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The Corporate culture of Nevada hospitals

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THE CORPORATE CULTURE OF NEVADA HOSPITALS

by

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ABSTRACT

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The initial focus of this study is to identify the dominant culture of Nevada hospitals and to determine whether hospital organizations in Nevada share similar corporate values and beliefs. If differences exist, what are the distinctions in those organizations that make them different? The competing values framework was used to diagnose four corporate culture types of each hospital. The clan culture possesses high affiliation and concern with teamwork and participation. The developmental culture is based on risk taking, innovation, and change. The hierarchical culture reflects values and norms associated with bureaucracy. The rational culture emphasizes efficiency and achievement (Quinn & Spreitzer as cited by Baker et. al., 2003).

Data was collected through the use of a cross-sectional mail survey to all hospitals in Nevada. The sample included 44 acute care, psychiatric, rehabilitation, and specialty hospital CEOs in the state of Nevada. Sixteen individual responses were returned, which represents 36.4% of the study population (n = 44).

The dominant corporate culture of Nevada hospitals was the clan culture (75%). Further analysis of the data was made using Chi-Square test to determine if the independent variables of ownership, geographical location and leadership determined the dominant corporate culture. Findings suggested that none of the independent variables yielded a significant value to support this premise. Pearson correlations were also conducted on this data to determine if any correlations exist with the clan dominant corporate culture. No significant values was reported, however, other variables were explored to help describe the homogeneity of Nevada hospitals.

The Corporate Culture of Nevada Hospitals

INTRODUCTION

Corporate culture is defined as an enduring set of values, beliefs, and assumptions that characterize organizations and their members (as cited by Cameron & Quinn, 1999). Nevertheless, however one defines it, corporate culture is essential to organizational success. Corporate culture in hospitals has been variously described as a myth, weak, unique, common across institutional lines, dysfunctional, a corporate mob, and residing in the many informal entities that exist in any complex formal organization (Hood, Smith, & Waldman, 2003). Corporate culture has a powerful influence throughout a hospital on such matters as who gets promoted, what decisions are made, and even how employees act (Arnold, Capella, & Sumrall, 1987).

An increasing body of evidence supports a linkage between corporate culture and its business performance. In the business area, evidence has confirmed that companies that put emphasis in key managerial components such as customers, stakeholders, employees, and leadership outperform those that do not have these cultural characteristics (Berrio, 2003). Furthermore, corporate culture creates both stability and adaptability for organizations. It reinforces continuity and consistency in the organization through adherence to a clear set of consensual values (Cameron & Quinn, 1999).

The need to diagnose and manage corporate culture is growing in importance, partly because of an increasing need to merge and mold different corporate cultures as structural changes have occurred such as consolidation, capitalism, and merger of hospitals (Cameron & Quin, 1999). Every hospital has a culture. As a living organization, people make a hospital work and its cultures ties people together, giving meaning and purpose to their day to day activities

and lives (Arnold, Capella, & Sumrall, 1987). Thus, understanding the prevailing culture in hospitals can introduce new forms of teamwork and bring forward best practice models (Robertson et. al., 1999).

Purpose of the Study

There is strong support for research and problem solving on issues related to corporate culture. Pressures to understand the impact of current health care practices and to solve apparent nursing shortages, escalating health care costs, and inter-professional conflicts have generated an increasing interest in the role of hospital culture and climate in effective health care delivery (Afifi et al., 1995). The purpose of this study is to describe the corporate culture of hospitals in Nevada by analyzing similarities and differences of corporate culture in hospitals throughout the state in comparison to ownership and geographical location. It also addresses the relationship that may exist among CEO's leadership styles and stakeholders' priorities to the corporate culture of these hospitals.

Research Questions

The study assesses Nevada hospitals' corporate culture utilizing the competing values framework (Cameron & Freeman, 1991). This study is organized around three basic questions:

1. What is the present dominant corporate culture of hospitals in Nevada?
2. What trends exist among corporate culture in comparison to ownership and geographical location in Nevada?
3. Is there a relationship between corporate culture and other organizational variables such as the CEO's leadership style and stakeholder priorities in each culture type?

The initial focus of this study is to delineate the dominant corporate culture type for Nevada hospitals through testing the following hypothesis:

Hypothesis 1: The predominant corporate culture within a hospital is related to the type of ownership.

Hypothesis 2: Corporate culture is affected by the geographical location of the hospital.

Hypothesis 3: The leadership style of the CEO will determine the corporate culture of the hospital.

Hypothesis 4: The importance placed on various stakeholders to the hospitals will determine the corporate culture of the hospital.

Significance of the Study

Like all organizations, health care delivery systems should be concerned with understanding the implicit beliefs, values, and assumptions existing within hospital organizations that motivate and shape the behavior of participating members (Afifi et. al., 1995). Thus, this study should enhance understanding of corporate culture types within hospitals in the state of Nevada. Secondly, this study should advance understanding of how CEO leadership style and stakeholder importance influence the corporate culture of hospitals in the state of Nevada.

Understanding the corporate culture in hospitals is important for several reasons. First, research suggests that the typical health care organization's corporate culture is seriously dysfunctional (Hood et. al., 2003). Thus, assessing hospitals' corporate cultures can expose this dysfunction, which may be at the root of health system problems. Second, staffing problems in hospitals, specifically, excessive turnover and professional withdrawal are becoming more serious. Assessing hospitals' corporate culture can render the symptoms that may be traced directly to job dissatisfaction and culture conflict. Lastly, as the health care system is evolving, change within hospitals are inevitable (Hood et al., 2003). Thus, it is not only important to understand the corporate culture of a hospital but also necessary to manage it in order to achieve

sustainable change in care delivery and, hence; improved outcomes (Hood et al., 2003). However, effective change in the healthcare system requires detailed, accurate knowledge of the current corporate culture.

This paper begins with a review and assessment of the current body of knowledge in relation to corporate culture. Also, included in this discussion is the conceptualization and measurement operation of corporate culture and leadership style. Next, the utilization of the Competing Values Framework (CFV) as a theoretical frame for corporate culture and leadership style will be discussed, followed by a detailed description of the methodology of the study. Finally, analysis of data, along with presentation and dissemination of findings will be presented. The paper closes with limitations of the study and recommendations for further research.

Definition of Terms

Clan Culture: Cultures that possess high affiliation and concerned with teamwork and participation (Quinn & Spreitzer as cited by Baker et. al., 2003).

Developmental Culture: Cultures that are based on risk taking innovation and change (Quinn & Spreitzer as cited by Baker et. al., 2003).

Hierarchical Culture: Cultures that reflects the values and norms associated with bureaucracy (Quinn & Spreitzer as cited by Baker et. al., 2003).

Rational Culture: Cultures that emphasize efficiency and achievement (Quinn & Spreitzer as cited by Baker et. al., 2003).

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Corporate Culture: An enduring set of values, beliefs, and assumptions that characterize organizations and their members (Cameron & Ettington as cited by Cameron & Quinn, 1999).

Leadership: The perception of hospital CEO's leadership attributes of themselves in the organization (Dastmalchian, Lee, & Ng, 2000).

