Factors Motivating Hospital CEOs to Commit to Ethical Integration in Their Institutions: A Quantitative Analysis

John J. Newhouse
Saint Joseph's University

Edward R. Balotsky
Saint Joseph's University

Bioethics has been the leading area of ethical focus and concern in the hospital industry. This focus on clinical operations and performance dominates the field of health care ethics. Much less attention has been paid to administrative ethics dealing with management concerns and overall organizational culture. This study examines what forces, both internal and external, cause hospital chief executive officers to pursue ethical integration within their organizations. In studying a range of factors, two issues prove to be the major motivators in this regard. These factors of market environment and patient satisfaction have strong economic overtones.

INTRODUCTION

The health care industry is unique as a social institution strongly connected to its local communities, yet viewed by society at large as a repository of skills, knowledge, and competency for the greater good of all. A major responsibility for assuring that health care organizations fulfill this social charter falls to the organization's chief executive officer and members of that person's senior management team. As Morrison states in her text describing the role of the health care administrator, *Ethics in health administration: A practical approach for decision makers*:

> "Health care administrators certainly do not provide the care, conduct the research, or design the technology. Yet, they are critical to the success of these system functions. They provide an environment where the important work of health care can take place; they are the creators of structure and support. Health care administrators have the ethical obligation to provide a safe environment for patients and employees. They are also the connection to the community and the stewards of the resources society invests in health care. (Morrison 2006, pp.1-2)".

Squazzo adds to the critical weight ethics represents for health care executives as she suggests that there is no simple way to assure staff behaves ethically. Yet, leading any health care organization requires administrators to understand how to instill and maintain cultures where ". . . . . ethical decision making and behavior are the norm." (Squazzo, 2012, p.32). This form of leadership skills must constantly be

practiced since a health care organization's success is very much dependent on having an effective ethical culture.

As important as it is to know how CEOs and senior administrators develop this competency and learn to practice it within their organizations, what is relevant for this research is what motivates hospital CEOs to commit to integrate ethical practices within their organizations. There is considerable literature on the role of bioethics and its relationship to clinical decision-making. The range of this work is impressive from ethical practices focusing on physicians' behavior to the role and work of hospital ethics committees (O'Reilly, 2008; Aleksandrova, 2008; Deshpande, 2009; Salladay, 2006; Davis, 2006; Mino et al., 2008; McGee et al., 2002). These studies examine various aspects of institutionalizing health care ethical practices such as the role of these committees to decide policy for patients' wishes or how ethics committees measure their impact and success, and what are effective strategies for training and the education of potential and current committee members. Much of this work then deals with how hospital ethics committees are structured and work (Ross et al., 1993; Cohen, 1990; Veatch, 1983; Scheirton, 1993). What is far less understood is how CEOs think about what represents effective ethical practices within their organizations and what factors motivate them to institute such practices. The need for a systematic approach to ethics operating within a supportive cultural framework has been advocated for some time (Buell, 2009). The American College of Healthcare Executives' (ACHE) initiative, Fund for Innovation in Healthcare Leadership, established in 2006, made ethics a key priority (Buell, 2009). ACHE has been a consistent champion of developing and practicing ethics for health care leaders as evidenced by the launch of its Ethics Self-Assessment project in 1992. The original Code began in the early 1940s and has seen continuing updating and improvements since that time (American College of Healthcare Executives, 2010). This history speaks to the acknowledged importance of ethical practices by leaders of health care but not on corporate ethical integration. There are a number of well-respected commentaries on the value and necessity of organizational-wide ethical practices that support the overall call for ethical leadership at the top of health care organizations. In the recent article *Ethical challenges and responsibilities of leaders*, Howard Prince, II, director of the Center for Ethical Leadership in the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin, offered the observation that in healthcare there is a growing problem of ethical misconduct and perhaps two of the leading reasons for this is a more acute scarcity of resource along with an increase in excessive competition. Prince comments, "We have to be good diagnosticians about what's going on in our organizations that could be corrosive" (Squazzo, 2012, p.37). Healthcare leaders have the obligation to establish a culture of ethics and foster this type of behavior with employees and staff.

