

LINKS BETWEEN ORGANIZATIONAL CULTURE AND STRATEGY AT DOCTOR'S COMMUNITY HOSPITAL

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ABSTRACT

An initial research effort utilizing a competitive strategy model to explain the success of a not-for-profit community hospital (Doctors Community Hospital, Landham, Maryland) led to a much deeper understanding of the relationships between culture, strategy, environment and organizational performance. Based on an in-depth case analysis, the following observation is offered: a successful organization exhibits a strong culture which is effectively linked to its competitive strategy and is in harmony with its competitive environment.

CONTEXT AND OVERVIEW

In 2002, we had the occasion to meet Mr. Phil Down, Chairman of the Board and CEO of Doctor's Community Hospital (DCH), a very successful institution located in Lanham Maryland. He invited us to visit DCH and agreed to our request to make DCH the focus of a case study. Toward this end, we toured the hospital facility and studied various documents. Initially, we tried to understand DCH in terms suggested by Michael E. Porter (1996)—that is, we drafted a molecule-like “activity system” for DCH, one which emphasized key activities. Subsequently, the Vice President of Planning for DCH deflected our enthusiasm, when she insisted that the success of DCH was based on a strong organizational culture. Thus we studied, among others, the work of Edgar H. Schein (1992), who describes the role culture can play in creating cohesiveness among internal stakeholders. We then returned to DCH to conduct more interviews. Subsequently, we completed a lengthy case study of DCH that is highly descriptive and which asks students to ponder the relationship between strategy and culture, Fratantuono and Sarcone (2004). In contrast, in this paper, we try to explicitly share the insights that emerged from our project.

Towards this end, in Sections II and III we summarize the major ideas we found in Schein and Porter. In Sections IV and V, we describe the history of DCH and the organization's environment. In Section VI, we use Schein's terminology to identify what we take to be the major aspects of the DCH culture and Porter's framework to identify key elements of the DCH strategy. Finally, in our closing remarks, we elaborate the following points: the success of DCH can be attributed to the strong links between the hospital's culture and strategy; while the works of both Schein and

Porter were useful to us, a “gap” remains between the two approaches; and when doing analysis of individual organizations in future, we believe it will be useful for us to search for symbiotic relationships between culture and strategy. We should note that many of the descriptive passages in Sections II through IV are excerpts from our case study.

ORGANIZATIONAL CULTURE

Edgar H. Schein is regarded as a leading authority on organizational culture. He describes culture as a

. . . pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems, Schein (1992, p.12).

He says that organizational culture has three major components that lie at different “levels of awareness” for both employees and outsiders. The first, “Artifacts and Creations,” are the most superficial component and are reflected in an organization's physical attributes and control mechanisms. The second, “Organizational Values,” are more deeply embedded; nonetheless, they are articulated by senior management, provide the rationale for the artifacts, motivate the operating philosophy of the organization, and on occasion are subject to debate. The third, “Basic Assumptions,” the foundation of organizational culture, are “invisible,” “taken for granted,” “preconscious,” and “not debatable.” They take shape as leaders form

fundamental views about the nature of reality and truth, human nature, human activity, human relationships, and the relationship of the organization to the environment.

Organizational cultures evolve over time, as the organization expands and diversifies or takes on new leaders and members. However, if an organization has a strong culture, then one would expect members of the organization to display a high level of awareness of the organization's values and intensely express approval—or perhaps disapproval—of those values.

To complicate matters, as an organization evolves, subcultures—centered on different functions, hierarchical levels, geographic locations, technologies, or products—can emerge. Thus, leaders must also proactively manage the different subcultures to avoid organizational conflict.

Schein believes that to effectively manage organizational culture, leaders must (a) understand how a culture forms, (b) know how to reinforce an existing culture; and (c) know how, when needed, to make an existing culture adapt to changing environmental conditions. Towards these ends, managers must act and communicate in ways that support values; give employees and stake-holders voice in shaping the work environment; and establish an incentive system consistent with cultural expectations.

In our view, Schein's emphasis on both the nature and management of culture provides insight about the internal mechanisms of the organization, into *how* the organization works. But we believe he leaves unanswered the question of *what* actual steps organizations must take to become competitively focused and maintain a competitive edge, especially with respect to the external environment.

