Assessment of organizational culture types in Gaza Strip hospitals

Avaliação dos perfis de cultura organizacional em hospitais da Faixa de Gaza

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Abstract

The aim of the study was to describe the organizational culture types and their dimensions at the governmental and non-governmental hospitals in the Gaza Strip of Palestine. It was a descriptive cross-sectional study that involved 400 participants of the governmental and non-governmental hospitals in the period between June and December 2018. The target population included all the working staff categories at the hospitals as physicians, nurses, paramedics, and administrators. About 60% of the sample was male and 40% was female. Most of the participants' age was between 20-40 years. Of these, 78.2% were having bachelor's or higher degrees and 17.9% were having diplomas or lesser degrees. Participants' sample sizes were diverse according to the types and capacities of their hospitals. The highest number of participants was from governmental hospitals with 82.5%, while 17.5% was from non-governmental hospitals. The highest determined types of management in Gaza Strip hospitals were clan and hierarchy-oriented cultures. The non-governmental hospitals had higher means than the governmental ones in all the organizational culture types. The comprehensive approach of organizational culture is desired to study the organizational culture type and realize its direction and trend before establishing new procedures or initiative programs.

Keywords: Hospital; Strategic Management; Organizational Culture; Palestine; Gaza Strip.

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Resumo

O objetivo deste estudo foi descrever os perfis de cultura organizacional e suas dimensões nos hospitais governamentais e não governamentais da Faixa de Gaza da Palestina. Trata-se de uma pesquisa transversal descritiva que envolveu 400 participantes de hospitais governamentais e não governamentais no período de junho a dezembro de 2018. A população de estudo incluiu todas as categorias de trabalhadores dos hospitais como médicos, enfermeiras, paramédicos e administradores. Cerca de 60% da amostra era do sexo masculino e 40% do feminino. A faixa etária da maior parte dos participantes situava-se entre 20 e 40 anos. Destes, 78,2% possuíam bacharelado ou pós-graduação, enquanto 17,9% possuíam apenas diploma de graduação ou níveis menores de formação. O tamanho amostral dos participantes foi diverso de acordo com os tipos e capacidades dos hospitais. O maior número de participantes foi de hospitais governamentais com 82,5%, enquanto 17,5% eram de hospitais não governamentais. Os perfis de cultura organizacional mais comuns nos hospitais da Faixa de Gaza foram a cultura de clãs e de hierarquia. Os hospitais não governamentais apresentaram médias superiores aos governamentais em todos os perfis de cultura organizacional. É recomendável o uso de uma abordagem abrangente da cultura organizacional de modo a estudá-la e perceber sua direção e tendência antes de se estabelecer novos procedimentos ou iniciativas.

Palavras-chave: Hospital; Gestão Estratégica; Cultura organizacional; Palestina; Faixa de Gaza.

Introduction

Organizational culture (OC) is the set of shared values, beliefs, and norms that influence the way employees think, interact, feel, and behave in organizations. Managing OC has been increasingly viewed as a lever for healthcare organizations (HCOs) performance. OC is an anthropological metaphor used to inform research and consultancy and thus to explain organizational environments (Mannion; Konteh; Davies, 2009). Recently, OC has been increasingly seen as essential for healthcare system operations (Frith et al., 2014).

However, healthcare has undergone a continuous change in recent decades, under the combined influence of a complex set of interrelated political, economic, and social factors. The reason for the existence of subcultures in healthcare systems is that HCOs have many different medical and administrative staff who are bound to shape the identity of these subcultures (Brooks; Brown, 2002). Cultures in hospitals consist of various subcultures, such as different units, professional groups, and functional groups. Unlike other organizations, hospitals and HCOs in its nature tend to have weaker or more fragmented cultures.

