

# Values-Based Leadership in a Healthcare Organization: Its Impact on Decision Making and Organizational Outcomes

A dissertation submitted

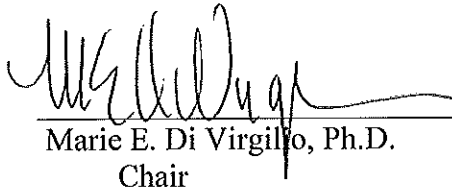
by  
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to  
Benedictine University

in partial fulfillment of  
the requirements for the  
degree of

Doctor of Philosophy  
in  
Values-Driven Leadership

This dissertation has been  
accepted for the faculty of  
Benedictine University.



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May 2014

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## **Abstract**

The aim of this study is to examine the values and value structure of senior executives in one healthcare organization and the dynamics involved in high-stakes decision making. Findings from this mixed method research suggests that when leaders share similar values and a common orientation towards personal-moral values, values-based norms and tactics develop that positively impact the decision-making process and contribute to the achievement of organizational goals.

*Keywords:* values, decision making, civility, senior leaders, healthcare executives

## **Dedication**

To my dad, James H. Wiggins, for teaching me “the value of values.”

## **Acknowledgments**

Although the dissertation bears my name, my deepest gratitude goes to everyone who has encouraged, mentored, and supported me during this process. First and foremost, my sincere thanks and appreciation goes to my study participants without whom this endeavor would not have been possible. Their knowledge, time, and resources have been the most significant contribution.

Next, I would like to thank my committee chair, Dr. Marie Di Virgilio, for being a mentor and coach and, most of all, for helping me to stay on track. You are truly a role model. A special thanks goes to my committee member Dr. Michael Manning for being a methodology expert while sharing his expertise. Your humility is genuinely impressive. And finally I thank Dr. Kurt Olson both for serving as a committee member and for offering valuable feedback. On the same note, my sincere thanks goes to Mr. David Fox and Dr. Jim Ludema for their true encouragement and support during the various stages of the program. I would also like to thank the technical support provided by Gwen McCutcheon for her prompt transcribing, Mary Gagen for statistical support, and Lynn Waldman for her editorship.

Last but not least, I thank John for his sincere support and my children, Abinaya and Dheeran, for their patience and encouragement. Finally, I thank my parents, Daniel and Kamala, and my brother, Premkumar, for their amazing sacrifice and love.

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# Chapter 1: Introduction

The challenges facing healthcare organizations in the United States today are far more complex than at any other time in our country's history. Leaders of healthcare organizations must deal not only with traditional challenges related to policy, economics, demographics, access, and quality of care, but with unprecedented challenges such as healthcare reform changes, federal budget deficit, and rising unemployment. To be successful in such turbulent and challenging times requires both a new leadership approach and reinvention of the supporting healthcare management systems. If we thought good leadership was important in the past, now it is critical. Michael J. Dowling, President and CEO of Long Island Jewish Health System states, "Leadership at its essence is about embracing change and figuring out where one needs to be. And leadership is about constant change" (Weinstock 2010, p. 28).

## ***Leadership in Healthcare***

Today in healthcare, with healthcare reform changes, federal budget deficit, and publically available quality outcome data, no one can deny the need for change in the national healthcare process. Healthcare leaders frequently find themselves called upon to make the right decision in some challenging, unpredictable situations. Clark (2008) has outlined some key leadership strategies from the National Health Service (NHS) for leaders to consider during such turbulent times: a) Set organizational direction (to create, communicate, and inspire the team with a clear vision), b)

Consistently deliver high-quality service (to empower the team to follow the vision while creating a “new normal”), and c) Demonstrate exceptional personal quality (vision and values-based decision making) (p. 30). The above framework on key leadership areas stresses the importance of strategy, quality, and values for organizational success. Sweeney and Fry (2012) contend that leaders’ values influence their attention, perception, judgment, decision making, and, most importantly, behavior. Values are conceived of as one of the critical contributors to the image and success of the organization as well as its leaders. Moral advocates throughout time have confirmed the need for honesty, integrity, business ethics, fairness, dependability, transparency, trustfulness, and character in leadership. According to Maguad and Krone (2009), the success of any organization depends on an environment where good ethics is practiced by everyone in the organization, and where leaders are the champions. The authors further suggest that without a deep value commitment from the top executives, the risk of failure is extremely high.