LITERATURE REVIEW

The conceptual foundation for studying organizational cultures has existed in the research literature since the early 1930's (Trice & Beyer as cited by McGee et al., 2003). However, the term "culture" has no single, agreed interpretation (Surber as cited by Savage, 2000). Therefore, numerous challenges exist in any study of the corporate culture in hospitals, these include: demographic decisions; evaluation of organizational attitude and behavior; methodological issues; and appropriate outcome measures (Hood et. al., 2003). A search for an appropriate research instrument that measures organizational culture identified a number of relevant studies, and one instrument that covers the issues needed to assess the corporate culture of Nevada hospitals and the leadership style of Nevada hospitals' CEO's.

Corporate Culture in Hospitals

Achieving the right kind of corporate culture is critical for hospitals. In general the corporate culture of U.S. hospitals are considered high in information complexity; as measured by the use of diagnostic/treatment categories for reimbursement, the number of multiple payers and the relatively moderate to low degree of resource scarcity, as measured by the a mount of economic and human resources spent per capita on health care services (Gerowitz et. al., 1996). Hospitals are social groups composed of people who pursue a common purpose and shared values and beliefs, and who therefore, possess a similar culture (Hood et. al., 2003).

Theory and concepts of corporate culture have particular applicability to hospitals, because the ability to achieve a common goal depends to a great extent on effective interrelations among people (Denison as cited by Hood et. al., 2003). Different organizations often have unique cultures and subcultures, and groups within an organization can possess their own values, attitudes, languages, and pattern of behavior. A hospital has a variety of subcultures- the

governing body, physicians, nursing, and departmental subcultures. So, a hospital is a hodgepodge of different subcultures- some strong, some weak, some internally focused, and some externally focused- all of which must knit together if the institution is to carry out its mission (Bice, 1984).

A hospitals' corporate culture is composed of four basic elements (Deal and Kennedy as cited by Arnold, 1987). First, they have values, basic concepts and beliefs for the organization. This establishes standards of achievement and success within the hospital in concrete terms. Second, they have heroes who personify the culture's values and serve as tangible role models for employees to follow. Third, they create rituals and ceremonies to systematically perform routines of day-to-day life in the hospital. Rituals are relatively routine manifestations that show employees the kind of behavior that is expected of them. Ceremonies are extravaganzas that provide visible and potent examples of what the hospital stands for. Fourth, there is a cultural network, the primary means of communicating within a hospital. It carries the hospital's values and heroic mythology (Arnold et. al., 1987)

Defining Corporate Culture

During the last two decades, the concept of corporate culture has emerged as an essential tool for understanding and possibly changing the behavior of individuals in organizations (Afifi et. al., 1995). There is no single universally accepted definition of the term "corporate culture", and this leads to a great deal of conceptual confusion and ambiguity in the literature. Depending on its theoretical inclination, the use of the term is used in different ways (Bagraim, 2001). Many concepts of culture are based on the assumption that as members of an organization negotiate shared meaning about issues relevant to the organization, they begin to formulate a set of commonly held beliefs or assumptions that guide their perceptions, thoughts, feelings, and

behaviors, with the organization (Afifi et. al., 1995).

Baker et. al. (2003), describe corporate culture as the widely held values and beliefs about appropriate behaviors and activities in the organizations. Hampden-Turner (1999) defines it as a pattern of basic assumptions invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration that has worked well enough to be valid and to be taught to new members as the correct way to perceive, think, and feel in relation to problems (as cited by Brown et. al., 2002).

Yet, according to Ouchi (as cited by Bice, 1984) corporate philosophy includes the organization's objectives, its operational procedures, and its social and economic environmental constraints. It is embracing this philosophy that leads to the development of smaller practices and modes of conduct that become corporate culture (Bice, 1984). Graves (as cited by Brown et. al., 2002) depicts corporate culture as the unique configuration of norms and behaviors that characterize the manner in which employees combine to accomplish tasks.

Researchers who have studied corporate culture suggest that these values and behaviors are products of organizational experience and influence many areas of organizational life (Baker et al., 2003). Cameron and Ettington (1988) reviewed a long list of published definitions of corporate culture and noted that in a majority of cases, corporate culture has been treated as an enduring set of values, beliefs, and assumptions that characterize organizations and their members (as cited by Cameron & Quinn, 1999). Due to this finding, this definition will be used in this study.

Measuring Corporate Culture

Corporate cultures are difficult to evaluate because their shared beliefs, values, and assumptions are not always explicit (Schein as cited by Davies et. al., 2003). Qualitative

approaches are advantageous in detailing the environmental factors influencing this socialization process (Afifi et. al., 1995). Furthermore, qualitative approaches help researchers to move beyond superficial explanations of culture and are greatly aided by conceptual frameworks that seek to explain important cultural dimensions (Davies et. al., 2003). However, when one of the objectives is to determine a degree of association and not to merely describe connections between dominant corporate culture type and other variables, then quantitative methods should be used.

A quantitative survey methodology that has shown promise for application is the competing values framework (Cameron and Freeman, 1991). This utilizes a scenario approach to eliciting responses from organizational members. It was originally developed by Quinn and Rohrbaugh in 1983 to examine the relationship between organizational culture and organizational phenomena (Dion, Johnson, & Obenchain, 2002). Over thirty indicators of effectiveness were statistically analyzed and reviewed by notable organizational theorist and researchers. Emerging out of this study were two main dimensions that organized the indicators into four main quadrants (Lawson, 2003).

The development and the use of the Competing Values Framework (CVF) as a tool for organizational diagnosis have evolved over the past several years. Past research using the core dimensions of the CVF suggest that the instrument is internally reliable and is strongly associated with different types of organizational performance (Cameron (1986) as cited by Gerowitz, 1996). The competing values framework has been applied in both healthcare and non-healthcare organizations. It has also been validated in a number of studies. For example, Kallaith, Bluedorn, and Gillespie (1999) used the CVF to validate its effectiveness in a hospital setting, and concluded it was an excellent measure of organizational activity (as cited by

Johsnon, 2002). Thus, this framework will provide a way to describe and explain qualitative information about organizational culture (Davies et. al., 2003).

The CVF is based on two main dimensions, focus and content. An organization is either strongly internally or externally focused. When put together, these two dimensions render a quadrant as seen in Fig. 1 with four culture orientations. The terminology used below was cited by Davies et. al.(2003) as shown in Fig. 1. This model was adapted from Cameron and Freeman (1991) who utilized the label set of clan, adhocracy, hierarchy, and market. This model was further modified to reflect the work of Denison and Sprietzer (1990) who used the terms groups, developmental and rational (as cited by Gerowitz et. al., 1996).

