10

THE WOMEN'S CO-OP

The Clash of Two Organizational Cultures

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This case focuses on choices, often fraught with conflict, made in order to sustain an organization. The events illuminate the role that organizational culture has in the preservation of a group's identity and underscore how it is the communal glue necessary to survive a volatile, hostile, and competitive environment. Although the case examines a feminist organization, lessons derived from understanding its transformation under duress are applicable to other vulnerable political and service organizations.

THEORETICAL AND PRACTICE PERSPECTIVES

The organizational culture perspective promotes a holistic understanding of organizational dynamics as well as organizational–environmental interactions (Frost et al., 1985, 1991; Ott, 1989; Schein, 1992; Smircich, 1983; Trice & Beyer, 1993). Culture is "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). To comprehend an organization's culture requires an understanding of its history, specifically strate-

gies for growth and development; processes of member socialization and cohesion; and day-to-day functionings that allow for stability *and* flexibility. An organization's culture creates a social order, sense of continuity, and collective identity. It is the lens through which members understand, interpret, and respond to environmental challenges (Ott, 1989; Schein, 1992; Trice & Beyer, 1993).

The elements of culture—norms, myths, behaviors, customs, symbols, and language—can be clustered into three levels: artifacts—"visible organization structures, and processes" (behaviors, art, technology); values—"strategies, goals, philosophies" (what "ought" to be); and basic assumptions—"unconscious, taken-for-granted beliefs, perceptions, thoughts and feelings" (notions of time, human nature, relationship to the environment) (Schein, 1992, p. 17). A cultural analysis captures the multilayered meanings of "obvious" elements, such as posters or seating arrangements, to the more subtle and ambiguous aspects of functioning such as who allies with whom, how money is discussed, or views of clients (Meyerson, 1991; Smircich, 1983; Trice & Beyer, 1993).

Organizations possess unique cultures, though there may be shared characteristics among similarly inclined groups. This distinct culture is generated by the intersection of the values, attitudes, and beliefs of society with respect to the organization's purpose; of relevant institutional sectors, such as human service, social movement, nonprofit sectors; and of the organization's founders and leaders (Ott, 1989). Considerable emphasis is placed on the role of founders and leaders, as signifiers of key values and assumptions that are to be preserved and transmitted and as change agents (Martin, Sitken, & Boehm, 1985; Schein, 1992; Siehl, 1985; Trice & Beyer, 1993).

Successful transformation is predicated on the change agent understanding the organization's culture. New ideas or solutions to problems, regardless of merit, will not be accepted into an organization if the culture (which by definition exists to ensure survival) is threatened. Organizational members may go so far as to engage in reactive or dysfunctional actions rather than risk the culture (Trice & Beyer, 1993). For cultural change to occur, the leader must possess an in-depth understanding of the status quo; be perceptive as to the new realities and why they necessitate change; be able to translate what she has learned about these new realities to other organizational members; be able to motivate these members to embrace change and participate in the change processes; manage anxiety that comes with learning and change; and stabilize the newly emergent cultural elements (Schein, 1992). Thus, the onus for transformation falls on the leader; but it will only succeed with the willing investment of the members.

Often, an organization engages in transformation to counter environmental threats or exploit environmental opportunities. Specifically, external crises can compel an organization to change in order to survive (Dyck, 1996;

Nutt & Backoff, 1997; Trice & Beyer, 1993). Organizational leaders or change agents must recognize the crisis, transmit the threat to organizational members, and convert the crisis into an opportunity for growth and development through the articulation of a vision and accompanying strategic plan (Dyck, 1996; Nutt & Backoff, 1997; Trice & Beyers, 1993). An organizational culture that promotes and facilitates cognitive and social learning by members greatly facilitates positive change outcomes (Lipshitz & Popper, 2000; Schein, 1992).

In this case, the organizational culture to be examined is that of a feminist health center. Feminist organizations are "hybrid" organizations in that as a "family" of organizations, they exhibit a variety of characteristics (e.g., missions, governance, strategies) while fitting under a common ideological umbrella. Further, these organizations operate in and are shaped by at least three different sectors: nonprofit, social movement, and human services (Hyde, 2001). Specifically, organizations, such as feminist health centers, are "social movement agencies" because they pursue their political agendas through the provision of programs and services to a disempowered or oppressed group (Hyde, 1992).