### ***Context and Rationale for Study***

Articles on leadership—particularly with values as a common denominator—abound, including discussions on values-based leadership (Ahn, Ettner & Loupin, 2011); congruent leadership (Stanley, 2008); clinical leadership (Clark, 2008); Level 5 leadership, servant leadership, and charismatic leadership (Caldwell et al., 2012); and Spiritual leadership (Karakas, 2010). Upon reading various articles on leadership perspectives in the literature, I was motivated to study the competing values that exist among senior healthcare executives at a complex environment. As a healthcare

practitioner for the past 20 years, both in India and United States, my familiarity with the healthcare environment is at a comfortable level. Also I consider my recent involvement as a Malcolm Baldrige National Quality Award Examiner (2012, 2013, and 2014) would be used as an added lens while looking at the leadership of organizations. The participants for the study will be senior healthcare executive leaders (president and vice presidents) of a small Midwestern community hospital associated with a major healthcare system. The executive team (ET) consists of the president and nine vice presidents. The following is the list of their titles:

- VP Operations-Patient Care Services/Chief Nurse Executive (CNE)
- VP Operations-Professional Services
- VP Finance and Support Services
- VP Medical Management
- VP Ancillary services and Community Health
- VP Human Resources
- VP Learning and Organizational Effectiveness
- VP Business Development
- VP Mission and Spiritual Care

According to Maguad and Krone (2009), “the executive leader is just not someone, who follows rules and policies. Instead he is ‘what one is’ and not ‘what one does’” (p. 210). The former is a result of his or her values and is not dependent on specific situations. Maguad and Krone state,

Values are the lens and filters through which the world is viewed. Codes of ethics created by individuals or organizations come from values. Leaders need to communicate about ethics and values in a way that explains the principles and values that guide their actions. (2009, p. 210)

### ***Purpose of the Study***

The purpose of this two-phase sequential mixed methods study is to answer the primary research question about what competing values arise among senior healthcare executives and the influence of these values on complex decision-making process.

The research question will also attempt to reveal the answers to the following few questions: a) What values exist among senior healthcare executives? b) Are these values shared? c) Do they compete with each other? d) If and when values compete, how are decisions, especially decisions critical to the organization, made? e) What are the dynamics observed during challenges in the decision-making process?

The focus of the study will be to understand the dynamics involved in the decision-making and prioritizing process among the leaders and not the decision itself. The quantitative data acquired through surveys prior to the informant interviews provided information on other questions: What are each leader's instrumental and terminal values? How does each leader prioritize the performance perspectives of a Balance Score Card? The quantitative data from the above questions were used to guide the interviews, while the qualitative data from the interviews were coded into meaningful clusters to answer the primary research question.

### ***Research Procedure***

The study employed a grounded theory methodology and did not offer preexisting propositions or hypotheses. To start with, quantitative data were generated both from the Rokeach Value Survey (RVS) by Rokeach (1973) and the leaders' prioritization on the weighting of the performance metrics in a Balance Scorecard (BSC), originated by Kaplan and Norton (1992). The data were used to initiate the conversation during the interviews, leading to a rich qualitative database. The grounded theory data were coded with the assistance of a qualitative research tool, Dedoose (<http://www.dedoose.com>). SurveyMonkey (<http://www.surveymonkey.com>) was used for metric prioritization of BSC, in which the study participants, before they were interviewed and as a tool for completing the RVS instrument, were asked to rate each category of the performance perspectives in the order of importance to them,. The interview protocol was developed following guidelines by Creswell (2009), and the grounded theory coding and theorizing were based on Gioia's method (Corley & Gioia, 2011; Strauss & Corbin, 1998).

### ***Content Organization***

There are five remaining chapters in this study. Chapter 2 is based on literature review of books and journal articles on values and value structure, values-based leadership, competing values framework, leadership perspectives in healthcare, and the decision-making process. Chapter 3 includes methodology in detail, which includes data organization, reading, memoing, and describing/classifying data into codes and themes. Chapter 4 includes the results from my research and an

interpretation of the data with a chain of evidence. Chapter 5 represents findings from the research based on existing studies, and visualizes the data by delivering a pattern or leadership perspective for practical purposes at the organizational level. Chapter 6 includes limitations, future suggestions to expand current study, and research implications for professional practice.

