What We Say, What They Hear: *Perceptions of Organizational Values and Ethical Climate in the Health Care Setting*

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Balancing the financial demands of hospital or clinic operations with the delivery of high quality, safe patient care is a vexing problem for health care executives. Operational goals around resource allocation present a challenge for leaders in that available resources are frequently not aligned with the demand for health care services.[1] Clinicians at the bedside often cite organizational constraints as primary barriers to the delivery of the care they believe to be aligned with their personal and professional obligations to patients.[2–4] Hence, these 2 priorities reside in perpetual tension. A moral conflict arises as each group attempts to reconcile these competing demands.

Part of the problem is that clinicians providing direct patient care are often disconnected from those who are responsible for resources and funding.[4] This disconnect makes it difficult to fully assess and respond to gaps in the cost–quality matrix. Evolution of health care funding toward a value-based infrastructure further accentuates the need to balance cost containment with patient care quality. Although there is a paucity of literature suggesting a measurable correlation between cost and quality,[5] these 2 elements of the health care delivery system are closely intertwined and involve multiple shared organizational components. These components are largely influenced by individual and group values and behaviors within them.[6] Strategies that seek to align stakeholders may help to alleviate the disconnects among them thereby increasing the potential for health care organizations to be financially sustainable while concurrently ensuring the delivery of high quality care.

This article reports the findings of a research study exploring the differences between health care executives and clinicians in their perceptions of what is most valued in their

organizations. In this study, health care executives were defined as the senior-most leaders in the health care organization (e.g., C-suite leaders). Clinicians included physicians, nurses, and certified nursing assistants. Among these populations, the study sought to identify correlations between perceptions of organizational values and ethical climate as the key predictor of behavior within the organization. Recommendations are discussed for how to mitigate moral conflict and its corollary moral distress among clinicians in an effort to improve overall organizational effectiveness.

STUDY FRAMEWORK: COMPETING PRIORITIES IN HEALTH CARE

The problem of health care costs and quality is not a new phenomenon. Mechanisms for health care financing (e.g., government reimbursement models) and service delivery (e.g., shifts from care delivered in homes by independent physicians to comprehensive services provided in acute care hospitals by interdisciplinary teams) have changed over time. This has required executives to adjust strategies and operational objectives to ensure organizational survival.[3] Market shifts from patient *need* for medical care to consumer-minded *demands* for expensive medical technologies without the ability to pay for their use, and the *desire* for concierge and convenience services have contributed to the evolution of the delivery system.[7]

Despite the altruistic assumptions in the historical delivery of medical care, the contemporary health care architecture is framed by economics. As such, goals for profitability are important if the enterprise is to build the capacity for replacing aging equipment and facilities, or if they are to provide the full range of services needed to improve the health of patients.[8] A vexing problem for health care executives is how to achieve that profitability in the face of diminishing reimbursement within the evolving health care landscape.

Lean methodology is one strategy health care organizations have adopted toward that end.[9] The Lean approach helps eliminate wasteful or redundant processes so as to maximize cost containment and add value to the patient care continuum. There is good alignment between Lean thinking and current consumer-driven trends in health care in that Lean identifies what customers want and then streamlines organizational processes in order to get there in the most efficient way possible.[10] Although the emphasis is often on the patient experience, the Lean approach is a resource allocation strategy with the goal of reducing overall costs of care.[11] An overemphasis on cost reduction associated with Lean could therefore send a message that financial considerations take precedence over compassion at the bedside. The result is dissonance in how clinicians view resource stewardship initiatives. Consequently, the perception exists that Lean efforts shift the focus away from patients towards efficiency gained through cost control.[12] As a result, when engaging in Lean efforts, clinicians may have difficulty reconciling their professional moral obligation to patients with the expectation of loyalty to the health care entity as an economic enterprise.[12]

These perceptions are exacerbated by current trends in health care quality improvement. Two general categories of initiatives are identifiable in the current literature on this topic. The first emphasizes specific measures for overall quality of care such as the 30-day hospital readmission rates,[13] or the percentage of hospital acquired infections.[14] The second pertains to the patient experience as measured by HCAHPS.[15] Each of these categories drives government-sponsored reimbursement and, consequently, receives a great deal of attention from executives—especially nursing leaders—in their attempts to balance fiscal performance with high quality, safe patient care. Despite the original intent of these patient-centered metrics to improve the quality of care, frontline clinicians frequently perceive improvements to be driven by economic considerations rather than by the "richness and humanity" of clinician interactions with patients.[12(p.41)] The expectation to balance a compassionate patient experience with institutional requirements for cost containment therefore precipitates a moral conflict for clinicians.

STUDY DESIGN AND METHODOLOGY

Using the online survey platform, Survey Monkey, and a quantitative, cross-sectional survey design, this study examined differences in perceptions of organizational values and ethical climate between health care executives and clinicians. Organizational values reflect an expression of what is most important in the health care enterprise, whereas ethical climate reflects resultant behaviors across the organization. In this study, differences in perceptions and correlations between organizational values and ethical climate were explored to precipitate an understanding of how values translate to behavior. The goal was to determine the antecedents of moral conflict arising from competing priorities for health care executives and clinicians. The original study was conducted as part of the author's doctoral dissertation.[5]

All elements of the original study were conducted in accordance with standards for ethics and compliance as well as applicable laws and professional codes of conduct for research. Permission to use survey instruments was obtained from respective authors for each element of the original research. The Capella University institutional review board (IRB) granted approval of the original research, and each of the participating health care enterprises deferred to that IRB approval in their decisions to participate. Informed consent was obtained before participants could proceed with the online survey tool.

This writing reflects a separate analysis and interpretation of study data extracted from the original dissertation research. The present analysis sought to evaluate the theoretical assumption that health care executives and clinicians have differing viewpoints about what is most important to the organization. In other words, executives and clinicians perceive that different values are expressed across the organization, and these values translate to specific behaviors.

INSTRUMENTATION

Two survey instruments were combined for use in this study. The first is the Competing Values Framework (CVF).[6] The second is the Ethical Climate Questionnaire (ECQ).[7] These tools required that subjects have the ability to read English