STRATEGIC POSITIONING AND FIT

Michael E. Porter posits that “operational effectiveness and strategy are both essential for superior performance.” Operational effectiveness refers to the ability to perform activities “better” than rivals, in order to reduce costs and improve quality. But, in an era of rapid dissemination of best practices and competitive convergence, advantage based on operational effectiveness is transient. Thus, while operational effectiveness is a necessary condition to competitive advantage, it is not a sufficient condition. In contrast, *sustainable* competitive advantage is the result of the activities undertaken by a company to deliver a product or service to targeted customers in a way that is distinctive and hard to mimic. Specifically, the company must either perform *different activities* from

those being provided by rivals or perform similar activities in *different ways*. In this light, strategy is about managing the activities of a firm so that they will exhibit three attributes.

First, activities must be consistent with a “strategic position.” That is, the company must decide to either produce a subset of an industry's products or services to a range of customers (variety based positioning); produce the full range of products or services for a group of customers (needs based positioning); or provide a product or service to customers who can be segmented from others and are accessible in different ways (access based positioning).

Second, the activities undertaken by the company in support of an established strategic position entail “tradeoffs.” Tradeoffs arise because the value of products and services being provided must conform to the company's image and reputation; because resources and processes must be specialized; and because management has finite coordination and control abilities. An awareness of tradeoffs shapes decisions by managers about what activities the company should pursue as well as which it should avoid. Furthermore, if tradeoffs are present, rivals will find it hard to move into a new strategic position if they simultaneously try to occupy an existing position.

Third, the activities must “fit” with one another. Taken separately, each activity must be consistent with the company's overall strategic position. Furthermore, each activity must reinforce others. Finally, the activities must be holistically coherent. This coherence contributes to system wide efficiency. It also serves as a defense mechanism from potential rivals: to use Porter's illustration, while the probability of a rival duplicating any single activity may approach one, the probability of a rival duplicating many activities is much less (.9x.9 = .81; .9x.9x.9x.9 = .66; and so on.).

Porter illustrates his ideas through the use of molecule-like activity-system maps, with each map a schematic representation of a company's “strategic position.” A map includes (a) a handful of high-order “strategic themes” that summarize the distinctive attributes of the company's product or service and (b) a larger number of clustered, linked “activities” undertaken to implement the themes.

In our view, Porter's emphasis on notions of positioning, tradeoffs, and fit provide an extremely useful framework for asking *what* a company should do to achieve sustainable competitive advantage. However, we do not find any explicit reference in his work to the cultural foundations of the enterprise or to

how organizational culture enables firms to pursue activities.

HISTORY OF THE DOCTOR'S COMMUNITY HOSPITAL

Doctors' Hospital was founded in 1975 by a group of leading community physicians, in Lanham, Maryland, a primarily working-class, ethnically diverse community, located in Prince George's county Maryland, just inside the Washington DC beltway. By the early 1980s, the hospital was suffering from a poor reputation and legal and financial problems. In 1985, American Medical International (AMI), Inc. purchased Doctors' Hospital from the original owners and in early 1986, Phil Down was named the Executive Director of AMI Doctors' Hospital.

Over the next three years, the corporate leadership of AMI realized their strategic rationale for the acquisition was faulty and they became disenchanted with Doctors' Hospital, as the institution respectively showed annual losses of \$434 thousand, \$2.96 million, and \$2.37 million for the 1987, 1988, and 1989 fiscal years, and a retained (cumulative) deficit over a 5-year period ending August 31, 1989 of \$8.4 million.

Meanwhile, starting in 1987, Phil and other members of his Management Group began to explore the possibility of purchasing Doctors' Hospital from AMI and converting it from a for-profit to a not-for-profit community based institution. After 18 months of negotiations with AMI, coordination among several professional entities, and consensus-building among numerous stakeholders, the Group achieved their objective. In early autumn of 1990, the newly named Doctors' Community Hospital (DCH) was registered as a non-stock corporation in the State of Maryland. Phil Down was named Chairman of the nine-member Board of Directors.

Funds for the acquisition were raised by the Maryland Health and Higher Educational Facilities Authority, which issued a total of \$51 million in bonds. The proceeds were used by the Group to cover the purchase price of the existing facility, facilities upgrades, new equipment, startup costs, and administrative expenses. The Authority became the DCH mortgage-holder. The financing arrangement implied that at the outset, DCH had a debt to equity ratio of roughly 110 percent.