LITERATURE REVIEW

The vast majority of studies dealing with healthcare ethics are in the bioethics/medical domain. These are studies focused on ethical questions related to clinical concerns and direct patient care (Clark, 2007; Boren, 2008; Deshpande, 2009; Aleksandrova, 2008). By extension there has been major work done on the importance of hospital ethics committees and their functions within institutional settings (Sallady, 2006; Mino et al., 2008; Micah, 2008; O'Reilly, 2008). McGee and his colleagues developed a landmark study in 2002 that asked the question of the perceived success and impact hospital ethics committees have on the ethical decision-making within their organizations (McGee et al., 2002). This national study suggested there was wide variation in how the Chairs of hospital ethics committees saw the success of their committee work in several categories. Four categories were seen as important contributors to their mission and goals: education, consultation/mediation, policy formulation/evaluation, and administrative functions. McGee et al. (2002) also reported major frustration dealing with administrative functions due mostly to physician and hospital administrator reluctance to either commit to policy development or to implement policies that would promote their work. Fenton and Arras (2010) called for an increased need for the application of bioethics across the globe (Fenton and Arras, 2010). Their premise was that institutional healthcare needs the guidance, beneficence, and disciplined thinking bioethics brings to the practice of medicine within all forms of organized healthcare delivery. What has been a more common

practice in most industrialized societies now needs to be applied in countries that have more newly developed centralized health systems with national health policies. Davis argued that many hospitals in the United States have experienced a failure in the development of their ethics committees and in their work to achieve ethically driven organizations (Davis, 2006). He sees this as an unfortunate gap in the evolutionary process for healthcare institutions. The logical progression would be to move beyond the work of the ethics committee to a broad institutional-wide ethics program supporting ethics audits, ethics training and education, and the promotion of ethics-based cultures of care delivery. Snow (2009) discusses the set-backs for hospitals when their care delivery lacks ethical input or is done in an ethical void. This work, as well as the studies described above, supports the relatively large volume of research dealing with bioethics and its application in patient care delivery. A more intense examination of healthcare ethics is needed to discover ethics as a topic in the arena of healthcare administration.

The texts by Kurt Darr (2005) and Eileen Morrison (2006) do offer a comprehensive review of ethics in health management and administration. Both books begin with a strong emphasis on moral philosophies and the origin of modern ethical practice having its roots in these schools of thought. Morrison explores the core ethical foundations of autonomy, non-malfeasance, beneficence, and justice as critically important to understand current ethical thinking and practice in the healthcare industry. She also spends a significant amount of time exploring the organizational and administrative aspects of ethics especially discussing areas of mission, culture, and compliance. In the last few chapters of her work, Morrison focuses on the practice of ethics from the viewpoint of administration. She explains, ". . . acting as an ethics-based administrator can provide you with a level of integrity that will last for your entire career in the field of health administration" (Morrison, 2006, p.267). Darr strikes a balance between administrative and biomedical ethical issues. He sees administrative ethics closely linked to concerns about mission, vision, organizational values and codes of practice and behavior. "An organization's values are inextricably linked to its culture. To transform the organization so that its culture is a living reflection of values that facilitate the mission and vision, management must know which values are present in the culture" (Darr, 2005, p.57). Also like Morrison, he limits his discussion of the integration of ethics within healthcare organizations to large institutional components such as the mission and vision statements or codes of ethics. Whether these items are the principle way CEOs assess the level of ethical integration within their organizations or the reasons they commit to ethical practices is not considered.

Silva notes, "Despite professional and public concerns and sometimes outrage about ethical transgressions, little about organizational and administrative ethics has appeared in the health care literature" (Silva, 1998). She ties these ethical gaps to a lack of organizational culture integrating ethics as a necessary cultural component in today's hospital industry. Her observation is that there is a significant amount of literature on healthcare ethics for various clinical situations but considerably less material on healthcare organizational and administrative ethics. Perry echoes the same theme, suggesting that healthcare managers may pay attention to their responsibility for ethical matters relating to clinical practices, but overlook ethical business and people management practices denying the obligations they have for the complete development of an ethical culture (Perry, 2002).