Figure 1. Competing Values Framework

Relationship based processes
Focus on flexibility, individuality, and spontaneity

CLAN CULTURE **Staff climate**: Cohesive, participative, sense of family **Leader style**: Mentor, facilitator, parent **Reward system**: Bonded by loyalty, tradition, ability to sustain interpersonal cohesion **Strategic emphasis**: Toward developing employee commitment and morale	DEVELOPMENTAL CULTURE **Staff climate**: Dynamic, creative, adaptive, entrepreneurial **Leader style**: Entrepreneur, risk taker, innovator, broker **Reward syst**em: Bonded by entrepreneurship, taking and sharing risks. **Strategic emphasis**: Toward innovation and growth
HIERARCHICAL CULTURE **Staff climate**: Rigid with emphasis on order, procedures, and predictability **Leader style**: Coordinator, monitor, organizer, and administrator **Reward system**: Based on following rules, policies, and procedures **Strategic emphasis**: Toward stability, predictability and smooth operations.	RATIONAL CULTURE **Staff climate**: External competitiveness, and goal achievement **Leader style**: Competitor, producer, director, hard driver and achievement orientated. Seen as expert. **Reward system**: Based n ability t access external resources, competition **Strategic emphasis**: Toward competitive advantage, market superiority, winning

Internal focus
Focus on internal smoothing and integration

External focus
Focus on competition and differentiation

Mechanistic-type processes
Focus on control, order, and stability

Fig. 1 Competing values model of culture types for organizations (adapted from Cameron & Freeman, 1991 as cited by Davies et. al., 2003; Denison & Sprietzer (1990) as cited by Gerwitz, et. al., 1996; and Hartnett, 2003).

While the competing values framework defines each of the four cultures as the "ideal" types, the model assumes that culture is not absolute. That is, organizations are unlikely to reflect any one type of culture. Rather, organizations are likely to reflect a combination of each culture type with some types being more dominant that others (Gerowitz et. al., 1996). This scheme is called the competing values framework because the criteria seem to initially carry a conflicting message (Quinn, 1988 as cited by Hartnett, 2002). Indeed, it displays the paradox that exists inherently in notions of effectiveness in organizations as they pursue competing, or paradoxical, criteria simultaneously (Hartnett, 2002).

Corporate Culture Types using the Competing Values Framework

The clan culture is internally focused and process oriented. This is reflected in the concerns for employee loyalty, commitment and group cohesion. It is associated with trust and participation through teamwork. The focus is on the maintenance of internal organizational relationships. Organizational success is defined in terms of developing member commitment to the organization (Gerowitz et al., 1996).

The developmental culture emphasizes innovations and adaptation designed to satisfy key external stakeholders. The structure, while goal directed is often fluid and organic, shifting with changes in the nature of the problem or task at hand and taking into consideration the interests, developmental needs and skills of described as dynamic, creating a stimulating environment that promotes creativity and growth (Gerowitz et. al., 1996). These organizations are entrepreneurial and rewards are linked to individual initiative.

The hierarchical culture values predictability. The focus is on the maintenance of internal organizational stability through the enforcement of rules and regulations. The internal process model most clearly reflects the traditional theoretical model of bureaucracy and public

administration that relies on formal rules and procedures as control mechanisms. Organizational success and effectiveness is defined in terms of control and stability. The staff climate is characterized as one of rigidity with primary motivations based on the groups needs for security (Gerowitz et. al., 1996).

The rational culture emphasizes performance in terms of organizational goal fulfillment and achievement. In this culture, motivation comes from a desire to achieve external competitive advantage. Organizations of this type are production oriented. Rewards come from the achievement of ends derived through managerial choice (Gerowitz et. al., 1996).

Leadership Style in the Competing Values Framework

Achieving the right kind of corporate culture is critical for hospitals. All the authors emphasize leadership in the shaping and management of corporate culture (Bice, 1984). There is an enormity of literature related to leadership. In contrast to other leadership theories, the competing values framework integrates contradictory leadership roles into one single framework and suggests that leaders should perform eight opposing supervisory roles in order to fulfill competing expectations (Shao, & Yang, 1996).

In the competing value framework, each "ideal" culture type is characterized by a particular style of leadership that reinforces and shares its values, staff climate and reward systems (Gerowitz et. al., 1996). Most organizational leaders tend to emphasize some roles, while ignoring the other roles completely (Shao & Yange, 1996). However, effective leaders demonstrate behavioral complexity, the ability to both conceive and perform multiple and contradictory roles when responding to conflicting and fluctuating demands (Denison et. al., 1995 as cited by Hartnett, 2002). Quinn argues that more effective leaders have the ability to play multiple, even competing leadership roles. They are expected to play all of these roles and

to simultaneously consider and balance the competing demands that are represented by each set of expectations (Quinn, 1988 as cited by Hartnett, 2002).

Leadership roles in the clan culture are seen as facilitator or mentor (Martin & Simon, 2002). Leaders are considerate, supportive and facilitate teamwork and group interaction. Leaders manage conflict and seek consensus. His or her influence is based on getting people involved in the decision-making and problem-solving process. Participation and openness are actively pursued. Leaders are aware of other and cheer for the needs of individuals. His or her influence is based on mutual respect and trust. Morale and commitment are actively pursued (Cameron and Quinn, 1999 as cited by Marin & Simons, 2002).

In the developmental culture, leadership is viewed as innovator or broker, and willing to take risks. In this culture, leaders concentrate on attaining organizational legitimacy and external support. These leaders envision change. Their influence is based on anticipation of a better future and generates hope in others. Innovation and adaptation are actively pursued. Leaders focus on where the organization is going and emphasize possibilities as well as probabilities. Strategic direction and continuous improvement of current activities is a hallmark of this style pursued (Cameron & Quinn, 1999 as cited by Martin & Simons, 2002).

In the hierarchical culture, leadership takes the role of monitor and the coordinator. Leaders tend to be conservative and cautious. Leaders keep track of all details and contribute expertise. His or her influence is based on information control. Documentation and information management is actively pursued. Leaders maintain the structure and flow of the work. His or her influence is also based on situational engineering, managing schedules, giving assignments, physical layouts. Stability and control are actively pursued (Cameron & Quinn, 1999 as cited by Martin & Simons, 2002).

Leadership roles in the rational culture are the producer and director. In the rational culture, leaders are viewed as goal-directed, frequently restructuring and defining success in terms of relative market position and access to external resources (Gerowitz et. al., 1996). Leaders actively pursue goals and targets are energized by competitive situations. Winning is a dominant objective, and the focus is on external competitors and marketplace position. Leaders get things done through hard work. His or her influence is based on intensity and rational arguments around accomplishing things. Productivity is actively pursued (Cameron & Quinn, 1999 as cited by Martin & Simons, 2002).

METHODOLOGY

Survey Tool/Instrument

A questionnaire consisting of 45 measures utilized a modified version of Cameron's Competing Values Framework and was expanded to include the variables of managerial leadership style (Quinn, 1988 as cited by) and key stakeholders analysis (Lawerence, 1989 as cited by Gerowitz et. al., 1996). CEO's were asked their perceptions of the hospitals' corporate culture, their managerial leadership style, and the degree of importance placed on key stakeholders to the hospitals (See Appendix 2).

Sixteen items were presented on the questionnaire to assess corporate culture type. The sixteen items were adopted from Yeung, Brockbank, and Ulrich (1991) as cited by Dion, 2002 and Cameron and Quinn (1999). Exact scale items are noted in Appendix 3-1. The sixteen questions were divided among four questions, which had four alternatives. CEO's were asked to rank the four alternatives depending on the extent to which each alternative was similar to their own hospital, where 1 was the most similar.

