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ORGANIZATIONAL CULTURE AND SOCIAL POWER: AN ANALYSIS OF A HEALTH CARE ORGANIZATION

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of the Ohio State University

by

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1986

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To the late Mary Perley Wakeman
ACKNOWLEDGEMENTS

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CHAPTER I. INTRODUCTION

BACKGROUND OF THE PROBLEM

The purpose of this study is to explore the relationship of social power, communication and organizational culture. Power is an integral part of organizational life. The use or evasion of power impacts upon the lives of many people through job performance, organizational effectiveness, career progression, etc. The primary mode of social influence, or power, in an organization is communication.

Social power is not an objective property which can be measured in terms of its physical characteristics. Rather, it lies in the relative perceptions of the individuals in the organization (Wheeless, Barraclough & Stewart, 1983). These perceptions are shaped through the meaning attributed by the individuals to various contextual features. This meaning structure is a product of many factors, including shared interpretations within the present social context.

Perceptions of social power are developed through communication in the organization. Individuals most often exert power by attempting to influence or gain the compliance of other members of the organization. The communication strategies used in decision-making and conflict resolution reflect the perceptions of power which are embedded in the social context.

This study investigates social power within the cultural context of the organization. Organizational culture is the sense-making reality which evolves from the communication activities of the organization and, in turn, shapes those activities. Culture develops through the collective experiences of organization members. These experiences include work activities, social interaction, group process and exposure to a variety of common work experiences. Over time, the meaning and values which are attributed to these events and activities become reified.
Myths, stories and legends serve to pass on the meaning, as new members are added to the system. Eventually, a set of themes and metaphors develop, which help to shape the perceptions of the members of the organization by calling attention to certain features of the environment. Further, these themes and metaphors serve to constrain behavior because they imply certain standards and rules for interaction.

The organization is more than a container within which communication occurs (Hawes, 1974). Rather, the organization is an interlocking network of communication which both adheres to and alters the existing objective structure. Generally, organizational culture includes two levels of meaning. At the explicit level, the themes of the culture are developed through the formalized activities and structures of the organization, such as the organizational philosophy, the legitimate structure of the system and the functional relationships within the organization and the environment. These explicit themes are usually in the conscious awareness of the members of the organization and often represent managerial philosophy and goals.

On a more implicit level, however, are the themes which evolve from the history of the organization. These themes point to values and beliefs which represent the underlying ideology of the system. This ideology evolves, in part, from underlying material structure. While the explicit themes of the culture are more readily articulated by members of the organization, the implicit assumptions may be more obscure. The evolution of culture is not a unidirectional, deterministic process, however. Rather, culture is significantly influenced by interactions of the workers at various levels of the organization. At the administrative level, the paradigmatic assumptions serve as signals to the organization about what is important and what gets rewarded. This, in turn, influences the establishment of organizational rules (Evans, 1982). At the production level, however, a local culture emerges around the interactions which focus upon the tasks of creating the product. This is especially true in human service organizations, such as the health care system selected for this study. Health care systems exist both as business and human service agencies. Consequently, the process of caring for human beings greatly influences the emergence of local cultural themes. Shared experience and interaction revolve around the delivery of patient care. Thus, the "top down" themes of the system are met with a set of assumptions, values and beliefs which operate from the "bottom up" as well. This multilevel evolution of organizational culture often results in a system of themes which constrain meaning.
and behavior in different ways. In order to understand fully the orientation of the organizational culture, both levels of understanding must be considered.

**RESEARCH QUESTIONS**

This study explores the way that themes of organizational culture constrain and enhance the exercise of social power. Three research questions guide the investigation:

1. How do the explicit cultural themes revealed in organizational philosophy, structure, values, roles and relationships shape the exercise of social power?
2. How do the implicit cultural themes suggested by historical values, beliefs and material conditions shape the exercise of social power in the organization?
3. How does the organization cope with the strain created by incongruities between the explicit and implicit assumptions about the exercise of social power in the organization?

**RESEARCH APPROACH**

The research questions were investigated using a multimethod field design in a health care organization. A health care organization was selected as the site for this study because it offered interesting contrasts between the economic constraints of administration and the values attached to patient care. Specifically, the health care organization has a unique human service mission in a broader culture which values altruism and egalitarianism. With present trends toward the reduction of health care costs, hospitals are carefully scrutinizing profit margins and following a "bottom line" approach. Since the product of health care is a human service, it is difficult to diminish the quality of that service in order to cut costs. In an attempt to increase the efficiency of the health care system, numerous cost-containment efforts are being implemented.

In many systems, health care professionals are being replaced by managers with a more traditional business perspective. Accordingly, these managers are attempting to create change in the culture of the organization to make it more open to cost-containment efforts. This cultural change is very difficult to achieve, due to the tenacity of the local cultural system. The legitimacy of the cultural system is inherently tied to the delivery of patient care. While it may be easy to
change management themes and functional expectations, it is very difficult to change the themes which reflect the quality of patient care.

The organization targeted for the investigation was a small rehabilitation hospital which is a part of a large midwestern university. The cultural milieu of the organization was evaluated through a combination of interviews, observations of communication in dyadic and group settings and analysis of written communication. Information obtained in the field observation was supplemented with personal interviews, written questionnaires and scaled instruments.

The data from this study suggest that the culture of the organization shapes the exercise of social power in several ways. First, the explicit themes of the system define the functional status differences. This, in turn, helps to determine when power functions must be conscious and when they are routine. The understanding of legitimate power structures significantly shapes the perceptions of the bases of social power. Similarly, the explicit culture system indicates to the members of the organization which modes of reward and punishment are acceptable. This enhances the ability of an individual to manipulate resources in order to shape the needs of others to achieve a desired outcome. The second effect of organizational culture upon the exercise of social power arises from the implicit beliefs and assumptions which have evolved during the history of the organization. This implicit system accounts for the unspoken material structure and the role of the dominant group. Generally, the implicit themes in the culture impinge upon the exercise of social power by determining when an individual is not to act. In other words, the ideology of the organization gives certain individuals the right to dominate without question. Through these assumptions, individuals in the organization know when they are to automatically conform to the power of the dominant group, without consciously acknowledging that they are doing so. These implicit themes also shape the individual's perception of his or her own potential for influence, through an understanding of the relationship to the dominant group and the probable outcomes.

The third way that organizational culture shapes the exercise of social power is through the development of new strategies for influence. At times, the functional expectations and explicit themes of the organization may be different from the implicit ideological assumptions. However, organizations tend to develop patterns of communication which support seemingly conflictual expectations and assumptions simultaneously. One way that the multiplicity of cultural expectations is supported is through ritualized behavior, which serves to mask inconsistencies by
featuring idealized patterns of communication. A second communication pattern which serves to support multiple cultural themes is the use of ambiguity in communication and decision-making. This ambiguity serves to grant the members of the organization a broader range of interpretations and acceptable behaviors. This, in turn, tends to decrease conflict which might occur if differing expectations were more openly expressed. A third strategy is to adapt the functional system to the ideological expectations. Conversely, a variety of behaviors might be employed which would immobilize the functional system, through passive resistance or non-participation. A fourth strategy would be to alter the perceptual system, by openly manipulating opinions to give the appearance of consensus, thus avoiding grievances. Finally, the organization may cope with the incongruencies by attempting to challenge the ideological themes. This may be done through a series of arguments which feature the inconsistencies and the need for change.

This study offers three major contributions to the present body of literature about organizational culture and social power. The first contribution is to the general understanding of the concept of organizational culture and the methodological approaches to the assessment of an organization. The data challenges the assumption that organizations function under a single theme or metaphor which guides and constrains behavior. Rather, it appears that organizations have systems of themes which are sometimes conflictual in their values and expectations. These themes emerge from both administrative and local levels. The local culture is influenced by the work activities (production) while the macroculture is influenced by environmental relationships and paradigmatic commitments and style of the administration.

The second major contribution of this research is to the general body of knowledge about social power. A majority of present research in the literature removes the study of social power (compliance-gaining) from the significant contexts in which it is exercised. These studies involve situations which often do not reflect the risk or consequence which is inherent in exercising social power in the organization. Further, research which is removed from the cultural context cannot reflect implicit assumptions about power. This study suggests that the situations where power is not exercised are defined by these implicit assumptions. Further, the data suggest that the exercise of social power may be more persuasive than coercive in the organization. Individuals may rely upon collective approaches to influence more often than dyadic approaches.
The third contribution of this research is to the understanding of change in the organization. Generally, research and prescriptive advice on managerial communication style presupposes that a single method of managing organizational change, conflicts and decisions involving subordinates is applicable to all organizations. In reality, the system of ideological assumptions and themes of the organization may necessitate a level of ambiguity for survival. Attempts to change the macroculture by changing functional relationships will meet with limited success, without corresponding shifts in the beliefs of the local cultural system.

Exploration of the contingent relationships of organizational culture and social power provide a richer base of information for efforts to affect change in an organization. With this additional information, prescriptive advice can be congruent with prevalent themes and patterns in the organization, and should, in turn, be more readily accepted and implemented. Thus, this study provides a way of looking at the culture of the organization which is useful for the evaluation of presently prescribed models for managerial communication with the cultural themes of the organizations which must implement them.

Chapter I has provided an introduction to the study of organizational culture and social power, a statement of the research questions which guide the investigation, a brief overview of the methodological approach and a summary of some of the findings and contributions to the research. The remainder of this text describes the study in detail. Following a review of literature related to organizational culture and social power in Chapter II, Chapter III outlines the methodological approach used in the study. Chapter IV provides a description and interpretation of the data and Chapter V presents a discussion of the implications of the study for the understanding of change in the organization.
CHAPTER II: REVIEW OF RELATED LITERATURE

The research questions outlined in Chapter I arise from a diverse body of literature. Chapter II presents a review of the literature which serves as the foundation of the assumptions and methodology of this study. Specifically, this approach includes a review of traditional approaches to social power, an overview of methodological approaches to the study of organizational culture and an analysis of prevalent themes about power in health care.

SOCIAL POWER

Traditional approaches to the study of social power have focused upon the definition of power, description of individual characteristics and behaviors and description of contextual features which are salient for the individual who exercises power. While the approaches do not provide a complete explanation of the operation of social power in an organization, they do provide the backdrop for the interpretation of observations in the field setting.

This section is divided into two parts. The first part, definitions of social power, outlines traditional explanations of the bases and perceptions of social power. In the second part, description of strategies and context, approaches to the description of individual power strategies and contextual characteristics are outlined. These descriptive categories are especially useful in the description of behaviors observed in the field observation.

DEFINITIONS OF SOCIAL POWER

The first section reviews the traditional definitions of social power. Three approaches are described. Raven's (1965) typology is a unilateral model which details the bases of social power as perceived by the person exercising the power (the source). Raven's model assists with the identification of concrete and personal resources which are often used in social influence.
The perception of the importance of these resources, however, is a function of cultural expectations.

The second model presented in this section is the typology outlined by Wheeless, Barraclough and Stewart (1983). This typology expands Raven’s definitions to include the perceptions of the target of social influence. This approach is helpful for the understanding of the operation of social power in the organization because it highlights the perceptual system between individuals rather than viewing the use of resources from a unilateral perspective. That is, this model considers how the source and target interpret the importance of the bases of power in a given context. This is helpful for understanding how individuals in an organization may frame their perceptions differently, depending upon cultural expectations. The culture of the organization shapes the value placed upon relationships and defines the obligation for compliance in the organization. These rules of behavior, in turn, shape the perceptions of the individuals in the social power context.

The third approach to social power which is outlined in this section is the psychological model proposed by Minton (1972). This explanation of social power highlights how perceptions of power are shaped by past experiences as well as present assessments. This is especially important for the consideration of social power in a cultural context, since the culture of an organization is shaped through past experiences. Thus, cultural beliefs about power are grounded in history and collective experience which shapes current perceptions. While Minton’s explanation is centered around the individual rather than collective interpretations, it does provide an explanation of how past experiences and expectations shape current perceptions and action.

Power has been defined from a variety of perspectives in the social science literature. Early definitions included the concept of power as a capacity of an individual (Tawney, 1931) and a capacity of position or a relationship (Lewin, 1938). Power has been defined in terms of force (Mechanic, 1962), intent (Dahl, 1957) and conflict (Haransyi, 1962). The most cogent definitions of social power from the communication perspective, however, are those which focus upon the relational and perceptual aspects of power.

Raven (1965) uses the term interchangeably with influence. Power is defined in terms of an agent’s ability to create psychological change through a system of force and resistance.
Wheeless, Barracough and Stewart (1983), on the other hand, adopt a different approach. They identify power as the "perceived bases of control that a person has over another person's behavior that would not have occurred otherwise" (p. 120). Power is vested in the source by the target through the target's perception of the situation and the relationship.

In the French and Raven (1959) definition, the critical element of power is the actual dependence of the target upon the agent's resources. Wheeless, Barracough and Stewart (1983), on the other hand, focus upon the perception of dependence or control. Additionally, French and Raven consider power to be the actual change or influence, while Wheeless, et. al., consider power to be the potential for the change. In this latter perspective, power is nested in the interpersonal perception of the individuals and their perception is operationalized through the selection of power strategies. In the large organization, interpersonal perception is shaped, in part, by the collective social reality of the organizational culture. Thus, power, through its dependence upon interpersonal perception, is also a function of the organizational culture.

Further definition of the power construct is offered through the delineation of the social bases of power. Power bases are related to the target's perception of the source's status, resources and personal attributes. Since power is a function of a social relationship, the bases of power are inherently tied to that relationship. The most generally accepted typology of power bases is Raven and Kruglanski's (1970), who delineate the following:

1. Reward power: based upon the target's perception that the agent has the ability to mediate rewards for him or her.
2. Coercive power: based upon the target's perception that the source has the ability to mediate punishment for him or her.
3. Legitimate power: based upon the target's perception that the source has the legitimate right to prescribe behavior for him or her.
4. Referent power: based upon the target's identification with the source.
5. Expert power: based upon the target's attribution of the source's knowledge or perception in relation to her or him.
6. Informational power: based upon a change in the cognitive elements of the target which result from the information communicated by the source.

Raven's typology provides a good description of the types of resources and characteristics which account for power dependencies, but it does not account for differing
perceptions of those resources. Since power, by definition, is a function of the perception of the source's resources by the target, it is also inherently tied to the value placed upon those resources in the system. In the large organization, the meaning of various resources is a product of the shared interpretation of the members of the cultural system. Thus, the legitimacy of the exercise of various power bases is determined by the value placed upon them in that culture.

Wheeless, Barraclough and Stewart (1983) offer a different approach to interpersonal power bases. They identify three general types of power: 1) power which operates on the basis of expectancies or consequences, 2) power which functions on the basis of interpersonal relationships or identification and 3) power which relies upon values and/or obligations. This approach focuses on the perception of the individual rather than the measureable resources. Thus, the fact that the source has the ability to reward or punish the target is not as important as the target's expectations for reward or punishment. Raven and Kruglanski's typology is unilateral and considers only the source, while the Wheeless, et. al. typology focuses on the system of source and target.

This typology is especially useful for the evaluation of the selection of power strategies in the large organization, since it reflects the process through which individuals operationalize power differences. This approach is inherently concerned with the expectations of the social system, the nature of the interpersonal relationships within that system and the values or obligations which are defined by the system. Thus, decisions about power or compliance-gaining strategies are not made in an objective vacuum, but in the context of the organizational culture.

While the Wheeless, et. al. model enriches the understanding of the operation of power in the organization, it does not strongly account for individual variables which may affect the propensity to exercise power when the circumstances dictate. Researchers have proposed that personality characteristics, such as self esteem (Javitz, 1980; Johnson, 1976; Raven & Kruglanski, 1970), dominance (Maslow, 1939), machiavellianism (Rolloff & Barnicott, 1978); Solar & Brehl, 1971), locus of causality (Swenson, 1973) and cognitive complexity (O'Keefe & Delia, 1979) may influence the initial selection of compliance-gaining strategies and the expectation for success or failure.

While it is evident that individual characteristics or traits do play a role in behavior, this study of social power focuses more upon the contextual features of the perceptual system than the traits of individuals. Traits are important in the present context, only in their effect on the
perceptual system. Minton (1972) discussed personality characteristics which may affect the perception of social power. He describes four distinct constructs: motivation, manifest power, subjective power and potential power.

Motivation is the desire to obtain social compliance and includes three components: drive (need), motivated behavior and goal. Drives are considered to be innate universal human characteristics which are tied to the concept of self-determination. The power motive, on the other hand, refers to the extent to which an individual is motivated to seek specific goals. Minton distinguishes competence motives (based upon a drive for self-determination, where power is an intrinsic reward) from power motives (based upon a drive to achieve power as an extrinsic reward). Drive, then, is more a function of individual personality characteristics while motivation is a synthesis of individual and social expectations. In the large organization, motivation may be determined by a number of factors in the cultural milieu. If, for example, the cultural environment tends to reward hard-driving achievement and upward mobility, then the individual may have strong motivational goals to "climb the corporate ladder" and seek power as an extrinsic reward. On the other hand, in an environment where upwardly-mobile individuals are seen as "pushy" or "power hungry", the individual may be motivated to maximum achievement within his or her own job level and the goal would be an intrinsic power reward.

Minton differentiates manifest power from potential power by the behavioral component. Potential power refers to the capacity of an individual to carry out an intended act (compliance), while manifest power is the actual performance of the influence. Minton points out that potential power implies that the individual has previously exercised (manifested) power, thus creating a potential for subsequent situations. Potential power is conceptually related to competence, while manifest power involves the activation of the potential power in a given situation. Minton posits that manifest power will vary across individuals, according to the effectiveness of the response in a situation. In the large organization, the effectiveness of the response to an influence attempt will, in part, be determined by the perceived legitimacy of the strategy employed.

This legitimacy is determined by the rules revealed in explicit cultural themes. Over time, individuals in the organization develop shared perspectives about the appropriateness of compliance-gaining behaviors. These perceptions become habitualized and become a part of the ideology of the organization (Deetz & Kersten, 1983). Thus, the cultural environment impacts
upon manifest power through explicit rules and structures and potential power through implicit ideological assumptions.

Minton's fourth construct, subjective power, refers to the individual's perception of his or her ability to implement intentions. Relating this concept to internal/external locus of control (Rotter, 1966), Minton points out that past reinforcement of power is an important variable in the subjective evaluation of its future use. Once a strategy is employed, the individual receives feedback from the reactions of other members of the social network and success of the strategy in achieving the desired outcome. For example, a secretary who uses a very direct approach to get a salary increase from the boss may be successful in getting the raise, but receive negative reinforcement from the other secretaries because the strategy employed is not legitimate for his or her status. The cool reception and resentment of the secretary's working colleagues will influence the probability of using a similar strategy in the future. This type of social reinforcement is another way the organizational culture impacts upon the exercise of social power. Behaviors which are perceived as legitimate for one status level in the organization may be negatively reinforced when used in another level. According to Minton, such reinforcements shape the subjective power of the individual.

This section has presented several definitions of social power which are useful as a foundation for the interpretation of perceptions of social power in the organization. While each of these approaches has significant explanatory value, none can be considered in isolation. Rather each complements the other perspectives to provide a broader interpretation of social power.

The following section presents approaches to the description of the context of power and the communication behaviors used in the exercise of social power.

DESCRIPTION OF STRATEGIES AND CONTEXT

This section provides an overview of recent approaches to the development of typologies for the description of communication behaviors which are manifested in the exercise of social power and the context for influence. The focus here is both upon the methodological approaches which have been used and the dimensions which have been identified. A general assumption of this research is that individuals consciously appraise context and then choose behaviors accordingly. It is further assumed that the selection of strategies and characterization of context is stable across organizations and systems and can be recalled by the individual. These
methodological assumptions differ from the assumptions of the study of organizational culture, where collective, rather than individual meaning is emphasized. Nonetheless, these typologies provide a useful language for the description and explanation of field observations.

The most frequently used typology is that developed by Marwell and Schmidt (1967). Subsequent studies have sought to refine the Marwell and Schmidt typology (Clark, 1979; Cody, McLaughlin & Schneider, 1981; Schenck-Hamlin, Wiseman & Georgacarakos, 1982) and identify salient dimensions of compliance-gaining messages (Falbo, 1977; Fitzpatrick & Wenke, 1979; Miller & Steinberg, 1975; Johnson, 1976). These approaches have generally lacked a clear connection with the power literature, however, and have little conceptual basis (Wheeless, Barraclough & Stewart, 1983).

Two methodological approaches have been used in these studies. The first utilizes hypothetical compliance-gaining situations and asks subjects to select a possible behavior or message from a list of methods which would be likely to elicit an appropriate response. The focus of these studies is the process used in the selection of communication messages in a compliance-gaining situation (McLaughlin, Cody & Robey, 1980; Marwell and Schmidt, 1967; Roloff & Barnicot, 1978; Sillars, 1980). The second approach attempts to elicit a list of compliance-gaining behaviors from the subjects using an inductive approach. In these studies, subjects are given a situation and asked to write down what they would do or say to get the desired result (compliance). This methodological approach focuses on the way subjects construct messages rather than the way they select messages. (Clark, 1979; Falbo, 1977; O'Keefe & Delia, 1979).

Acknowledging that context is an important variable in the analysis of compliance-gaining behavior, two recent studies have attempted to identify salient dimensions of context. Using a multi-dimensional scaling approach, Cody and McLaughlin (1980) asked subjects to write about the situations relevant to their social lives. After categorizing the situations, subjects were asked to evaluate twelve of the eighty-seven original situations. Multidimensional scaling produced two dimensions which were repeated at least once: intimacy and resistance. Three other dimensions (personal benefits, dominance and long-term/short-term consequences) were also obtained but not replicated across samples.

A second approach, by Hertzog (1982) attempted to expand and improve the methodological approach used by Cody and McLaughlin (1980). In their study of 145
nonredundant situations generated by college students, five categories of situations emerged: resistance to persuasion, values/rules, gender relevant/gender irrelevant, dominance and long-term/short term effects.

While these studies offer additional information about the way college students perceive compliance-gaining situations, they are limited in their generalizability to natural situations in the organizational setting for several reasons. First, the situations were generated by college students, who have limited experience in the significant decision-making situations involved in the organizational setting. Second, the situations which were generated appeared to lack the significance and risk inherent in the large organization. Finally, and most importantly, these studies are unable to account for the cultural variables which influence the perceptions of the subjects. In any hypothetical approach, the subject must frame the situation by imagining herself or himself in the context and anticipating how s/he would perceive it. This imagined context is not reflected in the responses of the subjects, nor is it necessarily congruent with the context intended by the researcher.

In the organizational setting, many variables impact upon the exercise of social power through compliance-gaining. An analysis of the dimensions of a compliance-gaining (power) context should account for variables which are imbedded in the cultural milieu of the social system in which it occurs. Among these variables are the interpersonal perception of the individuals involved, their relationship, the salience of the situation, the risks involved with a given outcome, the perceived legitimacy of a strategy and the patterns of positive and negative feedback in the social system. Information about these variables is generally assessed through interpersonal communication channels, which are typically not available in the methodological approaches discussed. Through the process of interpersonal communication, an individual gains an understanding of the meanings assigned certain behaviors by other members of the social group. These meanings tend to become reified over time and serve to constrain future behavior as well. Thus, in a compliance-gaining context, the individual considers both the objective risk or salience of the present situation and cultural definitions and constraints which are inherent in the organizational ideology.

The mechanism of cultural influence is complex and diverse. In the preceding discussion, traditional approaches to the definition and description of social power were addressed. The following section expands the understanding of the impact of organizational
The study of organizational culture is a rather recent emphasis in the communication literature. As such, there are few studies which clearly demonstrate the phenomena or test the appropriate research methods. Consequently, it is important to have a clear understanding of the theoretical underpinnings which guide the emergent methodology of this investigation. The following section presents an overview of the theoretical assumptions which serve as the foundation for the study of organizational culture. In the first part, theoretical assumptions of organizational culture are reviewed. This discussion outlines the definitions and operation of organizational culture and its impact upon the exercise of social power. The second part, methodological approaches, provides an overview of the methodological approaches which are advocated for the study of organizational culture. These approaches follow an interpretive perspective, emphasizing the meaning systems in the organization, rather than the communication roles and functions which are the focus of traditional research.

THEORETICAL ASSUMPTIONS ABOUT ORGANIZATIONAL CULTURE

As outlined in the first section of this chapter, traditional approaches to the study of social power presuppose a stable meaning system from context to context. For the most part, social power has been evaluated in isolation from the impact of collective interpretations and has focused upon the individual, rather than the group. This study represents a departure from this approach. Rather than observing power as a *product* of communication, power is considered a part of the communication *process* in the organization. Power is inherently related to the beliefs and values which are a part of a cultural meaning system. The following discussion provides an overview of the theory of organizational culture and its impact upon communication behaviors, such as the exercise of social power.
The study of organizational culture is founded upon the premise that organizational life is constituted through communication and, as such, all aspects of organizational life are the legitimate realm of research (Pacanowsky & O'Donnell-Trujillo, 1982). The prevalent metaphor for culture, as outlined by Pacanowsky and O'Donnell-Trujillo (1982), is a web: "man is an animal suspended in webs of significance he himself has spun......culture [is] those webs, and the analysis of it [is] therefore not an experimental science in search of law but an interpretive one in search of meaning " (Geertz, 1973, p. 5). The web metaphor draws attention to the confining nature of culture as well as its mobilizing aspects. Just as the spider inhabits only one web, so individuals are members of only one culture, to the exclusion of others. Thus, the study of organizational culture focuses not upon a comparison of one culture with another, but upon what one culture makes possible. (Pacanowsky & O'Donnell-Trujillo, 1982).

Culture is not merely a collection of stories, myths and artifacts in a kinship system; rather, it is a sense-making reality. It does not cause something to happen; rather, it serves as a context within which events occur (Pacanowsky & O'Donnell-Trujillo, 1982). Deetz (1982) emphasizes that all understanding is perceptual and that all "seeing" is "seeing as".

Seeing as, thus, is the not-yet-brought-to-awareness conceptual part of all perception. But these concepts are not essentially the member's own. They are borrowed from the larger society and from the particular organization of which the member is a part" (Deetz, 1982, p. 134)

Deetz (1982) goes on to point out that through the application of a perceptual framework in a particular situation, new meaning and concepts arise, which become habitualized and form the background for future situations. Over time, these become institutionalized in the form of stories, artifacts, physical arrangements and ways of doing things. In turn, they tend to "orient members' perceptions and provide meaning for organizational activities and objects" (Deetz, 1982, p. 134).

The principal means of shaping social reality is through language. It provides a means of objectifying new experiences and adding them to the previously existing body of knowledge (Berger & Luckmann, 1971). Deetz and Mumby (1984) add to this the argument that language is also the medium through which "the dominant ideological structures in the social system perpetuate themselves" (Deetz & Mumby, 1984, p.4) Since the control of discourse is usually in the hands of the dominant power groups, the language used metaphorically reinforces the
prevalent ideology by providing a framework for the social actor's response which is consistent with this group.

In a large organization, then, culture is the web of meaning and language is the thread with which the web is spun. Organizational culture serves to limit the scope of perception through its reinforcement of certain ideological assumptions. Using Therborn's (1980) modes of ideological interpolation, Deetz and Mumby (1984) discuss how an organization's culture perpetuates the dominant ideology and serves to define for its members: 1) what exists or does not exist (a sense of identity), 2) what is good, just, beautiful, enjoyable, attractive (normalization of desires) and 3) what is possible (giving shape to hopes, ambitions and fears). Organizational metaphors, in turn, serve to limit and shape social reality within the organization.