Following the acquisition, DCH experienced success. In 1993, DCH refinanced \$10 million of its debt obligations, and in 1997, converted a portion of their remaining debt to variable rate bonds. In turn, those moves enabled DCH to make several capital

improvements. Over the three-year period to 2003, among other projects, DCH installed the best critical care unit in the region, with 24 new beds; a new state of the art emergency room that was soon the 7th busiest in the state; a cardiac catheterization facility; multiple new nursing stations; and a very modern basic infrastructure. While eight other inpatient facilities were located within a ten-mile radius, in 2002, DCH managed to achieve an 85 percent occupancy rate for its 176 beds, a relatively high utilization rate by industry standards. By the late 1990s, DCH had earned a national reputation for excellence within the professional health care community and, for three years running, starting in 2000, was named by *U.S. News and World Report* as one of the top 50 hospitals in the United States.

COMPETITIVE ENVIRONMENT

Over the past 40 years, the U.S. health care environment has been difficult to navigate. Starting in the 1960s, expenditures on health care in the United States increased at a rapid rate, rising from 5.7 percent of GDP in 1965 to 14.9 percent of GDP in 2002, due to an aging population, advancements in technology, the growing availability of health insurance, and the evolution of expectations by patients and physicians. In light of rising costs, in the 1970s and 1980s, the federal government introduced various plans intended to reduce both the number and the duration of overnight hospital stays. In turn, the health insurance industry lobbied for a "managed care" model, which specified that hospitals would be reimbursed by insurers on a "cost-plus-basis," thereby shifting financial risk from the payers to providers. Starting in the early 1980s, to improve economic performance, some hospitals joined "horizontal networks" with similar institutions. Subsequently, private physician practices, clinics, and hospitals began to establish jointly-owned "vertical-networks"—indeed, by 1995 almost 28 percent of all U.S. hospitals were linked in such a structure. But, when economic gains remained elusive, experts began to advocate "virtual integration networks" in which separately owned entities would coordinate services and finances via operating agreements, contracts, or protocols; while such networks might result in more flexibility and efficiency, they would also require major adjustments in each institution and mutual trust among participants. By the turn of the century, U.S. hospitals were once again experiencing an increase in demand for in-patient admissions; but the composition of demand—a growing proportion of lower margin medical cases, rather than surgical cases—coupled with supply side constraints which drove up costs, resulted in "profitless growth."

In Maryland, hospitals operated in a unique environment: in 2002, Maryland was the only state with rate regulation still in place. The industry was regulated by the public-utility-minded Health Services Cost Review Commission (HSCRC). According to guidelines, every year the HSCRC approved rates for each Maryland hospital and established a “corridor” around those rates. If overcharges fell inside the corridor, the hospital had to repay the overcharges plus interest in the form of reduced approved rates in the next fiscal year; if the overcharges fell outside the corridor, then the hospital had to repay 140 percent of the overcharges, plus interest, in similar fashion. In contrast, if undercharges fell within the corridor, then the hospital would be able to recoup 100 percent of the undercharges in the following year, via a premium on approved rates; but the hospital would not be permitted to recoup undercharges that fell outside the corridor. While the objective of the HSCRC was to create stability across the state-level health care industry rather than ensure high profits for any particular hospital, the arrangement meant that each hospital was under constant financial pressure. From the viewpoint of each of Maryland’s 52 hospitals, the process was a “zero sum game.”

INGREDIENTS FOR SUCCESS

Strategic Focus

At its founding in 1975, Doctor’s Hospital was primarily a surgical hospital. Although DCH experimented with a few initiatives following the 1990 acquisition, the institution retained a relatively sharp focus as it evolved into a primary-level and secondary-level, adult-care, medical and surgical facility that could respond to roughly 95 percent of the inpatient needs of the immediate community. Conversely, the management team decided they would not: develop an obstetrics unit or a pediatrics unit; support open heart or cranial procedures; run a trauma center; provide an inpatient psychiatric unit; administer an alcohol rehabilitation center; evolve into either a teaching or research facility; or be a member organization of a larger, comprehensive health-care system. In Porter’s terms, DCH positioned itself to provide a limited range of services that were also being provided at other inpatient facilities, but to provide them in a *different way than rivals*.

