

**Generating Dynamic Capabilities through a Humanistic Work Ideology: The case of a certified-nurse midwife practice in a professional bureaucracy**

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The authors are grateful to Gautum Ahuja, Kim Cameron, Arran Caza, Jane Dutton and Gretchen Spreitzer for their insightful comments, generosity with their time and encouragement.

## Abstract

### **Generating Dynamic Capability through a Humanistic Work Ideology: The case of a certified-nurse midwife practice in a professional bureaucracy**

Strategic management research overlooks dynamic capabilities generated from the “humanistic side” of organizational life, such as relationships, compassion, virtuous actions, and honorable behavior. However, exploring these dynamic capabilities can provide the field of strategic management with a different viewpoint of how organizations create value through human processes. To examine this issue, the paper presents results from a case study of a nurse-midwife practice within a large research hospital. The study explores how the humanistic work ideology of the nurse-midwife practice creates dynamic capabilities. Through our theoretical analysis of the case study data, we develop a framework to explain the humanistic work ideology of the midwives and its linkages to human resource management and patient service capabilities. Lastly, we conclude with a discussion proposing that institutional pressures legitimize the humanistic work ideology of the midwifery practice.

Dynamic capabilities are collections of routines that enable organizations to respond to changing environments with value-creating strategies (Eisenhardt & Martin, 2000; Winter, 2002). While such capabilities are clearly desirable, they are only imperfectly understood; they are assumed to arise from human capital resources in causally ambiguous and socially complex ways (Hall, 1993; Boxall & Steeneveld, 1999; Boxall, 1998). In response to this combination of competitive importance and causal obscurity, the field of strategic management has engaged in a quest to understand how internal processes translate into dynamic capabilities. This research typically focuses on three areas: teamwork, organizational culture, and formal human resource management policies (Barney, 1986; Lado & Wilson, 1994; Wright, McMahan & McWilliams, 1994).

Ironically, in the push to understand how human capital contributes to dynamic capability, the human aspect has been neglected; this research largely overlooks the role of humanistic processes and concerns in organizational life such as relationships, compassion, and virtuous actions (Cameron & Caza, 2002; Spreitzer & Sonenshein, 2003). It seems unlikely that a full understanding of human capital's contribution is possible without a more in-depth understanding of humanism's role in generating dynamic capabilities (Cameron, Dutton & Quinn, 2003). The challenge for researchers is to go beyond their understanding of product- and service-based competencies to study organizations with core competencies rooted in the very best of human interactions, in the processes associated with them, and in their positive outcomes.

Unfortunately, most organizations yield to internal and external pressures and adopt traditional business models focused on survival, efficiency, and growth, leaving few examples of organizations with truly humanistic approaches to work. This scarcity, combined with the dearth

of theoretical development concerning humanistic organizing, has created a void. To date, research has had little to say about the role of humanistic processes in the generation of dynamic capabilities. To fill this void, this paper presents a study of a nurse-midwife practice in a large research hospital referred to as Big Hospital. This research project explored how the humanistic behavior resulting from the extraordinary work ideology of the nurse-midwife practice creates dynamic capabilities. Specifically, we examine how a work ideology emphasizing social relationships and humanistic interactions translates into human resource management and patient service capabilities, and how those capabilities enable the midwife practice to respond to the changing environment of the women's healthcare industry. These two capabilities are essential in healthcare organizations where meeting the needs of patients determines competitive success, and this can only be achieved through human capital (Parasuraman, 1987; Harber, Ashkanasy & Callan, 1997).

*Human resource management* (HRM) capabilities are the skill set needed to develop an organization's employees to support business needs and respond to the competitive environment (Huselid, Jackson & Schuler, 1997). They are the architecture sustaining the execution of a firm's strategy (Becker, Huselid & Ulrich, 2001). Traditional examples of organizational practices that support the development of HRM capabilities include teamwork, training, communication systems, and hiring practices. Through HRM capabilities, organizations can transform employee inputs into value-generating services and products, such as patient service capabilities. *Patient service* (PS) capabilities are the skills with which healthcare providers respond to a patient's unique needs (Tasso, Behar-Horenstien & Aumiller, 2002). They include not only technical competencies, but also the healthcare provider's ability to communicate with patients, and to demonstrate a caring attitude and empathy towards patients (Rider & Perrin,

2002). Furthermore, a capability for responding to the unique needs of individual patients demands genuine respect for a patient's values and medical preferences (Malloch, 2000).

