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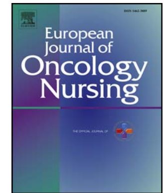

# Ethical leadership, professional caregivers' well-being, and patients' perceptions of quality of care in oncology

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ABSTRACT

*Purpose:* Although quality of care and caregivers' well-being are important issues in their own right, relatively few studies have examined both, especially in oncology. The present research thus investigated the relationship between job-related well-being and patients' perceptions of quality of care. More specifically, we examined the indirect effects of ethical leadership on patients' perceived quality of care through caregivers' well-being.

*Method:* A cross-sectional design was used. Professional caregivers (i.e., doctors, nurses, assistant nurses, and other members of the medical staff; n = 296) completed a self-report questionnaire to assess perceptions of ethical leadership and well-being, while patients (n = 333) competed a self-report questionnaire to assess their perceptions of quality of care. The study was conducted in 12 different oncology units located in France.

*Results:* Results revealed that ethical leadership was positively associated with professional caregivers' psychological well-being that in turn was positively associated with patients' perceptions of quality of care.

*Conclusions:* Professional caregivers' well-being is a psychological mechanism through which ethical leadership relates to patients' perceptions of quality of care. Interventions to promote perceptions of ethical leadership behaviors and caregivers' mental health may thus be encouraged to ultimately enhance the quality of care in the oncology setting.

## 1. Introduction

For almost three decades, numerous studies have carefully built a body of knowledge about the effects of healthcare professionals' practice environment factors and work characteristics (e.g., management at the unit level, hospital management, organizational support) on their psychological health and quality of care (Jones et al., 2013). Indeed, many work-related factors may influence quality of care. For instance, transformational leadership practices are associated with high quality of care and weak turnover intentions. Conversely, abusive leadership practices relate to poorer quality of care and strong turnover intentions in a sample of nurses working in different units (Lavoie-Tremblay et al., 2016). In the nursing context, Wong and Laschinger (2013) also showed that the more managers are seen as authentic, by emphasizing transparency, balanced processing, self-awareness, and high ethical standards, the more nurses are satisfied with their work and report higher performance. Furthermore, leaders who are able to create empowering work environments facilitate a range of positive work attitudes and behaviors among their subordinates (Bawafaa et al., 2015). Finally, ethical leadership predicts workers' well-being (e.g., work engagement) (Chughtai et al., 2015).

More generally, in the healthcare setting, the dominant approach has been to model simple sets of relationships whereby work-related factors are hypothesized to impact outcomes (e.g., well-being, quality of care) through unspecified or untested mechanisms. In addition, oncology studies on the determinants of healthcare professionals' well-being (i.e., experiencing high levels of positive affective states; Van Katwyk et al., 2000) and patients' perceptions of quality of care (i.e., patients' response given to their health care needs and expectations; Brédart et al., 2005) have been quite rare (Brown, 2014). However, some studies, outside of the oncology setting, showed that work-related factors had a significant impact on healthcare professionals' well-being (e.g., life satisfaction), which in turn significantly related to the patient experience and perceived quality of care (Montgomery et al., 2011).

For instance, Shirom et al. (2006) showed that overload indirectly predicted poor quality of care through its effect on physicians' burnout

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in a sample of specialists representing six medical specialties. Van Bogaert et al. (2014) also examined, in a sample of 1201 acute care staff nurses, the mechanisms (i.e., workload, social capital, decision latitude, and burnout) through which nurse practice environment dimensions related to nurse-assessed quality of care. The studied participants were registered nurses working in medical and surgical units, intensive care and medium care units, emergency room, operation theatre, and post anesthetic care units. Moreover, nurses' work engagement, conceptualized as an indicator of well-being (Hakanen and Schaufeli, 2012), mediated the relationship between ward service climate and patient-centered care in a sample of nurses working in 40 wards of retirement homes (Abdelhadi and Drach-Zahavy, 2012). Despite these encouraging findings, the relationships between ethical leadership, well-being, and patients' perceptions of quality of care have not yet been investigated. More generally, few studies sought to examine the mechanisms by which managerial practices have indirect effects on perceptions of quality of care (Westerberg and Tafvelin, 2014), especially in the oncology setting. We aimed to fill this gap in the present research and felt that this work may enhance our knowledge regarding the processes involved in delivering good quality of care. We may also identify modifiable factors that could be targets for managerial interventions.

Compared with other professions, healthcare professionals who provide direct care to patients generally display lower levels of well-being (e.g., satisfaction) (McHugh et al., 2011). More specifically, professionals working in oncology are at high risk for experiencing staff burnout because they often work in particularly stressful and burdensome environments (Penson et al., 2000). Yet, ethical leadership may be a means to enhance well-being and quality of care in oncology wards as the positive effects of these leadership behaviors on numerous individual and organizational outcomes (e.g., burnout, performance) have been extensively demonstrated in another settings (Ng and Feldman, 2015). Ethical leadership is defined as “the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement and decision making” (Brown et al., 2005, p. 120).

