Since the late 1970s, the “learning organization” has received a great deal of interest from researchers, academics and practitioners. Series of books and articles have been published, in an attempt to construct a “roadmap” for the achievement of an idealised image of the “learning organization” (Tsang, 1997). However, “despite the amount of interest in the topic, at the moment there is a limited amount of good empirical research” (Easterby-Smith, 1998), and no consensus on the main characteristics necessary for the construction of the “learning community”.

This paper tries to clarify the concept of the learning organization and to cast light upon the barriers to its application, by answering four research questions:

1. What is the difference between individual and organizational learning?
2. What type of learning does a learning organization need?
3. What are the necessary “blocks” and “foundations” of the learning organization?
4. Does a learning organization in practice differ from the learning organization as prescribed in theory?

We draw upon a framework that encompasses the principles of the learning organization, based upon the literature published in renowned academic journals, and we use it to explore the learning mechanisms in UK and Greek health organizations. We focus on their channels of information dissemination, and we emphasize the notions of knowledge, feedback, communication and dialogue.

It is widely acknowledged that learning may become the only sustainable competitive advantage for all the organizations, especially in knowledge-intensive industries (Stata, 1989). Thus, health-care organizations offer an ideal context for our study, because not only do they represent a knowledge-intensive sector, but they also provide particularly complex services, characterised by the interaction of multiple disciplines and by the need for constant updating with the latest medical techniques.

Comparative research in the UK and in Greece gave us the opportunity to study the process of learning from two different perspectives. We selected a UK Community Health Care Trust (CHCT), which has the reputation of a “learning organization”, and three Greek hospitals, which are the equivalent organizations responsible for the provision of health-care services. They all employ a large number of staff of various disciplines, they cover wide metropolitan areas (London and Athens respectively) and, hence, offer health services to a large number of patients from different social, economic, educational and cultural backgrounds.

In this paper, we first review the literature on individual and organizational learning and discuss how they relate to the learning organization concept. In the second section, we refer to the definitions and principles of the learning organization and analyse the framework we use for our comparative case study. In the third section, we discuss the results of our research for the UK CHCT and the Greek hospitals and, finally, we compare their learning mechanisms and draw conclusions regarding the barriers to building a learning organization.
features of the former, we need to step back and look into the process of individual and organizational learning. These processes are looked at separately, because they are very related yet different in nature (Argyris and Schön’s “paradox”, 1978[1]). According to Kolb (1984), “learning is the process whereby knowledge is created through the transformation of experience” (see Figure 1). Thus, learning encompasses two meanings:

1. The acquisition of skill or know-how, which implies the physical ability to produce some action.
2. The acquisition of know-why, which implies the ability to articulate a conceptual understanding of the experience.

Argyris and Schön (1978) argue that individual learning takes place only when new knowledge is translated into different behavior that is replicable.

Subsequently the mechanisms of memory and mental models (Kim, 1983; Senge, 1990a, b)[2] translate individual learning into organizational, through the “spiral of knowledge” (Nonaka, 1991). Tacit knowledge, hidden in individual minds (Simon, 1991), is embedded in routines and habits not directly visible to the outside world. The first step of acquiring organizational learning is to understand individual tacit knowledge, interpret and share it across the organization through observation, imitation and practice (Nonaka, 1991; Crossan et al., 1999).

Subsequently, tacit meanings need to be transformed into explicit, through shared understanding and coordinated action, so that all employees can integrate knowledge, operationalise it and use it to improve performance (Crossan et al., 1999). Finally, explicit information has to be internalised and embedded within everyday routines at all levels of hierarchy. Thus, individual learning converts into organizational learning (Nonaka, 1991).

However, the mechanisms that organizations use to learn are totally different from those of individuals (Argyris and Schön, 1978; Weick, 1991; Cook and Yanow, 1993; Popper and Lipshitz, 1998). Organizations and their members may learn completely different things. In many cases “the organization cannot seem to learn what every member knows” (Argyris and Schön, 1978). Hence, the link between individual and organizational learning is distorted (Kim, 1993)[3].