Lauer strongly urges hospital CEOs to set the tone within their organizations for the level of ethical standards their hospitals need to have. Buell stresses the need for CEOs to take action to establish ". . . a systematic approach to ethics so when ethical issues do occur, the organization's actions to address them match its core values" (Buell, 2009, p.54).

The need for senior healthcare administrators to behave ethically and to create a corporate culture that promotes ethical practices and decision-making continues to dominate discussions about ethical practice. Stango focused more on the ethical role of the chief financial officer than that of the CEO, but her message was similar, there needs to be an increased scrutiny of healthcare leaders regarding their ethical philosophies and practices for their organizations. Integrity starts at the top and without that commitment there can be no true ethical integration (Stango, 2006).

Literature dealing with what motivates hospital CEOs to pursue ethical practice is non-existent. Only tangential interpretations of this subject exist. This study begins to fill this major void of health

administration. It serves as an important first step in the understanding of the factors motivating hospital CEOs to pursue ethical integration within their organizations.

RESEARCH QUESTION

The central question of this study is what motivates hospital CEOs to commit to ethical integration. It sub-divides into three independent variables: the type of hospital the CEO represents, the size of the institution's operating budget, and the size of the organization's net margin. The study's null hypothesis is that any differences in how CEOs view this commitment by hospital type, operating budget, or net margins is a random event and not related to any of these three factors.

Design and Methodology

The three independent variables are compared to seven categories of dependent variables: market environment, patient satisfaction, administrator resources, medical resources, organizational culture, administrator/manager action, and administrator/manager behavior. These dependent variables are defined as: 1) Market environment: competitive forces, 2) Patient satisfaction: end-user perceptions of quality of care, 3) Administrative resources: institutional components that support ethical decision-making, 4) Medical resources: medical components that support ethical decision-making, 5) Organizational culture: ethical components upon which culture is built, 6) Administrative/manager action: specific decisions that impact key stakeholders, and 7) Administrative/manager behavior: ethical practices directed toward key stakeholders.

A quantitative methodology utilizing a survey research instrument is followed. The survey instrument was distributed randomly to a targeted audience of hospital chief executive officers in the mid-Atlantic states of Pennsylvania, New Jersey, Delaware, and Maryland. The instrument was validated through a pilot study of a six-member panel of hospital chief executive officers between November 2010 and January 2011. A draft survey instrument was developed based upon a review of the literature and distributed to this six-member panel for review. The review and rewrite process involved three iterations of the instrument before the panel affirmed the content and format of the survey was valid. In late February 2011, the revised instrument was distributed to 163 chief executive officers as the randomly selected CEO participants. By the end of March 2011, 52 completed survey instruments were returned representing a response rate of 31.9%. Of that number 32 instruments were acceptable and found to be error-free in completeness and response selection.

RESULTS

TABLE 1
CRONBACH'S ALPHA RESULTS WITH CONSTRICTION OF COMPONENTS IN MEDICAL AND ADMINISTRATIVE RESOURCES

Dependent Variables	Cronbach's Alpha Results
Patient satisfaction	.89**
Market environment	.93***
Organizational culture	.72*
Administrative behavior	.83**
Administrative action	.76*
Medical resources	.79*
Administrative resources	.70*

*α = acceptable reliability, **α = strong reliability, ***α = excellent reliability

The study's main research question is what motivates hospital CEOs to commit to integrate ethical practices in their organizations. The first level of data analysis was for survey instrument reliability. Measures of reliability were run on each of the dependent variable sets using the Cronbach's Alpha test, with α = .70-.79 considered as acceptable reliability, α = .80-.89 as strong reliability, and $\alpha \geq .90$ as excellent reliability. Initial reliability was achieved for five of the seven dependent variables. The Cronbach's Alpha scores improved from .48 to .70 by constricting and revising the variable sets. This was done for the variables of mission and ethics officer. Cronbach's Alpha measure then increased to an acceptable .79.