A Distinctive Organizational Culture

While a strong organizational culture is important to the success of any institution, this may be especially true for hospitals, where employees are often motivated by intrinsic values. At DCH, we found evidence of a

distinctive culture reflected in both artifacts and articulated values, such as the vision statement (“Continuously strive for excellence in service and clinical quality to distinguish us with our patients and other customers”), the mission statement (*Dedicated to Caring for your Health*) and the prominent poster displayed throughout the hospital (*Service Excellence Respect Vision Innovation Compassion Everyone*).

Perhaps more telling, members of the Management Group described themselves as “serious-minded,” “self-managing,” and “self-critical;” believed that as a team they got along well and had complementary personal attributes; placed a premium on loyalty to the organization and an old-fashioned work ethic; conveyed a sense of joint-ownership in the organization and pride in their co-workers; and believed their institution was distinctive. Furthermore, team members suggested that the lean staff and flat organizational structure were consistent with the managerial “culture,” in which all executives and directors were visible and accessible; there were no “turf wars;” communication lines were relatively informal, and where team members had to “be nimble” to engage in “proactive problem solving.” They characterized Phil Down as a kind and sympathetic leader who had an open and “old-fashioned” style of dealing with people; who had detailed knowledge of all aspects of the hospital; who had a cautious nature, good instincts, experience, and a strong track record which instilled confidence; and who was a “visionary leader” who had created a “visionary institution.”

Finally, we speculated that at DCH, artifacts and values are based on five interlocking assumptions: (1) people are responsible, motivated and capable of governing themselves; (2) organizations work best when individuals make contributions to the collective endeavor; (3) people feel willing to share ideas and assume responsibility when the risk of doing so is low because colleagues are caring and committed; (4) the best solutions result from a participatory process that champions procedural justice; and (5) the organizations’ customers expect and deserve high-quality consistently-provided health and social services.

Strategic Themes

In our analysis, four strategic themes are the basis of the activity system we constructed for DCH. In the Appendix, we provide a list of the associated activities that we identified for the organization.

Cultivate Personalized Relationships With Physicians. Physicians who treat patients in hospitals are either “general staff,” who have their own practices, or

“hospitalists,” who are directly employed by the hospital. General staff are “free agents”—they receive no direct remuneration from hospitals and are often affiliated with more than one hospital. When working with staff physicians, hospitals earn revenues by providing ancillary services and care associated with overnight stays. In contrast, if care is provided by a hospitalist, then a hospital is able to charge the patient or the insurer for physician services. Thus, to cultivate a relationship, the Management Group made important symbolic gestures, such as creating a physicians’ dining-room that dispensed high-quality free-food. As important, the Group worked to create a culture of respect for physicians based on open and honest communication and instituted a wide array of support mechanisms for both staff physicians and hospitalists; established an executive level Physicians’ Liaison responsible for maintaining good relationships with staff and for recruiting new physician practices to the hospital; and took several innovative steps which created a truly distinctive, physician-friendly environment. Finally, even though technology breakthroughs made it possible for physicians to provide “outpatient services” in their offices that previously had been performed in hospitals, DCH refrained from engaging in direct competition with physicians’ practices.

Manage the “Actual” and “Perceived” Quality of the Patient Experience. While physicians concentrated on the quality of health-care provided to their patients, the public tended to evaluate and respond to the “hotel services” dimension of the hospital stay. In turn, patients’ satisfaction with the hospital stay influenced their overall satisfaction with the surgical/medical procedures and with their physicians. Given this relationship, DCH instituted procedures to monitor and improve patient satisfaction. They also invested in transportable equipment and in facilities configurations that enhanced nurses’ productivity, reduced patients’ discomfort, and increased patients’ privacy. Furthermore, while the Management Group recognized that nurses arguably did more to shape the patient experience than any other group, they also acknowledged that their nursing staff was only average, and to compensate, they empowered selected nurses to serve as case-managers for all patients handled by one physician.

Foster a Can-Do Attitude Throughout the Institution In addition to technical factors, the Management Group believed the key to a good patient experience was personnel throughout the organization who had a “can-do” attitude, who felt empowered to act, and who believed they were part of a team. Thus, while the Group took many common-sense steps to enhance

communication channels and build a sense of community at the hospital, they made sure that they fully included 2nd and 3rd shift employees in all initiatives. In retrospect, while each activity sounds conventional, the cumulative effect was to create a very positive environment.

