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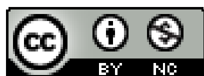

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THEMES IN HEALTH CARE CULTURE: APPLICATIONS OF CULTURAL TRANSFORMATION THEORY

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Abstract

Key aspects of culture change include familiarizing oneself with how relationships are structured and encouraging an awareness of how people relate to one another on a domination/partnership continuum (Eisler & Potter, 2014). In 2013, 200 nurse leaders were asked to rate their own cultures on a continuum of domination to partnership based on Eisler's Cultural Transformation Theory (1987). Of those nurse leaders, 37.5% rated their organizations as being closer to a domination culture than a partnership culture. These findings prompted the development and delivery of a webinar series that applied Cultural Transformation Theory to healthcare culture. The attendees noted an overall change in self-rating of their healthcare culture as they learned about domination and partnership culture. This shift in rating could indicate Cultural Transformation Theory's usefulness in understanding healthcare culture, and in identifying domination and partnership relationships. In discussions during the webinar three themes emerged: 1) Healthcare culture inclines toward domination and this has an impact on patients, 2) Leadership impacts organizational culture, and 3) Leaders are unaware of domination tendencies within their own cultures. Further discussion is needed to identify strategies that support cultural changes, ultimately leading to improvements in safety, quality, and patient experience within healthcare.

Keywords: Cultural Transformation Theory, domination, partnership, interprofessional, healthcare culture, nurse leaders

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Problem Identification

Despite a myriad of interventions and innovations, healthcare culture remains plagued by bullying and lateral violence, which contribute to poor quality care, substandard patient safety, inadequate coordination of care, marginal patient experience ratings, and poor provider engagement. Domination tendencies in healthcare culture may be the reason why the United States has seen little or no progress in safety and quality

outcomes. According to Chassin and Loeb (2013), when measured against the magnitude of the problem, improvements in healthcare following the release of the Institute of medicine (IOM) report (2000), *To Err is Human*, have been “underwhelming” (p. 2).

Theory can support understanding of phenomena that are not easily explained or understood, such as how cultures are structured and how they operate (Reeves & Hean, 2013). When practices fail, or do not endure over the long term, it may be because of a lack of a theory-driven cultural approach to their implementation (Suter et al., 2013). Reeves and Hean (2013) state that there is limited use of sociological perspectives that could help with understanding of imbalances in power / status, and gender and ethnic differences, and how they affect the delivery of effective healthcare.

Eisler’s (1987) Cultural Transformation Theory (CTT) is directed at helping understand how different cultures structure relationships. In CTT, culture is described on a continuum; at one end of the spectrum are domination systems, in which relationships are fear-based, rigidly hierarchical, and marked by a disdain for soft or caring values. In healthcare, this end of the spectrum is characterized by lateral violence, role and profession hierarchy, and fear of reporting safety issues. At the other end of the continuum are partnership systems, in which relationships are trust-based, equalitarian, and built around hierarches of actualization (Eisler, 1987). In healthcare, this end of the continuum is characterized by shared leadership, shared decision making, and interprofessionality.

According to Eisler and Potter (2014) a key aspect of culture change is familiarizing oneself with the components of domination and partnership models. Once healthcare professionals can recognize domination patterns, they can consciously foster relationships based on partnership. As one gains more awareness of patterns of domination, behaviors can be shifted, and as behaviors shift, so does the cultural climate of the organization.

The question posed is whether educating healthcare professionals in CTT will help them identify domination and partnership patterns within their healthcare relationships. Findings would support the assumption that culture is a phenomenon that is affected by factors at the individual as well as the group and organizational levels (Jones, 2007; Odegard, 2005). Changing an individual member's behavior is the basis for organizational change (Clark, 2013).

Cultural Assessment and Findings

In 2013, data was collected from nurse leaders who attended the national *Excellence in Nursing Institute* in San Antonio, Texas to determine where they identified their organization on the continuum of domination and partnership based on CTT. At this conference, 200 nurse leaders were introduced to CTT during a one-hour presentation. Domination and partnership were defined in the presentation as noted in Figure 1.

