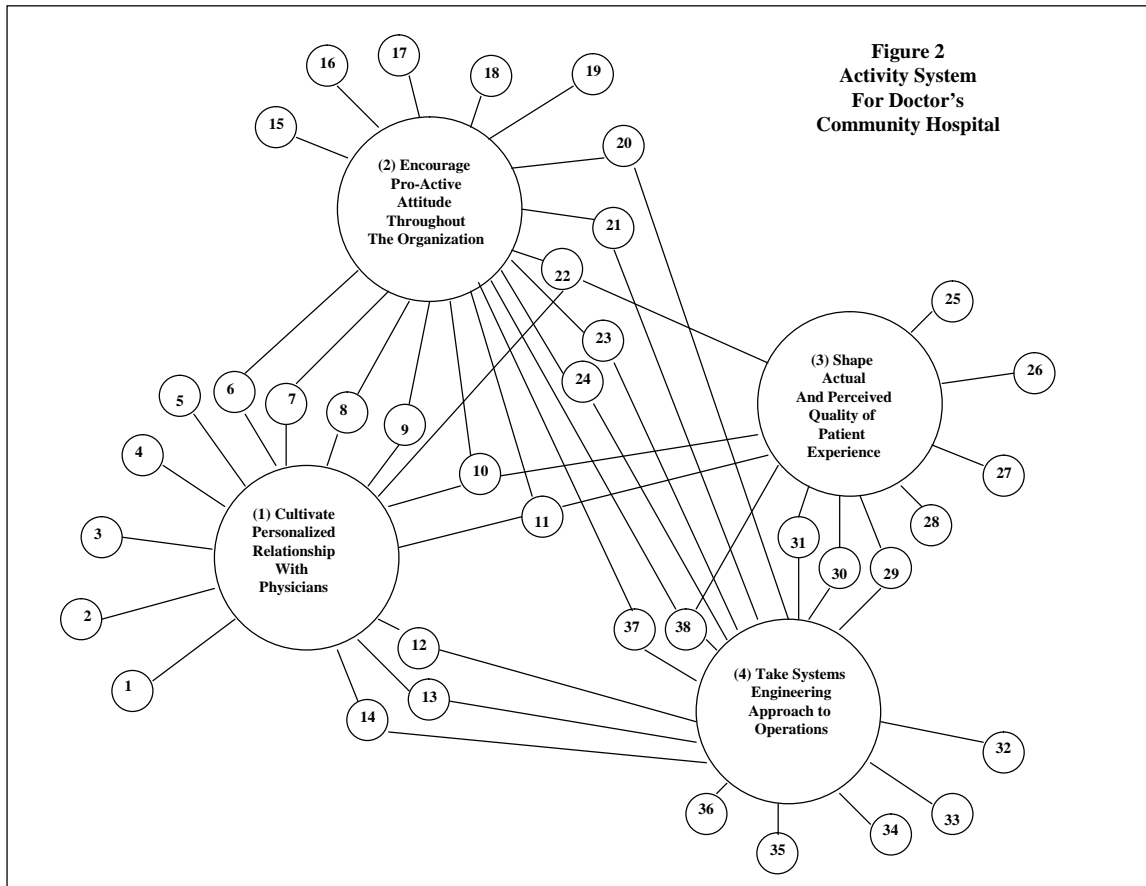
Activity 34: Trust and leverage the expertise and wisdom of the long-tenured Executive Leadership.

Activity 35: Pursue second-mover advantages by continuously scanning the external environment to see how the newest technology, and hardware and software systems perform at other institutions, and then move to adopt technology when it has proven successful.

Activity 36: Seek consensus between all interested and impacted stakeholders by communicating in an open, interactive style; by seeking input from second tier managers and from line-employees whenever possible; by maintaining a long-term view of relationships; and by learning to live with honest differences of opinion among the Management Group.

Activity 37: Use state of the art, flexibly-designed, multi-purpose rooms that could serve both cardiac and critical care patients to improve efficiency and increase utilization.

Activity 38: Empower selected nurses to discharge patients on behalf of physicians, to shorten duration of patient stay.



The values espoused by Phil Down and his management team and manifested in artifacts were particularly well-suited to the health care environment, in a few important ways. First, they created a climate of trust among various constituencies. Second, the fact that staff physicians, nurses, and support staff were permitted to participate in decision-making—and thus were subsequently in a position to receive legitimate recognition for their contributions—fostered in them a sense of affiliation with the hospital that rivaled their loyalties to their respective professions. In turn, this sense of belonging and ownership motivated physicians, nurses, and support staff to work toward meeting organizational objectives. Third, the absence of a formal, “top-down” management structure encouraged individual and collective contributions to innovation in designing operational systems and applying technology.

