What a fascinating time to be in family medicine. Not since the inception of the discipline have we seen such vision and reflection about who we are, who we serve, and how we can enhance our relevance in a dysfunctional health care system. Never before have we had such easy access to so much information (and misinformation) and such powerful tools to use for purposes ranging from diagnosis to documentation. Terms like personal medical home, evidence-based medicine, and quality improvement are now part of our daily discourse. It is clear that we and our practices must transform in a meaningful way to provide the highest quality care to our patients and communities, but the way to do this is murky at best.

The Need to Address Culture

In the 2001 Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, and in subsequent reports on patient safety, the authors note that the culture of medical practices must be addressed to improve the quality of care. But what exactly is medical practice culture, and what do we know about influencing this culture to effect positive practice change? The literature on medical practice culture is still limited.

In the article by Isaacson et al in this month’s issue of *Family Medicine*, organizational culture (defined in the article as “the taken-for-granted values, underlying assumptions, expectations, collective memories, and definitions” of a practice) was determined using participant observation and interviews. They found that a chaotic/disorganized practice structure or a divided structure impeded physician-staff communication, resulting in lack of shared values and few staff receiving flu shots. On the other hand, a businesslike, hierarchical culture that mandated flu shots drove attitudes and got the job done. There are many aspects of practice culture, however, that were not explored and so we were left uncertain as to whether it was the mandate and free immunizations or a shared value that was operating to increase immunization rates.

Assessing Practice Culture

The literature is a bit confusing on the topic of practice culture, not always differentiating between culture (shared basic assumptions or values) and climate (perceptions of organizational policies and specific behaviors). In addition, culture itself is conceptualized and measured by several different instruments.

In one instrument, for example, nine dimensions (collegiality, information emphasis, quality emphasis, organizational identity, cohesiveness, business emphasis, organizational trust, innovativeness, and autonomy) are explored to assess culture. Another instrument, however, only defines two dimensions: (1) organizational process and (2) the method by which an organization relates to the outside world and dichotomized each dimension into two categories. The process dimension is categorized as either organic (characterized by flexibility and spontaneity) or mechanistic (characterized by control and stability). The methods of relating to the outside world are categorized as internal (characterized by activities to smooth organizational function) or external (characterized by competition and differentiation from other organizations). These two dimensions, each with two characterizations, then define four cultural “types”—clan (internal, organic), hierarchy (internal, mechanistic), developmental (external, organic) and market (external, mechanistic).

Using the former, nine-dimensional instrument, Curoe et al found cultural differences based on practice size and ownership. Specifically, as size increased, the culture was less collegial and less cohesive with less organizational trust. Less organizational trust and less collegiality were also found to some extent in system-owned practices. Using the latter two-dimensional four-type instrument, Hann et al studied 42 general practices in England and found that while most (76%) practices were described...
Changing Culture

Those involved in practice improvement should focus on changing the dominant culture to one more in concert with the practice mission/vision of a practice, seeking to match aspects of practice structure and culture to achieve an optimal model of care. There is evidence that organizational culture on a large scale can be restructured.

For example, at a community hospital in Taiwan, a modification of the organizational culture was made following identification of problems associated with the existing culture. After the restructuring, employees reported feeling more respected and recognized. Similarly, in one US academic medical center, strong leadership and the creation of leadership teams was shown to drive practice culture change resulting in substantial improvements in the engagement and satisfaction of faculty, staff, students, and patients in addition to improving academic and financial performance.

As demonstrated by the Isaacsocn study in this issue of *Family Medicine*, practices with businesslike structures may be particularly well suited to accomplishing certain activities, like giving immunizations, which requires a highly organized, systematic, and task-oriented approach. Thus, when faced with a need to improve immunization rates, recognition of a disorganized practice culture could allow practice leaders to select a method of service delivery such as electronic reminders and standing orders that could compensate for lack of a shared mission/vision.

Conclusions

It is intuitive that aspects of practice structure and culture could influence practice outcomes. But, the diverse findings of the studies on culture and clinical outcomes suggest that there is no one best culture, and there is certainly more to practice improvement than merely changing a practice’s culture. Nonetheless, it is in our best interest to seek better ways to understand and use information about practice culture and climate to enhance practice performance and improve patient outcomes.

References