The culture of the organization, then, affects social power through its ability to shape the perceptions of its members. This perspective is remarkably different from more traditional conceptions, which tend to treat power as a stable construct. For example, power has often been viewed as a trait of powerful individuals (Blau, 1964; French, 1956; Kipnis, Castell, Gergen and Mauch, 1976). Similarly, power has often been treated as an object which exists in fixed amounts (Lammers, 1967) and should be structured (Ranson, Hinings and Greenwood, 1980; Kotter, 1978). Further evidence of this tendency to objectify and stabilize power is seen in discussions of the way it can be mapped (Weick, 1979) or graphed (Kahn, 1964) and, ultimately, managed in order to create change (Swingle, 1976), manage conflict (Boulding, 1965; Duke, 1976) and influence decisions (Kotter, 1978).

This approach to the understanding of power may mask its nature and function by ignoring the deeper structures which define it in the organization (Conrad, 1983). By imposing stability upon the construct, researchers tend to approach power as the cause of behavior and minimize the communication processes through which power is established and legitimized. The study of power as a stable, causal factor in conflicts may actually reflect the researcher's definition of the construct rather than its operation in the organization (Conrad, 1983).

Perceptions of power are central in an organization's cultural milieu. Stewart Clegg (1975) argues that images of organizational power appear on three planes: 1) the surface dimension, which guides and restricts the strategies which are used; 2) deep structures, which are based upon beliefs about the legitimacy of strategies and 3) interpretive structures, through
which deep structures influence overt activities. These three planes are similar to the deep and surface structures of organizational culture described by Deetz and Kersten (1983). In their discussion, surface structures identify the paradigm commitments of the organization. In power relationships, the surface structures would define the chain of command and channels of communication in the organization. Deep structures, according to Deetz and Kersten, include ideological beliefs and values upon which the surface structure is founded. Clegg's model similarly suggests that deep structures reflect prevalent organizational values and norms which define the legitimacy of strategies. Deetz and Kersten place the interface of deep and surface structures in the arena of work and communication. Clegg identifies this interface in structures of interpretation, such as conflict and decision making.

The key, then, to the understanding of power in the organizational setting is the understanding of its meaning in the organizational culture. One cannot merely look at the overt behaviors and structure of the system; one must understand the deeper structures which guide those behaviors.

These structures affect the operation of social power in several ways. First, organizational culture affects the exercise of social power by limiting the perceived power bases. The dominant ideology in the culture serves to limit the perception of what exists, calling attention to certain aspects of power and trivializing others. This, in turn, shapes the potential power of the individual. For example, if the cultural milieu of an organization perpetuates a "machine" metaphor, the prevalent images support a philosophy that the organizational efficiency is paramount. Individuals are viewed as parts of the machine which assist in achieving this goal. Interpersonal relationships in this system are secondary to the smooth, efficient operation of the system. In such an organization, power which is based upon values and/or obligations would be legitimized over power which functions on the basis of interpersonal relationships. Thus, the individual's assessment of his or her (potential) power would tend to focus upon those resources which would enable him or her to assist the organization to run smoothly. Information about the operation of the organization, for example, would be a valuable resource while information about personnel relationships would be less important.

Organizational culture further affects social power through the legitimation of certain power strategies within the social milieu. Compliance gaining behaviors (manifest power) are structured and normalized by the explicit cultural themes. This normative influence serves both to define and reinforce behavioral
patterns in the organization. For example, in an organization with a "family" metaphor, the prevalent images support a philosophy that the organization serves to nurture the growth of its members. Individual development through interpersonal relationships is paramount. Efficient operation can only be achieved when individual members are nurtured and growing. In such an organization, direct, impersonal strategies would be avoided, since they may go against the prevalent theme of harmony and attention to interpersonal relationships. In contrast, a member of an organization with the "machine" metaphor would tend to use more direct, impersonal or competent strategies which are more expedient and serve to keep the machine going, even at the expense of interpersonal harmony.

Organizational culture impacts upon the exercise of social power by defining the expected results of a compliance-gaining attempt. The dominant ideology gives pattern to the sense of the consequences of change and shapes hopes, ambitions and fears (Deetz & Mumby, 1982). The reification of past perceptions limits the scope of expectations for present behavior. For example, in an organization with "military" metaphor, formal, rigid hierarchy and conformity to rules is emphasized. In such an organization, predicted responses in a power strategy would be based upon an understanding of the hierarchical structure and the rules for communication within it. An individual would be unlikely to go outside of that structure to gain compliance, and would tend to emphasize the use of legitimate power bases. In the absence of legitimate power bases, the individual would be likely to perceive herself or himself as being powerless. Other means of exercising social power, through personal resources such as liking or caring, would not be used, since the individual would predict failure and potential negative feedback. Thus, through its power to limit the perception of what is possible, the dominant ideology of the organizational culture affects an individual's assessment of the context of compliance-gaining.

Finally, organizational culture impacts upon the exercise of social power by determining when compliance-gaining strategies are necessary. The implicit themes of the culture arise from the ideological assumptions which have developed over time. These assumptions become a part of the unconscious understanding of when organization members should permit another individual to be dominant. When compliance-gaining is necessary, it is because goals cannot be achieved under these implicit assumptions. Such situations are common when influence is attempted across status lines in the organization. In this circumstance, more conscious selection
of strategies and awareness of the explicit rules and assumptions comes into play.

With this foundation for the understanding of what constitutes organizational culture, attention is now focused upon the foundations of various methodological approaches. The following section outlines the assumptions of interpretive research, summarizes beliefs about the manifestation of organizational culture and presents several approaches to the study of organizational culture.

**METHODOLOGICAL APPROACHES**

Traditional approaches to organizational research emphasize the functional relationships and communication activities in the system. As the previous section has indicated, such approaches would be highly unsatisfactory for the understanding of organizational culture, since the focus of the analysis must be upon the interpretation of meaning. There are few studies in this area to serve as models for research methodology. The following discussion provides an overview of methodological approaches which have been advocated for the study of organizational culture. These include the analysis of communication performance (Pacanowsky & O'Donnell-Trujillo, 1983), account analysis (Thompkins & Cheney, 1983), fantasy theme analysis (Bormann, 1983) and metaphor analysis (Deetz & Mumby, 1984). The common thread woven through all of these approaches is that the language and activities of an organization are important indicators of cultural meaning. Some of these indicators are more explicit (surface interpretation) and some have deeper, implicit meanings. The linguistic and event analysis which frames the methodology of this study (Chapter III) is a distillation of the central concepts outlined in this section.

Recalling Geertz's (1973) description of culture as a web, it becomes evident that the approach to the study of organizational culture involves the interpretation of patterns of meaning in the social milieu. Such an approach is based upon the assumption that structures within the organization originate from human interactions and that individuals actively structure their own environments (Putnam, 1983). This is in direct contrast to the prevalent modes of organizational analysis which emphasize mechanistic, organic and cybernetic metaphors for the organization (Putnam, 1982).

The functionalist approach to organizational research is one of "inquiry from the outside" (Evered & Louis, 1981), generally based upon data collection which is removed from the
organizational context. In contrast, the approach to the study of organizational culture requires "inquiry from the inside", with researchers highly involved in the activities of organizational life.

The activities of organizational life are varied and complex. Deetz and Kersten (1983) identify the multileveled constructions of organizations, classifying both surface and deep structures. Surface structures include the paradigmatic commitments of the organization (domain, technology and ideology), the legitimate structure of the organization, the constitution of the organization (bases of participation and involvement) and the organization-environment linkage. The surface structure is the area of conscious awareness of organizational members. Deep structures, in contrast, include the beliefs and values and material conditions upon which the surface structure is founded. Deep structures often have a historical basis and include theoretical assumptions which govern surface action (Deetz & Kersten, 1983, p. 158). The interface of deep and surface structures is at the level of production processes (work) and social interaction (communication). Deetz and Kersten further explore the function of work to create relationships and communication to develop norms, values and meanings.

A variety of approaches are advocated for the study of surface and deep structures of organizational culture. Falcone and Kaplan (1984) identify two conceptual approaches which have been used in current research. The first treats culture as context within which organizational members function. From this perspective, culture is seen as relatively enduring and difficult to change. The thrust of this research views culture as a force which influences or constrains behavior, using culture as a predictor variable. From the second perspective, however, culture is both process and context. Research in this perspective involves the understanding of processes which lead to the establishment and support of organized behavior. This approach focuses on how organizational culture is established, rather than the effects of culture on the behavior in the organization. The general methodological approach to the study of organizational culture is based upon two guiding questions: what communication activities serve as occasions for sense-making in the organization and what sense do the organization members make of experiences (Pacanowsky & O'Donnell-Trujillo, 1982). Several communication activities are generally evaluated. Relevant constructs, such as meetings, seminars, publications are evaluated. Facts about the organization also provide a view of communication activities, since they often indicate "social knowledge or shared interpretations. Formal and informal organizational practices indicate shared views of how things should be done. Vocabulary
provides clues about constructs and practices. Interlocking systems of metaphors (Lackof & Johnson, 1980) indicate the structure of meaning in the organization. Stories are indicators of shared experiences by members of the culture. Finally, rites and rituals represent habituated reality for organizational members (Pacanowsky and O'Donnell-Trujillo, 1982).

One approach to the study of organizational culture is the analysis of communication performances. Using the notion of performance as both play-acting and accomplishment, Pacanowsky and O'Donnell-Trujillo (1983) emphasize that performances are contextual, episodic and improvisational. The heuristic list of communication performances which they detail as valid for the study of organizational culture includes:

1. Rituals: personal rituals which are trademarks for the individual task rituals, involved in the day to day activities of work; social rituals; organizational rituals, such as the company picnic.

2. Passions: storytelling, such as personal, collegial and corporate stories; passionate repartee, such as vocabularies and metaphors used in the organization.

3. Socialities: pleasantries, such as smalltalk; courtesies; sociabilities, such as joking and talking shop; privacies, such as confessing, complaining, etc. which go on behind closed doors.

4. Politics: showing personal strength, cementing allies, such as bargaining, attacking, defending, regressing.

5. Enculturation: learning the roles; initiation; learning the ropes (Pacanowsky & O'Donnell-Trujillo, 1983).

Pacanowsky and O'Donnell-Trujillo (1983) emphasize that cultural analysis should focus upon those patterns of performance and how these communication patterns shape organizational culture. They emphasize the need to look at the historical perspective of how episodes successively play out meaning in the culture.

One method of gaining this historical perspective is the use of account analysis (Thompkins & Cheney, 1983; Bantz, 1983). This approach utilizes actors' accounts of the meanings assigned to items in their environment and the rules for behavior. The analysis centers around an identified episode, or sequence of action which has some unity in the same time-space. As a participant observer, the researcher compares his or her understanding of the episode with that of the actor. This comparison could lead to confirmation of the validity of the
researcher's perspective or to post hoc modification of interpretation as the researcher learns of the actor's perceptions (Thompkins & Cheney, 1983).

In their study of organizational decision making in a communication class, Thompkins and Cheney (1983) point out that "accounts express decisional premises (or rules),......point to sources of decisional premises,......identify social units for whom the decision maker was prepared to give accounts at the time of making decisions,......reveal identification targets,......[and] help to explain the nature of the identification process" (Thompkins & Cheney, 1983, p. 131). Thus, account analysis affords an opportunity to evaluate the perceptions of the actors as they relate to the interface of deep and surface structures in the organizational culture. As the researcher explores the actor's perceptions, he or she comes to understand some of the deep values and meanings in the social system as well as the surface structures which impact in the communication arena.

Another interpretive approach to the study of organizational culture is the study of symbol systems. Bormann (1983) points out that the study of organizational culture should not only include the discovery of the patterns of communication forms, but also a "description of the dynamic tendencies within the communication systems that explain why the observed practices took place" (p. 101). This dynamic, according to Bormann, is the sharing of group fantasies. The sharing of group fantasies creates symbolic convergence, or the overlap of symbol systems and meanings of group members. The group first begins to characterize incidents or series of incidents in a setting other than the here and now. As the group fantasy evolves, the group alludes to a previously shared fantasy through verbal and/or nonverbal symbols or codes, thus developing an "inside joke". Eventually, the inside joke facilitates the evolution of a fantasy type, which is a "recurrent script in the culture of a group" (Bormann, 1983, p. 110). Bormann advocates the use of fantasy theme analysis in an organization by viewing the communication as a system which shares group fantasies. This provides an opportunity to understand the meaning of certain events.

A similar approach to the study of symbolism in the organization is metaphor analysis. Deetz and Mumby (1984) explore the relationship of power and information within an organization as it is expressed in the organizational metaphor. Metaphors, like fantasy themes, provide a sense of the deep structures in the culture. The metaphor serves to call attention to salient features of meaning as well as enrich understanding by enabling the individual to hold two
perspectives simultaneously. Deetz and Mumby (1984) note that metaphors may be orientational (reflecting the body as the locus of the world), ontological (projecting physical characteristics onto non-physical objects) or structural (projecting the characteristics of one experience onto another). They identify four relevant organizational metaphors: machine, family, military and conduit.

The scope of research literature about organizational culture is quite limited. Generally, there is more discussion of what should be evaluated than what has been done. There is strong emphasis upon using multi-method (Faules, 1982) or triangulated designs (Albrecht & Ropp, 1982). Such methodological approaches require a mix of quantitative strategies (e.g. surveys) with qualitative strategies, (e.g. naturalistic observation). Deetz (1982) offers the following guidelines for research:

1. Organizational tasks should be seen as autonomous and having integrity.
2. The understanding which makes a text maximally reasonable and coherent should be sought.
3. The interpreter should strive for the greatest degree of familiarity with the data to be interpreted.
4. Interpretation is transactive.
5. The results of interpretive research should be applicable to the organization under study. (p. 143-145).

These guidelines serve as a foundation for the evaluation of interpretive research in the organizational setting. No matter what methodological approach or combination of approaches is used, the research should focus upon both process and product. Organizational culture is not a causal factor in the context of behavior. Rather, it is a dynamic process which both shapes and is shaped by the ongoing communication systems in the organization.

The first two sections of this chapter have provided an overview of the traditional approach to social power and the foundations for the study of organizational culture. In the last section, I will comment upon some specific characteristics of professional ideology which contribute to the understanding of social power in the organizational culture of the health care system.
IDEOLOGY IN THE HEALTH CARE SYSTEM

In this section, I will highlight some unique characteristics of the ideology of health care professionals which may have an impact upon social power in the organization which was targeted for this study. Of particular interest is the potential effect of ideological assumptions upon the implicit themes of the culture. Specifically, I will discuss the impact of altruism, egalitarianism and gender orientation upon the exercise of social power and comment briefly on the effect of the material structure of health care. Deetz and Mumby (1964) have suggested that the organizational metaphors are an expression of the dominant ideology of the organization. This is especially relevant in the health care industry, since differing professional ideologies may have significant impact upon the organizational culture. An understanding of the value systems of health care professionals is central to the interpretation of patterns of behavior and conflicts in the organization.

Many health care professions embrace an altruistic ideology which emphasizes the value of self-sacrifice. The impact of this altruistic ideology is believed to be especially potent in the nursing profession's orientation toward social power. Nurses value the sacrifice of their personal needs and feelings in favor of the needs of the patient as paramount. In essence, this ethical stance dictates to nurses that, if people need, they must give (Muff, 1982). Altruism may affect the way that nurses assign meaning to power relationships in the health care setting. Power can only be justified if it is for the good of the patient; personal and professional needs must always be subservient to the needs of the patient. This is, perhaps, best illustrated by the common use of the term "compliance" to refer to getting the patient to follow a health care regimen (Dracup & Meleis, 1981). The underlying assumption is that it is only acceptable to use power (gain compliance) when it is for the good of the patient. Thus, compliance gaining attempts by nurses would probably be couched in the patient context.

A second ideological assumption which has significant impact upon the cultural orientation of the health care industry is the egalitarian or socialistic orientation of the industry. The right to equal access to medical care is a moral premise of society. Medical care is provided to all people, regardless of their ability to pay. Indeed, medical care is usually needed most by those who can least afford it. This orientation, coupled with altruistic assumptions, leads to further
devaluing of the individual needs of the nurse (Muff, 1982). Thus, nurses may tend to legitimize power strategies which will lead to the collective good, rather than individual achievement.

A third perspective of the nursing profession which may affect perceptions of power in the organization is the gender specificity of the profession. Since a majority of nurses are women, they share general socialization about power with other women in the culture. While the literature has tended to overemphasize the impact of sex-role socialization, there does appear to be evidence that women are socialized in an ambivalent fashion (Weitzman, 1982). The nursing profession exemplifies many of the characteristics which are culturally defined as "feminine" (Broverman, Vogel, Broverman, Clarkson & Rosenkrantz, 1972). Nursing is a nurturing, healing profession, which focuses on caring rather than curing (Grissum & Spengler, 1976).

Nurses are caught in a paradoxical situation regarding the use of social power. On the one hand, they have been viewed in the traditional medical system as the physician's "handmaiden" (a submissive role). On the other hand, the high consequences of failure to achieve goals for the patient's benefit would require a more competent approach. Thus, the historical ideological themes may suggest deference and feminine strategies such as indirectness, helplessness and personal rewards (Johnson, 1976), while explicit cultural themes suggest a more masculine approach (direct, impersonal and competent).

The economics of the health care industry may also affect the orientation toward power. Historically, the control of economic resources in the hospital has been in the hands of the physician. Physicians are independent practitioners who bring patient revenues into the hospital while nurses are employees of the organization. This is further illustrated by the common practice of placing the costs of nursing service as a part of the hospital room rate, along with housekeeping services (Gintzberg, 1981). The evolution of lay hospital administration as an independent practice has further compounded the problems of nursing management's access to power in the health care system (Hendricks, 1982). While the intent of this practice was to free care-givers from the burdens of administration, it has essentially removed nursing managers from control over their professional practice and access to the power necessary to make and carry out decisions (Hendricks, 1982). Thus, nursing management in a health care institution may rely upon different sources of power than hospital administration.

What, then, are the effects of these unique perspectives of the nursing profession and the health care industry upon their orientation toward social power? Discussions of power in the
nursing literature indicate consistency with the general organizational research in their objectification and stabilization of the construct. In the nursing literature, however, this leads to a pronounced dichotomization of power (Booth, 1983). Power is either possessed or not possessed (Munn, 1976), masculine or feminine (McGillick and Fernandes, 1983), caring or curing (Passau-Buck, 1982), or dominant versus submissive (Morrison, 1982).

The nursing literature emphasizes the egalitarian orientation of the profession in its advocacy of collective models of power (Dennis, 1983; Storlie, 1982). Androgynous management characteristics are advocated in response to the male/female dichotomy (Ziel, 1983). Finally, the nursing literature makes repeated reference to collaboration (Dennis, 1983) and catalytic roles (Munn, 1976) as the most appropriate for the profession. This emphasis probably stems from the perceived scarcity of power resources in nursing management. This scarcity of resources is largely due to the perpetuation of the economic control of physicians under the traditional medical ideology.

No matter what the organizational context, the ideological orientation of the members affects cultural themes and, in turn, the orientation toward social power. The research approach advocated in this study is designed to further evaluate organizational culture in terms of the overall themes and specific perspectives about social power. The literature presented in Chapter II lays the foundation for the understanding of organizational culture and social power. A part of this discussion has focused upon the perspectives of interpretive research as it relates to the study of organizations. In Chapter III, I will present the specific methodology used to operationalize interpretive concepts in this study: This includes a discussion of the research population, the variables in the research design and the methods of data collection.
CHAPTER III: METHODOLOGY

Chapter III describes the field research design used in this study. This approach provides access to general patterns of organizational culture and the manifestations of social power in the large organization. Following a description of the organization selected as the target of the study, Chapter III presents a discussion of the variables which serve as the focus of the data collection and the methods used to collect and analyze the data about the organization.

RESEARCH POPULATION

The organization selected as the target for this study was a teaching hospital affiliated with a large midwestern university. Specifically, the investigation centered around a 72-bed rehabilitation hospital within the larger university medical center.

This hospital was selected for the target of the study for several reasons. First, the system was readily accessible and had a history of being open to social science research activities. Access was further eased by the fact that the Executive Director (chief executive officer) of the hospital was new in his position and was interested in learning more about the culture of the organization and the specific relationships between the rehabilitation facility and the main hospital system. Second, the smaller facility was well suited for the study because of its unique clinical focus and physical separation from the main system in a satellite building. Since this facility has had a long, stable history and leadership, it was anticipated that it would have a unique cultural system. The third reason for the selection of this unit for study was its size. With a finite employee group of less than 150, this system offered an opportunity to study the system in detail, including a large portion of the employees. Further, the employees of this system were predominantly health care professionals who represented a wide cross-section of the medical, allied medical and nursing professions. Finally, as will be described further in Chapter IV, the structured approach to care in this system was an interprofessional team, rather than the traditional medical model. This team approach offered the researcher an opportunity to explore the exercise of power in an alternative approach to health care delivery.
VARIABLES IN THE RESEARCH DESIGN

The primary focus of the research is the discovery of major themes which guide the fundamental view of social power in the organization. Themes are patterns of understanding which are grouped around a central focus. They serve to mold the interpretation of reality for members of the organization by "informing members about what exists, what is good, and what is possible..." (Deetz & Mumby, 1984, p. 6). The variables which allude to organizational themes can be discovered in a variety of cultural phenomena. The analysis of these variables falls along two general lines: language analysis and event analysis.

LANGUAGE ANALYSIS

Human thought processes are metaphorically structured and defined. Consequently, language which contains significant imagery reflects the underlying conceptual system of the individuals. In an organization, this conceptual system is grounded in the collective experience of its members. Thus, imagery which is expressed in the organization's language is a reflection of the shared interpretation of its members.

Language analysis focuses upon the overall themes of the organization which are expressed in its cultural milieu. The emphasis is upon the discovery of patterns of images which are woven into a coherent meaning system in the organization. Both the content and the concordance of this system are considered. The content of themes is important because it carries with it implicit messages about expectations for behavior in the organization. The consistency of themes across the organization is both an indication of the degree of sharing of interpretation and values and the possibility of conflicting images between subgroups.

Of particular interest are themes which relate to social power. The power images in the language system are especially relevant because of their ability to: 1) call attention to specific features of the power context, 2) assign relative values to power strategies in the organization and 3) limit the range of expectations for compliance-gaining through the reification of existing structures. For example, in the target organization, the prevalent power theme is a team. This calls attention to the role of the coach, or leader, the role of the players and to amount of coordination in the system (game plan). Power strategies which are collaborative are valued (for the good of the team) and compliance-gaining could occur within that context.
The language analysis focuses on a variety of linguistic markers. These markers are characteristics of written and verbal communications which may provide clues to the prevalent cultural themes of the organization. Themes in the culture may be consciously articulated or they may be inferred from the linguistic system. Themes which are less conscious are referred to as implicit themes of the culture. Data collected from the analysis of these markers provides substantiation for the researcher's intuitive perceptions of themes in the organizational culture. The linguistic markers considered are: 1) speech imagery, 2) specialized vocabularies or slang, 3) terms of address and 4) stories or folktales. Each is described further in the following discussion.

1. SPEECH IMAGERY. Speech imagery may be displayed in a variety of ways. Specific attention is given to metaphors and themes presented in the analysis of written communication, verbal interviews and group discussions. The analysis of this data focuses upon: 1) the types of metaphors and themes represented and 2) the consistency of those images throughout the organization.

Generally, speech imagery can occur on two levels. On a broad level, members of the organization may refer to specific metaphors which call attention to features of the system. For example, an organization may reflect images of an orchestra, through written and verbal communication. This image may be represented by the use of terms such as "harmony", "fine-tuned operation" or "orchestrating a meeting". Since an orchestra usually consists of a group of independent artists who work together for a melodious outcome, this metaphor may suggest that there are relatively independent power structures within the organization which come under the "direction" of the conductor, who may be the chief executive officer or chairperson of the board. The vocabulary which includes expressions suggestive of "harmony" implies that there may be an emphasis in the organization upon compliance-gaining strategies which will go with the overall philosophy of the system and not appear discordant.

On another level, organizational speech may be more thematic than specifically metaphorical. The analysis at this level focuses upon the patterns of content themes and their implications for social power. This may, in part, reflect specialized language and, in part, content focus. For example, if a group used terms referring to "comfort" levels in their speech, it might be assumed that emotional issues were important. Such a thematic pattern might also indicate that
discomfort was the norm of the organization and, thus, comfort was featured because of its uniqueness.

In addition to the characterization of the metaphors which are present in speech, it is important to analyze the extensiveness of those images. Organization members may be more consciously aware of metaphors which are extensively displayed in the communication system. Thus, the impact of these metaphors may be more pervasive. The more subtle metaphors, on the other hand, may give a glimpse of the implicit ideological assumptions. The coherence of several themes is therefore of special interest.

Finally, it is also important to understand the consistency of these linguistic metaphors throughout the system. In the example of the “organization as orchestra”, one would anticipate that this metaphor would be uniformly expressed by all levels of the organization. If, however, only the upper management used metaphorical speech related to harmony and the lower management used metaphorical speech suggesting an “improvisational” image, this would suggest a theme of “jazz ensemble” rather than “orchestra” for this particular group. The implications of the image of “jazz ensemble” instead of “orchestra” are significant, since members of a jazz ensemble are usually solo performers who play together in an improvisational, sometimes discordant manner. Thus, the focus of such a metaphor is upon individual independence, rather than strong direction. Further, the lack of congruence of the two images may indicate that there is conflict in the organization.

2. SPECIALIZED VOCABULARIES. Specialized vocabularies are linguistic expressions which have unique meaning for a group. They may be found in both written and oral discourse, but are especially evident in group dialogue. While specialized vocabularies may also have metaphorical characteristics, they are unique in that they tend to set aside one group from another and reinforce collective identity. This is accomplished through the emphasis on group interests rather than universal ones and the masking or transformation of contradictions into forms which are more acceptable for the group. This process, in turn, solidifies implicit power hierarchies in the organization and the dominant ideology.

Specialized vocabularies may be a part of the overall linguistic system of a group or they may be shared by segments of the organization in the form of an “inside joke” or collection of slang expressions. The focus of data collection about specialized vocabularies is: 1)
identification of groups which have specialized vocabularies and 2) the content and extensiveness of those vocabularies. For example, in the target system, professionals may have a specialized vocabulary which sets them aside from other professionals in other parts of the system. This linguistic system may include such terms as "A.F.O.", "B.F.O.", or "A.D.L.". This system is unique to a group within the organization and tends to set this group aside by keeping the rest of the system in a state of ambiguity about the intended meaning. This ambiguity serves the group by helping them to remain in a "special" role, which affords a broader range of behaviors. As long as the group is unique, they do not have to conform to other values/norms.

The content of specialized vocabularies hints at the underlying value system. Most often, specialized vocabularies reflect the orientation of the work group. In the health care organization, this most often involves patient care. The extensiveness of the language system indicates the degree of enculturation of various subgroups in the organization. Pockets of specialized language among subgroups may indicate a variance in group focus or value system.

3. TERMS OF ADDRESS. Pleasantries and social exchanges in the organization may reveal more information about overall themes and power imagery. The collection of data about terms of address focuses upon: 1) the level of formality of the terms, 2) the differences between public and private address, 3) the reciprocity of levels of expression and 4) the uniformity of terms at various levels of the organization.