Sixteen items on the questionnaire also assessed the leadership style of the CEO. Quinn (1988) developed a 32-item survey to assess managers' performance on each of the eight leadership roles contained within the CVF(as cited by Hartnett, 2002). For the current study, this Competing Values Leadership Instrument (CVLI) was modified using only 16 of the 32 questions and adapted to assess hospitals CEO's leadership behaviors (Appendix 3-3). Numerous studies have provided supportive evidence of the reliability and validity of the eight scales that result from the CVLI (e.g. Cameron and Quinn, 1999; Dension et. al., 1995, as cited by Hartnett, 2002). For each item comprising the various domains, respondents indicated on a 7-point scale (1 = almost never to 7 = almost always) the frequency with which the CEO's perceive themselves to use each of the behaviors (See Appendix 3-2).

Fifteen questions on the questionnaire attempted to assess the importance placed on various stakeholders to the hospitals. For each stakeholder, CEO's indicated on a five-point scale (1 = irrelevant to 5 = very importance) the degree of importance placed on each stakeholder. See Appendix 2 for survey instrument.

Sample Population

The sample population was comprised of 44 acute care, psychiatric, rehabilitation, and specialty hospital CEOs in the state of Nevada and was drawn from the Nevada Hospital Association and the state-by-state hospital index from the Directory of America's Hospitals. This number represents 100% of the sampling frame population. The rationale for using only CEO's was that they represent major constituencies in the hospitals. That is, they are formal position holders who influence the hospitals' policy, direction, and performance. Reliance on the use of such key information in assessing organizational culture in the business domain is common.

Of the 44 surveys mailed, two were undeliverable for reasons such as "not at this address" and "no street delivery P.O. box number". Sixteen individual responses were returned. This represents 36.4% of the study population (n = 44). Based on the response rate, follow-up mailing was conducted which yielded no difference.

Data Collection Methods

Data was collected for this study through the use of a cross-sectional mail survey over a one-month time frame to hospitals in Nevada. Ethical approval was obtained from the UNLV Institutional Review Board and the CEOs of each hospital. The mail survey process utilized a modified version of tailored design method espoused by Dillman (2000) (as cited by Dion, Johnson, & Obenchain, 2002). In accordance with the tailored design method (Dion, 2002), survey recipients received a packet including a personalized introductory letter (Appendix 1), a letter of informed consent, a three page written survey, a self-addressed/postage paid envelope and the incentive. A one-page bibliography of the core literature related to this study and a 2004 calendar were used as incentives to promote goodwill and foster interest in the survey content.

For the collection of the survey data, the following tool was used. Four of the questions pertained to the corporate culture of the hospital. Sixteen of the questions pertained to the managerial leadership style of the CEO. Fifteen questions analyzed the importance placed on stakeholders. The remaining ten questions attempted to obtain descriptive and personal data about the hospital and the CEO. Past research using the core dimensions of the CVF suggests that the instrument is internally reliable and valid.

Data Analysis Process

The process of analysis involved two stages. The first stage consisted of diagnosing the dominant corporate culture type of the hospital and the dominant leadership style of the CEO

using the score sheets in Appendix 4-1 and 4-2.

For the four questions corresponding to each particular culture type, a mean score was calculated, yielding a numerical score for each culture type for each hospital (See Appendix 3-2). The type with the lowest numerical score was assigned the dominant organizational culture type for the institution. Rational for this approach was supported by Yeung, Brockbank, and Ulrich (1991) (as cited by Dion, 2002). See Appendix 4-1.

To diagnose a leadership style, a score sheet procedure was adopted from Johnson (2002). The rating given for each question corresponding to a leadership role was first recorded. Next, a mean was computed from the eight different leadership roles and yielded a leadership role rating. Finally, a mean was taken from each leadership role rating and yielded a leadership behavior model rating. This final rating was comprised of the four culture types and was used to diagnose the dominant leadership style of the CEO. The type with highest numerical score was assigned the dominant leadership style of the CEO. The Appendix 4-2 shows in detail how this calculation was computed.

The second stage of the analysis was to compute correlations and investigate the relationship between the primary dependent variable, corporate culture type, and to the independent variables of ownership, geographical location, leadership style and stakeholder importance. Using SPSS, descriptive statistics were used to analyze the data. Chi Square Test was used to evaluate the level of statistical significance attained by the relationship of the dominant corporate culture type to the independent variables. Lastly, Pearson's correlations were calculated to determine if any of the independent variables had a significant correlation with the dominant clan corporate culture type of the hospitals.

Variables

The four corporate culture types were treated as the primary dependent variable. The independent variables included ownership, geographical location, dominant leadership style, and stakeholder importance.

FINDINGS

Hospital Characteristics

Table 1. Descriptive Characteristics of Nevada Hospitals (n = 15)

Characteristics		*Percent*
Bed size	Less than 50	31.3%
	51 – 100	18.8%
	101 - 200	25.0%
	201 - 300	6.3%
	Over 300	18.8%
Ownership	Investor owned	37.5%
	State/local	25.0%
	Church affiliated	12.5%
	Not-for-profit	12.5%
	Federal	12.5%
Geographical location	Southern Nevada Urban	43.8%
	Rural Nevada	31.3%
	Northern Nevada Urban	18.8%
	Northern Nevada/ Northeast California	6.3%

The hospitals in the sample were diverse. The largest portion of the sample had less than 50 hospital beds (31.3%). Only 6.7% of the hospitals had bed sizes between 201 and 300 beds. Investor owned hospitals comprised of 37.5% of the sample, while 12.5% of the sample was owned by church affiliate, federal, and not-for-profit. The largest portion of the sample was located in the urban southern Nevada area (43.8%). Only 6.3% was located in Northern Nevada/Northeast California area (See Table 1).

CEO Characteristics

Table 2. Descriptive Characteristics of CEO of Nevada Hospitals (n=15)

		Mean (Standard Deviation) or Percent
Age	25 - 35	6.3%
	36 - 45	31.3%
	46 - 55	37.5%
	56 - 65	25.0%
Gender	Female	31.3%
	Male	68.8%
Education level	High school	6.3%
	Undergraduate	18.8%
	Graduate	75.0%
	Doctorial	0%
Salary	Less than 100,000	21.4%
	100,000 - 120,000	14.3%
	161,000 - 180, 000	28.6%
	181,000 - 200,000	14.3%
	Above 200,000	21.4%
Bonus eligibility	Yes	73.3%
	No	26.7%
Years as CEO		9.93 (8.10)
Current Years as CEO		4.14 (4.50)

The CEO's of the hospitals were also diverse. The largest portion of the CEOs was between the age of 46 and 55 (37.5). Only 6.3% of the CEOs ages ranged between 25 to 35 years of age. Male CEOs were the majority in the sample (68.8%) and 75% of the CEOs had graduate degrees. None of the CEOs in the sample had earned a doctoral degree. The salary ranges of the CEOs were about evenly distributed with 28.6% of salaries between $161,000 and $180,000. Most of the CEOs were eligible for bonuses (73.3%). The average number of years that the sample has been working as CEO of a hospital and at their current hospitals was 9.93 and 4.14 years respectively. (See Table 2).