Hernández Junco et al. (2008) report that additional components of the healthcare sector OC relate to the atmosphere, the workforce commitment, and warm human treatment. Professionals and non-clinicians also need to know and understand the organization's mission and have a clear and focused strategic direction (Carney, 2011). Therefore, some healthcare systems have used the study of the organization's culture as a tool to diagnose and improve their services. Indeed, an important and necessary part of any healthcare reform will lead to an increase in the management of OC. It is a challenge to find a theoretically robust and meaningful method of capturing cultural issues for those working in the organizations in question (Gale et al., 2014).

In organizations with strong cultures, most employees agree on the organizations' values (Chatman; Cha, 2003) and their organizations give their employees greater meaning, commitment, and guidance (Nystrom, 1993). As other studies have shown, HCOs with a strong culture achieve the desired results, such as a

low number of conflicts, job security, and stability (Nystrom, 1993). According to West et al. (2014), if an organization has strong values of compassion and security, the organization's employees learn the importance of care and safe practice. Therefore, they argue that if organizations aim for better care, they must concentrate on nurturing appropriate cultures (West et al., 2014).

Some studies have shown links between OC and results such as supplier satisfaction (Zazzali et al., 2007), medication administration error reporting (Wakefield et al., 2001), quality of diabetes care (Bosch et al., 2008), and the introduction of practices to improve quality (Shortell et al., 1995). The Medical Institute (IOM) in the USA has repeatedly emphasized the link between patient safety, medical well-being, and OC (Institute of Medicine, 2001; Kohn; Corrigan; Donaldson, 1999). In general, the extensive literature on OC was not matched by an evaluation of the OC in the medical literature (Hoff et al., 2004).

Thus, the organizational theories that provide the best models for understanding the hospital environment include: Handy's (1996) Role/Apollo culture, Schein's (1985) theory of OC in relation to the assumptions that define an organization, and Mintzberg's (1996) theory of organizational configurations and professional organization classifications. Finally, the approach of Mintzberg to OC and the characterization of the professional organization is appropriate to the hospital environment, where professional standards are established externally (Montgomery et al., 2011).

In Palestine, the Ministry of Health (MOH) is the main healthcare provider and serves as a regulatory body for the Palestinian healthcare system; it provides primary, secondary, and tertiary services for the whole population. However, one of the main determinants of the success or failure of their hospitals is the assumption that there is a correlation between the success of the hospitals and their emphasis on the values and concepts that motivate their members to commit themselves, work hard, innovate, participate in decision making, and work to introduce, maintain and improve the service.

The hospitals are organizations that introduce humanity services to ill people in abnormal and undesirable situations. Then, to present their services, they must have their own culture not only to produce their services but to achieve some degree of satisfaction with their patients besides the quality of services. In addition, to the best of the author's knowledge, this is the first attempted replication of the Competing Value Framework (CVF) developed by Cameron and Quinn (1999) regarding the assessment of the role of OC at hospitals in the Gaza Strip (GS). The CVF was developed and has been used in Western countries, which have very different OCs. This study thus attempts to determine its suitability for the Palestinian context, in particular, the hospitals in the GS. Its findings will be useful for healthcare managers and policymakers to improve the strategic situation of healthcare provision and to solve some of its stuck problems.

Methodology

The purpose of this study was to describe the perceptions of hospital staff about the types of OC in their hospitals and their dimensions within their governmental and non-governmental organizations (NGOs) hospitals in GS. OC typologies as perceived by employees were based upon Cameron and Quinn's (1999) cultural framework. According to available knowledge, this study considers a reference study of the types of OC perceived by participants from different departments in the hospitals sectors of the GS. The author focused on the participants' perceptions of OC because they are factors that are theoretically and empirically linked to the experience of employees in the workplace (e.g. Bass; Avolio, 1993; Schein, 2010; Trice; Beyer, 1993; Waldman; Yammarino, 1999).

The author conducted a non-experimental, descriptive study to describe perceptions of hospital staff about the types of their OC. A cross-sectional descriptive design was used when means differences between variables were being examined and described. The types of OC were the dependent variables, and the different dimensions of the cultures were the independent variables. OC was described in terms of OC sub-scale scores from the Organizational Culture Assessment Inventory (OCAI). Hospitals were described with scores from the demographic questionnaire. Different-sized hospitals were chosen

for the following reasons: first, due to the nature of this study, the author decided to include participants from different professional groups. Second, a cross-section of the hospitals would ensure the sample be representative of all GS hospitals.