In the following paper, we explore a linkage between work ideologies and the generation of dynamic capabilities in a nurse-midwife practice. Our observations are based on case study research described in the Methods section of the paper. In the theoretical analysis of the case study, we elaborate on the attributes of the practice's work ideology that contribute to its HRM and PS capabilities. Lastly, this paper concludes with a discussion proposing that institutional pressures legitimize the humanistic work ideology of the midwifery practice.

### **CONNECTING WORK IDEOLOGY TO DYNAMIC CAPABILITIES**

A work ideology is a set of shared, logically integrated beliefs binding individuals to their occupation (Trice & Beyer, 1993). These beliefs define specific work techniques and processes, explicit modes of reasoning, and prescribed ways of interacting with group members and stakeholders. Work ideologies also provides occupational members with a feeling that they possess unique values and abilities (Van Maanen & Barley, 1984). In addition, management research in the culture and resource-based traditions has suggested a linkage between work ideology and dynamic organizational capabilities.

From an organizational culture perspective, work ideologies can be seen as the core substance of a group's values, and certain types of work ideologies are expected to be more effective than others at developing an organization's dynamic capabilities (Trice & Beyer, 1993; Barney, 1986; Cameron & Quinn, 1998). A humanistic organizational culture would demonstrate that it valued members by showing concern for their well-being, growth, and development. Such a culture would offer advantages over one where positions of power were important, and members were expected to work by competing rather than cooperating (Cooke &

Rousseau, 1988; Wilkins & Ouchi, 1983). Members in humanistic work cultures report higher levels of job satisfaction and loyalty to the organization, and are therefore motivated to help their organization succeed (Kotter & Heskett, 1992). This motivation foster employees' involvement in helping the organization adapt to changes in its competitive environment through problem solving or new business initiatives (Rousseau, 1990). In addition, the constructive relationships and job motivation resulting from an employee-centered culture transforms into enthusiasm to provide high quality customer service (Schneider & Bowen, 1995; Goffee & Jones, 1996; Gittell, 2002).

Similarly, a resource-based view of the firm suggests that work ideologies have the potential to generate dynamic capabilities (Barney, 1986). Like the organizational culture perspective, the resource-based view of the firm asserts that organizational capabilities are a consequence of strong work values that define how to conduct business (Itami & Roehl, 1987). For such values, in the form of a work ideology, to generate organizational capabilities and ultimately a competitive advantage, three related conditions must be met. First, the organization's work ideology must create economic value by enabling it to differentiate products or reduce costs. Second, the work ideology must have attributes and characteristics that are not very common to most competitors in its industry. Lastly, the work ideology should be difficult for other organizations to imitate because of its tacitness, heritage, or basis in personal relationships (Hall, 1992). A work ideology that is common in an industry or easy to imitate can only provide an organization with competitive parity.

However, it is difficult for organizations to craft and maintain a unique, value-creating work ideology, particularly because of encroaching bureaucracy, isomorphic institutional pressures, and aggressive competitive environments (DiMaggio & Powell, 1983; Leonard-

Barton, 1992; Alder & Boyrs, 1996). Although some organizations clearly succeed, the means by which they do so remain ambiguous. As such, our intent is to explore the creation and preservation of a humanistic work ideology, and how it is incorporated into an organization's human resource management and customer service practices. The midwife practice at Big Hospital provides an interesting case study for such an exploration. Below, based on a theoretical analysis of the midwifery unit at Big Hospital, we develop a framework to explain the creation and maintenance of a humanistic work ideology, as well as its link to the generation of dynamic capabilities.

## **RESEARCH CONTEXT**

### **A Brief Profile of Big Hospital**

Located in the Midwest, Big Hospital is a comprehensive, research-oriented health system affiliated with a medical school. It is comprised of a general hospital, a children's hospital, and a women's hospital. In addition to these three hospitals, the health system includes specialized health centers, numerous outpatient clinics, and a health maintenance organization. The structure of Big Hospital typifies the professional bureaucracies described by Mintzberg (1979), with the core staff of the organization consisting of over 2,600 physicians and 2,400 nurses. Like other professional bureaucracies, each specialized area (e.g., surgery, dermatology, pediatrics) possesses a distinct work ideology developed from prior training, socialization, and shared experiences (Van Mannen & Barley, 1984).