TABLE 2
SUMMARY OF ONE-WAY ANALYSIS OF VARIANCE FOR THE INDEPENDENT VARIABLES OF HOSPITAL TYPE, OPERATING BUDGET, AND NET TOTAL MARGINS

Independent Variable	Dependent Variable	Df	M^2	F	P
Hospital Type	Patient Satisfaction	3	2.262	3.515	.028
	Administrative Resources	3	.005	.028	.993
	Medical Resources	3	.123	.381	.768
	Organizational Culture	3	.057	.402	.753
	Administrative Action	3	.066	.486	.695
	Administrative Behavior	3	.095	.597	.622
	Market Environment	3	2.623	3.176	.039
Operating Budget	Patient Satisfaction	2	.211	.251	.779
	Administrative Resources	2	.096	.658	.526
	Medical Resources	2	.015	.052	.950
	Organizational Culture	2	.083	.600	.555
	Administrative Action	2	.034	.252	.779
	Administrative Behavior	2	.102	.653	.528
	Market Environment	2	2.758	3.140	.058
Net Total Margins	Patient Satisfaction	2	.357	.415	.664
	Administrative Resources	2	.021	.139	.871
	Medical Resources	2	.152	.525	.597
	Organizational Culture	2	.030	.209	.813
	Administrative Action	2	.069	.497	.613
	Administrative Behavior	2	.058	.360	.701
	Market Environment	2	2.762	3.170	.057

All dependent variable sets were compared with each of the three independent variables of hospital type, net total margin, and operating budget using a one-way analysis of variance. The dependent variable of market environment showed a marginally significant relationship for both net total margin and operating budget. It was the only dependent variable to reveal differences among the status groups for these two independent variables. Greater significant relationships surfaced for the independent variable of hospital types. Not only was market environment significant but the dependent variable of patient satisfaction was significant at the p=.05 level. Both of these variables achieved a higher significant relationship than their relationship with net total margins and operating budgets.

TABLE 3
MULTIPLE CORRELATIONS FOR THE DEPENDENT VARIABLES OF MARKET ENVIRONMENT AND PATIENT SATISFACTION

Dependent Variable	Hospital Type	Mean Difference	Standard Error	P
Market Environment	Regional Medical Center Urban Teaching Hospital	1.43214	.47030	.005
Market Environment	Community Hospital Urban Teaching Hospital	.97143	.48572	.055
Market Environment	Community Teaching Hospital Urban Teaching Hospital ¤	.85714	.44781	.066
Patient Satisfaction	Community Teaching Hospital Urban Teaching Hospital	-1.09048	.39533	.010

Running a multiple correlation on the dependent variable of market environment for hospital types showed major differences between the CEOs of regional medical centers and the CEOs of urban teaching hospitals. Strong differences also occurred between CEOs of community hospitals and CEOs of urban teaching hospitals although this was statistically recorded as marginally significant. There was a similar finding between CEOs of community teaching hospitals and CEOs of urban teaching hospitals. Doing the same analysis for patient satisfaction showed major differences between community teaching hospitals and urban teaching hospitals.

The Duncan LSD test was run to determine genuine significance for the relationship between patient satisfaction, market environment and hospital types. There was statistical significance of .043 for patient satisfaction and .039 for market environment. The accurate interpretation is that a tendency for significance exists between these variables that are supported by the findings from the Duncan LSD analysis. Because this study represented a relatively low sample size, the message is to conduct further research in this arena to pay attention to these variables since they may prove to have genuine significant relationships given a larger subject population.