Non-probability convenience sampling was employed. The sample population was heterogeneous. Subjects were obtained from a population of fulltime-working employees. The sample can be described as stratified because the hospitals were categorized according to the hospital owners and the participants were further grouped by professions. The sample was also a random selection because individuals were chosen randomly from within each professional group. Therefore, selecting the sample in this way ensured that it would represent the hospitals (the study population) and the professional groups (the target population). The study targeted the hospitals' staffs in each profession including physicians, nurses, paramedics, administrators.

The total number of staff working in governmental and non-governmental at the time of calculating the sample was 3022. The author's initial goal was to obtain at least 341 questionnaire responses from the chosen sample. This total sample size was then increased to 400 . A response rate of 85% was obtained after about 470 questionnaires were distributed.

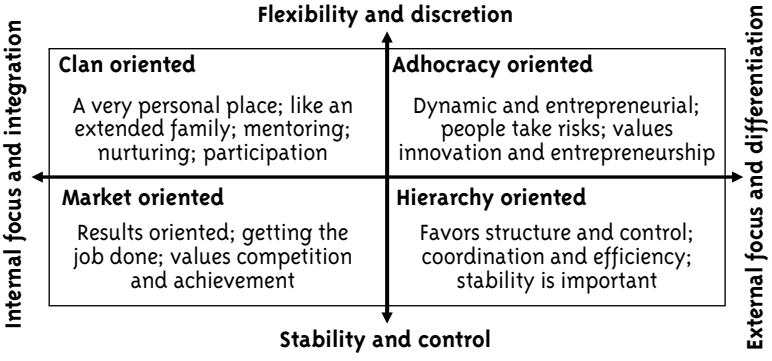
Organizational Culture Assessment Inventory (OCAI)

OCAI was developed by Cameron and Quinn (1999) based on an OC framework built upon a theoretical model referred to as the CVF. The OCAI is used to determine the OC profile based on the core values, assumptions, interpretations, and approaches that characterize organizations (Cameron; Quinn, 1999). In this framework, an organization has either a predominant internal or external focus, or it strives for flexibility and individuality, or stability and control.

The OCAI tool consists of six questions, and each question had four alternatives, thus making a total of 24 items. The OCAI adopted the normative scale, as the five-point Likert scale ranged from 1 (strongly disagree) to 5 (strongly agree), which was used by the author in this study instead of the ipsative scale (or forced-choice measurement) . The dependent variables were the OC types (clan, hierarchy, adhocracy, and market). The dominant cultural orientation was indicated by the highest score of the four types (Figure 1).

Several studies have indicated that the OCAI is a valid and reliable instrument in measuring OC. The instruments used in this study had been originally developed in English and were translated into Arabic for use with other researches. A standard three-step protocol reported by Burlingame and Blaschko (2010) was used when translating the questionnaire.

Figure 1 – Organizational culture four types



The Clan Culture is typified by a friendly place where people share a lot of themselves. The organization emphasizes the long-term benefit of individual development with high cohesion. The Adhocracy Culture is characterized by a dynamic, entrepreneurial, and creative workplace. The organization's long-term emphasis is on rapid growth and acquiring new resources. Market Culture is characterized by a results-oriented workplace. Leaders are hard-driving producers and competitors. The long-term concern is on competitive actions and achieving stretch goals. The Hierarchy Culture is characterized by a formalized and structured place to work. The long-term concerns of the organization are stability, predictability, and efficiency.