### **Dynamic Capabilities as a Starting Point**

The primary author's initial research relationship with Big Hospital began when the Organizational Effectiveness team of the hospital invited her to study how the sub-cultures of departments within the hospital influence the development of HRM and PS capabilities. Such

capabilities are crucial to Big Hospital's ability to fulfill its mission of leadership and excellence in patient care, research, and education. Likewise, they play an important role due to the economic and competitive challenges in the healthcare industry. In the current industrial environment, hospitals face increased competition for survival, pressures to reduce cost, and service demands driven by consumer preferences (Johnson, 2002; Rider & Perrin, 2002). Therefore, PS capabilities impact both the business and quality of healthcare by expanding the volume of patients served, reducing patients' complaints or legal actions, and increasing compliance levels for recommended health procedures.

During this initial study, several departments, including the nurse-midwifery group, were noted for exemplary HRM and PS capabilities. These capabilities were embedded in organizational processes such as the implementation of total quality management, the redesign of service operations, and the adoption of customer service practices from Corporate America. In short, the departments adopted best practices and innovatively configured resources to develop capabilities that addressed competitive changes in the healthcare industry.

Of these departments, the nurse-midwifery group is unique. Its capabilities are based in the technical aspect of healthcare, but its clinical competencies are supported by compassion and the courage to go beyond the call of duty for patients. Moreover, the relationships that the midwives have with each other sustain the group's capabilities. Solidarity, respect, collaboration, and supportive organizational routines characterize the relationship between the midwives in the practice and enable the group effectively integrate tasks (Gittell, 2002).

The midwife practice is also important from a strategic business viewpoint, as women often select health insurance policies and hospitals based on their perceptions of the women's health services provided (Braus, 1997). Finally, the practice is important since the delivery of a

baby is the most common reason for hospitalization, accounting for 13 percent of all hospital admissions and 5 percent of all hospital days (Rooks, 1997).

### **The Nurse-Midwifery Practice at Big Hospital**

The nurse-midwifery practice at Big Hospital was founded in 1983 by two nurse-midwives with the goal of providing patient-centered women's health care. Their success as a service is evident in their growth in 2002 to 7.2 full-time employment equivalents, filled by ten Certified Nurse-Midwives (CNM). The nurse-midwifery practice at Big Hospital is a full-scope practice, with 15% of their practice dedicated to well-woman gynecological services. The practice triages and evaluates all patients (including patients of physicians at Big Hospital) who have labor and delivery or other pregnancy problems. They are also on call to the Emergency Department to provide care to survivors of sexual assault. Overall, the nurse-midwives see patients in seven different health centers within the Big Hospital health system, making coordination of patient care even more complex than a typical midwifery or gynecological/obstetrics practice. In 2002, the midwives delivered 546 babies and had a total of 7,355 clinic visits.

### **RESEARCH METHODOLOGY**

Because of the midwifery practice's unique work ideology, the case study methodology is appropriate since it allows researchers to learn from organizational behavior that is "transparently observable" (Eisenhardt, 1989). Furthermore, an ethnographic methodology addresses the need for more strategic management research within organizations to understand how processes produce dynamic capabilities (Rouse & Dallenbach, 1999).

## **Data Collection**

During a two-year period, the primary author employed a variety of ethnographic methods to study the midwifery group's culture. The ethnographic methods ranged from low intrusion semi-structured interviews to high-intrusion participant observations (Bernard, 1994). Semi-structured interviews were conducted with the midwives and a variety of stakeholders, including obstetrics patients and their significant others (e.g., husbands, partners, parents, and birthing coaches), general nurses working at the hospital's birthing center, the physician director of obstetrics and gynecology, and administrative staff members at outpatient clinics. In addition to the semi-structured interviews, the primary author spent time within the practice as a participant-observer (Jorgensen, 1989). This role entailed visiting staff meetings, attending national midwifery conferences, and observing the midwives as they worked with patients and interacted with other members of Big Hospital's staff. Although the primary author began her field studies as an outsider to the midwives, the participant-observer role allowed her to penetrate the group and gain a deep and direct personal experience of life as a midwife.

In addition to the qualitative data collected by the primary author, the secondary author, who is the nursing director of the midwifery group, collected historical case data on the practice, explained the intricate operations at Big Hospital, and clarified medical terminology. Her participation is an example of auto-ethnography or the cultural study of one's own people (Hayano, 1979; Alder & Alder, 1987). Although auto-ethnography has the potential for biased findings, the primary author balances this perspective and provides a look at the midwifery practice from an organizational, rather than clinical, perspective.

## **Data Coding**

The data for this study includes over 200 pages of field notes. The qualitative analysis of this data uses an open-ended coding process that first examines the data for similar themes to understand the humanistic work ideology of the midwifery group's culture (Strauss & Corbin, 1998; Miles and Huberman, 1984). The themes are then organized into a set of coding categories. This open-ended coding allows identification of concepts and properties. Furthermore, the data analysis is iterative, fitting accounts into categories and refining categories as new themes emerge, with periodic analysis throughout the field study to refocus data collection. Figure 1 presents the final data analysis results within a framework.