Terms of address are usually not conscious after initial orientation to a system. Rather, they are part of the implicit ideological system which constrains behavior without conscious process. Thus the formality and reciprocity are significant in their ability to call attention to status differences and reinforce the ideology of the system.

Differences between public and private terms of address often reflect differences between explicit organizational expectations and local cultural norms. The secretary may refer to her boss as "Dr. Smith" on the telephone and "Jim" in private conversation. Similarly, the boss may refer to his secretary as "Karen" in private conversations and "my secretary" in communications with other people. Terms of public address may be seen as indicators of the formal philosophy of the organization, while private address may reflect the local operation of cultural expectations and interpersonal relationships. Further, these terms of address may be different at various status levels of the organization. Group members may address each other by
first name and non-group members by a more formal title. Top level executives may address their subordinates by formal titles and lower management may address subordinates by their first name.

4. STORIES AND FOLKTALES. Legends, stories and folktales in an organization bring its members into contact with the history of the organization. They metaphorically illustrate enduring attitudes and beliefs. Further, they may serve to instruct the new employee about cultural expectations. Folktales are similar to the group fantasy types described by Bormann (1983) in their expression of shared attitudes. Folktales and stories often include relevant power imagery. The imagery may reveal expectations about power relationships and rules for behavior in the organization.

The collection of data about stories and folktales focuses both upon the images implicit in the stories and the parables inferred in them. For example, in one organization, there is an enduring story of meetings with an outside group led by a very strong female leader known as "old iron shorts". The fantasy theme woven in this story suggests that strong female leaders are seen as inflexible and unfeminine. This would suggest that female managers in this organization would need to be cautious in using direct, impersonal compliance-gaining strategies, lest they be labeled as stiff or castrating. Thus, veiled in the humor of this folktale is a warning about the type of social power strategies which are legitimized for women in the organization.

Metaphoric speech, specialized vocabularies, terms of address and stories and folktales are all linguistic markers which provide data about the organizational culture and social power. A second level of analysis is also included in the research. This analysis, which focuses on events in organizational life, enriches the understanding of the overall themes of the organization and the operation of social power.

EVENT ANALYSIS

The events of the routine operation of the organization provide significant behavioral indicators of the underlying meaning structures of the system. Individuals tend to behave in a manner which reflects their overall perceptions. These perceptions are formed through a collective orientation to reality implicit in the organizational culture. Specific events which
punctuate organizational life may be seen as markers of this underlying conceptual system. While the activities of the organization are continuous, several events mark an opportunity to view this activity as frozen episodes. The specific event markers which provide data to supplement the understanding of organizational themes and social power are: 1) social events, 2) communication channels and structures, 3) orientation activities and 4) compliance-gaining episodes. Each of these events is described further in the following section.

1. SOCIAL EVENTS. Social events represent both informal and ritualized activities of the organization. The nature of social events provides interesting information about cultural expectations. The analysis of data about social events in the organization focuses upon 1) the types of events which occur (formal or informal), 2) the agenda for those events (what is discussed or what occurs) and 3) attendance at the events (who attends and the command nature of the attendance).

Formal social events often represent ritualized expression of cultural themes. Members of the organization know what behavior is expected of them and tend to follow these expectations in formal social events. In a sense, formal social events are a public expression of underlying themes in the organization. The nature of formal social events often reveals attitudes about authority in the organization, since they may be planned by management for employees or vice versa. In one organization, the management team planned an annual "employee recognition day", where they would serve a special meal to the staff (including set-up and clean-up afterward). The theme articulated in this event was that of "one big happy family" espoused by top level management. In this event, managers were playing the role of "parent" in serving the meal. It also demonstrated a desire to de-emphasize lines of authority in this organization, as managers were willing to be "servants" for at least one day a year.

Informal social events, while less predictable, are no less important in their ability to provide data about underlying themes of the organization. Informal gatherings for a drink after work may reflect the collegial approach of management in the organization. Raquetball or squash matches may reflect an underlying competitiveness among managers. While many informal social events are viewed as the expression of friendships in the organization, the very existence of these friendships is an important indicator of the general affective tone reflected in organizational themes.
Social events are often a context for organizational activity. Frequently, formal social events are seen as opportunities for individuals to explore interests outside of the work context. In some systems, however, these events may be the arena for conducting significant business. The type and content of conversation of social events may be an indication of their legitimacy as a part of organizational function. Similarly, informal social gatherings may reveal information about specific power relationships in the organization. These gatherings may be a time of collegiality where interpersonal support is given which would not be legitimate in the formal organizational setting. When a manager takes a colleague to lunch to discuss a delicate matter, in private, different compliance-gaining strategies may be employed than would be acceptable in formal interactions in the office.

Finally, attendance at social events is a significant reflection of organizational themes. "Command performances" may suggest clear lines of authority which are to be followed. If, for example, families are invited to the annual picnic, this may reflect an emphasis upon interpersonal relationships in the organization. Similarly, the attendance at informal social gatherings is indicative of power relationships in the organization. An employee may implicitly understand that s/he must go out with the boss when requested, but may perceive more choice about a gathering of colleagues. The presence of patterns of informal gatherings may further suggest coalitions of individuals within the organization.

2. COMMUNICATION CHANNELS AND STRUCTURES. Over time, the individuals in every organization develop both formal and informal channels of communication. The structures in these channels serve as event markers for the understanding of the fundamental meaning structure which led to their evolution. The organizational chart often represent the formalized expectations for communication, based upon organizational themes. Informal structures, on the other hand, may more accurately reflect the actual interpretation of these themes by members of the organization. The mode of communication in the organization is an indicator of both the legitimized power hierarchy and the strategies of communication which are most often utilized. The evaluation of communication channels and structures will focus upon: 1) the mode of communication (face-to-face, mediated, written, etc. 2) the content of the communication and 3) the consistency of the informal patterns with formalized structures.
The primary mode of communication in an organization often reflects general cultural themes. If, for example, a majority of communication is conducted in face-to-face, interpersonal channels rather than written letters or memos, this would suggest that the organizational themes focus upon interpersonal relationships. It would also suggest that, in a compliance-gaining situation, strategies which are more personal than impersonal would be perceived as legitimate.

The content of verbal or written communication is also significant for the understanding of the interpretation of social power in the organization. Are more significant issues communicated through written or interpersonal channels? The tendency to communicate important issues through written channels would suggest that personal compliance-gaining styles are only legitimate for certain issues in the organizations, especially if managers tend to use more direct, impersonal styles in written communication.

The consistency of formal with informal channels of communication is another important indicator of organizational culture. If the organizational chart suggests one pattern of communication and its members consistently use another, this would suggest that the culture legitimizes different strategies than those which are published for general information. By looking at the actual (rather than published) structure of communication in the organization, other patterns of legitimate power may be seen in informal coalitions.

3. ORIENTATION. Organizational enculturation usually includes both formal and informal processes. As a new employee joins the organization, s/he is oriented to the operation through a class or discussion, tour of the facilities, introductions to key personnel, and so forth. This type of orientation introduces the employee to the philosophy and formal policies of the organization. The content and structure of this formal orientation reveals the organization's general themes and interpretations of power. The analysis of data about orientation events focuses upon: 1) the content of orientation information (statement of philosophy, etc.) and 2) the formal and informal processes which are used to enculturate an individual.

The formal orientation process usually involves a statement of philosophy, which alludes to the images and metaphors which guide the overall organization. For example, a statement that the organization feels that "every employee is an important part of the team" would suggest that open communication is valued and that competent compliance-gaining strategies would be legitimized. On the other hand, if the philosophy statements included images which suggest that
the organization is a "family of caring individuals", this would indicate that more personal styles would be legitimized.

After the initial formal orientation, the new employee must then complete a more informal process as s/he "learns the ropes". This process may be guided by other employees or it may be a random process. The amount of guidance given the employee in the informal orientation process suggests the extent of control which the cultural system wishes to exert upon its members. In this informal enculturation, the new employee learns significant information about the strategies of behavior which are legitimized and normalized in the organization. The employee learns, through experience or observation, what modes of feedback are used in the social system. Further, s/he learns which behaviors are rewarded and which are punished in the system. At this level, the new employee often discovers inconsistencies between formal philosophy and the actual cultural expectations of the organization. For example, in the organization with a philosophy of "caring family", the employee may discover that impersonal compliance-gaining strategies are ineffective. Further, s/he may discover, through observation and experience, that individuals in the organization "punish" such behaviors through negative social feedback.

4. CONFLICT AND DECISION-MAKING EPISODES. Decision-making and the resolution of conflict are significant markers in organizational culture because they present a view of communication strategies used in the exercise of social power in the organization. Accordingly, they reflect both the general themes of the organization and the specific perceptions about power which have become salient for individuals in the system. Often, in the process of decision-making, individuals play out the unspoken cultural rules for behavior. Decision-making episodes provide an opportunity to observe the conflict management strategies as well as the behaviors used to gain compliance in the process.

The analysis of decision-making episodes focuses upon the types of decisions which are attended to as well as the process used in making decisions. The themes of the organizational culture tend to orient the individual to certain features of the environment. The types of issues which are the focus of decisions and conflicts are of particular interest. Further, the fundamental ideology of the system will dictate, to some extent, whether decisions are arrived at collectively or individually. Thus, not only the content of the decisions, but the individuals
engaged in the process provide clues about fundamental ideological assumptions and values in the culture.

Just as the types of issues involved in decision-making provide clues about cultural themes, the process of decision-making can be a reflection of the rules of behavior inherent in the culture. These rules of behavior may be played out through the featuring or masking of conflict issues as well as specific communication strategies used to gain compliance in decisions.

Further, communication behaviors which are displayed in conflict and decision-making represent past patterns of behavior which have been reinforced in the culture. Of special interest, then, is the range of behaviors displayed and the consistency of behaviors across decision-making contexts.

The range of behaviors displayed in decision-making episodes provides some index of the degree of reification of rules in the culture. For example, in a culture with a "family" metaphor, subordinates may be allowed to provide input into the decision-making process, but the decision would rest, ultimately, with the "father" or "mother" figure. In the decision-making process, conflicts may be tolerated about minor issues, but the authority of the parent-figure would probably never be openly challenged. The more reified the rules for behavior in the culture, the more consistent would be the behavior from person to person.

Similarly, evidence of consistent behaviors across various decision-making contexts may serve further to substantiate the pervasiveness of cultural themes. In the example just cited, one would expect that members of the organization would behave similarly in all decision-making situations, regardless of the "parent-figure".

Thus, decision-making and conflict episodes provide an opportunity to view patterns of behavior which would tend to substantiate assumptions made in other levels of analysis. Collectively, linguistic markers and event markers provide significant data about the general themes of the organization and the orientation to social power.
DATA COLLECTION METHODS

Data collection for this study generally occurred in four phases. The first phase was the system entry phase, when initial contacts with the organization were made and permission was gained to do the study. The second phase was the interview phase, when key individuals in the organization were interviewed to gain a basic understanding of the themes and expectations of the system. In the third phase, I worked with an assistant for independent observations of group interaction in a series of interprofessional group and department head meetings. The fourth phase of the research, verification, was built upon the preliminary conclusions of the first three phases. During this phase, initial impressions were explored further through written questionnaires and interviews with key individuals in the system. Each phase of the data collection is explained in more detail in the following section.

PHASE 1: SYSTEM ENTRY

The initial contact with the organization was through the Chief Executive Officer of the institution. After reviewing the prospectus for the study, he suggested that the rehabilitation hospital would be the most appropriate segment of the organization to study. The evaluation of this segment of the organization additionally provided the Executive Director with information he needed about the organizational culture and the relationships between the target system and the main hospital. Following this initial meeting, I interviewed the Administrator for Nursing, giving an explanation of the nature of the study. She assisted me with further identification of key individuals in the system which would need to be contacted about the study.

As initial interviews were being arranged, I contacted the hospital communication department to get a collection of written, public documents about the hospital and the rehab center. These included press releases, patient brochures, hospital annual reports, hospital magazines and employee newsletters. These publications were reviewed for both the type and content of the articles as well as trends over time. Approximately three years of written data were reviewed. Special attention was paid to the descriptions of individuals in the "employee of the month" section of the employee newsletters to determine the attributes used to describe the "ideal" employee in the system. Further, I explored these publications to find articles which might reveal key administrative attitudes and positions on issues.
During this phase and each subsequent phase of the data collection, I used every interface with the organization as an opportunity to observe interaction and activity. Comprehensive field notes were recorded, using observational, theoretical and methodological notes in the format suggested by Schatzman and Strauss (1973). Observational noted detailed actual behaviors and content of the conversations in the organization. They also included observations of the general environmental milieu, such as nonverbal behavior, seating arrangements, etc. Theoretical notes tied observations to existing theory and outlined assumptions for further theory development and observations. Methodological notes offered special comments on the research methods and suggestions for further investigations. Special attention was given "public" areas, such as hallways, lobbies and canteens where patient/staff interactions could be observed first-hand. Further, notes were recorded while waiting for interviews.

**PHASE 2: INTERVIEW**

After initial entry into the system and background evaluation, key department heads in the system were contacted for interviews. These individuals included the Executive Director from the main hospital system as well as the department heads from all services in the rehab hospital. It is important to note that between the initial entry phase of this study and the interviews, the Executive Director implemented a major reorganization of the administrative structure.

This corporate reorganization was a part of a major shift in the organizational focus which accompanied the hiring of the new Executive Director five months earlier. The change is especially important for two reasons. First, it appeared that there was an increased number of "public" communications as the new Executive Director sought to build familiarity with the system. This level of communication made certain organizational themes more salient during the period of inquiry. Further, the changes in the organization created a certain degree of stress and unrest in the system. During such periods of change, it is natural to discount old patterns and emphasize the value of new ones. Thus, the opinions of key administrators may reflect an unusual fervor which might not have been present during calmer periods in the life of the organization.

A total of fourteen interviews were conducted with department heads. Additionally, two head nurses were interviewed, since they have management responsibility over the largest
number of employees in the system. The clinical nurse specialist who is involved in orientation of new employees was also interviewed in this phase, as was another clinical nurse specialist who had been in the system for thirteen years. Finally I interviewed two secretaries; one interview was a formal, taped session and the other was more informal conversation.

The interviews provided an opportunity to observe the system and gather information about the perceptions held by key individuals in the organization. After an initial explanation of the purpose for the study and signing of consent for participation (Appendix A), interviews were audio-taped. Each session lasted 45-75 minutes. The focus of the interview was to gain perceptions about the linguistic and event markers in the system. The interview questions followed the outline found in Appendix B. This schedule reflects a general guideline of open-ended questions which were asked of each interviewee. I added additional probing questions, as needed, to enrich the quality of responses. The schedule of questions focused on the following:

1. Description of the organization (goals, philosophy, patterns of communication, affective qualities, values, etc.)
2. Description of the participant's perception of her or his role in the system (formal and informal roles, relationships with superiors and subordinates, etc)
3. Description of the ideal manager in the organization, based upon what the participant perceives the expectations of the system to be
4. Description of style of conflict resolution, decision-making and/or compliance-gaining in the system (strategies used, level of satisfaction with outcome, etc.)
5. Type of orientation to the system (formal and informal)
6. Social events and customs (formal and informal).

The description of the organization provides insight into the explicit themes which are present in the public, formal organization. The way an individual perceives his or her role within this system acknowledges both the formal and informal rules of behavior and values of the organization. The description of the ideal manager provides further information about the salient values for leaders in the organization. At the same time, the information gleaned from this part of the interview provides insight into the general expectations for style. Orientation, social events
and customs are all mechanisms for transmission of cultural information. Finally, through the analysis of the compliance-gaining or decision-making episodes, it is possible to gain a perspective about some of the implicit cultural themes which also appear to constrain behavior in the organization.

The interviews were not as structured as the schedule would suggest. I had special difficulty eliciting information about communication channels and structures and compliance-gaining episodes. Most participants gave little thought to communication structures; only two of the twenty people who were interviewed related actual compliance-gaining episodes. For the most part, the interview focused on decision-making and conflict resolution, rather than compliance-gaining.

As a result of the interviews conducted in Phase 2, I discovered that the primary cultural influence in the system was the interprofessional team which was charged with the care of the patients in the system. Therefore, Phase 3 focused specifically on the interaction in those groups.

PHASE 3: GROUP INTERACTION

Unlike traditional health care systems, where the physician has primary responsibility for decisions about patients treatment program, and other professionals follow her or his prescriptions, this organization is structurally poised to permit collaborative practice through a team decision-making approach. Accordingly, five interprofessional teams function in the system. Four of the teams are readily identified with the physicians who are in charge of the clinical service. Two teams are labeled "General Rehab" and are associated with their respective floor in the building and the physician who is in charge of service there. Two teams have a specific clinical focus (head injury and spinal cord injury) and the fifth team is affiliated with the pain management service. The fifth team stands somewhat apart from the others in its focus and operation, as will be highlighted in later sections.

Each team has a "panel" meeting every week to review patient care. In addition, they have a monthly "team" meeting where non-patient issues are discussed. There are other team meetings which involve the physical presence of patients and/or families, and I did not participate in these sessions. Rather, the focus of the observation at this point was on the "panel" meetings and the "team" meetings.
The "panel" meetings lasted two to three hours; "team" meetings generally were an hour long. Two panel meetings each were observed of the groups which would permit audio-taping of the meetings. For the other three groups, three meetings each were observed. One group would not permit outsiders to be present in "team" meetings, so interviews with the physician and psychologist were substituted for that group. Additionally, the pain management team did not have a structured meeting which was accessible to the researcher(s) during the time of data collection. The other three "team" meetings were attended and audio-taped.

During this phase of the research, I was joined by a communication faculty member who served as a trained research assistant. Prior to group observation, we discussed the focus and purpose of the study in order to gain a common foundation for the group observations. Independent observations and impressions of the group interaction would be recorded in field notes in the format which included observational notes, theoretical notes and methodological notes for independent observations (Shatzman & Strauss, 1973). During group meetings, we sat in the back of the room, recording independent notes about group process and linguistic content. Following each meeting, we met to compare impressions of the interaction. During these sessions, we compared field notes and discussed differences in impressions. Although we attended to different aspects of group process, at times, our interpretations of the interaction were remarkably congruent. At the conclusion of each meeting, we noted areas which we felt needed further attention or clarification in the next meeting. Our general impressions were further verified in the data gathered in Phase 4.

PHASE 4: VERIFICATION

The fourth phase of data collection provided additional information to substantiate impressions gained in the first three phases. Specifically, additional quantitative information was gathered about the groups and the individuals involved in them. Impressions were also shared with two group members who participate in more than one interprofessional team to determine the accuracy of impressions. Finally, impressions of the operations of the department heads in the system were verified through observation of a meeting between department heads and the administration from the main hospital system.
Individuals in each group were given a four part questionnaire to complete. The questionnaires were explained at the "team" meeting and distributed. They were anonymously returned to me through an envelope left with the hospital switchboard operator. Of the 55 questionnaires handed out, 42 were returned.

Three parts of the questionnaire related to specific group impressions and one related to group conflict management. Additional demographic data was collected on each subject (Appendix C), for the purposes of cross-comparisons.

During phase two and three, it became clear that the team metaphor was pervasive in the system. There appeared to be rather loose interpretation of the concept of team, however. It was important to gain a clearer understanding of the meaning of team process to the members of the organization. Thus, the first part of the questionnaire asked the group member to evaluate what type of team they thought their panel group was. In the group observations, it became evident that, while the teams were functionally structured for group decision making, the decisions were often choreographed by the physician. Using a three-part team typology developed by Kreidel (1985), team members were asked to expand their description of the team (Appendix D). The purpose of this exercise was to provide more depth to the team metaphor which seemed to be operational in the system. First, participants were asked to determine whether their team was a football, baseball or basketball team. Brief descriptions of the differences between these types of teams were given as follows:

1. Football teams rely upon coordination from above. The head coach directs the team, with each player having a narrow piece of the game plan. The players who handle the ball most gain the greatest recognition.

2. In baseball teams, the players function independently, although in a coordinated way. Individual performance is important and recognized. The manager has little to do other than to get the proper players into the game at the appropriate time in the right order.

3. In basketball teams, players interact spontaneously and must mutually adjust to each other. The flow and chemistry of the team is very important. The coach of a basketball team acts more as a catalyst than a director. The team is recognized as a unit, rather than as individuals.

Generally, these descriptions allude to very different power relationships in the teams. A football team, for example, represents traditional hierarchical control. Baseball, on the other hand, is more autonomous, while basketball is more collaborative.
Participants were asked to identify the coach of their team. It was assumed that the ability to acknowledge a coach required an understanding of the underlying power structure. They were further asked if the structure of the team was appropriate for the task at hand, and, if not, what type of team should be used. This was intended to identify the willingness of the team members to challenge the ideological assumptions.

The five teams observed in Phase III were quite different in their decision-making and conflict resolution processes. It was difficult to ascertain from the interviews whether these differences were due to the variation in clinical focus of the teams, a difference in rules for behavior which arose from underlying value differences or personal attributes of the leader and group members. In order to gain a better perspective of group member's perceptions and to validate initial impressions, the group behavioral inventory developed by Bales, Cohen and Williamson (1979) was included as the second part of the survey.

This inventory (Appendix E) permits group members to rate one another according to the frequency of displayed behaviors. Each group member rated themselves and every other member of the group. The advantage of this qualitative method of evaluation was its ability to show average group perceptions and to demonstrate the patterns of homogeneity or heterogeneity within and between groups.

This system for multilevel observation of groups (SYMLOG) provides information about impressions of group members along three dimensions: dominant/submissive (upward/downward), unfriendly/friendly (positive/negative) and task/emotional (forward/backward). The power dimension (dominant/submissive) relates to perceived control over group activity. This dimension is scored as upward/downward; the larger the score, the more the individual is perceived as dominating the group. The friendly/unfriendly dimension, on the other hand, relates to the socio-emotional expression of the individual; individuals who are generally perceived as friendly are scored highly positive. The third factor, task/emotional, relates to the orientation toward instrumentality in group process. Individuals rated high (forward) on this dimension are perceived as task-focused, rather than socially expressive. The inventory, which appears in Appendix E, asks each member of the group to rate the other members according to the behaviors listed. Team members were asked to score the instrument, based upon their average perceptions of other members of the team. Of the 42 surveys which were completed, only 19 contained complete SYMLOG data which could be used. The output of the computer
analysis (Appendix F) plots each individual along three dimensions and provides averages across individuals in the group.

The important contribution of the SYMLOG information is its fit with what Bales (1983) has called individual and organizational values. Patterns of behaviors are correlated to clusters of value; these value clusters reflect broader value orientation. These archetypes describe, among other things, the value of the individual regarding established authority, egalitarianism and altruism. Using the SYMLOG group diagrams, it is possible to determine the values which the groups attribute to one another. This is assumed to be a part of the explicit group value system. By comparing and contrasting explicit values with implicit linguistic and behavioral patterns, cultural contradictions can be unmasked.

The third part of the questionnaire was developed from the initial group observations. After attending ten "panel" meetings, it became obvious that groups varied according to their orientation to five distinct dimensions. The first dimension, rule orientation, was a function of the degree of formality of the rules for group interaction. The second dimension, decision making, varied according to the degree of leader-orientation in decision-making. The third variable, boundary rigidity, reflected the group's degree of openness to new ideas. Related to boundary orientation, the groups also varied in their expression of provinciality. Provinciality, in this case, was most often reflected in the groups flexibility and adaptability in response to alternative points of view. Finally, the groups seemed to vary according to their affective tone, with some groups clearly more supportive of individual members than others.

One way that group members may cope with incongruities in cultural expectations is by the use of strategic ambiguity (Eisenberg, 1984). By keeping the structure loose and open, members are given greater license to generate their own meaning, thus decreasing conflict. Accordingly, groups with less formal rule orientation, less rigid boundaries and more open attitudes permit a greater range of individual compliance-gaining behaviors.

A series of sixty word descriptors which reflected the five dimensions was presented in the third section of the questionnaire. Participants were asked to react the the descriptors, according to the degree that they perceived that the word described their group. The questionnaire and its key appear in Appendix G. Generally, it was anticipated that the higher the score, the more rigidly configured the group.
To further substantiate impressions of group decision-making and conflict resolution which were gained in phase III, the last section of the questionnaire included a quantitative measure of individual patterns of conflict style, which may affect the orientation to power in the organization. This quantitative approach supports impressions of group behavior. Impressions of conflict in the group were difficult to verify because of the number of people involved and the risk of breach of confidentiality. By using a more objective measure and framing it in the group context, individual differences could be minimized in light of average group scores.

Participants were given verbal instructions to rate their conflict resolution behaviors in the team context. It was anticipated that differences between groups in conflict resolution style would reflect differences in rules for behavior in each local culture.

The Organizational Communication Conflict Instrument (O.C.C.I.; Putnam & Wilson, 1982), which appears in Appendix H, measures conflict style along three dimensions: nonconfrontation, solution-orientation and control. The reliability of these subscales, as established by Putnam and Wilson (1982), is 0.93, 0.88 and 0.82 on the scales, respectively. Subsequent studies of the validity of this instrument suggest that responses are contingent upon situational variables. The dimensions of the instrument are defined by Putnam and Wilson (1982) as:

1. Nonconfrontation: indirect strategies for handling a conflict: choices to avoid or withdraw from a disagreement; such communicative strategies as silence, glossing over differences and concealing ill feelings.
2. Solution-orientation: direct communication about the conflict, behaviors that aim to find a solution, to integrate the needs of both parties and to give in or compromise on issues.
3. Control: direct communication about the disagreement: arguing persistently for one's position, taking control of the interaction and advocating one's position. (p. 647)

The style of conflict resolution relates to cultural assumptions about social power in two ways. First, the conflict resolution style reflects attitudes toward perceived cultural norms. A style, such as solution orientation, may be selected because it is highly valued in the system. On the other hand, the selection of a conflict resolution strategy may either be a default position, used when an individual implicitly knows not to resist, or may be selected when the individual understands that s/he will ultimately win or lose because of their status in the organization. For
example, in a conflict between departments, nonconfrontation may be selected because "it won't do any good anyway" (they lack the resources to create change). On the other hand, in a conflict between physician and physical therapist, nonconfrontation may be selected because the therapist understands that the physician will win (ideological control) and the physician understands that s/he does not need to exert energy to control, since compliance will be automatic.

Prior to the conclusion of the study, two key "panel" members were formally interviewed to verify impressions. I selected these two individuals because they were members of more than one team and could provide comparison data. Further, the physician director of one of the teams was interviewed to gain further insights into the interaction in that team.

At the conclusion of the study, it was agreed that I would return to the organization to present a summary of my findings. This presentation would include an analysis of prevalent themes and metaphors in the organization and a discussion of communications patterns which operate in the culture. Team analysis would be provided, upon request, along with possible directions for organizational change. This presentation addressed the expressed need of the Executive Director for more information about the organization.

Chapter III has provided an overview of the methodology used in the study of organizational culture and social power. In this discussion, I have explained the variables in the study and the methodological approach used to collect data about the organization. In Chapter IV, the significant data are presented as they relate to the three guiding research questions. Following each section of data presentation, a general discussion of the implications of the data is presented.
Chapter IV presents a description and interpretation of the data collected in the study. As described in Chapter I, the data collection was guided by three research questions:

1. How do the explicit cultural themes revealed in organizational philosophy, structure, values, roles and relationships shape the exercise of social power?
2. How do the implicit cultural themes suggested by historical values, beliefs and material conditions shape the exercise of social power in the organization?
3. How do members of the organization cope with the strain created by incongruities between the explicit and implicit assumptions about the exercise of social power in the organization?