Apply a Judicious Approach to Initiatives and a “Systems Engineering” Approach to Operations The fact that the acquisition of the hospital had been 100 percent financed by debt created a permanent and ever-present concern for the bottom-line. That concern, coupled with the basic economics of hospital management, strongly influenced the approach taken by DCH on several fronts. First, since hospitals primarily received remuneration based on illness classification rather than the actual services and tests provided, DCH took many small steps to reduce the average duration of the patient stay. Second, since some physicians generated more revenue, and margins with surgical patients were greater than margins with medical patients, DCH had initiated a plan for gradually reshaping the medical staff. Third, the Group had taken steps to increase the number of hospitalists in targeted units. Fourth, the Group had placed a premium on efficiency and productivity when it constructed the critical care and emergency room units. Fifth, in the critical area of information technology, the Group had encouraged progressive relationships between the hands-on practitioners in all functional hospital areas and IT programmers, and had insisted on one IT platform and compatible, off-the-shelf application modules. Finally, DCH had taken a holistic view toward all stakeholders and extended the idea of service to those more tangentially connected to patient care, such as the emergency rescue teams, who were employed by other companies.

CONCLUDING REMARKS

In this analysis, we relied heavily upon Schein’s multilevel description of organizational culture to recognize and describe the artifacts and stated values found at DCH, and to speculate about the unarticulated, underlying belief system of the institution. We relied on Porter’s definition of strategy as a framework to identify the tradeoffs inherent in the strategic position taken by DCH and for constructing a map of the hospital’s strategic themes and related supporting activities. Based on our analysis of DCH, we offer the following conclusions.

First, we think the DCH senior management staff has embraced a belief system which prizes participation, collaboration, self-governance, due process, and service, and has effectively used artifacts and

communicated values consistent with those beliefs to various stakeholders. As important, we believe that individuals have adopted those values in their daily activities.

Second, we think that there is a consistency and coherence in the activities we identified at DCH that conforms to Porter's notions of position and fit and helps explain the success of the institution. This gives us satisfaction and some confidence in the value of using Porter's framework.

Third, we think that the success of DCH can be attributed to the strong links between the hospital's culture and strategy. The culture resonates well within the organization and serves as the foundation for the formulation and implementation of the hospital's competitive strategy.

Fourth, in terms of the theoretical literature, as we worked with the frameworks suggested by Schein and Porter, we perceived a "gap" between the two approaches. In particular, we feel that while Schein's work helps one understand *how* organizations do what they do, Porter's work helps one understand *what* they do.

Fifth, in terms of methodology, as we created a map of the activity system for DCH, we felt that important components of culture permeated the themes and informed the various clusters of activities we had identified. To say this in another way, we came to believe that if DCH did not have its distinctive culture, it would not be able to perform its current activities. Thus, via our case study of a particular institution, we have much greater clarity on the following point: while Porter claims that it is the configuration of activities that provides an organization with a defendable strategic position in a competitive environment, we think that the underlying culture *enables* an organization to perform activities. In the future, when we analyze other successful organizations, we will

always be on the lookout for examples of symbiosis between culture and strategy.

Sixth, we note that while the approach endorsed by Porter was developed for the for-profit-sector, we have benefited from applying it to a regulated, not-for-profit, service oriented organization.

In looking ahead, the question remains as to whether or not the existing culture and strategy of DCH will remain relevant and effective in the difficult health care environment. This environment of "profitless growth" rewards neither service quality nor accessibility in a community hospital. To survive, it is possible that Phil Down may need to reevaluate his world view and redefine the organization's culture, mission and strategy.

