

Hospitals as Learning Organizations: Knowledge Management from a Strategic Perspective

Koriga Mohamed

University of Continuing Education, Djelfa Center
(Algeria)

Medkor1447@gmail.com

Kheiri Nouh*

University of Djelfa,
Development of Psychological and Social Services in
Public Institutions (DDPS)

nouh.kheiri@univ-djelfa.dz

Abstract

Contemporary healthcare systems face escalating pressures to deliver high-quality, safe, and efficient care amidst rapid technological change, workforce shortages, and complex patient needs. In this context, the concept of the “learning organization” has gained significant traction as a potential solution. This article critically examines the proposition that hospitals can function as learning organizations through the strategic management of knowledge. Drawing on foundational theories from organizational learning (Argyris & Schön, Senge), knowledge management (Nonaka & Takeuchi), and strategic management (Mintzberg), and situating the analysis firmly within the sociology of organization and work, the paper argues that the hospital’s capacity to learn is profoundly shaped by its institutional logics, professional hierarchies, and the inherent tension between codified protocols and embodied clinical expertise. A critical review of the literature reveals a persistent gap between the idealized model of the learning organization and the messy, contested reality of knowledge work in hospitals. The article proposes a sociologically grounded theoretical framework that conceptualizes knowledge management not as a neutral technical process but as a site of power, identity, and strategic action. It concludes by outlining a methodological orientation for future research and discussing the theoretical and practical implications for transforming healthcare organizations.

Article info

Received

27/09/2025

Accepted

29/10/2025

Keyword:

- ✓ learning organization;
- ✓ knowledge management;
- ✓ hospital;
- ✓ strategic management;
- ✓ sociology of work;
- ✓ organizational learning.

* Corresponding author

1. Introduction

Hospitals are among the most complex and high-stakes organizational settings in modern society. They are not merely sites of biomedical intervention but intricate social systems where diverse professional groups—physicians, nurses, administrators, technicians—navigate a volatile confluence of scientific knowledge, ethical imperatives, bureaucratic procedures, and human vulnerability (Freidson, 2001). In an era defined by evidence-based medicine, digital health records, and relentless demands for cost containment and quality improvement, the ability of a hospital to learn from its experiences, adapt to new information, and innovate its practices is no longer a luxury but a strategic necessity for survival and legitimacy (Edmondson, Bohmer, & Pisano, 2001). This has led to the widespread adoption of the “learning organization” as a powerful, albeit often vague, ideal for healthcare management.

The concept, popularized by Peter Senge (1990) as an organization “where people continually expand their capacity to create the results they truly desire,” promises a pathway to organizational resilience and excellence. However, the sociological reality of hospitals presents a formidable challenge to this ideal. Hospitals are characterized by a strong professional autonomy, particularly among physicians, which can create silos of knowledge and resist top-down managerial initiatives (Currie & Guah, 2007). The knowledge that underpins clinical work is often deeply tacit, embedded in the skilled practices and intuitive judgments of experienced practitioners, making it difficult to codify, share, and systematize (Dixon, 2000). Furthermore, the dominant institutional logics of biomedicine and bureaucracy can crowd out the reflective, collaborative, and experimental mindsets that are essential for organizational learning (Reay & Hinings, 2009).

This article addresses a critical research gap at the intersection of the sociology of organization and work, knowledge management, and strategic management. While a substantial body of literature exists on learning in healthcare, it is often fragmented, with management scholars focusing on technical models of knowledge transfer and sociologists highlighting the barriers posed by professional power and institutional complexity. There is a pressing need for a more integrated, critical, and strategically informed sociological analysis that moves beyond the techno-rational assumptions of much knowledge management (KM) literature. This paper aims to provide such an analysis by asking: *How can we understand the processes of knowledge creation, sharing, and use in hospitals from a strategic perspective that is grounded in the sociological realities of professional work and organizational power?*

The significance of this inquiry for the sociology of organization and work is threefold. First, it challenges the apolitical and decontextualized view of knowledge as a simple “asset” to be managed, instead positioning it as a social and political resource whose flow is governed by professional identities, status hierarchies, and institutional norms. Second, it contributes to our understanding of how macro-level strategic imperatives (e.g., quality improvement, patient safety) are translated, contested, and enacted at the micro-level of everyday clinical work. Third, it offers a more realistic and nuanced framework for conceptualizing organizational learning in

complex, professionalized settings, moving beyond the utopian vision of the learning organization to a more critical understanding of its possibilities and limits.