In Chapter IV, these three questions are addressed through the interpretation of data from the field analysis. The chapter is divided into three sections which represent the three research questions: explicit cultural themes, implicit cultural themes and patterns of coping with incongruencies. After a description of the data in each section, I offer an interpretation of the data in light of its implications for the exercise of social power in the organization.

**EXPLICIT CULTURAL THEMES**

The first section explores how explicit cultural themes shape the exercise of social power in the organization. Following a general description of the organization, I describe philosophy of the larger medical center and the target system and discuss the linkages between the two. I describe formal and informal channels of communication in
the organization as explicit structures in the cultural system. Social events and orientation programs are discussed as processes of enculturation which serve to communicate explicit themes. Finally, I discuss the values which are expressed by members of the organization. Data were gathered from three sources: the description of the ideal manager given in interviews, the description of desirable conflict management and decision-making strategies related in the interviews and the description of individual and organizational values gathered from the SYMLOG analysis. Data are then woven into a discussion of the explicit themes of the culture. In the final discussion of this section, I offer an analysis of the implications of the data for the exercise of social power. Specifically, I note how explicit themes define functional status relationships and determine when conscious power strategies must be used in order to achieve a goal. Explicit themes further affect power by shaping perceived bases of (manifest) power and legitimizing certain power strategies and modes of reward and punishment. Finally, I discuss how explicit themes of the organizational culture affect the use of social power by determining how an individual may influence another by shaping that person's needs in order to gain compliance.

For the purposes of the remainder of this discussion, the larger medical center complex is referred to as the macrosystem and the rehabilitation hospital is referred to as the target system. A description of these two elements and their relationships broadens the understanding of the remainder of the data.

THE ORGANIZATION

MACROSYSTEM

Situated in a midwestern city with a population of approximately 600,000, the hospital system is a multispecialty, comprehensive health care facility, with approximately 1000 beds. The institution is supported by state subsidies, since it is a part of a state university. The medical center complex includes six buildings:

1) An acute-care facility, with approximately 850 beds, housing operating rooms, recovery rooms, intensive care units, pharmacy and clinical laboratories

2) A facility which houses physicians' offices and laboratories

3) A psychiatric facility, with approximately 100 beds, which provides
services for adult and adolescent patients, as well as an eating disorders and sleep disorders clinic
4) A clinic building which houses 40 specialty clinics and an outpatient renal dialysis unit
5) An outpatient mental retardation treatment center
6) A rehabilitation hospital, with approximately 70 beds, housing physical, occupational, speech and other therapies.

In addition to the present buildings in the medical center complex, the university is constructing a 160-bed cancer research institute and planning for an arthritis and geriatrics center which will be built next to the rehabilitation hospital.

This health care system is associated with a large, midwestern university. Of special note are the large educational programs in medicine, nursing and allied health which are provided by the university. These programs all have student experiences in the target system.

In the following section, I provide a general description of the target system. This description includes a summary of the staff in the hospital and the patient care teams as well as a brief description of the general ambiance of the building.

THE TARGET SYSTEM

The target system was initially established in early 1960's as a state rehabilitation center. It became a part of the university medical complex in the mid 1960's and was complete in its present physical plant in early 1970's. Originally, the center had approximately 30 inpatient beds; it now has approximately 70.

The largest department in the center is the nursing department, which has 66 staff full-time equivalent positions. This includes: two head nurses, four assistant head nurses, an assistant director who is acting nursing director, a clinical specialist, an outpatient rehabilitation coordinator, a head nurse in the pain program and complement of registered nurses. Other staff in the center include:

1) Physical Therapy (eleven licensed Physical Therapists, including the director and seven aides)
2) Occupational Therapy (ten Occupational Therapists and one assistant)
3) Social Work (five full-time equivalent positions, including the director)
4) Speech Pathology (three Speech Therapists and two interns)
5) Psychology (three Psychologists, including the director; one intern, one psychometrist and one research assistant)
6) Recreational Therapy (one coordinator and one assistant)
7) One Exercise Physiologist
8) One Driver's Education instructor
9) One Dietician
10) Housekeeping (sixteen employees, including the director)
11) Administrative services

The staff of the hospital provide rehabilitation services for a broad spectrum of patients. Generally, these patients are assigned to one of five clinical services: spinal cord injury (includes patients who are left with varying levels of paralysis as a result of a spinal cord injury, often traumatic), head trauma (frequently individuals who have suffered head injuries and brain damage from automobile accidents and/or are recovering from unconsciousness or coma), pain management (patients on this service are usually victims of intractable pain which has affected their lives to the extent that they are suffering problems with weight control, loss of job, etc; this service focuses on helping the patient cope with the pain rather than eradicating it) or one of two general rehabilitation teams.

The general milieu of the hospital reflects the emphasis upon rehabilitation. The front doors automatically open to a newly remodeled waiting area that is frequently empty. Chairs and sofas in the room are built up to accomodate wheelchair transfers. Occasionally, a transportation van is parked in front of the doors and the doors opened by someone maneuvering a wheelchair through them. Patients in wheelchairs are found waiting outside of the elevators; some watch television while others wait to be transported or to transport themselves to therapy. Often, they carry a schedule of the events of the day with them; each treatment with its own separate time.

Despite what would seem to be a very depressing clinical situation, the atmosphere was remarkably positive. Staff bustled about, talking to each other and to the patients. Family members waited patiently and accompanied their spouses, friends or children to therapy. Patients and staff as well gathered in the canteen (vending room) for coffee, cigarettes and snacks.
A majority of my time in the building was spent in interviews and team meetings. As I waited for these events, I often used the opportunity to watch the activity in the waiting areas outside the elevators and in the canteen and hallways. The offices for each department are scattered throughout the building. With the exception of the physician's offices on the first floor, each department head has an office in their respective department.

With this understanding of the macrosystem and the target system, it is helpful to also explore the linkages between the two, since this relationship occupies an important place in the speech imagery of the target system.

LINKS BETWEEN THE MACROSYSTEM AND THE TARGET ORGANIZATION

The rehabilitation hospital is remote from the main buildings in the medical center, located in a separate building two blocks away. Although the buildings are connected by tunnels, managers and staff express a sense of isolation. This isolation is further accentuated by the formal communication linkages between the target system and the macrosystem.

Prior to the recent organizational changes implemented by the Executive Director, administrative links between the rehabilitation center and the main hospital were, at best, fuzzy, with many specialty services answering to different administrators. This resulted in a general lack of cohesion and goal orientation among the department heads.

This lack of connection to the mission and administration of the main hospital system is illustrated in the frequent reference to the "big house" and "over there" by the staff in the rehabilitation facility. There is a significant "step child" imagery evident in the references made to the main hospital. Staff and department heads often feel that their needs are given low priority in the system, and that their services are not valued as highly as others ("treated like a second class citizen"). This attitude is readily evident in the physical plant of the rehabilitation facility. While the main hospital is under constant renovation and improvement, the rehabilitation facility remains largely unchanged except for a recent remodeling of the lobby. A department manager noted that he believed patients in the rehabilitation hospital were less valued in the system. There appears to be a stigma attached to the patient class which carries over to the care-givers. Here is the following explanation:
Bad things happen to people who are bad...in the sense that if you end up disabled, you must have screwed up somewhere and that perception of the disabled has been demonstrated to generalize the people who work with the disabled...If you work with the disabled you must in some way, shape or form be less capable than people who don't, because if you weren't, why else would you be doing it. Why would you be working with this less fortunate population of people?

Thus, while the rehabilitation facility is a part of the larger medical center system, it remains functionally isolated from it. This has resulted in a "step child" perception which appears to have affected both the operation of the organization and its culture. As a result of the isolation from the main system, the rehabilitation facility has a strong local culture which is clearly reflects its clinical mission. This system has remained untouched by many of the profound economic and social changes which affect divisions in the system. Further, the management staff has been very stable over time, thus developing a historical base which serves to enhance the tenacity of patterns in the local culture. These patterns and themes in the local culture tend to reflect the implicit ideological assumptions of the "traditional" material and patterns of dominance in the health care industry.

The rehabilitation specialty has not experienced the market competition which is so prevalent in other medical specialties. Nonetheless, the physician remains the controlling force in the system. In a majority of clinical specialties, patients come to the system because they have consulted a physician for treatment. This gatekeeper function tends to legitimize the dominance of the medical profession. In the rehabilitation setting, however, patients come for a variety of services in one setting, thus legitimizing a more egalitarian system. It is interesting that, despite the perceived legitimacy of the egalitarian approach, the pattern of medical dominance remains an implicit ideology of the organization.

With this understanding of the nature of the target organization and its relationship to the macrosystem, I will now discuss the philosophy of each section. The philosophy of an organization represents the explicit organizational paradigm which shapes the organization and its relationship to the external environment.
ORGANIZATIONAL PHILOSOPHY

PHILOSOPHY OF THE MACROSYSTEM

The 1984 annual report from the hospital summarized the mission of the system as "Teaching. Research. Patient Care. This is the threefold mission of the... College of Medicine and Hospitals as we continue to provide the highest quality of health care in a most cost-effective manner". This statement emphasizes the impact of the medical educational system upon the health care institution. Following a long philosophical tradition which emphasizes the importance of medical education, this health care system integrates the teaching and research emphasis with the delivery of health care to patients. The importance of medical education in this system is further emphasized by the appointment of the Dean of the College of Medicine as the Vice President of Health Services in the Hospital in 1983. With this appointment, the Executive Director (chief executive officer) of the hospital is given the title of Assistant Vice President for Health Services in the University, and answers directly to the Dean of the Medical College.

As a part of the first phase of data collection, I reviewed four years of annual reports and employee newsletters. These newsletters contain articles about staff and news of upcoming events. This medium is the most uniformly read by the hospital employees and, thus, serves as a major communication link between administration and the workers. As such, it is the most likely vehicle for the administration to use to try to develop a common framework about the organization. I discovered that the newsletters reflected the variations in the emphasis of the organization. This was especially evident in the section entitled "Employee of the Month". The article about this employee describes his or her history in the organization and personal attributes which led to the award. While many of the descriptions included such adjectives as: pleasant, courteous, positive, empathetic and/or sensitive, they more frequently described employees as: reliable, meticulous, competent, dedicated, efficient, flexible, concerned with patient care and safety, capable, diligent, accurate, willing to go beyond job expectations, hard-working, exceptional problem solving ability and/or works in a systematic manner. While many of these attributes are highly valued in any employee, they were emphasized in the articles which described the "best" that the system had to offer.
The employee newsletter of January, 1983 announced the beginning of a new, system-wide cost-effectiveness program. During the next few months, the bi-monthly newsletter presented news articles about changes in the organization which were focused on cutting costs; at least one article in each issue was devoted to the program.

The April, 1984 newsletter announcement that the Executive Director was leaving the University post. In his praise of the Executive Director, the president of the University noted that "His management skills have resulted in more efficient use of the hospitals' resources and employee morale and productivity have continued to improve". The Executive Director described his vision for the organization in his hospital newsletter farewell to the employees of the hospital: "This is a time for all of us to look forward. The thread of excellence, integrity and competence are the forces to take our medical complex to greatness". In another article in the same edition, the Executive Director noted that "We have to be sure that patients leave on time, that food is not wasted, record keeping is done promptly and that in general the hospital runs very efficiently and everyone demonstrates absolute competence in their work."

Thus, it is evident that the administration highly valued efficiency and cost effectiveness during the early 1980's. This emphasis began to change, however in 1984, with the announcement of a system-wide program called "We care", which emphasizes positive patient relations. As a result of this program, employees were given awards for such things as being mentioned in a complimentary patient letter, selected "Employee of the month" or doing something special for a patient. This program seemed to mark an important shift in the image presented in the newsletters. From this point on, the descriptions of the "employee of the month" emphasized the "quality of caring" through descriptors such as: compassionate, pleasant, understanding, patient, considerate, calm, courteous, kind, cooperative, caring, calm and/or conscientious.

The changing focus of the mission of the medical center is perhaps best reflected in the philosophy of the administration of the system. In April of 1985, a new Executive Director was hired to fill the post which had been vacant for the past year. In his first public communications, the new C.E.O. clearly outlined his expectations for the organization. His first goal, he stated, was for everyone to learn to work with his six values:
openness, competence, initiative, accountability, loyalty and cooperation. Openness evokes honesty and integrity. Competence signifies having the basic skills to do your job while at the same time recognizing that one still needs to grow. Initiative implies risk, so I hope we can all be judicious risk takers. Accountability is all important, because we must all be responsible for the actions we take and be willing to learn from our failures as well as our successes. We are accountable to our patients, management and especially each other.

Teamwork is articulated as a core value in the current Executive Director's philosophy of management, and relates to his value for loyalty and cooperation in the organization. He identifies teamwork as the "key factor in making the organization work", noting that it includes a sense of "chemistry" and "trust" along with "agreement on philosophy".

Further, the new Executive Director advocates participation in decision making, trust and openness in communication. He expects people to "take risks and fail". In my interview with him, he noted that individuals should be "held accountable for the decisions that they make. When they are right, we congratulate them for succeeding; when they fail, we congratulate them if they pick themselves up and they sit down and evaluate what they did wrong and what they would do differently." He expects that individuals will be loyal; loyalty means "speaking up and speaking out. It doesn't mean yessing (me)". Thus, the ideal culture, according to him, would be one which would feature conflict and foster collaboration in decision making. He emphasizes that individuals should not have confidence in him, but should have confidence in themselves.

Finally, the Executive Director expressed the organizational mission differently than the past administration. Rather than emphasizing organizational efficiency and the teaching focus of the institution, he summarized the focus in stating "...we need to emphasize where we came from and who we serve. The patient is the one who must profit from all we do."

The interest in "where we came from" was reinforced further in my interview with him. He noted that every organization has some matriarch or patriarch type who functions in that role and gives the organization stability. His hope was to "find some of the matriarchs and patriarchs among our departmental directors to create those hero types and give them an opportunity to succeed." He also expressed an interest in creating positive traditions to bring people together at times other than "life and death and Christmas".

The new Executive Director clearly articulated his desire to change the culture of the organization. His approach to that change included several stages. The first stage was a sensing
or assessment of the culture on an administrative level. He accomplished this by interviewing many key administrators and managers in the macrosystem. Additionally, his interest in understanding the local culture seemed evident in his support of this research in a subunit of the organization.

The second step in cultural change was a public statement of his values and expectations. In magazine interviews, he clearly and consistently communicated the core values of "openness, competence, initiative, accountability, loyalty and cooperation". It is interesting to note that these values were also clearly defined, leaving no room for ambiguous interpretation of his expectations.

In addition to shifting explicit themes, a third part of his cultural change involved a change in the explicit, formal structure of the organization. This reorganization came after several months of evaluation and interviewing and was openly discussed before it was announced. The change in organizational structure eliminated three Assistant Executive Director positions and "flattened" the organizational chart.

The fourth strategy for cultural change was focused on the local level. The Executive Director noted the importance of the "history" of the organization which is implicitly expressed in the local culture. His strategy was to take some of the more tenured people in the organization and create "hero-types" by assisting them to succeed. His emphasis appeared to be to use local opinion leaders to create cultural change by influencing them to accept his values and expectations. He then would feature their behaviors in the organization as evidence of success in the new cultural system. It was clear that the Executive director intended to reinforce behaviors by featuring them in the organization. This reinforcement, over time, would create cultural change.

Turning now from the macrosystem to the target organization, I will describe the philosophy of that system. A remarkable difference in focus is expressed there. While the administration of the macrosystem attended to values for teamwork in management, the target system expressed a philosophy which was related to the clinical focus of the system.

**PHILOSOPHY OF THE TARGET SYSTEM**

One of the most remarkable characteristics of my interviews with department heads in the rehabilitation facility was their congruence in philosophy of the organization. Without
exception, each person I interviewed said the philosophy of the system was to rehabilitate patients. This clinical focus means:

>We are not really providing curative types of services. Other places in the hospital are not providing these types of services either, but over here .......we are trying to maximize whatever potential the patient has; focusing on the abilities they have, trying to work with those abilities and to get them as independent as possible....We help them to regain whatever level of health they are capable of.....It may not be the level they were functioning at prior to the disability, but certainly an optimum level for them.

The philosophy of rehabilitation is pervasive and prevalent in the target system. This focus defines the local culture, which is quite distinct from the macrosystem. In an acute care setting, the focus of clinical practice is curative or palliative; in a rehabilitation setting, the focus is restorative. The goal of acute care is returning the patient to a healthy state or assisting the patient to cope with terminal illness; the goal of rehabilitation is to help the patient achieve his or her maximum potential for function within physical constraints. Generally, society tends to value curative approaches more than rehabilitative, because of the potential for return to society.

The differences in clinical focus in the local culture serves to accentuate the sense of isolation in the rehabilitation hospital. This isolation may mean fewer resources or administrative support for the rehabilitation hospital. The "stepchild" theme, however, serves to strengthen the local culture by emphasizing the "specialness" of the system.

The strength of the "rehabilitation" theme in the target system is also due to the management practices. Most of the department heads in the rehabilitation hospital also provide direct patient care. Thus, the managers share the common patient focus which is the foundation of the local culture. This clinical focus, in turn, shapes management style as well as patient care. This may, in part, explain the clinical focus of their philosophy.

Extending the rehabilitation theme to the management practices, some interesting patterns are seen. For example, a rehabilitative focus may make the limits of achievement more salient than the possibilities, since patients in this clinical situation may have very real limits to their expected recovery. There may, further, be an emphasis on the concrete, rather than the abstract, since physical recovery is a major focus in the clinical setting. The members of the organization may tolerate a certain degree of passive/aggressive (acting out) behaviors from each other, because they expect that from their patients. This relates, in part, to the attitude of
powerlessness which comes with the disability. As one department head stated:

When you are sick you are allowed to relinquish your role....but you are responsible for seeking professional care. You accept that care and then you become well and you are back into your role in society. A person who has a physical disability, in a sense has a new role superimposed on (him)....it does not necessarily allow the person to go back to their role in life, but they have other things to learn....that is superimposed upon (them).

This attitude of powerlessness ("learned helplessness") carries over to staff interactions as well. In an interview with a staff member, it was noted:

I think it has got a little something to do with learned helplessness....When I first came here I had a lot more energy to fight things that I thought were not working well and I learned that it did not change the course of things...so I don't even bother to call them...I exhausted every possibility...I did everything I could.

Later, in the same interview, this person was discussing how patients "act out" against the staff:

The problem is in this kind of structure, even if you assert yourself productively, you are not going to win...it's still going to go the way the staff wants it. So, I think patients fight less and less the longer they stay here...They realize they are not going to win...and some of us see that as just a kind of natural adjustment when they stop fighting.

The close parallels between staff attitudes and patient behavior is clearly evident in this conversation. It is considered "normal" to resist control and try to change the system early in the rehabilitation process, but the patient (and staff) soon learn that they are powerless to change the system and give up. This "learned helplessness" leads to a sense of complacency and acceptance of the limitations of the system (or physical impairment).

With this sense of the major themes of teamwork, efficiency and caring in the macrosystem and rehabilitation and stepchild in the local culture, I will now turn to a discussion of the modes of communication in the organization. In this section, I will address explicit communication channels in the macrosystem and modes of communication which tend to strengthen themes in the target system.
COMMUNICATION CHANNELS AND STRUCTURES

While the primary focus of my data collection was not an analysis of communication channels and structures, I did observe a number of communication events which are salient to the understanding of the themes which operate in this culture.

Concomitant with the change in top administration of the medical center, there was a reorganization of the channels of communication through the formal organizational chart. Four management and administrative personnel who had functioned under the former administration noted how information was not shared vertically. Rather, decision-making was focused in the Assistant Executive Director level of the organization. The reorganization of the system eliminated this level of the administration and functionally realigned many elements of the organization. The resultant structure (Appendix I), strengthened administrative links between the target system and the macrosystem. It is important to recall that the Vice President for Health Affairs in the university is also the Dean of the medical school and the immediate supervisor of the Executive Director of the hospital. Thus, the dominance of the medical profession, which is a pronounced part of the historical ideology, is reified in the organizational chart.

The remainder of my discussion about communication channels and structures will reflect activities in the target system. Here, the informal channels appear to be more closely aligned with the patient care process than the management perspective. The focus of communication around clinical activities serves to strengthen the rehabilitation theme in the local culture and further set it aside from larger organizational goals and structures.

With the exception of communication about the patient’s clinical progress, a majority of communication in this system is accomplished in a telephone-mediated or face-to-face, verbal mode. For the most part, written communication is reserved for “official” interdepartmental issues. Often, these written communications are used to follow through on resolution of conflicts. It is generally acknowledged by all department heads in the system that they prefer to use a direct, interpersonal approach first, but will follow through with a written memo to solidify agreements and understandings, especially between departments.

Team communication differs from the interdepartmental processes. Every week, before “panel” meetings, a list of patients who will be discussed is circulated to the members of the team. This enables nurses and others who only care for a few patients to only attend a part of the meeting. The responsibility for this list usually rotates from service to service. This panel list also
serves as a bulletin board for team communication, since some teams will make notes of social activities or reminders of future events. There appears to be an unspoken legitimacy awarded those who get put on the panel list. In fact, the new dietician who had started just before I began the study, was struggling to get "put on the list". She perceived that, up to that time, she had been "added on" to the list and, thus, was not a legitimate member of the team. Thus, this list becomes a mechanism for team identity as a communication structure.

One very important part of the communication structure in this system is the patient chart. The patient chart is the primary mode of clinical communication. Through this chart, members of the team document their activities with the patient and their perceptions of the patient's progress. Of particular interest in this system is the persistence of the traditional medical approach to record keeping despite the "team" approach to care. In traditional systems, the physician is the "captain of the ship" who is responsible for planning and ordering the patient's treatment and recording the progress of the patients. These orders classically include directives for all allied health professionals and nurses and the progress note is seen as encompassing all treatment regimens. Under the team system, however, the goals for the patient are supposed to be mutually set by the team members, according to everyone's clinical expertise. It is the physician, however, who has the power of information control in this system. During panel meetings, the physician controls the charts and writes summaries of the patient's progress. Thus, despite the input from all members of the team, the physician continues to communicate as if the system were operating under the traditional medical model.

Communication channels and structures formally reinforce status relationships in the organization. Specifically, they reinforce the dominance of the medical profession in the organization. Team communication patterns further perpetuate this legitimate dominance through the informational control over the patient's chart. These channels and structures explicitly form power relationships in the organization. However, social events serve to pass on cultural information in a more informal way. In the following section, I will discuss a variety of social events of the macrosystem and the target system.

**SOCIAL EVENTS**

Social events are occasions which may serve to emphasize explicit status differences or give permission to diminish their importance. Social events serve to solidify cultural themes by
providing shared experiences upon which to build a common frame of reference. The social activities of the rehabilitation hospital contribute significantly to the development of local culture, through their emphasis on patient activities. In this section, I will discuss five general categories of social events in the rehabilitation center: system-wide social activities, departmental social activities, team social events, interpersonal (friendship) activities and social events which include the patients. For the most part, these events are planned by a cross-service committee of staff and management.

System-wide social events provide an opportunity for the staff to interact with top level administration. Through their participation in these events, the administration of the hospital communicates concern and appreciation to the employees. Additionally, during these events, there is an opportunity for both staff and management to set aside status differences and develop shared experiences. These experiences lead to the creation of a social meaning which may transcend organizational reality. This is especially important during times of organizational change, since the social reality provides a sense of stability and security in the organization. The Christmas party, Halloween party, employee recognition dinner and Run for Fun are events which are planned and carried out on a central level. My impression was that these events are treated as rather commonplace in the system. This was reinforced by the fact that the employee newsletter ran the same picture of the Halloween Party two years in a row!

The Christmas Party is usually an event which is put on by the food service for the employees. A party is held in the cafeteria the week before Christmas, usually for two hours in the afternoon. Night-shift employees are treated to a continental breakfast in the morning. This party is built around a central theme and includes food, festivities and a visit from Santa Claus. Employees only attend, with meal tickets distributed to them by their supervisors.

The Employee Recognition Dinner, held every spring, is a "gala affair" designed to recognize those employees with perfect attendance the year before and those with more than five years of service. Generally, the event begins with a reception "highlighted with classical music, shrimp, silver candelabras and fresh flowers". Following the reception, there is an awards ceremony and then a dinner for those with more than 25 years of service. Service pins are distributed by members of the Executive Council. It is interesting to note that, in 1984, the Executive Council presented the Executive Director a special award as "Employee of the Year" on behalf of the employees of the hospital.
The Halloween Party is like many other special events planned by the food service division. With special treats served by administrative staff in costume, this "theme" event is a special function for the employees.

The annual "Run for Fun" is a different type of event in the system. Unlike the social activities I have just described, this event is a drive to raise funds for the medical center and a nearby children's hospital. Approximately 300 employees, families and friends register for the run. This is the only system-wide event which includes families; a children's run was added recently. Medals are presented to the winners by the hospital Executive Director. I found it interesting that the only family-oriented event was the Run for Fun. Not only does the system recognize and reward tenure with the hospital (Employee Recognition Dinner) but also physical fitness (Run for Fun). Other accomplishments are recognized in the newsletter, rather than in a social event.

These system-wide social activities are frequently not well attended by staff in the rehabilitation center. Noting that they are "too far away", the staff of the rehabilitation center have asked, in the past, that the cafeteria have a Christmas party just for them. This further emphasizes the isolation of the rehabilitation hospital from the main system while reinforcing local culture. Essentially, the separate social events promote an in-group orientation which functions to lend stability to local culture through local social customs.

Departmental social functions seem, to some degree, to replace these system-wide events in the rehabilitation facility. At Christmas-time, each department planned its own separate social activity. These activities were usually dinners or parties at someone's house. Since most of the departments are small, these events are usually collaboratively planned and carried out. Each department sets its own rules about who attends these social gatherings. For example, in the occupational therapy department, Christmas parties had always included some people from other departments and spouses and children as well. When the numbers got too big, however, the party was made "adults only". There are many more spontaneous or informal departmental parties. These usually center around someone leaving or having a birthday or a baby; often they involve students or interns coming or going from the system. Many departmental activities may be spontaneous, informal friendship groups which gather after work. The departmental social events reinforce departmental interests over collaborative interests. Few interdepartmental
functions occur separate from team activities. This fragmentation is congruent with the clinical approach which emphasizes the independent role of each therapist.

There are other activities, however, which bring individuals together from different departments in the rehabilitation center. These include activities such as the volleyball team and various clinical team social functions. These functions, for the most part, are less structured than a Christmas party. Rather, they are spontaneous gatherings of groups of people for "pot lucks" or drinks after work.

It seems, then, that the most significant types of social events in the culture in the rehabilitation center are those which occur within departments and those which involve the team members. The team, then, becomes a primary mode of bringing the entire organization together in a common activity. This team activity reinforces the "rehabilitation" theme of the local culture.

My general impression was that these functions are mixed social and business. For the most part, the topics of conversation are both personal and business, but are not supposed to be too "heavy". One nursing service employee noted that she used to go to lunch with a group of people but stopped because they always "talked shop".

The rules for attendance are not clear. Generally, the staff believed that they "should" attend the more formal affairs, such as the department Christmas party, but the more informal events, such as T.G.I.F. gatherings, were less obligatory. Physician attendance at social gatherings varied with the individual. One team physician felt that the social activities were important to be able "to see the other members under a different setting, not just the hospital setting". This particular individual limits close friendships to one or two working colleagues.

