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SOCIAL WORK VALUES AND HOSPITAL CULTURE:
AN EXAMINATION FROM A COMPETING VALUES FRAMEWORK

by

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A dissertation submitted in partial fulfillment of the requirements
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ABSTRACT

The purpose of this study is to assess the perceptions of social workers employed in Florida hospitals in relation to the core values of their profession and the alignment of those values within the culture of their current work setting. The conceptual framework for the study was from organizational behavior theory specific to culture, values, and trust. The Competing Values Framework (Cameron & Quinn, 1999) provided a method to distinguish co-existing competing values within an organization. The research findings indicated that 65% of the professional social workers who participated in the study perceived that the core values of their profession are *very much in alignment* with the written mission statement of their hospital. However, less than half of the respondents (42%) stated the daily business of the hospital *strongly reflected* the mission statement. The social workers perceived the current culture of hospitals in Florida as being closely clustered among four cultures: clan, adhocracy, market, and hierarchy. However, they would prefer a stronger clan culture and less of a market culture in the future. A large majority (85%) of all respondents communicated that their work assignments allowed them to demonstrate their professional values on a regular basis. However, only 63% stated that they trusted that their hospital valued the knowledge and skills of their profession.

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CHAPTER ONE: INTRODUCTION

People are inclined to make career choices that satisfy and support their professional and personal values (Argyris & Schon, 1978). After making a career choice, the selection of a setting in which to practice their profession becomes equally important. Many organizational theorists believe alignment between an individual's personal and professional values and the organization for which he or she works contributes to retention, productivity, and job satisfaction (Argyris & Schon, 1978; Shafritz & Ott, 2001; Whiteley, 1995;).

Professionals who have chosen careers related to caring for the sick or injured gravitate toward hospital settings for employment, as hospitals have long been viewed as environments of care and assistance. However, in the past decade hospitals and other healthcare providers in the United States have undergone rapid and drastic change due to external influences such as managed care and rising costs (Decker, Wheeler, Johnson, & Parsons, 2001; Keigher, 2002; Laschinger, Finegan, & Shamian, 2001). Patient length of stay, cost containment, billable services and a plethora of other profit driven terms have become the common language in hospital settings. Nurses, social workers, physical therapists, physicians, and many other allied health related professionals, underwent rigorous education and training related to the physical, social and mental well-being and treatment of patients, not how to maximize profit. Therefore, the rules have changed, but the players have remained the same.

These changes represent a major shift in how hospitals nationwide do business. It

is unclear how these changes have influenced the way professionals perceive the culture of their hospitals since the changes have occurred, and whether the perceived cultures and professional values are aligned. The alignment of values between the individual and the organization strengthens the culture and provides clarity of expectations for success (Schien, 1996; Shafritz & Ott, 2001). Poor alignment of values has a negative impact on morale, job satisfaction, retention, and productivity (Rubino, 1998). One result of rapid change can be a drift from the organization's original mission. What the organization states that it does and what it is perceived as doing may have become divergent. If members of an organization perceive this incongruence and hold different values than those of senior management, then subcultures tend to emerge unknown to senior management (Martin & Siehl, 1983).

The purpose of this study was to examine how social workers perceive the current culture of hospitals in Florida. The conceptual framework for this study arose from the body of literature related to organizational change, culture, and values. A review of this literature revealed a growing body of research that reinforced the need to identify values that are understood and demonstrated within organizations as a way of facilitating change and understanding resistance to change.

According to Cameron and Quinn (1999), there are often competing values within organizations. These competing values are clustered into four frames: (a) clan culture, (b) hierarchy culture, (c) adhocracy culture, and (d) market culture. By identifying the degrees that organizations cluster into these four cultures, it may be easier to understand

what behaviors are perceived as valued and rewarded within the current cultural context. By identifying areas of misalignment between the values of the organization and the values of social workers, the social work profession may better be able to identify sources of misalignment. Regardless of the changes in social work practice settings, the core values of the profession appear to be adaptable to a broad range of specialty areas. They have proven to be remarkably steadfast over time (Gibelman, 1999). Identification of both alignment and incongruence between the organization and the individual may lead to initiatives that could strengthen the social work profession in the hospital setting.

Review of the Literature

Values and Organizational Culture

Values can be defined as whatever is cherished, appreciated, or respected (Pheysey, 1993). The Latin root for values is valor, which means strength. Values play a significant role in career satisfaction by setting our standards of behavior, decisions and goals (Mossop, 1994). The alignment between the values of an individual and the organization's values is demonstrated in behaviors. Commonly shared values demonstrate predictable and consistent patterns of behaviors that are observable. These behaviors reveal what the organization defines as quality expectations, expressed simply by the organization, and the freedom of individuals to align their actions within the boundaries of those expectations (Goman, 1997). Hospitals, like most organizations, have mission statements that attempt to articulate the values of their organizations and their

purpose for existence within a community. Recruitment and hiring practices of hospitals, their reward systems, and successes at retention are designed to reinforce that mission. Ideally, that mission statement is reflected in the organization's existing culture as demonstrated by behaviors.

According to Schein (1993), culture is the collective learning of a group that defines behavioral, emotional, and cognitive expectations. Shared values of the group help define the culture of an organization. During times of change, value systems may appear to be polarized, or competing, within an organization. According to Cameron and Quinn (1999), the culture of organizations can be diagnosed from a framework that identifies competing values. Competing values often exist within organizations.

The Competing Values Framework

The Competing Values Framework (Quinn & Rohrbaugh, 1983) offers a model with two dimensions that help define the culture of an organization. The first dimension identifies organizational effectiveness on a continuum where flexibility, adaptability, and dynamism are viewed as effective in some organizations, and stability, predictability, and durability are essential to others. The second dimension distinguishes effectiveness via internal or external orientation. Some organizations are viewed as effective if they are internally cohesive. The other side of this continuum is the organization that values interacting or competing with others positioned outside the organization.

Professional Identity, Trust and Organizational Culture

Professional identity is intertwined with role expectations within an organization. Professional identity contains values, styles of interaction, beliefs, norms, and goals (Ashforth, 2001). Values play a significant role in career satisfaction by setting our standards of behavior, decisions and goals (Mossop, 1994). These standards help us satisfy basic needs related to self-respect and confidence. Productivity, initiative, and motivation are outcomes related to self-respect and confidence.

Theories related to motivation and productivity and organizational culture have their roots in the social science literature. Abraham Maslow (1970) theorized that human motivation was based on successfully fulfilling a distinct hierarchy of needs. Building on Maslow's theory of human motivation, McGregor (1960) theorized that a flaw in management theory is the assumption that if lower needs (physiological and safety) are satisfied, workers would be productive, which therefore neglects the higher level needs. McGregor viewed social needs (belonging, acceptance) and ego needs (self-esteem) as needing to be met in order for organizations to be healthy and productive.

Argyris (1964) agreed with McGregor and suggested that employee initiative and participation had a direct correlation to how they were treated within the organization. If they were treated like children, they would behave accordingly and find ways to strike out. Behaviors such as sabotage, forming subgroups of support, or resigning from the organization were directly related to frustration and feeling devalued.

If trust is broken, morale and productivity are affected (Reina & Reina, 1999).

Successful negotiation of conflict can enhance and deepen trust because it confirms values between the parties that may have been assumed prior to the conflict. Conversely, lack of resolution to conflict affirms that there is no agreed upon value that defines the limits of interaction and fosters uncertainty related to future interactions (Nooteboom, 2003). In order for social workers in hospital settings to be effective, there must be a level of trust that confirms the shared values between the hospital and the social worker.

Change and Organizational Culture

The rapid changes that have occurred in health care over the past decade have inevitably had an impact on the organizational culture of hospitals nationwide. In times of rapid change, identifying and clarifying expectations becomes a challenge. One major impact of organizational change is the redefinition of jobs and job functions (Deal & Kennedy, 2000). According to Kurt Lewin's (Gold, 1999) early studies on change, people and jobs are matched by knowledge, attitudes, and skills. These three things define a person's expertise or specialty in their job. By developing some sense of expertise, their sense of status and prestige were boosted. If change is instituted in an organization that appears to rob an individual of the specialty or expertise that they perceive they have acquired, there is natural resistance to the change.

Schein (1993), states that the concept of culture is only viable if it addresses the human need for stability, consistency, and meaning. For organizations, a mission

statement becomes the working definition for strategic planning and drives how resources are used so the values of the stated mission are upheld (Whiteley, 1995). Vision and mission are based upon core values defined, shared, and accepted by the group. This becomes the basis of the group defining *who we are* and *why we are here*. Therefore, in order for organizational change to be effective, understanding how values infuse all human relationships is important.

Change initiatives that neglect to address the existing culture tend to fail. As many as seventy-five percent of restructuring, total quality management (TQM), and strategic planning efforts have failed, or created serious problems within the organization, because the initiatives neglected the organization's culture (Cameron & Quinn, 1999). Initiatives that are misaligned with existing culture often are met with mistrust, resistance, and resentment by members of the organization.

Social Work Professional Values

As a result of the changes that have occurred in health care, the potential exists for misalignment in hospital settings between the values of the hospital social worker and the values of the organization. External pressures and the internal response to those pressures have had an effect on virtually every professional employed in hospital settings. Hospitals and health professionals both find themselves in a state of organizational flux. Hospital social work, a health care specialization that dates back 100 years, has not gone unscathed. Misalignment of this sort can lead to job dissatisfaction, low morale, low

productivity, and high turnover (Goman, 1997).

For the purposes of this research, a *professional* social worker is defined as an individual who has earned a bachelor's or master's degree from a social work program accredited by the Council on Social Work Education or an international equivalent. Many generalizations exist related to the term *social worker*. It is not uncommon to see caseworker, social service worker, and social worker used interchangeably in job descriptions, television reports, and newspapers. Such common misrepresentation leads to a devaluing of the education, training, and skills that the profession itself deems necessary in order to be considered a professional social worker (Gibelman, 1999).

There are six core values for the profession of social work as defined by the National Association of Social Workers. They are as follows: (a) service, (b) social justice, (c) dignity and worth of the person, (d) importance of human relationships, (e) integrity, and (f) competence. This constellation of core values reflects what is unique to the social work profession (NASW, 2005).

The perception that the organization's mission continues despite organizational change, and validation that social work values are aligned with that mission, are important for trust between the social workers and the organization. During periods of organizational change, relationships between the individual and the organization are tested. If change strategies ignore the relationship between the individual and the organization, conflict occurs.

Statement of the Problem

The purpose of the study was to assess the perceptions of social workers employed in Florida hospitals in relation to the core values of their profession and the alignment of those values within the organizational culture of their current work setting.

The following questions guided the research:

1. To what extent do Florida hospital social workers perceive that the core values of their profession are aligned with the mission statement of the hospital in which they are employed?
2. To what extent do social workers perceive that the mission statement of their hospital is reflected within the current operations of the organization?
3. How do social workers perceive the current culture of their hospital in relation to their professional values?
4. What culture would hospital social workers prefer to see demonstrated in their organization?
5. To what extent do hospital social workers perceive that the tasks they perform within the hospital setting reflect their professional values?
6. To what extent do hospital social workers trust their organizations to support the practice of their core professional values?

Assumptions

1. It is assumed that persons who state on the questionnaire that they hold a

bachelor's in social work, a master's in social work, or a doctorate in social work have answered honestly.

2. It is assumed that the core values of professional social work as defined by the NASW Code of Ethics are embraced by those persons who have obtained a degree in social work.

Methodology

Population

The population for this study consisted of social workers employed in hospitals which are members of the Florida Hospital Association (FHA). The FHA provides a directory of hospitals to the public via their website (Florida Hospital Association, 2005). There are 217 hospitals in Florida listed as acute care facilities in the FHA directory. This directory was the most comprehensive list found by the researcher and includes facilities from 62 of Florida's 67 counties. The directory provided the hospital name, facility address, telephone, ownership (investor-owned, not-for-profit, public or government), county, number of beds, and House/Senate district. The bed capacity ranged from 25 beds to 1,498 beds. By statute definition (Hospital Licensing and Regulation, 2003), a *hospital* must offer intensive services beyond room, board and personal services for individuals who require diagnosis, treatment, or care for illness, injury, deformity, or pregnancy, and regularly has clinical laboratory, x-ray and surgical facilities available.

Prior to the initial mailing, telephone calls were placed to each hospital in an

attempt to identify the department(s) that housed social worker professionals and to attempt to identify a contact person who was willing to assist in distributing the surveys. To ensure that the participants have been educated and trained according to national standards of professional social work established by the Council on Social Work Education, responses from only those participants who hold a bachelor's degree in social work or a master's degree in social work were included in the study. In an effort to increase awareness and participation in the study, an announcement was placed in the Florida Chapter of Society for Social Work Leaders in Health Care (SSWLHC) newsletter.

Data Collection

Upon receiving approval from the Institutional Review Board at the University of Central Florida (Appendix A), the survey (Appendix B), and an introductory cover letter (Appendix C) were mailed to the potential participants. Names and organizational representation were kept confidential and are not disclosed in the findings or in future discussions. A self-addressed, stamped envelope was included to encourage participation.

Instrumentation

The first two pages of the survey included questions specific to education, hospital size, years of employment in health care, and the organization's mission. The *Organizational Culture Assessment Instrument (OCAI)* was utilized to aid in measuring

the perception of the participants regarding the culture of their organization. Permission to use the *OCAI* was obtained from Dr. Kim Cameron, who holds the rights to the instrument (Appendix D).

The *OCAI* is a self-administered survey instrument that clusters responses into four competing value frames that are: clan culture, hierarchy culture, adhocracy culture, and market culture. The way the responses cluster within these frames creates a profile of perceptions of the culture of an organization. Participants were asked to answer the survey based on their perception of the current culture and what they would prefer it to be in the future. The instruments were numerically coded for the purpose of identifying those who needed additional contact to increase the response rate.

Data Analysis

A description of how information collected from the *OCAI* was analyzed is presented in this section. The study was designed to address the key research questions via responses to the survey and *OCAI*.

Research Question 1, “To what extent do hospital social workers perceive that the core values of their profession are aligned with the mission statement of the hospital in which they are employed?” The fourth question on the survey addressed this research question. Participants were asked the following: In your opinion, does the written mission statement of your hospital reflect values that appear to be in alignment with professional social work core values? The response choices were: (a) very much in alignment, (b)

somewhat in alignment, (c) not at all in alignment, (d) am not sure, and (e) I am not familiar with the written mission statement. Frequency distribution by count and percentage were determined. Additional analysis of this question by subgroup was conducted. As the subgroup variables were at the nominal level of measurement, cross tabulation and chi-square analysis were used to determine if there were differences between the responses to this question by each subgroup.

Research Question 2, “To what extent do social workers perceive that the mission statement of their organization is reflected within the current operations of their organization”? Item five on the survey asked, “In your opinion, does the daily business of your hospital reflect the written mission statement?” The choices of responses were: (a) it is strongly reflected, (b) it is somewhat reflected, (c) it is rarely reflected, and (d) it is not reflected at all. The responses to this question were tabulated utilizing count and frequency distribution. Again, cross tabulation and chi-square analysis was used to determine if there were differences between the responses which were at the ordinal level of measurement and the subgroups, which were at the nominal level of measurement.

Research Question 3, “From a competing values framework, how do social workers perceive the current culture of their organization?” The OCAI contains six questions related to the following: dominant characteristics, organizational leadership, management of employees, organization glue, strategic emphasis, and criteria of success. Each question had four alternatives that were labeled A, B, C, & D. The responses linked to the culture type within the CVF as below:

Responses in alternative A link to clan culture

Responses in alternative B link to adhocracy culture

Responses in alternative C link to market culture

Responses in alternative D link to hierarchy culture

Participants were asked to divide 100 points among the alternatives with the greatest number of points assigned to the answer they felt was most similar to their organization. The profile score was determined by calculating the aggregate sum for each item, 8a-13d, on the *OCAI* in the *now* column, then calculating the mean for all responses (N=149), and dividing the mean by the number of questions, which was six. This calculation was repeated for all subgroups: BSW, MSW, and so forth, in order to determine a culture profile for each subgroup.

Research Question 4, “From a competing values framework, what culture would hospital social workers prefer to see demonstrated in their organization?” This question was assessed by calculating the aggregate sum for each item, 8a-13d, on the *OCAI* as described above but using the sums from the *future* column. The mean was then calculated for all responses (N=149), then divided by the number of questions, which was six. This calculation was repeated for all subgroups: BSW, MSW, and so forth, in order to determine a culture profile for each subgroup.

Research Question 5, “To what extent do hospital social workers perceive that the tasks they perform within the hospital setting reflect their professional values?” This question was addressed on item six on the survey that asked, “As a hospital social

worker, do you feel that your work assignments provide you with opportunities to demonstrate your professional values on a regular basis?" The response choices were: (a) yes, I am able to demonstrate my professional values consistently in my work assignments, (b) no, I am not able to demonstrate my professional values consistently in my work assignments, and (c) I am not sure. The level of measurement for this item was nominal and analysis of the results utilized frequency distribution by count and percentage. Cross tabulation and chi-square was utilized to evaluate if there was a difference in responses between this item by subgroups.

Research question 6, "To what extent do hospital social workers trust their organizations to support the practice of their core professional values?" Response to this question was assessed by item seven on the survey that asked: "As a professional social worker, do you trust that your hospital values the skills and knowledge of your profession?" The choices of responses were: (a) yes, I feel that my profession is valued in my hospital setting, (b) no, I do not feel that my profession is valued in my hospital setting, and (c) I am not sure how my hospital setting values my profession. The responses, all nominal data, were analyzed by calculating the frequency distribution of responses by count and percentage. Chi-square and crosstabulation was used to determine if there were differences between the responses and the subgroups. The analysis of the findings is discussed in Chapter Four.

Significance of the Study

Business and organizational psychology journals exhibit a large body of research related to the impact of organizational change and human behavior. The profession of social work provides important information regarding human behavior within the context of social systems but has little to offer in the way of data specific to their discipline and its interaction in the work setting. There is existing literature related to adaptability skills for social workers in times of change, validation of job activities, and possible future trends. These data assist professionals to define their roles within a changing environment. However, the social work literature does not reveal knowledge about organizational culture and competing values.

This research attempts to identify how hospital social workers perceive their work settings from a values and organizational culture perspective. The results may provide tangible information to hospital social workers that aid in the understanding of their current work environment, and how they need to position themselves as professionals for the future. The social work literature lacks research findings on hospital social work perceptions of their work setting from an organizational culture perspective. The research findings could help to conceptualize sources of conflict from a theoretical perspective that would be useful not only to social workers but to others within the organization as well. By understanding where value misalignment occurs, if it does, the profession may better be able to target areas of concern and offer opportunities for change. Social work, like many helping professions, must attempt to understand their work setting in order to

ensure a place for them in the future.

Organization of the Study

This dissertation was organized into five chapters. Chapter 1 includes the introduction to the problem, the conceptual framework, and the significance of the study. Chapter 2 provides a review of literature pertinent to theory and research on organizational culture, values, and hospital social work. Chapter 3 delineates the method in which the data was collected, the survey and instrument utilized, and population of the study. Chapter 4 describes the data results and the statistical methods used for analysis. Chapter 5 provides the findings, a summary of the study, and recommendations for future research.

CHAPTER TWO: REVIEW OF THE LITERATURE

This chapter provides a review of literature to support the rationale for this study. Research and theoretical perspectives on organizational culture and values, the impact of change on organizational culture, and the existence of competing values within organizations are reviewed. The chapter is organized into three sections: Values and Organizational Culture, the Impact of Change on Organizational Culture, and Competing Values within Organizations.

The first section of this chapter includes interrelated literature that describes how values contribute to and define organizational culture, the relationship between organizational mission and values, professional social work values, and the importance of alignment between the individual and the organization. The second section familiarizes the reader with literature related to the impact of organizational change on culture. This section provides theory and research germane to understanding the affect change has on individuals within organizations, as well as the effect of individuals on change initiatives. Literature related to professional identity, trust, managed care, and social work identity in health care is also reviewed in the second section. Literature that supports the rationale to examine issues related to alignment and perception of culture from a competing values perspective is presented in the third section. A discussion of research that demonstrates how competing values exist within most organizations and how these competing values influence change initiatives is provided. The topics in these three sections offer the

theoretical, empirical, and practical foundation for the design of the current study.

Values and Organizational Culture

Values can be defined as whatever is cherished, respected, or appreciated within an organization (Pheysey, 1993; Schein, 1990). According to Schein (1993), culture is the collective learning of a group that defines behavioral, emotional, and cognitive expectations as demonstrated by shared values. Values provide a sense of common direction for day-to-day operations within organizations (Deal & Kennedy, 2000; Schein, 1993). Commonly shared values demonstrate predictable and consistent patterns of behaviors that are observable. These behaviors demonstrate what the organization defines as quality, expectations expressed simply by the organization, and the freedom of individuals to align their actions within the boundaries of those expectations (Goman, 1997). Managing and communicating the value system of the organization to new members of that organization is the role of leadership (Rowse & Berry, 1993). When difficult choices need to be made, the shared values of the organization should guide those decisions (Deal & Kennedy, 2000). Schein (1990) asserts that in order to understand the organization, you must understand the culture. However, culture building is a long, continuous process (Schein, 1993; Whiteley, 1995).