The regulatory environment of Maryland posed its own set of challenges. The financial reimbursement regime placed a lid on prices. There was little room for management error, as miscalculations could not be easily passed on to consumers in the form of higher prices or to insurers through cost shifting. Thus, the DCH management team could only improve economic performance by reducing costs, fine-tuning patient mix, and simultaneously increasing patient volume.

The culture of DCH and strategy of the hospital also matched this aspect of the environment. With respect to strategic orientation, the decision by DCH to provide or support only a limited range of services not only helped control costs but was also consistent with Porter’s notion of tradeoffs. We also believe DCH was able to achieve operational efficiencies due to the systemic or holistic fit among the activities. With respect to values, members of the management team noted that since the organization was so heavily leveraged at inception, frugality and conservatism were part of the organizational culture—to the benefit of the organization, they coexisted

in a state of tension with an emphasis on innovation and quality. Those values were central to what we have labeled Theme 4 (Systems engineering approach/Judicious attitude), but were relevant to other themes as well; e.g., since hospitals primarily received remuneration based on illness classification rather than the actual services and tests provided, they empowered nurses to take incremental steps to reduce the average duration of the patient stay. Those values informed activities associated with multiple strategic themes. They ranged from seemingly simple innovations, such as providing nurses with individual and uniquely numbered cell phones (Activity 11) and designating key nurses as case managers (Activity 38), to major commitments, such as redesigning and using the old emergency unit as a holding area (Activity 31) and building flexible use critical care and emergency room units (Activity 37).

In an effort to contain costs, DCH also attempted to have a larger proportion of hospitalists on staff than at other hospitals, especially in the emergency room—oftentimes, the attending physician in the emergency room became the physician of record if the patient had to be admitted. And certainly, an environment supportive of physicians and dedicated to provision of patient care contributed to the ability of DCH to attract hospitalists.

Economically speaking, however, if DCH managers had been solely concerned with cost reduction, they would never have been successful—a point made by Porter and one that is clearly relevant in this instance. They also had to increase patient volume and actively manage patient mix. To accomplish the first of those objectives they had to attract both physicians and patients alike in sufficient number to achieve high capacity utilization. To accomplish the second, they had to pay close attention to the combination of physicians they were attracting to the hospital; that is, they had to purposefully induce physicians who had both new and established practices in specialties that involved surgeries or other higher margin procedures to make DCH their hospital of choice.

That logic led Phil Down and his team to perform activities differently than they were being performed at rival organizations. These were reflected in many of the activities associated with Theme 1: including physicians in decision-making (occasional retreats; routine dialogues); helping young physicians acclimate to the area (assistance with credentialing); making time at DCH more comfortable (existence of a physicians' dining room); and contributing to the success of the physicians' practices (running a call service; scheduling time in operating room; refraining from direct competition in out-patient services). Their efforts to build personalized relations with physicians, reinforced by attention to details of patient comfort, proactive attitude on the part of all employees that in turn helped ensure good clinical outcomes for patients, and by efficiency and flexibility in delivery of services, all helped distinguished DCH in the eyes of physicians. As suggested in Figure 2, the strategic themes and associated activities were coherent.

IMPLICATIONS FOR STRATEGIC MANAGEMENT

At this stage, we would first like to review the major points we make in our paper, and to then raise some larger issues in order to stimulate discussion. With respect to those larger issues, which include the nature of our methodology, the possible limitations and applications of our insights, and directions for future research, we would like to thank the editor and of this journal and two reviewers of an on an earlier version of our paper, who pushed us to think more deeply about those matters.

Summary

In section I of our paper, we noted that we were given the opportunity to write a business case study about Doctors Community Hospital (DCH), an organization that had achieved a decade of strong financial performance and a national reputation for excellence. We emphasized that at the outset of the project, we had only a superficial understanding of factors that contributed to the success of DCH. We described the iterative process by which we came to formulate our framework of analysis, a process that culminated in our ability to state a Proposition that identified four conditions we believe will hold for an organization that has managed to achieve financial viability and satisfy the interests of key stakeholders: (1) the organization's values are pur-

posefully cultivated by leadership and resonate with members of the enterprise; (2) the organization's culture serves as the foundation for its competitive strategic themes and associated activity systems; (3) the organization's culture and related strategy fit its competitive environment; and (4) the organization's activities reinforce organizational values.