Figure 1. Definition of Domination and Partnership Characteristics

Issue Concept	Domination	1 2 3 4 5 6 7 8 9 10	Partnership
Social and Economic Structures	Authoritarian in both the family and the state	⟺	Democratic in both family and the state
Traditions of Violence	Violence is justified and idealized	⟺	Non-violence and mutual respect are valued
Gender Relations	Feminine values are considered inferior to masculine values	⟺	Feminine and masculine values are equally valued. Caring is prized as a human value not a gender value
Health Care Culture	Chain of command, fear of reporting errors and rigid leadership hierarchy	⟺	Expertise noted at any level, peer coaching, partnerships are valued between professions
Patient Experience	Noncompliant patients are labeled, patients voice are not valued, paternalism	⟺	Patients are welcome to partner and direct care. Family are not considered visitors but a member of the care team
Employee and Physician Engagement	Lateral violence, bullying, criticism between disciplines	⟺	All professions are valued and all have equal voice

A sample of the self-assessment survey tool is shown in Figure 2.

Figure 2. Example of Self-Asessment Survey Tool Used at Excellence in Nursing Institute

Fostering Interprofessional Partnerships

In the organization or work place where you are employed, how are relationships structured?

Domination..**Partnership**

1	2	3	4	5	6	7	8	9	10

*Dimensions of partnership are adapted from *The Power of Partnership: Seven Relationships That Will Change Your Life* by Riane Eisler
Center for Partnership Studies
10/3/11

Results from the *Excellence in Nursing Institute* showed that 37.5% of the 200 nurse leaders rated their own organization a 5 or less on a 10-point scale indicating that they perceived their organizational culture as being closer to a domination culture than partnership culture.

These findings needed further exploration. All the participants were in nurse leadership roles, which may have influenced their assessment of domination in their cultures. Also, a one-hour education session may not have been sufficient to adequately teach application of CTT.

Project Overview

The scope of this project was to develop and deliver a four-part series of web-based sessions to introduce attendees to and educate them about CTT as a foundational theory for understanding healthcare culture.

The webinar series included four weekly sessions, each with distinct content. The key deliverables were: to introduce CTT and its history, to introduce partnership and interprofessionality as a healthcare practice that is influenced by culture, to suggest CTT as the theoretical underpinning for understanding how relationships are structured in healthcare, and to explore the impact that domination / partnership culture has on patients as well as how to operationalize partnerships within healthcare organizations.

Each presentation was 90 minutes in length and included 20 minutes for discussion and sharing. Each session included an online rating for each participant similar to the rating tool used at the *Excellence in Nursing Institute*. However, the rating scale for the project was changed from a 10-point to a 5-point scale for ease of on-line rating.

Methodology

The 4-part webinar series was titled "*Transforming Health Care Culture*." All content and the Power Point slides were created specifically for this project.

The participants were recruited from the Center for Partnership Studies Caring Economy Leadership Program (CELP) database. Ten attendees participated in the webinars, including one physician, four healthcare leaders, two nursing graduate students, one healthcare policy analyst, one business analyst, and one change facilitator. Each participant was given an internet link after registering for the webinar series through CELP, and at each scheduled webinar time they logged into the website where they could see the Power Point presentations. Each attendee could also hear and interact with the presenter as well as with each other.

All participants had an interest in the session topic or in other ways were already familiar with CTT. Attendance at each session varied, with Session One having nine participants, Sessions Two and Three having five participants, and Session Four having 3 participants. As all attendees were working professionals, the time of the sessions, which was during business hours, was not always conducive to attendance, and is noted as a limitation to this project.

Session One, entitled “Exploring Healthcare Today,” introduced CTT and connected CTT to healthcare organizational imperatives and the national agenda. Data on lateral violence and bullying in the healthcare setting was reviewed. Initiatives directed toward safety and quality that require interprofessional partnerships were reviewed and their effectiveness discussed. Partnership as a healthcare concept was introduced.

