FEATURE ARTICLE

The role of values-based leadership in sustaining a culture of caring

Karen E. Faith, BSW, MEd, MSc

Abstract—At the heart of healthcare are fundamental values like caring and compassion as well as the duty shared by healthcare organizations to address the care needs of those in their communities who are vulnerable, injured, or ill. A concern being raised by some political analysts in Canada is that fundamental values are being challenged by current economic and political influences that are reshaping the landscape of healthcare in this country. Influences from industry, technology, and business have significantly shifted healthcare from its moral foundations. A culture of caring is also challenged by the values and behaviours of individuals that negatively impact staff morale and inter-professional collaboration in many work settings. If a "culture of caring" is to survive the canons of cost containment, the impact of recurrent political wrangling, and other substantive influences, then healthcare must be guided by committed values-based leadership. Using case illustrations, this article attempts to explain the characteristics and role of values-based leaders in promoting those values that inspire a culture of caring.

At the heart of healthcare are fundamental values like caring and compassion as well as the duty shared by healthcare organizations to address the care needs of those in their communities who are vulnerable, injured, or ill.[1] It has been my experience, having worked as a clinical ethicist in several healthcare settings, that most healthcare providers, professionals, and administrators have chosen this field because values related to caring closely resonated with long-held personal values. A concern being raised by some political analysts in Canada is that fundamental values of caring are being significantly challenged by current economic and political influences that are essentially reshaping the landscape of healthcare in this country.[2,3] The literature on organizational ethics in healthcare asserts that current ethical tensions that exist between traditional values of caring and fiscal prudence are likely to prevail.[4,5] Maintaining a culture of caring is also challenged by the values and behaviours of individuals that negatively impact staff morale and interprofessional collaboration in many work settings.[6] Other prevailing influences have come from industry, technology, and business, which, in the opinion of some experts, have caused a cultural shift from the healthcare field's moral foundations.[5] If a "culture of caring" is to survive the canons of cost containment, the impact of recurrent political wrangling, and other substantive influences, then healthcare must be guided by values-based leadership.

Schein[7] states that a significant function of being a leader in an organizational setting is to influence or change culture.[7] Values-based leadership is a term used to describe organizational leaders whose core values or ethical principles are fundamental to the way they interpret and execute their leadership role.[8] Values-based leaders regard organizational values as substantive in guiding the daily actions and decisions undertaken by them, their staff, and volunteers. When referring to ethical leadership, Treviño and Brown[9] maintain that leaders "must be more than individuals of high character. They must "lead" others to behave ethically. If so committed, values-based leadership can influence and help to sustain a culture of caring. For the purpose of this discussion, values or ethical principles associated with values-based leadership pertain not only to those typically cited in the literature like integrity and social responsibility but also include values of caring, compassion, and collaboration.

A culture of caring "invites the human spirit back into the workplace. [It] is based on caring-healing values and theoretical-philosophical and moral foundations."[5] A culture of caring is largely relationship centred, recognizing that "for human beings, there is no true separation-only interdependence."[10] Values consistent with a culture of caring are reflected in organizational mission, vision, and value declarations and often include caring, compassion, and collaboration. Ideally, such values become an important aspect of measuring quality. There is still some question about whether the impact of values-based leadership on organizational culture can effectively be measured in today's complex healthcare environments.[11] This is an area worthy of greater attention and research.

ILLUSTRATIVE CASE EXAMPLES

I will attempt to show how values-based leadership can influence a culture of caring by using two case examples. Both cases are based on a number of actual situations and are offered as a way to show concepts

Corresponding author: Karen E. Faith, BSW, MEd, MSc, Private Ethics Consultant, Toronto, Ontario, Canada
(e-mail: kefaith@rogers.com)
Healthcare Management Forum 2013 26:6–10
0840-4704/$ - see front matter

http://dx.doi.org/10.1016/j.hcmf.2012.07.001

highlighted in this discussion. These cases have been edited to protect the privacy of both healthcare settings and individuals.

In version number 1 of the case examples, circumstances are described in which values-based leadership is not shown. The skills, knowledge, and characteristics of values-based leadership are shown in version number 2 in both example cases.

Case A

Vivian was a seasoned social worker who had years of experience working in geriatric settings where she received praise from colleagues and supervisors for the values and principles she upheld in her work. In her new job on a busy medical floor, she noted the number of food trays being returned to food services untouched by several elderly inpatients. She suspected that there might be a problem with the level of assistance these elderly inpatients required at mealtime.