Analysis of Data

Table 3. Descriptive Statistics for the Corporate Culture Types of Hospitals in the Sample

Characteristics		Mean	Rank	SD
Culture Score	Clan	1.44	1 - 4	.39264
	Hierarchical	2.25	1 - 4	.55528
	Developmental	2.69	1 - 4	.75000
	Rational	2.86	1 - 4	.71279
		# of Hospitals		%
Dominant Culture Type	Clan	12		75.0%
	Developmental	1		6.3%
	Hierarchical	1		6.3%
	Rational	1		6.3%
	No Dominant Culture	1		6.3%

The average time it took to complete the survey was 14.14 minutes. The majority of the hospitals were diagnosed as having a clan culture (75%). Only 6.3% of the hospitals were dispersed equally among the other three culture types (See Table 3). For the four questions corresponding to each particular culture type, a mean score was calculated, yielding a numerical score for each culture type for each hospital (See Appendix 3-2). The type with the lowest numerical score was assigned the dominant organizational culture type for the institution (See Appendix 4-1).

The mean score computed for the clan culture was 1.44 on a 1 to 4 scale (1 being most similar). The hierarchical culture had the second most similar mean score with a value of 2.25 on a scale 1 to 4 (See Data Analysis Process in the Methodology section for review).

Comparison of Corporate Culture Type to Hospital Ownership

Table 4. Cross Tabulation of Dominant Corporate Culture Type to Ownership

			Ownership					Total
			Investor owned	Church affiliated	State/local	Not-for-profit	Federal	
Culture Type	Clan	Count	5	1	2	2	2	12
		% within Culture Type	41.7%	8.3%	16.7%	16.7%	16.7%	100.0%
		% within Ownership	83.3%	50.0%	50.0%	100.0%	100.0%	75.0%
	Developmental	Count	0	0	1	0	0	1
		% within Culture Type	.0%	.0%	100.0%	.0%	.0%	100.0%
		% within Ownership	.0%	.0%	25.0%	.0%	.0%	6.3%
	Hierarchical	Count	0	1	0	0	0	1
		% within Culture Type	.0%	100.0%	.0%	.0%	.0%	100.0%
		% within Ownership	.0%	50.0%	.0%	.0%	.0%	6.3%
	Rational	Count	1	0	0	0	0	1
		% within Culture Type	100.0%	.0%	.0%	.0%	.0%	100.0%
		% within Ownership	16.7%	.0%	.0%	.0%	.0%	6.3%
	No Dominant Culture*	Count	0	0	1	0	0	1
		% within Culture Type	.0%	.0%	100.0%	.0%	.0%	100.0%
		% within Ownership	.0%	.0%	25.0%	.0%	.0%	6.3%
Total		Count	6	2	4	2	2	16
		% within Culture Type	37.5%	12.5%	25.0%	12.5%	12.5%	100.0%
		% within Ownership	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Equals to 2 or more culture types with equal values.

In comparing the culture type to the ownership, the only significant difference was of the investor owned hospitals. Of those, 83.3% had a clan culture. Investor owned hospitals in this category, represent 41.7% of all hospitals that were diagnosed with the dominant clan culture. (See Table 4)

Comparison of Corporate Culture Type to Hospital Geographical Location

Table 5. Cross Tabulation of Dominant Corporate Culture Type to Geographical Location

			Geographical location				Total
			Southern Nevada Urban	Northern Nevada Urban	Rural Nevada	Northern Nevada/ Northeast California	
Culture Type	Clan	Count	6	2	3	1	12
		% within Culture Type	50.0%	16.7%	25.0%	8.3%	100.0%
		% within Geo. location	85.7%	66.7%	60.0%	100.0%	75.0%
	Developmental	Count	0	0	1	0	1
		% within Culture Type	.0%	.0%	100.0%	.0%	100.0%
		% within Geo. location	.0%	.0%	20.0%	.0%	6.3%
	Hierarchical	Count	0	1	0	0	1
		% within Culture Type	.0%	100.0%	.0%	.0%	100.0%
		% within Geo. location	.0%	33.3%	.0%	.0%	6.3%
	Rational	Count	1	0	0	0	1
		% within Culture Type	100.0%	.0%	.0%	.0%	100.0%
		% within Geo. location	14.3%	.0%	.0%	.0%	6.3%
	No Dominant Culture*	Count	0	0	1	0	1
		% within Culture Type	.0%	.0%	100.0%	.0%	100.0%
		% within Geo. location	.0%	.0%	20.0%	.0%	6.3%
Total		Count	7	3	5	1	16
		% within Culture Type	43.8%	18.8%	31.3%	6.3%	100.0%
		% within Geo. location	100.0%	100.0%	100.0%	100.0%	100.0%

*Equals to 2 or more culture types with equal values.

In comparing the corporate culture type to geographical locations, the only significant difference was of the hospitals that resided in urban Southern Nevada. Of those, 85.7% had a clan culture. This represents 50% of all hospitals with a clan culture type. Also of the urban Southern Nevada hospitals, 14.3% were diagnosed with a rational culture. This comprises 100% of all hospitals with a rational culture type. (See Table 5)

CEO Leadership Style

Table 6. Descriptive Statistics for the Leadership Style of CEO in the Sample

Characteristics		Mean	Range	SD
Leadership Style	Rational	6.17	1-7	.47186
	Clan	5.94	1-7	.55902
	Hierarchical	5.66	1-7	.79517
	Developmental	5.44	1-7	1.08972
		# of CEOs		%
Dominant Leadership Style	Clan	3		18.8%
	Developmental	2		12.5%
	Hierarchical	3		18.8%
	Rational	5		31.3%
	No Dominant Culture*	2		18.8%

*Equals to 2 or more culture types with equal values.

The dominant leadership style of the CEOs in the sample was with the rational culture type (31.3%). The remainder of leadership styles was closely distributed among the other culture types (See Table 6). To diagnose a leadership style, a score sheet procedure was adopted from Johnson (2002). The rating given for each question corresponding to a leadership role was first recorded. Next, a mean was computed from the eight different leadership roles and yielded a leadership role rating. Finally, a mean was taking from each leadership role rating and yielded a leadership behavior model rating. This final rating comprised up the four culture types and was used to diagnose the dominant leadership style of the CEO. The type with highest numerical score was assigned the dominant leadership style of the CEO.

The rational culture leadership style had a mean score of 6.17 on a 1 to 7 scale (7 being almost always). The clan culture leadership style was closely behind with 5.94 on a scale 1 to 7 (See Data Analysis Process in the Methodology section for review).

Comparison of Corporate Culture Type to CEO Leadership Style

Table 7. Cross Tabulation of Dominant Corporate Culture Type to Dominant Leadership Style

			Leadership Style					Total
			Clan	Developmental	Hierarchical	Rational	No Dominant Culture*	
Culture Type	Clan	Count	3	2	2	3	2	12
		% within Cult. type	25.0%	16.7%	16.7%	25.0%	16.7%	100.0%
		% within lead. style	100.0%	100.0%	66.7%	60.0%	66.7%	75.0%
	Developmental	Count	0	0	1	0	0	1
		% within Cult. type	.0%	.0%	100.0%	.0%	.0%	100.0%
		% within lead. style	.0%	.0%	33.3%	.0%	.0%	6.3%
	Hierarchical	Count	0	0	0	1	0	1
		% within Cult. type	.0%	.0%	.0%	100.0%	.0%	100.0%
		% within lead. style	.0%	.0%	.0%	20.0%	.0%	6.3%
	Rational	Count	0	0	0	1	0	1
		% within Cult. type	.0%	.0%	.0%	100.0%	.0%	100.0%
		% within lead. style	.0%	.0%	.0%	20.0%	.0%	6.3%
	No Dominant Culture*	Count	0	0	0	0	1	1
		% within Cult. type	.0%	.0%	.0%	.0%	100.0%	100.0%
		% within lead. style	.0%	.0%	.0%	.0%	33.3%	6.3%
Total		Count	3	2	3	5	3	16
		% within Cult. type	18.8%	12.5%	18.8%	31.3%	18.8%	100.0%
		% within lead. style	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Equals to 2 or more culture types with equal values.