Team social activities are generally informal. Often, food is brought to the "panel" meetings and shared with everyone. Frequently, the monthly "team" meetings are a time for social (eating) activities. These meetings are usually collaboratively planned, with everyone bringing a dish or contributing to pizza, etc. At one panel meeting, a bouquet of balloons was delivered in honor of one of the therapist's birthdays and everyone sang to her. There appears to be a concerted effort, on the part of some teams, to emphasize the social events. The teams spend a part of their meeting times making arrangements for the luncheons, etc.

A number of social events in the target system revolve around the coming and going of students, residents and interns. This reinforces the importance of the teaching function in this hospital system. Teams will have special luncheons to welcome new residents and parties to
mark their leaving. These gatherings seem to have ritualistic overtones, as suggested by the fact that they are "expected" in the system. One resident even called after he left to see when the group was going to go out for his party. As one team member noted, "We really didn't do anything for him (when he left)"; they planned to meet at a local restaurant for drinks after work. Team social events which include students emphasize the explicit philosophy of the organization. The local "team" welcome enables the members of the rehabilitation to develop their own interpretation of these themes through a shared orientation.

The third level of social events in the rehabilitation hospital are those activities which involve the patients. Apart from the usual holiday festivities, patients are involved in a number of social activities as a part of their rehabilitation process. These activities are usually arranged by the recreation therapist, with other staff accompanying those events which require extra help, such as the outing to the state fair. On a department level, the Occupational Therapy Department has "breakfasts" or "lunches" specially prepared by or for the patients. These may be attended by several members of the patient care team who are not members of the department. Patient-related social activities are significant for two reasons. First, they provide an opportunity for the staff to interact with the patients in a non-clinical environment. More importantly, however, these events emphasize the fact that social events are viewed as an important part of the clinical treatment of the patient. They are valued as therapeutic. Thus, it is not only "fun", but significantly important for the members of this culture to engage in regular social activities. This makes the lack of such events across departments all the more conspicuous.

The second type of social events involving patients is more individualized. These events include parties to celebrate markers of progress in the patient's recovery. For example, when a patient progresses to the point that s/he is ready to use a wheelchair, the staff orders the chair and throws a "wheelchair party". A similar celebration may mark a patient's departure from the hospital after a long stay. These events are opportunities for the team members to share in a sense of accomplishment, while acknowledging the patient's progress. This type of social event clearly attends to the inherent values of the local culture: progress toward rehabilitation or discharge.

Collectively, social events in the target system mark the importance of the clinical mission of the organization. By far, the most frequent social activities occur on the team level and involve the "business" of patient care. The second most frequent occasion for social gathering
reflects student activities, thus emphasizing the teaching role of the medical center. In the macrosystem, however, social events are more formal. The more formal events tend to emphasize status differences, because they leave little room for interpretation of the hierarchical relationships. Informal activities, however, are more ambiguous about power relationships, permitting a broader range of behaviors.

Social events provide an opportunity for cultural information to be shared in a ritualized fashion. On another level, cultural information is shared when an individual gains entry into the organization. The process of orientation in this organization occurs through both formal and informal processes. On the formal level, there is an initial orientation program provided by the macrosystem. This program is one day long and focuses on organizational policies and procedures and personnel issues. In the next section, I will describe the orientation process which occurs in the target system.

**ORIENTATION TO THE SYSTEM**

Despite the unique nature of the team approach to care in the rehabilitation hospital, the orientation to the system follows rather traditional patterns. New employees at the hospital go through a one-day orientation in the main system, where they are introduced to the organization and various personnel policies and procedures. After that, each department is responsible for its own orientation to the service. Most of the individuals I interviewed felt that their orientation to the system was rather unstructured. For the most part, nurses are oriented under a "buddy" system, where they work with a preceptor for a period of time before assuming full patient responsibility.

For the most part, orientation for higher status employees is loosely structured. The ambiguity of the process enhances flexibility in role adaptation. Department heads are largely self-directed in their orientation. The normal pattern for orientation was to make appointments to talk with key individuals and "get to know the system". The nursing administrator sent out questionnaires to the staff and management, asking their impressions of the organization. From their reactions, she was able to formulate a set of major goals for the system. The dietician worked with the outgoing dietician for a few days following her orientation to the main system. Before her predecessor left, she left her a set of notes and goals and attended a team meeting with her.

Orientation to the team varies almost as widely as orientation to the main system. For example, in one team meeting, a new therapist was attending with one of the "old-timers". During
the meeting, there was constant communication between them. First, the older therapist explained the format of the meeting and how to give the report. The two wrote notes back and forth almost continually during the meeting. It was clearly evident that the "rules of the game" were being carefully laid out. This was not true in the case of the new resident physicians, however. Rather, the residents were more or less thrust into a position of having to operate in a team format, with little knowledge of the individuals on the team or their capabilities. Only one team planned a formal orientation for the new residents. During this orientation, they planned for the resident first to meet the team informally at lunch; following this, the new resident was to come to the panel meeting without having to play a major role, just so s/he could "observe how (we) do things". There was clear intention on the part of the team members to teach the newcomer the team process early, so that the pattern of communication in the team meetings would not be disrupted.

It is interesting to note that the only professional group that the team members expressed an interest in orienting was the physician group. It was clearly evident that physicians were expected to function in their new role as resident on the team almost immediately. Since this role usually was one of team leader, it was important to the team (but not necessarily to all the attending physicians) that the new resident understand how the team worked. Physicians, unlike other allied health professionals, appeared to spend little time teaching group process. Thus, the responsibility for team orientation was perceived to fall on the shoulders of the non-physician team members.

The level of specificity perceived to be necessary for the physician orientation is incongruent with the more ambiguous orientation of department heads. The important shift appears to be related to who is doing the orientation. The expressed need for lower status employees to orient the physician probably comes from an interest in preserving the communication relationships in the teams. This, in turn, leads to greater stability in the local culture, despite frequent changes in team membership.

Orientation to the team function is a critical continuity issue in the organization. Team members rotate frequently, sometimes as often as every six months. Thus, the new member who rotates to the service must be oriented to the team. Teams vary markedly in their orientation to group process and decision-making. The single most stable member of the team is the attending physician. S/he has the most opportunity to determine the enduring rule structure of the
system. Why, then, is the orientation process so ambiguous? The answer lies in the implicit assumptions of the organization. Eisenberg (1984) notes that ambiguity is necessary to preserve individual initiative and self actualization in the face of the aggregate. Although the team is functionally collaborative, the physician group is dominant in the ideology. When the "rules" of the system are not explicitly demonstrated through physician dominance, individuals are free to attribute their own meaning to the behaviors of others in the group. In other words, individuals may assume the intentions of the other team members (give them the benefit of the doubt) when that intent is not clearly specified.

Orientation not only passes on behavioral norms, it describes, for the member of the organization, significant values. In my data collection, value orientation was addressed in interviews and the SYMLOG group assessments. It is important to bear in mind that the values which are related in the following section are explicit values. These are the individual interpretation of ambiguously stated expectations for ideal behavior. In general, the ambiguous expression of values in this organization enables multiple interpretations while at the same time preserving a sense of unity (Eisenberg, 1984).

**EXPLICIT CULTURAL VALUES**

During the interviews with department heads in the rehabilitation system, I asked each person to describe the characteristics of the ideal manager. I further asked them to define excellence for me, since this theme had been expressed in the public communication of the past administration. These questions were designed to gain a perspective on the values of the administration of the system and its orientation toward growth and change.

Twelve department heads interviewed described the ideal manager as a "team player" or "someone who has a rehab focus". Further, "openness" and "honesty" were mentioned by eight of the twelve department heads. Seven department heads also identified that a good manager in the system had to be flexible, creative and a self starter. While these values are explicitly stated, their meaning remains obscure. Unlike the Executive Director, who clearly defined what he meant by various qualities, the department heads were vague in their interpretations. This was especially evident when I asked the twelve department heads to define excellence. Each individual had his or her own interpretation of how excellence was measured
and defined. Although they agreed with the concept and value of excellence, each defined it differently. Two of the more tenured managers mentioned efficient use of resources as a sign of excellence while the three newer managers mentioned visibility and a national reputation as signs of excellence. Similar patterns are seen in the definition of the team. I was told by all twelve managers that the teams varied with the personality of the physician who was in charge of the service. This was the first hint of the ambiguous definition of the expectations for team function.

Members of the teams were given an opportunity to further define the team concept in the fourth phase of the analysis. I asked team members to expand upon the concept of team, by identifying the type of team they believed they were working with. The team types were designed to represent three separate types of power relationships. All assumed that there was a legitimate coach. The football team represents the classical medical ideology, with the coach in control, just as the physician is under the classical "captain of the ship" doctrine. The baseball team represents the most ambiguous type of ideological structure. Representing autonomy in practice, the baseball team has the greatest flexibility in individual function. The basketball team, on the other hand, was believed to represent a more collaborative form of governance, with the group really determining the outcome of the game, not the coach. Using the questionnaire in Appendix D, team members were first asked to identify the type of team they had and justify their choice. Table 1 lists the identification of the type of team by group membership.

Table 1
Identification of Type of Interprofessional Team

<table>
<thead>
<tr>
<th>TEAM TYPEa</th>
<th>GROUP</th>
<th>FOOTBALL</th>
<th>BASEBALL</th>
<th>BASKETBALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEAM A</td>
<td>9</td>
<td>22.2</td>
<td>55.6</td>
<td>22.2</td>
</tr>
<tr>
<td>TEAM B</td>
<td>7</td>
<td>0</td>
<td>57.1</td>
<td>42.9</td>
</tr>
<tr>
<td>TEAM C</td>
<td>7</td>
<td>28.6</td>
<td>42.8</td>
<td>28.6</td>
</tr>
<tr>
<td>TEAM D</td>
<td>6</td>
<td>16.7</td>
<td>83.3</td>
<td>0</td>
</tr>
<tr>
<td>TEAM E</td>
<td>7</td>
<td>0</td>
<td>28.6</td>
<td>71.4</td>
</tr>
<tr>
<td>COLUMN TOTAL</td>
<td>36</td>
<td>14</td>
<td>52.7</td>
<td>33.3</td>
</tr>
</tbody>
</table>

aIndicates percent of group indicating team type
Nineteen of the 36 respondents identified their team as a baseball team (52.7%). The only noticeable difference between the teams was on the pain service, where 5 of the 7 team members (71.5%) stated that they thought the team was a basketball team. Overall, 84.2% of the respondents felt that this type of team was appropriate for the task at hand. This is consistent with the group observations. Team E appears to function with much more mutual interaction than the other services (a basketball team type). The coach of that team is less identifiable, as is seen in Table 2.

Table 2
Identification of Team Coach

<table>
<thead>
<tr>
<th>GROUP</th>
<th>N</th>
<th>M.D.</th>
<th>PSYCHOL.</th>
<th>COMB.</th>
<th>TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEAM A</td>
<td>9</td>
<td>66.6</td>
<td>0</td>
<td>33.3</td>
<td>0</td>
</tr>
<tr>
<td>TEAM B</td>
<td>7</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TEAM C</td>
<td>7</td>
<td>85.7</td>
<td>0</td>
<td>14.2</td>
<td>0</td>
</tr>
<tr>
<td>TEAM D</td>
<td>7</td>
<td>71.4</td>
<td>14.2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TEAM E</td>
<td>8</td>
<td>12.5</td>
<td>37.5</td>
<td>37.5</td>
<td>12.5</td>
</tr>
<tr>
<td>COLUMN TOTAL</td>
<td>38</td>
<td>65.8</td>
<td>10.5</td>
<td>21.1</td>
<td>2.6</td>
</tr>
</tbody>
</table>

\(^a\)Indicates percent of group identifying this person as coach
As is clearly indicated by this table, most of the team members identified the physician as the coach of the team. If we removed Team E from the data, 80% of the team members identified the physician as the coach of the team. It is clear, from the group observations, that Team E has much more blurred boundaries between services and a collaborative approach to decision making.

Although the participants acknowledged that they functioned reasonably autonomously in the organization, they identified the dominance and guidance of the medical profession in the organization. Further, all but four respondents stated that they thought the team structure and coach were appropriate for the task at hand. The baseball team structure provides the greatest flexibility in function to the members of the organization. When faced with the strain between functional expectations and the underlying ideology, this autonomous structure probably serves to prevent conflict and challenges against the implicit themes of the culture. The selection of the baseball team as the metaphor for the functional system is a further illustration of the way ambiguity is used in this organization. Of the three types of teams used in the analysis, the basketball team and football teams have the most explicit structure. Football teams function under the direction of a central coach authority while basketball teams have more explicit expectations for player interactions. Clearly, the baseball team provides the greatest room for individual expression.

The ambiguity of the team structure facilitates the coexistence of competing ideological systems in the organization. The implicit assumptions of the "medical model" assume that a single group is dominant (the physician); the implicit expectation for team function, however, assumes a more egalitarian and altruistic approach. These competing ideologies are managed well in "baseball team" systems. This structure creates ambiguous power relationships, thus obscuring potential conflict. It further allows each team member to maintain control over their own practice, while the physician is in ultimate control of the therapeutic program. Thus, the individual therapists have the freedom to adopt any number of interpretations for behavior in the team meetings and the system continues to function with little struggle.

In their completion of the SYMLOG group behavior inventory, team members were given an opportunity to rate each other according to their perceptions of group behavior. The SYMLOG analysis places the individual in a three dimensional space, along the dimensions of dominance
(upward/downward), friendliness (positive/negative) and instrumentality (forward/backward). The average scores for these subscales are plotted on graphs which appear in Appendix F. These data are derived by averaging each team member's assessment of their own and other team member behaviors in the group meetings. Generally, raters were similar in their evaluations of each other. Table 3 demonstrates inter-rater reliability for each group along the three subscales of the SYMLOG behavioral inventory.

Table 3
Inter-Rater Reliability\(a\) of Assignment of Group Behaviors:
SYMLOG Inventory

<table>
<thead>
<tr>
<th>GROUP</th>
<th>N</th>
<th>U-D</th>
<th>P-N</th>
<th>F-B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team A</td>
<td>5</td>
<td>0.13</td>
<td>0.61</td>
<td>0.59</td>
</tr>
<tr>
<td>Team B</td>
<td>5</td>
<td>0.75</td>
<td>0.00</td>
<td>0.86</td>
</tr>
<tr>
<td>Team C</td>
<td>5</td>
<td>0.86</td>
<td>0.57</td>
<td>-0.44</td>
</tr>
<tr>
<td>Team D</td>
<td>5</td>
<td>0.52</td>
<td>0.88</td>
<td>0.89</td>
</tr>
<tr>
<td>Team E</td>
<td>7</td>
<td>0.91</td>
<td>0.57</td>
<td>-1.61</td>
</tr>
</tbody>
</table>

U-D = Upward/Downward  P-N = Positive/Negative  F-B = Forward/Backward
\(a\)Chrombach's alpha

Since the subscales include both positive and negative numbers, some values are greater than one. The poor reliability in the one group on the dominance scale may have resulted from a cluster of individuals who were very submissive. Individuals who have a tendency to have low downward scores are not accurate predictors of dominance. The group which had the low reliability on the friendliness dimension had a coalition of close friends on the team. These friendships may have distorted values, since individuals tend to minimize negative behaviors among their friends. The difficulty with accurately portraying the task orientation probably stems from the ambiguity of group process. Since individuals interpret task functions differently, they appear to assign different values to task-oriented behavior.

The position of the individual in SYMLOG space is, according to Bales (1983)
determined, in part, by their value orientation. Value types are clusters of group behaviors which Bales (1981) has correlated with certain societal values. Using the average group data, summarized graphically in Appendix F, it was possible to assign value types to team members. These value types are indications of the way that group members perceive each other. Collapsing all groups, Table 4 indicates the frequency with which various value types appeared in the SYMLOG analysis.

The most interesting feature of the SYMLOG data from the teams in the rehabilitation facility was the way that several individuals clustered around a single style. This homogeneity facilitates an understanding of a general value orientation, according to the SYMLOG archetype. Table 4 identifies the values types which were determined by the SYMLOG analysis. The letter type identifies the place the individual has in the SYMLOG three dimensional space. In order for a dimension to be included, the score must be greater than three.
Table 4
Individual and Organizational Value Types: SYMLOG Analysis

<table>
<thead>
<tr>
<th>TYPE</th>
<th>DESCRIPTION</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPF</td>
<td>Active teamwork toward common goals, organizational unity</td>
<td>8</td>
</tr>
<tr>
<td>DPF</td>
<td>Dedication, faithfulness, loyalty to the organization</td>
<td>7</td>
</tr>
<tr>
<td>P</td>
<td>Equality, democratic participation in decision making</td>
<td>7</td>
</tr>
<tr>
<td>UP</td>
<td>Popularity and social success, being liked and admired</td>
<td>6</td>
</tr>
<tr>
<td>PF</td>
<td>Responsible idealism, collaborative work</td>
<td>4</td>
</tr>
<tr>
<td>DNF</td>
<td>Self sacrifice, if necessary to reach organizational goals</td>
<td>2</td>
</tr>
<tr>
<td>UNF</td>
<td>Active reinforcement of authority</td>
<td>1</td>
</tr>
<tr>
<td>DP</td>
<td>Trust in the goodness of others</td>
<td>1</td>
</tr>
</tbody>
</table>

U=Upward, D=Downward, P=Positive, N=Negative, F=Forward, B=Backward
N=36

A list of all the SYMLOG value descriptions appears in Appendix J. Of particular interest are the three value descriptions which occur most frequently. The following are identified as correlated characteristics: "acceptance of the tasks given by authority" (UPF), "acceptant of authority, ...downgrade the importance of power" (DPF), and "unconcerned with status differences" (P). These values are consistent with the image that status differences are avoided in the group process and that conflict is neither openly embraced nor avoided. This pattern assists the team members to function in the system by emphasizing collective rather than individual gain. Thus, the ambiguity of the team structure enables team members to defer individual power to the group. By using a collective approach, group members can manipulate
perceptions to increase ambiguity. If the group decides an issue, then individual interpretation can be preserved. The underlying assumption is that a test of authority would place the physician in a dominant position. Such a test, however, would create conflict which could be destructive to patient care. This care, above all else, is the common foundation which enables these different ideological systems to coexist in the organization.

The general value for collective approaches to social power which is suggested by the team metaphor is supported in episodes recounted by department heads. Relationships between department heads are less clear than in the "team". Interaction on the department head level is, at best, disjointed ("like a baseball team without a coach"). There is a sense of provinciality in the system. Individual department heads tend to mind their own areas, not paying attention to what is going on in the rest of the system. Almost every manager noted that there are few conflicts in the system. The conflicts which were recounted usually had to do with support services and not professional services. These conflicts were usually masked, rather than featured in the system, however. As one manager stated: "I have enough things to be concerned about here and...I can't do anything about those things anyway, most of them, unless it impacts upon our patients, then obviously I have to be involved."

In addition to masking conflict in the system, there appears to be a general lack of collective goal setting and decision making. Rather, every department acts independent of one another.

Everybody is....just doing something until there is a problem. You go on until there is a problem, and then when the problem comes up, then you deal with it rather than maybe doing troubleshooting and anticipating some of the problems that may occur.....The way it is now it's kind of a hands off type of thing and we are not going to get involved unless there is a problem.....It leaves you just kind of free floating around and not....working as a team, to pull the team together.

One consequence of this pattern of provinciality and lack of involvement in decision making is that the department heads may not be consulted on decisions which affect them. When this occurs, ambiguity is no longer tolerated; there is a reactive approach to correct the problem. For example, the lobby in the hospital was recently remodeled. It is a lovely, carpeted area for families to wait and visit. As one manager stated" It looks real nice, but it's not real functional for being in a rehab hospital. You can't get around in the lobby. You've got a beautiful lobby, you can't get a
wheelchair in it....they can't do transfers onto the couch with the arms down like that.... I don't think oftentimes that the patients are first in the administration's mind and they don't know what goes on down here". Another nurse commented "It's real pretty, but where are the gimps going to go?"

There appears to be a lack of synchronicity and mutual adjustment in the system as a result of this independence and isolation. Perhaps this is best illustrated by a story shared among the department heads.

For fifteen years we have complained that the clocks are not synchronous in the building because we are not on a synchronized system like they are in the main hospital. And so, one time, it was so disturbing that the patient would be ten minutes late when they get into therapy, but by the clock they looked at before they got there they were on time, until they would get to PT and then they were late. The way the administrator back then said, we will tell maintenance to look at the clocks once a week. And so, it was their job to look at the clocks throughout the building once a week. But the clocks were still off. So he later checked with maintenance and they said "Sure, I look at the clocks once a week. They all have a different time!" They were never changed! So PT starts taking care of his clocks and I take care of mine, and .... we call the time system and check them once a week, and what they do in the other departments I don't know.

Perhaps just as remarkable as the humor in this story is its illustration of the tolerance of the problem. Rather than changing the system, the system adapted to the problem. This pattern of "benign neglect" is another means of preserving the ambiguity in the system. Since it was not clear whose responsibility the clocks were, the problem was tolerated. The difference between problems which are tolerated and those with are not is probably the consequence of the problem.

When problems must be addressed, a collective approach to power or persuasion is used.

In spite of these patterns of conflict resolution and decision making on the department head level, most managers described their compliance-gaining style as very direct and competent. Most described a series of contingent strategies which they would use to influence someone in the system. These strategies varied greatly according to the status of the individual and the context of the episode.

One administrator, for example, recounted that she believed that she should never really have to tell someone what to do. If she reached that point, it would probably be necessary to get rid of that person. She prefers, if necessary, to influence people through a group. "You can usually find enough people around ....who have the same interests that you have to pull
them on to a consensus-making group and get the consensus to go the way you want it to. (This) is a gentle way because then the person who does not want to do it realizes that it is.

not just you alone who thinks that the change should be made. " She goes on to say that this technique is preferred, because it is not so easy to sabotage: "It is better if their peers are all looking at them saying, do it....I seldom get in a position where it is just me and somebody. There is usually at least one or two other people who have interest in seeing the change made." The use of the term "consensus-making group" in this account is especially interesting, since it seems to be a coercive term rather than a collaborative one. The interpretation of "consensus" here is getting a couple of people to see things your way and then collectively persuading the third. Thus consensus is not a unique product of several individuals' perspectives, but is a single perspective accepted by the group. Consensus-building in this context is synonymous with persuasion.

A similar approach to compliance-gaining is described by another manager. "I very seldom hand down mandates that originate with me. If I do, it's something that's been mandated to me by someone else, and I usually don't have any control. Usually what we do is we just state the problem, and then discuss it as a group and listen to the solutions and end up accepting the solution that I think will work best." In this case, the manager is indirectly controlling the group by proposing his solution and getting the group to accept it. This collective approach permits the group to attribute the cause of the change to collective needs (which are consistent with egalitarian ideology) rather than to the individual. This preserves the ambiguity in the system and permits a broader range of interpretation and, in turn, responses.

The collective approach to compliance-gaining is used in other contexts as well. In the pain service, a team meeting is used to "confront" the patient who is doing poorly. "The power of that influence attempt is also significant if you have fifteen people saying, look, you got to clean up your act and start doing something here." Thus, in this context, the patient is prevented from manipulating the staff by being confronted by all of them at once.

The pain management team also rewards patients through a team approach. A ritual of closure is performed prior to the patient's discharge from the hospital. During this ritual, the members of the team praise the patient and tell him or her about the amount of progress they have made and what goals they might set for the future. The approach is honest and very affirming for the patient. Thus, in addition to the persuasion of threat, this group uses reward
power effectively to reinforce effective coping patterns and persuade the patient to continue in their progress after discharge.

In the interpersonal, one to one situation, however, the staff is much less assertive with higher status staff. Lower status employees, such as the secretaries I interviewed, varied their compliance gaining techniques with the status of the individual they were trying to influence. For the most part, they avoided confrontation with those who were in power over them. Rather they would keep quiet and "dream about throwing (her) out the window" or complain behind their backs. One secretary muttered politely and said "Yes doctor, of course, sir" to her boss on the phone, and then stuck her tongue out at the phone before she hung up. Later, when another secretary was in her office and she wanted to tell me something confidential, she told the other woman "Do me a favor, and tiptoe out very quietly and close the door behind you".

The reification of rules of behavior brings with it a sense of the consequence of breaking the rules. One of the stories which recurred in the system was about a physician who was a team leader and was "forced" to leave the system. Apparently, this person was an ex-military physician who was very authoritarian. As one manager describes:

He could not bend, he could not yield, he could not change, he had to demand. It was his style and we just could not...take that demanding..... I suspect he felt so uncomfortable that he left. I don't think we deliberately made life miserable for him, we just went along treating our patients, and that was very frustrating to him. He may have given direct orders to physical therapists who then went along and treated their patients and that was very frustrating to him. ...A new therapist might do exactly what he said, but a senior therapist might say 'yes, but I also this patient needs..' and in effect might circumvent him by going to the resident and saying 'I really think this patient needs...' and the resident said yes and we circumvented him..... The patient has to get good care and I will circumvent anybody to get that. I will work around anybody, or I will directly confront anybody to get that.

In this episode, an unspoken rule of the culture was consistently broken. The physician insisted on being autocratic and giving each therapist a detailed prescription for treatment, rather than respecting their unique expertise and ability to assess and plan for the patient's care. This behavior violates cultural norms which, as one department head states: "there are clearly areas where you just don't tread. I mean all of us know a little about what the next guy is doing, but...you know just how far you can go with that. You don't say to the physician, well, have you
ever thought about giving him aspirin. You just don't do it......there is a sharing of perceptions that may not be strictly from a particular professional orientation." The modes of punishment used in this episode are also ambiguous. When conflict was "featured", each therapist simply continued to follow old patterns and ignored the physician's directions. They used legitimate mechanisms to indirectly manipulate the physician. Thus, although the physician's status rights were ignored, s/he would have had a difficult time attributing malevolent intentions, when each therapist was behaving in a competent way.

To summarize three levels of values are explicitly advocated in the culture. The first level relates to communication style (openness, honesty, trust, directness), the second relates to personal skills (rehabilitation focus) and the third relates to the style of decision making (a team player). The team player theme further suggests that the organization values collective action, egalitarianism and avoidance of conflict. Collaborative approaches to social influence are valued above individual approaches.

DISCUSSION

The explicit cultural themes, revealed in the organizational philosophy, values, structures, roles and relationships shape the exercise of social power in four ways. First, they define the functional status and authority relationships. These relationships outline the legitimate bases of power for the members of the organization.

The second effect of the explicit cultural themes is upon the perception of the bases of power. Three explicit themes are suggested here: team, stepchild and rehabilitation. The team metaphor shapes the bases of power by calling attention to collaborative or group efforts. Resources are pooled. Collectivity is favored over individualism. This suggests an egalitarianism which is not necessarily supported in the implicit metaphor.

The stepchild theme places the individual in a position of being less valued and different than the rest of the system. The bases of power available to the stepchild are usually personal, rather than material. This converges with the team metaphor, in that pooling of personal resources may be perceived as a more powerful position. The rehabilitation theme has several implications for the exercise of social power. First, it suggests that the individual has a right to relinquish power and trust that s/he will be taken care of. Therefore, the power motive may not be as strong in this culture. Second, the rehabilitation theme suggests that the person in power has
a right to manipulate (control) in order to gain compliance. Thus, the rehabilitation theme would shape perceived bases of power by calling attention to coercion and reward bases.