## **Chapter 2: Literature Review**

### ***Introduction***

Leadership is one of the world's oldest occupations. Historically, leaders such as priests, chiefs, and kings served as symbols, representatives, and models for their people. It is a complex phenomenon, involving the interaction of three important elements: the leader, the followers, and the situation or context (Nahavandi, 2009). In this chapter, I will focus on literature where the field of values, leadership, and decision making unfolds. I will start with individual values and value systems and then follow with leadership perspectives specific to healthcare organizations. Because my research is on the dynamics of the decision-making and prioritization process, I will detail briefly the literature on the decision-making process.

Being a healthcare practitioner and, concurrently, a student in the values-driven leadership program, I developed an interest in the study of values and value structure among senior healthcare leaders. In addition to values, I will explore how values influence the decision making among senior leaders. To understand more about the content of values, I will highlight key theory, research, frameworks, and measurement of values. The most appropriate theoretical context for my study is based on the original work done by Rokeach (1973). Despite the fact that Rokeach did not design his instrument with business organizations in mind, the Rokeach Value Survey (RVS) has been one of the most widely used instruments in organizational studies. For my study, I have attempted to relate values-based articles from the social studies arena



and, though few, from healthcare. Hence, in the next few pages, I will focus on the theories, structures, and measurement of values. I will then describe the leadership theories and framework related to values, such as values-based leadership and the competing values framework. After clarifying the topic of values, I will outline the literature on decision making, another important variable defining leadership practices.

## **Values**

A common theme throughout the literature is that leaders should possess a strong foundation of personal, professional, and societal values. Then what is a value?

*Merriam-Webster* defines values as “something intrinsically valuable or desirable”

(<http://www.merriam-webster.com/>). Talcott Parsons, an American sociologist,

proposed in the 1930s that “values are the most fundamental standards that he or she

has to go by; values place things, acts, ways of behaving, and goals of action on an

approved-disapproved continuum” (Fu & Liu, 2009, p. 18). American anthropologist

and social theorist Clyde Kluckhohn (1951) defined value as

a code or a standard which is persistent through time, or more broadly put which organizes a system of action. Value is a conception, explicit or implicit, distraction of an individual or characteristic of a group, of the desirable, which influences the selection from available modes, means and ends of action. (p. 395)

Taking a more “state of existence” approach, Rokeach (1973) defined value as

an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end state of existence. A value system is an enduring organization of beliefs concerning preferable modes of

conduct or end-states of existence along a continuum of relative importance. (p. 5)

A more recent definition by Fu et al. (2009) is similar to Rokeach's definition where values are "a conception, explicit or implicit, distinctive of an individual or characteristic of a group, of the desirable, which influences the selection from available modes, means and ends of action" (p. 225). The above definitions and statements indicate that values are abstract, important, and highly influential on the attitudes and actions of both individuals and groups.

Values can be described from multiple perspectives: content (aesthetic, cognitive, and moral), intent (instrumental and terminal values), generality (situation-specific, similar to work values), intensity (weak or strong), and level (individual or social values) (Roe & Ester, 1999). Despite values being an important topic, in his review of titles and abstracts across all issues of four major journals (*Academy of Management Journal*, *Administrative Science Quarterly*, *Harvard Business Review*, and *California Management Review*) in alternate years from 1960s through 1990s, Miles (2007) noticed the following general pattern. Leadership styles and values begin to appear in late 1960s and dramatically increased in 1970s, before falling off in 1980s and 1990s, where the focus was on teams, alliances, and knowledge.

Furthermore, values are considered deep-seated, developing their roots during an individual's early childhood. Parents, friends, teachers, and external reference groups

can all influence an individual's values. They influence one's beliefs, attitudes, and eventually behavior. Values are broad preferences concerning appropriate course of action or outcome. According to Fernandez (2004), they also reflect a person's sense of right or wrong. Values are closely related to the concept of ideology. If values reflect the cause behind an attitudinal or behavioral decision, an ideology reflects the conscious deliberation of values-driven decisions (Rohan & Zanna, 2001).

### ***Value Systems***

According to Rokeach (1973), an individual, through experience and the process of maturation, integrates the isolated and absolute values learned from various contexts into a hierarchical system as relevant to his own priority. Values have a strong motivational component as well as cognitive, affective, and behavioral components. They define standards and refer to a single belief that concerns a desirable mode of behavior or end-state. They transcend objects and situations, and a significant content of a value may directly concern adjustive, ego defense, knowledge, or self-actualizing functions. Values are the cognitive representation of not only an individual's needs but also of his or her societal and institutional demands. They are not goals, but goals are chosen based on one's values. Also, values are not ideals or beliefs, even though both are acted upon through a value element. Beliefs refer to the categories of true or false, possible or impossible, correct or incorrect, whereas values refer primarily to the categories of good or bad and right and wrong. As the basis of his Rokeach Value Survey (RVS), Rokeach (1973, p.3) identified five assumptions about human values:

a) each individual possesses only a relatively small number of values, b) all people

possess the same values but to varying degrees, c) values are organized into value systems, d) culture, society, and personality are primary determinants of individual values, and e) human values affect many phenomena of interest.