Three types of organizational learning have been identified in the literature: single-loop, double-loop and triple-loop learning. In single-loop learning, decisions are based solely on observations and result in the correction of errors. Double-loop-learning encourages critical rethinking of the existing knowledge, which has proven inadequate (Argyris, 1977). Finally, triple-loop learning forces the individual to challenge deep-rooted assumptions and norms that have previously been inaccessible, because they were either unknown or known but undiscussable (Argyris and Schön, 1978). Therefore single-loop is about “doing the same things differently”, double-loop is about “doing completely different things”, and triple-loop is “changing the assumptions about the way things are done”.

There is no unified definition of organizational learning, because different academic studies are based upon diverse theoretical assumptions (Easterby-Smith, 1997) and thus give emphasis on different characteristics of organizational learning, such as:

• the changing and acquisition of meanings through collective actions (Cook and Yanow, 1993; Kim, 1993);
• the reinforcement of improvements in knowledge, actions, behaviors and performance (Huber, 1991; Fiol and Lyles, 1985; Nevis et al., 1995); and
• the capacity for collective acquisition of knowledge, ideas and insights through the sharing of experiences (Marquardt, 1996; Nevis et al., 1995; Stata, 1989).

These features of organizational learning can flourish within an environment that facilitates changes in the way people learn “how to learn” (Pedler et al., 1986; Senge,
Principles and building-blocks of the learning organization: the framework for the study

The definition of the learning organization that incorporates the main characteristics of organizational learning is Garvin’s (1993): “A learning organization is an organization skilled at creating, acquiring and transferring knowledge, and at modifying its behavior to reflect new knowledge and insights”. Research, so far, has identified various characteristics of a learning organization that support the creation, acquisition, transfer and utilisation of knowledge. Senge (1990a,b) refers to five “component technologies”, Garvin (1993) identifies five main activities of the learning organization, Nevis et al. (1995) produce a framework with ten facilitating factors of learning, while Popper and Lipshitz (1998) emphasise the importance of continuous learning. The identified characteristics can be gathered into five groups, which constitute the basic building-blocks of the learning organization (Goh, 1998). Hence, the five principles we highlight for our framework are:

1. Mission and vision.
2. Leadership.
3. Experimenting culture.
4. Transfer of knowledge.
5. Teamwork and co-operation.

The five principles cannot operate without two supporting foundations. These are:

1. The organizational design.
2. Employee skills and competencies.

Principle 1: mission and vision

A widely shared and understood mission enables staff at all levels to develop their skills and capabilities, take responsibilities and contribute to organizational performance (Senge, 1997; Pearn et al., 1995). Vision encourages employees to acknowledge the expectations-reality gap, and provides incentives for learning and improvements (Huber, 1991). This is possible when there is a dynamic and actively involved leadership that considers employees as “the core competitive advantage” of the organization (Nevis et al., 1995; Popper and Lipshitz, 2000). Hence, principle 1 is closely related to principle 2.

Principle 2: leadership

Leadership in a learning organization empowers employees, encourages an experimenting culture, rewards learning, supports innovative suggestions and frequently generates learning opportunities on-the-job (Nevis et al., 1995; Pearn et al., 1995; Marquardt, 1996). Managers are seen as coaches, leaders are viewed as teachers, designers, stewards and facilitators (Senge, 1990a,b, 1997; Ellinger et al., 1999). However, involved leadership cannot accomplish its goals, unless there is a system of knowledge dissemination and sharing, which represents principle 3.

Principle 3: transfer of knowledge

Skill and knowledge acquisition within a group is of limited use, unless it can be transferred, in order to energize creative ideas in other departments or units (Garvin, 1993). Critical thinking and reflection are required for the dissemination of valid and reliable information. Furthermore, learning from past failures makes knowledge explicit and enables its transfer from individual to organizational level (Marquardt, 1996). Nevertheless, good transfer of knowledge cannot support its utilisation, unless there is teamwork to implement the proposed solutions.

Principle 4: teamwork and co-operation

The diversity of team members’ knowledge and backgrounds stimulates dialogue, brainstorming and team problem solving (Garvin, 1993; Isaacs, 1993). “Everyone in a learning organization is aware of and enthusiastically accepts the responsibility to be a learner, as well as to encourage and support the learning of others” (Marquardt, 1996). However, none of the above principles can flourish, without “openness to experience, encouragement of responsible risk taking and willingness to acknowledge failures and learn from them” (McGill and Slocum, 1993). These are all characteristics of an experimenting culture.