The third way that the explicit themes of the organization shape social power is through their ability to shape the context, thus defining when compliance-gaining is needed. The explicit themes of the organization, through its structure and channels of communication, determine when compliance is automatic (due to status). As the SYMLOG data indicated, this culture values submission to authority to some extent. The ability to determine when compliance-gaining efforts are needed is closely tied to the implicit ideological assumptions of the organization, which give support to the explicit structure.

A fourth way that explicit themes of the culture shape social power is through the legitimation of certain modes of reward and punishment in the organization. When an individual is permitted to manipulate resources to gain compliance, a greater repertoire of strategies may be available. Most often, the types of resources which are manipulated will be intangible, such as information or personal rewards. The use of "soft" resources decreases the perceived risk with failure; failure of a coercive effort which involved the use of concrete resources could have damaging effects in an organization where ongoing relationships are necessary. In the rehabilitation hospital, managers related that they gained compliance by shaping the perceptions of the individuals through group efforts. This is one strategy for shaping the needs of others by manipulation of perception (information resources). Other strategies for the use of information as a medium of power were seen in the way that professionals used the control of the chart and restricted codes to maintain expert power. By maintaining control of the patient record, the physician remains dominant; by maintaining the use of a specialized language system, other professionals are able to remain dominant over the patients. All of these strategies are legitimized through the use of explicit cultural themes.

In this section, I have discussed ways that explicit cultural themes are expressed in the culture of the organization through its philosophy, communication channels and structures, social events, orientation programs and explicit values. I have also discussed four ways that the explicit themes of the organization shape the exercise of social power. In the next section, I will address themes which are more implicit in the culture.
IMPLICIT CULTURAL THEMES

On an implicit level, the ideological assumptions of the organization account for more of the unspoken rules of power. Implicit themes are usually transparent to the organization and are discovered through critical analysis of cultural systems. For the purposes of this discussion, I will describe two sources of information about implicit themes in the culture. The first occurs on the linguistic level and includes terms of address, speech imagery and specialized language. The second is the analysis of the data about "team" metaphors collected in the fourth phase of the research. In the concluding section, I will discuss how the implicit themes revealed in the data shape the exercise of social power. Specifically, I will discuss how they shape potential power by determining when a person is not to act.

TERMS OF ADDRESS

In the rehabilitation center, the terms of address vary according to the profession and status of the individual. Generally, staff physicians are referred to as "Doctor" while other allied health professionals are referred to by first name. Residents, on the other hand, are addressed by first name. During one team meeting, a new resident physician made a special effort to ask the first names of the team members. Another exception to the use of the term "Doctor" to address the physicians is the use of first names by psychologists. Generally, the psychologists and physicians reciprocally address each other by first name. This is probably reflective of their parallel professional status.

Staff members address their department heads by first name, with one exception. The director of housekeeping refers to herself (and is addressed by her staff) as "Miss". This appears to reflect more traditional social norms and respect for a senior manager in the system. In private, she is referred to by her first name by other department staff.

Patients are, for the most part, referred to by first name. Family members are addressed in a more formal way, using first and last names. This reflects both the "permission" which health care professionals are given because of their patient's sick role and the familiarity which appears to develop with the patients during their long stay in the hospital.
Terms of address tend to preserve the dominance of the medical group and reinforce status differences. Members of the organization acknowledge the expert power and functional authority of the physician when they refer to her or him as "Dr."

**SPECIALIZED VOCABULARIES**

Over time, the health care professions have developed a specialized vocabulary which reflects the clinical focus of their work. In addition to the "normal" health care vocabulary, however, the rehabilitation specialty has a unique specialized vocabulary. This vocabulary system is pervasive and uniformly understood by all professionals in the system. This pervasiveness is one more indication of the extensiveness of cultural themes which center around the patient situation.

Two major language patterns were observed. The first pattern is to use abbreviations for phrases which are common in the culture. Thus, when someone refers to a patient's ability to dress and feed himself or herself, this is called "A.D.L." for "activities of daily living"; "I & O" refers to "intake and output"; "B.F.O." refers to a device which assists a patient by supporting the arms for feeding; a "b.k." amputee has an amputation below the knee.

The second pattern of the linguistic system is to use jargon which is unique to the patient in the rehabilitation setting. This includes referring to patients as "quads" or "paras" (having injuries resulting in quadraplegia or paraplegia); patients who develop contractures are said to "pretzel up"; patients daily toilet activities are called a "bowel program"; patients learn to do "wheelies" in their wheelchairs; the patient's normal state (before the injury or illness) is referred to as "premorbid" (reinforcing that the patient will never be "normal" again; i.e. the patient will always be "postmorbid"). Additionally, common activities are given special names in the culture. For example, instead of dressing, a patient "dons" (puts on) or "doffs" (takes off) clothes; instead of "eating", the patient "feeds"; instead of walking, the patient "ambulates"; instead of "arms", the patient has "upper extremities".

Collectively, the specialized language system serves to objectify the patient in the system. The staff describes voluntary action on the part of the patient (e.g. eating) in terms which make the patient an inactive recipient, rather than a participant (e.g. feeding). Thus, the linguistic system, serves to compartmentalize the patient as well (e.g. referring to the patient as a "quad"). This is consistent with the compartmentalization of care which is provided in the system. It is not,
however, consistent with the personal terms of address which are used in discussing the patients. The objectification and compartmentalization of patients in the language system probably serve to assist the staff in detaching from the clinical situation. One staff member acknowledged the need to stay somewhat detached in order to be able to cope with the sadness of the situation.

The use of restricted codes through specialized vocabularies preserves in-group orientation and promotes a state of ambiguity with others who do not share in the language system. This, in turn, leads to an increase in trust for the in-group with a restriction in understanding for the out-group. Further, the restricted code may be very functional in an organization with multiple conflicting themes and expectations. In such a cultural system, there is often ambiguity and role confusion. A specialized vocabulary system leads to a heightened sense of expertise and role definition and legitimizes expert power in relationships with families and patients.

SPEECH IMAGERY

Panel meetings were weekly rituals which brought all of the team members together to report on the patient's progress and needs. All but the pain service met in a large room, seated around a conference table. The physician(s) sat at the head of the table and therapists were predictably seated around the outside. Individuals came and went during the meetings, according to the order of patient presentation. Generally, these sessions were long and tedious to observe. Group members reported in an automatic fashion, therapy by therapy, on each patient. After each patient was "panelled", there was some general discussion about discharge or future treatment. Presentations became longer as patients neared discharge and their home environment was evaluated. As staff became more familiar with the patient, the pace of the conversation picked up.

Panel meetings were also a time when staff were away from the patients and with their peers. Despite the boredom of the meetings, there were occasional stories and jokes told. As we listened to the conversation in the team meetings, we identified a significant number of
themes which recur in team communication. While these themes may not be strictly metaphorical on their own, they do represent images which are consistent with the "rehabilitation" focus of the organization. It must be acknowledged that, occasionally, the conversation in the panel meetings indicated a "venting" of frustrations with a very stressful clinical task. The eleven content themes which are described below are general themes which recurred in all levels of conversation across all groups.

1. POWER. A significant amount of the language used in describing patient's behavior related issues such as cooperation, manipulation and control. Most of the content about power in the team interaction reflected the struggle between control and autonomy. Staff presented apparently paradoxical perspectives in their discussion of the patients: the desire to have the patient comply with their prescription for success versus the desire to have the patient develop as much control over their lives as possible. Patients who resisted the prescribed program were labeled as uncooperative and manipulative. As one nurse related, "I told the patient we were going to have to work on cooperation!"

   With the exception of the pain service, it was generally acknowledged that the patient did not have a role in his or her care, aside from presenting the problems for which the staff prescribed solutions. As one team member stated, patients tend to "act out" against the staff for the first few weeks, and then they gave up: "The problem is in this kind of structure, even if you assert yourself productively, you are not going to win.....it's still going to go the way the staff has to have it go to keep it functioning. So I think patients fight less and less the longer they stay here. They become an old timer."

   Control themes manifested themselves in many ways. For example, patients were often late for appointments (one way they could control their schedule). Control by the staff was often exerted in terms of giving the patients cigarettes. Smoking behavior was often manipulated between staff and patient, with staff refusing to give in to patient's demands for cigarettes on his or her own schedule.

2. SOVEREIGNITY. The sovereignty theme appears to arise from the right of the staff to prescribe for the patient and family, because they have superior knowledge about the rehabilitation situation. This general struggle between equality and inequality manifests itself in an elitist perspective. The degree of sovereignty varies from team to team. One of the general rehabilitation teams and the head injury team, for example, are more willing to allow the patient to
explore the limits of their disability, without saying "no, that is not possible". While the physician in charge of the spinal cord team says that no patient should be told they will never walk, etc., there is a strong sense that the staff believes that only they have the right to determine the limits to which a patient should try to regain function.

3. NORMALITY. Related to the concept of power, the theme of normality focuses on the legitimate right of the staff to determine what is normal for the patient. The content themes revolve around the struggle between deviance and compliance with what has been determined to be normal. There is generally some tolerance for "acting out" behaviors early in the rehabilitation process, but less as time goes on. "Acting out", then, is anything the staff defines as abnormal. While there is some attempt to recognize "premorbid" personality characteristics, for the most part, the staff determines which behaviors are deviant in the hospital, regardless of prior characteristics. Phrases such as "he knows how to work the system" and "We just need to talk to him about his attitude in general and he needs to be more compliant" are typical of this thematic strain.

4. TEMPORALITY. Time appears as a significant theme throughout the conversation in the team meetings. This attention to temporality is probably a result of the rather slow, tedious process of recovery. Generally, time appears as a theme when discussions centered around progress (appropriate progress for the amount of time in therapy), scheduling (being on time for appointments) and tenure in the system (being an "old timer").

5. ADVOCACY. The advocacy theme relates to the right of the patient to determine his or her own interests versus the right of the staff to protect the patient from harm. This theme recurred frequently in discussions of discharge and the home environment. Conflicts in this area often resulted from differences in staff opinion about their willingness to let patients go home to environments that did not feel were completely safe.

6. OBJECTIFICATION. As I discussed earlier, there was significant objectification of the patient in the specialized language system. When a patient was to be presented for discussion at the team "panel" meeting, the staff said they were going to "panel the patient" (rather than discuss the patient at the panel meeting). With the exception of one of the general rehabilitation teams and the pain team, patients were usually discussed in objective terms, with little reference to the patient by name.

7. MOTIVATION. The patient's involvement in his or her rehabilitation process was
most frequently described in terms of motivation. Keeping the patient motivated to improve was a nearly constant concern for the staff. Motivation was described both in terms of its presence and its appropriateness. The staff manipulated the patient to foster motivation, through reward systems (verbal acknowledgement, cigarettes, special privileges) and through planned behavior modification. Motivation was an interesting theme, considering the objective, passive terms used to describe patient activities. Patients were described as if they were inanimate objects, yet expected to take an active part in being motivated to recover.

8. FUNCTIONALITY. Aside from power, functionality is the most frequently mentioned theme in the language system. The word functional is usually associated with physical activities and movements of the patient, in describing the progress of therapy. Just as often, however, the word functional is used to describe behaviors and attitudes. In both cases, it appears as if the staff has the legitimate right to determine what "functional" is, in terms of the patients physical status and rehabilitation progress.

9. GROUNDING. Another theme which is woven throughout the communication in the team meetings is the appropriateness of patients and family expectations and actions. There is an assumption that appropriate expectations should be grounded in reality, not hope or fantasy. The realism is usually defined in terms of the staff's knowledge of the patient's condition and their experiences with similar patient's in the past. There is an expectation that issues will be confronted productively; when a family has faced the reality of the patient's status, they are labeled as realistic and have gained credibility with the staff. Families or patients who expect to achieve levels beyond what the staff feels they are capable of are labeled unrealistic.

10. GATEKEEPING. As a part of maintaining motivation and progress for the patient, the staff will withhold information which they believe that the patient cannot handle. In one meeting, the physician became upset because one of the therapists had told a patient that she had "broken her neck". In spite of the fact that the patient had, indeed, suffered a spinal cord injury in the neck, the physician felt that the staff should not come out in plain language and say that to the patient. Similarly, a physician noted that he felt that the patient should never be told that they would not walk again (they would figure that out for themselves). The staff appeared to give information to the family and patient only when they thought they could handle it. In other
words, the information was kept until the family was realistic and appropriate in their understanding of the patient's status. Sometimes information was shared to increase realism, as well.

11. METONYMY. Apart from the objectification of the linguistic system, the patient was "fragmented" in the panel meetings. In presenting the patient for discussion, four of the teams discuss the patient by specialty group, with medicine, nursing, physical therapy, etc. each presenting their report on the progress of the patient. Since each of these specialty areas has a specific focus with the patient, the result is a division of patient into functional areas. There is, of course, input from everyone about the psycho-social progress of the patient, but there is a tendency to look at the one segment of the patient's clinical care area at a time. The patient is further fragmented through the linguistic system, as I have already described.

Generally, the themes represented in the linguistic system suggest a ruling class ideology. Legitimate power has both expert and moral force. Social norms prescribe that the patient relinquishes the right to control and prescribe to the health care professional. The staff, in turn, have a moral obligation to control for the patient's good. While the staff expects and tolerates a certain amount of resistance to their control, they expect patients and families to follow their advice and therapeutic regimen. When this compliance is not achieved, the patient is persuaded to comply or is manipulated to behave appropriately (for their own good). This manipulation usually takes the form of behavior modification, through the manipulation of rewards and punishments.

The ruling class ideology appears to be strikingly different from the egalitarian values of the health care professions and the explicit themes of the organization. Rather than sharing power with the patient, the staff implicitly acknowledges the supremacy of the health care professionals. This supremacy is the same ideology as the traditional "medical model" which gives the same level of control to the physician over other allied health professionals. In many ways, the members of the organization describe themselves and behave as if they were the disabled patients. New team members soon learn that they will not be able to change the system and they "give up". One physician noted that he grew tired of always saying "we've tried that and it didn't work", so he just says "OK, we'll try it for three months" and lets the team discover for themselves that it won't work. This attitude is remarkably similar to the approach used with the patients, when the staff lets the patients discover for themselves that they will never walk again.
Different strategies for compliance-gaining are used at the patient level than at other levels. Open manipulation of rewards and punishments is "therapeutic" at the patient level, but would have a negative impact at the team level. Norms for patient interaction dictate that the patient "should" be motivated to comply with the therapeutic regimen without challenging the authority of the health care professionals. Norms for team interaction dictate that the staff "should" be motivated to comply with physician control without challenging his or her expertise and legitimate right to control. The strategies for influence differ in each, because of the nature of the relationships and the personal risks involved with failure. If a staff member fails to get a patient to comply, the patient suffers; if that same staff member challenges the physician and fails, the staff member suffers!

The themes in the linguistic system reveal attitudes about power which, on the surface, appear to be inconsistent with the values outlined in the SYMLOG analysis and with the professional orientation toward altruism and egalitarianism. How do competing ideological systems coexist in the same organization? The key seems to be their shared focus upon the patient. The egalitarian value system of health care focuses upon access to information and service; the medical model focuses upon control of those resources. Both share a focus of patient welfare. Similarly, altruism dictates sacrifice of individual interests for the collective good; the medical model focuses upon individual expertise and right to control. Both share a focus of patient welfare. These seemingly dichotomous themes are coexistent and complementary as long as one does not challenge the other.

The organization supports competing ideological assumptions in a variety of ways. Most notably, the organization promotes a rather ambiguous communication pattern which facilitates the coexistence of competing themes by avoiding conflict. This ambiguity is discussed further in the last section of this chapter.

DISCUSSION

The implicit assumptions of the organizational culture appear to be in sharp contrast to the explicit themes and values. When the more transparent images in the language system are revealed, themes of provinciality and control are evident. These themes, in turn, shape the orientation to social power in the organization in two ways.
First, the implicit themes determine the true power relationships in the organization. Health care professionals are historically given the right to control through their expertise and knowledge. The physician does not have power as an objective property; rather, s/he has power as a result of the patient’s dependence upon his or her expertise and their deference to his or her authority. The implicit themes of the organization support this medical model. The professional has the power because of superior knowledge or expertise. The implicit assumptions of the culture let the members know when to be deferent to one another’s authority. Most notably, these assumptions dictate when it is appropriate to challenge the authority or control of the physician.

The second way that implicit themes shape the exercise of social power is by determining when a person is expected not to seek to gain compliance. This unspoken understanding dictates when an individual is expected to follow authority. The explicit themes of the culture may shape the legitimate form of the social power context, but the implicit themes help shape the perception of that context. In the rehabilitation hospital, the team structure is the legitimate context for compliance-gaining, but the ideology of medical supremacy shapes the way that context is perceived.

Implicit themes cannot be considered in isolation from the explicit levels. Rather, themes operate systematically to define the culture. The implicit themes are the deeper meaning upon which the surface dimension is built. The interaction of these themes, in the communication activities of the organization, defines the processes by which organizational production is carried out. The target system in this study has an explicit “rehabilitation” theme which appears to shape both patient process and management. This philosophy dictates teamwork (egalitarianism) as the logical process or organizational activity, due to the multiplicity of professional therapists. It is only when this rehabilitation theme is considered in conjunction with the implicit ideological assumption of legitimate control that the process of team function makes sense. The explicit rules for social power (egalitarianism) can only be understood in conjunction with the implicit assumptions of control and dominance. Explicit structure shapes context; implicit structure shapes perception.

Perhaps the best gauge of the ideological structure in an organization is an understanding of the circumstances when the dominance of one group is not challenged. For example, in the team meetings, there was never a discussion or challenge of the right of the
physician to be the team leader or gatekeeper of the chart. Therapists made out reports on slips of paper and never questioned why all notes were not integrated under a single care plan. Historically, the physician writes orders and the nurses and therapists follow them. Similarly, there was almost automatic deference to the physician's right to determine the discharge date for the patient. Implicit themes of the culture imply that this is within the legitimate realm of the expertise of the physician that s/he has a right to control, because of that.

While there are clearly areas where implicit power structures dictate automatic deference and compliance in the organization, there are many more areas where the contrast between explicit and implicit themes creates strain on the organization. In the following section, I will explore some of the communication patterns used by members of this culture to cope with this strain. These include rituals which legitimize functions, use of strategic ambiguity to avoid situations which increase dissonance, adaptation of the functional system to meet ideological assumptions, adopting behaviors which immobilize the system, manipulating perceptions to give the appearance of consensus and challenging the system through cycles of arguments.

COMMUNICATION PATTERNS WHICH SUPPORT CULTURAL INCONSISTENCIES

A variety of patterns have been developed, over time in the organization to assist the members of the culture to deal with the inconsistencies between the explicit and implicit themes of the culture. These patterns serve to reify existing or new structures, mask the dissonance created by the inconsistencies, adapt the functional system to the make it conceptually congruent or challenge the implicit assumptions of the organization. In this section, I discuss how these patterns are manifested in the organization. The concluding discussion focuses upon how the implications of these patterns for the organization.

RITUALS

A number of rituals have evolved in the organization which assist the members of the culture in dealing with the strain created by conflict between functional expectations and
ideological assumptions. These rituals involve team function. The pattern of "panel" and team presentations assumes ritualistic qualities in the organization. A patient is elevated to legitimate status when they are first "panelled". The process of reviewing and discussing patient care is ritualized and tends to emphasize the autonomy of the individual therapists. When one group member suggested that the group report by goals of care, this was soon adapted to the ritualized "review of system approach". This ritual assists the team members by reifying patterns of communication. This, in turn, masks the underlying powerlessness of the non-dominant groups by making their contribution seem to have some special importance. The rituals of team function enable the teams to cope with deviance, as well. Deviance tends to feature the strain in the system. Ritualized behavior assists in coping with deviance, because it limits the range of tolerable behaviors.

When groups have attempted to change the underlying assumptions of the culture by realigning power relationships, they have developed new rituals of patient care which feature other patterns of behavior. This is true in the pain management team.

RITUALS

The pain management team differs from the other teams in several ways. The most obvious difference is the patients they serve. The patients who come to the pain management service have been experiencing pain for most of their lives. The process of coping with the pain has consumed so much of their existence that they no longer are able to function in a normal life. Usually, patients seek this service as a last resort, hoping to find new ways to cope with the pain. Thus, the pain management team addresses many more behavioral and psycho-social issues than it does physical issues.

Unlike the other teams, this team has two group meetings a week. One meeting includes patients in a discussion of mutually formed goals for treatment; the second session is more like the "panel" meetings held by other services. The format of the meetings is different from the other groups, as well. This team does not sit around a large conference table. Rather, they sit in chairs in a circle in a small room. Anyone in the room (even observers!) becomes a part of the group. Team membership is different from the other groups. Speech Therapy is not involved and Occupational and Physical Therapists have a more limited role. The pharmacist, who
was not involved in any other panel groups, is an active participant in this team. Similarly, the
dietician takes a much more active role in this team.

Another difference between the pain management team and the other teams is its
approach to the patient. Since the focus of the therapy is assisting the patient to develop new
coping skills, the patient is an integral and active participant in the therapy. Goals for the hospital
stay are set with the patient, usually by the clinical nurse specialist who works with the service.
The reports in the "panel" meeting reflect these goals, thus continually keeping the group
oriented toward the patient's progress. No decisions are made regarding the patient's plan of
care without first consulting the team.

The leadership of this group is different than other groups, as well. Responsibility for the
meetings appears to be shared between the psychologist, physician and clinical nurse specialist.

It was noted earlier in this chapter that the team members had a difficult time identifying the
"coach" of their team. The physician and resident manage the charts, while others participate
openly. The physician, for the most part, was less directive than other team physicians were. The
most authoritarian I saw her become was when the resident suggested a drug which she felt
should not be used. At this time, she corrected the resident, in front of the entire group. One
group member noted that, at times she "gives a little speech" and everyone knows not to argue
with her. This appears to be one more example of a context where the physician can exert
control in a legitimately medical area.

The pain management team appears to share a more cohesive meaning system than
other teams, as evidenced by the significant number of inside jokes and generally positive tone.
Like the second rehabilitation team, this team models more positive reinforcement among for its
members. There appears to be spontaneous attention to the support and reinforcement of the
team members. This is modeled through one of the rituals of the system. When a patient is ready
for discharge, s/he is brought to a panel meeting. During that meeting, each member of the panel
shares with the patient their perspective about the amount of progress that s/he has made and
the goals that should be considered for the future. During the entire experience, the patient is
not allowed to respond to the team, although they certainly do give very reinforcing nonverbal
expressions! Through this ritual, the psychologist and therapists model affirmation for each
other. It is an incredibly uplifting experience for the patient, and seems to call attention to the
importance of reinforcement and progress in this team.
Finally, this team's linguistic system reflects a different orientation to power and control than the other services. In this clinical service, the patient is to be empowered to cope with his or her life. There is a recognition that compliance may not be the ultimate goal of therapy. As the psychologist noted "(the patient) is compliant, but I don't know if he is getting anything out of this". There is considerable attention paid to getting the patient to become an active participant in life. "Pain behavior" is a common word, describing the patients behavioral response to pain. The important emphasis, here, is that the patient has a role to play in his or her illness. Coercion does not play as large a role in this service as the others. As the psychologist noted, "The moral of the story is you can't make adults do anything they don't want to do". There is, however, a recognition that the patients need to try to become a part of the program. It appears that some reluctance is tolerated, but only to a limit. "I think we need to look at the issues of compliance. (He) needs to oblige us. We aren't just giving him a bed."

The rituals of the pain management service feature a different set of ideological assumptions. Rather than featuring the control of the ruling elite, this team features collaboration and patient participation. The rituals of team process reflect this. It would appear that this difference in local culture is due, in part, to the nature of the patients who are the focus of that service. The goal of pain management is more palliative than restorative. The success of the therapy is limited by the patient's ability to cope, rather than physical parameters. This would necessitate the sharing of control, as the patient learns to regain control and repattern his or her life. In contrast, the spinal cord service deals with patients who have very concrete physical limitations to recovery. Restoration requires physical manipulation as well as psychosocial adaptation. Thus, control and manipulation are legitimate parts of therapy. In this service, local culture reveals thematic language with significant control imagery. Thus, the type of care which is provided for the patient may, in fact, shape local culture. This may, in turn, lead to a different set of themes and orientation toward power. In the case of the teams in the rehabilitation hospital, these differing ideological systems are supported through patterns of rituals and group process. This assists the members of this team to cope with the strain of inconsistencies by elevating the egalitarian ideology to a more conscious level.
STRATEGIC AMBIGUITY

A second, more common, way that members of the organization cope with the differences between explicit and implicit assumptions is through the use of strategic ambiguity. Eisenberg (1984) defines strategic ambiguity as purposefully using communication strategies which provide the receiver with a broad range of interpretations. Patterns of strategic ambiguity "promote unified diversity" (p.230). That is, they allow for competing goals and values to exist simultaneously in the same system. The major strength of Eisenberg's position is its identification of the value of ambiguity in an organization. In the present context, however, I am loosely defining "purposeful" While I agree that great leaders and politicians often purposefully decide to be ambiguous, this strategy is often more intuitive than purposeful. In this organization, ambiguity is often a group phenomenon. As I have discussed, the "baseball" team structure permits a greater amount of ambiguity in group process. By keeping the process loose, the members of the team are permitted a broader range of interpretations. When there is a more explicit structure in the group, the inconsistencies become more pronounced, and conflict ensues. Strategic ambiguity is especially evident in the decision-making processes in the teams. An example illustrates the type of patterns which have developed.

This episode occurred during a panel observation. The social worker had gone to a patient's home to evaluate her readiness for discharge. In her presentation at the panel meeting, she noted that, while the patient had limitations in her functions, arrangements had been made for a special assistance program. Following this presentation, there was a heated discussion about the ability of this patient to care for herself at home. The various therapists expressed concern about her safety. There was active exploration of the issues, including a discussion of the right of the staff to determine what is best for the patient. The physician director orchestrated most of the discussion, asking questions and interjecting his opinion. Finally, he asked how the staff would feel if a "60 minutes" camera appeared on their doorstep after the patient was discharged. There was also some problem solving about how to make the home environment safer for this person. In the end, the physician asked for a show of hands of the team as to who would want this patient to be discharged home. No one responded. After some additional discussion, he once again asked for a show of hands and no one responded. I was told later that
the physician was quite frustrated with everyone's lack of commitment to the decision and had to decide about discharge himself.

In this example, the panel members leave the situation ambiguous by not participating in the decision. This leaves the team leader uncertain of their intentions. Of course, there are many other ways of not participating in group process, such as avoiding the meetings or falling asleep during them. Whatever the process, avoidance is one method of strategic ambiguity. Avoidance is neither compliance or defiance. When decisions are avoided, the ideologic structure is not confronted. This episode illustrates one way that ambiguity is built into the system: decisions are avoided. Team members defer to the power of the physician by deliberately avoiding confrontations. This leaves the physician believing that a consensus has been reached and the team believing that they have truly had input into the decision-making process.

Ambiguity assists the organisation to cope with different ideological assumptions in several ways. Since it permits a variety of interpretations, ambiguity also permits a broader range of acceptable behaviors. This, in turn, decreases the risk for retaliation in compliance-gaining attempts. Ambiguity permits greater flexibility in attribution during conflict. This, in turn, assists individuals to defer accountability to "safe" targets, thus minimizing conflict. One important mechanism for ambiguity is collective approaches to social power. In addition to pooling resources, collective efforts decrease risk of failure for the individual by permitting the target to attribute the effort to the group. Finally, ambiguity serves to preserve the existing value system and ideological structure. Eisenberg (1984) notes that the role of the leader is to state messages at a level which agreement can occur. It is clear that the ambiguous group process in the "panel" meetings serves that function.

