Organizational Culture and TQM Practices:  
A Case Study of a Sri Lankan Public Sector Hospital

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Abstract

The study reported in this paper was carried out to examine how TQM implementation is accomplished, when culture change of a Sri Lankan public sector hospital is attempted in particular, on history of its TQM implementation efforts. Drawing from a Habermasian critical perspective, some ethnographic methods were employed as the methodology. The paper reports some findings and implications of the study as follows.

Culture of the hospital has been changed from non-cohesive status to the cohesive status as a result of the Japanese 5-S based TQM activities implemented in 2000. However, TQM practices of the hospital have reinforced its culture change effort. Cohesive culture of the hospital was evidenced with positive teamwork, change oriented risk recognition, long-term orientation, incremental technology, and transferable visible.

The TQM practices were evidenced with managerial commitment, non-managerial commitment, strategic focus, customer focus, human resource focus, process management, managing supplier relations, managing employee relations, and global focus. The positive teamwork appeared as the core cultural value, which was seen with managerial and non-managerial commitment to continuous improvement.

The positive teamwork value has reinforced the other cultural values. The managerial and non-managerial commitment has reinforced the other TQM practices. Therefore, TQM practices of the hospital were seen with its cultural integration as both managerial (i.e., the director and Divisional Heads) and non-managerial (i.e., the doctors, Nursing Sisters & nurses, Technical Staff, Midwifery Staff, Clerical Staff, and Support & Auxiliary Staff) employees have shared those practices collectively.

The hospital as a health care service provider has improved its service outcomes/performance combining both clinical and TQM oriented activities together. The hospital as a public sector organization in Sri Lanka has improved its service outcomes/performance through the Japanese 5-S based TQM activities implemented in 2000 as its modernization/innovative program. As a result, it has been awarded with several national level quality awards for the success and being more responsive to the public demands. Presently the hospital functions as a model public hospital in Sri Lanka. The findings reinterpret the existing understanding about public sector organizations in Sri Lanka that their innovative programs mostly mismatch with the attitudes and skills of the participants.
In overall, performance of the hospital reinterprets the existing understanding about public hospitals in Sri Lanka that their rigid administrative environment discourages the efforts of enhancing their quality of service.

As implications, the findings may be useful to public sector organizations particularly, public health care service providers in Sri Lanka and other developing countries to be more responsive to public demands through successful integration of TQM implementation.

To overcome the limitations of this single case study, future studies on the topic need to be conducted as comparative cases and survey research, including private sector hospitals in Sri Lanka.

Keywords: organizational culture; TQM practices; the Sri Lankan public sector hospital

1. INTRODUCTION
1.1 Research Background
Total quality management (TQM hereafter) is a world-wide famous topic today among both practitioners as well as academia in the field of business management. TQM is widely practiced by business organizations today irrespective of their category and scale of business in order to stay competitive in the market satisfying the stakeholders’ needs, including customers.

But many approaches to quality management, including TQM hardly give long-term success to organizations. This is mainly because of the problematic nature of organizational culture (OC hereafter) within which managers find it difficult to integrate their quality management activities (Stahl and Grigsby, 1997).

Therefore, this study found a gap to investigate the connection between OC and TQM practices at the organizational level.

1.2 Research Purpose and Question
1.2.1 Research purpose
Although quality management needs to be practiced in Sri Lankan organizations in order to enhance their business performance, such efforts face a big challenge due to many negative reasons. The challenge is mainly due to the cultural and behavioral mismatch within the organizations, when they try to practice quality management within their organizational boundaries (Nanayakkara, 1992).

The issue seems to be critical to public sector organizations in Sri Lanka, when they try to implement new management systems. It has been found that the reforms and innovative programs introduced in public sector organizations in Sri Lanka mostly mismatch with the attitudes and skills of the participants. Therefore, those innovative programs simply become technical, rather than managerially meaningful to the organizations (Samarathunga and Bennington, 2002; Gunathunga, 2003).

But by implementing new management systems, some public sector organizations in Sri Lanka have achieved a certain degree of success. As a key example, a Sri Lankan public sector hospital which practices TQM has won several national level quality awards in Sri Lanka. By implementing Japanese 5-S based
TQM activities, the hospital has achieved a reasonable business success (Kaluarachchi, 2004; Withanachchi et al., 2004; Withanachchi et al., 2007).

Therefore, based on the background and public sector organizational set up mentioned above, this study was given motivation to investigate TQM implementation effort of the above mentioned hospital within its cultural set up. However, it was understood that a modernization effort like TQM implementation in an organization needs to be studied within a longer-range, because it is seen as a historically and culturally constructed phenomenon. Moreover, such an effort is gone through the attempt of culture (1) change of the organization. Hence, as far as this study concerns, the attempt of culture change was seen as a challenge to the hospital, when it implements TQM. Having this understanding, the purpose of this study was to:

*Investigate TQM implementation effort of the Sri Lankan public sector hospital within the attempt of its culture change.*

1.2.2 Research question

Modernization is a claim made by many organizations today. In these discourses, organizations try to enhance their operational efficiency and quality of service adopting new managerial practices. On surface, the goals behind modernization are acceptable to many in the organization. The goals of modernization may be evaluated in diverse ways. In fact, one individual’s interpretation given to modernization goals may be contradictory to another’s interpretation given to the same. Hence a surface call to modernize by managers can present new challenges to their modernization efforts in organizations (Kunda, 1992; Alvesson and Berg, 1992; Alvesson and Willmott, 1996; Mintzberg, 1994; Cyert and March, 1992).