Principle 5: an experimenting culture

An important part of the learning organization is its ability to create new knowledge and insights; this requires open-mindedness and dialogue, which help employees discover their hidden assumptions or mental models (Kim, 1993). An experimenting culture sets aside resources for employees to engage in creative pet projects, develops rewarding mechanisms for those that excel in this area and tolerates errors. “If learning comes from experience, the more one can plan guided experiences
The building blocks of the learning organization cannot contribute to organizational learning without the two supporting foundations.

Foundation 1: organizational design
A learning organization needs a structure that supports the upward and downward circulation of information. Research has shown that learning capability is negatively related to formalization and hierarchies (Goh, 1998; Easterby-Smith, 1997) and positively related to the minimization of boundaries between functions, informal networking and dialogue (Nevis et al., 1995; Schein, 1993; Isaacs, 1993). However, communication mechanisms cannot bolster the learning organization, unless employees possess the right skills and capabilities to promote single-, double- and triple-loop learning.

Foundation 2: employee skills and competencies
A learning organization also needs to be accompanied by lifelong learning (Pearn et al., 1995). That is why HR practices of learning organizations focus upon selecting people for what they are able to learn, not for what they already know (McGill and Slocum, 1993; Senge, 1990a,b; Nevis et al., 1995). The learning organization is also based upon other new capabilities, such as reflective thinking and team-building (Senge, 1997), which equip employees to search for interdependencies within the different departmental functions, and to link their learning to the learning of the organization as a whole (Nevis et al., 1995).

Teamwork and co-operation along with the transfer of knowledge are central characteristics of the learning organization. But they cannot in themselves create a learning community. They need to be surrounded by shared leadership, clarity and support for the mission and an experimenting culture. Furthermore, the whole edifice is insecure, if not buttressed by the supporting foundations, the organizational design and the employee skills and competencies (Figure 2).

Results
Our interviews in the UK and in Greece cast light upon the weaknesses and inefficiencies that differentiate theory from practice. We first examine the learning mechanisms of the UK CHCT and then the Greek organizations. Our results are analyzed regarding each principle and foundation of the selected theoretical framework and help us draw comparative conclusions.

The UK Community Health Care Trust
As an independent NHS Trust (Robinson and LeGrand, 1994), it covers the wide London area, with a workforce of around 1,500 staff, which is distributed among different localities. In order to function as a “learning organization”, it introduced the model of “shared leadership” (Porter-O’Grady, 1991), a framework designed to produce a structure that would promote clinical issues and involve all staff in the improvement of services and decision making. The structure is relatively flat and consists of the Board of Directors, three senior posts, the local Clinical Practice Groups, and the Clinical Facilitators, who are key people in the dissemination of knowledge within the organization. All the above bodies attend the Trust Clinical Practice Forum[5]. Our research examines the presence of the building-blocks and foundations of the learning organization, and helps us draw conclusions regarding the function of the Trust’s learning mechanisms.
**Clarity and support for mission and vision**
The HR manager of the Trust played a paramount role in introducing the new structure of “shared leadership” and was determined to cultivate the “seed” of the “learning organization”. However, there was neither clear understanding of the objectives nor unified communication for this vision:

… People have not fully understood what shared leadership is all about and that goes from directors, all the way through the organization (risk and audit manager).

The clarity and support for the mission one impeded by an apparent inability to integrate managerial with clinical agenda:

Much more focus is given on clinical development type of work and ensuring that individual clinicians deliver services to standards (director of operations).

The Board’s ultimate goal and vision is the practitioners’ involvement in decision making:

The philosophy of shared leadership are about practitioners developing a set of rounded skills – it is not just about service delivery at the point of patient care, it is about influencing strategy, policy, guidelines (locality manager).

However, most of the staff do not embrace the vision and do not want to get involved in strategy-making. They basically view shared leadership mechanisms as a means of information acquisition, not an opportunity for interactive team-learning.