Within the feminist movement, there are two broadly defined ideological streams that shape the culture of feminist organizations. Simply stated, these streams are women's rights and women's liberation (also termed older vs. younger, bureaucratic vs. collectivist, reform vs. radical). These differences were particularly pronounced in the early stages of contemporary feminism, the late 1960s to mid-1970s (Echols, 1989; Ferree & Hess, 1985; Freeman, 1984; Hyde, 1992, 1995; Riger, 1984).

The women's rights branch embraced a more integrationist approach and favored strategies of public education, affirmative action, litigation, electoral politics, and public interest reforms. It generated hierarchical organizations with often clearly delineated roles and positions. Authority, including decision making, was largely determined by who held which positions (e.g., executive director, president of the board). Often, a national organization would be formed and a series of federated chapters, which followed the dictates of the central office, would then be started. The best-known women's rights organization is the National Organization for Women (NOW).

Women's liberation activists, largely influenced by their experiences in the radical Civil Rights and Student Left movements, rejected the integration strategy. They established organizations that reflected the revolutionary fervor of the times. Most of these groups were devoted to consciousness raising and political actions, though increasingly service organizations were founded. Services were understood as an expression of liberationist politics and were viewed as viable alternatives to, and critiques of, status quo offerings. There was little hierarchy in these organizations, which used some form

of collectivist governance, including job rotations and consensus decision making. Authority rested in the whole group rather than with individuals. Liberation organizations were linked through decentralized, grassroots networks; prominent ones included Redstockings, the Chicago Women's Liberation Union, and the Furies.

Each stream exhibited certain strengths and weaknesses. For example, the women's rights branch made significant legislative inroads, yet is criticized for reproducing a male model of social control through its bureaucratic tendencies. Women's liberation developed some of the most innovative and politicized means of service delivery, much of which has been absorbed into "empowerment" practice. Yet the liberationist approach is viewed as inefficient, often reifying process over product.

As the feminist movement progressed, those organizations more closely identified with women's rights tendencies had a greater chance of survival. One major reason for this has to do with actions of the New Right movement, which attacked feminist causes and organizations through legislative, fiscal, and direct-action tactics (Hyde, 1995). Women's rights organizations, although vulnerable, had relatively more resources than liberationist organizations to counter New Right activities. Additionally, more of the New Right targets, specifically health centers (because of abortion), were in the liberationist branch (Hyde, 1992). Activists in liberation groups relied heavily on the organization's culture for emotional fortitude (Hyde, 1994; Morgen, 1995). In turn, they defended the organization's culture, even if it left them in a weakened state within the larger environment.

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THE CASE

THE WOMEN'S CO-OP

BACKGROUND

The Cooperative Health Project (CHP) is a feminist abortion and gynecological clinic located in a Midwest town of about 30,000 people. Its founding members embraced socialist-feminist values (liberationist branch), infused into the health services, political education programs, and collectivist governance. Members argued that feminist politics could be achieved through services that challenged "patriarchal medical models" and thus emphasized patient rights, education, and participation. The clinic was part of a broader feminist health movement; the approach was unique and controversial, pioneered in a few feminist and low-income health clinics in the country.

The organization was regularly targeted by right-to-life forces, which picketed the clinic and engaged in public harassment campaigns. One consequence of this opposition was that the clinic was unable to consistently secure medical malpractice insurance, mandatory for the provision of health care. The risk created by this hostile environment, combined with the type of services offered, rendered insurance too expensive. This, in turn, threatened CHP's ability to continue as an autonomous health care organization. In May 1990, after years of wrestling with the crisis, CHP members had to decide whether to continue as a health clinic, with substantially limited services, or accept an offer from Planned Parenthood Federation of America (PPFA) to become an affiliate.