TABLE 4
MULTIVARIATE WITHIN SUBJECTS RESULTS FOR THE DEPENDENT VARIABLE GROUPS OF PATIENT SATISFACTION, ORGANIZATIONAL CULTURE, AND ADMINISTRATIVE ACTION

Variable	Value	F	Hypothesis	Error df	Significance
Patient Satisfaction	.393	6.800	5.000	22.000	.001
Organizational Culture	.585	3.122	5.000	22.000	.028
Administrative Action	.763	1.367	5.000	22.000	.275

The Wilk's Lambda multivariate test for within subjects was used to determine whether or not there were differences between the means of the subjects for the various dependent variable groups. Table 4 displays the results of this test for the dependent variable sets of patient satisfaction, organizational culture, and administrative action respectively. The statistical significant differences among items ranged from .001 to .275, which indicates this difference was not due to random responses by subjects, but to deliberate differences between responses for both patient satisfaction and organizational culture.

DISCUSSION

Two factors stood out in this analysis, the dependent variables of market environment and patient satisfaction. Whether CEOs represented institutions with large, moderate, or relatively low net margins or operating budgets, or whether they were CEOs of community hospitals, community teaching hospitals, urban teaching hospitals, or regional medical centers, there was meaningful differences in how they responded to factors they used to identify their motivation for pursuing ethical integration. It was clear the reality of their markets in terms of competitive factors and the importance of patient satisfaction within the larger context of delivering health care services were motivating factors. The type of institutions these CEOs represented showed significance differences for patient satisfaction as well as market environment. The largest differences existed between urban teaching hospitals and regional medical centers in terms of the market environment and between community teaching hospitals and urban teaching hospitals for patient satisfaction.

The market environment difference between CEOs of urban teaching institutions and those of regional medical centers is best understood through the differences of how these two types of institutions view their respective market environments. Regional medical centers traditionally draw patient volume from wide geographic areas with distinctions made between primary, secondary, tertiary, and even quaternary markets. Urban teaching hospitals have a more concentrated patient market. The exception to this rule are patients from areas such as out-of-state, nationally, or even international driven by the reputation of the organization. These patients, however, do not comprise the majority of patient volume.

For patient satisfaction, the two types of hospitals that showed statistical significance were community teaching institutions and urban teaching hospitals. A possible explanation for this difference is that community teaching hospitals usually have a strong commitment to quality patient satisfaction. It is a singular agenda for their mission and vision of the community they serve. Urban teaching hospitals usually have multiple strategic agendas including medical research and medical education along with patient care delivery. The urban teaching hospital CEOs need to balance the importance of patient satisfaction with the critical agendas of research and teaching.

The results of this data strongly suggest only a few factors motivate hospital CEOs to integrate ethical practices in their organizations. CEOs respond to what is happening in their external environments regarding competitive forces, and they respond to patient satisfaction issues in the delivery of health care services. All of the other factors: administrative resources such as mission and vision, medical resources such as codes of ethics, organizational culture such as philosophies based on general ethical principle had no meaningful impact for CEOs to commit to ethical integration. Even administrative behaviors or action failed to serve as motivators. It was only those factors that have tangible economic impact, whether due to business and referral volumes or legal costs from malpractice issues, triggered the CEO response for institution-wide ethics integration.

CONCLUSION

The findings of this study are disturbing within the larger context of health administration. Major support for incorporating ethics throughout hospital management is widely promoted by the American College of Healthcare Executives. This is also the case for the American Hospital Association and the various state chapters of AHA. There is no shortage of professional organizations in health administration making the strong case for ethical practice and behavior in the business of health care services and

delivery. Yet, this study suggests a narrower perspective is used by hospital chief executive officers. It is an economically driven perspective focused on market environments and perceived patient satisfaction.

This conclusion demands further investigation. It is based on only one region of the United States. It is impossible to know whether these results would be replicated in other regions of the country or nationally. The accurate interpretation from this study is that in this area of the country the motivating factors used by hospital CEOs to pursue ethical integration are quite limited, based primarily on concerns with economic overtones. In a nation where health care is perceived as market-driven and practiced in ways that support that perception, these motivators for ethical integration are no surprise. But if America's acute care, hospital industry is to ultimately fulfill its social charter within this society, there will need to be additional factors influencing the motivation of hospital chief executive officers to develop and create an integrated ethical culture within their institutions.