We believe this framework explains the humanistic work ideology of the midwifery group's as well as how a work ideology generates HRM and PS capabilities. Although a humanistic work ideology is difficult to maintain in a bureaucracy, our framework depicts how the midwifery "calling" and socialization into the profession develops their work values and serves as driving forces behind their high level of commitment to the practice and its patients (Bellah, Madsen, Sullivan, Swidler & Tipto, 1985; Chester, 1997; Benner 2001). The institutionalization of occupational norms influences the practice's adoption of a structure employing clan control mechanisms (Van Maneen & Barley, 1984; DiMaggio & Powell, 1983). These clan control mechanisms facilitate the execution of the group's work ideology by generating a collective mission, consensus decision-making, and the efficient coordination of work (Ouchi, 1980; Alvesson & Lindkvist, 1993). Additionally, the group's feministic values empower the nurse-midwives by encouraging resilience to the bureaucracy of Big Hospital (Rothschild-Whitt, 1979). In turn, this resilience preserves the humanistic work ideology of the practice by developing an internal structure that buffers both the nurse-midwives and their

patients from adverse bureaucratic routines. (Sutcliffe & Vogus, 2003; Worline, Dutton, Frost, Kanov & Maitlis, 2002). The next section presents a detailed analysis of the framework illustrated in Figure 1.

## ANALYSIS

### Developing a Humanistic Work Ideology

**Midwifery as a Professional Calling.** A recurring topic during interviews and job shadowing was how the midwives could be so dedicated to a career with long, grueling working hours that required them to constantly straddle the fence between nurse and physician, manage sometimes difficult and demanding patients and interact within a hierarchical administration. The midwives consistently expressed the idea of midwifery as a calling-- a career choice that brings personal fulfillment and a connection to the greater community by providing a valuable service (Bellah, Madsen, Sullivan, Swidler & Tipton, 1986). As Midwife Ruth<sup>1</sup> states: *“Being a certified nurse midwife was a calling for me. I felt called to give expert, sensitive, and personal care to women. I particularly wanted to prevent emergency and pre-term deliveries.”* Likewise, Midwife Leah expresses, *“Midwifery is a calling ... I have often thought that. I can’t imagine having been anything different (except maybe a rock star!)”*

Individuals who view their careers as callings have a deep personal investment in their work and pursue their careers partly for monetary gain, but mainly because of a strong identity and commitment to their profession (Wrzesniewski, McCauley, Rozin & Schwartz, 1997). In certain occupational communities, such as midwifery, work is a source of meaning and value where the worker is strongly connected to the community she serves (Van Maanen & Barley, 1984; Bellah et al., 1986). This viewpoint is expressed by Midwife Leah:

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<sup>1</sup> The midwives’ names have been disguised to ensure anonymity.

*Most people do not go into midwifery because of financial reasons. Most who enter midwifery are nurturing personalities and view work as a “calling” to make a difference with their lives.*

Coupled with this calling is the midwife’s view of herself as a public servant with a desire to contribute to society (Hall, 1968). Nurse-midwives have historically viewed their occupation as a social mission and have unified as a profession to improve the life of mothers and their babies, especially those who are economically disadvantaged (Rook, 1997). Indeed, Midwives Sarah and Ruth passionately describe the calling to midwifery:

*I became a midwife to help underserved populations. I feel a strong source of commitment to help the poor and minorities through my clinical work at community centers.*

*I chose midwifery because the whole process of creating another human is miraculous and being able to be part of it is an honor. I cry almost every time I do a birth. Midwives are in a unique position to help people become a part of a healthy, both physically and emotionally, family unit, whoever that unit consists of. It is a privilege.*

The call to midwifery and the strong sense of professional norms translate into a valued patient-service philosophy. As patients and their significant others so often articulate:

*This program is an invaluable service provided by the [Big Hospital] health service. The personal care provided by the midwives made our experience comfortable and enjoyable. We will choose a midwife over an OB with our next child.*

*It seems to me that nurse-midwifery is the only proper way to approach the birth of a child. I love all you wonderful committed ladies!*

*I had preconceptions about what Big Hospital would be like (cold, unresponsive to my needs, etc.). I found just the opposite to be true. All the nurse-midwives who participated and cared for me during labor and birth and after followed any request I had and were very sensitive to my needs.*