Version number 1

When Vivian shared her concerns with the unit manager, his response was to effectively shut Vivian down. "Are you a team player Vivian?" he asked her. "We need team players, not trouble makers," he cautioned her. For this manager keeping the status quo, maintaining the bottom line by coming within budget at the end of the fiscal year were his priorities. By his response and demeanour toward Vivian, it was evident that the unit manager neither saw the problem nor did he wish to see the problem as Vivian had defined it. Within the team, it was well known that the unit manager was not open to dissenting views. He conferred with only a few members of the team with whom he had confidence of agreement. He favoured authority over collaboration. Vivian's interaction with the unit manager helped her to understand why her colleagues on the interprofessional team had failed to address such matters in unit meetings. Her experience with the unit manager marked the beginning of an unfortunate period in Vivian's work life. The moral distress she subsequently encountered working in this environment caused her to question her future in this healthcare setting.

Version number 2

When Vivian shared her concerns with the unit manager, his response modeled for values-based leadership. The unit manager considered Vivian's observations as an opportunity to re-assess the quality of care for frail elderly patients on this unit. His efforts to assist the team in researching the problem of uneaten meals and his support to the team in undertaking quality improvement were aligned with organizational values of providing compassionate quality care to patients. His actions, decisions, and behaviour inspired his team because he "walked the talk," enabling them to work collaboratively on an identified quality gap. Vivian learned that concerns could be raised, diverse opinions respected, and that values of caring were important in the daily activities undertaken by staff. Vivian's satisfaction in her job and the respect she had for the interprofessional team and its leadership were tied to experiences such as these.

Discussion case A

In version 1, the unit manager shows the human pitfall of what Heffernen terms "willfull blindness."[12] According to Heffernen, willfull blindness happens when a person chooses not to address information because it may either challenge his/her thinking or require him/her to take a particular action. As Heffernen states, willfull blindness often involves turning a "blind eye to problems and conflicts we just don't want to deal with."[12] Similarly, Bird[13] refers to this human phenomenon as "moral deafness." Willfull blindness or moral deafness are evident when leaders dismiss, challenge, or, worse still, ignore important information in favour of keeping the status quo, avoiding conflict, or having to take action. Under this type of leadership style, teams learn to avoid flagging problems as a means for survival, which contributes to the "moral silence" of otherwise caring individuals. According to Bird, moral silence occurs when people fail to speak up or defend important values or ideals due in large part of resistance or barriers they face in a particular situation. Webster and Baylis[14] identified that moral distress can be experienced when there is an "incoherence between what one sincerely believes to be right, what one actually does, and what eventually transpires." Therefore, moral distress can be encountered when a person who is acutely aware of the moral obligations or actions that should be undertaken in a particular situation fails to speak up and the problem remains unresolved. In version 1 of this case example, Vivian did speak up but was unsuccessful in convincing her unit manager to take the appropriate course of action. Vivian encountered moral distress because she felt that patient care was being compromised, which did not align with her values and principles as a healthcare professional. What she witnessed as a team member was the moral silence of her colleagues, which was another source of her distress.

In healthcare settings, what often evolves under such leadership is a fractured inter-professional team. Silos of communication are formed in contrast to a collaborative team environment. It is common knowledge that such team collaboration is key to providing quality patient care. Job satisfaction suffers, which, in turn, may result in staff retention problems.

Healthcare professionals and healthcare workers like Vivian thrive in work settings when values they witness in daily activities and decisions made by leaders align

with their own ideals and principles.[15] In version number 2, the unit manager is respectfully open to Vivian's concerns and demonstrates a willingness to examine the matter further. He led his team by example and inspired them to examine the values and duties implicit in addressing such concerns. He validated Vivian's contribution as well as the principled approach to her work. His response and leadership promoted a shared sense of responsibility for upholding organizational values. This is values-based leadership in action.

Case B

It was well known by the inter-professional team members that when Dr. Cora was on rotation tensions escalated. Dr. Cora was in her early 40s and had suffered health problems after a painful divorce. Although she had on occasion displayed gruff and inpatient behaviour in the past, she had been previously able to redirect this behaviour and communicate in a more respectful tone with staff. In the past few months, however, it was not uncommon for her to shout at staff and abruptly leave a meeting with a patient or patient family member when the conversation became somewhat challenging. Communication about patient care during Dr. Cora's rotations was becoming increasingly problematic. Many team members feared that this situation was threatening the quality of care given to patients. Individual members of the inter-professional team had confided their concerns to senior-level managers and professional practice leaders. However, no one on the team was aware that any measures were being undertaken to address the concerns they had raised about Dr. Cora's behaviour or the impact it was having on patient care and team functioning.