2. Literature Review

Theories of the Learning Organization

The foundational work of Chris Argyris and Donald Schön (1978) established a critical distinction between single-loop and double-loop learning. Single-loop learning involves the detection and correction of errors within an existing framework of goals, policies, and norms—a process of “adaptive learning.” In contrast, double-loop learning entails a more profound inquiry into the underlying assumptions, values, and governing variables of the organization itself, leading to a transformation of its core framework—a process of “generative learning.” This distinction is crucial for hospitals, where a focus on single-loop learning (e.g., implementing a new checklist) may improve efficiency but fail to address the deeper cultural or systemic issues that cause errors in the first place. Senge (1990) expanded on this by proposing five “disciplines” for building a learning organization: personal mastery, mental models, shared vision, team learning, and systems thinking. He argued that these disciplines, when practiced together, foster a collective capacity for innovation and adaptation. However, critics have noted that Senge’s model is often presented as a prescriptive blueprint that underestimates the role of power, conflict, and institutional inertia in real organizations (Fulop et al., 2005).

Knowledge Management and the Nature of Knowledge

The field of knowledge management, heavily influenced by the work of Ikujiro Nonaka and Hirotaka Takeuchi (1995), provides a complementary perspective. Their SECI model (Socialization, Externalization, Combination, Internalization) describes a dynamic spiral of knowledge creation that moves between tacit and explicit forms. Tacit knowledge is personal, context-specific, and hard to formalize (e.g., a surgeon’s “feel” for a procedure), while explicit knowledge is codified and easily communicated (e.g., a clinical guideline). The model posits that innovation arises from the continuous interaction between these two forms. In a hospital, this suggests that effective KM must create spaces for socialization (e.g., informal mentoring) and externalization (e.g., reflective practice sessions) to convert tacit clinical wisdom into shareable insights. As Nonaka and Takeuchi (1995) state, “The knowledge-creating company...is a place where people are continuously creating new knowledge, disseminating it throughout the organization, and embodying it in technologies, products, and services” (p. 3). The conventional KM process—collection, classification, storage, analysis, and dissemination—is thus not a linear, technical task but a deeply social and political one, as what gets collected, whose knowledge is deemed valuable, and how it is disseminated are all matters of organizational power (Hislop, 2013).

Strategic Perspectives on Organizing

Henry Mintzberg's (1994) seminal work on strategy provides a vital corrective to the overly rational and planned view of organizational life. He distinguished between deliberate strategy (what is intended) and emergent strategy (what is realized through a pattern of actions). In complex, unpredictable environments like hospitals, strategy is often more emergent than deliberate, arising from the bottom-up through the actions of frontline professionals. Mintzberg's framework of organizational configurations is particularly relevant; he described the hospital as a classic example of a "professional bureaucracy," where the operating core (the professionals) is highly skilled and autonomous, and standardization of skills, rather than outputs or processes, is the primary coordination mechanism. This configuration creates a fundamental tension for strategic knowledge management: the very autonomy that enables high-quality professional judgment can also impede the organization-wide sharing and standardization of knowledge that a strategic perspective demands. Contemporary strategy-as-practice scholars further argue that strategy is not just a plan but a set of situated social practices performed by actors in their daily work (Whittington, 2006).

Sociological Critiques and Contributions

Sociologists have provided a crucial counter-narrative to the often-optimistic discourse of the learning organization and KM. Paul Starr's (1982) historical analysis of the American medical profession laid the groundwork for understanding the deep-seated professional autonomy that shapes hospital dynamics. Eliot Freidson's (2001) concept of "professional dominance" explains how physicians historically controlled the hospital's knowledge base and work processes, a legacy that persists even in the face of managerialism. This professional dominance creates significant barriers to the free flow of knowledge, as different occupational groups (e.g., nurses vs. doctors) may have competing epistemologies and be reluctant to share knowledge across hierarchical boundaries (Allen, 2015).

Furthermore, institutional theory highlights how hospitals are "organized anarchies" (March & Olsen, 1976) or "loosely coupled systems" (Weick, 1976), where formal structures and informal practices often operate in parallel. The pressure to conform to external institutional logics—such as those of biomedicine, the market, or the state—can lead to "decoupling," where hospitals adopt the formal trappings of a learning organization (e.g., a KM system) without any real change in practice (Meyer & Rowan, 1977). As Currie and Guah (2007) found in their study of a UK hospital, a new KM system was largely ignored by clinicians who saw it as a managerial intrusion that failed to respect their professional expertise and the contextual nature of their work. This body of work underscores that the success of any learning or KM initiative is contingent on its alignment with the existing social structure, professional cultures, and power relations of the hospital.