In the nursing context, numerous studies recently underlined the importance of ethical leadership (Eide et al., 2016; Gallagher and Tschudin, 2010; Makaroff et al., 2014). Elements that are necessary to underpin ethical leadership in the nursing practice are “respect, loyalty, commitment and understanding the impact that our behavior can have on others” (Gallagher, 2017, p. 515). She also emphasized that respect for patients and for those close to them, as well as for colleagues, is essential for ethical leadership. “Valuing people's individuality and contribution is essential. Respect and value for others is demonstrated by being open-minded, communicating and connecting well and showing sensitivity. A leader who is respectful and values others is more approachable and trustworthy, helps others to feel secure and sets a good example” (Gallagher, 2017, p. 515). Furthermore, “ethical leadership is all about establishing a culture that sets the tone – a culture where there's an epidemic of kindness, but also of good judgement, and where everyone feels committed to the shared daily work of giving excellent, safe, compassionate care. It's also about making sure that everyone enjoys their work, because if you don't, you won't do it well” (Gallagher, 2017, p. 516).

First, ethical leaders create an effective unit organizational culture for optimal patient care. Indeed, ethical leadership enables the development of cohesive and adaptive work teams sharing understanding, goals, and aspirations (Zheng et al., 2015), and increases loyalty and commitment to people and the organization (Gallagher, 2017), which may ultimately lead to enhanced patients' perceptions of quality of care. Ethical leaders also create a culture of patient- and family-centered care as a means to improve patients' perceptions of quality of care. More generally, followers of ethical leaders exhibit stronger job performance. Indeed, they report more positive attitudes (e.g., affective organizational commitment, organizational identification) as they develop a positive perception of work environment. In turn, to reciprocate to ethical leaders for fair treatment, subordinates are likely to display greater work performance (Ng and Feldman, 2015), thus potentially improving patients' perceptions of quality of care.

Second, prior studies showed that ethical leadership behaviors enable supervisors to develop trust-based relationships with their subordinates (Brown et al., 2005). The presence of such relationships in the workplace can subsequently lead to higher levels of work engagement (Chughtai et al., 2015) and lower levels of burnout (Mo and Shi, 2018). Li et al. (2014) also showed that the positive relation of ethical leadership to subordinates' occupational well-being (i.e., job-related contentment and job-related enthusiasm) was mediated by distributive justice (i.e., perceptions of justice concerning the decisions about outcomes and resources allocation) and interpersonal justice (i.e., perceptions of justice concerning the treatment received) in a sample of workers from two 2010 Fortune 500 companies located in China. In other words, ethical leaders make decisions about resources and outcomes allocation with fairness and treat their followers with dignity and respect, leading to high levels of well-being among their subordinates.

Yet, healthcare professional well-being is widely believed to have significant and positive effects on patients' perceptions of quality of care. Indeed, burnout is negatively linked to the quality of care that patients receive and positively associated with maladaptive outcomes such as turnover and absenteeism, in a sample of registered nurses employed at a large metropolitan public health service in Australia (Cheng et al., 2016). Nurses' job satisfaction is also negatively and positively related to intent to leave and quality of care, respectively (Tervo-Heikkinen et al., 2009). The units where the participants worked were medical, surgical, and neurological inpatient wards. Moreover, Van Bogaert et al. (2013) showed that high levels of nurses' work engagement were associated with higher self-reported quality of care in a sample of nurses of two Belgian psychiatric hospitals.

Healthcare professionals with high levels of burnout may not put in as much effort into punctuality, take excessive time off or leave their jobs, thus disrupting the continuity of care (Cheng et al., 2016). Impaired mental health is also linked to cognitive impairments, including decreased attention (Sokka et al., 2016), which can alter the patients' perceptions of quality of care. Moreover, low well-being creates more emotional distance in the patient–healthcare professional relationship and reduces emotional resilience, thereby also contributing to degrade patients' perceptions of quality of care (Van Bogaert et al., 2014). However, in most previous studies on the link between healthcare professionals' well-being (e.g., work engagement) and quality of care, researchers used health professionals' self-evaluations of care quality (Van Bogaert et al., 2013, 2014). In this case, it is difficult to precisely evaluate the relationship between well-being and quality of care as common method bias is widely assumed to inflate relationships between constructs assessed using self-reports (Podsakoff et al., 2003). In addition, to our knowledge, no studies have examined staff well-being in relation to patients' perceptions of quality of care in oncology settings. We focus on these issues in the present research and formulate the following hypotheses:

**Hypothesis 1.** Ethical leadership is positively associated with patients' perceptions of quality of care.

**Hypothesis 2.** Oncology healthcare professionals' well-being mediates the positive relationship between ethical leadership and patients' perceptions of quality of care.

## 2. Methods

### *2.1. Participants*

A cross-sectional design was used. Specifically, this survey was

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