Planned Parenthood is one of the most recognized providers of sexual and reproductive health care in the United States. Its mission includes the belief that "every individual has a fundamental right to decide when and whether to have a child, and that every child should be wanted and loved." Planned Parenthood offers a wide range of family planning, prenatal, HIV-AIDS, gynecological, abortion, infertility, and adoption services through "unique, locally governed health service" clinics. It has more than 100 affiliated clinics and national research and education centers.

The case opens moments before the decisive board meeting, with flashbacks to critical moments in the organization's history provided.[1] It is told through the recollections of Hannah as she awaits the start of the meeting. Hannah is a founding member and has served in numerous roles, including coordinator of the entire clinic during the 1980s. Her primary interest is accessible health care for low-income women. She often plays the role of conciliator and is valued for her capacity to see many angles. Although Hannah

can be exasperated with some CHP processes, her commitment is unwavering. It has been her political and social home for 20 years. She describes the communal dedication in this way—"we worked at the collective; we played, we ate, we slept, we practically made love to the collective."

Board of Directors Meeting (May 1990)

An unusually large turnout, Hannah observes. She is more used to seeing decisions postponed for lack of a quorum than not being able to find a seat in the now packed conference room. In looking around the room, she recognizes many clients, volunteers, part-time workers, and the other full-time collective members; all are here to learn the fate of this organization. Hannah wonders if they are as tired of all the crises as she is. "Doubtful," she mutters to herself. "I've been around this way too long."

The board members have yet to arrive. Hannah knows from Gina, her partner and board member, that the group is having dinner together first to try once again to reach consensus regarding the acceptance or rejection of Planned Parenthood's offer. Yet people are getting restless; the meeting is going to start late and last well into the night.

Maria, another long-time collective member, joins Hannah—"What do you think they'll do about Planned Parenthood? I'd hate to work for that bunch of middle-class, professional, medical types." Hannah smiles; Maria is known to be a passionate defender of the clinic and a skeptic of anything remotely mainstream. "I don't know," Hannah responds. "The financial and political protection are tempting. It would be nice to have some security for a change." A volunteer, overhearing their exchange, exclaims, "Hannah, you of all people should know better than that. This is such a special place, and Planned Parenthood would just ruin that." Julie, a part-time worker, anxiously chimes in, "But my hours have been cut back for lack of money. We need this help." Maria, with barely veiled disgust, retorts—"Look, you haven't been around here as long as we have. It makes me sick that we might affiliate with an organization that has done terrible things to third-world women with birth control and sterilization. Planned Parenthood's a business, and that's not what we are." "Maybe that's what we should be," Julie responds. "If we had been more responsible earlier, we wouldn't be in this mess today. It's about time we grew up." Attempting to smooth over a conflict that would no doubt be repeated throughout the meeting, Hannah weighs in—"Well, you need to remember that we did have help getting into this mess. The right-to-life picketers did a lot of damage, and there's no reason to think they will leave us alone. There is a lot to consider, like the need for a regular doctor and consistent insurance coverage, as well as our principles. I'm sure the board is taking everything into account."

At that moment, the board members arrive. The nine women look grim and tense. "Who'd have thought that when we started, we'd end up in this

predicament. It all seemed so promising way back then," Hannah thinks. As the board members get settled, she drifts back to the early, heady years of the collective.

A PROMISING START (EARLY 1970S)

The Cooperative Health Project opens its doors as a clinic of "women helping women." Those first few months are chaotic, but members[2] feel exhilarated. Finally, they can meld their politics with the provision of needed services. The women requesting care seem to appreciate their efforts. Within the first year, they have basic gynecological and abortion services, which include political education for patients on their reproductive rights and a small community education program.

Yet, founding members know that offering women's health care, in general, and abortion services, in particular, would meet with opposition. Indeed, they anticipate it: "We are quite aware of how controversial a service we are offering. . . . [But] we are just as much against forced abortion as we are people running around telling women they have to have children. We feel a woman's body is her own. . . . We are more than a simple abortion clinic. We hope to be a total women's clinic." Opposition comes quickly—a barrage of letters to the editor of the town newspaper refers to CHP as a "slaughterhouse." CHP staff believe that this is an orchestrated campaign and choose to ignore it, assuming that the quality and innovation of the clinic speaks for itself.