The Organizational Mission and Values

Organizations define the reason for their existence through their mission

statement. According to Drucker (1990), the organizational mission comes before anything else. The mission of an organization does not change randomly with leadership or external influences. The mission statement provides a long-range objective that is operational and can be translated into activity. There should be congruence between the mission statement and the activities that occur within an organization (Weinbach, 2003). Drucker (1990) emphasizes this point by using hospital mission statements as common examples of misalignment between the mission and the activity of the organization. According to Drucker, hospitals often state that their mission is health care. However, hospitals do not take care of health, they take care of illness. A mission statement should focus clearly on what an organization tries to do and then attempt to do it so that those associated with it understand the common goal.

The values and vision of organizational framers initially drive the mission (Bolman & Deal, 1997; Deal and Kennedy, 2000; Drucker, 1990). The mission statement becomes the working definition for strategic planning, new initiatives, and how members are rewarded. The mission should determine how resources are used so the values of the mission are upheld (Drucker, 1990; Weinbach, 2003; Whiteley, 1995). These shared values eventually become shared assumptions within the organization (Schein, 1993). Organizational mission based upon core values, once defined, shared, and accepted by the members of the group, become the organization's culture. The members of the organization then work under the assumption they are in agreement as to who they are and why they are there.

Within hospital settings, there often exist different occupational groups. These different groups may have different values, priorities, and decision-making strategies, which can create barriers to communication of change. In order to develop a sense of interrelatedness between occupational groups, trust that participation across disciplines will not weaken professional ethics, control, or quality needs to be developed (Hansen, 1995). When groups within an organization hold values that are different from the values of the dominant culture, subcultures can emerge. Subcultures attempt to reinforce professional identity and most often emerge when a group of individuals feel threatened (Martin & Siehl, 1983; McMurray, 2003).

Professional Social Work Values

Over the past century, hospitals have been a firm and reliable employment venue for professional social workers (Berkman, 1996; Ginsberg, 2001; Massachusetts General Hospital, 2003). While the role of social workers in hospitals is discussed later in this paper, the core values of professional social work are introduced in this section in an attempt to demonstrate how the profession has defined, shared, and accepted its values. The National Association of Social Workers (1999) defined the core values of professional social work as follows:

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective: (a) service, (b) social justice, (c) dignity and worth of the person, (d) importance of human relationships, (e) integrity, and (f) competence. This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience. (The National Association of

Social Workers, 1999).

These same values were promoted by the Council on Social Work Education (CSWE) and formed the foundation from which the curriculum content was defined for accredited social work degree programs in the United States (Council on Social Work Education, n.d.). For the purposes of this study, it is assumed that persons who identify themselves as professional social workers share these core values. The values promoted by the social work profession are similar to those advocated by bioethics. Watt & Kallmann (1998) examined the six core social work values in comparison to the core principles of bioethics, which are autonomy, beneficence, non-maleficence, and justice. They concluded that there is a great deal of compatibility between the two. Service and social justice parallel the bioethics value of justice. Autonomy offers a distinct parallel to the social work value of dignity and worth of the person and the right to self-determination.

The values embraced by social work demonstrate the emphasis that the profession places on human worth and environmental justice. They are also clearly translatable into a variety of practice settings. The profession appears to be less clear in articulating what it can do. This lack of clarity regarding tasks that social workers perform has long plagued the profession (Ginsberg, 2001; McMichael, 2000; Moore, 1995). The media has often loosely described any activity that is related to child welfare or the poor as social work (Ginsberg, 2001). However, the media cannot be blamed for all ambiguity related to the definition of social work. The profession itself has struggled with the indistinctness of

what a professional social worker does (Gibelman, 1999; Rosenfeld, 1983; Ross, 1993; Specht & Courtney, 1994). Social work, like teaching and nursing, has struggled for professional status over the past 100 years (Gibelman, 1999). However, unlike teaching and nursing, most people will not be exposed to a social worker in a professional capacity over the course of their lifetime (Ginsberg, 2001). The reason for this is that social workers have most often worked with complex issues, marginalized groups, and vulnerable populations.

Barker (1995) offered a succinct definition of social work as “the applied science of helping people achieve an effective level of psychosocial functioning” (p. 221). According to Rosenfeld (1983), connecting people in need to valuable resources demonstrates the most valuable skill and expertise of the social work profession. Gibelman (1999) suggests that the broad skill base of the profession enables social workers to position themselves in a variety of settings where need is demonstrated.

The Bureau of Labor Statistics (2004) reported employment data on 477,000 social workers in 2002. Of those, 95,000 worked in mental health and substance abuse settings, 107,000 worked in health, and 274,000 were employed in schools or child/family settings. This same broad professional scope has been severely criticized, by some, as an abandonment of social work’s original mission, which was to address social ills, such as poverty, alcoholism, mental illness, and corruption (Specht & Courtney, 1994). Regardless of the academic debate over what a real social worker is, there is little doubt that need for the skills the profession provides will intensify. The Bureau for Labor

Statistics (2004) anticipates that employment of social workers will increase faster than the average for all other professions through 2012.

Alignment of Values: The Individual and the Organization

A good fit between the organization and the individual is essential to organizational health (Shafritz & Ott, 2001; Sullivan, Sullivan, & Buffton, 2002; Valentine & Lucero, 2002). Human resource theory assumes that organizations exist to serve human needs, and each is dependent on the other (Bolman & Deal, 1997).

Values are key indicators of one's personal identity. According to a study by Hitlin (2003), core identity in relation to values determines group attachment and social interaction. Values also play an important part in establishing and maintaining a sense of identity within an organization. Professional values set the standards for decisions, behavior, goal setting, and client interaction (Mossop, 1994). Values shared by organizations and the individuals within them help clarify what is expected of both (Deal & Kennedy, 2000; Shafritz & Ott, 2001). This alignment sends a message that all are working on a shared vision with the same goal in mind.

Shared vision within an organization fosters initiative and risk-taking (Senge, 1990). Individual hard work does nothing toward assisting a team effort until there is alignment of that work with a shared vision. That does not mean an individual forfeits their personal interests for the larger team vision; instead, when alignment is present, the team vision is an extension of their personal vision.

Maslow (1970) perceived values as having been supplied to an individual by the acceptance of oneself, the world around them, and human nature in general. According to Maslow, the difference between a healthy person and an unhealthy one is the perception of themselves. A healthy person views themselves as capable, accepting, distinct, and separate from the world, yet an integral part of it. He terms this state as being self-actualized, the highest level of need gratification in his famous hierarchy of needs.

However, according to Maslow's theory of human motivation (1970), a person must satisfy four more basic needs in order to reach this state. The needs are (a) physiological, (b) safety, (c) love or belongingness, and (d) self-esteem. Satisfaction of all of the needs Maslow identified is possible within an organizational setting. The security that comes from a worker's income may address the first two needs. Validation of one's worth by acceptance to a group helps satisfy the third need of love or belongingness. According to McGregor (1960), one common misunderstanding that managers have of human needs is the assumption that once lower level needs are met, such as having a job and income, fear of losing these things no longer exists. When change or misalignment occurs, security and trust are threatened and, with some reality, the lower level needs begin to reemerge and overshadow belongingness, self-esteem, and self-actualization. Need satisfaction that contributes to creative and positive interaction is eclipsed by survival needs.

Douglas McGregor (1960) offers an explanation as to why some managers appear to disregard the value of human needs within organizations. The concepts of Theory X

and Theory Y propose that managers' assumptions regarding people and motivation determine their supervisory style. Theory X managers, according to McGregor, assume that people do not like to work, that they need clear direction for tasks, and are content if their lower level needs are met. Theory Y managers assume that people are internally motivated and want to do their jobs well. Theory Y assumes that self-direction and self-control are rewarding, and that people will actually seek responsibility and challenge if the proper conditions exist within an organization. The central construct of Theory Y is the value of integration between the individual and the organization. If the needs of the individual are not met, the needs of the organization will not be met either (McGregor, 1960). Theory Y assumes that people will work in a self-directed manner only to the extent that they are committed to the common objectives of the organization.

Understanding one's place within an organization and believing in that role contributes to confidence and career satisfaction (Mossop, 1994). The collective perception about the organization's commitment to its perceived values is referred to as the climate of an organization (Ashforth, 1985; Schein, 1990). Climate measures the outcome of culture rather than the culture itself. According to a study by McMurray (2003), when a subculture within an organization shares the values and belief of the host organization, the climate within the subculture tends to be positive. Conversely, weakly aligned relationships between the subculture and the dominant culture create negative climates (Barrett, 2003; McMurray, 2003).

In recent years, many companies have redesigned their organizations in an

attempt to function as value-based cultures (Barrett, 2003; Gibelman, 1999; Thornbury, 1999). As altruistic as this endeavor sounds, it may have more to do with profit than a desire that members of these organizations be happy at work. A number of organizations have exhibited significant improvement in profitability following projects that had a specific focus of attempting to change their organizations and still maintain the values they espouse. One such project implemented within the Sellotape organization in 1994 resulted in an increase in profitability from 3 to 10 percent in two and a half years (Sullivan et al., 2002). The future leader may have an increased desire to explore issues related to human resource development if there continues to be a financial consequence of not doing so (Quinn & Spreitzer, 1991).

The Impact of Change on Organizational Culture

According to Cameron and Quinn (1999), the rapid rate of change that has occurred within organizations is due to the rapid change that has existed in the external environment. They state that during the 1990s, 46 percent of the 500 biggest companies dropped off the Fortune 500 list. According to Cameron and Quinn, in the 1960s approximately half of the employees working in industrialized countries made or assembled something. However, forty years later, only one eighth of workers are still involved in the making or moving of goods (Cameron & Quinn, 1999). This shift is attributed to the evolution of information technology and has greatly contributed to the need to redefine workforce needs (Cameron & Quinn, 1999; Schein, 1996). The need for

change within organizations is inevitable because of the dynamic that occurs between organizations and the world around them (Drucker, 1990).

The three most common initiatives that have occurred in the last twenty years are quality management programs, downsizing initiatives, and restructuring plans (Cameron & Quinn, 1999). Many of these initiatives have fallen short of the intended results, which were primarily to manage change. One explanation for this may be that these change projects were initiated to change how organizations do business but did not target the organization's existing culture. Initiating change without consideration to the culture of the organization, as evidenced in the goals, values, and expectations of the individuals who make up the organization, tends to be ineffective in achieving long-term change (Cameron & Quinn, 1999; Hooijberg & Petrock, 1993; Sullivan, Sullivan, & Buffton, 2002).

According to Trompenaars & Wooliams (2003), change cannot be real if strategic plans and cultural values are incongruous. Change should be a process of enriching existing values rather than replacing one behavior for another. Organizational commitment, job involvement, job satisfaction, and low turnover have all been attributed to shared group values (Goodman, Zammuto, & Gifford, 2001).

The Impact of Change on Individuals and the Organization

Kurt Lewin, one of the earliest scholars on the subject of change, theorized that all human behavior was related both to one's personal characteristics and to the social

situation in which one finds oneself (Gold, 1999). According to Lewin's studies, knowledge, attitudes, and skills bond people to their jobs. These three things define a person's expertise or specialty in their profession, and their sense of status and prestige are attached to this. If a change is instituted in an organization that appears to rob an individual of the specialty that they have acquired, there is natural resistance to the change (Whiteley, 1995).

Change, Professional Identity, and Trust

According to Schein (1993), the concept of organizational culture is only viable if it addresses the human need for stability, consistency, and meaning. Therefore, culture formation is always on the path of patterning and integration. Once stability and patterning have been established, then the members may develop a set of shared assumptions.

If this is true, it is understandable why rapid change efforts within organizations often fail (Cameron & Quinn, 1999). Change challenges stability. Structural stability enables group members to establish shared assumptions of how the group will react, think, and feel (Schein, 1993). These shared assumptions contribute to trust. Teamwork is reliant on trust (Cruise-O'Brien, 2001; Shaw, 1997). Without one, the other cannot exist.

According to Cruise-O'Brien (2001) trust within organizations is based upon the following action points: (a) openness, (b) communication, (c) care and concern, (d) support and recognition, and (e) fairness. Shaw (1997) offered a similar model of trust:

achieving results, integrity in action, and demonstrating concern. Goodwill alone without the power, competence, or influence to achieve results does not build trust. Integrity is demonstrated by consistency between what is said and what is done. Concern for others offers the basic assumption that we trust those who care about us. Trust is dependent on predictability, or patterning (Drucker, 1990).

Trust operates within limits of tolerance based on shared values and expected behaviors. The limits of trust are determined by interactions between individuals and groups. Behaviors outside the limits of tolerance cause mistrust and the limits must be renegotiated in order for trust to be reestablished. Successful negotiation of conflict can augment and deepen trust because it confirms values that may have been assumed by the parties prior to the conflict. Conversely, lack of resolution of conflict supports the perception that there are no agreed upon limits of interaction based on shared values and deepens mistrust related to future interactions (Nooteboom, 2003). Discussion that lacks action and is insincere is rhetoric, and one hallmark of an unskilled management team (Shaw, 1997). Rhetoric undermines integrity because words often do not match action. Actions should match words and demonstrate consistent and shared values. A new vision for an organization will remain a dream without the cooperation of others (Rowell & Berry, 1993).

Once a level of trust has been established, there is an absence of fear and employees learn that they have a voice (Herriot et al. 1998). Individual input is valued and appreciated. High trust organizations demonstrate active collaboration across teams

or units, enhanced organizational learning, and individual empowerment (Shaw, 1997). When individuals feel that they can trust the people with whom they work, morale and initiative increase (Reina & Reina, 1999).

What happens to an organization when trust is broken? Within hospital settings, social work, like nursing or physical therapy, is one of many disciplines. According to Senge, (1990) a discipline is a set of skills or competencies acquired by following a certain path. Along that career path, individuals begin to define their worth within their chosen career. According to Schein (1993), career anchors help clarify a career by examining what component he or she would not be willing to give up. The anchors are: (a) security, (b) autonomy/independence, (c) technical/functional, (d) managerial, (e) entrepreneurship, (f) service/dedication, (g) pure challenge, and (h) life-style integration. In times of transition, an individual's career anchor may help or hinder their perception of the transition. For example, if security is a main anchor for an individual, transition may feel more threatening than it would to an individual who is anchored by pure challenge.

Persons who identify themselves by their profession first and their organizational affiliation second may have different expectations from their careers than employees who do not (Gibelman, 2003). Professionals are often trained to work autonomously and may rely on professional education rather than organizational training as their primary frame of reference and ideological commitment.

As discussed earlier in this work, climate demonstrates how well the culture of the organization is perceived by its members. In times of change, the perception of shared

values, support, and trust can be challenged (McMurray, 2003). Concern over decrease in quality, loss of identity, and resentment of top-down decision making may be common in health care settings (Decker et al., 2001). A study of nurses who had endured significant organizational changes demonstrated a high correlation between communication with management and feeling both empowered and trust in management. The conclusions demonstrated that honest communication and information were key components in building trust during and after times of change (Cruise-O'Brien, 2001).

When employment is agreed upon, the employer and the employee make a commitment to each other (Decker, Wheeler, & Johnson, 2001). During times of change, individuals within organizations may experience feelings of betrayal and mistrust. This leads to low morale and reduced productivity (Decker et al., 2001; Reina & Reina, 1999). Two common strategic initiatives for change, cost-cutting and innovation, are mutually exclusive unless they are implemented carefully within a context of trust (Shaw, 1997). In a study conducted within a large health system, employees were asked their perceptions of the effects of recent organizational change (Decker et al., 2001). The finding demonstrated feelings of betrayal, sacrifice of quality for profit, loss of identity, and increased job stress. The change that is driven by external forces, such as managed care, can increase fear and mistrust if the result of that change is perceived as a shift from the perceived mission and purpose of an organization. Change, such as those noted above, has been strongly evident in many hospital settings over the past decade.

The Changing Hospital Culture and Managed Care

Hospitals were once viewed as charitable organizations whose primary existence was to care for the sick in their communities (Globerman & Bogo, 2002; Massachusetts General Hospital, 2003; Rosenberg & Weissman, 1994). Hospitals have since become revenue sources for many investor-owned companies (Kelly, 1998). The increase of private for-profit companies developing or purchasing existing health care institutions was encouraged by the passing of the Health Maintenance Act of 1973. Prior to this act, most hospitals, and human service agencies, were run by public entities or charitable organizations. Since then, the potential for profit was realized and for-profit companies began building, or buying, hospitals, nursing homes, and establishing home health agencies. Public welfare became corporate profit (Rosenberg & Weissman, 1994).

Historically, human service agencies were less driven by fiscal concerns and more focused on client care (Drucker, 1990). Those times have passed. Through the years, it has become more difficult to see major differences in operation between the for-profit world and the not-for-profit world (Weinbach, 2003). This shift was primarily related to government funding which had exceeded \$200 billion by the year 2000 for human services (Martin & Siehl, 2001). This massive expenditure gave rise to an increased call for accountability and cost containment in human service arenas.

In health care, managed care was heralded as the solution to increased medical costs and has been a major driver of accountability and cost containment. The former fee-for-service environment has begun to fade into history. Many insurance carriers have

changed into capitated contracts (Kadushin & Egan, 1997) which pays a provider of care a fixed fee to provide services to a patient for a set period (Martin, 2001). If the patient does well, the provider makes money. If the patient does poorly, the provider loses money. With capitated contracts, each provider must evaluate their overhead costs and conduct a cost-benefit analysis to determine if their expenses are directly related to this new goal of the wellness of the client (Berkman, 1996; Kadushin & Egan, 1997).

Because of these changes, each professional who interacted with a patient had their role in that interaction scrutinized to determine if that interaction contributed to cost containment or profit (Poole, 1996). Non-direct care provided by nurses, occupational therapists, physical therapists, speech therapists, physicians, social workers, and psychologists all faced budget cuts (Poole, 1996). Hospital administrators responded to economic pressure by attempting to restructure their organizations into departments of integrated disciplines, often combining several administrative positions (Poole, 1996). Many hospitals decentralized social work departments into interdisciplinary departments, assimilated them into nursing units, or eliminated them entirely (Mizrahi & Berger, 2001; Ross, 1993). Managed care forced extensive review of services by outside reviewers unfamiliar with the patient. Chipman (1995) argued that even the shift in semantics from patient or client, to customer or consumer places emotional distance between the practitioner and help-seeker by treating care as a commodity for purchase. In the past, clinicians were taught to treat each client as a complex and unique individual that encompassed social histories, familial interactions, and self-concepts. Managed care

reviewers at the other end of a toll-free number, according to Chipman (1995), have reduced clients to a short list of observable behaviors connected to a diagnosis with a timetable to resolve the problem. The method of treatment is ignored. Managed care, according to Chipman, has reduced clinical practitioners to technicians who fix broken parts of a person at a pace and intensity controlled by remote case auditors who have not, and never will, meet the client. This shift to treatment that is externally driven has had an impact on many disciplines in health care, including social work (Poole, 1996).

Social Work Identity and Health Care

The topics discussed in the preceding sections relate to values, alignment between the individual and the organization, trust, and change. During the past decade, health care settings have undergone dramatic changes. The advent of managed care has forced rapid change in health care organizations (Chipman, 1995; Decker et al., 2001). Human service environments, including health care, have become increasingly demanding and competitive; and, therefore, managers have had to develop the mindset of an entrepreneur (Poole, 1996). These changes have forced departments and professionals within the hospital setting to be assertive and proactive to protect their jobs. According to several studies in the past decade, social workers felt devalued as a profession and feared loss of professional identity in hospital settings (Globerman, 2002; Holliman, Dziegielewski, & Teare, 1998; Mizrahi & Berger, 2001; Poole; 1996).

External pressures of cost containment and managed care have driven health care

organizations to redesign, restructure, or downsize almost every department in health care settings. Within hospitals, social work struggled for identity (Berger et al. 1996; Globerman & Bogo, 2002; Mizrahi & Berger, 2001). Identity is intertwined with roles. Each role contains values, styles of interaction, beliefs, norms, and goals (Ashforth, 2001).