The professional calling of the midwives is distinct within the Big Hospital health care system. This distinction raises an important question: what differentiates this program from the other practices within the system? One reason for this distinction may be that midwifery is a calling all of its own. For example, Johnson (2001) argues that many physicians are no longer “called” to medicine, but choose it as a prestige career. Likewise, general nursing has become

routinized and focuses less on patient service because of managed health care, administrative tasks, and time pressures resulting from the nursing shortages. A second reason may be that midwives center their work around patient advocacy and that differentiate them from other nurses (Scoggin, 1996; Hampton, McQuitty & Hampton, 2000). This advocacy entails supporting and protecting patients, communicating information to them about their condition, and allowing patients to make educational choices. Note that this advocacy role is different from the typical nurse-patient advocate model due to the midwives' advanced training, authoritative role, and autonomous practice.

**Socialization into the Midwifery Profession.** For the majority of the nurse-midwives at Big Hospital, their professional values began with their sense of calling to midwifery. They then developed these values through their formal education and on-the job training, which socialized them into the unique work ideology of midwifery. This process represents the beginning stages of bonding with the profession by learning its values and traditions (Van Maneen & Barley, 1984). During this stage, nurse-midwives develop a sense of professional identity by absorbing the jargon, techniques, and protocols associated with midwifery. The training serves as a valuable socialization tool for passing on the intricate knowledge and art of midwifery and is a major rite of passage for nurse-midwives. For the midwives at Big Hospital, their training helps them develop a cognitive map to guide their humanistic interactions with patients and other stakeholders:

*To become an expert in nurse midwifery, you need formal education and a diversity of “hands on” experiences. Through these experiences, the nurse-midwife develops an ability to make each patient’s care unique by combining her knowledge with compassion [Midwife Priscilla].*

*The experiences of the clinical internship prepare you for the actual job of midwifery. It gives you the hands-on experience you need. To become a midwife, a student needs to work 80 hours weeks to see a variety of birthing situations and how midwives respond to them, not doctors. You cannot learn this tacit knowledge of a midwife by working a typical work-week or learn about how we operate. So much we do is different from the medical or textbook model of birthing. Our*

*approach to birthing incorporates the patient's emotional, psychological and physical well-being [Midwife Esther].*

The unusual and long work-hours during and after training further socialize the midwives into their profession by encouraging relationships with other midwives

Although the calling of the nurse-midwife is essentially a function of self-selection, through training and socialization, midwives form a collective dominant logic that shapes the profession's work ideology and defines a holistic approach to patient-centered care (Weick, 1979; Prahalad & Bettis, 1986). Normative isomorphism facilitates the implementation and protection of this work ideology into organizations. Normative isomorphism reflects when the viewpoints of a profession are introduced into organizations to legitimize its work ideology and ensure occupational autonomy. (DiMaggio & Powell, 1983). In the next two sections, we discuss how normative isomorphism influences the midwives humanistic work ideology through governance mechanisms and resilience.

### **Executing a Humanistic Work Ideology**

**The Midwife Practice as a Clan.** The midwives' ability to adopt occupational values of their profession facilitates the execution of its humanistic work ideology. For example, the governance of relationships in the midwifery practice is consistent with Ouhi's (1980) notion of a clan. Whereas bureaucratic control mechanisms rely on rigid rules, close surveillance, and hierarchical rank to guide employee effort, clan control mechanisms rely on goal congruence, shared values, and strong feelings of solidarity to govern behavior within a group. In groups using clan control mechanisms, solidarity and shared objectives bind organizational members. The solidarity between clan members stems from their necessary dependence on, and respect for, each other (Durkheim, 1933; Kunda 1992). The shared governance paradigm in the midwifery practice is seen in the collective approach to diverse matters such as how to organize work and

how to treat patients (Wilkins & Ouchi, 1983; Alvesson & Lindkvist, 1993). As Midwife Naomi explains:

*We have a group consensus model. What I mean by that is, we make practice decisions as a group and then abide by them. For example, if I follow another Certified Nurse Midwife, and she has made a plan with a patient, I will follow it even though it is not what I might have done, as long as it doesn't go against our group's decisions.*

In the midwifery practice at Big Hospital, collegiality and professional standards support efficient clan control mechanisms, since the group can adopt the existing professional-midwifery culture with minimal socialization costs (Wilkins & Ouchi, 1983). Effective clan control mechanisms demand human resource management policies that align recruitment, development, and retention with the group's work ideology since the major means of control derive from previous training, careful selection, and socialization. This process is accomplished in the practice by recruiting midwives with training from prestigious programs and with previous nursing experience. The recruitment process is enhanced by Big Hospital's commitment to staff development, excellent compensation and flexible work environments. The success of the human resource management practices is evident in the extremely low turnover percentages. The majority of midwives have worked in the practice for at least five years, and these long-term relationships reinforce the clan control mechanisms.