The modernization program examined in this study argues that TQM implementation in the Sri Lankan public sector hospital may lead to change its culture. More specifically, this study examined what is being achieved in TQM implementation effort, focusing on how it is accomplished by the hospital in order to deliver its services targeting more responsiveness to the patient and public demands.

In this efforts, TQM was intended to change working practices of the hospital to encounter the discourse about what it means to be responsive giving rise to its culture change. In this way, the views that assume culture of the hospital may be changed at the stake of its TQM rationality are seen as problematic. This is mainly because of its different subcultures or different employee categories which may not easily be integrated towards the TQM rationality. Thus, attempts to change the ways of practicing TQM to achieve the success may not readily be accepted but may challenge the hospital. This study tried to explore these tensions and contradictions by asking:

*How TQM implementation is accomplished, when culture change of the hospital is attempted and what does this accomplishment mean for those who are touched by it?*
1.3 Conceptual Research Framework

The identified question was to inquire how TQM implementation in the hospital is accomplished within the attempt of its culture change. Culture change process of the hospital was identified as the culture change taken place from non-cohesive status to the cohesive status. Its TQM implementation was identified as a TQM process that evolves over time.

It was assumed that the introduction of TQM practices in the hospital may lead to change its culture. Moreover, it was assumed that the cohesive culture and TQM practices of the hospital as a whole may improve its service outcomes within the influence of national culture values. Having this understanding, the conceptual framework of this study was formulated as depicted in Figure 1.

1.4 Research Methodology

The present study is an extension of the study I carried out in the same hospital in 2004. During the present study, I employed both historical ethnography (Thomas, 1993) and field ethnography (Hammersley and Atkinson, 1995) for the primary data gathering purpose. In overall, I employed the ethnographic techniques: direct observations, short-time interviews, obtaining documentary evidence, participative observations, and in-depth interviews to understand the quality management history, culture, and employee
### Table 1: Sample of interviews carried out in the hospital

<table>
<thead>
<tr>
<th>Category of Staff</th>
<th>Number of Staff Members in the Hospital</th>
<th>Number of Staff Members Interviewed</th>
<th>Date(s) Interviewed</th>
<th>Interviewed % (Approximately)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managerial Staff</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director/CEO</td>
<td>1</td>
<td>1</td>
<td>17/12/2007</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Middle Management / Divisional Heads</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Medical Officer</td>
<td>1</td>
<td>1</td>
<td>19/12/2007</td>
<td></td>
</tr>
<tr>
<td>Matrons</td>
<td>2</td>
<td>1</td>
<td>18/12/2007</td>
<td></td>
</tr>
<tr>
<td>Administrative Officer</td>
<td>1</td>
<td>1</td>
<td>19/12/2007</td>
<td></td>
</tr>
<tr>
<td>Accountant</td>
<td>1 6</td>
<td>1 5</td>
<td>18/12/2007</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Non-managerial Staff</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultants/Doctors</td>
<td>100</td>
<td>40</td>
<td>21/12/2007, 24/12/2007, 25/12/2007, 26/12/2007</td>
<td>40%</td>
</tr>
<tr>
<td>Nursing Sisters &amp; nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Grade</td>
<td>3</td>
<td>3</td>
<td>01/01/2008</td>
<td></td>
</tr>
<tr>
<td>Grade I</td>
<td>7</td>
<td>5</td>
<td>11/01/2008</td>
<td></td>
</tr>
<tr>
<td>Grade II</td>
<td>270 280</td>
<td>72 80</td>
<td>01/02/2008, 06/02/2008, 08/02/2008, 14/02/2008</td>
<td>30%</td>
</tr>
<tr>
<td>Technical Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MLT</td>
<td>13</td>
<td>2</td>
<td>01/01/2008</td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td>12</td>
<td>2</td>
<td>01/01/2008</td>
<td></td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1</td>
<td>1</td>
<td>14/02/2008</td>
<td></td>
</tr>
<tr>
<td>Radiographers</td>
<td>2</td>
<td>1</td>
<td>14/02/2008</td>
<td></td>
</tr>
<tr>
<td>Cardiographers</td>
<td>2</td>
<td>1</td>
<td>30/01/2008</td>
<td></td>
</tr>
<tr>
<td>Dispensers</td>
<td>4 34</td>
<td>1 8</td>
<td>30/01/2008</td>
<td>25%</td>
</tr>
<tr>
<td>Non-professional Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery Staff</td>
<td>76</td>
<td>30</td>
<td>02/01/2008, 03/01/2008, 16/02/2008, 20/02/2008</td>
<td>40%</td>
</tr>
<tr>
<td>Clerical Staff</td>
<td>40</td>
<td>15</td>
<td>08/01/2008, 10/01/2008</td>
<td>40%</td>
</tr>
<tr>
<td>Support &amp; Auxiliary Staff</td>
<td>310</td>
<td>30</td>
<td>27/12/2007, 31/01/2008, 12/02/2008, 15/02/2008</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>846</td>
<td>208</td>
<td></td>
<td>25%</td>
</tr>
</tbody>
</table>

Source: Castle Street Hospital for Women (2007); Researcher’s interview transcripts
actions of the hospital.