Source: based on Cameron and Quinn (1999)

Results

Characterists of hospitals and participants

A total of five hospitals in GS were included in this study. Three of these were public hospitals (AlShifa, AlAqsa, AlRantisi) and two were NGOs hospitals (AlAwda, Public Aid). This decision was made to ensure that the various OCs in the different hospitals were represented. The gender representation of the participants included about 60% male individuals (n =227) and 40% female individuals (n =153). The average age of the participants was between 20 and 40 years. The selection of participants in this age group (young adult) was important because they are at their prime stage of identity formation, ready to intimacy, and compassion. Similarly, young adults are highly motivated, capable of self-efficacy and self-concept, which lead to attaining the work requirements.

The percentage of participants by profession was 37.2% nurses, the highest frequency, physicians constituted 28.8% of the group, administrators 19.0%, and paramedics 15.0%. Also, 55.3% of the participants were derived from compound hospitals, 26.4% were from small hospitals and only 18.3% were from the large hospitals. This indicates that the author opted to include a diverse set of staff categories as well as participants from varying sizes of hospitals as classified by the MOH. This inclusion was intended to ensure the multiplicity of the culture, views, and to determine the discrepancy between categories. Also, the number of participants was based on the size of the hospitals where they work. Given the diversity of participants, different types of tools may be needed to deal with the different categories, regarding which category had the necessity to start the improvement, and where exactly the focus of efforts had to be amplified.

As shown in Table 1, 65.1% of the participants worked at hospitals for a period ranging from one to ten years. However, a significant number (81%) worked for six or more years in the healthcare sector. Around 71% of participants were ordinary employees while nearly 21% were heads of sections or departments; the rest had other positions. This may indicate that healthcare workers in GS hospitals may have different knowledge and awareness about the cultures of those hospitals.

Table 1 – Demographic profile of participants

Variable	Valid No.	Percentage
Educational level		
Secondary school	15	3.8
Two-year degree diploma	70	17.9
Bachelor	231	59.1
Master	48	12.3
Doctorate	27	6.9
Total	391	100
Occupation position		
Employee	279	71.2
Section Head	34	8.7
Department Head	47	12
Others	32	8.1
Total	392	100
Work years in hospital		
1-5	106	27.3
6-10	147	37.8
11-15	76	19.5
16-20	42	10.8
21≤	18	4.6
Total	389	100
Work years in the healthcare sector		
1-5	72	19.1
6-10	138	36.6
11-15	78	20.7
16-20	56	14.9
21≤	33	8.7
Total	377	100

Hospitals' organizational culture types

To depict the general overview of the hospital's OC, the author obtained cultural profiles of the hospitals by examining the participant ratings (the mean and standard deviation values) of each of the four OC types (Table 2). After calculating the mean of each dimension of each culture type,

the author found that the perceptions of OC's dimensions were the highest with the clan culture, hierarchy culture, and adhocracy culture at 3.36, 3.27, and 3.24 respectively (Figure 2). Five of the six content areas also demonstrated a congruent OC, as perceived by the participants (Figure 3).

Table 2 – Descriptive statistics of the organizational culture types

Culture type	N.	Mean	SD
Clan	400	3.36	0.83
Adhocracy	400	3.24	0.80
Market	400	3.19	0.80
Hierarchy	400	3.27	0.86

Figure 2 – Hospitals organization culture types

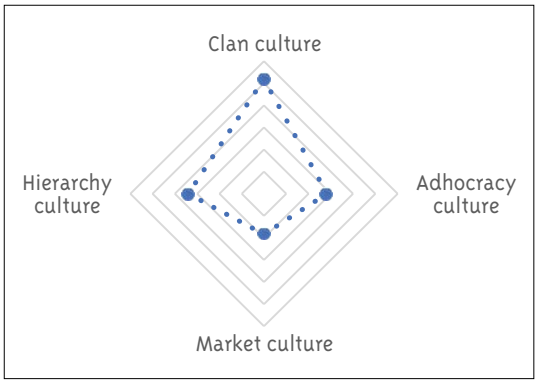
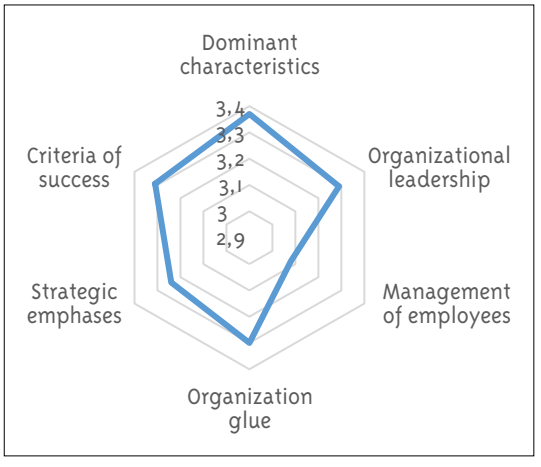