Overall, the clan control mechanisms integrated with the philosophy of midwifery promote attachment and commitment to the practice. This commitment in turn motivates the midwives to go beyond minimum performance expectations. In addition, it promotes the emotional well-being of practice members by providing a work environment that integrates humanistic values into its governance mechanisms (Ouchi & Johnson, 1978 Gittell, 2002):

*We place a value on getting along. We have need for harmonious relationships and are willing to work on this. This does not mean we always agree and that we don't get angry with each other. Our group is able to feel anger, talk about it, forgive and hug after. We*

*are all human in need of understanding. How well we treat each other transcends into how well we treat our patients* [Midwife Leah]

**The Feministic Values of the Midwifery Practice.** In addition to clan control mechanisms, the work ideology of the midwifery practice is implemented through a feminist approach to organizational structure. The feminist organizational form is a variant of a normative approach to governance, such as clan control mechanisms (Martin, Knopoff & Beckmman, 1998). Feminist organizations focus on employee well-being, governing through egalitarian relationships, consensus decision making, and shared leadership responsibilities.

The midwifery practice at Big Hospital epitomizes the feminist (Hofstede, 1980; Martin, Knopoff & Beckman, 1998; Ashcraft, 2001). It is founded on a women-centered mission that promotes empowerment of both its members and patients through self-reliance and egalitarian relations (Reinelt, 1994). Furthermore, the midwives at Big Hospital bring a women-centered perspective to their work, and the practice's strengths lie in its independence and the egalitarian sisterly connections the midwives have with each other. The independence of the practice results *"from the great relationships we have with physicians. They respect our practice and allow us to pretty much practice autonomously"* [Midwife Leah]. Although the nursing manager is the practice's leader, *"authority is decentralized and grounded in expertise, experience capabilities, and individual strengths of the midwives, not titles and hierarchical levels"* [Midwife Esther]. For instance, one midwife's authority may be based on her knowledge of alternative medicine. Another may be the group's expert on serving a certain demographic group of patients or in issues related to lactation.

In fact, some of the midwives feel their practice succeeds because its feminist organizational structure: *"Our work relationships are affected by how women approach work."*

Others within Big Hospital share this sentiment: “*Only women could make a midwifery practice successful.*” Even patients and their significant others appreciate the feministic-orientation of the practice:

*I'm very glad that women midwives are there for us women who prefer a gentle and caring health service. Because midwives are women they understand women's health issues better. They are more personal during labor and delivery. They are available to answer your questions personally 24 hours a day, and even during the postpartum aspect of pregnancy.*

*I'm glad to have women such as the midwives for these most important female/family events in my life*

This feminist structure is reinforced by communication that encourages expression of work feelings and constructive management of conflict (Ashcraft, 2000). “*We have regular meetings. We communicate about our individual patients and clinics via e-mail regularly. We confront each other when we are concerned about an event*” [Midwife Ruth]. Furthermore, this feminist communication style is used when working with colleagues outside the group. “*Over the years, we learned to nurture relationships and build networks through constructive communication with the key people we need to serve our patients – those doing genetic counseling, radiology, social work, etc.*” [Midwife Priscilla]. Such communication is uncharacteristic for Big Hospital, where communication within and across groups is difficult because of the sheer size and complexity of the organization.

In summary, the feminist value governing the midwives' interactions derive from the cultural heritage of midwifery and is another example of integrating a profession's work values into organizational life. They succeed because of their alignment with the practice's mission of women-centered healthcare and have been validated by external stakeholders because of the women's health movement (Rushing, 1993). Moreover the feminist work values allow the midwives to see their work as a form of activism in changing how the medical community

perceives women's health issues. The midwives work hard at preserving the group's feminist governance principles, which they perceive as vital to the practice and fulfilling their calling to midwifery.

### **Preserving the Work Ideology through Resilience**

The above values and ideologies of the midwifery practice at Big Hospital are maintained through the group's resilience. In organizational theory, resiliency is an organization's ability to achieve desirable outcomes amidst adversity and barriers (Sutcliffe & Vogus, 2002). Resiliency requires positive adjustment, adaptation to challenging circumstances, and innovative solutions when the work situation is not ideal (Worline et al., 2002).