Given the rich history of social work in hospital settings, feelings of devaluation and identity loss are understandable. Social work has had an important role in hospitals for 100 years. Dr. Richard Cabot hired the first social worker, Ida Maude Cannon, at Massachusetts General in 1905. Dr. Cabot recognized that the personal lives of patients could not be separated from whatever illness caused them to be hospitalized (Massachusetts General Hospital, 2003). Ms. Cannon and Dr. Cabot implemented processes that measured and documented social work intervention and included the social perspective of the patient in the treatment plan. Planning for the care the patient would need upon discharge, assessing their support system, advocating for change when the formal system was inadequate, and providing a voice for the patient within the medical setting was the primary function of social work in hospitals. This function became known as discharge planning (Gibelman, 2003; Massachusetts General Hospital, 2003). From 1905 to 1915, more than 100 additional hospitals had hired social workers (Barker, 1995). Professional identity in hospitals was further strengthened in 1918 with the creation of The American Association of Hospital Social Workers. Hospital social work thus became the first specialty area within the profession of social work. National

recognition of this specialty was advanced in 1926, when the US Veterans Bureau began employing social workers in its hospitals (Barker, 1995).

The process of discharge planning became increasingly important in hospital settings in 1983 when Medicare instituted a pricing system of diagnostic related groups (DRGs). DRGs were designed to control costs by linking patient length of stay in a hospital to a patient's diagnosis. The diagnosis determined how long someone should be hospitalized, and costs related to hospital stays beyond those parameters were frequently denied. An early, and comprehensive, biosychosocial assessment of the patient and their post-hospital needs became an important component of controlling costs. Conducting comprehensive psychosocial assessments to determine the emotional and concrete needs of clients had long been considered a strength of the social work profession (Berkman, 1996; Kelly, 1998; Ross, 1993).

However, a trend began in the early 1990s that revealed that the nursing profession had begun to assume the discharge-planning role in hospitals, often under the title of case manager (Holliman et al., 2003). In a study of 336 hospitals (Berger, et al., 1996), it was reported that social work's role in discharge planning decreased almost eight percent in two years. In a separate study, hospital social workers reported that social work leadership positions were being assumed by nurses, turf battles with nursing professionals were occurring, and that they felt devalued as a profession (Mizrahi & Berger, 2001).

Lack of clarity of roles between nurses and social workers are recurring themes in

much of the social work literature relative to hospital social work. A 1998 study (Holliman, et al.) examined differences and similarities between social work and nurse discharge planners in 58 hospitals. The findings demonstrated that private hospitals were more likely to hire nurses as discharge planners than social workers. Similarly, hospitals with fewer than 250 beds were more likely to hire nurse discharge planners. Of the respondents (n=178), 117 were social workers, 83 of whom had a master's degree in social work (MSW), and 34 held a bachelor's degree in social work (BSW). Fifty-three of the 178 respondents were nurses. Only 12 nurses held master's degrees, 21 held bachelor's degrees, and 5 nurses had only a certificate or diploma. The median income for the nurse discharge planners who held bachelor's degrees was \$43,398, while the median income for social workers with a bachelor's degree was \$32,359. Nurse discharge planners with a master's degrees earned a median income of \$50,832, however social workers with a master's degree only earned a median income of \$35,351. These median salary findings were consistent with the Bureau of Labor Statistics (2004). The study further revealed that 85 percent of tasks were the same for social workers and nurses. Differences in discharge planning tasks revealed that nurses were more likely to spend time on duties related to auditing records, assessing outcome measures, and insurance verification than were social workers. Social workers more often engaged in assisting with advance directives and end-of-life cases, child abuse assessment, substance abuse intervention, or home visits.

The concept of equal pay for equal work is not new and was a recurrent theme in

both the civil rights and equal rights movement. Professionals who have more education but earn less money than others performing the same task are likely to feel devalued (Globerman & Bogo, 2002; Holliman et al., 2003). It is interesting to note, especially in light of the study above, that no literature was found that compared social work education to nursing education.

Challenges social workers face related to identity may be in the nature of the business itself, which is human behavior (Gibelman, 1999, 2003; Ginsberg, 2001). Social workers have difficulty demonstrating their efficacy because there is often not quantifiable *product* in working with humans. Like the profession of education, much of what is done for clients is not immediately measurable. This is complicated by the fact that social workers are usually consulted on the most complex and challenging cases (Gibelman, 1999). Social work clients are often the chronic and persistently mentally ill, persons who live in poverty, victims of abuse, drug or alcohol addicts, trauma patients, the terminally ill, or illegal immigrants. Brilliant (1986) suggested two decades ago that social work's professional identity may suffer because of their connection with disadvantaged populations, and attests that social work education programs do little to teach professional assertiveness and leadership in core curriculum. Keigher (1995) asserts the social work in health care has been diminished, at least in part, because social workers rarely publish research findings or promote the profession in journals read by anyone other than social workers. As a result, most hospital administrators would be unfamiliar with the skills or knowledge provided by formal social work education. This

lack of pedagogic interaction with other disciplines has been cited by many as a contributor to social work's lack of identity (Gibelman, 1999; Globerman, 2002, Kadushin & Egan, 1997).

There is a national standard for social work education established by the Council on Social Work Education (Council on Social Work Education, n.d.). Social work education in the United States consists of the following foundation areas of study: (1) human behavior in the social environment, which includes biological, psychological, cultural, sociological, and spiritual development across the lifespan; (2) social welfare and policy; (3) social research; (4) social work practice with individual, families, and groups; and (5) field education. Values and ethics, diversity, social and economic justice, and populations-at-risk must be clearly articulated throughout the curriculum. All professional social workers who have graduated from an accredited program should be able to demonstrate these basic skills. Professional social workers who obtain graduate degrees in social work are expected to master these skills in addition to a specialization offered by their specific graduate program. This area of specialization may be clinical, also known as psychotherapy, administration, or community organizing (Bureau of Labor Statistics, 2004; Ginsberg, 2001).

Gibelman (1999) argued that social work must learn to adapt to the technicalities, legal requirements, and reimbursement systems of managed care or risk being excluded from providing service within the health care environment. In light of this discussion, do social workers in hospitals today feel their values align with their organization? The

following section presents a viewpoint that suggests that most organizations have cultures that demonstrate competing values within them.

Competing Values within Organizations

According to Deal and Kennedy (2000), corporate cultures develop in relation to certain activities that they must play out in order to do business. How a company performs those activities determines the values that are communicated to those who work within the organization. As discussed in earlier sections, organizations where values between the individual and the organization appear to be in alignment demonstrate high productivity, have less turnover, and high morale (Barrett, 2003; Bolman & Deal, 1997; Shafritz & Ott, 2001; Sullivan, et al., 2002).

An assessment of values alignment can assist organizations, and individuals within them, in determining what Barrett (2003) terms as cultural entropy. Cultural entropy is the amount of energy that individuals spend on concerns and issues that are unrelated to their work. Organizations with good values alignment, or low cultural entropy, have fewer problems attracting and retaining employees because there is congruence between perceived and demonstrated values.

The Competing Values Framework

Understanding an organization's culture and values from the conceptual framework of competing values can assist in defining what individuals perceive about

their organization's culture now, and what they would prefer in the future. According to Schein (1996), organizations often fail to pay attention to their own culture and the subcultures within them. They are assumed. Schein theorized that change initiatives were largely unsuccessful because leaders who set out to change norms within their organizations were more likely to be changed by them instead.

Following a study of 4,000 scenarios of change, Trompenaars & Wooliams (2003) recommended eight steps to implementing change. They were as follows:

1. develop an envisioned future in order to know what to aim for
2. diagnose the current culture using a cross-cultural assessment tool
3. define core values and the ideal culture that would embed the core values
4. define major business dilemmas that cause tension between the current culture and the envisioned future
5. develop a plan to reconcile four or five of the major dilemmas
6. diagnose the current leadership competence to reconcile values dilemmas
7. implement the new design and
8. define concrete action plans.

The steps described above delineate the need to identify existing culture before implementing change. The Competing Values Framework assists in diagnosing the perception of how strongly values are perceived as demonstrated within organizations without ascribing meaning to the values.

The Competing Values model for diagnosing organizational culture was

originally intended to measure organizational effectiveness (Kalliath, Bluedorn, & Strube, 1999). However, it has become a device for creating organizational profiles and conducting analysis from them (Cameron and Quinn, 1999; Quinn & Rohrbaugh, 1983; Quinn & Spreitzer, 1991). The Competing Values Framework offers a model with two dimensions that help define the culture of an organization. The first dimension identifies organizational effectiveness from a seemingly polarized perspective where flexibility and adaptability are viewed as effective in some organizations, and stability and control are essential to others. The second dimension distinguishes effectiveness via internal or external orientation. Some organizations are viewed as successful if they are internally cohesive. The opposite, or competing, perspective would be an organization with an external orientation where interacting or rivalry with those positioned outside the organization would be rewarded. These two dimensions form four quadrants that demonstrate the competing values framework (Figure 1).

		Flexibility and Discretion			
Internal Focus and Integration	Clan Culture: The focus is on internal maintenance with flexibility. The organization values loyalty, teamwork, and tradition. Human resource development is emphasized. Cohesion, morale, and employee participation is valued.	Adhocracy Culture: The focus is on external positioning with flexibility. The work setting is dynamic and ever-changing. Entrepreneurship and risk taking are valued. New and unique products or services, and individualism are rewarded.	External Focus and Integration		
	Hierarchy Culture: The focus is on internal maintenance with a need for stability and control. Procedures govern what people do. Low cost, dependable delivery and smooth operations are most valued. Formal rules and polices hold the organization together.	Market Culture: The focus is on external positioning with a need for stability and control. People who are competitive and goal oriented would be rewarded. There is an emphasis on winning. Success is defined as market share and penetration.			
		Stability and Control			

(Cameron & Quinn, 1999)

Figure 1: The Competing Values Framework

The culture label defines the distinguishing characteristics of each quadrant within the Competing Values Framework. These four quadrants help define what people within an organization value as effective, right, and good for their organization. They represent opposite, or competing, assumptions of flexibility versus stability, and internal versus

external focus (Cameron & Quinn, 1999; Quinn, 1988). These four clusters of criteria define the perception of the core values of the organization (Cameron & Quinn, 1999). It is assumed that all organizations develop combinations of behaviors from all four quadrants, with one or two being more dominant than others (Quinn, 1988).

The Clan culture is in the upper left quadrant closest to flexibility and discretion and an internal focus. An organization that would cluster primarily in this quadrant would represent shared values and goals, cohesion, teamwork and corporate commitment to the well-being of its employees. Employee participation, commitment, and loyalty would be demonstrated in the clan culture.

The lower left quadrant represents a hierarchy culture that demonstrates values toward stability and control with an internal focus. These organizations represent a traditional model of structure that provides clear procedures that govern what people do. The key values of the hierarchy culture are efficiency and reliability. Each job has clearly defined tasks and procedures to accomplish these tasks.

The adhocracy culture, found in the upper right quadrant of the model, has a focus on flexibility and discretion with an external focus. The focus for an organization that demonstrates this value system would be on adaptability, flexibility, and creativity. Risk taking would be valued with a high degree of individualism. Structure is related to projects and the organization would reorganize itself with each new project.

The final quadrant represents the market culture with a concentration on stability and control and an external focus. Market culture functions as a market itself and focus

on profitability and secure customer bases. Transactions with external clients, contractors, suppliers, and so forth are the focus of this culture. Competitiveness and productivity are key values of a market culture.

Within the competing values framework, change can only occur when there is transcendence. Transcendence occurs when members of a group are confronted with a paradox and the pattern of values they hold are no longer adequate to deal with that paradox (Cameron, 1986). A paradox is defined as a seeming contradiction and is perceived during times of rapid change. When an individual or group is able to transcend the paradox, or work through it, actual change can occur because the paradox offers new possibilities for development. Successful confrontation and resolution of a paradox is fundamental for change because paradox reveals assumptions and tension between old and new.

The purpose of this research was to examine the perception of values alignment of social workers in Florida hospitals in relation to their core professional values. It attempts to identify the extent that Florida hospital social workers perceive their hospital mission statements are aligned with their values and how much the mission statement is reflected in daily business. This research also attempts to measure whether social workers perceive that their assigned tasks permit them to demonstrate their professional values and to what extent they trust that those values are supported by their hospital settings. It further attempts to identify an aggregate perception of how Florida hospitals cluster in the four cultures of the Competing Values Framework from the perspective of hospital social

workers. How social workers perceive their cultures now and how would they prefer them to be in the future are diagnosed utilizing the *Organization Culture Assessment Instrument (OCAI)*.

Data Analysis

A description of how information collected from survey and the *OCAI* were analyzed is presented in this section. The study was designed to address the key research questions via responses to the survey and *OCAI*.

For Research Question 1, to what extent do hospital social workers perceive that the core values of their profession are aligned with the mission statement of the hospital in which they are employed; the responses are presented by using percentage frequency distribution. Cross tabulation analysis was used to determine if there were differences between the responses and the education, number of years employed in health care, and number of years employed in their current hospital setting.

For Research Question 2, to what extent do social workers perceive that the mission statement of their organization is reflected within the current operations of the organization, the responses were analyzed by utilizing percentage frequency distribution. Again, cross tabulation was used to determine if there were differences between the responses and the education, number of years employed in health care, and number of years employed in their current hospital setting.

Research Question 3, from a competing values framework, how do social workers

perceive the current culture of their organization, is addressed in items 8a – 13a of the instrument. The aggregate scores of all respondents were analyzed utilizing cumulative frequency distribution to determine perception of the current hospital culture.

Research Question 4, from a competing values framework, what culture would hospital social workers prefer to see demonstrated in their organization. Cumulative frequency distribution tables were used to analyze these preferences. Aggregate scores were also examined for items 8b – 13b on the survey which queries how they would prefer their hospital to be in the future.

For Research Question 5, to what extent do hospital social workers perceive that the tasks they perform within the hospital setting reflect their professional values, the responses are presented by using percentage frequency distribution. Cross tabulation was used to determine if there were differences between the responses and the education, number of years employed in health care, and number of years employed in their current hospital setting.

Research question 6, to what extent do hospital social workers trust their organizations to support the practice of their core professional values, cross tabulation was used to determine if there were differences between the responses and the education, number of years employed in health care, and number of years employed in their current hospital setting. The responses were also analyzed by utilizing percentage frequency distribution.

Significance of the Study

Business and organizational psychology journals exhibit a large body of research related to the impact of organizational change and human behavior. The profession of social work provides important information regarding human behavior within the context of social systems but has little to offer in the way of data specific to their discipline and its interaction in the work setting. There is existing literature related to adaptability skills for social workers in times of change, validation of job activities, and possible future trends. These data assist professionals to define their roles within a changing environment. However, the social work literature does not reveal knowledge about organizational culture and competing values.

This research attempts to identify how hospital social workers perceive their work settings from a values and organizational culture perspective. The results may provide tangible information to hospital social workers that aid in the understanding of their current work environment, and how they need to position themselves as professionals for the future. The social work literature lacks research findings on hospital social work perceptions of their work setting from an organizational culture perspective. The research findings could help to conceptualize sources of conflict from a theoretical perspective that would be useful not only to social workers but to others within the organization as well. By understanding where value misalignment occurs, if it does, the profession may better be able to target areas of concern and offer opportunities for change. Social work, like many helping professions, must attempt to understand their work setting in order to

ensure a place for themselves in the future.

Organization of the Study

This dissertation was organized into five chapters. Chapter 1 includes the introduction to the problem, the conceptual framework, and the significance of the study. Chapter 2 provides a review of literature pertinent to theory and research on organizational culture, values, and hospital social work. Chapter 3 delineates the method in which the data was collected, the survey and instrument utilized, and population of the study. Chapter 4 describes the data results and the statistical methods used for analysis. Chapter 5 provides the findings, a summary of the study, and recommendations for future research.

CHAPTER THREE: METHODOLOGY

Introduction

This section provides information related to the research questions that guided this study, the design of the study, methods utilized to collect the data, and how the data was organized. The purpose of the study was to examine how professional social workers perceived the culture of hospitals in Florida from a values perspective. The conceptual framework for this study originated from organizational behavior literature related to change, culture, and values.

Problem Statement

The intention of the study was to assess the perceptions of social workers employed in Florida hospitals in relation to the core values of their profession and the alignment of those values within the organizational culture of their current work setting. The following questions guided the research:

1. To what extent do Florida hospital social workers perceive that the core values of their profession are aligned with the mission statement of the hospital in which they are employed?
2. To what extent do social workers perceive that the mission statement of

their organization is reflected within the current operations of the organization?

3. How do social workers perceive the current culture of their organization in relation to their professional values?
4. What culture would hospital social workers prefer to see demonstrated in their organization?
5. To what extent do hospital social workers perceive that the tasks they perform within the hospital setting reflect their professional values?
6. To what extent do hospital social workers trust their organizations to support the practice of their core professional values?

Population

This section describes the target population for the study, the efforts exerted to contact that population, and response rates. As the population size was unknown, it was not feasible to create a sample of the population. Therefore, it was determined that each of the 217 hospitals in the Florida Hospital Association (FHA) directory (Florida Hospital Association, 2005) would be contacted in an attempt to reach as many hospital employed social workers as possible. The FHA directory also provided contact information for psychiatric, rehabilitation, and specialty facilities. However, because reimbursement guidelines vary for these types of facilities, only those hospitals listed as acute care were included so that the population identified would be employed at hospitals with

comparable funding.

Upon receiving approval from the Institutional Review Board at the University of Central Florida, calls were placed to the main telephone number of each of the acute care hospitals listed in the FHA directory in an attempt to identify the scope of the social work population. During this investigative phase, each facility operator was asked the following question: May I speak to the social work department? The calls were forwarded to departments with a variety of titles.

Due to the widespread use of voice mail in hospital systems, it was not always possible to speak directly to a department contact. A script was utilized that explained the purpose of the study, requested the number of social workers employed, and a request for participation; this method was employed for both live contact and voice mail. All but one facility contacted agreed to have the surveys mailed directly to them for dissemination. In the case of the exception, the facility provided a list of individual social workers and requested the packets be sent directly to them. Before conclusion of the phone call, contacts were asked if they would be willing to provide contact names of social workers at other hospitals in their area. By utilizing third party contacts for this snowball technique, the researcher was able to identify additional hospital contacts.

If direct contact was unsuccessful, a message was left on voice mail that explained the study and provided the researcher's contact information. One week later, a second phone call was placed to those facilities that did not respond to the voice message. If no contact name was acquired after two telephone attempts, packets were mailed to the

facility, addressed to the Director of Social Work.

Instrumentation

A description of the questionnaire and survey instrument is described in this section. A questionnaire was created to collect the following information:

1. education level,
2. number of years employed in health care
3. number of years employed in this particular hospital.

In addition to these data, the following perception questions were asked:

4. In your opinion, does the *written* mission statement of your hospital reflect values that appear to be in *alignment* with professional social work core values?
5. In your opinion, does the daily *business* of your hospital reflect the written mission statement?
6. As a hospital social worker, do you feel that your work assignments provide you with opportunities to demonstrate your professional values on a regular basis?
7. As a professional social worker, do you trust that your hospital values the skills and knowledge of your profession?

In an attempt to diagnose how the social workers perceived the culture of their organization, the *Organizational Culture Assessment Instrument (OCAI)* was used.

Validity and reliability of the *OCAI* are discussed in the next paragraph.

The *OCAI* is a self-administered survey instrument that clusters responses into four competing value frames that are: clan culture, hierarchy culture, adhocracy culture, and market culture. The responses cluster within these frames and create a profile of perceptions of the culture of an organization. The *OCAI* contains six questions related to the following: dominant characteristics, organizational leadership, management of employees, organization glue, strategic emphasis, and criteria of success. Each question has four alternatives. Participants were asked to divide 100 points among the alternatives with the highest number of points assigned to the answer they felt was most similar to their organization. The survey asked that they respond to each question twice; (1) how they perceive their hospital currently, and (2) how they would prefer it to be in the future.

In determining the usefulness of the *OCAI* for this particular study, the reliability and validity of the instrument had to be satisfactorily established. Several studies offer evidence that the instrument is reliable and therefore measures culture types consistently. One study (Quinn & Spreitzer, 1991) utilized the *OCAI* with 796 executives from 86 different public utility organizations. Cronbach's alpha coefficients were computed for each of the four culture types with the findings statistically significant compared to normal standards of reliability. The analysis demonstrated Cronbach alpha coefficients at .74 for clan (group), .79 for adhocracy (developmental), .73 for hierarchal, and .71 for market (rational). In a separate study, Yeung, Brockbank, and Ulrich (1991) offered evidence of reliability by utilizing the *OCAI* to query 10,300 executives from 1,064

companies. Reliability coefficients exceeded satisfactory levels. The results showed the clan culture reliability was .79, the adhocracy culture reliability was .80, the hierarchy culture reliability was .76, and the market culture reliability was .77. Zammuto and Krakower (1991) examined organizational culture of higher education using the *OCAI*. Reliability was demonstrated in each of the culture types as follows: clan reliability was .82, adhocracy reliability was .83, hierarchy reliability was .67, and market reliability was .78.