In comparing the corporate culture type to the dominant leadership style, the only significant difference was of the CEOs that had either a clan leadership style or a rational leadership style. Of the CEOs who possessed a clan leadership style, 100% of the CEOs in this category was diagnose as having a clan hospital culture. This represents 25% of all CEOs who had a clan hospital culture. Of the CEOs with a rational leadership style, 60% were diagnosed with a clan hospital culture. This also represents 25% of all hospitals with a clan hospital culture. (See Table 7)

Hospital Stakeholders

Table 8. Descriptive Statistics of Stockholder's Importance

	N	Mean	Std. Deviation
Physicians	16	4.50	1.414
Nurses	16	4.50	1.414
Patients	16	4.38	1.544
Board members	16	4.31	1.537
Line staff	16	4.25	1.571
Federal government	16	4.19	1.047
Local community groups	16	4.06	.998
Payers	16	3.94	1.340
State/local government	16	3.88	1.360
Professional peers	16	3.75	.856
Local press	16	3.56	.727
Corporate staff	16	3.06	2.294
Other hospitals in the city	16	2.63	1.928
Affiliated medical school	16	2.50	1.966
Main employee union	16	1.06	1.569

Some sources of power and influence in an organization may have little direct impact on the organization. Others affect the organization in a great deal (Faerman et. al., 1990). Analyzing the degree of importance place on hospital stakeholders is a good way to start mapping the complex network of power and influences that most affects the organization .The top five stakeholders to the sample of hospitals are physicians, nurses, patients, board members, and line staff respectively. (See Table 8)

Statistical Analysis of Hypotheses

Table 9. Pearson's Correlation of Hypotheses

		Clan Leadership Style	Rational Leadership Style	Developmental Leadership Style	Hierarchical Leadership Style	No Dominant Leadership Style	For-Profit Hospitals	Government Hospitals	Not-for-Profit Hospitals	Southern Nevada Hospitals
Clan Culture	Pearson Correlation	.324	-.127	.255	-.153	-.561(*)	.244	-.313	.078	.323
	Sig. (2-tailed)	.221	.639	.341	.572	.024	.363	.237	.774	.223
	N	16	16	16	16	16	16	16	16	16

- Correlation is significant at the 0.05 level (2-tailed).

Pearson correlations were conducted on the data to determine if any correlations exist with the clan dominant corporate culture. Due to the small sample, independent variables were grouped together. No significant values were reported that would support the four hypotheses.

Table 10. Pearson's Correlations of Other Variables

		Rational Leadership Style	Large Hospitals	Government Hospitals	For Profit Hospitals	Other Hospitals In the City	Southern Nevada Hospitals
Rational Leadership Style	Pearson Correlation Sig. (2-tailed)			-.522 .038			
Large Hospitals	Pearson Correlation Sig. (2-tailed)			.733 .001	-.600 .014	-.882 .000	
Government Hospitals	Pearson Correlation Sig. (2-tailed)	-.522 .038	.733 .001			-.605 .013	
For Profit Hospitals	Pearson Correlation Sig. (2-tailed)		-.600 .014			.640 .008	.618 .011
Other Hospitals in the City	Pearson Correlation Sig. (2-tailed)		-.882 .000	-.605 .013	.640 .008		
Las Vegas Hospitals					.618 .011		

Other variables were explored to help describe the homogeneity of Nevada hospitals. For profit hospitals are less likely to be large hospitals; they tend to place a great degree of importance to other hospitals in the city and they are mostly located in Las Vegas. Government hospitals CEOs are less likely to have a dominant leadership style, more like to be a large hospital, and less likely to be place a great degree of importance to other hospitals in the city.

CONCLUSIONS

Discussion of Results

One major impact of this study was the opportunity to explore corporate culture in the state of Nevada. Another major impact was the opportunity to assess if ownership, geographical location, leadership style, or stakeholder priorities influences the dominant corporate culture of Nevada hospitals. Chi Square test was conducted to assess the four hypotheses of this study. Hypothesis 1 stated that the predominant corporate culture within a hospital is related to the type of ownership. The probability that this association is due to chance is less than 48.4% and does not support premise that the predominant corporate culture within a hospital is related to the type of ownership. Hypothesis 2 stated that the corporate culture is affected by the geographical location of the hospital. The probability that this association is due to chance is less than 58.2% and does not support premise that the corporate culture is affected by the geographical location

of the hospital. Hypothesis 3 stated that the leadership style of the CEO would determine the corporate culture of the hospital. The probability that this association is due to chance is less than 62.2% and does not support premise that the leadership style of the CEO would determine the corporate culture of the hospital.

Hypothesis 4 stated that the importance placed on various stakeholders to the hospitals would determine the corporate culture of the hospital. A one-way ANOVA was attempted to examine the relationship to the between stakeholders and the corporate culture of the hospital. However, due to the low response rate, a value could not be adequately computed.

Nevada Hospitals' Corporate Culture

Despite not proving any strong correlations among the variables explored, there is strong evidence that Nevada has a homogenous corporate culture in hospitals. In the sample, 75% of Nevada hospitals were diagnosed as having a clan culture. Of the clan culture type, 41.7% of the clan culture hospitals were investor owned and 50% resided in the urban Southern Nevada area. Southern Nevada has a powerful influence in the business arena throughout the state of Nevada. Because of the small sample size and the concentration of investor owned hospitals in Southern Nevada, this may be skewing the results.

Few hospitals today are faced with stable environments. In recent years, the health care system has witnessed unprecedented turmoil. At a time with fluxuating and transforming environments in the health care system, (e.g. the shortage of hospital staff), hospitals are very much concerned with human resources issues such as morale, teamwork, participation and involvement. All of which are keys components of a clan culture type.

The clan culture type implicates that Nevada hospitals have also increased their efforts in building census from the bottom line up. They are striving at building a sense of community in

which there is autonomy and self-management teams. However, it should be understood that there is no one "right culture" and all four types of cultures were present in all the hospitals in the sample however in varying degree.

CEO Leadership Style

Research supports that the leadership of an organization dictates or drives the corporate culture of an organization. However there seem to be no significant association between the corporate culture of the hospital and the dominant leadership style of the CEO. In the sample of hospitals, 75% of the hospitals were diagnosed with a clan culture type, while only 25% of the clan corporate culture was governed by CEOs with both clan and rational dominant leadership styles. I had expected that there would be a perfect correlation between the CEO leadership style and the corporate culture of the hospital. That is, the CEOs that possess a clan culture leadership style should represent 100% of the hospitals with a clan corporate culture.