The midwives demonstrate resilience when confronted with the medical community's opinion that midwifery is not mainstream medicine and thus not as credible. This opinion is reinforced in the United States, where the health care system includes a mainstream provider – the Gynecologist/Obstetrician. As Chester (1997:15) asserts in her book, “The right of a certified nurse midwife to practice is tied into issues of power over collaboration or backup medical care and issues of competition and control.” For the midwives at Big Hospital, maintaining the practice's credibility involves the resilience to integrate the art of midwifery with the medical model of women's healthcare. *“This demands the group staying abreast of current trends in both worlds and practicing evidence-based medicine to determine what is best for our patients”* [Midwife Martha].

In addition to managing their identity within the medical community, the midwives confront adverse pressures from the hospital's administration and insurance companies to shorten their patient interaction time and improve the group's financial performance. However, these goals go against the basic principles of nurse-midwifery that emphasize a high level of

patient interaction and service, regardless of cost. Although the midwives at Big Hospital still spend a considerable amount of time with their patients, time and financial pressures have forced them to develop alternatives to patient service. For instance, general knowledge needed by patients is now codified in pamphlets or displayed on the group's website. Staff nurses at the various clinics perform screenings before prenatal visits, and the group has become extremely efficient at using the telephone and e-mail to address patients' concerns and maintain the practice's commitment to caring service.

Lastly, the resilient nature of the midwives is evident in how the practice "protects" its patients from the bureaucratic culture of Big Hospital. As conveyed by a two-time patient of the midwives:

*The midwife practice is the only way to deliver a baby at Big Hospital if you don't mind going natural. The general OB practice has so much red tape and poor service. The midwives protect you from this red tape.*

When possible, the midwives control every aspect of the patient's interaction with the healthcare system at Big Hospital:

*Once a midwife patient enters the system, the majority of their interactions are with us. If they need to see a specialist, we suggest one that we trust, and who will provide the same level of service we provide to our patients. To ensure quality service, we also triage our own patients. This is not done in the physician practices at Big Hospital.*

This buffering function maintains the group's control and protects patients from negative environmental influences (Thompson, 1968). Patients appreciate this approach and in fact will separate a bad Big Hospital experience from their perception of the midwifery practice:

*My stay in the hospital was terrible. It was the total opposite of my giving-birth-experience! Suddenly I was not treated like a human being. I felt like most of the staff tried to get me into a certain pattern. There was no time to ask for my personality. No time (or what other reason could it be?) to see the individualism. No information about different options to solve a problem. It was one of the worst experiences of my life! But, the midwives were great!*

*The labor experience was not ideal. Since the hospital was very busy, we were not given a room and did not have access to a bed, a shower, or any of the things we'd brought from home to aid*

*labor. I don't have any complaints about the midwives though, but the facilities were seriously lacking.*

The resilient behavior has become ingrained in the midwifery practice's identity. The midwives know that threats exist to their work ideology. However, confronting the threats have become part of their strategy and provide purpose to the practice's mission (Goffee & Jones, 1996).

## **DISCUSSION**

This project began with a study of the generation of dynamic capabilities from a positive organizational scholarship lens. With this goal, the researchers collected case study data from a nurse-midwifery practice known for its HRM and PS capabilities rooted in humanistic interactions and value-centered work processes. Through our analysis of this data, we find that the practice's work ideology is a central tenet supporting its humanistic behavior. Therefore, we propose that a sub-culture's work ideology provides an understanding of how humanistic behaviors in organizations create capabilities. Supporting this perspective, the paper presents a theoretically-grounded model to explain the development, execution, and preservation of a humanistic work ideology.

Interestingly, the findings suggest that a professional calling and socialization into an occupational community provide the starting point for a humanistic work ideology. The sense of calling, rigorous socialization, and membership in an occupational community all promote a collectivist and communal approach to work that is a contrast to the competition and individualism in most organizations (Van Maanen & Barley, 1984; Cameron & Caza, 2002). More importantly, though, we find that implementing a work ideology through occupational norms legitimizes humanistic behavior in organizations by providing members with a justification for their work values and a dedication to service (DiMaggio & Powell, 1983). The

occupation norms empower group members to act as renegades or tempered radicals, behaving outside the norms of the broader organization and opposing some of its policies (Meyerson & Scully, 1995; Kondra & Hinings, 1998). Developed from previous values and beliefs, tempered radicals bring an alternative philosophy to the status quo of bureaucracy, and this bridging of two philosophies fuels organizational learning and transformation.