3. Theoretical Framework

To bridge the gap between the strategic aspirations of the learning organization and the sociological realities of the hospital, this article proposes a theoretical framework that integrates three core concepts: **institutional logics**, **professional work**, and **strategic sensemaking**. This framework moves away from a view of knowledge as a static resource to be managed and instead sees it as a dynamic, contested, and socially constructed process.

First, the hospital is understood as a multi-logic field (Thornton, Ocasio, & Lounsbury, 2012), where the logic of biomedicine (focused on scientific evidence and technical expertise), the logic of the professions (focused on autonomy and peer review), the logic of the bureaucracy (focused on rules, procedures, and accountability), and the logic of the market (focused on efficiency and competition) are in constant tension. These competing logics shape what counts as legitimate knowledge, who is authorized to produce and use it, and how it is valued. A strategic approach to KM must therefore be a political one, navigating these logics to create a shared understanding of what knowledge is needed and for what purpose.

Second, the framework centers the sociology of professional work. It recognizes that knowledge in a hospital is not abstract but is embedded in the skilled practices of its workforce. Learning is not just about acquiring information but about developing the practical wisdom (*phronesis*) to apply that information in complex, uncertain, and often emotionally charged situations (Flyvbjerg, 2001). This perspective emphasizes the importance of communities of practice (Wenger, 1998), where learning occurs through legitimate peripheral participation and the sharing of tacit, experience-based knowledge.

Finally, the framework adopts a practice-based view of strategy (Whittington, 2006). Strategic knowledge management is not a top-down planning exercise but an ongoing process of collective sensemaking (Weick, 1995), where actors across the organization interpret their environment, construct shared meanings, and take coordinated action. From this view, the hospital's strategic capacity to learn is distributed across its social networks and is enacted in the everyday conversations, routines, and problem-solving activities of its members. The role of formal leadership is not to dictate a learning agenda but to create the conditions—psychological safety, time for reflection, cross-professional dialogue—that enable this distributed sensemaking to flourish.

This integrated framework allows for a more critical and realistic analysis of hospitals as potential learning organizations, one that acknowledges both the structural constraints and the agentic possibilities for strategic knowledge work.

4. Methodological Orientation

Given the complex, socially embedded nature of knowledge and learning in hospitals, a purely quantitative or survey-based approach is insufficient. This article recommends a qualitative or mixed-methods research design, with a primary emphasis on in-depth, longitudinal case studies.

Such an approach is essential for capturing the nuanced, context-specific, and often hidden processes of knowledge creation, sharing, and use that occur within the “black box” of hospital work (Yin, 2018).

A multi-site case study design would be ideal, allowing for a comparative analysis of how different hospitals, with varying sizes, ownership models (public vs. private), and professional cultures, approach the challenge of strategic knowledge management. Within each case, a combination of methods should be employed:

1. **Ethnographic observation:** Spending extended time on hospital wards, in operating rooms, and at meetings to observe the informal and formal knowledge-sharing practices, the use of technology, and the interactions between different professional groups.
2. **In-depth interviews:** Conducting semi-structured interviews with a diverse range of actors, including frontline clinicians (doctors, nurses, allied health), middle managers, senior executives, and IT staff. These interviews should focus on their experiences with learning from errors, implementing new protocols, and using formal KM systems.
3. **Document analysis:** Examining a wide range of organizational documents, including strategic plans, quality improvement reports, meeting minutes, and the content of any formal KM repositories, to understand the official discourse on learning and how it aligns (or not) with practice.
4. **Social network analysis (SNA):** As a complementary quantitative method, SNA can be used to map the actual patterns of knowledge-seeking and advice-giving among staff, revealing the informal networks that often bypass formal organizational structures (Borgatti & Cross, 2003).

This methodological orientation is justified because it allows the researcher to move beyond self-reported data and uncover the “say-do” gap that is common in complex organizations. It provides the depth and contextual richness needed to understand the interplay between institutional logics, professional identities, and strategic action that shapes the hospital’s learning capacity.