Board Meeting (May 1990)

Hannah sighs wistfully, "such excitement and dedication in those first few years. We really thought we were going to make a difference. And the opposition, while annoying, seemed minimal." She turns her attention to Renee, the board president, who is calling the meeting to order. Hannah, trying without luck to make eye contact with Gina to see if she can guess the decision, wonders, "Will tonight mean all those years of commitment and struggle are going to go down the drain?" Maria breaks through these musings and nods to the board members—"I wish they'd get on with this. It's like waiting for the ax to fall, and there's no good solution to this neverending mess."

GROWING PAINS (MID TO LATE 1970S)

The collective grows from 5 to 25 members, becoming a bit more diverse in the process. Members remain committed to service provision and the fight for

reproductive rights. Outwardly, the clinic seems as true to its politics as ever. Staff open a "problem gynecology clinic" to provide nonroutine care on the premises (rather than referring to other practices). The regular abortion, gynecological, and the newer well-woman's clinics are expanded.

They publish a position paper, "Feminist Health Workers as Political Activists," which articulates and defends how service providers do political work. The paper emphasizes the revolutionary nature of self-help, viewing clients as a constituency, political education as part of medical care, and the defense of abortion rights. The writers are highly critical of mainstream, reformist "women's" and "family planning" clinics.

Yet internally, conflicts emerge over political ideology, job responsibilities, governance, and staff credentials. Because of the clinic's growth, members decide to consolidate several administrative functions and designate areas of service specialization. Everyone is still trained in all fields, but for efficiency's sake, each member specializes in one or two areas. This restructuring is done only after a prolonged and rancorous debate about the nature of collectivism, which in its purest form calls for everyone to do everything. As part of this debate, and as a means of affirming nonhierarchical divisions, members reject a differential pay scale.

Members constantly revisit this restructuring, struggling with a balance between egalitarianism and efficiency. They experiment with specific job assignments, a further form of specialization, and also decide on a two-tiered staff structure: One is either a collective member, involved in all aspects of center governance, or a contract worker, involved only in clinic operations. Contract workers tend to have some professional training, which sparks another debate on pay equity. The collective again rejects differential compensation, noting that "there are many members of the organization who have special skills and training that we are not recognizing with pay differentials."

In addition to this more specialized staff structure, collective members also create a board of directors. The board is formed so that it can be used when the project applies for grant money, since most foundations require one. CHP members think of it as a "paper" board that is composed of former center members who are "people they can trust with the collective process."

At this time, the collective issues a policy and procedures manual, an attempt to address the increasing specialization within the organization. They set aside *Mao's Little Red Book*, which had been the personnel guide. Staff restates its commitment to "ideals of participatory health care, informed medical consumerism, patient's rights, and women-oriented health." Many members, however, express concerns that the manual, and other changes, signal the transformation to a more mainstream organization.

Another problem emerges during this time. Members are faced with the prospect of having no physicians (needed for abortion and some gynecolog-

ical procedures). CHP relies on a pool of area doctors, one of whom requests that the clinic cover his malpractice payments (ob/gyn insurance is one of the costliest). The organization is caught between giving this doctor special treatment, something it does not want to do because everyone should be supported equally, and paying for all physicians' insurance, which is not financially possible. CHP does not have enough money to purchase its own insurance policy that could cover all staff. It provides a loan for this doctor, but fails to resolve the larger problem of acquiring available, self-insured physicians.

CHP experiences the first of many doctor shortages. At first, the clinic argues about whether to hire a staff physician. Many see such a move as institutionalizing hierarchy, male elitism, and professional credentials, all antithetical to the organization's philosophy. When the clinic is unable to consistently maintain a "guest" pool, it decides to hire a doctor who has "good technical skills" but is "abrasive and insensitive." This decision only happens after a hotly contested debate over skill versus philosophical compatibility, with skill apparently taking precedence. Members hope that the doctor is "trainable" in a feminist approach to health care.