In brief, there is no clear understanding and communication of the vision and the goals of the “shared-leadership” structure.

**Leadership and involvement**
The HR director envisaged shared leadership as a way of “democratizing clinical decision making and structuring responsibilities around what you need to deliver clinical care”. But the Trust leaders find it difficult to balance the diverse and often contradictory roles of being a coach, a facilitator, a steward and a teacher, as required in a learning organization (Senge, 1990a,b).

In the beginning, leaders provided no guidance and training for practitioners:

There was no willingness within the organization when we got in the shared leadership model to provide any development for the staff (locality manager).

Later on, the presence of managers becomes highly influential, but still unable to provide support and direction, thus, reflecting a “leadership imbalance”. On the one hand:

There are too many managers and directors involved and the Forum is supposed to be for the practitioners… that is one of the reasons why people don’t come [to the Forum].

Because they don’t see it as being their Forum (risk and audit manager).

And, on the other hand, they are:

… weak on being directional, on saying “this is going to happen and this is going to happen this way” (locality manager).

Moreover, management does not always allow time and space for debate and systemic thinking:

There were occasions where debate has been stopped and stifled before it came to a logical conclusion (health visitor).

However, occasionally, there are opportunities for learning (basically operational and single-loop)[6]. Hence,
leadership oscillates between high involvement and lack of direction for the staff, and as a result fails to contribute to the building of the learning organization, as prescribed in theory.

Transfer of knowledge
Clinical facilitators are those responsible for the distribution of individual-level learning, to the group and organizational level. However, their role has been either misjudged or simply ineffective. For this reason the HR Director admits:

I am reducing them by half, because what they tend to do and are not supposed to do, is that they spend a lot of time doing supervision, which is not a “personal-therapy session” … I fear we spend a lot of time talking on a one-on-one basis and the rest of our time goes to meetings.

Meetings are meant to be a central mechanism for sharing learning but, in practice, the local groups of practitioners do not always live up to their part. Lack of staff or commitment of existing employees are major factors of their malfunction. They have reached a stage, where:

… each group has to identify clinical priorities, and think about what they can do to meet those priorities … So, first it is needed to get staff to commit to the group (clinical facilitator).

The necessity of reflective thinking to underpin the transfer of knowledge has not been encouraged yet, because groups are still at the first step of problem-identification. The Trust Forum initiates dialogue, but PowerPoint presentations of diverse projects from different localities are unable to stimulate debate and transfer of learning: People do not want the information in that format. They want something interactive … They want to be able to come up with a discussion (risk and audit manager).

Moreover, people do not always understand the importance of sharing best practices[7]. Thus, benchmarking and transfer of knowledge from other localities or outside Trusts are minimal.

Hence, the necessary determinants of the transfer of learning are either missing or insufficient.

Teamwork and co-operation
Teamwork within a learning organization is not a mere gathering of professionals in order to produce a common project. It involves critical thinking and co-operation, which means:

being able to learn and encourage others to learn (locality manager).

Nevertheless, the clinical effectiveness groups lack systemic thinking:

People see things in isolation. They don’t see a pattern … And they aren’t sufficiently aware of what’s required to make a change (risk and audit manager).

Furthermore, self-motivation is not enough to keep staff on the track of the learning organization:

It is very hard to keep self-motivation up … If staff are left to their own devices, nobody challenges them, nobody gives them any inspiration, they are pulling a salary check at the end of the month and nobody is saying: “Have you worked your salary?” (nursing homes manager).

These multi-professional groups merely report back to the Forum, rather than contributing to interactive team-learning: What’s the purpose of local groups just reporting back? It should be about sharing ideas or bringing problems and discussing how we can meet the problems (clinical facilitator).

Therefore, meetings become aimless and time-wasting:

People meet because they meet. We had a meeting that it was one hour and a half, and more than an hour was reporting back from other meetings (health visitor).

Finally, the difference between national objectives and local priorities undermines teamwork. For instance, one Health Authority focused upon the service delivery for diabetics, while a relevant locality had patients with mainly cardiac-disease problems and was unwilling to participate in projects that did not address their immediate needs.