Figure 3 – Dimensions of the organizational culture of hospitals



Cultural congruence indicates that the diverse components of an organization's culture are aligned (Cameron; Quinn, 2006). This study found that clan culture is dominant in four of the six content areas. These results are consistent with previous studies that aimed to identify the predominant culture within the Palestinian Primary Healthcare Centers of the MOH and the Primary Healthcare Centers of the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) by using the CVF and examining its influence on the adherence to the Clinical Practice Guideline for Diabetes Mellitus (Radwan et al., 2017). Opposed to our results, the author concluded that in private Jordanian hospitals, the hierarchy type was the most dominant culture, and clan culture was the least (Saif, 2017).

Clan culture is defined in part by relationships characterized as close and family-like. Clan culture finds resonance with the construct of collectivism (Hofstede, 1984). Clan leaders act in a facilitative, supportive way and may take on a parental role. In contrast, hierarchical culture is characterized by a formalized and structured workplace. Stability, predictability, and efficiency are valued within the organization as well as respect for position and power (Cameron; Quinn, 2006). This study's result is similar to those indicated by Zhou et al. (2011) when they studied OC at 87 public hospitals in China in preparation for reforms in public health. In his study, Zhou et al. (2011), also confirmed the OC of public hospitals in China was mainly internally focused. Therefore, the staff could consider the hospital as a big family in which people shared the values and common goals and expected to be empowered more by their leader acting as a mentor or a father in the family. This pattern helps to consolidate staff commitment to the hospital with loyalty and close bond among colleagues.

In addition, other factors responsible for the hierarchy culture include high control within the workplace, a high degree of formality in the relationships between managers and employees, and rigidity in the work environment. The dominance of this pattern of OC can be explained in the sense that the leaders of these hospitals behave like owners and are not healthcare administration experts. Therefore, they rely on instructions

to control the situation at hand and to achieve their goals. These types of hospitals placed a strong emphasis on increased productivity and maintaining efficiency. The leaders were tough and demanding; they could not be facilitators or adapt important management techniques, such as teamwork and human resources development.

The results showed that the dominant characteristic, organizational leadership, staff management, and strategic emphases were of the clan type and human relations oriented (Table 3). This human resource management approach was characterized as "clan" by placing people at the center of the hospital's concerns, as expressed by the employees. These dimensions were therefore combined with organizational leadership, sharing the same characteristics, with their strong clan component, might have the most influence on the general OC. The strength of culture reflects both the integration of agents within the organizations, commitment to the organizations' goals and sharing their objectives. It is suggested that reinforcing this clan human-oriented culture with the focus on results and outcomes, may be more useful for the management of the hospital.

In the analysis of the six domains of OCAI, the results in all hospitals showed that; (1) within the "dominant characteristics" domain, the majority of the participants consider the organization as an extended family where they share a lot among themselves. This had an average score of 3.63, the highest of all domains` items; (2) the clan culture dimension was followed by the hierarchy culture dimension with 3.41, and the lowest score was the market culture dimension with 3.20. This refers to the main atmosphere of the hospitals in GS, which experience mixed two culture types. The first type (clan culture) focuses on the internal aspects of the hospitals through the daily operational procedure and relations. However, the second type (hierarchy culture) is more related to the decision-making process and its implementation in up-down hierarchy nature. In coincidence with that, the domain of "organizational leadership" reveals that the highest mean for the clan and hierarchy cultures are 3.42 and 3.30 respectively.