In section II, we described the history of DCH and the health care environment. At the national level, the federal government and third party payers pressured hospitals to control costs and assume greater portions of risk. In the state of Maryland, hospitals did not have either the ability to raise prices or the incentive to reduce prices outside established bands. While physicians who practiced at hospitals often were not employees of those hospitals, physicians did play a critical role in the overall financial health of those organizations. Finally, hospitals were subject to competing claims by other stakeholder groups and were difficult to manage.

In section III, we describe the culture and strategy of DCH. We use those descriptions to illustrate the factors we think "explain" the success of DCH, and led us to integrate the ideas of Schein, Porter, and Kotter and Heskett. Our description of the culture of DCH relies on the categories provided by Schein. We have described what we took to be meaningful artifacts and important values in the culture of DCH, and even went so far as to speculate about underlying assumptions. All that we heard struck us as consistent, and suggested to us a purposefully managed, strong, and distinctive culture that evolved over time and was central to the success of the organization. To describe strategy, we relied on the work of Porter. We came to understand that the leadership had made choices about the range of services DCH would and would not provide. In their selected arena, they appeared to understand that the best way to differentiate the hospital would be to perform a range of standard activities differently than they were being performed by rivals. Towards this end, we were able to construct a Porter-like activity system for DCH, one that included four higher order strategic themes that respectively focused on relations with physicians, attitudes toward staff, quality of service to patients, and disciplined management, as well as thirty-eight supporting activities. We also came to believe that Phil Down and his team recognized that a culture which emphasized values such as individual responsibility and accountability; cooperation based on trust, respect, and compassion; and operations that balanced dedication to quality of service with concerns for efficiency were extremely well suited to that environment. *In our view, if DCH did not have its unique culture, it would not have been able to implement the many activities associated with its strategic themes. DCH achieved success by choosing a niche in the health care environment and by performing a limited array of activities differently than rivals. The success enjoyed by DCH over the years reinforced cultural assumptions and values.*

Methodology and Analytical Framework

In terms of gathering data, our understanding of the extremely complex health care environment was based on the academic literature on the health care industry, hospital industry association reports, and government reports. Our understanding of the environment was also based on the insights provided by one of the co-authors of this case, who has twenty-five years of first-hand experience as a manager in the health care industry. To gather information about the history, culture, and strategy of DCH, we reviewed hospital source documents and archival records; toured the facility on two occasions; conducted in person or telephone interviews with ten members of the management team and engaged in informal conversations with physicians, nurses, and support staff. During all formal and informal conversations, we took extensive hand-written notes. Since we solely relied on qualitative data sources to gather information, some may wonder if we were biased to the point of hearing only what we wanted to hear or seeing only what we see; we hope and think we did not. To help ensure the validity of our findings, we tried to ensure that the information in all our data sources converged. Furthermore, we asked all members of the DCH senior management team to review and approve the content of the case study that serves as the basis for this article before we submitted the case for publication.

In terms of theory, if we had any *a priori* leaning, it was that we hoped we might be able to apply the insights of Michael Porter, perhaps by creating an activity system for the hospital. But given feedback we received following our first visit to DCH, our subsequent reading of Edgar Schein, the opinions expressed by hospital members during our second visit, and finally our reading of John Kotter and James Heskett, we came to recognize that in isolation, none of the models proposed by those authors adequately captured the information we encountered. Thus, we attempted to integrate their ideas, as illustrated in Figure 1; structured those ideas via a Proposition; and then provided a description, based on our interpretation of data, which illustrated how the four conditions of our proposition were present in the case of DCH.

Given that process, we realize we have to be very careful about what we claim for our results, lest we be accused of circular reasoning; that is, since our analytical framework was informed by the actual experience of DCH, there can be no surprise that our description of the success of DCH conforms to the framework. So on this we want to be clear: the direction of our thinking runs from the particulars of DCH to our framework of analysis, and the descriptions we provide of DCH—while illuminating in their own right—are intended to illustrate why we thought it necessary to articulate an image of clear, strong, and balanced links among environment, culture, and strategy.