In the hospital, I mainly carried out the above data gathering techniques in the Director's Office, Nursing Sisters' rooms, Divisional Heads' rooms, doctors' rooms, patients' wards, waiting rooms, and Quality Management Unit.

The ethnographic interviews were carried out focusing on the different employee categories: the director/the CEO, Divisional Heads, doctors, Nursing Sisters & nurses, Technical Staff, Midwifery Staff, Clerical Staff, and Support & Auxiliary Staff (see Table 1). Most of the interviews took the form of short-time interviews. Some interviews were carried out in depth based on the data gathering requirements.

Some important data gathered during the direct and participative observations were kept as field notes. Most of the field notes highlight the manner in which the hospital tries to operationalize its 5-S based TQM activities in order to enhance the service outcomes/performance. For example, a site called "5-S Corner" indicates the sequence of activities to be carried out in the waste management process.

As the documentary evidence, I obtained and reviewed the annual reports, action plans, policy manuals, quality manuals, process charts, and operational manuals prepared by the hospital.

Addressing the question and hypotheses, for the data analysis purpose of the present study, I reviewed my interview transcripts, field notes, and other documentary evidence. Using the historical ethnographic data, I reviewed some key activities or events (i.e., continuous improvement oriented activities) taken place in the hospital during its culture change process. On the other hand, using the field ethnographic data, I tried to locate the causal relationships among the culture, TQM practices, clinical and TQM oriented activities, and service outcomes of the hospital.

2. LITERATURE REVIEW

2.1 Organizational Culture

In a conceptual research paper, Smircich (1983) describes five metaphoric views of OC: comparative management (e.g., Hofstede, 1991, 1997); corporate culture (e.g., Peters and Waterman, 1982); organizational cognition (e.g., Schein, 1985; Johnson, 1988; Robbins, 2005); organizational symbolism (e.g., Martin, 2002; Alvesson, 2002); and unconscious processes and organization (e.g., Martin and Meyerson, 1988). The author invites culture researchers to conduct their studies on organizational analysis within this metaphoric assumptive context.

But there are several other perspectives of OC. Some of those are: integrative, differentiation, and fragmentation perspectives (Martin, 2002); objective and subjective perspectives (Burrell and Morgan, 1979); postmodern perspective (Martin, 2002); and critical perspective (Deetz, 1996; Willmott, 1993; Kunda, 1992). All these competing perspectives highlight the complicated nature of conceptualizing OC.

According to some postmodern and critical organizational researchers (e.g., Martin, 2002; Deetz, 1996; Willmott, 1993), organizations are understood with cultural manifestations in multitude ways. For them, cultural
manifestations are best understood not as a unitary whole, but as a mixture of cultural manifestations at different levels. This highlights the existence of subcultures within which managers face difficulties to integrate their quality management efforts at the organizational level.

Thus in contrary to metaphoric culture views, based on the critical views mentioned above, this study used an integrative and (2) level-wise (3) approach to conceptualize the culture of the hospital in order to investigate how TQM activities are integrated within its organizational boundary. Therefore, addressing the question, the conceptual definition given to OC in this study refers to:

- Observable artifacts and non-observable values that may differ at both managerial and non-managerial levels of the hospital.
- Managerial levels of the hospital refer to its senior and divisional managerial levels.
- Non-managerial levels of the hospital refer to its professional and non-professional staff levels.

### 2.2 TQM

The works of quality gurus (Deming, 1986; Juran, 1995; Crosby, 1979; Feigenbaum, 1991; Ishikawa, 1985) are recognized as the original knowledge contribution to the field of TQM. They recognize TQM as a set of manifestations and requirements for the success of organizations.

TQM practices of organizations need to be understood using a process thinking (Dale et al., 1997; Anschutz, 1995; Porter and Tanver, 1998; Hammer and Champy, 1993; Wilkinson et al., 1998). For these scholars, TQM process improvement continuously provides potential benefits to organizational stakeholders, including customers.

Using metaphoric views of culture, some scholars (Dale, 1994; Krosid, 1999; Kaye and Anderson, 1998; Kaye and Dyason, 1995; Padhi, 2000) understand that TQM practices can easily be integrated within the organization. Hence, these scholars see OC as a shared system to practice TQM.

### 2.3 TQM in the Health Care Sector

Since the empirical work of this study belongs to the TQM practices adopted by a health care service provider, some TQM literatures on health care are reviewed in order to understand the topic in specific.

Many scholars (e.g., Kunst and Lemmink, 2006; Eggli and Halfon, 2003; Li, 1997; Yang, 2003; Meyer and Collier, 2001) emphasize that both clinical and quality improvement oriented activities need to be combined in order to deliver better health care services to the public.

Scrivens (1995) finds that employees and patients should be well focused by health care service providers through the combination of both clinical and quality improvement oriented activities.

An investigation of quality management practices of health care organizations needs to be linked with their service processes and outcomes (Donabedian, 1980).