In brief, we did not observe teamwork and cooperation, such as would emphasize debate and sharing of learning between different disciplines and localities.

Experimentation
Experimentation with new clinical approaches or new operational systems and mechanisms is restricted, following the regulations of the Labor Government. Kessler and Coyle-Shapiro (1995) in their survey indicate that a large number of employees do not consider innovative practice, unless they are forced. And even when new ideas are generated, only incremental changes happen[8]. Lack of time and work overload, also, inhibit learning and experimentation:

People are very pressed … They need to have designated time to get the learning they need (health visitor).

Furthermore, the guidelines set are quite restrictive for the clinician:
They are so rigid that then you don’t look at the person as a person, or the clients for their needs, because it [the guideline] says you have to do this and this and this (director of operations).

The Labor Government has left little space for experimentation:

This government is extraordinarily directional and tells you exactly what they want you to do, and how to do it … the conservative administration was very flexible. They told you what to do, not how to get there (locality manager).

Nevertheless the HR director believes that it is possible to reconcile the tension between national standards and local needs:

There is diversion of practice and a lot of scope for learning and experimentation, and for applying that learning locally, never mind the guidelines. There is always going to be a sort of local interpretation of standards.

In summary, experimentation is allowed within the limits set by the Government guidelines.

Judging from the above analysis, the basic principles of our framework are rather inefficient in the UK CHCT. However, we acknowledge the effort of management to promote their implementation through “shared leadership”. Furthermore, we identify that the Trust possesses the two supporting foundations of the learning organization edifice, namely a flat organizational design and qualified and skilled employees.

Organizational design
The UK Trust, through a flat organizational structure, tries to devolve decision making to the local level and to encourage teamwork:

We have now in place a mechanism to allow every person to contribute to the agenda for the Trust, to the strategic direction (medical director).

However, the flow of information within the Trust is very much top-down, a process that contradicts the main idea of “democratizing decision making”. But networking and informal learning are quite common throughout the Trust:

A lot of discussions happen informally. You sit down with a cup of coffee and, when you have finished your gossiping bits, you realise you are discussing a client (health visitor).

Hence, the Trust possesses the appropriate structure for the learning organization.

Employee skills and competencies
The Trust has put a great deal of emphasis upon employee development and training. It has a post of Professional Development Adviser, responsible for identifying and satisfying the staff’s training needs, according to the budget. Clinical facilitators have also a key role in this process. They: facilitate clinical performance, which involves supporting the staff, addressing their training needs, giving them clinical supervision and looking at how they can deliver the service better clinically.

The Personal Development Portfolio[9] underpins the principle of life-long learning, by helping employees to set a personal career path and to be responsible for their self-development.

In conclusion, we need to underline that, regarding the UK CHCT, the mechanisms of a learning organization in practice differ from the theoretical learning organization model. Our results concerning the Greek hospitals are subsequently reviewed.

Greek hospitals
Public hospitals consist of clinics, each one dedicated to a different specialty. There are two types of clinics: the university clinics affiliated to the diverse medical schools of Greece and the State clinics, which employ their own doctors. The former have a clinical, research and educational role. The latter are responsible only for the treatment of patients and occasionally for the training of residents. General hospitals often have both types of clinics[10]. The organizational structure of Greek hospitals is hierarchical. The line of command from the top-down passes from: the scientific committee, which controls the hospital’s functions, the medical service with its directors of sectors, who monitor medical practice, the board, the directors of clinics, the clinicians, and finally the nursing service, which supervises the nurses.

There is formal communication between the different hierarchical levels and each body operates within the organizational structure set by the State. Hence, in all three Greek hospitals that we studied, we observed parallel learning mechanisms, which we subsequently analyze. We review the principles of the Greek “learning organizations” as a whole, without discussing each hospital separately.

Clarity and support for mission and vision
There are neither vision and strategy determined by the board, nor short-term goals set by the directors:

There is no clinic in Greece that sets a budget. Nor is there a pre-decided fund to support the function of the hospitals, according to one’s local needs and priorities. All is left to luck (clinic director).

The structure, resources and organization of Greek health organizations are determined
by the Government, and those that are familiar with the everyday functional deficiencies and the local priorities do not participate in the decision-making process:

The people who face the problems are not those that vote the laws (clinic director).