IMMOBILIZING THE SYSTEM

Another way of coping with the strain of inconsistencies is to immobilize the system. In doing this, the team members openly acknowledge the paradox and refuse to participate in the decision making process. One episode of team decision-making clearly illustrates this process.

The first example stems from a discussion in a panel meeting as to whether the patient should be told that he would never walk again. The therapist was arguing that this would allow him to make realistic plans about returning to work. After some general discussion, the physician
stated "It is my policy to never tell the patient they will never walk again. The patient will always ask you but then they never want to hear what you're going to say. My patients will never hear from me that they will never walk again. That's not being dishonest...there are theings going on in research that we aren't aware of." At the conclusion of the monologue, the psychologist chimed in that the impact of the physician was so strong, and it was decided that he would talk to the family to help them prepare.

Two things are interesting about this episode. First, the statement that "It is my policy" occurred several times during the group observations. Apparently, this is a clear articulation of the law of the team. When the physician says "It is my policy", there is no team decision making. The second interesting point of this episode is the possessive nature of the physician's statement about the patient. "My patients will never be told" reflects a singular, rather than team approach.

I asked this physician who made the decisions about the patient's care. He stated "If there is any conflict after deliberation, after discussion, we vote on it. There are very few times that we have voted, but that was what was agreed upon to try to decide on what the team should do." The team agreement, however, is not always upheld by him. He notes "...There are some times myself when I have to say to the patient, well...I don't really agree to this, but then we have decided ...that it should be done. ....I have found some resentment from the team when I say that..."

The net result of this paradox to the team is a lack of clear-cut decision making. Rather than compromising to reach a solution, many issues are stalemated. Apparently many issues come up over and over in the "team" meetings. A clear message to end discussion is sent, however, when the physician states "It is my policy", he is identifying an end to the discussion. As he stated:

Someone has to deal out the policy, not the team....You know, I had to cut off and say that 's not our policy or something like that. There are things that I really believe in as a doctor and you know I never give in on that and I think if it's medical....something you cannot compromise, then I just say, that is our policy.

Thus, if the physician believes that an issue is "medical", he has the right to control the decision; otherwise, the team decides. It is especially interesting that this physician perceives that there are few opportunities for the group to vote on an issue.
Group members find other ways to immobilize the system by using paradoxical communication. I was the recipient of one of those paradoxical communications during my data collection. When I asked the groups to complete the written questionnaires, no one objected. When the surveys were collected, however, I found that three therapists had written me long notes on the back of the consent form. These individuals explained that they objected to the nature of the study and had better things to do with their time. They then completed the survey, but did not sign the consent form! This is a classic example of a returned paradox. It was obvious that the therapists felt compelled to go along with the collective decision to participate in the study but chose to immobilize that response by making the data unusable.

ADAPTATION OF THE FUNCTIONAL SYSTEM

As I discussed in the previous two sections, one way that the team members cope with the inconsistencies between the implicit and explicit expectations is to bring the functional system into line with the underlying ideology. This is accomplished through rituals and strategic ambiguity, but it is also accomplished through the type of decision-making process which is used. The data from the questionnaires which compares decision-making and conflict resolution style illustrate a level of functional adaptation. The five groups were observed to behave as if there were variations in their orientation along five dimension: rule explicitness, leader-orientation in decision-making, openness to alternative ideas (boundary rigidity), sense of provinciality (having the right to tell the patient what to do) and affective tone. In an attempt to ascertain whether they were able to perceive the evaluate the group along these dimensions, I developed a survey, asking them to rank the group along sixty word descriptors of these dimensions (Appendix F). The mean scores of each dimension of the survey appear in Table 5. It should be noted that the Team E scored higher on all dimensions, except for rule orientation. This would be consistent with the orientation of that group toward a more supportive, environment. The only group which scored higher on the rules orientation than the Team E was the Team B. In this team, the group leader was quite animated and involved in the group process, but was also unpredictable in his manner of conducting the meetings. It is also worthy of note that Team A scored lowest overall. This is consistent with the observation of rigid structuring in that group.
Table 5.
Mean Scores Along Five Dimension of Group Culture

<table>
<thead>
<tr>
<th>GROUP</th>
<th>N</th>
<th>RULES ORIENT</th>
<th>DECISION MAKING</th>
<th>BOUNDARY PROVIN-ORIENT. CIALITY</th>
<th>AFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEAM A</td>
<td>9</td>
<td>29.25</td>
<td>30.25</td>
<td>38.50</td>
<td>34.50</td>
</tr>
<tr>
<td>TEAM B</td>
<td>7</td>
<td>38.50</td>
<td>39.50</td>
<td>42.00</td>
<td>42.50</td>
</tr>
<tr>
<td>TEAM C</td>
<td>7</td>
<td>29.67</td>
<td>40.00</td>
<td>44.67</td>
<td>43.67</td>
</tr>
<tr>
<td>TEAM D</td>
<td>6</td>
<td>28.33</td>
<td>38.67</td>
<td>43.67</td>
<td>41.00</td>
</tr>
<tr>
<td>TEAM E</td>
<td>7</td>
<td>34.75</td>
<td>40.75</td>
<td>45.25</td>
<td>45.75</td>
</tr>
</tbody>
</table>

The only dimension which showed significant differences between the teams was the decision-making dimension. A one way analysis of variance performed on the dimension scores, with the team as a grouping variable revealed a significant difference between the TEAM A and the other four teams (F-value of 4.6185, probability (tail) of 0.0197 at 11 d.f.). A summary of the T-Test comparisons between groups appears in Table 6. Reliability of this subscale was calculated at $r=0.7834$. 
Table 6
T-Test Matrix Comparing Team A with Other Teams: Decision-Making Dimension

<table>
<thead>
<tr>
<th>GROUP</th>
<th>T-VALUE</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEAM B</td>
<td>2.7277</td>
<td>0.0197</td>
</tr>
<tr>
<td>TEAM C</td>
<td>3.2601</td>
<td>0.0076</td>
</tr>
<tr>
<td>TEAM D</td>
<td>2.8143</td>
<td>0.0168</td>
</tr>
<tr>
<td>TEAM E</td>
<td>3.7922</td>
<td>0.0030</td>
</tr>
</tbody>
</table>

\[a\] Values at 11 d.f.

The lower the score on the inventory, the more rigidly structured the interaction in the group. A low mean score on the decision-making dimension indicates a strong leader-orientation. This is consistent with the group observations of the Team A. In this case, there has been functional adaptation of the group to the implicit assumptions of physician dominance. While group members "act out" and try to avoid decision making, they nonetheless submit to the rigid physician leadership.

A second way that groups functionally adapt to the implicit assumptions of the culture is through conflict management style. While conflict management style is conceptually an individual variable, I asked participants to complete Putnam and Wilson's (1982) Organizational Communication Conflict Inventory, to see if the culture of the groups appeared to influence a group trend toward conflict style. The mean group scores along the three dimensions of the scale (nonconfrontation, solution orientation, control orientation) appear in Table 7.
Table 7.
Mean Scores of Teams on Subscales of O.C.C.I.

<table>
<thead>
<tr>
<th>SUBSCALE</th>
<th>TEAM A</th>
<th>TEAM B</th>
<th>TEAM C</th>
<th>TEAM D</th>
<th>TEAM E</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONCONFRONTATION</td>
<td>64.25</td>
<td>72.00</td>
<td>68.00</td>
<td>55.33</td>
<td>66.25</td>
</tr>
<tr>
<td>SOLUTION ORIENTATION</td>
<td>29.75</td>
<td>26.50</td>
<td>30.33</td>
<td>41.00</td>
<td>28.25</td>
</tr>
<tr>
<td>CONTROL ORIENTATION</td>
<td>26.00</td>
<td>32.00</td>
<td>26.67</td>
<td>28.33</td>
<td>32.00</td>
</tr>
</tbody>
</table>

The lower the score on the subscales, the more tendency toward nonconfrontation, solution orientation and a need to control in decision making. It is interesting to note that Team A had the lowest scores on the nonconfrontation and control scales. This is consistent with their pattern of avoiding conflict and trying to control the outcome. Team B had the lowest scores on the solution-orientation subscale. This is the group in which the leader asked for a "show of hands" about a problem. Team D, on the other hand, had significantly higher scores on the solution-orientation subscale than any other group (F=3.7280, probability =0.0374). Reliability on this subscale was r=0.7317. A summary of the T-test matrix comparing the head injury team with the other four teams appears in Table 8.
Table 8
T-Test Matrix Comparing Team D with other Teams: Solution Orientation

<table>
<thead>
<tr>
<th>GROUP</th>
<th>T-VALUE&lt;sup&gt;a&lt;/sup&gt;</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEAM A</td>
<td>2.9265</td>
<td>0.0138</td>
</tr>
<tr>
<td>TEAM B</td>
<td>3.1558</td>
<td>0.0091</td>
</tr>
<tr>
<td>TEAM C</td>
<td>2.5955</td>
<td>0.0249</td>
</tr>
<tr>
<td>TEAM E</td>
<td>-3.3167</td>
<td>0.0069</td>
</tr>
</tbody>
</table>

<sup>a</sup> Values at 11 d.f.

Team D has functionally adapted to the expectations of the ideological system by avoiding solutions to conflicts. This group was especially interesting, because the physician leader and most group members were identified as very submissive, yet task oriented. The group process was characterized by a great deal of task-focused discussion which ended with the physician summarizing and making the decision. Thus, this group has functionally adapted to the implicit themes by becoming more submissive and oriented away from group decision-making.

Of course, a word of caution must be exercised about the generalizability of these results, because of the small sample size. The reliability of the other subscales was significantly lower than those reported as significant. Nonetheless, the information gathered in the fourth phase of the research provided some validation to the observations made in the groups and the information obtained in the interviews.
MANIPULATING GROUP PERCEPTIONS

One way that the teams are able to function is by adapting the team (egalitarian) structure to a "baseball" or "football" mode of operation, which preserves the existing ideological structure. Another way of coping with the strain is to manipulate the group to give the appearance of consensus. I discussed earlier how department heads and managers describe their techniques of persuading through group consensus. This is often the case in the team meetings, as well. When a disagreement occurs between the physician and the group, one of two patterns typically emerges. Either the group reframes the physician's opinion into a form which is acceptable to them (restates it after discussion or offers a solution which is similar, yet different than the physician's) or the physician restates the problem in his or her own way, thus "owning" the identification of the problem and the control of the solution. In this way, group perception is manipulated so that the dominant force (physician) is preserved, yet each party believes that they have won. This is closely tied to the strategic ambiguity that I mentioned earlier.

CYCLES OF ARGUMENTS

One of the last ways that the system copes with the dissonance created by conflicts between implicit and explicit cultural assumptions is to challenge the underlying ideology of the organization. This challenge usually comes in the form of cycles of arguments in group process. One team member noted that the same issues kept coming up over and over in team meetings, with no resolution. One reason that resolution did not occur was probably due to the ambiguity in group decision making, but another reason was that the arguments challenged the dominance of the physician. In reality, such issues will continue to cycle over and over because they provide an outlet for cultural strain. This type of challenge provides a safe mechanism for the groups to challenge the dominant authority.

DISCUSSION

Although the members of the organization are able to cope with the strain of the inconsistencies between explicit and implicit themes in the culture through their communication processes, this strain does take its toll, nonetheless. The paradoxical nature of the cultural system leads to role confusion and a sense of unpredictability. This, in turn has an impact upon trust in the organization. Trust is an important element of social power. When a trusting
relationship has been established, there is less need for overt compliance gaining activities.

Luhmann (1979) notes that trust "serves to overcome an element of uncertainty in the behavior of people". Despite the paradoxical nature of the cultural assumptions in the rehabilitation hospital, a sense of stability stems from knowledge of past patterns and performance. Rituals reinforce these patterns.

Honesty and openness were significant themes used to describe the qualities of the good leader. Perhaps this is a reaction to past experiences with an administration where information was not shared with subordinates. Openness increases trust by providing information which is the basis for predictability in a relationship.

Social activities also increase trust. It is notable that, in this system, the most trustful and positive teams were those with shared activities. Conversely, the most defensive team was the one where the physician stated that he felt socially isolated.

The pain management team is known for its sense of humor. There were more inside jokes and laughter in that team than any other. This may have been due, in part, to the personality of the psychologist who worked with the team. Luhmann (1979) states, however, that joking and humor can only exist in a trusting environment. One cannot feel free to joke unless there is an ability to predict the reaction of the other person. The key difference in the trust level, here, appears to be that this group ritualizes the values of the explicit metaphor, rather than adapting to the implicit themes.

Distrust in an organization leads to a narrowing of perspective and a simplification of information. When a person is distrustful, s/he needs more information, but narrows the amount of information which s/he can rely upon. This narrowing of perspectives is evident in the fragmentation of approach by the team. Each person relies upon his or her own little piece of experience or knowledge. This, in turn, facilitates an attitude of provinciality and control.

Luhmann notes that inner certainty may be substituted for external certainty in order to achieve trust. This is most obvious in the provincial language of the staff in team meetings. In this case, the staff is able to displace uncertainty about external relationships with a sense of inner "rightness". While these attitudes may be functional for the team in achieving a level of trust necessary to achieve team goals, they have serious implications for the patients. The difficulty with trust in response to the paradoxical themes of the culture leads to greater provinciality and
manipulation of the patient. Thus, the strain created by the incongruencies between explicit and implicit organizational themes leads to an attitude of distrust in the organization. The members of the system cope with that in two ways. One is to increase individual sense of rightness and control and the other is to change patterns of communication to increase predictability or, failing that, permit ambiguity without penalty for differing interpretations.

This study has investigated the operation of social power in the context of the culture of a health care institution. It was discovered that the culture of this organization has evolved from two levels, administrative and patient care. This evolution has led to the development of a local culture with different themes than the macrosystem. There is no clear cut organizational theme, rather there is a system of themes which interact and complement one another. The culture of the organization shapes the exercise of social power in three ways.

First, organizational culture affects social power through the explicit themes revealed in the organizational philosophy, structure, values, roles and relationships. These, in turn, define the functional status relationships in the organization and contexts when compliance-gaining strategies are necessary and appropriate. The explicit themes further shape the perception of the bases of social power and legitimize certain compliance-gaining strategies for the members of the system. Finally, the explicit themes of the culture legitimize certain modes of reward and punishment in the organization, which determines how individuals may shape the needs of others in order to gain compliance.

A second impact of the organizational culture upon the exercise of social power occurs at the implicit level. The underlying ideological structure of the organization is revealed in the language patterns which are transparent to the members of the culture. These assumptions are largely unconscious and shape the true power relationships in the system. More importantly, the implicit themes determine potential power and, ultimately, when compliance will be automatic, with deference to authority.

Finally, I discussed ways that communication patterns in the organization support competing themes in the culture. While the inconsistencies in expectations can lead to distrust, individuals usually cope by developing rituals which legitimize one level or the other, using strategic ambiguity in group process, adapting the functional system to meet ideological
assumptions, using behaviors which immobilize the functional system, manipulating perceptions in order to give the appearance of consensus and challenging the implicit themes through cycles of arguments.

In Chapter V, I expand upon the discussion of organizational culture and social power by exploring some implications for organizational change. Specifically, I will discuss the process of development of organizational culture, the role of key individuals in cultural process, the role of systems of themes in an organization, the function of ambiguity in an uncertain organizational environment and approaches to organizational assessment and change.
CHAPTER V: IMPLICATIONS FOR ORGANIZATIONAL CHANGE

Social power is, among other things, the primary mode of creating organizational change. The use of informational power, through persuasion, is an important mechanism for altering perceptions in the organization. Further, social influence is used to change patterns of behavior in the organization. This final chapter offers an expansion of the discussion of organizational culture and social power by exploring some of the broader implications of the research. First, some ideas about the evolution of organizational culture are discussed. The effects of the material conditions and products of an organization as they relate to the organizational culture are highlighted. Further, I describe ways that local cultures develop and what their impact is upon the systems of cultural themes in an organization. Methods that organizations use to cope with the changing economical and social environment are outlined. The functionality of ambiguity and other communication strategies in an organization are also explored.

Finally, I propose a model for organizational change which includes a sensitivity to the operation of power in the culture. This model includes an assessment of cultural themes, plans for intervention which are based upon existant communication patterns and intervention strategies which include key opinion leaders in the organization.

Organizational culture evolves from a variety of communication activities and organizational processes. The multilevel construction of culture is clearly evident in the data described in this study. On the macrosystem level, cultural themes reflect environmental relationships and paradigmatic commitments of the organization. The driving force at this level is the economic conditions and resource requirements of the organization. For example, in the health care organization, the material structure has traditionally dictated that the physician was the gatekeeper of services. This function was derived from the role of the physician in bringing patients into the health care system. Patients have traditionally sought the care of a physician and the physician has brought the patient to the health care system. With the creation of Health Maintenance Organizations, however, this pattern is changing. The gatekeeper in the health...
care organization is now the insurer or the corporation, rather than the physician. This change has necessitated a corresponding shift in material assumptions of the health care systems. Hospitals are now more market-driven than ever before. This has led to a change in explicit themes in the organization, as cost-containment is now more salient.

The material conditions of the organization may dictate the environmental relationships, but the personality and philosophy of the top administration impacts significantly upon the explicit structure and relationships. The historical perspective of the early administration leadership is carried over into new generations of managers. Top management sends messages about organizational priorities and behavioral expectations to members of the organization. These may be strategic, as was evident in the communication of the new Executive Director or more indirect. When an organization changes hands, new generations of managers come in with different expectations. Yet, the culture of the organization may remain largely unchanged, because of the impact of local, cultural expectations.

The local culture evolves differently than the macrosystem. Local culture reflects, in part, greater social and cultural beliefs. This is especially evident in the differences between the eastern and western cultures. The success of "Theory Z" (Brozovich & Shortell, 1984) style of management in Japan is partially dependent upon greater cultural norms which make it easier for workers to accept egalitarian approach and a rigid hierarchical system.

Local culture is also affected by the type of product or service which is provided. For example, a manufacturing plant operation would have a local culture which differed significantly from the health care culture in this study. In a manufacturing plant, workers' interactions on the assembly line may be very limited. Their interactions during lunch and after-work social hours, however, would be very different. In the rehabilitation hospital people talked about their patients more than the hospital. Their loyalties surround the patient rather than the institution. In an industrial setting, on the other hand, communication may revolve more around the organization than the product. Thus, local culture might reflect different themes.

A third element which may affect local culture is the presence of opinion leaders. Lazarsfeld, Berelson and Gaudet (1948) proposed that mass media is communicated through a two-step flow process. Mediated communication is disseminated and interpreted by local opinion leaders in the community who filter and interpret information for others. Since broader organizational philosophy and goals are most often communicated through mediated rather than
interpersonal form, we can assume that the two-step flow may also operate in organizations. The influence of opinion leaders is most related to (their): "personification of certain values (who one is); (2) to competence (what one knows); and (3) to strategic social location (whom one knows)" (Katz, 1975, p. 313). Local opinion leaders were acknowledged by the Executive Director of the macrosystem as the "matriarchs and patriarchs" of the organization. In reality, tenure may not be as important for an opinion leader as credibility and central location.

Many organizations remain remarkably stable over time, despite tumultuous changes in the economic and social environment. While this stability is due, in part to the tenacity of the local culture, it may also be due to the use of ambiguity in communication. Organizations which have explicitly defined and rigid functional systems may be easily unbalanced when prevailing interpretations are challenged. Rigid configuration leads to a narrowing of alternatives for behavior. Eisenberg (1985) has noted that this is especially true with value systems. Individuals need to have the freedom for self expression in the collective environment. High levels of specificity may limit that freedom and its corresponding adaptability.

Organizations which are undergoing change tend to have greater amounts of specificity at the time of a shift in organizational paradigm or administrative personality. This heightened specificity sends messages to the local culture of paradigmatic and programmatic changes. Local opinion leaders interpret these changes for the local culture system, then adapt the message to meet their own needs. For example, in the target organization, the Executive Director sent a message about teamwork to the organization. The interpretation in the rehabilitation hospital was consistent with their image of (baseball) team. If, however, the Executive Director wanted a basketball team, he would have to work toward greater levels of specificity. This heightened specificity might be very destructive, however, if it caused the inherent ideological conflicts to emerge in the system.

Ambiguity can be very functional for an organization because it allows parallel ideological systems to operate. Such systems are most likely to emerge in organizations where there is a professional value system or work ethic which operates at the local level. For example, industrial plant workers might have a different value system than human service providers. The value of altruism and egalitarianism are not as likely to be seen on an assembly line as in a human service agency. Consequently, the local culture would be more likely to adopt themes of the upper
administration. Ambiguity in organizational structure may not be as important in this organization as it is in a system with competing cultural themes.

The second condition where ambiguity can be functional is during a period of organizational change. During such a period, ambiguity functions to allow a gradual shift in perceptions which will allow the local and macrosystem cultures to coexist. There is a general assumption clarity is important for effective communication (Eisenberg 1985). This study indicates that ambiguity can be just as functional. Perhaps the key to effective leadership is an understanding of when ambiguity is functional and when it is not.

Ambiguity may be dysfunctional when the lack of clarity interferes with the product in an organization. If, for example, the lack of clear cut decision-making resulted in poor patient care, then ambiguity would be seen as dysfunctional. Ambiguity may also be dysfunctional in an organization when it results in high levels of distrust. Trust is based upon predictability in communication. Ambiguity does not necessarily mean distrust. Rather, there can be trust built upon lack of specificity. When, however, an individual is strategically ambiguous in one circumstance and specific in another, distrust will result, especially if the specific message is not congruent with the individual's interpretation.

Finally, ambiguity can be dysfunctional when economic and social changes require major readjustments in the organizational paradigm. This might occur, for example, in an organization such as the Chrysler Corporation which was forced by economic conditions to focus on quality in production. Under those circumstances, persistent ambiguity would have impeded progress in organizational change. Similarly, in the rehabilitation center, there was a change required by an accreditation agency for collaborative charting and goal setting. This change forces greater emphasis upon process in the team meetings. It, further, makes power issues more salient as the expectation for sharing in decision making is more clearly defined. Lack of clarity about the meaning of mutual goal setting could result in a continuation of ambiguity in group process.

How, then, does an organization change its culture? Often, during changes in administration there is a heightened interest in sensing the organization. The philosophy of the new administration is announced. The organizational chart is changed and yet the culture remains the same. Cultural change requires more than a paradigmatic shift. It requires a slow adaptation of the perceptual orientation of the organization members. Generally, planned
change in a culture should include a careful assessment of the existing organization, a plan for intervention should include both local and macrosystem culture and an intervention strategy which includes key opinion leaders in the system.

This study is one approach to assessment of an organizational culture. While it may be appropriate for a small system or subsystem, such as the target population, it would be too time consuming for a larger system. The first phase, then, is to identify units of the organization which appear to be representational of the overall culture. The initial assessment should include an analysis of linguistic and event markers to discover major thematic systems in the culture. The initial analysis should also identify individuals who appear to be key opinion leaders in the local culture. These opinion leaders are important to create any lasting local cultural changes.

Plans for organization intervention should include a consideration of fundamental power relationships in the organization. Paradigmatic shifts which flush out ideological conflicts should be carefully evaluated. If the organizational goals require a shift in the underlying power structure, then ideological commitments must be evaluated. The process of challenging ideological commitments is slow and time consuming. It necessitates the exposure of core values and attitudes and the development of a common frame of reference about key communication processes, such as decision making and conflict resolution. The plan for intervention should include a consideration of the level of specificity which is required in the organization. In the cultural analysis, ambiguity may be an indication of underlying ideological conflict. The role of ambiguous communication processes should be considered before high levels of specificity are imposed. The plan for intervention should include a consideration of the types of communication patterns which will be compatible with local cultural themes.

The implementation of cultural change must occur on several levels. At the local level, key opinion leaders should be involved early in the process. Recalling that collaborative approaches to power are often selected in complex organizations, key opinion leaders should be given an opportunity to share in the perception of key concepts. On a broader level, mediated communication should include shifts in organizational themes. Key cultural events, such as orientation and social activities should be used as forums for interpersonal communication which would increase an understanding of explicit themes. Finally, cultural change should include a consideration of the way key members of the system can become sensitive to cultural themes. The process of cultural change is slow and requires periodic
surveillance and reanalysis. Mumby (1984) notes the role of the researcher in critical interpretation as one who trains members of the organization to continue the process. Ideally, members of the local culture should be attuned to themes and meanings at that level.

Social power is, ultimately, the medium for change in the organization. The perception of social power is enmeshed in the cultural system. The use or evasion of power is shaped by and, in turn, shapes that culture. Through persuasion and social influence, ideological assumptions may be exposed and challenged. This paper has presented one method of evaluating organizational culture. It has shown how implicit and explicit themes in the culture affect the exercise of social power and how organizations adapt to multiple ideological assumptions. Through careful investigation of the operation of power in the organizational culture, lasting cultural change can be accomplished.
REFERENCES


APPENDIX A
CONSENT FOR PARTICIPATION IN RESEARCH
THE OHIO STATE UNIVERSITY
DEPARTMENT OF COMMUNICATION

I consent to participate in the research study entitled "Organizational Culture and Social Power"

Mary Jo Perley, or her authorized representative has explained the purpose of the study, the procedures to be followed and the expected duration of participation. Possible benefits of the study have been explained.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any questions I have raised have been answered to my full satisfaction. I understand that I am free to withdraw consent at any time and to discontinue participation in the study without prejudice to me. The information obtained by me will remain confidential.

Further, I specifically agree to permit the content of my conversation with the researcher to be audiotaped, by placing my initials here___________.

Finally, I acknowledge that I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

DATE: _______________ SIGNED: __________________________

(Principal investigator or his/her authorized representative)
APPENDIX B
INTERVIEW SCHEDULE

1. First, I am going to ask you some general questions about ___________
Every organization has an overall philosophy and goal. What do you see as the most important
goal recognized by this organization?

2. I would like to ask you a few questions about your job here at _________
   a. What is your position?
   b. What are your primary job responsibilities?
   c. How many people (if any) do you supervise?
   d. What do they do?
   e. Outside of the duties designated in your job description, what other roles do you
      fill in the organization? (probe for formal and informal roles)
   f. How much of your time is spent in these informal roles rather than formal job
      responsibilities.

3. Let's turn, for a moment, to the social atmosphere at___________. Almost every
   organization has planned social events, such as Christmas parties, picnics, etc. What type of
   formal social events do you have at ____________?
   a. Who plans these?
   b. Who attends them?
   c. Is business ever conducted at these social functions?
   d. What would happen if you didn't go?

4. Many times employees get together in spontaneous, informal social groups for events such as
   a beer after work. What types of informal social events happen at__________?
   a. Who attends these (who is invited)?
   b. How often do these gatherings happen?
   c. What is discussed?
   d. Do you ever socialize with your boss in informal settings?
      How often?
      At whose request?
      What do you discuss?

5. Many organizations have customs or traditions such as the person who is leaving the
   organization buying everyone a drink. What traditions are followed at__________?

6. Sometimes, members of an organization have favorite stories they retell over and over. Tell
   me a couple of your favorite stories that are told here.