The success of health care organizations mostly depends upon their leadership commitment which leads to integrate different participants in continuous quality improvement
3. EMPIRICAL RESEARCH FRAMEWORK

The TQM program investigated in this study argues that the introduction of TQM practices in the Sri Lankan public sector hospital may lead to change its culture. In fact, TQM implementation is intended to change working practices of the hospital to encounter the discourse about what it means to be responsive giving rise to its culture change. This seems to search the principle of 'social theory in practice'.

Habermasian studies (Habermas, 1984) are the key examples of analyzing and developing a social theory in practice. Habermas believes that only through self-reflection and communication actions of people can be controlled in humanistic and democratic ways. It is through interaction and communication with the participants.

For Habermas, successful communication is upgraded by four major variables: comprehensibility, objectivity, subjectivity, and validity. Habermas sees the ideal type communication situation when the chances for a dialogue are equal for all participants.

From these critiques, in this study, TQM discourse was understood as a managerial rationality that evolves in the hospital over time. In this way, the views that assume culture of the hospital may be changed at the stake of its TQM rationality are seen as problematic. Hence, the Habermasian ideal type communication principle was used as a guiding principle to examine how different employee categories of the hospital are integrated towards its TQM rationality.

With this critical understanding and as an expansion of the conceptual research framework, the following framework was developed in order to carry out the empirical study in the hospital (see Figure 2).

Based on the empirical research framework, for the purpose of this paper, the following two hypotheses were considered in order to examine how TQM implementation of the hospital is accomplished within the attempt of its culture change.

Hypothesis 1 (H1): A cohesive culture of the hospital may be created by its continuous and improvement oriented TQM practices.

Hypothesis 2 (H2): A cohesive culture of the hospital with its TQM practices may enhance its service outcomes.

4. THE SRI LANKAN PUBLIC SECTOR HOSPITAL

4.1 About the Hospital in Brief

The Castle Street Hospital for Women (CSHW hereafter) (4), a public sector maternity hospital in Sri Lanka was initiated in 1950. Presently it functions as the largest maternity hospital in Sri Lanka with 450 beds, providing maternity, gynecology, and neonatal care services to the public. Annually, there are 16,000 to 18,000 baby deliveries with an average of 27% Caesarian deliveries are taking place in the hospital.

During the first 50 years of service, CSHW has functioned as a governmental hospital in Sri Lanka with its traditional administrative systems and measures, rather than adopting new management systems and measures to
Figure 2 Empirical research framework
Source: Researcher’s original construction
**Organizational Culture and TQM Practices**

Table 2 Continuous improvement oriented activities of CSHW

<table>
<thead>
<tr>
<th>Years</th>
<th>Activities/Events</th>
<th>Classification of each activity</th>
<th>Naming for the analytical purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Implementation of Kaizen (work improvement teams, suggestion scheme, just in time, total productivity maintenance, and mistake proofing)</td>
<td>Organization Development</td>
<td>OD1</td>
</tr>
<tr>
<td></td>
<td>Implementation of 5-S program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>Training of Divisional Heads in productivity improvements</td>
<td>Staff Training</td>
<td>ST1</td>
</tr>
<tr>
<td></td>
<td>Training of Divisional Heads and operational staff in productivity improvements</td>
<td>Staff Training</td>
<td>ST2</td>
</tr>
<tr>
<td></td>
<td>Renovation of wards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvements to all quarters</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supply of surgical hospital furniture</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Renovation of labor rooms A and B</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Publish Quarterly Statistics Bulletin and Annual Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Organization of Health Information Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training of Clerical Staff in public relations and office management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Construction of labor room C</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Renovation of labor rooms A and B</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvements to office and stores</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Location management training for Nurses and Midwives</td>
<td>Staff Training</td>
<td>ST4</td>
</tr>
<tr>
<td></td>
<td>Introduction of 10 CTG machines</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvement of Neonatology Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvements to OPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvement of record keeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of tools for record keeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establishment of a performance appraisal system</td>
<td>Employee Relations</td>
<td>ER1</td>
</tr>
<tr>
<td></td>
<td>New computers for the office staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Introduction of Laparoscope and Colposcope</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvements to kitchen</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training of Divisional Heads and Doctors in TQM</td>
<td>Staff Training</td>
<td>ST5</td>
</tr>
<tr>
<td></td>
<td>Equipments for new operating theatre</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvements to ICU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Training of Cleaning Staff on infection control</td>
<td>Staff Training</td>
<td>ST6</td>
</tr>
<tr>
<td></td>
<td>Improvements to the laboratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training of Nursing Staff on neonatal and intensive care</td>
<td>Staff Training</td>
<td>ST7</td>
</tr>
<tr>
<td></td>
<td>Install a computerized information system</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Castle Street Hospital for Women (2006); Researcher's interview transcripts

Note: For the analytical purpose, each activity was classified and named according to the clinical and TQM oriented activities shown in Table 6. Moreover, they were organized according to the respective time periods.
deliver better services to the public. This is mainly because of that public sector hospitals in Sri Lanka are administered within a set of rigid rules and regulations (5) posed by the Ministry of Health. Staff for the hospitals is allocated by central and/or provincial ministries of health. Hospital managers rarely enjoy the authority to recruit personnel. Generally, shortages of staff positions exist in many categories of staff. The remuneration packages of staff hardly stimulate performance improvements of the hospitals. In general, work environment also seems unsatisfactory for employees (Ministry of Health, Sri Lanka and Japan International Cooperation Agency, 2003).