Thus, the objectives and structure put in place nationally do not satisfy the needs locally. Furthermore, there is no concerted action from all disciplines towards a common goal; just a vague mission – the treatment of the patient – which does not translate into specific objectives for everyone on staff. The activities of the practitioners are fragmented and, only under circumstances of emergency, do people from different specialties cooperate.

In brief, there is no overall organizational purpose to inspire people to learn and share learning. The members of the Board, who ought to exercise this role, are rarely related to the medical profession or health-care services. They are mainly appointed by the State and their relations with the directors and the rest of the staff are distant.

Leadership and involvement

The clinic director has three roles. He is responsible for the treatment of patients, for teaching the residents and conducting medical research. The younger he is, the more willingly he encourages residents to learn new things, to work on projects and experiment. He provides guidance and consultation to the residents and staff, he is accountable for the function of the clinic, but has no legitimate power to decide on any significant organizational changes.

Directors stay in this position for life, and this permanence leads to loss of interest in their profession, which becomes a routine job:

When we sit around a table and discuss with the same people for ten or more years, what new element can we contribute to science?…

Most of the doctors adopt the attitude and culture of a public servant after a number of years and they stop being interested in research (clinic director).

Head nurses and directors lead through informal discussion with the staff, which “helps ease tensions, stress or even anger”. However, occasionally, their leadership style is directive:

You have to be near the girls all the time, to observe and anticipate their every move, and basically play the policeman (head nurse).

The leader is the role model, the teacher who knows best:

The director is after all the director, the whole system revolves around him, he’s a bit above everybody else and the clinic is his absolute responsibility” (resident).

There are also cases where directors try to motivate the residents with awards for their performance in the exams. But this basically rewards single-loop learning and not reflective and critical thinking.

Transfer of knowledge

The main channel for the dissemination of knowledge is the morning round of all doctors, residents and nurses with the Director, who visits the patients and gives directions for their treatment. However, little space is left for innovative learning dissemination. Single-loop is the type of learning acquired and shared, albeit in a fragmented and situational way (Kim, 1983). There are PowerPoint presentations of interesting incidents made by different groups of residents every week, but they are usually too specialized for the rest of the audience to follow. Clinicians are not encouraged to attend seminars and workshops, because lack of personnel impedes their leaving the hospital during weekdays. Communication with other hospitals always serves a purpose other than learning; to borrow machinery or inquire after medical analyses that the clinic cannot provide. Hence, sharing of learning is reflected on a formal top-down transfer of single-loop medical knowledge.

Teamwork and cooperation

Clinics hold meetings aimed to inform the members of the group, without promoting teamwork. The meaning of cooperation is:

Do your job right, do not talk if you don’t have to, say what you have to say in a few words (head nurse).

Nevertheless, there are a lot of informal, personal contacts:

It’s like in the army: the old residents get to pass the information on to the new ones (resident).

Residents fill in for each other:

There is a friendly façade. If we had more workload, then all relations would be more tense (resident).

However, no synergies are possible among the clinics within the same hospital, because each one represents a separate entity, which follows the rules and orders of its own director. Errors and problems that may appear stay within the clinic and solutions are not communicated. In brief, there are no voluntary teamwork and open communication among staff, unless absolutely necessary.

Culture of experimentation

Certain clinics introduce innovative techniques and equipment from abroad, but
they constitute a small minority. A new approach is used only when it does not bring in new expenses for the hospital:

We cannot introduce best practices from other hospitals, unless the costs allow us to do so (head nurse).

New medical techniques are applied, only after they have been acknowledged by worldwide research and presented in international conferences. Nurses and residents follow the doctors’ orders; thus, risk-taking and initiatives are minimized.

**Organizational design**

The structure of the hospitals in Greece is highly hierarchical, rigid and bureaucratic. Certain issues have not been properly arranged by law, such as the education of residents or the decision-making process. The HRM department is merely administrative, without any legitimate or recognized contribution to the organization:

I do not know what this department does I... guess it takes one’s papers and moves them to another place (clinic director).