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APPENDIX

Activity System for Doctors Community Hospital

Theme 1: Cultivate Personalized Relationships With Physicians

- Activity 1:** Construct a Physician's Dining Room, proximate to the executive office suite, which provides free-meals from early morning till late evening; creates goodwill, a place where physicians and management interact and takes on symbolic importance.
- Activity 2:** Invite physician input on facility renovation thereby giving physicians a voice in the planning process.
- Activity 3:** Refrain from providing outpatient or clinic services that directly compete with services physicians are providing in their individual practices.
- Activity 4:** Hold bi-annual, expenses-paid retreats for management and physicians to strengthen informal communication channels and relationships.
- Activity 5:** Create an in-house, for-fee, answering service so physicians can have timely access to professional and personal messages.
- Activity 6:** Provide proactive administrative support to help physician's navigate the credentialing requirements of the hospital and other organizations.
- Activity 7:** Eliminate the language from DCH bylaws that mandated all physicians must serve "on-call" hours; instead, provide monetary incentives to encourage self-selection.
- Activity 8:** Invest in the newest technology requested by physicians when consistent with the range of services DCH seeks to provide.
- Activity 9:** Provide doctors' equitable access to most desired times for surgeries and procedures; try to give individual physician's clusters of time to promote efficiency.
- Activity 10:** Employ Executive-Level Physician's Liaison responsible for attracting new physician practices and ensuring physicians' concerns and needs are addressed.
- Activity 11:** Designate qualified nurses as case managers for patients "by doctor," rather than "by-floor" basis, to streamline communication about patients' status with physicians.
- Activity 12:** Provide each on-duty nurse with a cell-phone, with number registered at the front desk and in nurses' stations, to reduce inefficiency and physicians' "on-hold" time.
- Activity 13:** Include physicians in governance at the Board of Directors level.
- Activity 14:** Give physicians' responsibility for monitoring the quality of professional services and participating in the hospital's risk management.
- #### Theme 2: Encourage Pro-Active Attitude Throughout Organization
- Activity 15:** Use a 360-degree interview process, involving superiors, peers, and subordinates, before hiring new managers.
- Activity 16:** Keep the senior management staff and other departments lean and flat and delegate authority throughout the organization.

Activity 17: Use monetary incentives, not directives, to achieve results, including wage-differentials for nurses to staff the 2nd and 3rd shifts and weekend slots.

Activity 18: Maintain standing, inter-departmental collaborative teams to share knowledge, anticipate problems, and come to solutions on routine operational issues.

Activity 19: Establish inter-departmental collaborative teams for planning of major projects, such as renovations to the emergency room and critical care units.

Activity 20: Seek fair outcomes when addressing employees' personal and workplace concerns; for example, DCH has avoided downsizing staff during stressful times.

Activity 21: Empower managers with responsibilities for critical operational decisions.

Activity 22: Publicize individual contributions to team success via monthly in-house publications.

Activity 23: Celebrate organizational milestones and recognize important staff accomplishments in regular hospital-wide forums.

Activity 24: Ensure visible and accessible executive leadership, by locating office suite near main entrance and having management present during second and third shifts.

Theme 3: Shape "Actual" and "Perceived" Quality of Patient Experience

Activity 25: Monitor and Manage Patients' Perceptions of Nursing Staff:

Activity 26: Retain a highly skilled and experienced infection control coordinator.

Activity 27: Provide high-quality "hotel services," including meals served in patient rooms and in the cafeteria; telephone and television services; and appearance and cleanliness of patients' rooms, of newspaper/gift shop, and of family waiting rooms.

Activity 28: To promote patient privacy, create special hallways that are only used to transporting patients to and from surgery suites or treatment rooms.

Activity 29: Provide digital posting in ER of patient status, including stage of treatment and elapsed time from when the patient was admitted, to provide all ER personnel an overview of conditions on the floor, to sensitize them to progress with particular patients, and to cultivate a sense of urgency and professionalism.

Activity 30: Provide patient services at bedside, when feasible, via transportable equipment, to reduce patient discomfort and enhance productivity.

Theme 4: Maintain Judicious Attitude Toward Initiatives and "Systems Engineering" Approach to Operations

Activity 31: Limit scope of support to providing primary-level and secondary-level medical and surgical services.

Activity 32: Pursue second-mover advantages by continuously scanning the external environment to see how the newest technology, and hardware and software systems perform at other institutions, and then move to adopt technology when it has proven successful.

Activity 33: Maintain disciplined, conservative attitude towards financial resources to manage the acquisition-related debt burden; avoid further financial risk; and effectively refinance debt to fund renovations and expansions.

Activity 34: Seek consensus between all interested and impacted stakeholders by communicating in an open, interactive style; by seeking input from second tier managers and from line-employees whenever possible; by maintaining a long-term view of relationships; and by learning to live with honest differences of opinion among the Management Group.

Activity 35: Trust and leverage the expertise and wisdom of the long-tenured Executive Leadership.