Hence during the first 50 years of service, the culture of CSHW appeared as non-cohesive towards its service performance. The non-cohesive culture of the hospital was seen with its individualistic work orientation, change oriented risk aversion, short-term orientation, minimum technology for both clinical and administrative activities, and visible that poorly displayed its quality of service.

4.2 TQM Implementation at CSHW

However in January 2000, a new director was appointed as the CEO of the hospital. Then the director was surprised by the high mortality ratio of the hospital. He noted that in most cases, high mortality ratio was due to the infections spread out within the hospital and other inappropriate care after treatment. They could have been prevented by the collective effort of the staff.

Hence with the objective of lowering the mortality rate, the said director introduced 5-S (6) based TQM activities in April, 2000 (7)

Table 3 Operationalization of cohesive culture

<table>
<thead>
<tr>
<th>Variables</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Positive Teamwork (TW)</td>
<td>Team spirits, teamwork results, inter group activities, team-based trainings</td>
</tr>
<tr>
<td>2. Change Oriented Risk Recognition (RR)</td>
<td>Positive attitudes towards continuous improvement oriented changes, perceived changes as opportunities for continuous improvement</td>
</tr>
<tr>
<td>3. Long term Orientation (LTO)</td>
<td>Long-term organizational and staff benefits, staff skills development</td>
</tr>
<tr>
<td>4. Incremental Technology (TC)</td>
<td>Incremental technology development, human oriented technology</td>
</tr>
<tr>
<td>5. Transferable Visible (VB)</td>
<td>Pleasant service environment, improved service facilities</td>
</tr>
</tbody>
</table>

Organizational Culture and TQM Practices

as the modernization program of CSHW. The continuous improvement oriented activities which have contributed to change the culture is shown in Table 2. The activities are recognized as the historical activities or events taken place during the culture change process of the hospital.

4.2.1 Cohesive culture

The activities shown in Table 2 have functioned as the continuous improvement oriented activities of the hospital. They have contributed to change the culture of the hospital from non-cohesive status to the cohesive status. For the analytical purpose, the cohesive culture was operationalized with positive teamwork (TW), change oriented risk recognition (RR), long

Table 4 Empirical evidence for cohesive culture of CSHW

<table>
<thead>
<tr>
<th>Variables</th>
<th>Empirical Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Positive Teamwork (TW)</td>
<td>Work improvement teams (WIT): team-based training in productivity, TQM, location management, public relations and office management, intensive care and infection control</td>
</tr>
<tr>
<td>2. Change Oriented Risk Recognition (RR)</td>
<td>Suggestion scheme; mistake proofing; “5-S Corner”; positive attitudes towards productivity, TQM, location management, public relations and office management, intensive care and infection control trainings by middle level managers and operational level staff, nurses and midwifery staff, nursing staff, and cleaning staff respectively.</td>
</tr>
<tr>
<td>3. Long-term Orientation (LTO)</td>
<td>Quarterly Statistics Bulleting and Annual Report: Health Information Unit: improved record keeping; staff performance appraisal system; staff trainings for productivity improvement, TQM, location management, public relations and office management, intensive care and infection control</td>
</tr>
<tr>
<td>4. Incremental Technology (TC)</td>
<td>Improved labor rooms; computerized information systems; computers for the office staff; new CTG machines; Laparoscope and Colposcope; equipments for the new operating theatre; surgical hospital furniture; ward renovation; new labor rooms; improved Neonatology Unit, OPD, ICU, and laboratory</td>
</tr>
<tr>
<td>5. Transferable Visible (VB)</td>
<td>Improved labor rooms, OPD, office and stores, kitchen, and quarters; ward renovation; new labor rooms</td>
</tr>
</tbody>
</table>

Source: Researcher’s interview transcripts and field notes
Table 5 Empirical evidence for TQM practices of CSHW

<table>
<thead>
<tr>
<th>Variables</th>
<th>Empirical Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Managerial Commitment (MC)</td>
<td>Democratic leadership style; practical approach to quality management; work improvement teams; social responsibility</td>
</tr>
<tr>
<td>2. Non-managerial Commitment (NMC)</td>
<td>Work improvement teams; responsibility and involvement in quality management activities</td>
</tr>
<tr>
<td>3. Strategic Focus (SF)</td>
<td>Strategic planning; action plans; performance targets</td>
</tr>
<tr>
<td>4. Customer Focus (CF)</td>
<td>Customer satisfaction surveys; waiting time surveys; suggestion scheme; public complaints (patient care is the core focus)</td>
</tr>
<tr>
<td>5. Human Resource Focus (HRF)</td>
<td>Staff distribution, staff update, staff training, and staff welfare for both clinical and non clinical staff categories</td>
</tr>
<tr>
<td>6. Process Management (PM)</td>
<td>Kaizen (work improvement teams, suggestion scheme, just-in-time, total productivity maintenance, and mistake proofing); waste management process; admission and discharge policy guidelines; medical and nursing guidelines; research and studies; performance reviews (using national and global indicators); organization results; information for quality management (information management)</td>
</tr>
<tr>
<td>7. Managing Supplier Relations (MSR)</td>
<td>Maintenance of information, specifications, and contacts continuously with both medical and non-medical suppliers in order to avoid shortages of the patients’ requirements</td>
</tr>
<tr>
<td>8. Managing Employee Relations (MER)</td>
<td>Work improvement teams; progress reports; reward system</td>
</tr>
<tr>
<td>9. Global Focus (GF)</td>
<td>Productivity and quality management, global level performance indicators (e.g., WHO indicators); employee participation in international level health care management workshops and seminars</td>
</tr>
</tbody>
</table>

Source: Researcher’s interview transcripts and field notes

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term orientation (LTO), incremental technology (TC), and transferable visible (VB) as shown in Table 3.