Table 3 – Dimensions of organizational culture types

Types of Organizational Culture	Mean
Clan Culture	
The organization is a very personal place. It is like an extended family. People seem to share a lot of themselves	3.63
The leadership in the organization is generally considered to exemplify mentoring, facilitating, or nurturing.	3.42
The organization emphasizes human development. High trust, openness, and participation persist.	3.33
The organization defines success based on the development of human resources, teamwork, employee commitment, and concern for people.	3.31
The management style in the organization is characterized by teamwork, consensus, and participation.	3.30
The glue that holds the organization together is loyalty and mutual trust. Commitment to this organization runs high.	3.16
Adhocracy Culture	
The glue that holds the organization together is the commitment to innovation and development. There is an emphasis on being on the cutting edge.	3.36
The organization defines success based on having the most unique or newest products. It is a product leader and innovator.	3.35
The organization is a very dynamic entrepreneurial place. People are willing to stick their necks out and take risks.	3.25

continued...

Table 3 – Continuation

Types of Organizational Culture	Mean
The organization emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	3.19
The leadership in the organization is generally considered to exemplify entrepreneurship, innovation, or risk-taking.	3.18
The management style in the organization is characterized by individual risk-taking, innovation, freedom, and uniqueness.	3.10
Market Culture	
The glue that holds the organization together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.	3.29
The organization defines success based on winning in the marketplace and outpacing the competition. Competitive market leadership is key.	3.25
The leadership in the organization is generally considered to exemplify a no-nonsense, aggressive, results-oriented focus.	3.24
The organization is very results-oriented. A major concern is with getting the job done. People are very competitive and achievement-oriented.	3.20
The organization emphasizes competitive actions and achievement. Hitting stretch targets and winning in the marketplace are dominant.	3.19
The management style in the organization is characterized by hard-driving competitiveness, high demands, and achievement.	3.00
Hierarchy Culture	
The organization is a very controlled and structured place. Formal procedures generally govern what people do.	3.41
The glue that holds the organization together is formal rules and policies. Maintaining a smooth-running organization is important.	3.41
The organization defines success based on efficiency. Dependable delivery, smooth scheduling, and low-cost production are critical.	3.34
The leadership in the organization is generally considered to exemplify coordinating, organizing, or smooth-running efficiency.	3.30
The organization emphasizes permanence and stability. Efficiency, control, and smooth operations are important.	3.26
The management style in the organization is characterized by the security of employment, conformity, predictability, and stability in relationships.	2.89

Moreover, the "management of employees" domain in the organization that is characterized by the security of employment, conformity, predictability, and stability in relationships, presented the lowest item between all domains' items with a mean 2.89. The hospitals are characterized by teamwork, consensus, and participation. Similarly, individual risk-taking, innovation, freedom, and uniqueness are characteristics that have been featured prominently. Under the "strategic emphases" domain, the organization emphasizes human development, high trust, openness, and participation persist had the highest mean with 3.33. The organization defines success based on having the most unique or newest products, the product leader and innovator variable was the highest item under the OCAI's sixth domain "criteria of success".

To compare the OC types with the different hospital sizes, One Way-ANOVA test was used. The compound hospital (Al-Shifa) in this study, had the lowest means in all culture types with

3.07, 2.99, 2.95, and 2.94 for clan, adhocracy, market, and hierarchy cultures respectively at p-value = 0.00. The small hospitals had the highest means with 3.93, 3.73, 3.71, 3.88 at the same significant level. Post-Hoc-Scheff test showed differences between the three hospital sizes. The author suggests that consensus may be clearer in small organizations and the culture dimensions may also be perceived more clearly. Generally, small to medium-sized organizations are rigid in mindset and are also controlled by the owner or founder.