The Board Meeting (May 1990)

"Well that sure didn't happen," Hannah recalls. "He didn't last but a few months, and the staff meetings were battlegrounds over his employment." She barely pays attention to the approval of the last meeting's minutes and the relaying of announcements. "No wonder we're all so burned out and tired of this decision," she thinks. "It's been with us for years. The problem is that most of the younger workers don't know that. They don't know how hard we tried to resolve it, and they just don't seem as committed to our original vision. And, they certainly don't know how difficult it became once the Republicans took power. It was all we could do to survive."

RIGHT-WING PRESSURE (LATE 1970S TO MID-1980S)

In the late 1970s, anticlinic picketing begins. Picketers demonstrate on days when abortions are performed, harassing clients and staff. In 1979, the clinic is firebombed and picketing intensifies, part of a wave of anticlinic violence that is sweeping the country. The clinic responds by holding a pro-choice rally, which has a "wonderful turnout." The local paper runs a favorable editorial, noting that the clinic "has managed to stay pro-female without becoming violently anti-male."

With the landslide right-wing victories in the 1980 elections, the CHP (like feminist clinics) finds itself in an increasingly hostile climate. Clinic picketing, especially client and staff harassment, increases. Right-to-life organizations escalate their hostilities by launching a billboard campaign that condemns CHP workers as "baby killers" and threatening to publicly name CHP leaders and health care providers.

CHP members are now confused over how to respond. There is simply not enough staff to deal with this political crisis and to maintain quality services. Much time and energy are spent on clinic coverage because the physician situation remains a problem. In 1984, the clinic reluctantly agrees to meet with police in the hopes of gaining support and protection; this has limited success. Members also agree to emphasize political education with clients by encouraging them to write to legislators and local newspapers. In 1985, the clinic accepts voluntary help in the form of pro-choice pickets and patient escorts, most of whom are from the area's National Organization for Women (NOW) chapter. Aside from these momentary efforts, CHP is unable to formulate a plan for dealing with the continuous, and debilitating, presence of the right-to-life activists.

The Board Meeting (May 1990)

Renee thanks everyone who has offered opinions and support, "It's been an extraordinarily difficult process for all of us. There are many factors to consider. The Planned Parenthood offer is a generous one, but it has drawbacks too. Unfortunately, and despite some clear preferences, the board could not come to consensus as to what we should do." At this point, the barely contained group erupts into verbal chaos. Julie seems to lose all color in her face; Maria storms out of the room. Hannah thinks, "Well, our long-standing tradition of wavering continues."

ORGANIZATIONAL INDECISION (MID TO LATE 1980S)

The lack of malpractice insurance continues to trouble the CHP. Another self-insured physician, and former collective member, is hired. Collective members struggle with having a part-time professional in their midst. The doctor, who wishes to become a collective member again, expresses feelings of marginalization. This situation exemplifies the larger struggle within the CHP—finding the balance among feminist philosophy, an approach to collectivist governance that is more efficient, and the recognition of different kinds of ex-

pertise involved in maintaining the clinic. CHP members also wish to reinvigorate clinic service expansion plans that had stalled in the last few years, even though personnel and funds are not available.

After several months of painful negotiations, the physician asks to end her contract. Although still supportive of CHP, she cannot tolerate endless debates about her merits as a collective member. The clinic must again resort to guest doctors. In addition to losing this physician, the collective also loses several members who resign for a variety of reasons. To save money, the collective does not fill these vacancies and its membership falls to 15.

A consultant is hired to assist them with the tensions. After several weeks, he notes that, whereas there is considerable closeness among collective members, the decision-making process rarely moves beyond the idea stage. There is no clear evaluation of service quality. The collective is not able to engage in long-term planning, or to think strategically about its resources. The consultant commends the organization for its commitment to fulfilling a feminist approach to health care through programs and services, but expresses concern over the lack of clear accountability and future planning.

The affirmation of their dedication is like a life preserver. This commitment becomes the rallying cry for the collective—members want to save this at all costs. Yet they are not able (or willing) to incorporate the other components of the consultant's message. Short-term, crisis planning prevails.