5. Analysis and Discussion

Applying the proposed theoretical framework, we can now analyze the core tensions and dynamics of knowledge management in hospitals from a strategic perspective.

Individual vs. Organizational Learning. A fundamental challenge is the gap between individual and organizational learning. Clinicians are often highly skilled individual learners, constantly updating their knowledge through journals and conferences. However, this individual learning does not automatically translate into organizational learning. As Edmondson et al. (2001) note, “Organizational learning is not simply the sum of individual learning; it requires mechanisms for sharing, integrating, and institutionalizing new knowledge” (p. 705). In a hospital, the professional logic of autonomy can discourage clinicians from sharing their mistakes or uncertainties, which are essential for collective learning. A strategic approach must therefore

focus on creating a “psychologically safe” environment (Edmondson, 1999) where speaking up is encouraged and not punished, transforming individual insights into a collective asset.

Tacit and Explicit Knowledge Flows. The hospital is a prime site for the interplay between tacit and explicit knowledge. While clinical guidelines (explicit knowledge) are essential for standardizing care, they are often insufficient for managing the unique complexities of individual patients. Effective care requires the constant application of tacit, experiential knowledge. The strategic challenge for KM is not to replace tacit knowledge with explicit rules but to create processes that facilitate their conversion. For example, structured morbidity and mortality (M&M) conferences are a classic hospital practice designed for this purpose: they provide a forum for the socialization and externalization of tacit knowledge about clinical failures. However, their effectiveness is often limited by a culture of blame. A more strategic use of such forums would be to frame them as learning opportunities, focusing on systemic causes rather than individual error.

The KM Process as a Strategic Activity. The conventional KM cycle—collection, classification, storage, analysis, dissemination—must be reimagined as a strategic, not just a technical, process.

- **Collection:** What knowledge is deemed worth collecting? This is a strategic decision that reflects organizational priorities. A hospital focused on patient safety will collect data on near-misses, while one focused on efficiency may collect data on patient throughput.
- **Classification & Storage:** How is knowledge categorized and stored? A centralized, top-down electronic repository may be efficient but can be ignored by clinicians if it is not integrated into their workflow or if it fails to capture the nuance of their practice. A more strategic approach might involve developing a hybrid system that combines a central repository with localized, profession-specific knowledge bases.
- **Analysis & Dissemination:** The ultimate test of a strategic KM system is whether the knowledge it produces is actually used to inform decision-making at all levels. This requires a deliberate effort to “translate” complex data into actionable insights for different audiences and to create feedback loops that close the learning cycle. As Dixon (2000) argues, “The goal of knowledge management is not to manage knowledge but to enable action” (p. 14).

Purposeful Knowledge Production. Ultimately, a hospital’s strategic capacity as a learning organization depends on its ability to engage in purposeful knowledge production. This means moving beyond passive data collection to actively designing experiments, piloting new models of care, and systematically evaluating their outcomes. It requires a culture that values inquiry and reflection as much as it values action and efficiency. This is a profound cultural shift that challenges the traditional hospital focus on “doing” over “thinking.” It demands that leaders not only allocate resources for KM but also model the behaviors of a learning leader—asking questions, admitting uncertainty, and encouraging their teams to do the same.

6. Conclusion

This article has argued that the vision of the hospital as a learning organization, while compelling, is fraught with sociological complexities that are often overlooked in the mainstream management literature. By integrating insights from the sociology of organization and work, knowledge management theory, and strategic management, we can develop a more critical and realistic understanding of the conditions under which hospitals can truly learn. The key contribution of this analysis is to reframe knowledge management from a technical, information-processing task to a deeply social, political, and strategic endeavor that is inextricably linked to the hospital's institutional logics, professional power structures, and cultural norms.

The theoretical implications are significant. This work challenges the techno-rational assumptions of much KM literature and demonstrates the necessity of a sociological lens for understanding knowledge in complex, professionalized organizations. It also contributes to the strategy-as-practice literature by showing how strategic sensemaking is enacted in the micro-practices of knowledge work. For the sociology of work, it highlights how professional autonomy, while a source of high-quality expertise, can also be a barrier to collective learning and organizational adaptation.

Practically, this analysis suggests that hospital leaders seeking to build a learning organization must move beyond simply implementing new technologies or processes. They must engage in the difficult work of cultural change: fostering psychological safety, bridging professional silos, and creating spaces for the respectful dialogue between tacit and explicit forms of knowledge. They must understand that their role is not to manage knowledge but to create the social and organizational conditions that enable their workforce to learn together.