Based on the operationalization, some empirical evidence for the cohesive culture is shown in Table 4.

**4.2.2 TQM practices**

The hospital recognizes TQM at its strategic level. Its vision, mission, and policies are TQM oriented. Its ultimate goal is to maintain the performance excellence. The elements of its performance excellence are identified based on the Sri Lankan National Quality Award (SLNQA) criteria. However, the hospital operationalizes its TQM activities adopting Japanese 5-S principles as a system. Under the 5-S system, it implements small group activities: work improvement teams (WIT) and suggestion scheme (SS). Table 5 illustrates some empirical evidence for the adopted TQM practices.

**4.2.3 Culture change process**

It was noted that TQM practices of the hospital have reinforced its continuous improvement oriented activities (i.e., historical activities or events) which changed the culture from non-cohesive status to the cohesive status. In other words, particular TQM practices have functioned as the driving forces behind the continuous improvement oriented activities implemented since 2000.

Figure 3 demonstrates how culture change process has taken place within the hospital as a result of implementing the continuous improvement activities. Each historical activity has been reinforced by the respective TQM practice(s). Each activity has contributed to change the culture from non-cohesive status to the cohesive status appropriately. The cohesive culture was evidenced with positive teamwork (TW), change oriented risk recognition (RR), long term orientation (LTO), incremental technology (TC), and transferable visible (VB) [see Figure 4 to understand the relationships more clearly].

In fact, the so far analysis justifies the **Hypothesis 1 (H1): A cohesive culture of the hospital may be created by its continuous and improvement oriented TQM practices.**

**4.2.4 Service outcomes**

Since the hospital is specialized in maternal & gynecological care services, its service outcomes are evaluated using Maternal Mortality Rate (MMR), Still Birth Rate (SBR), Neonatal Mortality Rate (NMR), Perinatal Mortality Rate (PMR), and Neonatal Infection Rate (NMR). Figure 5 exhibits how service outcome/performance rates of the hospital have been improved since 2000.

According to the data exhibited in Figure 5, the hospital has improved its service outcomes gradually over time. During 2000 to 2006, it has reduced Maternal Mortality Rate (MMR) from 11.0 to 3.9. This is approximately 64% improvement in the service performance. During the same period, it has reduced Still Birth Rate (SBR) from 11.2 to 7.3. This is approximately 35% improvement in the service performance. Moreover, Neonatal Mortality Rate (NMR) and Perinatal Mortality Rate (PMR) from 7.9 to 7.1 and from 19.2 to 14.1
Figure 3 Demonstration of CSHW’s culture change process
Source: Created by the researcher from Tables 2, 4, and 5
Note:  = Historical activities reinforced by the TQM practices
      = Cohesive culture created by the historical activities
which are 10% and 26% improvements in the service performance respectively (Although the improvement of NMR appeared negative around the years 2001 and 2002, the hospital was able to secure the positive growth of NMR during the other respective years). In most cases, the rates have been reduced better than the relevant national figures applicable to Sri Lanka and other developing countries. For example, Neonatal Infection Rates (NIR) around the year 2000 are 10.6 and 33 for Sri Lanka and other developing countries.
Figure 5 Review of CSHW’s service outcomes

Source: Castle Street Hospital for Women (2007)

Notes: 1. MMR=Maternal Mortality Rate, SBR=Still Birth Rate, NMR=Neonatal Mortality Rate, PMR=Perinatal Mortality Rate, and NIR=Neonatal Infection Rate

2. MMR/10,000 Live Births, SBR/1,000 Total Births, NMR/1,000 Live Births, PMR/1,000 Total Births, and NIR/100 Total Births, (Total Births=Live Births+ Still Births)

3. The data on service outcome rates are not available for the periods before 2000 due to non-maintenance of proper record keepings by the hospital

4. No major improvements or changes in the public health care sector in Sri Lanka were noticed during the considered time period (i.e., 2000-2006.)

respectively.

Although the hospital has to handle maternal & gynecological care matters of the patients, it does not only focus on the clinical activities. Instead, it tries to combine both clinical and TQM oriented activities together. Table 6 illustrates some empirical evidence for the clinical and TQM oriented activities generally carried out by the hospital in order to enhance its service outcomes.