The Board Meeting (May 1990)

"Sisters, please, we need to calm down and discuss things," implores Renee. "That's all we do is talk," someone yells. Shouts another: "What's the point of a board if no decisions get made." Beth, another organizational veteran, attempts to intervene: "We all need to participate in this; that's what we're about." The group settles a bit, and Renee attempts to start again. She says that what the board would like is some guidance from CHP supporters and members to see if there are any clear preferences for action. Maria, who has returned, mumbles, "This is like beating a dead horse; we've done this before." Hannah nods, and wonders if Planned Parenthood knew all along how vulnerable the clinic was and is.

THE CRISIS (LATE 1980S)

The CHP is still not able to acquire sufficient malpractice coverage for its doctors, and staff face the possibility of closing down the organization. As an independent clinic, situated in a politically hostile environment, affordable

insurance cannot be found. Many doctors in town choose not to associate with or assist the clinic for fear of right-wing reprisals. Medical residents from a nearby hospital offer their services on a contractual basis, but the hospital refuses to extend malpractice coverage to work done at CHP. Thus, CHP relies on a shrinking pool of part-time physicians. Abortion and gynecological services are cut back, the well-woman's clinic and the problem gynecology program are eliminated. Education and public relations programs continue, but no longer have a collective member assigned to coordinate events.

The reduction of services produces a deeper fiscal crisis. Staff layoffs, based on seniority, occur, a plan that is referred to as "tragic but necessary." The collective is reduced to eight members. Some laid off workers are rehired on a part-time, hourly basis as contract workers. Within weeks, contract workers report feeling marginalized and alienated from the collective. Collective members feel overwhelmed by the crisis.

The board of directors, which has been largely inactive, is asked to help. Yet with little development having occurred, it is unclear what board members can and should do. Some make inquiries to various foundations, but little grant money exists. Others offer their services as mediators, trying to help the clinic survive on an interpersonal basis. As the CHP deals with the increasing likelihood of shutdown, the board grapples with the new knowledge that it may be fiscally responsible for organizational debts. Whereas board membership had started as a voluntary gesture of goodwill, it now signifies a serious financial risk for individuals.

A temporary solution comes along when an older doctor, nearing retirement, agrees to be the clinic's physician. He has no experience with CHP, but is pro-choice and, more important, has his own insurance coverage. However, he makes only a one-year commitment in order to buy some time for the organization.

Board and staff members report feeling burned out and frustrated. Although still committed to being a "feminist workplace," they are hard-pressed to find a more permanent solution to the malpractice crisis and to reinvigorate the collective's membership and offerings. At this time (June 1989), the Planned Parenthood Federation offers a possible resolution.

The Board Meeting (May 1990)

"It's hard to believe," thinks Hannah, "that all this nonsense with Planned Parenthood has been going on for just a year." She recalls the suspicion of the collective to the initial proposal. And then there were the meetings with Planned Parenthood, which became increasingly antagonistic. "Clearly," thinks Hannah, "we're good enough to be taken over. Why can't we be good enough to survive on our own?"

THE OFFER (1989–1990)

In 1989, the regional Planned Parenthood office makes overtures to the CHP to become a federation affiliate. Initially, CHP members ignore these efforts, but Planned Parenthood persists. Finally, CHP agrees to an information meeting with a regional Planned Parenthood director.

The meeting is held in a coffee shop in CHP's town. Hannah, Gina, and Renee represent the collective. Planned Parenthood's regional director, Josephine, is accompanied by Tracy, a clinic worker from an affiliate in another part of the state. After introductions, Josephine takes control of the meeting with businesslike efficiency. She lays out the benefits of affiliating with Planned Parenthood, emphasizing that this is a time of crisis for CHP, in particular, and feminist health clinics, in general. Her list includes insurance under the federation's policy, clinic protection money, and legal assistance. CHP could maintain, and probably expand, its abortion, gynecological, and educational services, but only in accordance with Planned Parenthood guidelines. Tracy then chimes in enthusiastically, indicating how much she's learned at Planned Parenthood and how exciting it is to do such important work. The CHP representatives mostly take in the information and ask few questions. They learn, however, that to affiliate would mean that CHP would no longer exist as an autonomous organization that espoused socialist/feminist principles and collectivist governance. As a unit of Planned Parenthood, they would have to adopt those goals and procedures. Josephine assures them that they would still be able to serve the populations they wanted to through even more comprehensive health programs.