At the most rudimentary level, the relationship between data and theory in our analysis of DCH is consistent with the methodological approach advocated by sociologists Barney G. Glaser and Anselm L. Strauss (1967). Glaser and Strauss make the case for the construction of “grounded theory,” the inductive process of discovering theory from existing data (p. 1), which stands in contrast to theories “generated by logical deduction from *a priori* assumptions (p. 3).” They argue that in general, grounded theories provide a better “fit” with data and are more useful for helping researchers “predict” or “explain” behavior than “logico-deductive” theories (p. 5). Their description of the inductive process is consistent with our DCH-related research: “Generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of research (p. 6).”

At the same time, we do not want to overstate matters. First of all, Glaser and Strauss work through a range of important issues, including the nature of data sets, categories of theories, theory formulation, and the role of the individual researcher in the theory building process. They do not explicitly spend time describing insights that emerge from case studies of individual organizations, and we certainly recognize that there are limitations associated with evidence that comes from a single case study. Second, leaving aside for a moment the fact that we are working with a single case study, we acknowledge the very modest contribution to theory-building represented by our analytical framework. The numerous works about management in general or the hospital sector in particular that we noted at the outset all talk in some form or another about environment, culture, and strategy. So too do a range of corporate strategy textbooks. We have simply fine-tuned and stated with greater clarity ideas expressed by others.

Finally, we believe the points we have made raise a set of key question associated with individual case studies as vehicles for knowledge creation. What is the relevance of insights that surface from the process of researching and writing an individual case study? How can the insights from an individual case be compared to those which emerge from other case studies? At which point is there sufficient evidence, built up from a range of cases, to formulate theories?

Limitations and Applications

Our framework of analysis and our stated Proposition are open to criticism of three types. First, our definition of “success” is vague: that is, we say that a firm is successful if it manages financial viability and satisfies the interests of key stakeholders. Second, if one were to locate a firm that is experiencing “success”, but for which one of the four conditions we state is absent, then the logic of our Proposition will crumble. Third, our Figure 1

and our Proposition suggest that strategy at DCH was formulated in a deterministic fashion; that is, that all that occurred over a decade at DCH was the result of a coherent model that was articulated by Phil and his team on the day they gained independent control of the hospital.

Given the first two of these concerns, a comparison of our stated Proposition to the findings reported by Collins and Porras (1994) in their highly influential work quickly lays bare the existing limits associated with our insights, but also suggests some possible merits. On the negative side of our ledger, Collins and Porras have a much more robust definition of success. They base their insights on an exhaustive treatment of 18 “visionary” companies, each of which was established before 1950; managed to survive through more than one life cycle of products and services; prospered under more than one CEO; earned a reputation as the premier organization in its respective industry; and made an indelible imprint on society (p. 2). With respect to financial performance, they note that for the period 1926 to 1990, an investor would realize more than 15 times more earnings for every \$1 invested in a fund comprising their 18 firms than a general market fund. In that light, our statement of success does seem paltry. On the positive side, however, Collins and Porras claim their work “shatters” twelve existing myths about successful companies (p. 7-11). Their description of those shattered myths suggests that we are on the right track in seeking links among environment, culture, and strategy. In particular, they argue that: the leaders of visionary companies concentrate on building internal firm “architecture” and “an enduring institution” (Myth 2); while visionary companies do not have to have some socially agreed “right” set of core values, those in the company do have to deeply believe the articulated values (Myth 4); visionary companies tend to keep their core values tightly fixed (Myth 5); and visionary companies are not outwardly focused on beating the competition, but instead concentrate on self-improvement (Myth 10).

In an attempt to meet the second concern head on—and keeping in mind the insights of Collins and Porras—we imagine for the purpose of illustration a spectrum of hypothetical organizations that have experienced a period of financial viability and satisfied the interests of key stakeholders. At one end would be those which base their competitive position on a generic low-cost leadership approach; exist in an environment primarily consisting of contractual relationships with external stakeholders; provide standardized products; employ routine operational processes; and have rigid, hierarchical organizational structures and cultures that leave little room for discretion by individual workers. At the other end would be those which base their competitive position on a differentiation approach; exist in a complex environment consisting of trust-based relationships with external stakeholders; provide sophisticated and to some degree customizable products or services; employ flexible and knowledge-intensive operational processes; and have fluid, flat organizational structures and organizational cultures that simultaneously promote self-actualization and teamwork among employees. The attributes of the firms among the second set of organizations are certainly more intriguing—and to most readers probably more appealing—than the first. Nonetheless, we provocatively assert that at either end—or for that matter at some interior point—of our spectrum, that there would be clear strong and balanced links among those three elements.