Session Two, entitled, “Cultural Transformation Theory and Interprofessionality,” explored the theory as foundational to healthcare and specifically to interprofessionality. Interprofessionality was defined and discussed. CTT was reviewed in detail.

Session Three, entitled, “What Does Partnership Mean for Patients?” reviewed three patient complaints from patient relations records from an academic health system, followed by discussion of domination / partnership culture related to the cause of the complaints. The financial implications of domination and partnership culture on healthcare organizations was discussed.

Session Four, entitled “Operationalizing a Partnership Culture,” provided healthcare strategies that encourage a partnership culture. The use of strategic planning, goal setting, and leadership development to start an organizational journey towards a partnership culture were discussed. The discussion included the implications partnerships have for safety, quality, engagement and patient experiences.

Each attendee was given the on-line survey to rate his or her own healthcare culture on a continuum from domination to partnership. The first session providing the survey before any content was delivered. For all other sessions the survey was offered at the end of the session. Definitions for each point on the survey scale were: 1 = primary domination relations, 2 = primarily domination relations with some exceptions, 3 = a roughly even mix of both kinds of relations, 4 = primarily partnership relations with some exceptions, and 5 = exclusively partnership relations. The rating scale is shown in Figure 3.

Figure 3. Rating Scale Used in Transforming Health Care Webinar Series Survey

1	2	3	4	5
Primarily Domination Relationships	Primary Domination Relationship with Some Exceptions	Roughly Even Mix of both kinds of relationship	Primarily Partnership Relationships with Some Exceptions	Primarily Partnership Relations

One of the strengths of using a prospective on-line survey embedded in the presentation is that it captured participation of all attendees at the time of the sessions for optimum response rates. Another strength of this survey type was that neither the presenter nor the participants could see the results specific to an attendee, so results were anonymous. The 5-point scale was easy to set up within the presentation, and definitions provided to the participants with each survey ensured clarity. A limitation of the design was that the response rate was bound by attendance and not all participants attended each session, which caused variability of response rates for each session.

Each attendee also rated his or her overall experience with the webinar series via an on-line survey that was sent out after the last session.

Quantitative Results

The average of all the rankings combined for the webinar series demonstrates a rating of 2.78, which is slightly more toward partnership than domination. The overall change from baseline rating collected before the first session was 3.2. The rating of 2.2 at the end of the final webinar shows that attendees' rating shifted toward domination culture between the first session and the last session. The rating for the overall satisfaction with the webinar series was 4.83 on a 1-5 scale.

Qualitative Results

Theme 1: A Culture of Domination and the Impact on Patients

The first theme identified by participants was the connection between domination cultures in healthcare and among healthcare providers, and its impact on patients. They

referred to their healthcare environments as being “top-down”, as having a lot of “hierarchy” and “patriarchy.” One attendee commented, “Domination has influenced our healthcare policies and the environments in which we work.”

In connecting the culture to the effect it has on patients, one attendee reported, “For example thrown objects in an operation room when a patient is on the table means that the patient is a part of it. Some of the behaviors that healthcare workers direct toward others do not stop at the healthcare level. This is a huge contributor to poor patient experience.”

Another attendee noted that a physician “has to really go out of their way to be sure that patients are hearing respect in their voices when they are referring to other team members.” Fear for patients who tried to establish a partnership with healthcare providers was articulated. One participant stated that a patient may “come to the table as a full participant and be very much looked down upon and put in their place essentially.” Another reflected that in her organization, if you are a doctor, “You rule. You are not questioned and that really reflects back on patients.”

Theme 2: Leadership Impacts Organizational Culture

The second theme identified was the importance of leadership behaviors. One attendee noted that healthcare leadership “would be in shock regarding their culture because their experience is so different from those they lead.” Another noted the domination tendencies of leaders to try to force relationships in their culture by stating, “If interprofessionality or teamwork, which are partner behaviors, are mandated by senior leadership they are destined to fail.”

Theme 3: Leadership is Unaware of Domination Tendencies

A third theme identified was the overall impression of senior leader in regards to cultural understanding. One attendee stated, “If you look at our executive leaders you will realize that leadership often rank themselves higher on a collaboration partnership

scale than the rest of the organization. I really think our leaders see themselves as really collaborative. So I think there's ignorance and not having a clear mirror. I think in that way leadership is siloed."