Additional studies offer evidence of the validity of the *OCAI*. 334 institutions of higher education were examined (Cameron & Freeman, 1991) with 3,406 respondents. Validity of the culture instrument was demonstrated when the domain in which the organizations excelled, the structure, and decision-making matched the culture type. Zammuto and Krakower (1991) provided further evidence of instrument validity in an unrelated study of higher education culture. Dominant cultures were evident in all of the findings and the core values of those cultures could be measured by the *OCAI*. Quinn and Spreitzer's study (1991) examined culture by utilizing a multitrait-multimethod analysis using two different instruments examining the same cultural dimensions. Their findings support the validity of the *OCAI* for determining organizational culture types.

Data Collection

This section describes the method in which the data was collected and recorded. The data collection process occurred over a period of two months. As hospital contact

information was obtained, a cover letter, questionnaire, the *OCAI*, and a self-addressed stamped envelope were mailed. As a result of the efforts described above, surveys were mailed to all of the 217 hospitals in the Florida Hospital Association Directory. Long-distance telecommunication costs and postage made additional requests for participation unfeasible.

Analysis

Analysis of Response Rate

The method for analysis of the response rates is reported in this section. The findings of this analysis are discussed in detail in Chapter 4. Frequency distribution and percentage analysis of the population were utilized to present the response rates from the data collected. As noted above, survey packets were mailed to 217 hospitals in Florida. Telephone calls, e-mail, and personal contacts revealed 50 hospitals that confirmed that they employed professional social workers; however, 6 of these hospitals declined participation due to internal policy restrictions. Third party informants identified 11 additional hospitals as possibly employing social workers. Forty-four hospitals stated that they do not employ social workers. Therefore, social workers employment remained unknown in 112 hospitals.

Valid responses were received from 66% (n=29) of the 44 hospitals known to employ social workers. Third party informants identified 11 additional hospitals that possibly employed social workers, from which 7 responded (64%). From the final 112

hospitals where social work employment was unknown, responses were received from 37 hospitals (33%). Table 1 demonstrates the rate of return for each group.

Table 1

Survey return rate

Population	Number of Hospitals	Response Rate
Number of hospitals known to employ social workers	44	66% (n=29)
Number of hospitals estimated by third parties to employ social workers	11	64% (n=7)
Number of hospitals in which social work employment was unknown	112	33% (n=37)

There were 176 individual surveys were returned. The criteria for a survey to be considered valid and subsequently included in the study findings were as follows: the participant must have a bachelor's in social work, a master's in social work, or a doctorate in social work, and the *OCAI* instrument must be scored completely. Six returned surveys contained scoring errors and were invalidated for inclusion. Twenty-one of the respondents did not hold a social work degree and were excluded from the study. Valid surveys were received from 149 social workers representing 64 different hospitals. 24% (n=36) of the respondents held a bachelor's in social work (BSW) only, 76% (n=112) held a master's in social work (MSW), and 1 reported a doctorate in social work (DSW).

Length of employment information was collected and revealed that 59% of the respondents had been employed for more than 10 years in health care. Table 2 provides additional information about the participants' employment in health care. Detailed presentation of these data is presented in Chapter 4.

Table 2

Years of employment

Years	Employed in Health care	Percentage	Employed at Current Hospital	Percentage
0-3	23	15%	53	36%
4-6	25	16%	28	19%
7-9	14	9%	17	11%
10 or more	88	59%	51	34%

Research Questions and Analysis of Survey Items

Statistical methods of analysis of the survey data as related to the research questions are outlined below and presented in Table 3. The findings are reported and discussed in Chapter 4.

Research Question 1, "To what extent do hospital social workers perceive that the core values of their profession are aligned with the mission statement of the hospital in which they are employed?" The fourth item on the survey addressed this research question. Participants were asked the following: In your opinion, does the *written* mission statement of your hospital reflect values that appear to be in *alignment* with professional

social work core values? The response choices were: (a) very much in alignment, (b) somewhat in alignment, (c) not at all in alignment, (d) am not sure, and (e) I am not familiar with the written mission statement. Frequency distribution by count and percentage were determined. Addition analysis of this question by subgroup was conducted. As the subgroup variables were at the nominal level of measurement, cross tabulation and chi-square analysis were used to determine if there were differences between the responses to this question by each subgroup.

Research Question 2, “To what extent do social workers perceive that the mission statement of their organization is reflected within the current operations of their organization”? Item five on the survey asked, “In your opinion, does the daily business of your hospital reflect the written mission statement?” The choices of responses were: (a) it is strongly reflected, (b) it is somewhat reflected, (c) it is rarely reflected, and (d) it is not reflected at all. The responses to this question were tabulated utilizing count and frequency distribution. Again, cross tabulation and chi-square analysis were used to determine if there were differences between the responses which were at the ordinal level of measurement and the subgroups, which were at the nominal level of measurement.

Research Question 3, “From a competing values framework, how do social workers perceive the current culture of their organization?” The OCAI contains six questions related to the following: dominant characteristics, organizational leadership, management of employees, organization glue, strategic emphasis, and criteria of success. Each question had four alternatives that were labeled A, B, C, and D. The responses

linked to the culture type within the CVF as below:

Responses in alternative A link to clan culture

Responses in alternative B link to adhocracy culture

Responses in alternative C link to market culture

Responses in alternative D link to hierarchy culture

Participants were asked to divide 100 points among the alternatives with the greatest number of points assigned to the answer they felt was most similar to their organization. The profile score was determined by calculating the aggregate sum for each item, 8a-13d, on the *OCAI* in the *now* column, then calculating the mean for all responses (N=149), and dividing the mean by the number of questions, which was six. This calculation was repeated for all subgroups: BSW, MSW, and so forth, in order to determine a culture profile for each subgroup.

Research Question 4, “From a competing values framework, what culture would hospital social workers prefer to see demonstrated in their organization?” This question was assessed by calculating the aggregate sum for each item, 8a-13d, on the *OCAI* as described above but using the sums from the *future* column. The mean was then calculated for all responses (N=149), then divided by the number of questions, which was six. This calculation was repeated for all subgroups: BSW, MSW, and so forth, in order to determine a culture profile for each subgroup.

Research Question 5, “To what extent do hospital social workers perceive that the tasks they perform within the hospital setting reflect their professional values?” This

question was addressed on item five on the survey which asked, “As a hospital social worker, do you feel that your work assignments provide you with opportunities to demonstrate your professional values on a regular basis?” The response choices were: (a) yes, I am able to demonstrate my professional values consistently in my work assignments, (b) no, I am not able to demonstrate my professional values consistently in my work assignments, and (c) I am not sure. The level of measurement for this item was nominal and analysis of the results utilized frequency distribution by count and percentage. Cross tabulation and chi-square were utilized to evaluate if there was a difference in responses between this item by subgroups.

Research question 6, “To what extent do hospital social workers trust their organizations to support the practice of their core professional values?” Response to this question was assessed by item seven on the survey that asked: “As a professional social worker, do you trust that your hospital values the skills and knowledge of your profession?” The choices of responses were: (a) yes, I feel that my profession is valued in my hospital setting, (b) no, I do not feel that my profession is valued in my hospital setting, and (c) I am not sure how my hospital setting values my profession. The responses, all nominal data, were analyzed by calculating the frequency distribution of responses by count and percentage. Chi-square and crosstabulation were used to determine if there were differences between the responses and the subgroups.

Summary

This chapter described the problem to be investigated, how the population was identified, efforts made to contact the population, methods of data collection, breakdown of the respondents by education, and length of employment in health care. Only the surveys that met the study criteria were included in the analysis described in Chapter 4. One hundred and forty-nine valid responses were received from social workers responded to the request to participate in the survey. Cross tabulation analysis of the valid surveys revealed that 75% of the respondents held a master's degree in social work. More than half (59%) had been employed in health care for 10 years or more. Further discussion of these findings is found in Chapter 5.

CHAPTER FOUR: DATA ANALYSIS

Introduction

The purpose of this study was to assess the perceptions of professional social workers employed in Florida hospitals in relation to alignment of their values and the organizational culture of their current work setting. This chapter is organized as follows: (a) description of the research group, (b) description of the variables, (c) analysis of the variables, (d) findings related to the research questions, (e) additional findings, and (f) summary of the findings.

Research Group

The participants in the study were professional social workers employed in hospitals in Florida. In order for participants to be eligible for inclusion in the study, they must have stated on the returned survey that they had obtained a bachelor's degree in social work (BSW), a master's in social work (MSW), or a doctorate in social work (DSW). Valid surveys were received from 149 professional social workers representing 64 different hospitals. Bed capacity of the represented hospitals ranged from 42 beds in the smallest hospital to 882 in the largest. According to the FHA directory, there are hospitals in 62 out of Florida's 67 counties. Thirty-three (53%) of the counties with hospitals were represented in the population.

Description of the Variables

The questionnaire distributed to the population contained 13 questions. The first question related to social work education. Participants were asked specifically if they held a degree in social work and to report the level of education (BSW, MSW, or DSW). The purpose of this question was to ensure that the participants were professional social workers whose education met the nationally established standards of the profession. If the educational criterion were not met, the survey was invalidated (n=21) and not used for analysis.

The next two questions queried participants on their employment experience related to health care. Respondents were asked to identify how many years they had been employed in health care. The responses were sub-grouped as follows: (a) 0-3 years, (b) 4-6 years, (c) 7-9 years, and (d) 10 or more years. The second employment question asked participants to identify how many years they had been employed in their current hospital using the same subgroups as described above. Analysis of these variables is found in the following section.

The next four questions addressed the mission statement of the hospital, social work core values, and how the social workers perceived they were valued as a profession within the hospital. Question four on the survey asked participants for their perception of the alignment between the written mission statement of their hospital and professional social work core values. The next question was also related to the mission statement and asked if the daily business of the hospital reflected the written mission statement.

Question six on the questionnaire asked the social workers if they felt their work assignments provided them with opportunities to demonstrate their professional values on a regular basis. Question seven on the questionnaire asked whether professional social workers trusted that their hospital valued the skills and knowledge of their profession. Analyses of these responses are presented in the next section.

The final section of the questionnaire utilized the *Organizational Culture Instrument* (OCAI) to profile the social workers' perceptions of the current culture of their hospital and examine how they would prefer it to be in the future. The OCAI contains six sections related to organizational culture. They are:

1. Dominant Characteristics
2. Organizational Leadership
3. Management of Employees
4. Organizational Glue
5. Strategic Emphases
6. Criteria of Success

Participants were provided four alternatives for each section and asked to weigh each alternative according to how closely it reflected their hospital culture. The sum of the four alternatives should equal 100. For each section, the participants were asked to first answer according to their perceptions of their cultures *now*, then answer again on how they would prefer their cultures to be in the *future*. Analyses of the culture responses are provided in the following section.

Analysis of the Variables

The first three questions on the survey related to social work education and length of employment. These responses were nominal data, and frequency distribution of the subgroups revealed that the majority of the participants held a master's in social work (76%, n=112), 24% (n=36) reported a bachelor's in social work (BSW), and one reported a doctorate in social work (DSW).

Subgroup analysis of years employed in health care, also at the nominal level of measurement, revealed that 68% (n=102) of the participants had been employed in health care for 7 years or longer. Crosstabulation of these data revealed that nearly 60% (n=67) of the MSW participants and 55% (n=20) of the BSW participants had been employed in health care for 10 years or longer. Table 4 compares years of employment in health care by social work degree.

Table 3

Social work degree and years of employment

Social Work Degree	Years employed in health care			
	0-3 years	4-6 years	7-9 years	10 or more years
BSW	7	3	6	20
MSW	16	21	8	67
DSW	0	0	0	1
Total	23	24	14	88

Less than half of the respondents (46%) had been employed in their current

setting for 7 years or longer. Thirty-six percent (n=53) had worked in their current hospital for 3 years or less. The details of the respondents' years of employment in their current hospital setting are provided in Table 5 below.

Table 5

Social work degree and current hospital employment

Social Work Degree	Years worked in current hospital				Total
	0-3 years	4-6 years	7-9 years	10 or more years	
BSW	14	6	6	10	36
MSW	38	22	11	41	112
DSW	1	0	0	0	1
Total	53	28	17	51	149

The bed size and ownership of the hospital in which the respondent was employed was determined by the code on the back of the survey. Only 12 (8%) of the 149 respondents were employed in investor-owned facilities. Social workers employed in not-for-profit facilities responded at the highest rate (83%, n=124). Only 13 (9%) of the social work respondents worked in public-or- government-owned owned hospitals. For coding purposes, bed size of the hospitals was sub grouped by the following: (a) less than 100 beds, (b) 100-250 beds, (c) 251 – 500 beds, and (d) over 500 beds. Table 6 provides the frequency statistics for bed size of the employing hospitals by response count.

Table 6

Hospital bed size

Bed size	Frequency	Percent	Cumulative Percent
less than 100 beds	7	4.7	4.7
100-250 beds	39	26.2	30.9
251-500 beds	47	31.5	62.4
over 500 beds	56	37.6	100.0
Total	149	100.0	

Findings Related to the Research Questions

Research Question One

Research Question One asked, “To what extent do Florida hospital social workers perceive that the core values of their profession are aligned with the mission statement of the hospital in which they are employed?” The fourth question on the survey addressed this research question. Participants were asked the following question: “In your opinion, does the *written* mission statement of your hospital reflect values that appear to be in *alignment* with professional social work core values?” The response choices were: (a) very much in alignment, (b) somewhat in alignment, (c) not at all in alignment, (d) am not sure, and (e) I am not familiar with the written mission statement. From the 149 responses analyzed, 65 % (n=97) described the mission statement of their hospital as very much in alignment with social work core values, while 34% (n=50) perceived the mission statement as being somewhat in alignment with social work core values. One social worker reported that the mission statement was not at all in alignment with social work

core values and one responded that they were not familiar with the mission statement. A higher percentage of BSW respondents (72%) agreed that the mission statement was very much in alignment with social work values than MSW respondents (63%), although chi-square analysis of this association, $X^2(6, N=149) = 3.37, p > 0.05$, did not demonstrate statistical significance. Table 7 displays the results of crosstabulation of social work degree with alignment of social work values and the hospital mission statement.

Table 7

Alignment of social work values: mission statement and education

“In your opinion, does the <i>written</i> mission statement of your hospital reflect values that appear to be in <i>alignment</i> with professional social work core values?”					
Social Work Degree	Very much in alignment	Somewhat in alignment	Not at all in alignment	Not familiar with the mission statement	
BSW	26 (72%)	10 (28%)	0	0	36
MSW	71 (63%)	39 (35%)	1	1	112
DSW	0	1	0	0	1
Total	97	50	1	1	149

Analysis of additional variables revealed that 67% of the 88 social workers who had been employed in health care for 10 or more years stated that the mission statement was very much in alignment with social work values. Figure 2 provides a bar graph that illustrates this finding.

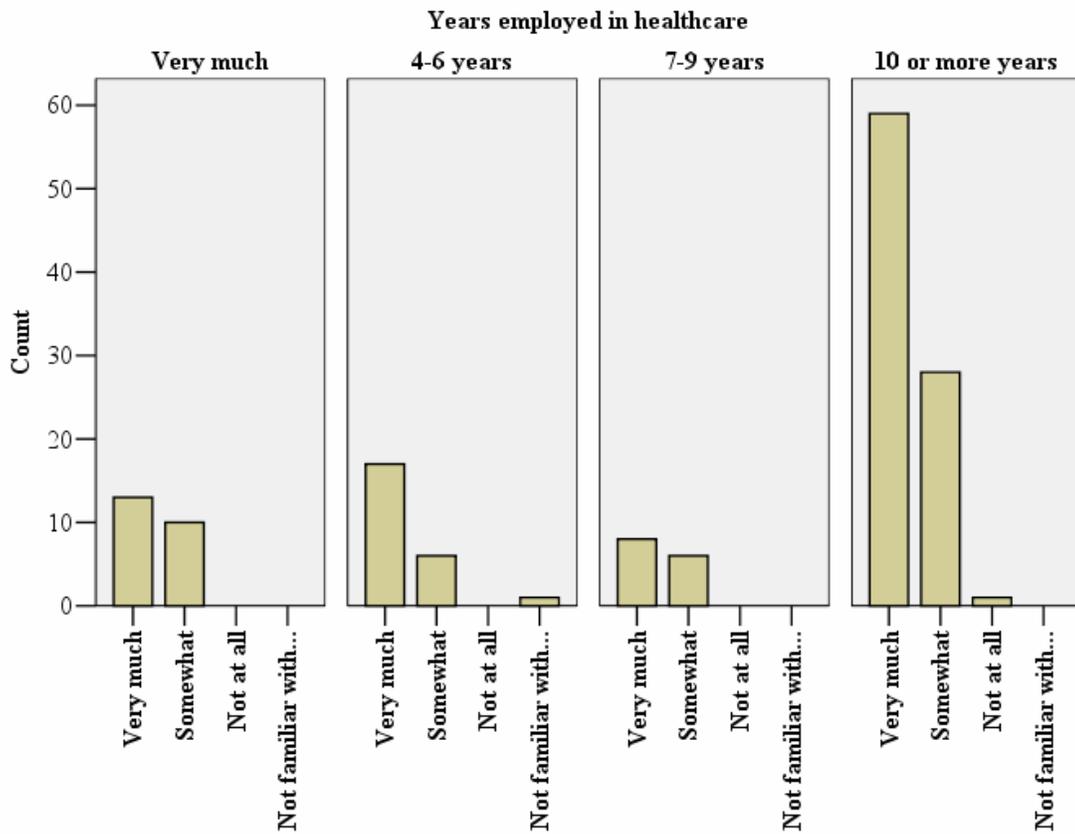


Figure 2 Mission statement and alignment by years of employment

Similarly, analysis of social workers employed in their current hospital 10 years or more revealed that 71% of the 36 social workers also stated that the mission statement was very much in alignment with social work values. Chi-square analysis of these findings did not demonstrate statistical significance at < 0.05 .

The largest number of respondents in this research was employed in not-for-profit hospitals (n=124). Crosstabulation of values and the mission statement and hospital ownership disclosed that 68% (n=84) of those employed in not-for-profit hospitals and

62% (n=8) employed in public-or- government-owned hospitals stated that the mission statement was strongly aligned with social work values, compared to 42% (n=5) of those respondents who were employed in investor-owned facilities. However, the small sample size of the subgroups challenge additional inference related to these findings.

Research Question Two

Research Question Two asked, “To what extent do social workers perceive that the mission statement of their organization is reflected within the current operations of the organization?” The questionnaire addressed this problem by asking respondents the following: “In your opinion, does the daily *business* of your hospital reflect the written mission statement?” The choices of responses were: (a) it is strongly reflected, (b) it is somewhat reflected, (c) it is rarely reflected, and (d) it is not reflected at all.

Frequency analysis of this question by hospital ownership revealed that only 23% of those employed in public-or- government-owned hospitals, 44% employed in not-for-profit hospitals, and 33% of those employed in investor-owned facilities agreed that the mission statement was strongly reflected in the daily business of their hospital. Chi-square analysis of these data did demonstrate statistical significance, $X^2 (8, N=149) = 17.745, p < 0.05$.

Six MSW respondents stated that the mission statement was rarely reflected in the daily business of their hospital. Cross tabulation analysis of this finding revealed that two of those six were employed in public-or- government-owned owned hospitals, three in not-for-profit hospitals, and one from an investor-owned hospital. Table 8 provides the

frequency response for all participants regarding the mission statement of the hospital as it is reflected by the daily business.

Table 8

Daily business and mission statement

Responses	Frequency	Percent	Cumulative Percent
It is strongly reflected	62	41.6	41.6
It is somewhat reflected	79	53.0	94.6
It is rarely reflected	6	4.0	98.7
It is not reflected at all	1	.7	99.3
Did not respond	1	.7	100.0
Total	149	100.0	

Crosstabulation of this question by hospital ownership revealed the following: 37% (n=55) of those employed in not-for-profit, 3% (7) of those employed in investor-owned and 23% (n=3) of those employed in public-or- government-owned hospitals depicted the daily business of their hospital as strongly reflecting the mission statement. Sixty percent (n=37) of those employed in hospitals with less than 500 beds depicted the daily business of their hospital as strongly reflecting the mission statement. More BSW respondents (53%) than MSW respondents (38%) depicted the daily business of their hospital as strongly reflecting the mission statement. These data are displayed in Table 9.

Table 9

Daily business and mission statement by education

Social Work Degree		Does the daily business of hospital reflect the mission statement?					Total
		It is strongly reflected	It is somewhat reflected	It is rarely reflected	It is not reflected at all	Did not respond	
BSW	Count	19	17	0	0	0	36
	% BSW degree	52.8%	47.2%	.0%	.0%	.0%	100.0%
MSW	Count	43	61	6	1	1	112
	% MSW degree	38.4%	54.5%	5.4%	.9%	.9%	100.0%
DSW	Count	0	1	0	0	0	1
	% DSW degree	.0%	100.0%	.0%	.0%	.0%	100.0%
Total	Count	62	79	6	1	1	149
	% all degrees	41.6%	53.0%	4.0%	.7%	.7%	100.0%

Crosstabulation with Chi-square analysis of the subgroups described above did not demonstrate statistical significance at <0.05 .