The analysis indicated that the clinical and TQM oriented activities (8) carried out by the hospital in order to enhance its service outcomes have been backed up by its cohesive culture and TQM practices. The positive teamwork (TW) appeared as the core cultural
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Figure 6 Demonstration of the causal relationships among cohesive culture, TQM practices, clinical and TQM oriented activities, and service outcomes of CSHW
Source: Created by the researcher from Figure 5 and Tables 4, 5, and 6
Note: See Tables 4 and 5 for meaning of the abbreviations
### Table 6 Empirical evidence for clinical and TQM oriented activities of CSHW

<table>
<thead>
<tr>
<th>Activities</th>
<th>Empirical Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control Activities</td>
<td>Infection control activities are carried out to reduce Maternal Mortality Rate, Neonatal Mortality Rate, Still Birth Rate, Perinatal Mortality Rate, and Neonatal Infection Rate</td>
</tr>
<tr>
<td>Diagnostic Activities</td>
<td>Diagnosis activities are carried out in the laboratory, Radiology Dept., and Cardiography Unit. Urgent laboratory investigations are done from private laboratories</td>
</tr>
<tr>
<td>Patient Admission &amp; Transfer</td>
<td>Patient admission and transfer procedures are handled using new records keeping. Pregnant mothers are transferred form other hospitals located throughout Sri Lanka</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Essential drugs, surgical consumables, and surgical non-consumables are handled in order to avoid shortage of drugs required for patients during the period. Further, the hospital receives bio-medical engineering services with the respective medical equipments</td>
</tr>
<tr>
<td>Employee Relations</td>
<td>The hospital values the interrelationship and empowerment of its staff members. Annual events and competitions, special loans schemes, insurance schemes, and retirement schemes are offered to boost the staff morale</td>
</tr>
<tr>
<td>Staff Training</td>
<td>The subjects covered by the staff trainings belong to the Breast Feeding, Early Child Care Development, Quality Improvement in Perinatal Care, Productivity and Quality Management, and Employee Relations. Clinical meetings and case presentations are conducted for the Medical Officers by the Clinical Society. Nursing Officers are trained in clinical matters, including Neonatal Care and Midwifery. Supportive staff is trained in office maintenance and disciplinary procedures. Officers are trained in basic management and productivity and quality improvement</td>
</tr>
<tr>
<td>Infrastructure Development</td>
<td>Maintenance of the office and buildings: renovation of the ICU, Wards, Neonatology Unit, Laboratory and OPD, Neonatology ICU, and Quarters of MOO are the major infrastructure developments taken place by 2006</td>
</tr>
<tr>
<td>Organization Development</td>
<td>The Quality Management Unit organizes a series of events to sustain the implementation of Japanese 5-S based TQM focusing on quality and safety in healthcare. A Quality Week is celebrated each year with competitions among the employees</td>
</tr>
</tbody>
</table>

Source: Castle Street Hospital for Women (2007); Researcher’s interview transcripts

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value which was seen with managerial (9) and non-managerial (10) commitment (MC and NMC) to continuous improvement.

The positive teamwork value has reinforced the other cultural values. The managerial and non-managerial commitment has reinforced the other TQM practices. Hence, TQM practices of the hospital were seen with its cultural integration as both managerial and non-managerial employees have shared those practices collectively.

The managerial employees or managerial subcultures are represented by the director (the CEO) and Divisional Heads (the middle management). The non-managerial employees or non-managerial subcultures are represented by the doctors, Nursing Sisters & nurses, Midwifery Staff, Technical Staff, Clerical Staff, and the staff belong to support & auxiliary services. Figure 6 demonstrates the causal relationships among cohesive culture, TQM practices, clinical and TQM oriented activities, and service outcomes of the hospital.

In fact, the so far analysis justifies the Hypothesis 2 (H2): A cohesive culture of the hospital with its TQM practices may enhance its service outcomes.

5. FINDINGS

The analysis addressing the question and two hypotheses indicated that the culture of the hospital has been changed from non-cohesive status to the cohesive status as a result of the Japanese 5-S based TQM activities implemented in 2000. However, TQM practices of the hospital have reinforced its culture change effort. Cohesive culture of the hospital was evidenced with positive teamwork, change oriented risk recognition, long-term orientation, incremental technology, and transferable visible.

The TQM practices were evidenced with managerial commitment, non-managerial commitment, strategic focus, customer focus, human resource focus, process management, managing supplier relations, managing employee relations, and global focus. The positive teamwork appeared as the core cultural value which was seen with managerial and non-managerial commitment to continuous improvement.

Moreover, the positive teamwork value has reinforced the other cultural values. The managerial and non-managerial commitment has reinforced the other TQM practices. Therefore, TQM practices of the hospital were seen with its cultural integration as both managerial (i.e., the director and Divisional Heads) and non-managerial (i.e., the doctors, Nursing Sisters & nurses, Technical Staff, Midwifery Staff, Clerical Staff, and Support & Auxiliary Staff) employees have shared those practices collectively.

Cohesive culture and TQM practices of the hospital as a whole have improved its service outcomes/performance since 2000. Most of its service outcome rates have been improved better than the respective national figures of Sri Lanka and other developing countries.

Although the service outcomes like infection and maternal mortality rates are more clinical oriented, they have been well backed up by the TQM oriented activities. In other words, the hospital as a health care service provider has
improved its service outcomes/performance combining both clinical (infection control activities, diagnostic activities, and patient admission & transfer) and TQM oriented activities (medical supplies, employee relations, staff training, infrastructure development, and organization development) together.