Regarding the OC types with the different characteristics of the participant, the study showed that paramedics had the highest mean with all types of culture 3.77, 3.54, 3.47, 3.63 for clan, adhocracy, market, and hierarchy culture respectively at a statistically significant level = 0.00. The physicians had the lowest mean with all types of culture with market culture being the lowest, with a score 3.01. The Post Hoc-Scheff test showed that differences were between nurses, physicians, and paramedics. The head of departments scored the lowest means of all OC types in their different hospitals at a significant level (p-value = 0.00) except for the market culture, which was not at a significant level (p-value = 0.103). The researcher refers to the high expectation and awareness of the OC concept from the head of departments that may have its effect on this regard.

The possible explanation of the good mean score of the hospitals' OCs may be related to expectations which affected the self-reported responses. Possibly, hospitals' staffs in GS have lower expectations and less exposure to other contexts. Therefore, they reported more positive perceptions about OC regardless of their actual satisfaction with their hospitals. The analysis of OC assessed by different groups of healthcare staff would help managers determine whether there are differences in the mindset of hospital staff groups. Based on that, the leader could develop the most appropriate strategies, which focus on the specific groups to achieve consistency in the desired OC pattern. It also suggests that leaders manage human resources overall or by groups effectively. The managers could be better equipped to define the policies that have great impacts on each target group of the hospitals' staff.

Discussion

Having drawn a picture of the overall culture profile as well as the profiles of each of the six cultural attributes, one can now interpret these profiles from several different perspectives. At least four comparison standards are available: (1) the type of culture that dominates the organization, (2) discrepancies between the current and preferred future culture, (3) the strength of the culture type that controls the organization, (4) the congruence of the culture profiles generated on different attributes and by different individuals in the organization.

To date, relatively few studies in medical group practices have examined the OC (Brazil et al., 2010). It has been argued that OC can be more prominent in small medical group practices because they typically lack the formalized structure of a large HCO; culture can therefore be a particularly important determinant in the performance of healthcare (Zazzali et al., 2007). Recent medical practice studies have found that the OC is linked to doctors' job satisfaction (Zazzali et al., 2007) and the reduction of medication errors (Kaissi et al., 2007).

If understanding a place's culture requires considering the diversity of staff in a hospital, it is precise because they interact with one another. Therefore, it is important to consider the internal cultural diversity of hospital society; this is essential for a better understanding of the institution and for transforming society's life and overcoming conflicts of interest and tensions in social life. Hospitals have certain notoriously dominant trends, such as the formation of strong groups with centralized political institutions. The formation of these hard cores, or core sets, has its origins in theAt least six comparison processes of consolidating administrative policies directed since the foundation of the healthcare organization, which tends to give a specific characteristic to the construction of administrative policymaking in a hospital through a hierarchical "bureaucracy" of experts, which is institutionalized over time through a relationship. According to Bennett and

Franco (1999), "the OC varies significantly between different organizational units (such as hospitals and healthcare centers)".

This study reveals that organizational clan (collaborate) culture type distinguishes the unique status of Palestinian hospitals which places a premium on the cohesion of teamwork involvement and consensus. Clan culture has been effectively compatible with Palestinian organizational strategic objectives. It showed a strong source of motivation and behavioral control towards collective ends, especially during crisis periods.

The similarity in the level of scores in most of the dimensions reveals the state of culture that was already existing in GS hospitals. This implicates that the strength of the relations between these dimensions and refers to the impact each dimension has on the other dimension. Therefore, when an OC initiative or program focused on some of the dimensions of culture, the other dimensions will be affected (spill-over effect), and incrementally unpredictable positive effects will change the direction of the hospitals' OCs.

The management of employees and strategic emphases within hospitals' culture dimensions were the weakest areas and the dominant characteristics and criteria of success were the strongest ones, which indicates that the challenge faced the hospitals' staffs is the management behavior with a daily focus on short-term goals, which may prohibit them from taking a part in the OC building. The dimensions of organizational glue, organizational leadership, with the strongest ones still need quality improvement strategies to be adopted. However, the lower percentages of these dimensions (68%) occurred mainly due to a weakness in one or two related variables of these dimensions. This might direct the promotion and supportive actions of stakeholders and providers on these specific issues.