Another shared, "I truly believe senior leaders have a very different experience, so it's not just that they don't want to see it, but in a domination culture, they do not have the same experience as line staff."

The group used words such as "unconscious", "foreign", "resistant", and "disbelief" to describe the overall impression of leadership understanding of culture.

Interpretation

The webinar series was designed to familiarize attendees with the components of domination and partnership relationships in a culture and to determine whether a greater awareness of domination/partnership culture changed the perception of their own cultures. Attendance and number of attendees who took the domination / partnership rating during each session varied, which is a limitation to any relevant findings. The findings are limited in their ability to determine whether there were changes in perception of domination versus partnership culture by attendees. It cannot be determined if the overall ranking of their organization from the beginning of the series to the last webinar rating changed more than might have happened by chance (Issel, 2009).

The findings from the webinar series are similar to the findings in the *Excellence in Nursing Institute* survey in identifying that healthcare has an element of domination within its culture. In the webinar series the baseline ratings showed that 22% of the attendees' perceived their organization to be oriented toward domination; only 11% considered their cultures to be exclusively partnership-based.

The shift in rating by attendees from the beginning of the webinar series to the end may indicate that as attendees learn about domination culture, they are more able to

recognize it within their own cultures. This confirms the need for continued exploration of culture as the foundation for healthcare outcomes and interprofessional practices. There are no other projects or studies like this in the literature that attempt to rate healthcare culture based on a theoretical framework, or more importantly, on relationships of domination and partnership, which can be seen as contributory to healthcare outcomes.

More research is needed on the impact of healthcare relationships on patients, though this project confirmed the notion that healthcare workers perceive that their culture and interprofessional relationships do affect patients. Few studies look at this correlation directly. More exploration also needs to be done on the impact of leadership on culture and culture change.

Discussion

The implications of this project are far-reaching. All healthcare leaders are being tasked to lead change within their organizations to improve outcomes. These change efforts may well be futile depending on where their organizational cultures are on a domination / partnership continuum. Armed with these considerations, healthcare leaders can now have a better understanding of why efforts to improve safety, quality, and employee and patient experience continue to flounder. Healthcare leadership may choose to focus efforts on cultural transformation as a strategy for change instead of tactics that may not net desired outcomes in the absence of a culture that is based on partnership.

The webinar series "*Transforming Healthcare Culture*" allowed for rich dialogue that identified themes that can become a call to action for healthcare organizations. The first theme identified is an affirmation that domination culture impacts patients. Further consideration should be given to the strong possibility that patients' experiences will not improve until healthcare culture is addressed, and interprofessionality and partnership between care givers improves. Many healthcare organizations today are spending money, time, and effort on improving their patients'

experiences without first considering improving their cultures and addressing how the relationships of those who care for patients are structured. This knowledge can help healthcare organizations focus on efforts that will lead to desired outcomes.

The second and third themes addressed the importance of leadership in healthcare, a subject that is much discussed and written about. These two themes bring to light a possibly startling realization that although current healthcare leadership is extremely important to the creation of culture, current leaders may be unaware of domination tendencies in their organizations and be least able to assess it, compared to others not in leadership roles. It should not be surprising that leaders in a domination system may not be aware of their own domination style or tendencies.

It is hoped that these identified themes will spur new efforts to understand leadership needs in healthcare today, and raise questions about how leaders are chosen and trained. This calls for further reflection on the reality that current leadership may be contributing to the inability of healthcare to transform its own cultures.

This project contributes to the understanding of healthcare culture based on how relationships are structured, and provides a launching pad for other studies. CTT provides a common language and context for the little-understood and little-discussed topic of how healthcare relationships are structured. More work is needed to assess healthcare culture based on relationships, and how culture affects patients and healthcare outcomes, as well as what kind of leaders are needed to lead healthcare forward to improved safety, quality, staff and provider engagement, and patient experience.

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