Research Questions Three and Four

Research Question Three asked, “How do social workers perceive the current culture of their organization in relation to their professional values?” Research question four asked, “What culture would hospital social workers prefer to see demonstrated in their organization?” The method used to assess both of these questions was the OCAI.

The OCAI is a self-administered instrument that provided the researcher weighted scores that revealed how responses clustered into four competing value frames (CVF). For this study, internal consistency was determined for the *OCAI* by Cronbach's alpha. There were 12 items relative to each of the four cultures. Cronbach's alpha for the four culture sections were as follows: *clan culture*, .870, *adhocracy culture*, .765, *market culture*, .792, and *hierarchy culture*, .763.

The competing values, as defined by CVF are: *clan culture*, *hierarchy culture*, *adhocracy culture*, and *market culture*. The clustering of scores within these frames created a profile of the organizational culture of Florida hospitals as perceived by the professional social workers employed in them. The OCAI contains six questions related to the following: dominant characteristics, organizational leadership, management of employees, organization glue, strategic emphasis, and criteria of success. Each question had four alternatives that were labeled A, B, C, & D. The responses linked to the culture type within the CVF as below:

Responses in alternative A link to clan culture

Responses in alternative B link to adhocracy culture

Responses in alternative C link to market culture

Responses in alternative D link to hierarchy culture

Participants were asked to divide 100 points among the alternatives with the greatest number of points assigned to the answer they felt was most similar to their organization. The OCAI required that the respondents first score the questions on how

they perceived their hospital *now* and then again by how they would prefer it to be in the *future*. To score the OCAI responses, the aggregate sum of each alternative was computed. For example, all A scores were added, then all B scores, and so forth. The aggregate sum of each alternative was then divided by the number of participants for each sub-group. This provided a mean score for each sub-group of participants. There are six categories in the OCAI; therefore the mean score of the sub-group was divided by six, which provided the score for each culture.

The range of aggregated mean scores for all subgroups was as follows: *clan* 23-34, *adhocracy* 15-24, *market* 19-30, and *hierarchy* 14-30. The highest score (37 points) for *clan* now was demonstrated in the BSW subgroup in hospitals that have 100-250 beds. Conversely, the lowest score (15 points) was found in the MSW subgroup in hospitals that have 100-250 beds. MSW participants who were employed in hospitals with 100-250 beds demonstrated the lowest *adhocracy* culture (14 points). The subgroup that demonstrated the highest *adhocracy* culture response (24 points) was made up of social workers who had been employed in their current hospital for 4-6 years. Social workers in public-or- government-owned hospitals reported the lowest *market* culture (19 points), while MSW participants in hospitals with over 500 beds reported the highest market culture (33 points). Social workers in public-or- government-owned hospitals also reported the lowest *hierarchy* culture (16 points), while social workers in hospitals with 100-250 beds reported the highest *hierarchy* score (30 points). The aggregated culture profile scores for all participants (n=149) are found in Table 10.

Table 10

Culture profile aggregate scores all participants

	Now	Preferred Future	Discrepancy
Clan Culture	28	39	11 points
Adhocracy Culture	19	23	4 points
Market Culture	27	17	10 points
Hierarchy Culture	26	21	5 points

Interpretation of the culture profiles

The results of the OCAI provided information on discrepancies between current and preferred culture. According to Cameron and Quinn (1999), discrepancies of ten or more points indicate where misalignment may be perceived by members of an organization. Those findings are reported in this section. Analysis of the aggregated scores of all respondents revealed there was a discrepancy of 11 points between the *now* (28 points) and *preferred future* (39 points) within the clan culture that demonstrated that the respondents preferred a stronger clan culture than they currently have. Additionally, they indicated that they preferred less dominance in the market culture in the future (17 points) than now (27 points). There is closer alignment between the perception of *adhocracy culture now* (19 points) and *preferred future* (23 points). Similarly, the overall perception was that the *current hierarchy culture* (26 points) was closely aligned with the *preferred hierarchy culture* (21 points) with a difference of only 5 points. These findings

are demonstrated in Figure 3 below.

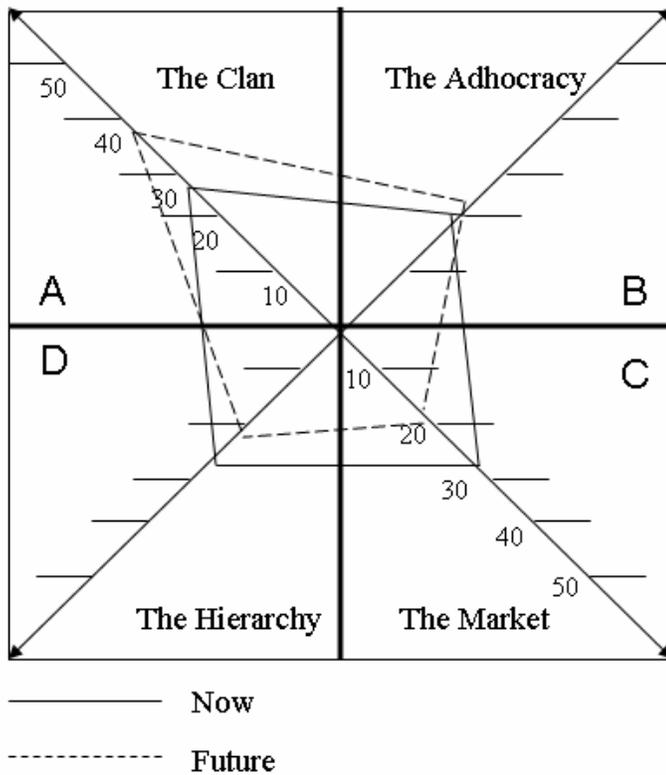


Figure 3 Culture profile all participants

In addition to the aggregate scores of all the participants as described above, exploration was conducted to determine if culture perception changed according to subgroups within variables. A discrepancy of ten or more points was not found within responses for any of the variables in *adhocracy culture* or *hierarchy culture*.

Discrepancies of ten or more points were found between *now* and *future* in the *clan culture* and the *market culture* only. These findings demonstrate a possible misalignment, or cultural incongruence, and are discussed in the following section. Interestingly, the

highest score (37 points) for *clan* now was demonstrated in the BSW subgroup in hospitals that have 100-250 beds. Conversely, the lowest score (15 points) was found in the MSW subgroup in hospitals who have 100-250 beds

Analysis of the culture profile by education of the respondents revealed that MSW participants demonstrated a 12-point discrepancy in the clan culture between *now* (27 points) and *preferred future* (39 points). Examination of the profile responses by hospital bed size disclosed that respondents who were employed in hospitals with 100 – 250 beds reported a 16-point discrepancy in the clan culture between *now* (25 points) and *preferred future* (41 points). They also indicated that they would prefer less dominance in the market culture in the *future* (14 points) as opposed to *now* (27 points). BSW culture profiles were closely aligned between *now* and *preferred future* with no culture demonstrating a point gap of ten or more.

Interpretation of the culture profiles by hospital ownership revealed ten point or more discrepancies in all three subgroups, investor-owned, not-for-profit, and public-or-government-owned owned. The largest discrepancy was found in from respondents in the investor-owned subgroup. There was a 17-point difference in the clan culture between *now* (24 points) and *preferred future* (41 points) from respondents from investor-owned hospitals and a 20-point gap between market culture *now* (33 points) and *preferred future* (13 points). Respondents employed in not-for-profit hospitals revealed a ten-point preference for clan culture in the *future* (39 points) as opposed to what they perceived it is *now* (29 points). Social workers employed in public-or- government-owned owned

hospitals revealed that they preferred a stronger clan culture in the *future* (38 points) than is demonstrated *now* (28 points). The figures and table demonstrating the culture profiles for each subgroup referenced above are located in Appendix E. Figure 4 below demonstrates the *now* and *preferred future* profile for the subgroups and clustering into each culture quadrant.

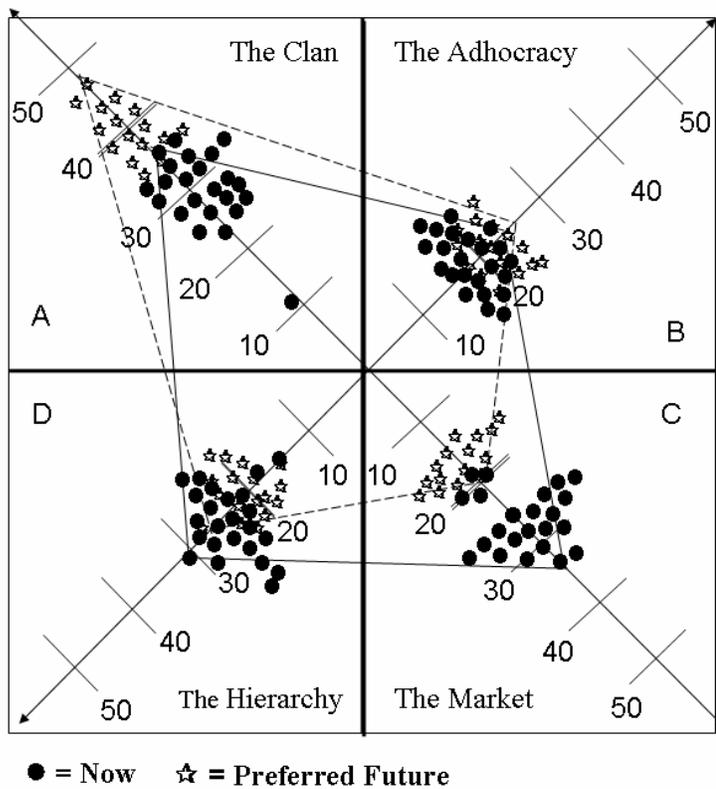


Figure 4: Culture profile for now and future, all subgroups

Analysis of the point discrepancies in the *adhocracy* and *hierarchy* cultures did not reveal gaps of ten points or greater. Table 11 demonstrates the culture profile scores for *now* and *future* that did demonstrate a discrepancy of ten or more points.

Table 11

Culture discrepancies between *now* and *future* by variables

Variable	Subgroup	Culture where incongruence found	<i>Now</i>	<i>Preferred Future</i>	Point Difference
Education	MSW	Clan Culture	27	39	12 points
		Market Culture	28	17	11 points
Hospital Ownership	Investor-Owned	Clan Culture	24	41	17 points
		Market Culture	33	13	20 points
	Not-for-Profit	Clan Culture	29	39	10 points
	Public/Gov.	Clan Culture	28	38	10 points
Years employed in health care	0-3 years	Clan Culture	31	41	10 points
		Market Culture	26	14	12 points
	4-6 years	Clan Culture	23	36	13 points
		Market Culture	30	16	14 points
	7-9 years	Clan Culture	34	48	14 points
10 or more yrs.	Clan Culture	27	38	11 points	
		Market Culture	28	18	10 points
Years employed in current hospital	0-3 years	Market Culture	27	16	11 points
	4-6 years	Clan Culture	26	37	11 points
		Market Culture	29	17	12 points
	7-9 years	Clan Culture	32	44	12 points
	10 or more yrs.	Clan Culture	27	40	13 points
		Market Culture	29	18	11 points
Hospital bed size	100-250 beds	Clan Culture	25	41	16 points
		Market Culture	27	14	13 points
	Over 500 beds	Clan Culture	26	36	10 points
		Market Culture	30	19	11 points

Research Question Five

Research Question Five asked, “To what extent do hospital social workers perceive that the tasks they perform within the hospital setting reflect their professional values?” The sixth item on the survey asked the following: As a hospital social worker, do you feel that your work assignments provide you with opportunities to demonstrate your professional values on a regular basis? The response choices were: (a) yes, I am able to demonstrate my professional values consistently in my work assignments, (b) no, I am not able to demonstrate my professional values consistently in my work assignments, and (c) I am not sure. A large majority of the 149 respondents (85%, n=126) answered yes to this question. Three stated they were not sure. Analysis of responses by hospital ownership revealed that 83% (n=10) of those employed in investor-owned hospitals, 85% (n=106) employed in not-for-profit hospitals, and 77 % (n=10) employed in public-or-government-owned owned facilities responded positively to this statement. Chi-square analysis did not demonstrate statistical significance at <0.05 .

Cross tabulation of responses to this question with education revealed similar responses; 86% (n=31) of BSW respondents and 84% (n=112) of MSW respondents stated that their work assignments provided opportunities to demonstrate their professional values on a regular basis, however, chi-square analysis did not demonstrate statistical significance at <0.05 . Similarly, evaluation of responses by bed size revealed over 80% of participants from each subgroup stated that their work assignments provide them with opportunities to demonstrate their professional values on a regular basis. Chi-

square analysis did not demonstrate statistical significance at <0.05 .

Research Question Six

Research Question Six asked, “To what extent do hospital social workers trust their organizations to support the practice of their core professional values?” Perception of this question was assessed by item seven on the survey that asked: As a professional social worker, do you trust that your hospital values the skills and knowledge of your profession? The choices of responses were: (a) yes, I feel that my profession is valued in my hospital setting, (b) no, I do not feel that my profession is valued in my hospital setting, and (c) I am not sure how my hospital setting values my profession. Only 60% (n=67) of the MSW respondents answered positively to this question as compared to 72% (n=26) of the BSW respondents. One-third (n=35) of the MSW participants communicated that they did not trust that their organization valued the skills and knowledge of their profession, and 9% stated that they were not sure.

Figure 5 demonstrates that only 63% (n=94) of the 149 social work respondents reported that they trusted their organization valued the skills and knowledge of their profession.

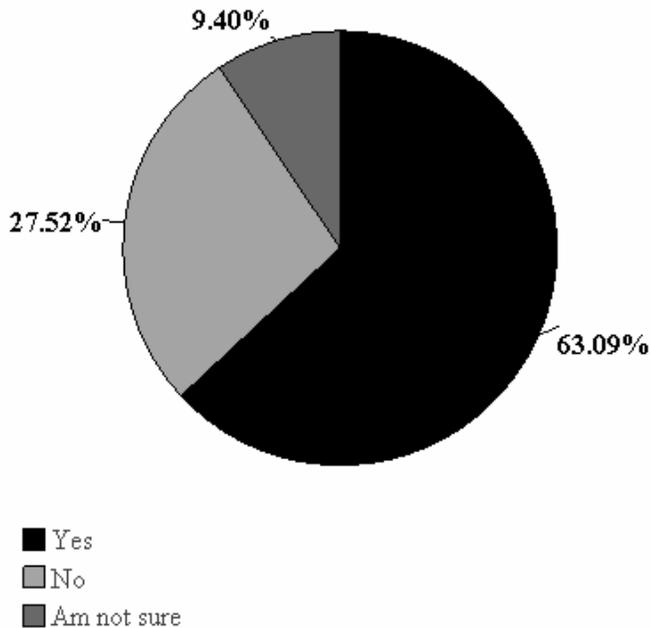


Figure 5 Trust that hospital values the skills and knowledge of profession

Crosstabulation analysis of variable subgroups that answered *yes* to this question demonstrated similar findings. No subgroup demonstrated a frequency percent of over 65%, however Chi-square analysis of these data did not demonstrate statistical significance at <0.05 .

Other Findings

Professional social work employment in Florida Hospitals

In preparation for this study, the researcher found no data that revealed the extent of employment for social workers in Florida hospitals. To facilitate tracking the response rate, each survey was assigned an identifying code prior to mailing. The presence of the

code was disclosed in the cover letter, and participants were ensured confidentiality. Coded responses enabled the researcher to track response rates as well as sort responses by hospital ownership, bed size, and county. The initial screening efforts of this study revealed that only 50 hospitals out of 217 hospitals employed social workers. Analysis of the responses that were returned revealed an additional 14 hospitals that employed professional social workers. The frequency analysis of the responses by hospital ownership is provided in Table 12.

Table 12

Hospital ownership

	BSW	MSW	DSW	Total
Investor-owned	5	7		12
Not-for-Profit	29	94	1	124
Public/Government	2	11		13
Total	36	112	1	149

Summary

The research findings indicated that out of 149 participating professional social workers, 97 (65%) perceived that the core values of their profession are *very much in alignment* with the written mission statement of their hospital. Less than half of the respondents (42%) described the daily business of the hospital as strongly reflecting the

mission statement. The social workers perceived the current culture of hospitals in Florida as being closely clustered among four cultures: clan, adhocracy, market, and hierarchy. However, they would prefer a stronger clan culture and less of a market culture in the future. A strong majority (85%) of all respondents communicated that their work assignments allowed them to demonstrate their professional values on a regular basis. However, only 63% stated that they trusted that their hospital valued the knowledge and skills of their profession.

CHAPTER FIVE: DISCUSSION AND RECOMMENDATIONS

Introduction

This chapter is organized as follows: (a) statement of the problem, (b) research group, (c) conceptual framework, (d) significance of the study, (e) design, (f) research questions with discussion of the findings, (g) other findings, (h) recommendations for future research, and (i) implications for practice. Efforts to identify the population for the study are provided in the section describing the research group. The conceptual framework section provides a brief description of literature that defines culture, organizational trust, and values. The significance of the study section provides findings that relate to the literature and the variables chosen for examination in the research.

Statement of the Problem

The purpose of this study was to examine how social workers perceived the current culture of hospitals in Florida. The conceptual framework for this study arose from the body of literature related to organizational change, culture, and values. A review of this literature revealed a growing body of research that reinforced the need to identify values that are understood and demonstrated within organizations as a way of facilitating change and understanding resistance to change.

Research Group

Participants for this study were sought from the 217 hospitals listed in the directory of the Florida Hospital Association (Florida Hospital Association, 2005). Prior to this research, the employment status of professional social workers in Florida hospitals was unknown. Initial screening efforts revealed 50 hospitals that employed professional social workers. Analysis of the responses revealed an additional 14 hospitals that employed professional social workers. These findings are encouraging and suggest that there continues to be a role for professional social work in hospital settings.

In an attempt to identify participants for the study, calls were placed to the main telephone number of each of the acute care hospitals listed in the FHA directory. One unanticipated difficulty of this method was the widespread use of voice mail within hospital systems. If direct contact was unsuccessful, a message was left on voice mail that explained the study and provided the researcher's contact information. One week later, a second phone call was placed to the facilities that did not respond to the voice message. If no contact name was acquired after two telephone attempts, packets addressed to the Director of Social Work were mailed to the facility. This method was time-consuming and costly and extended the anticipated timeline for the mailings by several weeks. Additionally, long-distance telecommunication and postage costs made subsequent requests for participation unfeasible.

There were a total of 176 individual surveys returned. For the purposes of this study, a participant must have had a bachelor's degree in social work, a master's degree

in social work, or a doctoral degree in social work in order to be included in the study population. Six returned surveys contained scoring errors and 21 of the respondents did not hold a social work degree at any level and were excluded from the study. Valid surveys were received from 149 social workers representing 64 different hospitals. As the population size was unknown, it was not feasible to create a sample of the population and all valid responses were used for analysis.

Conceptual Framework

The conceptual framework for this study was derived from organizational behavior literature concerned with the relationship of values, trust, and change to organizational culture. The literature review focused on theory and empirical research related to individual values and organizational value alignment, the impact of change, trust and change, and professional identity. External pressures and the internal response to those pressures have had an affect on virtually every professional employed in hospital settings. Hospitals and health professionals alike find themselves in a state of organizational flux, and these changes have created the potential for misalignment in hospital settings between the values of the hospital social worker and the values of the organization. Misalignment of this sort can lead to job dissatisfaction, low morale, low productivity, and high turnover (Goman, 1997).

Commonly held values of a group help define the culture of an organization (Schein, 1993). During times of change, value systems may appear to be polarized, or

competing, within an organization. When this occurs, organizational members may find themselves disagreeing with the direction the organization is moving, and experience feelings of mistrust and betrayal (Argyris, 1964; Reina & Reina, 1999). According to Cameron and Quinn (1999), the culture of organizations can be diagnosed from a framework that identifies competing values. Competing values often exist within organizations, especially following times of change.

The study utilized a model called the Competing Values Framework (CVF) (Quinn & Rohrbaugh, 1983) which provides an examination of two dimensions of an organization that help define the culture. Within the first dimension, organizational effectiveness can be viewed from opposite perspectives; flexibility, adaptability, and dynamism are viewed as effective in some organizations, while stability, predictability, and durability are essential to others. The second dimension distinguishes effectiveness via internal or external orientation.