The hospital has been awarded with Akimoto 5-S Award (Best 5-S Implementer in Service Sector, 2001), National Productivity Award Winner (Service Sector, 2001), Kaizen Award Runner up (2002), Sri Lankan National Quality Merit Award (Large Scale Service Sector, 2002), and National Productivity Gold Award (Service Sector, 2003) for being more responsive to the public demands through successful 5-S based TQM implementation. Presently it functions as a model public sector hospital in Sri Lanka.

6. CONCLUSIONS AND IMPLICATIONS

The study reported in this paper inquired the question of how TQM implementation is accomplished, when culture change of a Sri Lankan public sector hospital is attempted and what does the accomplishment mean for those who are touched by it. Drawing from a Habermasian critical perspective some ethnographic methods were employed as the methodology. The paper based on the findings reports some conclusions and implications of the study as follows.

Culture of the hospital has been changed from non-cohesive status to the cohesive status as a result of the Japanese 5-S based TQM activities implemented in 2000. However, TQM practices of the hospital have reinforced its culture change effort. Cohesive culture of the hospital was evidenced with positive teamwork, change oriented risk recognition, long-term orientation, incremental technology, and transferable visible.

The TQM practices were evidenced with managerial commitment, non-managerial commitment, strategic focus, customer focus, human resource focus, process management, managing supplier relations, managing employee relations, and global focus. The positive teamwork appeared as the core cultural value which was seen with managerial and non-managerial commitment to continuous improvement.

The positive teamwork value has reinforced the other cultural values. The managerial and non-managerial commitment has reinforced the other TQM practices. Therefore, TQM practices of the hospital were seen with its cultural integration as both managerial (i.e., the director and Divisional Heads) and non-managerial (i.e., the doctors, Nursing Sisters & nurses, Technical Staff, Midwifery Staff, Clerical Staff, and Support & Auxiliary Staff) employees have shared those practices collectively. The findings support the previous literature on TQM (Dale, 1994; Kroslid, 1999; Kaye and Anderson, 1998; Kaye and Dyason, 1995; Padhi, 2000).

The hospital as a health care service provider has improved its service outcomes/performance combining both clinical (infection control activities, diagnostic activities, and patient admission & transfer) and TQM oriented activities (medical supplies, employee relations, staff training, infrastructure development, and organization development) together. This reaffirms the previous TQM literature on
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health care (Kunst and Lemmink, 2000; Eggli and Halfon, 2003; Li, 1997; Yang, 2003; Meyer and Collier, 2001; Scrivens, 1995; Donabedian, 1980).

The hospital as a public sector organization in Sri Lanka has improved its service outcomes/performance through the Japanese 5'S based TQM activities implemented in 2000 as its modernization/innovative program. As a result, it has been awarded with several national level quality awards for the success and being more responsive to the public demands. Presently it functions as a model public hospital in Sri Lanka. The findings reinterpret the previous evidence on public sector organizations in Sri Lanka (Nanayakkara, 1992; Samarathunga and Bennington, 2002; Gunathunga, 2003).


As implications, the findings may be useful to public sector organizations particularly, public sector health care service providers in Sri Lanka and other developing countries to be more responsive to public demands through successful integration of TQM implementation.

To overcome the limitations of this single case study, future studies on the topic need to be conducted as comparative cases and survey research, including private sector hospitals in Sri Lanka.

ACKNOWLEDGMENT

The author would like to extend his warm gratitude to Prof. Tomofumi Amano, Prof. Masao Yokouchi, and Prof. Yongdo Kim for their guidance to the study. The author also extends his sincerity to all study participants of the Castle Street Hospital for Women for their kind cooperation during the empirical work.

NOTES

(1) In this paper, the terms 'culture' and 'organizational culture' are used interchangeably.

(2) Both values and artifacts of the hospital were appropriately considered in conceptualizing its culture.

(3) Culture levels of the hospital refer to its managerial and non-managerial employee levels. The managerial employee level consists of the director (senior management) and Divisional Heads (middle management). The non-managerial employee level consists of the professional and non-professional staff members. The professional staff members are the consultants or doctors, Nursing Sisters & nurses, and Technical Staff. The non-professional staff members are the Midwifery Staff, Clerical Staff, and the staff belongs to support & auxiliary services.

(4) Presently the hospital functions as a teaching hospital for the medical students.

(5) A general norm is that the rigid administrative environment of public sector organizations in Sri Lanka discourages their innovative programs.

(6) 5'S abbreviates the Japanese words Seiri (Tidiness), Seiton (Orderliness), Seiso (Cleanliness), Seiketsu (Standardization),
and Shitsuke (Discipline).

The introduction of Japanese 5-S based TQM activities in the hospital notes the starting point of TQM implementation in a public hospital in Sri Lanka. After the successful TQM implementation in the hospital, the Ministry of Health established a section called the Quality Secretariat which is responsible for the cultivation and development of a quality oriented culture in public hospitals in Sri Lanka. Presently, the Secretariat runs the National Quality Assurance Program (NQAP) for tertiary hospitals in Sri Lanka.

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(6) Most of the activities function as the core business activities of the hospital. However, other business activities (e.g., accounting and finance) carried out by the hospital were excluded from the analysis.
(7) Managerial commitment of the hospital refers to the commitment to continuous improvement by its managerial level employees.
(8) Non-managerial commitment of the hospital refers to the commitment to continuous improvement by its non-managerial level employees.

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