It is responsible neither for setting goals, nor for supporting, training and appraising the staff. On the contrary, it is a filing service, which keeps employees’ records, posts the announcements of openings (mainly for nursing staff) and orders the medical equipment for the hospital[11].

In summary, the organizational structure is hierarchical, with a bureaucratic HRM department, which has absolutely no strategic role either in the design or in the supervision of the learning process.

**Staff skills and capabilities**

Clinics are supposed to provide the training for residents; nevertheless, most learning is based on memorizing, and learning-by-doing is limited:

There is no formally organized and institutionalized training system for the residents (resident).

Even in presentations and meetings of the residents, the issues discussed cannot attract the attention and interest of the majority. Furthermore, the conferences and seminars:

cover a huge variety of subjects and many times they recite the same things... they only give you some stimulants for learning (resident).

Moreover, the residents have very limited time to devote to learning and self-development:

How can you improve your work when you have to be in the hospital for emergencies ten whole days a month?.

Some doctors believe in life-long learning: Never say “I know everything”. A doctor becomes dangerous, when he thinks he’s “got the hang of it”.

However, there are others who:

after 20 or 30 years in the clinic have given all there is to give ... Such a system does not promote learning (clinic director).

In the above, we identified the learning mechanisms of the Greek hospitals, which fail to support the theoretical principles of the learning organization. In order to draw general conclusions on the process of learning within health organizations, we need to compare our results for the UK and Greek health-care services. This is the subject of the next section.

**Discussion**

Health-care organizations in both countries encounter certain common barriers to the building of the learning organization; nevertheless, we also identified differences in the operation of their learning mechanisms, due to their dissimilar inner and outer contexts. In particular, the Trust is relatively autonomous, under the UK government guidelines, to design its organizational structure, with the HRM department’s contribution. On the contrary, in Greece, the Ministry of Health sets the rules and codes of practice for the hospitals and HRM is restricted to a formal bureaucratic role. Both differences and similarities of the learning mechanisms in UK and Greek organizations are subsequently reviewed.

Our study shows that the CHCT has not accomplished a clear understanding of an overall strategic vision, while the Greek hospitals have not even set a mission. In all organizations, we identified a gap between the practitioners’ day-to-day expectations and top management’s aspirations, as well as a lack of understanding of the importance of learning, for the organization as a whole. Tension also exists between the nationally set standards (controlling for medical practice in the UK, and utilization of resources in Greece) and local needs.

In addition, leadership has not taken up the role that is required in a learning organization. Highly hierarchical Greek organizations inhibit the development of leaders as facilitators, coaches and stewards, and emphasize the role of the directive, “infallible” teacher. The UK Trust, on the other hand, lacks leaders that would direct and inspire staff to share learning, although it encourages clinicians to participate in decision making.
In both countries the organizations support single-loop individual learning, mainly through seminars and workshops, for the correction of errors and the acquisition of new skills. No training is provided to promote critical and reflective thinking or team interaction and open dialogue. The transfer of learning is slow and partial. However, the UK organization’s structure is flat and provides certain opportunities for teamwork and cooperation, through formally assigned multi-disciplinary groups and meetings, albeit occasionally time-consuming. On the contrary, in Greece, the rigid hierarchies do not encourage teamwork, unless there is pressure of emergencies or trade-union problems.

Experimentation and use of new operational systems and mechanisms are restricted by government guidelines, in both countries. UK organizations are more closely controlled for the level of provision of their services, while Greek hospitals receive less supervision regarding their services and more regarding their expenses[12].

Lack of time and personnel, as well as unclear accountabilities in case of error, and lack of commitment, impede staff from taking risks for improving processes and services and from picturing themselves as part of a system with interrelated and interdependent practices. Open communication among Trust localities, as well as among clinics of Greek hospitals, is limited.

The presence of different subcultures (Meyerson and Martin, 1987) within the UK organization has been verified in Greek health services as well. Doctors, nurses and residents have developed their own sets of personal goals, beliefs, mental models and behaviors. Thus, the acquisition of a “collective meaning”, which would lead to organizational learning, has not been achieved.