Within the CVF model, some organizations are viewed as effective if they are internally cohesive while other organizations value interacting or competing with entities outside of the organization. Members of an organization perceive the intensity that is given to these internal and external foci as define what the organization values most. (Cameron & Quinn, 1999; Quinn, 1988). It is assumed that all organizations develop combinations of behaviors from four cultures: (a) *clan*, (b) *adhocracy*, (c) *market*, and (d) *hierarchy*, with one or two being more dominant than others (Quinn, 1988).

The *clan* culture reflects flexibility and discretion with an internal focus. An

organization that would cluster primarily in this culture would represent shared values and goals, cohesion, teamwork, and corporate commitment to the well-being of its employees. Employee participation, commitment, and loyalty would be demonstrated in the clan culture.

The *adhocracy* culture demonstrates a focus on flexibility and discretion with an external focus. An organization that demonstrates this value system would focus on adaptability, flexibility, and creativity. Risk taking would be valued with a high degree of individualism. Structure is relative primarily to projects and the organization would reorganize itself with each new project.

A *market* culture has a concentration on stability and control with an external focus. Market culture focal points are related to profitability and a secure customer base. Transactions with external clients, contractors, suppliers, and so forth are the focus of this culture. Competitiveness and productivity are key values of a market culture.

A *hierarchy* culture would reflect stability and control with an internal focus. These organizations represent a traditional model of structure that provides clear procedures that govern what people do. The key values of the hierarchy culture are efficiency and reliability. Each job has clearly defined tasks and procedures to accomplish these tasks.

Significance of the Study

Alignment of Values

A good fit between the organization and the individual is essential to organizational health (Shafritz & Ott, 2001; Sullivan, Sullivan, & Buffton, 2002; Valentine & Lucero, 2002). Human resource theory assumes that organizations exist to serve human needs, and each is dependent on the other (Bolman & Deal, 1997). Within organizations, values can be defined as whatever is cherished, respected, or appreciated (Pheyse, 1993; Schein, 1990). Shared values provide a sense of general direction for day-to-day operations within organizations (Deal & Kennedy, 2000; Schein, 1993). These shared values express predictable and consistent patterns of behaviors that are observable and demonstrate what the organization defines as quality (Goman, 1997). A mission statement should clearly reflect what an organization is trying to do. Operations, or daily business, of the organization should reflect that mission so that the common goal is identifiable and shared by all members (Drucker, 1990). These shared values eventually become shared assumptions, or culture, of an organization (Schein, 1993). The members of the organization then work under the assumption that they agree as to who they are and why they are there.

This study revealed some areas where there appeared to be incongruence between social work values and the hospitals in which they are employed. It further examined how strongly professional social workers perceive that the mission statement is reflected in the daily business of their hospital.

Change, Professional Identity, and Trust

When rapid change occurs, as it has in health care over the past decade, individuals within organizations may experience feelings of betrayal and mistrust (Decker et al., 2001; Reina & Reina, 1999). This is because the assumption that both the individual and the organization are working toward a common goal has been challenged by change. Employment is viewed as a mutually beneficial agreement and when rapid change occurs without regard to these assumptions, trust is broken (Shaw, 1997). Trust is essential to teamwork (Cruise-O'Brien, 2001; Shaw, 1997).

High trust organizations demonstrate enhanced organizational learning, active collaboration across teams or units, high morale, low turnover, and individual initiative (Reina & Reina, 1999; Shaw, 1997). Change in organizations often elicit concern over decreased quality, loss of professional identity, and resentment of change initiatives that do not appear to reflect shared values (Decker et al., 2001).

Research Questions with Discussion of the Findings

Question 1: To what extent do Florida hospital social workers perceive that the core values of their profession are aligned with the mission statement of the hospital in which they are employed?

Result: The fourth question on the survey addressed this research question.

Participants were asked the following question: “In your opinion, does the *written* mission statement of your hospital reflect values that appear to be in *alignment* with professional social work core values?” The results demonstrated that 65% of social workers in Florida hospitals perceive the mission statements of their hospital were strongly aligned with professional social work core values and 34% of social work participants reflected that the mission statement was somewhat aligned with the core values of professional social work. A higher percentage of BSW respondents (72%) agreed that the mission statement was very much in alignment with social work values than MSW respondents (63%). Of those social workers who had been employed in health care for 10 or more years, 67% stated that the mission statement of their hospital was very much in alignment with social work values. Seventy-one percent of those employed in their current hospital for 10 or more years stated that the mission statement of their hospital was very much in alignment with social work values. Social workers employed in not-for-profit hospitals represented the largest group of respondents, and 68% stated that the mission statement of their hospital was very much in alignment with social work values. Only 42% of those who are employed in investor-owned hospitals stated that the mission statement of their hospital was very much in alignment with social work values. Chi-square analysis of association between the variables did not demonstrate statistical significance at <.05 level.

Discussion: While more than half of the respondents related strong alignment within values, more than 30% of respondents within all subgroups stated that the mission

statement of their hospital was somewhat in alignment with social work values.

According to the literature on values and culture, strong alignment between individual values and those of the organization is essential to the overall health of the organization. Drucker (1990) stated that the organizational mission should come before anything else and should not change randomly with leadership or external influences.

Question 2: To what extent do social workers perceive that the mission statement of their organization is reflected within the current operations of the organization? On item five on the survey participants were asked the following: “In your opinion, does the daily *business* of your hospital reflect the written mission statement?”

Result: Only 42% of the respondents stated that the mission statement is reflected in the daily business of their hospital. Only 23% of those employed in public-or-government-owned hospitals, 44% employed in not-for-profit hospitals, and 33% of those employed in investor-owned facilities agreed that the mission statement was strongly reflected in the daily business of their hospital. Chi-square analysis of these data did demonstrate statistical significance, $X^2(8, N=149) = 17.745, p < 0.05$.

Discussion: A relationship was revealed using Chi-square analysis that was statistically significant at $p < 0.05$ level. Crosstabulation findings further reveal that less than 50% of those who responded to the survey indicate that the mission statement is strongly reflected in the daily business of their hospital. According to Drucker (1990) integrity is demonstrated within organizations by observable consistency between what is said and what is done. The mission statement provides a long-range objective that is

operational and can be translated into activity. There should be congruence between the mission statement and the activities that occur within an organization (Weinbach, 2003). The majority of the social workers who responded to this study did not perceive that the mission statement of their organization was reflected in the current operations of their organization.

Question 3: How do social workers perceive the current culture of their organization in relation to their professional values? This question was addressed by utilizing the OCAI which provides a profile of the current perceived culture by participants according to a Competing Values Framework (CVF). The competing values, as defined by CVF are: *clan culture*, *hierarchy culture*, *adhocracy culture*, and *market culture*. The clustering of scores within these frames created a profile of the organizational culture of Florida hospitals as perceived by the professional social workers employed in them. The OCAI contains six questions related to the following: dominant characteristics, organizational leadership, management of employees, organization glue, strategic emphasis, and criteria of success.

Result: The finding for this question revealed an aggregate mean score of 28 for clan culture, 19 for adhocracy culture, 27 for market culture, and 26 for hierarchy culture. The highest score (37 points) for *clan now* was demonstrated in the BSW subgroup in hospitals that have 100-250 beds. Conversely, the lowest *clan* score (15 points) was found in the MSW subgroup also in hospitals with 100-250 beds. MSW participants who were employed in hospitals with 100-250 beds demonstrated the lowest *adhocracy*

culture (14 points). The subgroup that demonstrated the highest *adhocracy* culture response (24 points) was comprised of social workers who had been employed in their current hospital for 4-6 years. Social workers in public-or- government-owned hospitals reported the lowest *market* culture (19 points), while MSW participants in hospitals with over 500 beds reported the highest market culture (33 points). Social workers in public-or- government-owned hospitals also reported the lowest *hierarchy* culture (16 points), while social workers in hospitals with 100-250 beds reported the highest *hierarchy* score (30 points).

Discussion: Strong Clan cultures value loyalty, teamwork, and tradition.

Adhocracy cultures value risk taking and entrepreneurship. A market culture values competition and market share goal attainment. Organizations with strong hierarchy cultures would have clear policies and procedures, low cost, and dependable delivery of services. (Cameron & Quinn, 1999) The OCAI provides a profile of how participants perceive their current culture. The analysis of the aggregated mean of the culture profile scores from all 149 participants based on competing values, as demonstrated by the OCAI, indicated that social workers perceive the culture of their hospitals to be clustered similarly in all four quadrants.

Question 4: What culture would hospital social workers prefer to see demonstrated in their organization? This question was also addressed by utilizing the OCAI which provides a second profile of the culture that would be preferred by participants in the *future* according to a Competing Values Framework (CVF).

Result: A discrepancy of 10 or more points between how social workers perceived their hospital culture *now* and how they would prefer to see it in the *future* were found in 14 subgroups in both *clan* and *market* culture. This discrepancy was not found in the comparison of scores in *adhocracy* and *hierarchy* cultures for *now* and preferred *future* for any subgroup. Respondents employed in not-for-profit hospitals revealed a ten-point preference for clan culture in the *future* (39 points) as opposed to what they perceived it is *now* (29 points). Social workers employed in public-or-government-owned owned hospitals revealed that they preferred a stronger clan culture in the *future* (38 points) than is demonstrated *now* (28 points).

Discussion: Analysis for all subgroups demonstrated that participants preferred less of the attributes of a *market* culture in the future and a stronger *clan* culture. Interpretation of the culture profiles by hospital ownership revealed ten point or more discrepancies in all three subgroups, investor-owned, not-for-profit, and public-or-government-owned owned. The largest discrepancy was found in the investor-owned subgroup. Although the population for that sub-group was small (n=12), the scores represent a 17-point difference between how strongly their culture reflects a clan culture *now* (24 points) and how much they would prefer it in the *future* (41 points). Social workers employed in investor-owned hospitals also reveal a 20-point gap between market culture *now* (33 points) and *preferred future* (13 points) demonstrating that they prefer a shift from a *market* to *clan* culture in the future. Shared values provide a sense of common direction for day-to-day operations within organizations (Deal & Kennedy,

2000; Schein, 1993).

Question 5: To what extent do hospital social workers perceive that the tasks they perform within the hospital setting reflect their professional values? The sixth item on the survey asked the following: “As a hospital social worker, do you feel that your work assignments provide you with opportunities to demonstrate your professional values on a regular basis?”

Result: The majority of the 149 respondents (85%, n=126) answered *yes* to this question. Analysis of responses by hospital ownership revealed that 83% (n=10) of those employed in investor-owned hospitals, 85% (n=106) employed in not-for-profit hospitals, and 77 % (n=10) employed in public-or- government-owned owned facilities responded positively to this statement. Both BSW (86%) respondents and MSW respondents(84%) stated that their work assignments provide opportunities to demonstrate their professional values on a regular basis .Evaluation of responses by bed size revealed that over 80% of participants from each subgroup stated that their work assignments provided them with opportunities to demonstrate their professional values on a regular basis. Chi-square analysis of these subgroups did not demonstrate statistical significance at <0.05.

Discussion: The majority of the subgroups of variables perceived that the tasks that they perform in their hospital settings reflect their professional values. The analysis of the finding did not demonstrate statistical significance at <0.05.

Question 6: To what extent do hospital social workers trust their organizations to support the practice of their core professional values? Perception of this question was

assessed by item seven on the survey that asked: “As a professional social worker, do you trust that your hospital values the skills and knowledge of your profession?”

Result: Out of 149 valid responses to this question, only 63% of the social workers agreed with this statement; I feel my profession is valued in my hospital setting. 60% (n=67) of the MSW respondents answered positively to this question as compared to 72% (n=26) of the BSW respondents. Crosstabulation analysis of variable subgroups who answered *yes* to this question demonstrated similar findings. No subgroup demonstrated a frequency percent of over 65%, however Chi-square analysis of these data did not demonstrate statistical significance at <0.05 .

Discussion: The results of this question indicated that 65% or less of social workers who participated in this study felt that their profession was valued in their hospital setting. These finding were similar within the subgroups of the variables of education, hospital ownership, bed size, and length of employment.

According to several studies in the past decade, social workers reported feeling devalued as a profession in hospital settings and feared loss of professional identity (Globerman, 2002; Holliman, Dziegielewski, & Teare, 1998; Mizrahi & Berger, 2001; Poole; 1996). Although not statistically significant, the findings of this study also demonstrate that only 63% of the participating professional social workers trusted that their hospital valued the skills and knowledge of their profession.

If groups within an organization embrace values that are different from the values they perceive are reflected in the dominant culture, subcultures can emerge. Subcultures

attempt to reinforce professional identity and most often emerge when a group of individuals feel threatened (Martin & Siehl, 1983; McMurray, 2003). According to McMurray (2003), when a subculture within an organization shares the values and belief of the host organization, the climate within the subculture tends to be positive. Conversely, weakly aligned relationships between the subculture and the dominant culture create negative climates (Barrett, 2003; McMurray, 2003).

Other Findings

Analysis of the surveys received for this study revealed only 12 of the 149 (8%) respondents were employed in investor-owned hospitals. Courtesy calls and mailed replies from hospital contacts who received the survey revealed 44 hospitals reported that they did not employ social workers. A case management director informed the researcher that the investor-owned hospital where she was employed did not employ social workers in any of their 32 hospitals in Florida. She further stated that her hospital was in the process of hiring paraprofessionals to conduct the discharge planning function. This information was useful in providing information about hospital employment opportunities for social workers in Florida that had not been previously documented.

Recommendations for Future Studies

The results of this study suggest a need for additional research in the following areas:

1. Further research is recommended on job satisfaction and the specific tasks the social workers perform in hospital settings be conducted. This information would assist the profession in identifying the professional attributes needed to remain employable and enhance success for social workers in a rapidly changing health care environment. This study revealed that social workers perceived that they were able to demonstrate their professional values in their work settings, but many did not perceive that they were valued as a profession by their organization. Additional insight into this finding may assist in clarifying areas where conflict may exist.
2. Additional research on which professionals, or paraprofessionals, in hospitals are performing tasks such as discharge planning, crisis intervention, ethics consultation, and case management may provide information from an objective perspective that is function specific rather than discipline specific. This would facilitate study participation regardless of training or discipline, and may contribute information about hospital employment and job function that would be valuable in the future.
3. Comparative research on core social work education and nursing education may be an important contribution toward strengthening social work's professional identity in health care. Professionals who have more education but earn less money than others performing the same task are

likely to feel devalued (Globerman & Bogo, 2002; Holliman et al., 2003). This research was absent in the literature and may be useful to provide clarity as to the specific skills and knowledge that social workers contribute to health care. According to Keigher (1995), social workers rarely publish research findings, or promote the social work profession, in journals outside the discipline of social work. As a result, most hospital administrators would be unfamiliar with the skills and knowledge provided by formal social work education. This lack of academic interaction with other disciplines has been cited by many as a contributor to social work's lack of identity (Gibelman, 1999; Globerman, 2002, Kadushin & Egan, 1997).

Implications for Practice

This research was exploratory and attempted to identify how hospital social workers perceive their work settings from a values and organizational culture perspective. The conceptual framework for this study provides an understanding of the importance of a mission statement that is demonstrated by the business of the organization. It further provides support for clear alignment between the values of an individual and an organization for optimal organizational health. The findings of this study demonstrated that 65% of the social workers who participated in the study perceived that the mission statement of their hospitals was in alignment with the core values of the social work

profession. However, only 42% perceived that the daily business of the hospital in which they worked *strongly reflected* the mission statement. These findings may assist social workers, and others within health care as well, in identifying sources of conflict from a theoretical perspective. They may also assist administrators examining whether their daily operations match their mission statements.

In addition to values alignment, this study utilized theory on organizational change to conceptualize the impact of change on professional identity and trust. The findings were interesting in that over 80% of the social work participants in all subgroups perceived that their work assignments provide opportunities to demonstrate their professional values. However, only 63% of the participants stated that they trusted that their organization valued the skills and knowledge of their profession. This finding would suggest that social workers have a certain degree of autonomy in their daily tasks because, as noted above, the majority of the social workers did not agree that the daily business of their hospital *strongly reflected* the mission statement.

The Competing Values Framework was used as a conceptual framework for diagnosing organizational culture primarily because it assumes that there are competing values at work in any organization. The *Organizational Culture Assessment Instrument (OCAI)* provides a method to measure the perception of what is currently emphasized by an organization and generates a profile that demonstrates where individuals perceive an organization places its value. Additionally, the *OCAI* offers a second profile of what individuals would prefer to see in the future. By comparing the two profiles, it is possible

to see where there is misalignment in what is perceived to be valued and what the individual thinks should be valued in the future. The participants in this study revealed that they would prefer more of a *clan* culture and less of a *market* culture in the future. Social work, like many helping professions, must attempt to understand their work setting in order to ensure a place for them in the future. A better understanding of external forces that influence health care, an active role in change initiatives, and proactive measures to increase professional identity may strengthen the profession for its future in health care.

APPENDIX A
INSTITUTIONAL REVIEW BOARD APPROVAL FORM



THE UNIVERSITY OF CENTRAL FLORIDA
INSTITUTIONAL REVIEW BOARD (IRB)

IRB Committee Approval Form

PRINCIPAL INVESTIGATOR(S): **Amanda Evans**

IRB #: **05-2372**

PROJECT TITLE: **Social Work Values and Hospital Culture: An Examination
from a Competing Values Framework**

- New project submission
- Continuing review of lapsed project # _____
- Study expired _____
- Initial submission was approved by full board review but continuing review can be expedited
- Suspension of enrollment email sent to PI, entered on spreadsheet, administration notified _____
- Resubmission of lapsed project # _____
- Continuing review of # _____
- Initial submission was approved by expedited review

Chair

Expedited Approval
 Dated: 8 Feb 2005
 Cite how qualifies for expedited review: #7

Exempt
 Dated: _____
 Cite how qualifies for exempt status: _____

Expiration
 Date: 7 Feb 2006

IRB Co-Chairs:

Signed: 
 Dr. Sophia Dziegielewska

Signed: _____
 Dr. Jacqueline Byers

Waiver of documentation of consent approved
 Waiver of consent approved

NOTES FROM IRB CHAIR (IF APPLICABLE): Waiver of consent is approved if second page of consent with the signature page is not included. If included it needs to be clear in the directions how this form cannot be mailed back with survey and stay anonymous.

Received revised consent letter 3/4/05.BW (informational sheet)

C. UCFIRB Form

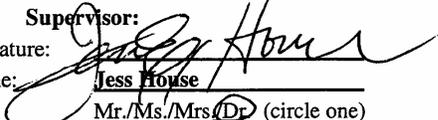
The complete IRB packet must be submitted by the 1st business day of the month for consideration at that monthly IRB meeting. Please see page 6 of this manual for detailed instructions on completing this form.

1. Title of Project: Social Work Values and Hospital Culture: An Examination from a Competing Values Framework.

2. Principal Investigator(s):

Signature: _____	Signature: _____
Name: <u>Amanda Evans</u>	Name: _____
Mr./ <u>Ms.</u> /Mrs./Dr. (circle one)	Mr./Ms./Mrs./Dr. (circle one)
Degree: <u>Ed.D.</u>	Degree: _____
Title: _____	Title: _____
Department: <u>Educational Research, Technology and Leadership</u>	Department: _____
College: <u>College of Education</u>	College: _____
E-Mail: <u>aevans@fgcu.edu</u>	E-Mail: _____
Telephone: <u>(239) 590-7829</u>	Telephone: _____
Facsimile: <u>(239) 997-8341</u>	Facsimile: _____
Home Telephone: <u>(239) 997-0407</u>	Home Telephone: _____

3. Supervisor:

Signature: 	Degree: _____
Name: <u>Jess House</u>	Title: _____
Mr./Ms./Mrs./ <u>Dr.</u> (circle one)	Telephone: _____
Department: <u>Educational Research, Technology and Leadership</u>	Facsimile: _____
College: <u>College of Education</u>	E-Mail: _____

4. Dates of Proposed Project (cannot be retroactive): From: February 15, 2005

To: March 31, 2005 IRB Approval Date 2/8/05 - 2/7/06. Buj

5. Source of Funding for the Project: (project title, agency, and account number) N/A

6. Scientific Purpose of the Investigation: An examination of values and organizational culture from a competing values framework. The study will focus on examination of values alignment between hospital social workers and their perceptions of the culture of their organization of employment.

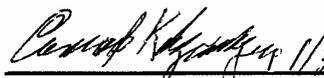
7. Describe the Research Methodology in Non-Technical Language: (the UCFIRB needs to know what will be done with or to the research participants) The study utilizes surveys mailed to social workers in Florida acute care hospitals. Participants are provided self-addressed stamped envelopes for return of surveys. Voluntary participation is emphasized in the cover letter (attached) and the consent form (attached).

8. Potential Benefits and Anticipated Risks. (Risks include physical, psychological, or economic harm. Describe the steps taken to protect participant. There are no anticipated risks to participants in this survey.