The most important factor of decision making was identified to be OC and it is also considered as the most challenging factor for organizations (Devi Ramachandran; Choy Chong; Ismail, 2011). Moreover, OCs in hospitals are, in most cases, weak cultures which include two or more different subcultures such as doctors or nurses (Traczyńska; Kunecka, 2018). In the preferred scenario, improvements to hospital care would be delivered through a balance and a uniform strengthening of the four types of cultures (clan, adhocracy, market, and hierarchy). An organization that can balance opposing cultural characteristics seems to have the best chance to successfully implement change and sustain it. This is according to Quinn and Rohrbaugh (1983) who assert that effective organizations present contradictory cultures. The study suggests that to build a hospital OC that can suit both current and future expectations of healthcare workers, it is important to take individual and institutional variations into account. More specifically, because one size cannot fit all, it is necessary to integrate some of the other cultural types' dimensions into the dominant one, to serve both the diversity and the expectations of healthcare staff.

Final remarks

Hospitals' OCs are, in most cases, totally oriented cultures. In the preferred scenario, improvements to hospital care would be delivered through a balance, and a uniform strengthening of the four types of cultures. The organization that can balance opposing cultural characteristics seems to have the best chance to survive more and successfully implement improvement and change programs.

The clan and hierarchy cultures are perceived as the predominant cultures in the GS hospitals investigated in this study. In the Palestine context which is surrounded by crises and tries to survive under conflict, these types of OC are more logical to be presented prominently in hospitals, especially in the GS. Hospitals are a very personal place where staff shares a lot among themselves. Benefiting from the limited resources and sustaining quality results required more control over the unstable conditions, thus, supporting a more structured process of decisions and non-flexibility of implementations, and also in the atmosphere of family and collectivism.

The author argues that hospitals can benefit more from these relatively strong areas of the culture dimensions in supporting the other moderate or weak areas in two ways. The first is by increasing the focus of enhancement on the weak dimensions' activities. This is because the improvement effort

will focus more on a lesser number and specific cultural dimensions. The second is by continuous reinforcement of strong dimensions that will positively affect the other OCs' dimensions because they had interrelated construction. The analysis of each variable in this study has helped to determine that the two components that need to change urgently are organizational glue and strategic emphases of the hospital.

The comprehensive approach of culture means that hospital managers need to study culture and realize its direction and trend before they establish any new procedures or initiative of programs (change partially or totally). The assessment of OC will offer a roadmap and scan the obstacles areas that may be found in the hospitals' strategic plans before starting their procedural actions. This may lower their trial-errors process, decrease faults, and increase the hospitals' opportunities to succeed. As provided by the comprehensive approach of OC, implementing actions might develop in parallel behaviors, not in just a unidirectional method or approach.

Researchers who have been interested in conducting a study in this line will strongly believe that the culture of any given place has a great influence on the corporate strategy and the working structure of that particular place. This refers to the fact that this is the glue that holds any given organization to contribute to the performance and commitment of the employees. So, it is recommended that managers or administrators develop a long-term plan in a manner that can meet the benchmarking and the modality level of hospital values. Management is an art, which mobilizes and coordinates the possibilities of work and employees, and can make use of their potential.

The author considered some of the implications for further studies of OC in hospitals and healthcare settings; (1) it is imperative to use ipsative scales for OC evaluation as this would require participants to provide more accurate answers by allocating a higher score for each item according to its importance; (2) further research should be developed to understand the values, attitudes and human relationship factors contributing to strengthening a healthy OC; (3) when OC changes must be made, the age group of the HCOs must be considered to fulfill the desired strategic goals and also to prevent any unbearable reverse; (4) further research could be performed by comparing OC types and leadership styles with different healthcare settings, as in the private sector and primary healthcare centers; (5) one could also compare the OC types with other sectors like health sciences education facilities in the same context of the GS.

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Recebido: 03/06/2020
Aprovado: 03/08/2020