The third concern, that our depicted framework and stated Proposition have an air of determinism, reflects a larger debate in the field of strategic management, one focusing on the very nature of the process of strategy formation. The work of Porter, for example, which is so central to our own exploration, emphasizes the ability of an organization to properly choose a position in an external environment and to ensure that strategic themes and supporting activities are consistent with the chosen position. On the other side of the conversation are those who believe that strategy formation emerges via a process of experimentation, improvisation, and even evolution. While Mintzberg (1994) may be the most well known contributor to this line of thinking, Collins and Porras also weigh in: visionary companies are willing to take risks and seek new challenges (Myth 6); and visionary companies often make “their best moves by . . . trial and error, opportunism, and . . . accident” (Myth 8, p. 9).

In response to the third concern, we believe that if anything, the emphasis we place on Schein’s definition (“culture is a pattern of shared basic assumptions that the group learned as it solved its problems of external ad-

aptation and internal integration”); our sense that culture will be deeply embedded in strategic themes as reflected in the second and fourth conditions associated with our Proposition (i.e., the organization’s culture and related strategy fit its competitive environment; and the organization’s activities reinforce organizational values); and our description of the degree to which decision making at DCH was characterized by an effort to achieve consensus among affected stakeholders all suggest that we sympathize with Mintzberg, Collins and Porras, and others who see strategy formation as emergent rather than deterministic.

Despite the limitations and concerns associated with our framework, in the future, we personally will have in mind our template of strong, clear, and balanced links among environment, culture, and strategy as we investigate other successful organizations. We believe our description of the distinctive culture and strategy of DCH—embellished as it is with a map of the hospital’s activity system—and our efforts to relate those to the complex healthcare environment can provide a point of comparison for researchers investigating other hospitals. We hope that others will retrace our steps to see if they agree with our interpretation of Schein, Porter, and Kotter and Heskett and the articulation of our Proposition. If they do, then we also hope they will find it useful to apply our framework to their analyses of other for profit and not for profit organizations. In this spirit, we offer the following questions for discussion. Can the template of Figure 1 and the conditions included in our Proposition generally be applied to other organizations? Can one imagine circumstances in which a successful company would not exhibit one of the four conditions we identify?

Finally, while not necessarily a concern, there is an obvious limitation to our framework that nonetheless suggests a possible line of inquiry. That is, we have offered a Proposition that describes conditions that will hold for an organization that has been successful for a number of years. However, at any point in time, there are numerous organizations that are experiencing either gradual decline or crisis. In those instances, would the proper diagnosis be that the organization did not have proper alignment and links among culture, strategy and environment? Would a new leader take it as his or her first priority to create alignment and establish links?

Directions for further research

The framework of analysis we developed is backward-looking with respect to time and somewhat static in nature. In reality, as the future unfolds, the environment confronting any organization will be dynamic and there will be a tendency for the environment to move out of alignment with strategy and culture. When this occurs, management must decide how to respond.

That was the case for DCH: despite their decade of success, by the early 2000s, the management team was confronted by a range of issues. Most pressing among these, for the four years 2000 through 2003, DCH experienced operating margins of 1.4%, 1.3%, -1.3% and -1.1% respectively, a profile below the average of other hospitals at both the national and state levels. DCH had to formulate a response that would achieve additional operational efficiencies or new sources of revenue. Toward this end, by 2003, DCH began to wonder if they should take on new debt in order to finance expansion; attempt to recruit new groups of surgeons; construct new medical office buildings on the DCH campus; support areas of care they had previously eschewed; engage in strategic alliances with other facilities; or directly compete with physicians who were offering out-patient services at their respective practices.

Those challenges and the preliminary plans of DCH led us to wonder how DCH and other organizations that have previously been successful—and thus exhibited the four conditions we have articulated—might handle the process of adjustment. Once again, we suggest lines of possible future research by asking a set of questions. Would an organization alter or enlarge the boundaries associated with currently existing culture and strategy, or would it take actions that actually leaped across those boundaries? In that context, to what extent would a previously successful organization reconfigure its existing activity system or its strategic themes? Alternatively, while the necessity of shaping a response might cause some strains on culture, would organizations abandon existing

values? Although we speculate that the process of change in an organization would be inherently conservative, we recognize that a more informed answer to this last set of questions can only come by further study of the response fashioned by DCH, perhaps articulation of a second Proposition, and systematic investigation of other organizations.

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