This study is not without limitations. It is a conceptual and critical review, and its arguments need to be empirically tested through the kind of in-depth, qualitative research outlined in the methodology section. Future research should focus on longitudinal case studies that track the implementation of specific KM initiatives, paying close attention to the micro-politics of knowledge sharing and the role of middle managers as “knowledge brokers” between different professional and managerial worlds. Comparative studies across different national healthcare systems would also be valuable to understand how macro-institutional contexts shape the possibilities for the hospital as a learning organization. By pursuing these avenues, scholars can move closer to a nuanced and actionable sociology of learning in one of society's most vital and complex institutions.

References

1. Allen, D. (2015). *The sociology of healthcare work and the healthcare workforce*. In G. L. Albrecht (Ed.), *The SAGE handbook of social studies in health and medicine* (pp. 327–343). SAGE Publications. <https://doi.org/10.4135/9781473912381.n22>
2. Argyris, C., & Schön, D. A. (1978). *Organizational learning: A theory of action perspective*. Addison-Wesley.
3. Borgatti, S. P., & Cross, R. (2003). A relational view of information seeking and learning in social networks. *Management Science*, 49(4), 432–445. <https://doi.org/10.1287/mnsc.49.4.432.14428>
4. Currie, G., & Guah, M. W. (2007). Conflicting institutional logics: The impact of new public management on professional autonomy in a medical setting. *Journal of Health Organization and Management*, 21(6), 535–552. <https://doi.org/10.1108/14777260710834125>
5. Dixon, N. M. (2000). *Common knowledge: How companies thrive by sharing what they know*. Harvard Business Press.
6. Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative Science Quarterly*, 44(2), 350–383. <https://doi.org/10.2307/2666999>
7. Edmondson, A., Bohmer, R., & Pisano, G. (2001). Disrupted routines: Team learning and new technology implementation in hospitals. *Administrative Science Quarterly*, 46(4), 685–716. <https://doi.org/10.2307/3094828>
8. Flyvbjerg, B. (2001). *Making social science matter: Why social inquiry fails and how it can succeed again*. Cambridge University Press. <https://doi.org/10.1017/CBO9780511810503>
9. Freidson, E. (2001). *Professionalism: The third logic*. University of Chicago Press.
10. Fulop, N., Allen, P., Clarke, A., & Black, N. (2005). *Studying the organisation and delivery of health services: A reader*. Routledge. <https://doi.org/10.4324/9780203647451>
11. Hislop, D. (2013). *Knowledge management in organizations: A critical introduction* (3rd ed.). Oxford University Press.
12. March, J. G., & Olsen, J. P. (1976). *Ambiguity and choice in organizations*. Universitetsforlaget.
13. Meyer, J. W., & Rowan, B. (1977). Institutionalized organizations: Formal structure as myth and ceremony. *American Journal of Sociology*, 83(2), 340–363. <https://doi.org/10.1086/226550>
14. Mintzberg, H. (1994). *The rise and fall of strategic planning*. Free Press.
15. Nonaka, I., & Takeuchi, H. (1995). *The knowledge-creating company: How Japanese companies create the dynamics of innovation*. Oxford University Press.
16. Reay, T., & Hinings, C. R. (2009). Managing the rivalry of competing institutional logics. *Organization Studies*, 30(6), 629–652. <https://doi.org/10.1177/0170840609104803>

17. Senge, P. M. (1990). *The fifth discipline: The art and practice of the learning organization*. Doubleday.
18. Starr, P. (1982). *The social transformation of American medicine*. Basic Books.
19. Thornton, P. H., Ocasio, W., & Lounsbury, M. (2012). *The institutional logics perspective: A new approach to culture, structure, and process*. Oxford University Press.
<https://doi.org/10.1093/acprof:oso/9780199601936.001.0001>
20. Weick, K. E. (1976). Educational organizations as loosely coupled systems. *Administrative Science Quarterly*, 21(1), 1–19. <https://doi.org/10.2307/2391875>
21. Weick, K. E. (1995). *Sensemaking in organizations*. SAGE Publications.
22. Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity*. Cambridge University Press. <https://doi.org/10.1017/CBO9780511803932>
23. Whittington, R. (2006). Completing the practice turn in strategy research. *Organization Studies*, 27(5), 613–634. <https://doi.org/10.1177/0170840606064102>
24. Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). SAGE Publications.