Hence, the question might be why there appears to not be a direct relationship between the corporate culture of the hospital and the leadership style of the CEO. In my best guess, leadership style is likely to be contingent on roles, responsibilities, and context in which the CEOs work in the hospitals in Nevada. Because 41.7% of the dominant clan culture type was investor owned, logically it should be of no surprise that the largest portion of CEOs possessed the rational culture leadership style (31.3%). That is, CEOs are focus on competitiveness, goal achievement and productivity, key trademarks of investor owned institutions.

The investor owned influence on hospitals could further explain Nevada hospitals' CEOs having this competitive orientation towards rival and being driven by customer focus and premium returns on assets (Cameron & Quinn, 1999). This is also a key trait of investor owned hospitals in general. In a rational leadership style, CEOs tend to emphasize processes such as

goal clarification, rational analysis, and action taking. They want to ensure that the hospital is effective in productivity and efficiency. While teamwork and morale is very important to their hospitals as an overall culture, in terms of hospital CEO managerial leadership style, they are most concerned about making the bottom line.

Survey Bias

While it is apparent that Nevada hospitals possess a dominant clan culture type, these results may be influenced by a survey bias. Three different studies using the Competing Values Framework also yielded the dominant corporate type being the clan culture. In a study conducted by Angel Berrio (2003), she diagnosed the dominant culture type of Ohio State University Extension. A sample was drawn from a population of three personnel categories, professionals, paraprofessionals, and support staff. An analysis of the highest mean scores obtain (mean = 28.44) showed that the dominant culture type for OSU Extension personnel was the clan culture.

Another study by Dion et. al. (2002) revealed similar findings. They collected data through the use of a cross-sectional mail survey of academic administrators of four-year-plus, not-for-profit, private, and public institutions in the United States and the District of Columbia. The sample included key informants as chief academic officers and directors of institutional research. A total of 922 responses were retained and recorded in which 464 (50.3%) institutions were diagnosed with a dominant clan culture type. Gerowitz et. al. (1996) has also used the CVF in the hospital setting. They examined the role of top management team cultures in hospitals located in Canada, the UK, and the USA. Out of 122 hospitals surveyed, 49 (40.2%) were diagnosed having a clan culture type.

Limitations of the Study

The findings and results of this study need to be reviewed critically in light of several limitations. Culture is complex and systemic, thus no one technique or method can or should be used to construct a definitive description of the culture. Reliance on a single method to measure culture will produce results containing the bias of that method. A complex system requires multiple measures using multiple methods to assess. It should be also be noted that the findings of this study were a result of a small sample size. Thus the use of the small number of hospitals in the study, acts to decrease the generalizability of the findings.

Hospitals in this research survey are characterized as having an uniform culture. This is a gross over-simplification that ignores the presence of hospitals' subcultures. Furthermore, because data collected in this sample was from only the CEOs of the hospitals, a common method bias may act to distort the findings and blunt conclusions.

In addition, this study involves the cross-sectional, self-administered questionnaire design, which was used for collecting data. The shortcoming of this method is that these estimations are retrospective and subjective. It is believed that constructing a corporate culture is a process that cuts deeply into the fabric of people's relationships, their patterns of communication and interaction, and their regard for their own potential as well of the organization they serve (Newman, 2001). Lastly, this study compared dominant corporate culture types at one point in time. This approach is limited in its ability to detect causal relationships (King and Andeson (1995) as cited by Dion et. al., 2002).

Methods for Improving the Survey

To counteract the possible methodological shortfall of using only CEOs in this study, multiple respondents from each hospital should have been solicited. This way, a mean score

could have been computed from each of the hospitals' multiple respondents. This would have given a more reliable diagnosis of the dominant corporate culture of each of the hospitals.

Also in reference to the importance placed on stakeholders, no true relationship could be established due to the low response rates and the way the questions was structured. CEO's were asked to respond on 5-point Likert scale to the degree of importance placed on each stakeholder. As a result, CEOs gave several stakeholders the same rank of importance. For example, nurses and physicians had the same value, with patients not far behind. However, we would have expected for patients to have the highest value, then perhaps, physicians and nurses following.

As a result of this question structure, it was very difficult to assess for a relationship with the corporate culture of the hospital. The measure could have been more useful if CEOs were forced to rank the stakeholders in consecutive order in terms of importance. More statistical analysis could have then been used to determine if a relationship exists with corporate culture.

Relevance of Corporate Culture and Leadership Surveys

One major opportunity that has resulted from this study is the applicability of corporate culture and leadership surveys. Because the corporate culture is deeply embedded in all layers of organizations, it is important that each level of the organization is used in assessing the corporate culture. From the literature review we have learned that most organizations are made up of several subcultures. Not all levels of the organization may perceive the same values, beliefs, or assumptions of the organization. Even CEOs and senior board members possess a certain type of subculture. Therefore, using only such persons to assess corporate culture can create a great bias.

In reference to leadership surveys, it also important to choose co-workers and subordinates to evaluate the leadership attributes of executives and leaders. Asking CEOs to

evaluate their own leadership skills can again produce a bias. Different levels of the organization may perceive executives and managers leadership skills to be very different to how they might perceive themselves. Therefore using multiple personnel can produce a mean, which would be more reliable assessment of the leadership skills.

Recommendations for Future Research

Beyond the limitations and scope of this research, several opportunities for research exist. One opportunity for future research exists with examination of the variables noted in this study. One purpose of this study was to explore different corporate culture types in hospitals in comparison to ownership and geographical location. However, this study did not include investigation into the relationship of the hospital size in comparison to the dominant corporate culture. Since no attempt was made to investigate this variable, future research should include such.

In addition, future studies examining corporate culture in hospitals should also include multiple participants representative of the critical factions in the hospitals. Inclusion of other administrative team members and department heads will enhance efforts to obtain a meaningful assessment of corporate culture. The domain of hospitals is also an area ripe for examination of corporate culture subcultures. Thus, inclusion of other participants in hospitals studies would provide a meaning contribution to the literature on the operation of hospitals.

Next, research opportunities exist for understanding hospitals that reveal a balanced (e.g. no-dominant) corporate culture type. The literature supports this designation and further notes that successful hospitals often have no particular dominant culture type (Cameron & Quin, 1999). Hospitals were assigned the designation of "no-dominant" where similar emphasis was given to two or more culture types. This can present an excellent research opportunity as well.

To further assess hospital corporate cultures, specific instruments must be designed and incorporated into research as well. Although previously established methodologies may be applicable, new instrumentation is also necessary. Observational studies may provide useful insights into rites, rituals, and ceremonials. Another useful assessment technique involves studying organizational writings, for example, annual statements, promotional materials, newsletters, and mission statements.

Lastly, opportunities exist for understanding the strength of corporate culture type. In this study, no distinction was made between strength within a particular corporate culture type. For example, strong cultures are associated with homogeneity of effort, clear focus and higher performance (Cameron & Quinn, 1999). Research in this area can also add to the literature of corporate culture assessment.

In closing, the corporate culture of hospitals is difficult to assess objectively, because it is grounded in shared assumptions of individuals in the organization (Dion et. al., 2002). There is no one best way to diagnose cultures, but administrators and managers can learn much about their hospital's corporate culture in a limited amount of time. Although findings of this study indicate, that ownership, geographical location, and CEO leadership style had no integral effect on the frequency of the dominant corporate culture of hospitals in Nevada, the exploration opportunity was of essence.