9. Describe how participants will be recruited, the number and age of the participants, and proposed compensation (if any): Participants will be recruited via a mailed survey to acute care hospitals in Florida. Participants will be adults who hold a minimum of a bachelor's degree. There is no compensation proposed to participants.

10. Describe the informed consent process: (include a copy of the informed consent document) Participants are asked to complete the informed consent (attached with survey instrument) and return it with the survey in a self-addressed, stamped envelope.

I approve this protocol for submission to the UCFIRB.



Department Chair/Director Date

Cooperating Department (if more than one Dept. involved)

Department Chair/Director Date

APPENDIX B
A SURVEY OF HOSPITAL SOCIAL WORK

A SURVEY OF HOSPITAL SOCIAL WORK: CORE VALUES AND ORGANIZATIONAL CULTURE

Dear Colleague,

Thank you for agreeing to participate in this research. Your input will help provide valuable information related to the profession of social work within hospital settings. The survey will take approximately 15 minutes to complete.

1. Do you currently hold a degree in social work?

YES. → If you answered *yes*, which of the following degrees have you obtained? (Please check all that apply)

- Bachelor in Social Work
- Master in Social Work
- Doctorate in Social Work

NO

2. How many years have you been employed in healthcare?

0 – 3 years, 4– 6 years, 7 – 9 years, 10 or more years

3. How many years have you worked in this particular hospital?

0 – 3 years, 4– 6 years, 7 – 9 years, 10 or more years

The following questions are related to your *perception* of the mission and values of your hospital setting and your role within that setting.

4. In your opinion, does the *written* mission statement of your hospital reflect values that appear to be in *alignment* with professional social work core values?

- Very much in alignment
- Somewhat in alignment
- Not at all in alignment
- Am not sure
- I am not familiar with the written mission statement

5. In your opinion, does the daily *business* of your hospital reflect the written mission statement?

- It is strongly reflected
- It is somewhat reflected
- It is rarely reflected
- It is not reflected at all

6. As a hospital social worker, do you feel that your work assignments provide you with opportunities to demonstrate your professional values on a regular basis?

- Yes, I am able to demonstrate my professional values consistently in my work assignments
- No, I am not able to demonstrate my professional values consistently in my work assignments
- I am not sure

7. As a professional social worker, do you trust that your hospital values the skills and knowledge of your profession?

- Yes, I feel that my profession is valued in my hospital setting
- No, I do not feel that my profession is valued in my hospital setting
- I am not sure how my hospital setting values my profession

The Organizational Culture Assessment Instrument (OCAI)

Below you will find six sections that tell us about your organization: Dominant Characteristics, Organizational Leadership, Management of Employees, Organization Glue, Strategic Emphases, and Criteria of Success.

- There are four alternatives for each section. Please read each alternative. Some may more strongly reflect your setting than others. The total of all four alternatives should be 100. For example, in question 1, if you think alternative A is the *most* like your organization, alternatives B and C are *somewhat* similar to your organization, and alternative D is *not* similar you might give 55 points to A, 20 points to B and C, and 5 points to D.
- In the box under the heading of NOW, please assign a number that best reflects your hospital as you think it is now. In the next box, labeled FUTURE, choose the alternative that best reflects how you would like your hospital to be in the future.

A sample response is provided below:

1.	DOMINANT CHARACTERISTICS	NOW	FUTURE
A	This organization is a very personal place. It is like an extended family. People seem to share a lot of themselves.	55	65
B	The organization is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.	20	20
C	The organization is very results oriented. A major concern is getting the job done. People are very competitive and achievement oriented.	20	10
D	The organization is a very controlled and structured place. Formal processes generally govern what people do.	5	5
	Total	100	100

PLEASE PROVIDE YOUR PERCEPTIONS RELATED TO YOUR HOSPITAL BELOW

HOW YOU SEE IT NOW **HOW YOU WOULD LIKE IT IN THE FUTURE**

8.	DOMINANT CHARACTERISTICS	NOW	FUTURE
A	This organization is a very personal place. It is like an extended family. People seem to share a lot of themselves.		
B	The organization is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.		
C	The organization is very results oriented. A major concern is getting the job done. People are very competitive and achievement oriented.		
D	The organization is a very controlled and structured place. Formal processes generally govern what people do.		
	Total	<i>100</i>	<i>100</i>

9.	ORGANIZATIONAL LEADERSHIP	NOW	FUTURE
A	The leadership in the organization is generally considered to exemplify mentoring, facilitating, or nurturing,		
B	The leadership in the organization is generally considered to exemplify entrepreneurship, innovating, or risk taking.		
C	The leadership in the organization is generally considered to exemplify a no-nonsense, aggressive, results-oriented focus.		
D	The leadership in the organization is generally considered to exemplify coordinating, organizing or smooth-running efficiency.		
	Total	<i>100</i>	<i>100</i>

10.	MANAGEMENT OF EMPLOYEES	NOW	FUTURE
A	The management style in the organization is characterized by teamwork, consensus, and participation.		
B	The management style in the organization is characterized by individual risk-taking, innovation, freedom, and uniqueness.		
C	The management style in the organization is characterized by hard-driving competitiveness, high demands, and achievement.		
D	The management style in the organization is characterized by security of employment, conformity, predictability, and stability in relationships.		
	Total	<i>100</i>	<i>100</i>

11.	ORGANIZATION GLUE	<i>NOW</i>	<i>FUTURE</i>
A	The glue that holds this organization together is loyalty and mutual trust. Commitment to this organization runs high.		
B	The glue that holds this organization together is commitment to innovation and development. There is an emphasis on being on the cutting edge.		
C	The glue that holds this organization together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.		
D	The glue that holds this organization together is formal rules and policies. Maintaining a smooth-running organization is important.		
	Total	<i>100</i>	<i>100</i>

12.	STRATEGIC EMPHASIS	<i>NOW</i>	<i>FUTURE</i>
A	The organization emphasizes human development. High trust, openness, and participation persist.		
B	The organization emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.		
C	The organization emphasizes competitive actions and achievement. Hitting stretch targets and winning in the marketplace are dominant.		
D	The organization emphasizes permanence and stability. Efficiency control and smooth operations are important.		
	Total	<i>100</i>	<i>100</i>

13.	CRITERIA OF SUCCESS	<i>NOW</i>	<i>FUTURE</i>
A	The organization defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.		
B	The organization defines success on the basis of having the most unique or newest products. It is a product leader and innovator.		
C	The organization defines success on the basis of winning in the marketplace and outpacing the competition. Competitive market leadership is the key.		
D	The organization defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost production are critical.		
	Total	<i>100</i>	<i>100</i>

Thank you for taking time to participate in the survey!

APPENDIX C
SURVEY COVER LETTER

Amanda Evans, MSW
1307 Driftwood Drive
North Fort Myers, FL 33903

May 7, 2005

Dear Colleague,

I am writing to ask for your participation in a study of medical social workers employed in Florida acute care hospitals. The study is the focus of my doctoral research at the University of Central Florida related to organizational change, culture, and values. My faculty supervisor is Jess House, Ph.D. The purpose of the study is to determine how professional social workers perceive their current acute care hospital settings.

Results of this survey will be useful to better understand the interrelationship between professionals, their values and the organization of which they are a part. This information is especially important in times of rapid change. I am hoping that you will participate by completing the attached survey and returning it in the enclosed self-addressed stamped envelope. The survey takes approximately 15 minutes to complete. Participation in the survey is entirely voluntary. There are no anticipated risks, compensation or other direct benefits to you as a participant in this survey. You are free to withdraw your consent to participate and may discontinue your participation in the interview at any time without consequence. **If you choose to participate, could you do so immediately? I must have your response by the 1st of June in order to include your feedback in the study.**

A comment on my survey procedures; an identification number is printed on the back cover of the questionnaire so that I can check your name off the mailing list when it is returned. The list of names will be destroyed upon the closing of the response time so that individual names can never be connected to the results in any way. Protecting the confidentiality of participants is very important to me, as well as the University. If you have any questions regarding your rights in the study, you may contact the UCFIRB Office, University of Central Florida Office of Research, Orlando Tech Center, 12443 Research Parkway, Suite 207, Orlando, FL 32826. The phone number is (407) 823-2901.

If you have any questions or comments about this study, I would be happy to talk with you. My phone number is (239) 691-0753 or you can write to me at the address on the letterhead. Thank you very much for helping with this important study.

Sincerely,

Amanda Evans, MSW
Doctoral Student, Educational Leadership
University of Central Florida

APPENDIX D
PERMISSION TO USE OCAI

Evans, Amanda

From: Cameron, Kim [cameronk@bus.umich.edu] **Sent:** Wed 3/23/2005 6:18 PM
To: Evans, Amanda
Cc:
Subject: RE: OCAI use
Attachments:

Dear Amanda:

Thank you very much for your message and request for permission to use the OCAI. You are welcome to use the instrument for your dissertation research in Florida hospitals. Best of luck in the project. I would be delighted if you would care to share your results with me.

Best wishes.

Kim Cameron
Professor, Management and Organizations
University of Michigan

From: Evans, Amanda [mailto:aevans@fgcu.edu]
Sent: Mon 3/21/2005 3:21 PM
To: Cameron, Kim
Subject: OCAI use

Dear Dr. Cameron,

I am a doctoral candidate with the University of Central Florida. I have done a great deal of reading about research relating to competing values in organizations and the Organizational Culture Assessment Instrument. I wonder if I could obtain your permission to use the OCAI for my doctoral research which seeks to measure perceptions of social workers in Florida Hospitals? My committee has reviewed the instrument. I find this line of research so beneficial in understanding change in organizations and feel the information would be beneficial in assisting my profession to better understand their organizations. I enjoy reading your work and wish you continued success. Thank you for your consideration.

Amanda Evans
College of Professional Studies
Division of Social Work
Phone: (239) 590-7829
Fax: (239) 590-7758
Florida Gulf Coast University
10501 FGCU Boulevard South
Fort Myers, FL 33965-6565

APPENDIX E
ORGANIZATIONAL CULTURE PROFILES FOR SUBGROUPS

APPENDIX E

Table 13

Perception of current culture by subgroups

Variable	Subgroup	Clan Culture		Adhocracy Culture		Market Culture		Hierarchy Culture	
		Now	future	Now	future	Now	future	Now	future
Education									
	MSW	27	39	21	24	28	17	27	21
	BSW	33	40	18	22	24	16	26	18
Hospital Ownership									
	Investor-Owned	24	41	15	19	33	13	25	22
	Not-for-Profit	29	39	20	24	26	17	26	20
	Public/Government	28	38	20	19	19	15	16	15
Years employed in healthcare									
	0-3 years	31	41	17	22	26	14	28	22
	4-6 years	23	36	16	19	30	16	29	27
	7-9 years	34	48	22	22	20	15	21	19
	10 or more yrs	27	38	20	25	28	18	25	19
Years employed in current hospital									
	0-3 years	29	38	19	23	27	16	26	22
	4-6 years	26	37	15	20	29	17	28	23
	7-9 years	32	44	24	25	21	15	23	19
	10 or more yrs.	27	40	20	25	29	18	25	18
Hospital bed size									
	100-250 beds	33	42	18	26	25	18	25	19
	100 – 250 beds	25	41	18	23	27	14	30	21
	251 – 500 beds	32	41	18	25	26	17	24	20
	Over 500 beds	26	36	18	22	30	19	25	22

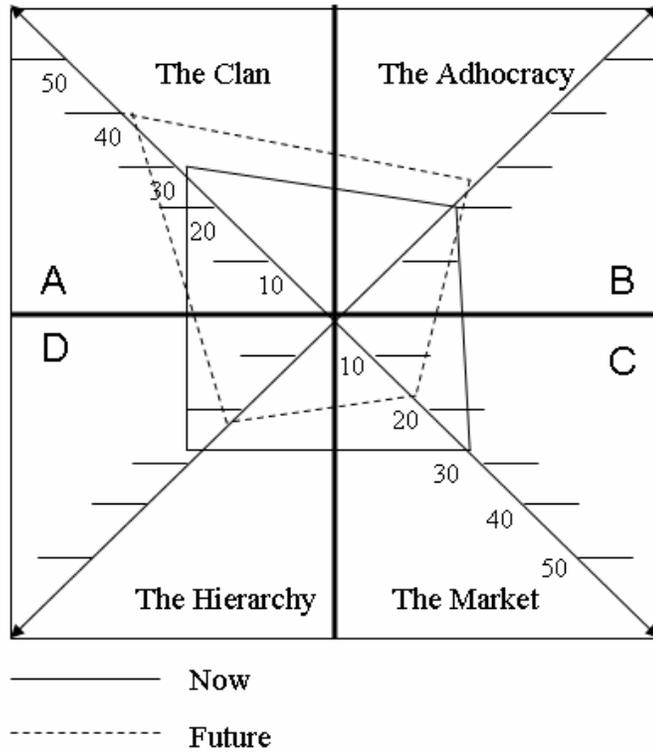
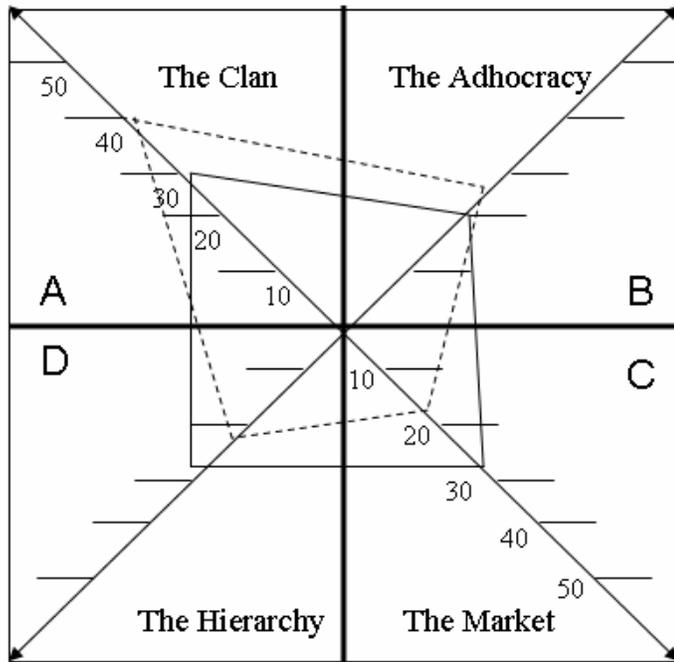


Figure 6 Culture profile MSW participants



————— Now
 - - - - - Future

Figure 7 Culture profile participants from investor-owned facilities

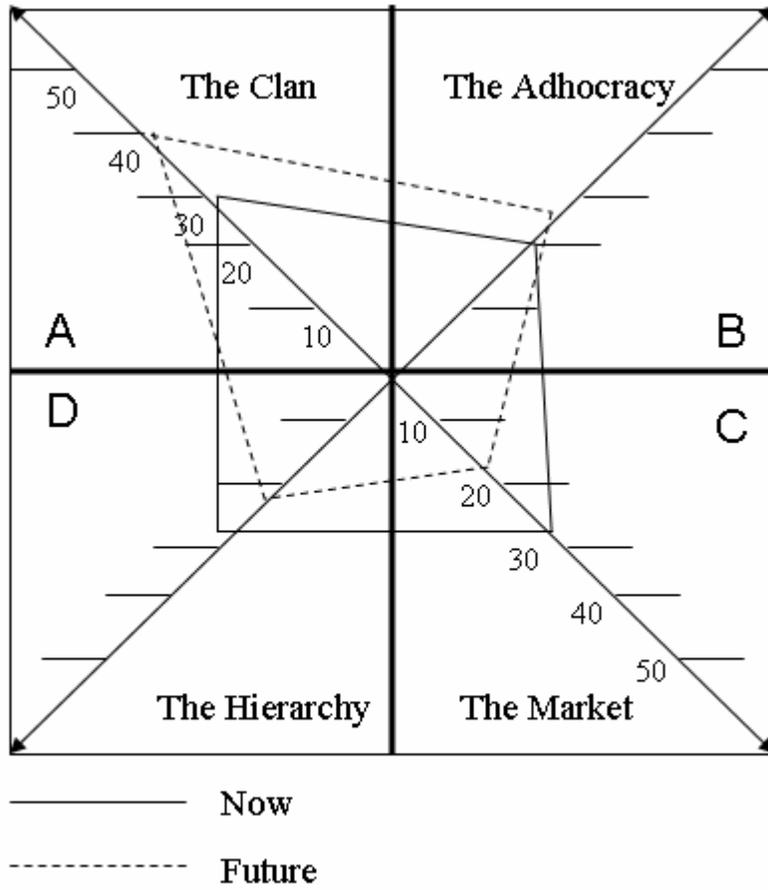


Figure 8 Culture profile participants from not-for-profit facilities

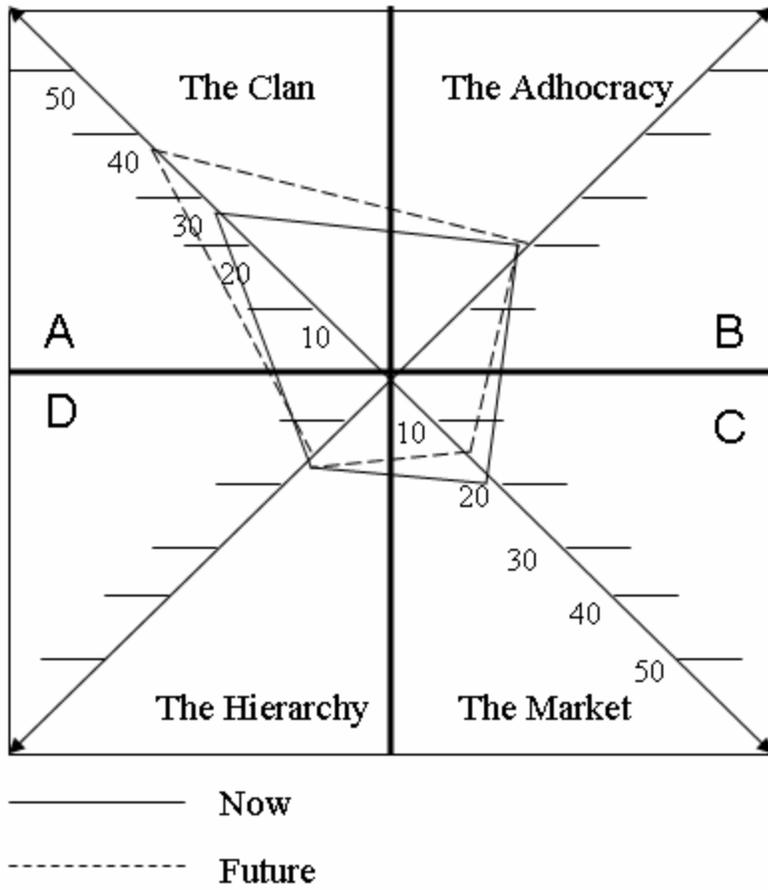


Figure 9 Culture profile participants from public-or- government-owned facilities