REFERENCES

Aleksandrova, S. P. (2008). Survey on the experience in ethical decision-making and attitude of Pleven University Hospital physicians towards ethics consultation. *Medicine, Health Care and Philosophy 11,* (1), 35-42.

American College of Healthcare Executives. *About ACHE. 2010*. http://www.ache.org/newclub/career/ethself.cfm (accessed January 13, 2012).

Boren, S. (2008). *Ignoring ambiguity: Legitimating clinical decisions* [dissertation]. Miami, FL: University of Miami.

Buell, J.M. (2009). Ethics and leadership: Setting the right tone and structure can help others in their decision making. *Healthcare Executive,* 24, (3), 54-57.

Clark, P. A. (2007). Decision-making in neonatology: An ethical analysis from the Catholic perspective. *Internet Journal of Catholic Bioethics,* 1, (1).

Cohen C. B. (1999). Ethics committees. *The Hastings Center Report,*(2), 29-34.

Darr, K. (2005). *Ethics in health services management.* Baltimore, MD: Health Professions Press.

Davis, W. (2006). Failure to thrive or refusal to adapt? Missing links in the evolution from ethics committees to ethics programs. *HEC Forum,* (4), 291-297.

Deshpande, S. (2009). A study of ethical decision making by physicians and nurses in hospitals. *Journal of Business Ethics,* 90, (3), 387-397.

Fenton, E. and Arras, J. (2010). Bioethics and human rights: Curb your enthusiasm. *Cambridge Quarterly of Healthcare Ethics,* 19, (1), 127-133.

Lauer, C. S. (2006). Why we do the right thing. *Modern Healthcare,* 36, (18), 22.

McGee, G., Spanogle, J. P., Caplan, A. L., Penny, D. and Asch, D. (2002). Successes and failures of hospital ethics committees: A national survey of ethics committee chairs. *Cambridge Quarterly of Healthcare Ethics,* 11, (1), 87-93.

Micah, H. D, (ed.) (2008). *Ethics by committee: A textbook on consultation, organization, and education for hospital ethics committees*. Lanham, MD: Rowam & Littlefield.

Mino, J., Copel, L. and Zucker J. (2008). A French perspective on hospital ethics committees. *Cambridge Quarterly of Healthcare Ethics,* 17, (3), 300-307.

Morrison, E. E. (2006). *Ethics in health administration: A practical approach for decision makers.* Sudbury, MA: Jones and Bartlett Publishers.

O'Reilly, K. B. (2008). Willing, but waiting: Hospital ethics committees. *American Medical News.* http://www.ama-assn.org/amednews/2008/01/28/prsa0128.htm (accessed February 2, 2010).

Perry, F. (2002). *The tracks we leave: Ethics in healthcare management.* Chicago: Health Administration Press.

Ross, J. W., Glaser, J. W., Rasinski-Gregory, D., Gibson, J. M. and Bayley, C. (1993). *Health care ethics committees: The next generation.* Chicago: American Hospital Publishing.

Salladay, S. A. (2006). Making difficult choices. *Nursing,* 36, (1), 26-27.

Scheirton, L. S. (1993). Measuring hospital ethics committee success. *Cambridge Quarterly of Healthcare Ethics,* 2, (4), 495-504.

Silva, M. C. (1998). Organizational and administrative ethics in health care: An ethics gap. *Online Journal of Issues in Nursing,* 3, (3), Manuscript 1.

Snow, M. (2009). When ethics fail: Learning to spot the warnings of compliance failure. *Modern Healthcare,* 39, (49), 24.

Squazzo, J. D. (2012). Ethical challenges and responsibilities of leaders. *Healthcare Executive,* 27, (1), 32.

Stango, M. R. (2006). Ethics, morals, and integrity focus at the top. *Healthcare Financial Management,* 60, (6), 50-54.

Veatch, R. M. (1983). Ethics committee proliferation in hospitals predicted. *Hospitals,* 57,(13), 48-49.