For the success of hospitals in Nevada, a distinctive dominant clan corporate culture perhaps has become a source of comparative advantage. This corporate culture type helps unify hospitals, keeping employees and managers from straying too far. However, due to the fact that corporate culture is a highly complex phenomenon that is not easily understood nor readily

characterized, further elaboration will be a fruitful avenue for future research in the hospital setting.

Appendix 1

Letter to Participants

University of Nevada, Las Vegas
Department of Public Administration/
Health Care Administration
Sherese Warren
(702)-326-7388
sherese_w@hotmail.com

March 26, 2004

Mr. /Ms. CEO
123 Streets
Las Vegas, Nevada 89142

Dear Mr. /Ms. CEO,

Hello, my name is Sherese Warren and I am a graduate student in the Public Administration Department at the University of Nevada, Las Vegas. In partial fulfillment of the requirements for a Master of Public Administration Concentrate in Health Care, a professional paper must be submitted. The focus of my professional paper is a descriptive analysis of corporate culture in Nevada hospitals. The chair of my professional paper committee is Dr. Chris Cochran, who will be working closely with me in the collection, treatment, and analysis of all data. One of the purposes of the study is to determine whether hospital organizations in Nevada share similar corporate values and beliefs. If there are any differences, what are the distinctions in those organizations that make them different?

My research interests in health care focus on the organizational dynamics that help shape the way health care organizations are governed. In particular, hospital organizations are known to be guided by a sense of shared values and principles in the organization. How these values and principles are implemented and adopted in the organization are also of interest to me. As a result, I have opted to investigate corporate cultures in Nevada hospitals. Very little research is found on this particular concept in the field of health care, thus; this is truly an inventive opportunity for me to explore. As a student, research serves as basis for the application of information learned. Hence, any assistance in this process would be greatly appreciated.

I recognize that you are a busy individual with a rigorous schedule that may hinder the time you can contribute in my research endeavors. However, I cannot express enough gratitude if you would be able to take a few minutes out of your schedule to complete and return the enclosed survey no later than **Friday, April 9, 2004**. You may be assured of complete confidentiality. No one outside of the university will have access to the questionnaire. (ID numbers will be used to identify the CEO and corresponding hospital.)

Please feel free to contact me if you have any questions, comments, or concerns. Thank you for your time and any assistance in this exiting research opportunity.

Sincerely,

Sherese Warren
Graduate Student
UNLV Department of Public Administration

cc: Chris Cocharn, Ph. D.
Associated Professor
Department of Public Administration
Health Care Administration Program

Appendix 2

Survey Instrument

Appendix 3

Tables of Survey Items

Appendix: 3-1

Competing Values Corporate Culture Assessment Instrument

Clan Culture

1A. My hospital is a very personal place. It is like an extended family. People seem to share a lot of themselves.
2A. The bond that holds my hospital together is loyalty and mutual trust. Commitment to this hospital runs high.
3A. My hospital emphasizes human development. High trusts, openness, and participation persist.
4A. My hospital defines success on the basis of development of human resources, teamwork, employee commitment, and concern for people.

Developmental Culture

1B. My hospital is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.
2B. The bond that holds my hospital together is commitment to innovation and development.
3B. My hospital emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.
4B. My hospital defines success on the basis of having the most unique or newest products. My hospital is a product leader and innovator.

Hierarchical Culture

1C. My hospital is very results orientated. A major concern is with getting the job done. People are very competitive and achievement orientated.
2C. The bond that holds my hospital together is formal rules and policies. Maintaining a smooth running organization is important.
3C. My hospital emphasizes permanence and stability. Efficiency control and smooth operations are important.
4C. My hospital defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost production are critical.

Rational Culture

1D. My hospital is a very controlled and structured place. Formal procedures generally govern what people do.
2D. The bond that holds my hospital together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.
3D. My hospital emphasizes competive actions and achievement. Hitting stretch targets and winning in the marketplace are dominant.
4D. My hospital defines success on the basis of winning in the market place and outpacing the competition. Competitive market leadership is key.

Source: (adopted by Yeung, Brockbank & Ulrich, 1991 as cited by Dion, Johnson, & Obenchain, 2002).

Appendix 3-2

Competing Values Leadership Instrument (CVLI)

Extended Version

Clan Culture

Facilitator

4. Facilitates consensus building in the hospital.
16. Builds teamwork among board members.

Mentor

10. Listen to the personal problems of subordinates.
15. Show empathy and concern when dealing with subordinates.

Developmental Culture

Innovator

5. Experiments with new concepts and procedures.
12. Searches for innovations and potential improvements.

Broker

2. Exerts upward influence in the hospital.
14. Persuasively sells new ideas to board members.

Hierarchical Culture

Coordinator

1. Protects continuity in day-to-day operations.
11. Keeps track of what goes on inside the hospital.

Monitor

7. Compares records and reports to detect discrepancies in them.
9. Works with technical information.

Rational Culture

Producer

3. Maintains a "results" orientation in the hospital.
8. Sees that the hospital delivers on stated goals.

Director

6. Makes sure everyone knows where the hospital is going.
13. Clarifies priorities and direction.

Source : (Quinn (1988) as cited by Hartnett, 2002).

Appendix 4

Scoring of Survey Items

Appendix: 4-1

Competing Values Corporate Culture Assessment Instrument
A Worksheet for Scoring

	1A
	2A
	3A
	4A
	Sum (total of A responses)
	Average (sum divided by 4)

	1B
	2B
	3B
	4B
	Sum (total of B responses)
	Average (sum divided by 4)

	1C
	2C
	3C
	4C
	Sum (total of A responses)
	Average (sum divided by 4)

	1D
	2D
	3D
	4D
	Sum (total of A responses)
	Average (sum divided by 4)

Lower scores indicate the cultures that tend to be emphasized most in the hospital.
Lowest possible score is 1, which indicates the most dominant culture type.

(Source: Cameron & Quinn, 1999).

Appendix 4-2

Competing Values Leadership Instrument (CVLI)

Scoring Sheet – Leadership Behavior Models (CVF)

Instruction: Enter the rating for each question from Part B in the column 4 and compute the Question # Rating, Role Rating, and Model Rating following the instructions in the footnotes below the table.

1. Leadership Behavior Model	2. Leader Role	3. Question #	4. Question # Rating	5. Leadership Role Rating	6. Leadership Behavior Model Rating
Clan Culture	Facilitator	4			
		16			
	Mentor	10			
		15			
Developmental Culture	Innovator	5			
		12			
	Broker	2			
		14			
Hierarchical Culture	Coordinator	1			
		11			
	Monitor	7			
		9			
Rational Culture	Producer	3			
		8			
	Director	6			
		13			

1. Leadership Behavior Model: Leadership Behavior Model per the CVF.
2. Leader Role: Leadership role per the CVF.
3. Question #: Question number from Part B of the Hospital Corporate Culture and Leadership Survey.
4. Question # Rating: Score for each question from Part B of the Hospital Corporate Culture and Leadership Survey.
5. Leader Role Rating: Sum of column 4 for each role divided by 2.
6. Leadership Behavior Model Rating: Sum of column 5 for each model divided by 2.

Source: (Johnson, 2002).

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