We further find that executing and preserving a humanistic work ideology in bureaucratic organizations is difficult. Although some bureaucratic organizations enable the coordination and control of work, traditional bureaucracy makes it difficult to embrace work values emphasizing humanistic processes (Alder & Borys, 1996). The nurse-midwife practice at Big Hospital tackles this obstacle by employing a mode of governance that combines clan-like control mechanisms with feminist organizational values. These normative control mechanisms proactively shape the practice's values regarding human resource management policies and patient services. Thus over time, the midwifery group developed a unique shared meaning of work not only defined in concrete rules, but also in the hearts and minds of its members (Lado & Wilson, 1994).

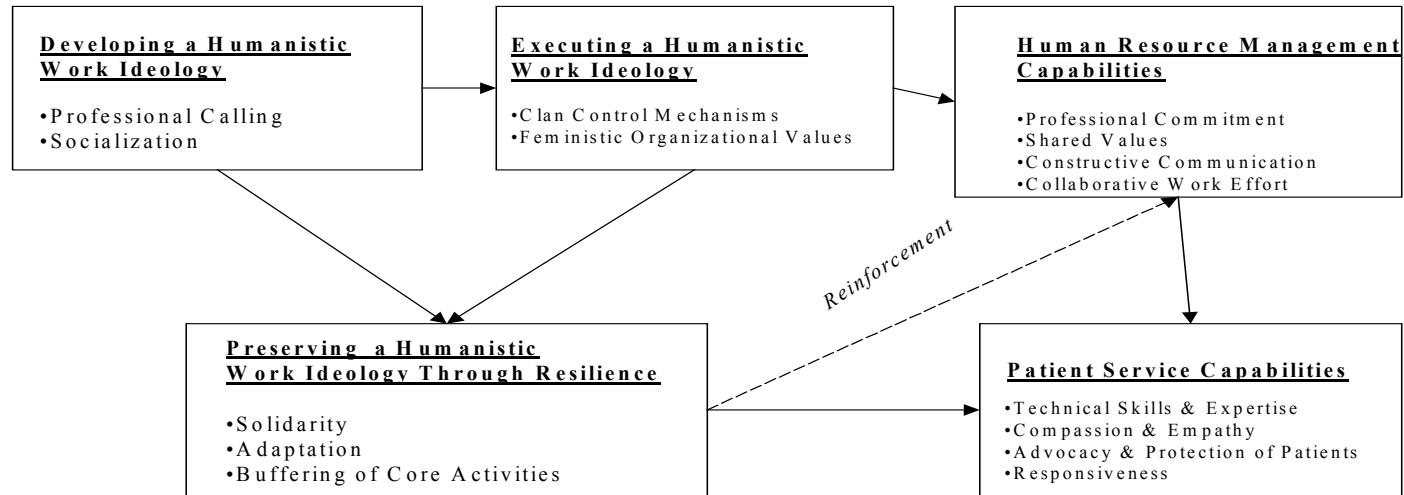
An interesting question that emerges during this study is whether the humanistic work ideology of the practice would succeed without strong feminist values. Without such values, the group might need to work harder at resisting bureaucratic isomorphism by buffering their core competencies (Martin, Knopoff & Beckman, 1998). For the midwives, even though the masculine values of competition and achievement permeate the hospital, their humanistic work ideology is legitimized through external coercive pressures from patients, the women's health movement and managed health care companies. This legitimacy is evident in the imitation of their birthing procedures by physicians, but is not fully achieved, as the medical community has adopted only the clinical aspects of the midwifery practice.

## CONCLUSIONS

In closing, this paper contributes to the growing number of studies of positive organizational elements. Although it is limited to a single case study, it represents a starting point for examining an extraordinary organization driven by humanitarian principles despite its bureaucratic environment. The lessons from the midwives' -- passion for their work, egalitarian management styles, and resiliency when confronting adversity -- have broader managerial implications beyond the healthcare industry, especially in a society that devalues individuals who work in "caring" professions. Despite this societal devaluation, many occupations are demanding a more humanitarian approach to work. This paper provides the groundwork for understanding how a work ideology relates to strategic outcomes and how such relationships can help organizations become more humanitarian. The model in this study can be used by organizational theorists and practitioners to explore other examples where it "pays" to care about individuals and value social relationships. In addition, future research could consider how organizations preserve this humanistic work ideology as the group grows or as it becomes more difficult to isolate the group from bureaucratic norms.

Figure 1

## A Framework Linking Humanistic Work Ideology to Dynamic Capabilities



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