Version number 1

A Professional Practice Leader (PPL) had been approached by several members of the inter-professional team working with Dr. Cora. They shared concerns about Dr. Cora's behaviour towards staff and the negative impact this was having on the team and, more importantly, on patient care. The PPL reported these concerns in a timely manner to the appropriate senior clinical leadership. The medical director was contacted about the problems between Dr. Cora and the inter-professional team. He subsequently spoke to Dr. Cora about the reported difficulties but, because of privacy concerns, none of this was shared with the PPL.

After several months, frustrated by the lack of response and after a continued stream of complaints she was receiving from staff who worked with Dr. Cora, the PPL decided to consult with the hospital bioethicist. The PPL had lost confidence in senior leadership. In her opinion, important ethical standards and organizational values had been seriously compromised in the way these difficulties were being ignored and enabled. Team members were "burning out," and there was a growing problem with sick leave on the unit. In approaching the hospital bioethicist, the PPL had hoped she would find help in advancing her concerns and in ensuring a more effective organizational response. According to her experiences, the existing structure for reporting and addressing such problems had failed.

Version number 2

When problems about Dr. Cora's behaviour were shared with the PPL, she was able to advocate for the interests of the allied professionals on this team by advancing concerns through the prescribed reporting structure. Within the organization's reporting structure, there were mechanisms through which concerns could be escalated and advanced to senior leadership. The organization had developed a protocol to review reports of disruptive and intimidating behaviour that included ethical and procedural guidelines for responding to these types of problems. The appropriate level of medical, nursing, and administrative leadership was engaged. The leaders involved devised a suitable intervention in accordance with ethical and procedural guidelines. These guidelines also helped to address principles of fairness and transparency in responding to the situation while protecting right to privacy. In assisting Dr. Cora and the inter-professional team, these senior leaders consciously modeled the values reflected in the organization's mission, vision, values, and goals. Dr. Cora's privacy, personal problems, and circumstances were protected while the inter-professional team was helped to tackle the difficulties in communication and team functioning. In addition, the team was assisted in identifying proactive steps to be taken the same challenges resurface. The PPL and the inter-professional team observed that senior leadership upheld organizational values while demonstrating that organizational protocol and procedures were effective.

Discussion case B

Values-based leadership is best supported through organizational structures and resources like ethical guidelines, policies and procedures that are designed to promote ethical decision making and values-based behaviour within the organization.[16] This case example shows how disruptive and intimidating behaviour if left unaddressed can negatively influence the work setting and more importantly threaten compromise quality patient care. In 2008, the Joint Commission flagged disruptive and intimidating behaviour on the part of physicians and staff members as a serious patient safety concern. The authors stated that, "organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it."[6] The Joint Commission declared that code of conduct and processes for managing disruptive behaviours are part of leadership standards. Is this

enough? According to Grojean et al.,[17] leaders are also obligated to ask that colleagues and subordinates change their values when these conflict with professional standards or organizational values. The debate about whether personally held values are ever amenable to change is worthy of its own discussion. However, the challenge to leaders that was articulated by Grojean et al. emphasizes that leadership should actively address values and behaviours exhibited by others in healthcare settings that do not align with those of the organization. Formal processes and mechanisms for the review of such organizational challenges provide the structure, but it is the vision, values, and qualities of leadership that ultimately determine whether ethical principles like fairness and transparency are met.

CONCLUSION

The influence of politics and economics is evident in the struggles healthcare settings face in addressing healthcare demands while meeting fiscal requirements. Challenging values and disruptive behaviours found in many healthcare settings have compromised a culture of caring to the extent that the Joint Commission Report regarded this problem as serious requiring a "Sentinel Event Alert" to its member organizations.[6] If a culture of caring is to be truly valued and preserved, then the field of healthcare must continue to be guided by values-based leadership.

Some research has attempted to examine the unique stressors and challenges faced by leaders in upholding ethical standards and values in their daily administrative duties.[18] However, more needs to be known about the personal burdens faced by values-based leaders in healthcare today. With such knowledge, timely and relevant ethics resources can be developed helping to better support and sustain values-based leadership long-term.