7. Next, I would like to get some information about your orientation to ________. What type of
   formal orientation program did you have when you started to work here?
   a. Beyond that, how did you actually "learn the ropes" here (learn what was expected in
      the job, how people were expected to behave, etc.)
b. If you were responsible for helping a new employee learn about __________, how would you go about it?

7. One of the things you learned when you came here was how to communicate in the system. I would like to learn more about the channels of communication which are used here.
   a. On the average, do you spend most of your time talking to people face to face or on the telephone?
   b. If you really wanted to get your boss’ attention about an important issue, how would you do it?
   c. What types of routine communications are used here (monthly reports, memos, newsletters, etc.)
   d. Who do you get written communication from? How often?
   e. How would you go about communicating to the chief executive? (chain of command, written or verbal)
   f. If you needed to talk with a manager or employee in another part of the building, would you call them or go to their office?
   g. Do people make appointments to discuss routine matters with you? Important matters?
   h. How often do you follow up conversations with written memos? What types of information do you communicate in writing? Verbally?

8. This is very helpful. Let’s turn for a minute to discuss your relationship with your boss (supervisor). What is his or her position?
   a. Describe your boss for me (probe for affective as well as demographic or functional information)
   b. What do you like best about your boss?
   c. What do you like least about your boss? (If you could change something about your boss, what would it be?)
   d. Overall, are you satisfied with your relationship with your boss? (on a scale of one to ten)

9. Now, let’s explore, for a minute, your relationship with your subordinates. Who answers to you in the “chain of command”?
   a. Describe this person for me. (probe for affective as well as demographic or functional information)
   b. What do you like best about this person?
   c. What do you like least about this person? (If you could change something about him or her, what would it be?)
   d. Overall, are you satisfied with your relationship with this person? (on a scale of one to ten)

10. Most managers in an organization like to know how they are doing on the job. What means are used at __________ to give feedback about performance? (probe for formal and informal)
    a. How do you get good information?
    b. How do you get bad information?

11. Sometimes an individual can do their job well functionally, and yet not really seem to fit in well
with the organization. How would you know if you fell into this category?

12. Taking this a little further, most managers in an organization know what is expected of them. Describe the ideal manager at __________for me (probe for affective as well as functional characteristics)

13. This last section deals specifically with management functions. A big part of every manager job is getting people to do things, even when they may not want to.
   a. What are the most common situations where you have to influence people?
   b. Thinking back on the last few months, describe a situation for me where you felt very successful in influencing someone to do something.
      How did you handle the situation?
      Why did you handle the situation that way?
      How important was the outcome to you?
      What did you think about most when you were planning what to do?
      What made you feel most satisfied with the way you handled this situation?
      Did you get any feedback about the way you handled it?

   b. Finally, I would like for you to think back on the last few months and describe a situation for me where you were dissatisfied with the way you influenced someone.
      How did you handle the situation?
      Why did you handle the situation that way?
      How important was the outcome to you?
      What did you think about most when you were planning what to do?
      What made you feel most dissatisfied with the way you handled this situation?
      Did you get any feedback about the way you handled it?
BACKGROUND INFORMATION

Before completing the information on the following sheets, would you please provide the following background information for the study? Complete each item below.


2. SEX:  ____ FEMALE  ____ MALE

3. OCCUPATION:  ____ Physical therapist
                  ____ Occupational therapist
                  ____ Recreational therapist
                  ____ Speech therapist
                  ____ Registered Nurse
                  ____ Social Worker
                  ____ Psychologist
                  ____ Dietician
                  ____ Physician
                 Other: ____________________________

4. Job Title: __________________________________________

5. Length of employment: ______________________________

6. Patient care team: __________________________________

7. Length of time associated with this team: ______________
Most people describe the approach to patient care as a team approach. As we all know, teams vary greatly according to their goals and structures. Sometimes it is easier to think of teams in familiar terms, such as sports. Below are brief descriptions of the similarities and differences of three types of sports teams:

Football teams rely upon coordination from above. The head coach directs the team, with each player having a narrow piece of the game plan. The players who handle the ball most gain the greatest recognition.

In baseball teams, the players function independently, although in a coordinated way. Individual performance is important and recognized. The manager has little to do other than to get the proper players into the game at the appropriate time in the right order.

In basketball teams, players interact spontaneously and must mutually adjust to each other. The flow and chemistry of the team is very important. The coach of a basketball team acts more as a catalyst than a director. The team is recognized as a unit, rather than as individuals.

1. Thinking about the three types of sports teams just described, which type of team do you think your patient care team is? (check one)

   __football team  __baseball team  __basketball team

2. Explain why you chose this type of team.

3. In what way is your patient care team similar to the description?
4. In what way is your patient care team different from the description?

5. Who is the coach of your team?

6. What is the ultimate goal of your team?

7. Do you believe that the structure of your team is appropriate for the goals at hand? Why?

8. If you do not believe that the structure of your team is appropriate for the goals at hand, then which type of team do you believe would be more effective? Why?
DIRECTIONS: On the left below are some descriptions of typical group behaviors. Across the top of the columns, you should write in the names of all of your group members, following the column marked YOURSELF. Next, you should rank your group members according to the frequency with which you generally see these behaviors displayed in the panel and team meetings. Try to think about how each person behaves, on the average, and rate the behaviors according to the frequency you think they are displayed, as 0=NOT OFTEN, 1=SOMETIMES, AND 2=OFTEN.

You will notice that the first column is marked YOURSELF. In the row to the right of each description in this column, indicate how you saw yourself behaving in the group by writing in the appropriate number (0,1,2). Then proceed to rate each of the members of your team in a similar fashion. Thank you.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>NAMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Active, dominant, talked a lot</td>
<td></td>
</tr>
<tr>
<td>2. Extraverted, outgoing, positive</td>
<td></td>
</tr>
<tr>
<td>3. Purposeful, democratic, Task leader</td>
<td></td>
</tr>
<tr>
<td>4. Assertive, business-like manager</td>
<td></td>
</tr>
<tr>
<td>5. Authoritarian, controlling, disapproving</td>
<td></td>
</tr>
<tr>
<td>6. Domineering, tough-minded, powerful</td>
<td></td>
</tr>
<tr>
<td>7. Provocative, egocentric, showed off</td>
<td></td>
</tr>
<tr>
<td>8. Joked around, expressive, dramatic</td>
<td></td>
</tr>
<tr>
<td>9. Entertaining, sociable, smiling, warm</td>
<td></td>
</tr>
<tr>
<td>10. Friendly, egalitarian</td>
<td></td>
</tr>
<tr>
<td>11. Worked cooperatively with others</td>
<td></td>
</tr>
<tr>
<td>12. Analytical, task-oriented, problem-solving</td>
<td></td>
</tr>
<tr>
<td>13. Legalistic, had to be right</td>
<td></td>
</tr>
<tr>
<td>14. Unfriendly, negativistic</td>
<td></td>
</tr>
<tr>
<td>15. Irritable, cynical, wouldn't cooperate</td>
<td></td>
</tr>
<tr>
<td>16. Showed feelings and emotions</td>
<td></td>
</tr>
</tbody>
</table>

SCALE: 0=NOT OFTEN  1=SOMETIMES  2=OFTEN
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td>Affectionate, likeable, fun to be with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Looked up to by others, appreciative, trustful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Gentle, willing to accept responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Obedient, worked submissively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Self-punishing, worked too hard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Depressed, sad, resentful, rejecting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Alienated, quiet, withdrawn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Afraid to try, doubts own ability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Quietly happy just to be with others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Passive, introverted, said little</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 1. Unexpanded Average SYMLOG Field Diagram
(Team A)

*THE FOLLOWING PERSONS
(OR OBJECTS) HAVE
DUPLICATE LOCATIONS:
U-D  P-N  F-B
0  11  -2
0  11  .4
Figure 2. Unexpanded Average SYMLOG Field Diagram (Team B)

*THE FOLLOWING PERSONS (OR OBJECTS) HAVE DUPLICATE LOCATIONS:

<table>
<thead>
<tr>
<th>U-D</th>
<th>P-N</th>
<th>F-B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>3</td>
</tr>
</tbody>
</table>
Figure 3. Unexpanded Average SYMLOG Field Diagram
(Team C)
Figure 4. Unexpanded Average SYMLOG Field Diagram
(Team D)

The following persons (or objects) have duplicate locations:
U-D  P-N  F-B
4  9  0
-1  9  0
Figure 5. Unexpanded Average SYMLOG Field Diagram
(Team E)

*THE FOLLOWING PERSONS (OR OBJECTS) HAVE DUPLICATE LOCATIONS:
U-D  P-N  F-B
-3   12   3
 3   12   3
APPENDIX G

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INSTRUCTIONS: Below are some words which may be used to describe characteristics of groups. Thinking about this interprofessional team at ________, indicate the extent to which you think this word describes this group. Mark your response to the right of each word by circling a number; the higher the number, the more accurately you think the word describes the group. For example, if you feel that the group is very disorganized, you would circle a number “5” to the right of the word disorganized. Please respond to every item.

1. formal 1 2 3 4 5 22. agreeable 1 2 3 4 5
2. structured 1 2 3 4 5 23. helpful 1 2 3 4 5
3. orderly 1 2 3 4 5 24. cohesive 1 2 3 4 5
4. predictable 1 2 3 4 5 25. encouraging 1 2 3 4 5
5. stable 1 2 3 4 5 26. supportive 1 2 3 4 5
6. prescriptive 1 2 3 4 5 27. exclusive 1 2 3 4 5
7. autocratic 1 2 3 4 5 28. closed 1 2 3 4 5
8. single-minded 1 2 3 4 5 29. territorial 1 2 3 4 5
9. self-assertive 1 2 3 4 5 30. jealous 1 2 3 4 5
10. cooperative 1 2 3 4 5 31. discouraging 1 2 3 4 5
11. unstable 1 2 3 4 5 32. unprotected 1 2 3 4 5
12. group-oriented 1 2 3 4 5 33. permeable 1 2 3 4 5
13. decisive 1 2 3 4 5 34. flexible 1 2 3 4 5
14. impermeable 1 2 3 4 5 35. indecisive 1 2 3 4 5
15. rigid 1 2 3 4 5 36. hindering 1 2 3 4 5
16. variable 1 2 3 4 5 37. open-minded 1 2 3 4 5
17. divisive 1 2 3 4 5 38. spontaneous 1 2 3 4 5
18. inflexible 1 2 3 4 5 39. nonsupportive 1 2 3 4 5
19. permissive 1 2 3 4 5 40. adaptable 1 2 3 4 5
20. inclusive 1 2 3 4 5 41. democratic 1 2 3 4 5
21. resistant 1 2 3 4 5 42. open 1 2 3 4 5
43. collaborative 1 2 3 4 5
44. universal 1 2 3 4 5
45. relaxed 1 2 3 4 5
46. informal 1 2 3 4 5
47. quarrelsome 1 2 3 4 5
48. intolerant 1 2 3 4 5
49. conflictual 1 2 3 4 5
50. rejecting 1 2 3 4 5
51. certain 1 2 3 4 5

52. stiff 1 2 3 4 5
53. consensual 1 2 3 4 5
54. hostile 1 2 3 4 5
55. tolerant 1 2 3 4 5
56. random 1 2 3 4 5
57. accepting 1 2 3 4 5
58. tentative 1 2 3 4 5
59. leader-oriented 1 2 3 4 5
60. friendly 1 2 3 4 5

KEY
RULE ORIENTATION: ITEMS 1, 2, 3, 4, 5, 6, 11, 16, 19, 38, 56
DECISION-MAKING ORIENTATION: ITEMS 7, 8, 10, 12, 13, 35, 41, 43, 49, 53, 59
BOUNDARY ORIENTATION: ITEMS 14, 15, 20, 27, 28, 29, 30, 32, 33, 44, 50, 57
PROVINCIALITY: ITEMS 18, 21, 34, 37, 40, 42, 45, 48, 51, 52, 55, 58
AFFECT: ITEMS 17, 22, 23, 24, 25, 26, 31, 36, 39, 47, 54, 60
Figure 7: Organizational Chart Part II
SHORT DESCRIPTIONS OF VALUE TYPES
Arranged by number and code name (Code name = location in the cube space)

1 U Individual prominence, financial success, personal power
2 UP Popularity and social success, being liked and admired
3 OPE Active teamwork toward common goals, organizational unity
4 UF Efficiency, strong effective management
5 UNF Active reinforcement of authority, rules, and regulations
6 UN Tough-minded, self-oriented assertiveness
7 UNB Rugged, self-oriented individualism, resistance to authority
8 UB Having a good time, releasing tension, relaxing control
9 UPB Protecting less able members, providing help when needed
10 F Equality, democratic participation in decision making
11 PF Responsible idealism, collaborative work
12 F Conservative, established, "correct" ways of doing things
13 NF Restraining individual desires for organizational goals
14 N Self-protection, self-interest first, self-sufficiency
15 NB Rejection of established procedures, rejection of conformity
16 B Change to new procedures, different values, creativity, growth
17 PB Friendship, mutual pleasure, recreation
18 DP Trust in the goodness of others
19 DPF Dedication, faithfulness, loyalty to the organization
20 DF Obedience, respect for authority
21 DNF Self-sacrifice if necessary to reach organizational goals
22 DN Passive rejection of popularity, going it alone
23 DND Admission of failure, withdrawal of effort
24 DS Passive non-cooperation with authority
25 DPD Quiet contentment, taking it easy
26 D Suppression of personal needs and desires
1 UF INDIVIDUAL PROMINENCE, FINANCIAL SUCCESS, PERSONAL POWER:
often inferred from behavior perceived to be very active, domi­
nant, talkative; correlated characteristics may include high
physical or emotional energy, tendency to identify self with
powerful persons or images such as a powerful parent, modern
technology, wealth, weaponry, symbols of national greatness; may
be a response to competitive challenge from outside or within
the organization; may be a result of active attempts to suppress
an underlying fear of attack or domination by others or a chronic
fear of weakness or failure.

2 UP POPULARITY AND SOCIAL SUCCESS, BEING LIKED AND ADMIRE:
often inferred from behavior perceived to be very socially extro­
verted, outgoing, positive; correlated characteristics may
include original sociable temperament, receipt of high accep­
tance, recognition, admiration from either outside or within the
organization, expansive feeling of high personal involvement, ex­
pansive self picture including high confidence in own task abil­
ity as well as own interpersonal warmth; may be a result of iden­
tification of self with an idealized parent, or a result of ac­
tive efforts to overcome underlying feelings of depression.

3 UFF ACTIVE TEAMWORK TOWARD COMMON GOALS, ORGANIZATIONAL UNITY:
often inferred from behavior perceived as purposeful democratic
task leadership; correlated characteristics may include identifi­
cation of self with an idealized authority, acceptance of the
tasks given by authority, feeling of liking others, may be re­
luctant to recognize any dislike, may depend upon the power of
over-idealized positive feelings to submerge, deny, or trans­
form negative feelings and dislikes within the group, may struggle to
be super-competent in spite of feelings of wanting to quit, or to
show rebellious independence.

4 UF EFFICIENCY, STRONG EFFECTIVE MANAGEMENT:
often inferred from behavior perceived as assertive, business­
like, strictly impersonal; correlated characteristics may in­
clude emphasis on loyalty rather than liking among members, iden­
tification with an impersonal plan, a right and correct way of
doing things in order to realize the plan, goal, or task pre­
scribed for the group by higher authority, a tendency to be in­
sensitive to individual differences, to adhere literally to the
plan as he or she conceives it without regard to consequences,
possibly preoccupied with anxiety about punishment for failure.

5 UNF ACTIVE REINFORCEMENT OF AUTHORITY, RULES, AND REGULATIONS:
often inferred from behavior perceived as authoritarian, control­
ling, disapproving; correlated characteristics may include strong
identification of self with authority, with the right and respon­
sibility to punish others for wrongdoing or lack of discipline;
may be activated by felt threat to survival of self or group
from outside sources, or from internal sources of weakness, dis­
loyalty, or evil intent, real or imagined; may include tendency
to blame others for own faults, need to view the self as per­
fect, blameless, and as a hero in the defense of the group from
urgently present dangers, both external and internal.
TOUGH-MINDED, SELF-ORIENTED ASSERTIVENESS: often inferred from behavior perceived as domineering, powerful, contemptuous of the welfare of others; correlated characteristics may include physical strength, overactive aggressive temperament, build-up of anger from frustration, long exposure to situations ruled by violence, force, threats of force, deception, distrust, lack of social solidarity and support, threat to survival, need to depend upon self alone; consequent belief in "survival of the fittest" as the "law of the jungle", contempt for weakness and dependence, fear of being weak and trustful, hence vulnerable.

RUGGED, SELF-ORIENTED INDIVIDUALISM, RESISTANCE TO AUTHORITY: often inferred from behavior perceived by authority as provocative, egocentric, show-off; correlated characteristics may include a conception of the self as having fought with a bad authority and won, a special contempt of "nice little girls and boys" who knuckle under to authority, a tendency to display the self as fascinating, amazing, shocking, unrestrained, spectacular, mysterious, or incalculable, a tendency to attract attention by extravagant mannerisms, dress, or speech; may be directed to others who display submissive dependence, conventionalism, or authority.

HAVING A GOOD TIME, RELEASING TENSION, RELAXING CONTROL: often inferred from behavior perceived as joking around, expressive, dramatic, often motivated by underlying negative feeling, disguised and discharged in jokes or humorous behavior; the effect is to shift the feeling tone in a positive direction, and to increase the feeling of freedom and self confidence in dealing with threatening situations and overpowering negative emotions—fear, anxiety, depression, alienation from others, hopelessness, fatigue, frustration, etc.; requires a sense of perspective, ability to resist authority, demands of convention.

PROTECTING LESS ABLE MEMBERS, PROVIDING HELP WHEN NEEDED: often inferred from behavior perceived as entertaining, sociable, smiling, warm; correlated characteristics may include tendency to give others emotional support, concern for their comfort and welfare, concern to keep the emotional tone of the group on the warm and friendly side, may be motivated by a naturally nurturant temperament, or by experiences of hostile attack by an authoritarian parent or other dangerous and threatening person; may feel anxiety at any signs of disagreement or conflict, fears attack on members who may be seen as unable to meet task demands.

EQUALITY, DEMOCRATIC PARTICIPATION IN DECISION MAKING: often inferred from behavior perceived as friendly, unconcerned with status differences, unafraid of disagreement, correlated characteristics may include lack of anxiety, lack of hostility, high self confidence and favorable self picture, seems to appreciate and enjoy others, aims to elicit friendly reactions from others, and expects to be accepted and valued as an equal; background often includes parents or others who gave unconditional and unconflicted love; there are, however, "false positives", who seem to be motivated by fear of hostile attack or domination.
1 PF RESPONSIBLE IDEALISM, COLLABORATIVE WORK:
often inferred from behavior seen as working cooperatively with others without any obtrusive status concerns, optimism with regard to task success, and altruism with regard to others; correlated characteristics may include tendency not to see domination and to deny or overlook unfriendly behavior of others, to feel admiration for others and see the good in them, tends to agree and to attract interaction from others because they wish to receive agreement, may be uncritical about authority and attracts contempt from cynical members because of this, believes in love.

12 F CONSERVATIVE, ESTABLISHED, "CORRECT" WAYS OF DOING THINGS:
only inferred from behavior seen as strictly analytical, task-oriented, problem-solving; correlated characteristics may include an unquestioning acceptance of the task as given, and the authorized way of doing it, a serious and searching attitude toward truth or the best precedents, a constrained, persistent and impersonal manner, continuous attention to the task and a lack of humor, a desire to have things highly organized, well-defined, and under control; may be trying to prevent anxiety about expected punishment from authority if things are not done properly.

13 NF RESTRAINING INDIVIDUAL DESIRES FOR ORGANIZATIONAL GOALS:
only inferred from behavior seen as persistently legalistic, a pervasive attempt always to be right; correlated characteristics may include a firm conviction that one is right and is the agent of authority, that one properly understands and interprets the law, the rules and regulations, the task, logic, and rationality; insists on compliance, induces guilt and fear of punishment in others, though strict compliance may appear to others to be unpleasant, or too costly, inefficient, injurious to the general welfare of the organization, outmoded or irrational.

14 N SELF-PROTECTION, SELF-INTEREST FIRST, SELF-SUFFICIENCY:
only inferred from behavior that seems unfriendly, negativistic, persistently in disagreement with attempts of others to preserve solidarity, equality of opportunity, common rewards, and common fate of the group as a whole; correlated characteristics may include a fear of being drawn into a dangerous trust in others, who may then turn on one, a fear of being drawn into mediocrity, or into an over-involvement that will prevent one's own rise in status, a fear that the group as a whole will not survive, and that one must provide security for the self at all costs.

15 NB REJECTION OF ESTABLISHED PROCEDURES, REJECTION OF CONFORMITY:
only inferred from behavior that seems irritable, cynical, evasive, uncooperative; correlated characteristics may include negative attitudes toward the group as well as the task, criticism of conventionality in general, often a dissatisfaction with the self, society, and one's situation in life as well; often seems to embrace personal and political positions that seem radical to the majority of the group; may emphasize personal freedom and autonomy, wishes to "stand alone", perhaps to provoke rejection; may refuse to accept expected social role—age, sex, occupation, social class, citizenship; resents authority, fears domination.
16 B CHANGE TO NEW PROCEDURES, DIFFERENT VALUES, CREATIVITY, GROWTH:
often inferred from behavior that seems emotionally expressive,
responsive to feeling and intuition rather than to the intel­
etual control ordinarily thought to be necessary to rational prob­
lem solving and task performance; may be motivated by rejection
of authority and demands of the present task, or by boredom and
fatigue, but also may be motivated by the feeling that one has a
better or more creative idea, or that creativity requires some
relief or protection from presently established routine demands,
that growth and development require time, some play and patience.

17 P8 FRIENDSHIP, MUTUAL PLEASURE, RECREATION:
often inferred from behavior that seems affectionate, likeable,
oriented to present pleasure and fun, rather than to the demands
of the task or other serious concerns; correlated characteristics
may include tendency to attract jokes, friendly and personal
small talk; may tend to identify with underprivileged persons of
all kinds, favors emotional supportiveness and warmth, favors an
assumption of expanding resources, interested in personal growth,
social change conducive to growth, wants to raise the status of
the underprivileged, to share liberally, without preconditions.

18 DP TRUST IN THE GOODNESS OF OTHERS:
often inferred from behavior that seems appreciative, trustful,
dependent, calm and ready to admire others; correlated character­
istics may include a low participation rate, a tendency to emu­
late admired others; may be seen as observant and understanding;
related to others primarily in pair relationships, seldom address­
es the group as a whole; may be introverted and easily aroused
to sympathy, concerned with others in pain; avoids showing nega­
tive behavior, may have an underlying concern about, or fear of
dominant and cruel attacks by others; "tender-minded", sensitive.

19 DPF DEDICATION, FAITHFULNESS, LOYALTY TO THE ORGANIZATION:
often inferred from behavior that seems submissive, gentle,
accepting to accept responsibility, acceptant of authority, stable,
practical, good, conforming; correlated characteristics may in­
clude considerable inhibition, underlying anxiety about pleasing
authority, attempt to control anxiety or guilt by being very
nice and good; may show a tendency to overlook or downgrade the
importance of power, aggression, and material wealth in human
affairs, and to emphasize instead the importance of love, for­
giveness, acceptance of one's lot in life, and helping others.

20 DF OBEDIENCE, RESPECT FOR AUTHORITY:
often inferred from behavior that is submissive and very hard
working, persistent, even obsessive, in attempts to please
authority; correlated characteristics may include lack of humor,
inhibition of feelings, lack of expressiveness, an impersonal
neutral manner with regard to other members, marked carelessness
and caution in both working and speaking, an apparent concern
with serious thoughts which are kept to the self; may be fearful
that if thoughts and emotions are expressed they will be found
objectionable, embarrassing, or too revealing of the self.
21 DN SELF-SACRIFICE IF NECESSARY TO REACH ORGANIZATIONAL GOALS:
often inferred from behavior that seems self-punishing, so hard­
working that the person feels martyred, tends to complain and
make others (particularly those in authority, or those who are
seen as the origin of task demands) feel ashamed or guilty about
requiring so much; correlated characteristics may include high
factual dependence upon a demanding and punishing authority,
either present, or in the past, an identification with such a
feared person which extracts both extreme obedience, and extreme
ambivalent hostility, resentment of dependence, and self pity.

22 DN PASSIVE REJECTION OF POPULARITY, GOING IT ALONE:
often inferred from behavior that seems depressed, sad, resent­
ful; correlated characteristics may include social introversion,
a lack of social responsiveness, motivation may include concealed
envy, "sour grapes" attitude resulting from a failure to attain
social success, a feeling of loss of a valued part of the self,
a tendency to withdraw and mourn the loss; attitudes may tend to
devalue physical attractiveness, social-climbing techniques,
attractive clothes, cars, houses, and other possessions that may
assist popularity; the self may be demeaned or made unattractive.

23 DN ADMISSION OF FAILURE, WITHDRAWAL OF EFFORT:
often inferred from behavior that seems to indicate a feeling of
alienation both from the task and from other group members; quit­
ting the task, actually trying to leave the group, absenteeism,
slow-down of work, lack of participation, showing discouragement
and dejection, absent-mindedness, preoccupation; motivation
may involve factors outside the group, or in it, such as fatigue,
standards of success set too high, failure or fear of failure,
disagreement with direction of group goals, or conviction that
group goals are impossible, or that the means employed will fail.

24 DB PASSIVE NON-COOPERATION WITH AUTHORITY:
often inferred from behavior that seems similar to "non-violent
resistance"; may be motivated by a conviction that what is being
required by authority is wrong, or that particular group goals
or conventions are wrong, but that one should be "civil" in disobedience—one should seriously advocate a different set of val­
ues; may proceed from a history or experience of injustice, or
from present demands; may involve anxiety, fear of failure,
moral disapproval, or fear of personal guilt if one conforms;
attempt is to shame authority and avoid active punishment.

25 DB QUIET CONTENTMENT, TAKING IT EASY:
often inferred from behavior that seems to indicate that the per­
on is quietly happy just to be with others—active participation
is not required, either to please others or to accomplish group
tasks; may occur in a relaxed period after a job felt to be well
done, or may be a result of lack of experience as to what the
task requires, lack of training or ability, temporary disability;
or illness; the group is felt to be friendly and protecting, re­
sources are felt to be available, alienation from the task is not
felt, identification with others in a similar situation is likely.
SUPPRESSION OF PERSONAL NEEDS AND DESIRES;
often inferred from behavior that seems markedly introverted,
passive, uncommunicative, inexpressive, inhibited; may proceed
from a conviction that any active effort, any desire or feeling
that may lead to active effort, will result in failure, frustra­
tion and pain; therefore all desire, aspiration, effort, or at­
tempt to change the situation or the condition of the self is
given up; may result from repeated severe frustration; a kind of
"learned helplessness" may set in, neither positive nor negative
feeling about anything is expressed, the "self" is given up.

AVERAGE;
a value position too close to the center of all three of the
major dimensions of polarization to be further classified; may
result from a tendency both to approach and to avoid each of
the polar value positions because of frustrating experiences
in relation to each; may involve mental images of "horrible
examples" of persons, philosophies, or ideologies at each pole
that are rejected; may result in the inability to decide or to
act, hence very low participation in the group, or may at times
appear as a tendency to switch back and forth on issues, dis­
agreeing with others no matter which side they may take.