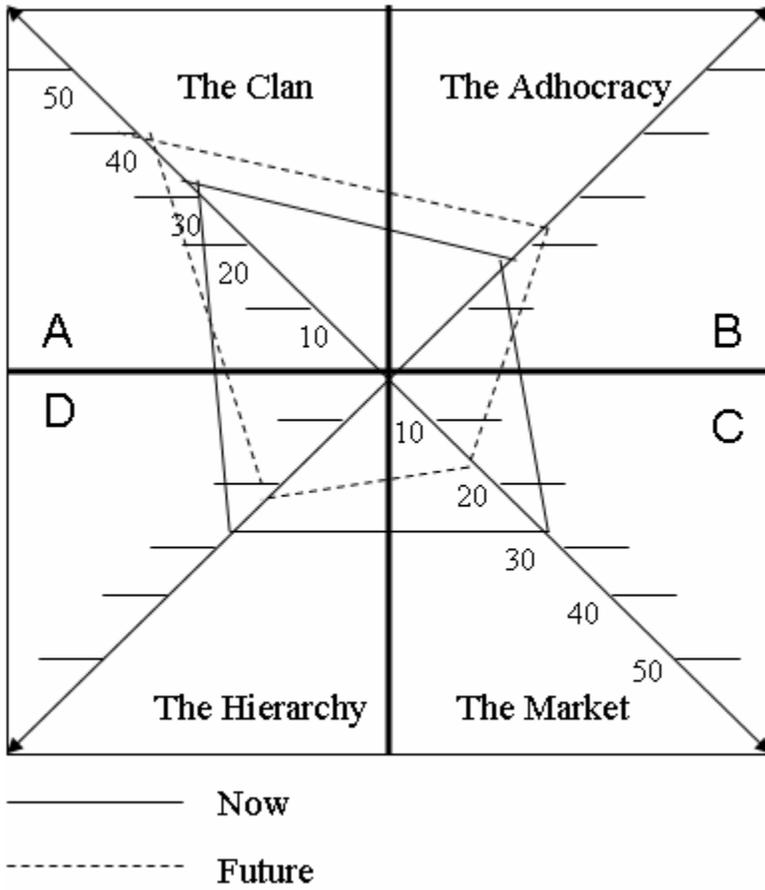


Figure 10: Culture profile participants employed in health care 0 – 3 years

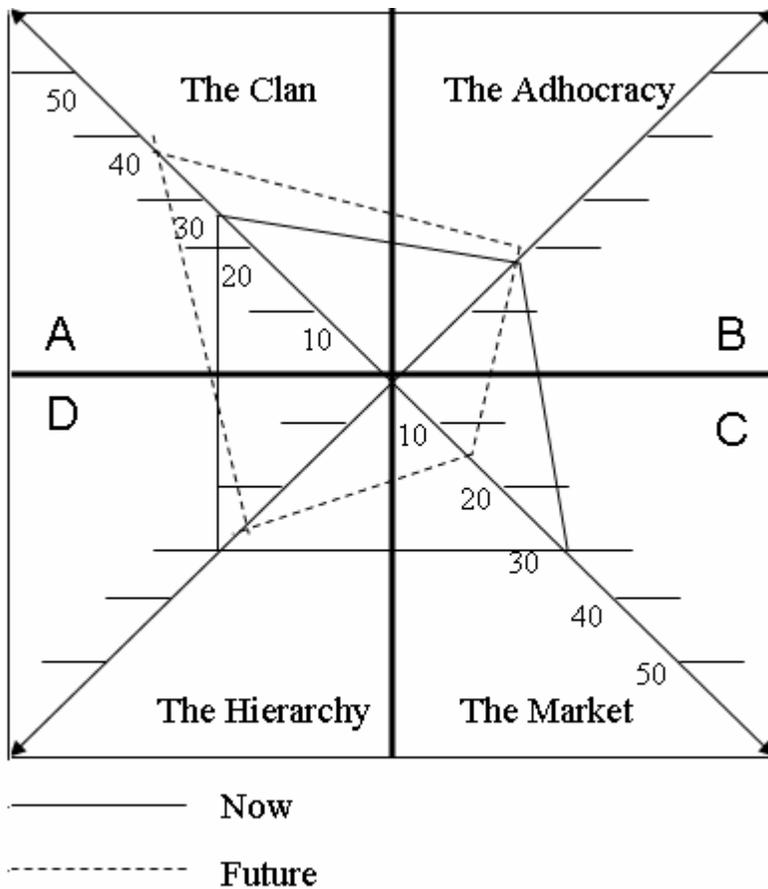


Figure 11: Culture profile participants employed in health care 4 – 6 years

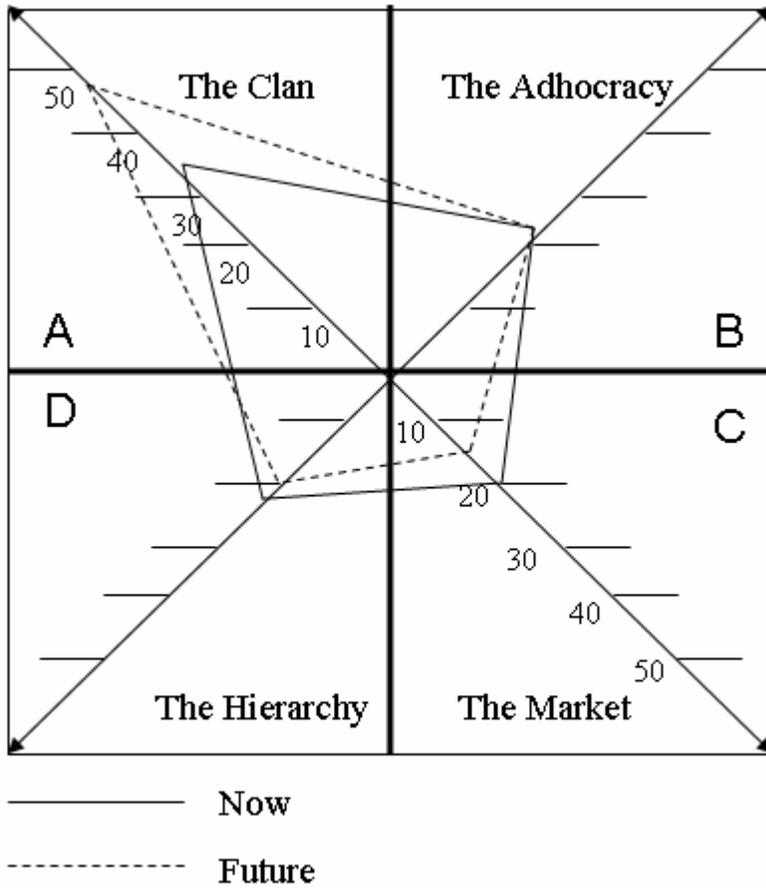


Figure 12: Culture profile participants employed in health care 7 – 9 years

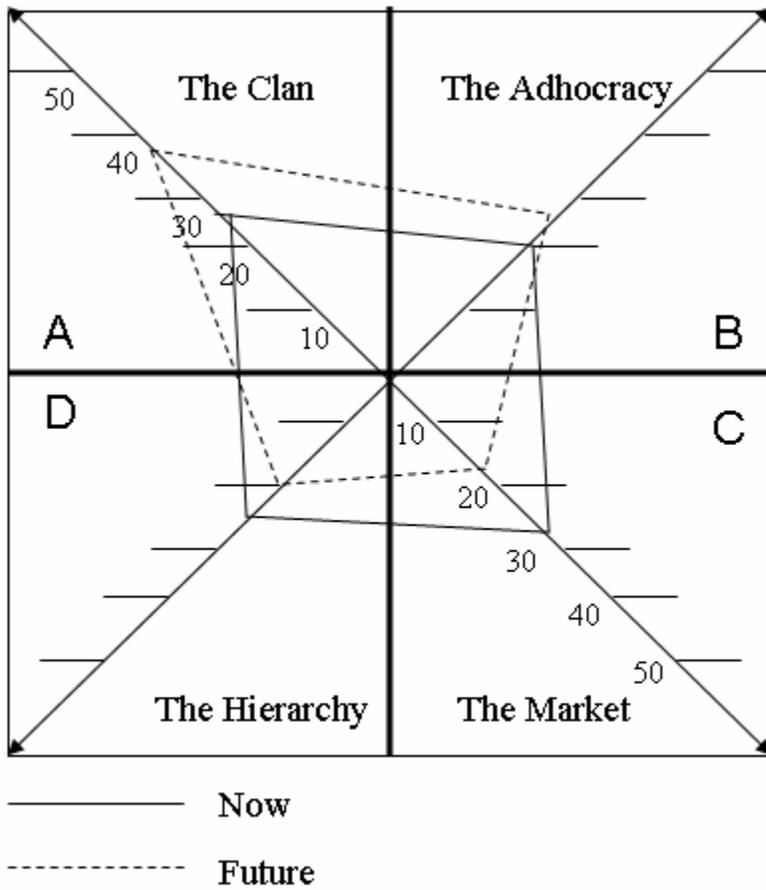


Figure 13: Culture profile participants employed in health care 10 or more years

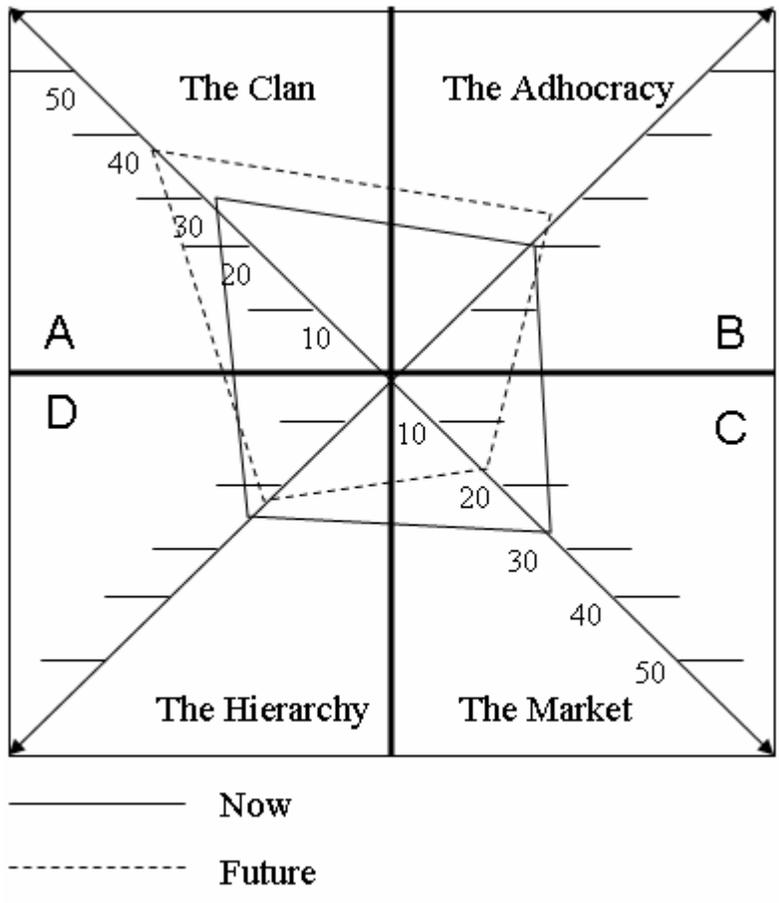


Figure 14: Culture profile participants employed in current hospital 0 – 3 years

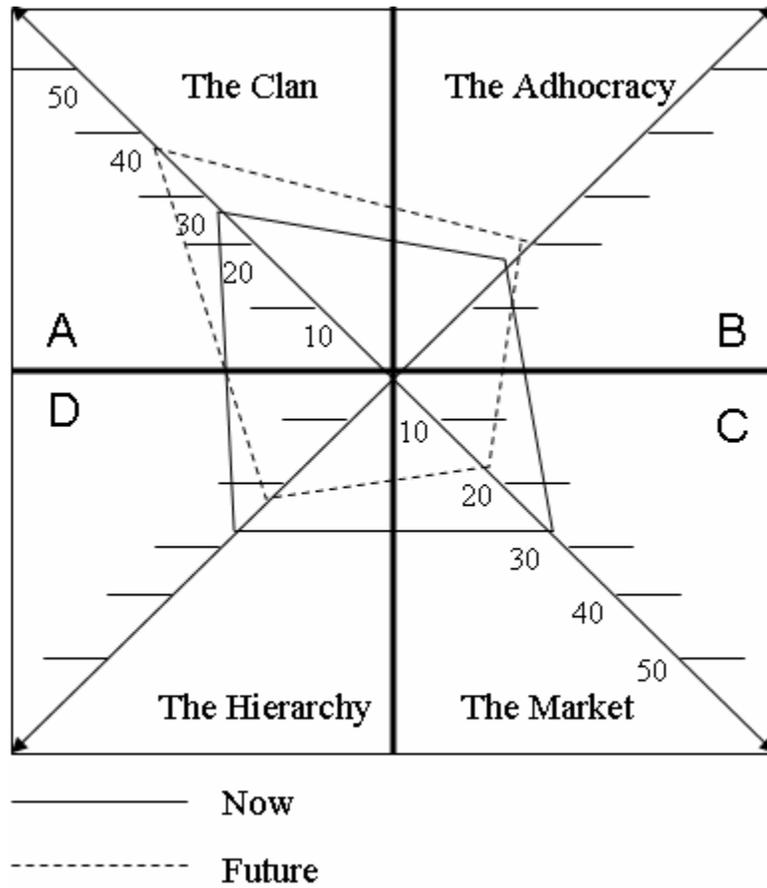


Figure 15: Culture profile participants employed in current hospital 4 – 6 years

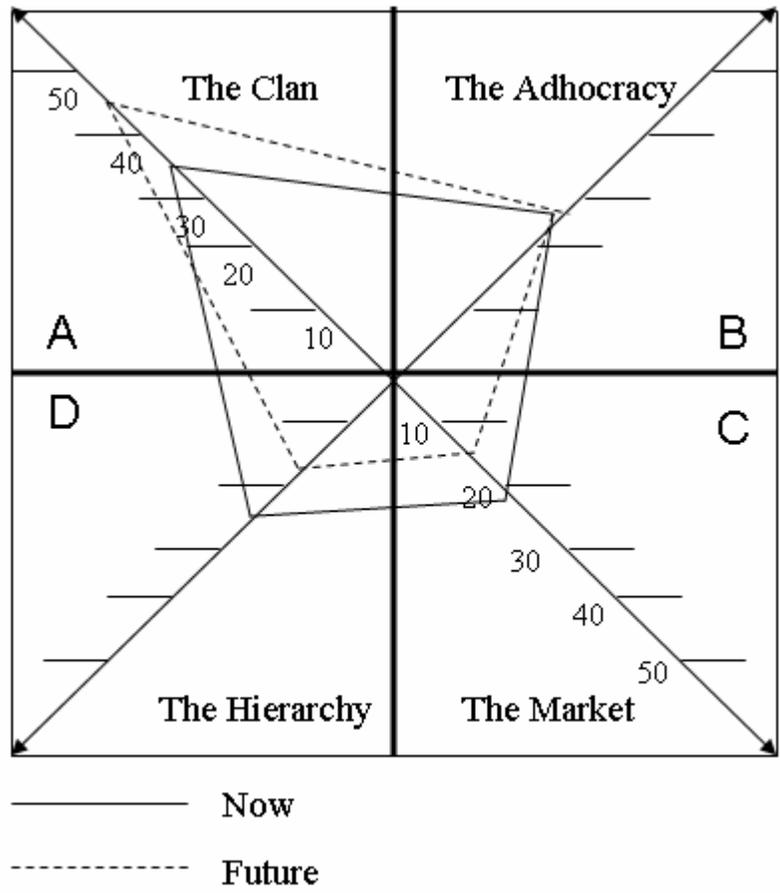


Figure 16: Culture profile participants employed in current hospital 7 – 9 years

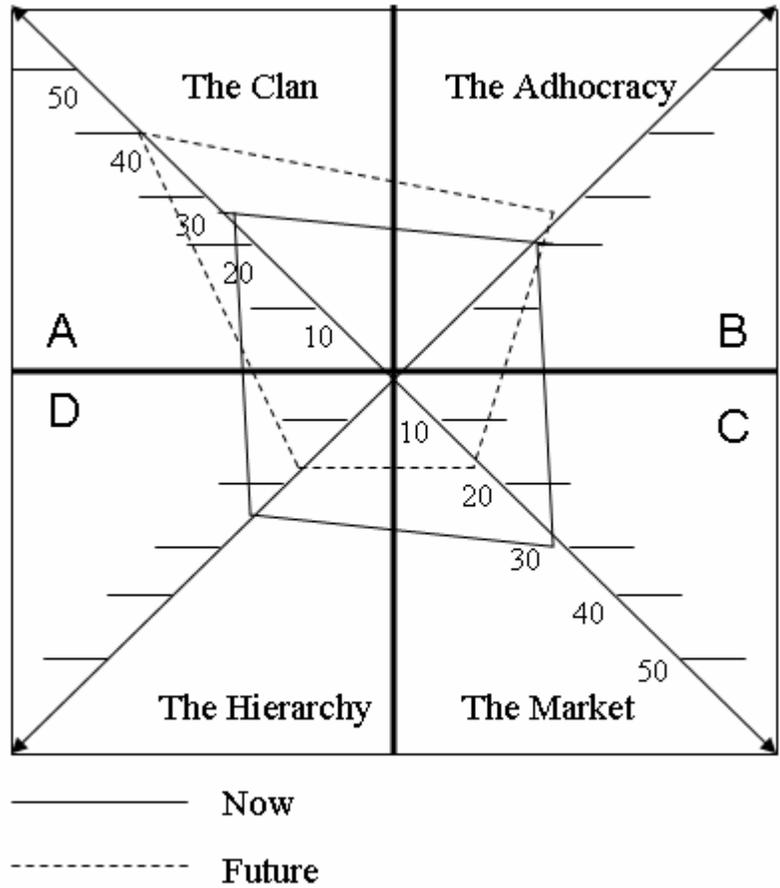


Figure 17: Culture profile participants employed in current hospital 10 or more years

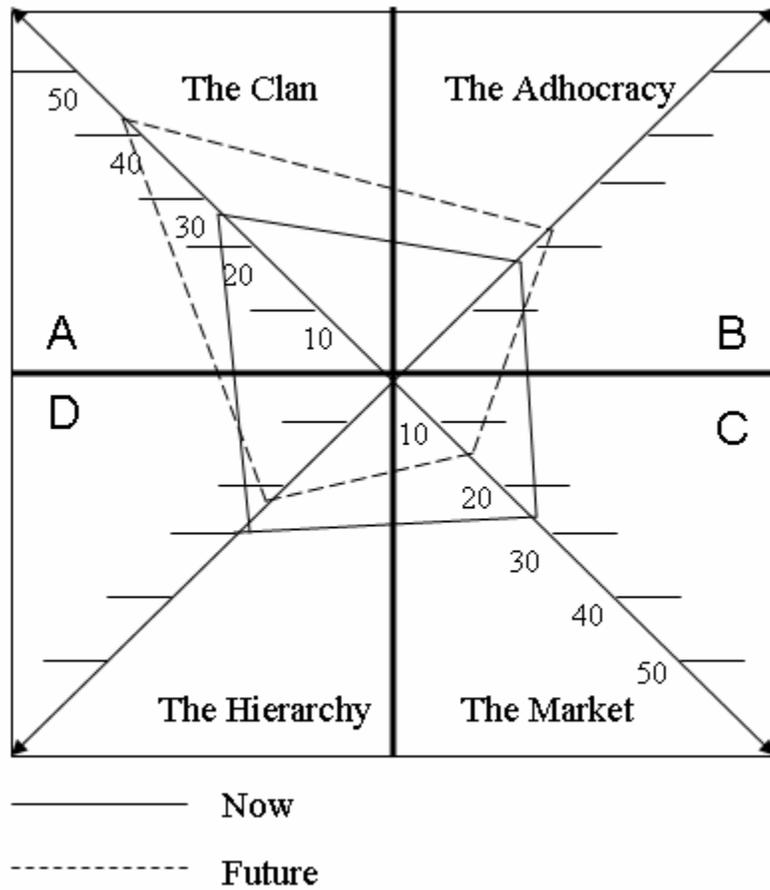


Figure 18: Culture profile participants employed in hospitals with 100 – 250 beds

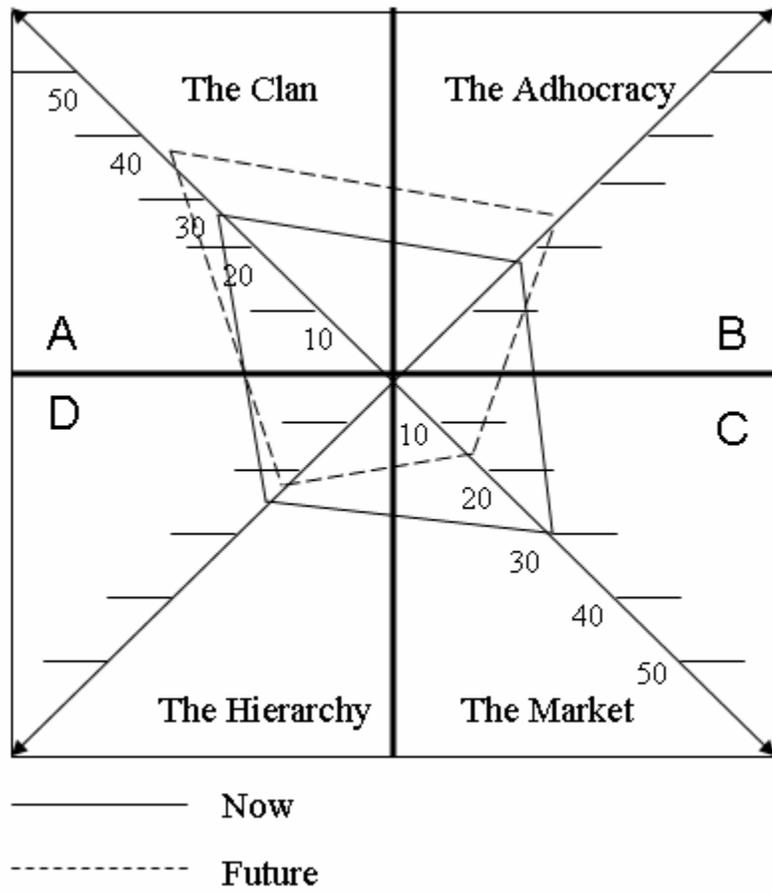


Figure 19: Culture profile participants employed in hospitals with over 500 beds

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