In their report to CHP about the meeting, Renee, Gina, and Hannah attempt to lay out the pros and cons in a balanced fashion. Many of the members express relief that financial and insurance worries would be resolved. Others feel that they are "selling their souls." Affiliation means adhering to a more mainstream philosophy and entails more bureaucratic, medical-model approaches. Yet they also understand that alone they cannot come up with the resources to obtain malpractice insurance.

CHP tries to negotiate with Planned Parenthood around maintaining a version of its socialist ideology and collectivist governance. Planned Parenthood refuses. Affiliation means that an organization fully takes on the Planned Parenthood identity—including mission, services, governance, program evaluation, staffing, and political directives. All affiliates follow Planned Parenthood policies and procedures and are certified by the national office.

CHP members are increasingly uncomfortable about the Planned Parenthood offer, yet are not able to reach consensus in terms of accepting or rejecting it. Planned Parenthood then ups the stakes. It announces that CHP can either affiliate with the federation, or the federation will establish its own office in the community, thus directly competing with CHP. CHP members have

no way of assessing the validity of this ultimatum, though they feel that they are caught and either way will lose. The collective turns the decision over to the board, with the understanding that all CHP members will be consulted and briefed before any decision is finalized.

The Board Meeting (May 1990)

Remembering those fateful negotiations with Planned Parenthood, Hannah thinks, "maybe desperate times call for desperate measures." She realizes that Renee has managed to regain some semblance of control over the meeting. The group has done a collective meditation in order to focus and now, for seemingly the millionth time, is listing the benefits and costs of affiliating with Planned Parenthood. Then, it is hoped, some direction will become clear. Hannah sadly realizes that no matter what the outcome is, the CHP will never be the same even if it decides to remain autonomous. She feels that she, and others, have been bled dry.

DISCUSSION QUESTIONS

Organizational Culture

1. Organizational culture is comprised of many different elements (e.g., norms, symbols, rituals, values). What are the key elements of CHP's culture?
2. When using an organizational culture perspective, it is important to understand and examine the underlying meaning of the cultural elements. For each element listed (in Question 1), indicate what its meaning is to individuals and to the organization as a whole. Identify the origins of these meanings. What is the essence of CHP's culture?
3. Organizational founders and leaders play a pivotal role in shaping the culture and in guiding its transformation. Who, individuals or groups, are the founders and leaders of CHP? What influence do these people have on the organization's culture?
4. Organizational culture is the lens through which a group understands and negotiates its environment. Who are the key environmental actors with whom the CHP must contend? How is the impact of these actors understood from the CHP's perspective?
5. Given what the organization wants to accomplish, what are the strengths and weaknesses of this culture?

6. Planned Parenthood also possesses a distinct culture. Although information is limited, answer Questions 1 to 5 with Planned Parenthood as the focal organization. For those questions that cannot be answered, indicate how you might discover that information.

The Decision

1. Identify the reasons or factors that favor affiliation with Planned Parenthood, keeping in mind the cultural analysis just completed on both organizations.
2. Identify the reasons or factors that argue against affiliation with Planned Parenthood.
3. What additional information would you like to have? Why? How would you obtain this information?
4. Should CHP affiliate with Planned Parenthood? Why or why not?

Implications

1. If you choose affiliation, how do you propose to address the concerns that CHP members have about losing their identity?
2. What steps are needed to ease this transition—on the part of Planned Parenthood and CHP—or does that matter (perhaps just saving the programs is sufficient)?
3. Does affiliating with Planned Parenthood essentially mean that CHP will need to give up its culture?
4. If you choose not to affiliate, how do you propose to sustain CHP? What changes need to occur in philosophy, governance, and service delivery to make survival more likely?
5. Where will you obtain doctors' coverage and insurance?
6. What plans do you have for resource development?
7. How will you address the frustration and disintegration that seems to have been building over the last few years?
8. In the end, what cultural transformations need to occur, and how do you propose that they be implemented? In other words, how would you turn crisis into opportunity?