Based on his theoretical context, he identified two kinds of values: instrumental and terminal values, for a total of 36 values. Though they are related and have a functional relationship to each other, they are separately organized into a lasting hierarchical organization of perpetual importance, as detailed below.

### **Terminal values**

Rokeach (1973) suggested that the two kinds of terminal values, personal and social, were differentiated by focus: self-centered or society-centered and interpersonal or intrapersonal. An individual's attitude and behavior are a result of his or her priority level between the two kinds of values. Salvation and peace of mind are examples of personal terminal values, while world peace and brotherhood are examples of social terminal values. Increases in one personal value will lead to increases in other personal values and decreases in social values, while increases in one social value will result in increases in other social values and decreases in personal values. Based on intuitive, theoretical, and empirical grounds, Rokeach suggests that a human possesses about 18 terminal values. Terminal values are motivating because they represent the ultimate or end goals. They are neither immediate nor periodic nor satiate in nature. An individual is constantly striving to achieve these goals during his or her lifetime.

**Instrumental values**

Rokeach (1973) also identified two kinds of instrumental values: moral and competence. Moral values refer to modes of behavior that are interpersonal and not focused on an end state of existence. For example, when a moral value such as honesty is breached, the individual develops a sense of guilt and wrongdoing. On the other hand, competence values are also called self-actualization values. They are personal in nature, and violation of a competence value such as creativity by an individual could result in feelings of inadequacy. Although all values denote to some degree what an individual believes he or she “ought to” or “should” do, moral values more than any other kind convey this sense of “ought.” Individuals may also experience dissonance between two moral values as well between a moral and a competence value. Humans have a minimal of five or six dozen instrumental values. Instrumental values are motivating because they are considered to be a necessary means for attaining the desired end goals or terminal goals.

**Functions of values and value system**

Rokeach (1973) noted in his book that “values are multifaceted standards that guide an individual’s ongoing activities, and the value system is a learned organization of principles that assists with the individual’s ability to resolve conflicts and make decisions” (pp. 13–14). Values guide conduct in a variety of ways, such as the following: a) leading a person to take a particular political standard on social issues; b) predisposing an individual to favor a preferred religious or political ideology and identity; c) assisting with the presentation of self and others as explained by Goffman

(1959); d) employing certain standards in the evaluation and judgment of self and others; e) comparing self and others while determining moral and competence values; f) acting to persuade versus dissuade others in terms of one's beliefs, attitudes, values and actions; and g) assisting with rationalization during the application of defense mechanisms. In addition to, they serve to initiate, maintain and enhance self-esteem.

### **Measurement of values**

Values, which are considered stable in adults, motivate people's behavior. They reflect real differences between cultures, social classes, occupations, religions, and political orientations, and hence they impact conflict resolution and decision making.

Lee, Soutar, and Louviere (2008) listed several instruments in the measurement of values and value system:

- 1973-Rokeach Value Survey
- 1983-Kahle's list of values
- 1983-Mitchell's values and life styles survey
- 1992-Schwartz Value Survey

Although a number of approaches have been used to identify values, each approach has shown that individual values affect one's beliefs, attitudes, behavior, and preferences in a variety of contexts, including cross-cultural comparisons. Meglino and Ravlin (1998) note that values are most commonly measured either by normative or ipsative approaches. Normative approaches measure values independently of each other, while ipsative approaches are designed to assess the relative importance or

preference among a series of values. Ipsative approaches are less prone to social desirability bias because the respondents have the option of only prioritizing the existing list of values. In the case of normative approaches, respondents rate all values as important and sometimes require a control for social desirability.

Proponents of the ipsative approach suggest that because values are less consciously held, the only way to surface values is to force respondents to think about them and to make a choice between competing values. I will explain the Rokeach Value Survey (RVS) and the Schwartz Value Survey (SVS) because I have used the RVS with my interviewees and because the SVS was derived from the former instrument.