KEY CONSIDERATIONS

The following are offered as five considerations to promoting excellence in values-based leadership:

1. Leaders should be groomed and chosen not just because they possess the right set of skills, experience, or academic achievements but also because they possess personal qualities that will effectively model for other values in the workplace. Leaders must be reflective in considering values in their daily leadership activities.
2. Efficiency is crucial in today's healthcare management strategies. However, efficiency can also be a trap. Cost containment and changes to improve efficiency can be used to justify actions, decisions, or behaviours that do not align with organizational values. Decisions regarding efficiency and cost containment require leaders to collectively examine the values as well as ethical implications of their decisions.
3. Leaders must avoid the temptation to succumb to willful blindness in their daily interactions with others. A culture of caring must enable stakeholders to raise concerns to ask controversial questions, to express diverse opinion, within a context of mutual respect and responsibility for upholding shared values.
4. Leaders must show moral fortitude and follow ethical guidelines when addressing behaviours, actions, and/or decisions that are disruptive, disrespectful, and/or harmful to the organization, staff, patients, or patient family members. They must also ensure that staff and leaders are validated and rewarded for exemplary commitment to upholding and promoting values in the workplace.
5. Concern must be extended to the well-being of leaders. Ethics support and resources should be available to assist them in avoiding burnout and to mitigate the negative consequences of moral distress. Supporting and sustaining values-based leadership long-term is important in promoting a culture of caring within the field of healthcare.

REFERENCES

1. Pellegrinao E, Thomasma D. *For the Patient's Good: The Restoration of Beneficence in Health Care*. New York, NY: Oxford University Press; 1988.
2. Romanow R, Silas L, Lewis S. Why medicare needs Ottawa. *Globe and Mail*, Jan 16:2012.
3. Picard A. Health System "makes a mockery" of medicare values. *Globe and Mail*, March 9:2011.
4. Graber DR, Kilpatrick AO. Establishing values-based leadership and value systems in healthcare organizations. *J Health Hum Serv Adm*. 2008;31:179–197.
5. Watson J. Caring theory as an ethical guide to administrative and clinical practices. *Nurs Adm Q*. 2006;30:48–55.
6. The Joint Commission. *Sentinel event alert: behaviors that undermine a culture of safety*. Available at: http://www.jointcommission.org/sentinel_event_alert_issue_40_behaviors_that_undermine_a_culture_of_safety/. Accessed.
7. Schein E. *Organizational Culture and Leadership*. San Francisco, CA: Jossey-Bass; 1992.
8. Viinamäki O. Intra-organizational challenges of values-based leadership. *Electron J Bus Ethics Organ Stud*. 2009;14:6–13.
9. Treviño L, Brown M. Managing to be ethical: debunking five business ethics myths. *Acad Manag Exec*. 2004;18:69–81.
10. Safran D, Miller W, Beckman H. Organizational dimensions of relationship-centered Care: theory, evidence, and practice. *J Gen Intern Med*. 2006;21:S9–15.
11. Rathert C, Fleming DA. Hospital ethical climate and teamwork in acute care: the moderating role of leaders. *Health Care Manage Rev*. 2008;33:323–331.
12. Heffernen M. *Willful Blindness: Why We Ignore the Obvious at Our Peril*. Toronto, ON, Canada: Doubleday; 2011.

13. Bird F. *The Muted Conscience: Moral Silence and the Practice of Ethics in Business*. Westport, CT: Quorum; 1996.
14. Webster G, Baylis F. Moral residue. In: Rubin S, Zoloth L, eds. *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*. Hagerstown, MD: University Publishing; 2000: 217–230.
15. Gaudine AP, Beaton MR. Employed to go against one's values: nurse managers' accounts of ethical conflict with their organizations. *Can J Nurs Res*. 2002;34:17–34.
16. Gibson JL. Organizational ethics and the management of health care organizations. *Healthc Manage Forum*. 2007;20:32–34,38–41.
17. Grojean M, Resick C, Diskson M, et al. Leaders, values and organizational climate: examining leadership strategies for establishing an organizational climate regarding ethics. *J Bus Ethics*. 2004;55:223–241.
18. Mitton C, Peacock S, Storch J, et al. Moral distress among health systems managers: exploratory research in two British Columbia health authorities. *Health Care Anal*. 2011;19:107–121.