

## Editorial

# Culture and quality: an anthropological perspective

Anthropologists study culture. As a medical anthropologist interested in the role of culture in health care, I have been intrigued by the growing number of articles that point to organizational culture as an important factor related to quality of care [1]. What has most caught my attention are the differing and sometimes conflicting views as to just what is meant by ‘organizational culture’ and the best way to study it. Apparently one review cited 15 different definitions [2]. In much of the literature I have seen, culture is defined as ‘an “attribute”, something the organization “has”, along with other attributes such as structure and strategy’ [3]. Culture is seen as an independent variable that can be manipulated through management interventions in order to achieve organizational goals.

Research studies from this approach tend to reflect a positivist stance, using structured instruments which pre-define the institutional attributes of interest and explore the correlation between these attributes and the quality-related outcomes of interest. A number of studies have looked, for example, at the relationship between a ‘teamwork culture’ and quality-related outcomes, such as hospital performance indicators [4], nurse turnover [5], and patient satisfaction [6]. However, as Scott *et al.* [7] point out, many of the studies that have suggested a link between culture and performance are methodologically weak and have difficulty defining and operationalizing culture. In addition, such studies contribute little to our understanding of how organizational cultures are created and communicated, and the mechanisms through which culture influences performance.

Anthropology takes quite a different approach to culture. Most anthropologists would define culture as the shared set of (implicit and explicit) values, ideas, concepts, and rules of behaviour that allow a social group to function and perpetuate itself. Rather than simply the presence or absence of a particular attribute, culture is understood as the dynamic and evolving socially constructed reality that exists in the minds of social group members. It is the ‘normative glue’ [8] that allows group members to communicate and work effectively together. It is an empirical question as to whether members of an organization have a shared culture, and anthropologists have long pointed out that in fact virtually all complex societies (including health care organizations) tend to have a number of co-existing, overlapping and competing subcultures. In contrast with studies that attempt assign cultural ‘typologies’ to organizations, anthropological research would aim to identify groups with shared cultural knowledge, and understand how subcultures co-exist and interact within the larger organizational environment.

Anthropologists have traditionally used a qualitative research approach to study culture, and such an approach is well suited to many of the complex questions confronting researchers interested in quality and culture. More than just a set of data collection methods, qualitative research is an approach which seeks to understand events, actions, norms and values from the perspective of the people who are being studied (what anthropologists refer to as the ‘emic’ approach). It emphasizes context and the ways in which features of a specific situation or setting impact upon the phenomenon under study. Because qualitative research tends to be flexible and iterative, it allows for the discovery of unexpectedly important topics which may not have been visible had the researcher been limited to a pre-defined set of questions or data collection methods.

Identifying a group’s culture—that shared reference system that guides and is reflected in group members’ behaviour—is not a simple task, and requires a range of methodological tools. The classic form of qualitative research, with roots in anthropology and sociology, is often known as ethnography or naturalistic enquiry. Ethnography is in fact, a research strategy that draws on a range of both qualitative and quantitative methods, and seeks to understand the ‘cultural lens’ through which members of a group perceive their world. This kind of inquiry is most likely to be used when situations are novel or complex and the researchers are not yet sure what questions to ask of whom. Examples of ethnography in health care include a study of clinical reasoning among haematologists [9] and a study of the impact of managed care on clinical decision-making for mental health [10]. In this issue, Waring [11] reports on a qualitative study that explored the values, motivations and alliances that influence physicians’ attitudes and behaviour towards incident reporting. The study suggests the existence of professional subcultures which present barriers to and opportunities for improving incident reporting.

Anthropologists also use a number of more structured data collection techniques to study culture. The most common of these techniques include free listing, pile sorts and rank order methods [12]. These techniques produce numerical, quantifiable data but are included in the qualitative research ‘toolbox’ because their purpose is to identify and analyse cultural domains from the point of view of respondents. These methods have been used extensively in the field of international health, but much less so closer to home. Cultural consensus analysis is another method used by anthropologists to identify groups with shared values, and which may be especially useful to those interested in studying organizational culture. Smith *et al.* [13] used this method to identify

clinic subcultures with conflicting values that had potential importance for clinic operations.

Culture is a complex and multi-faceted concept, and its study requires conceptual models and research methods that can reflect this complexity and which acknowledge the existence of multiple views and voices. Anthropology and qualitative research have much to offer those interested in culture and quality, and I hope that more researchers in the future will be motivated to apply these approaches to the understanding of organizational culture and its impact on the quality of health care.

**Patricia M. Hudelson**  
Hôpitaux Universitaires de Genève  
Médecine Communautaire  
Genève  
Switzerland

## References

1. Davies HTO, Nutley SM, Mannion R. Organisational culture and quality of health care. *Qual Health Care* 2000; **9**: 111–119.
2. Brown A. *Organisational Culture*. London: Pitman, 1995.
3. Scott T, Mannion R, Davies HTO, Marshall MN. Implementing culture change in health care: theory and practice. *Int J Qual Health Care* 2003; **58**: 111–118.
4. Rondeau KV, Wagar TH. Hospital chief executive officer perceptions of organizational culture and performance. *Hosp Top* 1998; **76**: 14–21.
5. Gifford BD, Yammuto RF, Goodman EA. The relationship between hospital unit culture and nurses' quality of work life. *J Healthc Manag* 2002; **47**: 13–26.
6. Meterko M, Mohr DC, Young GJ. Teamwork culture and patient satisfaction in hospitals. *Med Care* 2004; **42**: 492–498.
7. Scott T, Mannion R, Marshall M, Davies HJ. Does organisational culture influence health care performance? A review of the evidence. *J Health Serv Res Policy* 2003; **8**: 105–117.
8. Kropp R. *The Importance of Organizational Culture*. Advanced management Services, Inc., USA: [www.amsconsulting.com/ARTorgculture.htm](http://www.amsconsulting.com/ARTorgculture.htm)
9. Atkinson P. *Medical Talk, Medical Work*. London: Sage Publications, 1995.
10. Ware NC, Lachicotte WS, Kirschner SR, Cortes DE, Good FBJ. Clinical experiences of managed mental health care: a rereading of the threat. *Med Anthropol Q* 2000; **14**: 3–27.
11. Waring J. A qualitative study of the intra-hospital variations in incident reporting. *Int J Qual Health Care* 2004; **16**: 347–352.
12. Weller S and Romney AK. *Systematic Data Collection*. Newbury Park, CA: Sage Publications, 1988.
13. Smith CS, Morris M, Hill W *et al*. Cultural consensus analysis as a tool for clinic improvements. *J Gen Int Med* 2004; **19**: 514–518.