We conclude that absence of appropriate leadership, lack of time and commitment for teamwork and experimentation, as well as absence of mechanisms to communicate double- and triple-loop learning, are common barriers to the learning organization in Greece and the UK. However, we need to underline that Greek hospitals encounter additional problems, such as the lack of strategic vision, the absence of an HRM department actively involved in the learning process and the unfit-for-learning hierarchical structure, which inhibit participatory decision making, and thus influence negatively not only teamwork and cooperation, but also knowledge transfer and shared leadership.

Conclusion

The objective of our study was to understand the role of the learning principles in the formation of the learning organization and identify the barriers to their application through comparative qualitative research. We conclude that the health care organizations studied are not learning organizations according to the theoretical framework. They do, however, use and transfer single-loop knowledge every day. Health organizations need to consider the barriers to learning – highlighted in our study – and start taking steps towards their elimination, with the development of an HRM department actively involved in decision making, being the first and most important step.

Future research should focus upon the effects of HRM on each principle of the learning organization, as well as upon its contribution to the creation and communication of double- and triple-loop learning.

Notes

1 “Organizations are not merely collections of individuals, yet there are no organizations without such collections. Similarly, organizational learning is not merely individual learning, yet organizations learn only through the experience and actions of individuals. What, then, are we to make of organizational learning? What is an organization that it may learn?”

2 Memory is the retention of the acquired skills and knowledge, and mental models are the “tacit” and “explicit” interpretations of the world around us. Senge (1990a, b) describes mental models as deeply held internal images of how the world works, which have a powerful influence on what we do, because they also influence what we see.

3 Organizational learning is hindered when: it aims at the correction of errors, without the codification of the knowledge for future reference (“situational learning”); groups or individuals learn within an organization, but the whole organization cannot benefit from that learning (“fragmented learning”); and learning bypasses the standard and established systems or procedures, leaving parts of the organization uninformed (“opportunistic learning”).

4 Apart from the recent writings of academics in the field of the learning organization, we used government papers and documents, electronic governmental resources (WWW sites), internal reports, meeting minutes, as well as survey data.

5 The board includes the medical, finance, HR and operating directors, as well as the chief executive and the head of information
management and technology. The three senior posts are: the audit and risk manager, the research and practice development manager and the professional education and training manager. Finally, the Clinical Practice Groups or Clinical Effectiveness Groups are inter-disciplinary groups of practitioners. Practitioners and managers attend the Trust Clinical Practice Forum, which is the main meeting held every month and the central mechanism of shared leadership for involving staff in decision making.

6 A total of 70 per cent of staff feel supported when they want to learn new skills and a lower 60 per cent see management as encouraging suggestions (Kessler and Coyle-Shapiro, 1995).

7 We interviewed a practitioner who had come up with an innovative process of dealing with an operational issue – which baffled all localities – and did not share it across the Trust, simply because she “had never thought of doing that”.

8 Sixty-eight per cent of staff may agree that creativity is encouraged within the Trust and another 64 percent may believe that mistakes are acceptable as long as lessons are learned from them. However, 43 per cent feel that change occurs slowly and another 43 per cent agree with the statement that “people here have much to do without trying to find better ways of doing things”. Finally, only 38 per cent think that there are adequate resources devoted to pursuing new ideas.

9 The PDP is a folder that practitioners use to keep track of their achievements, needs and learning gaps. It helps them identify the different competencies and skills necessary for each discipline. For instance, nurses require courses on immunization and vaccination, health visitors need to know more about child care and support of drug addicts, while most of the practitioners ask for computer courses and project management training.

10 In Greece, there are five universities that have a medical school and cooperate with university clinics. The doctors in a university clinic are professors employed by the university, not the hospital. The doctors of the state clinics are employed by the Ministry of Health according to each hospital’s needs. In Athens, university clinics are dispersed among the diverse general hospitals, given that there is only one university clinic and multiple State clinics for each specialty. For our research, we interviewed clinicians from surgery (university clinic), cardiology, neurology and physiatrics (State clinics).

11 It has the role of “Clerk of the works”, according to Tyson and Fell’s (1986) typology.

12 Nevertheless, Greek hospitals often surpass their budget, which is determined by the State. In that case, the latter has to cover the loss, thus increasing the National Debt.

References and further reading