#### Rokeach Value Theory and Survey

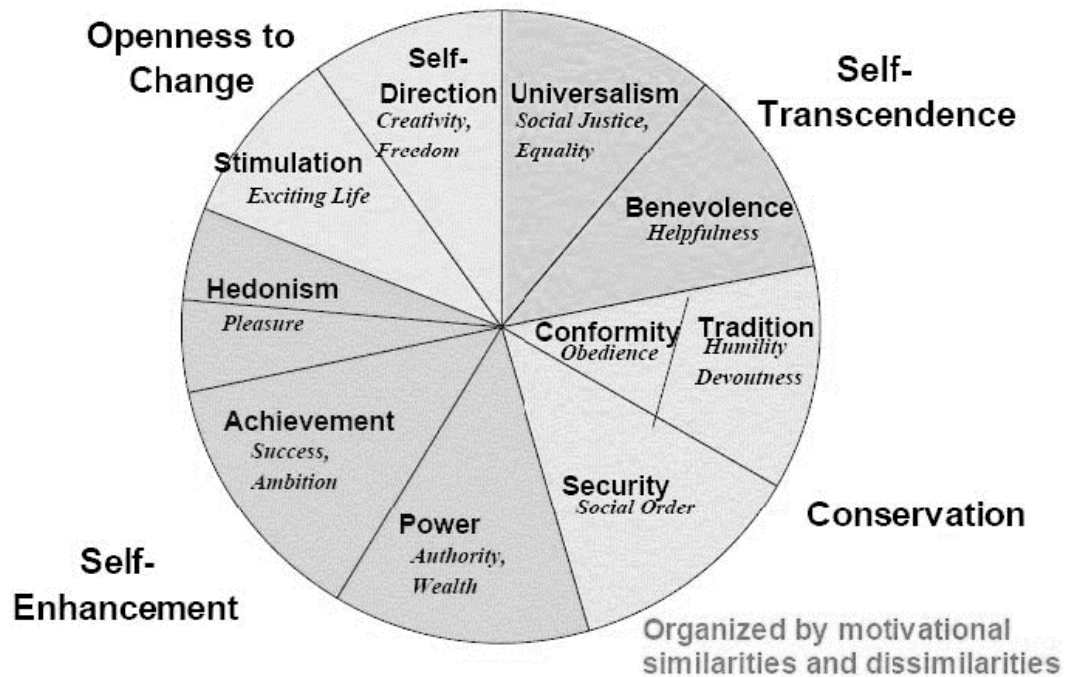
Rokeach developed a theoretical perspective on the nature of values in a cognitive framework and a value measurement instrument. Both are widely used and accepted by psychologists, social and political scientists, economists, and others interested in understanding the concept of values, what individuals value, and the ultimate function, standard, and purpose of values and value system (Johnston, 1995). The RVS (Rokeach, 1973) consists of 18 terminal values (end states of existence) and 18 instrumental values (modes of conduct) listed in alphabetical order. The task of the research participant is to arrange the 18 terminal values—such as world at peace, freedom, salvation, wisdom, etc.—followed by the 18 instrumental values—such as courageous, broadminded, logical, responsible, etc.—“in order of importance to YOU, as guiding principles in YOUR life” (Rokeach 1973, p. 27). This instrument was initially designed for rank-order rating, as noted above, but more recent studies

have provided evidence that ratings on a seven-point Likert scale yield similar results. A major criterion in choosing the 36 values was their comprehensive and universally applicable nature. Rokeach developed the RVS based on interviews and in-depth reviews of language and of the existing literature on values. A sample of the instrument is located in Appendix A: Rokeach Value Survey for reference.

#### Schwartz Value Theory and Survey

Schwartz Value Theory is a hypothesized structure of the relationship between the values identified by Rokeach. It suggests that the 10 values each named after its central goal follow a quasi-circular structure in which adjacent values are likely to be congruent, whereas values on opposite sides of the structure are likely to be in conflict. As noted in Figure 1, the Schwartz Value Survey (SVS, 1992) values are spaced in a circle but not equally spaced. From the top right position, moving clockwise, the motivational types are as follows: universalism, benevolence, conformity and tradition, security, power, achievement, hedonism, stimulation, and self-direction.





Source: Adapted from Shalom Schwartz, personal communication, 2012

**Figure 1. The Quasi-Circumplex\* Structure of Individual Values from Schwartz' Analyses**

Schwartz contends that values are psychological constructs inherently linked to personality, motivation, and behavior, but they have unique contribution for understanding any psychological phenomenon that somehow ties in with evaluation, justification, rationalization, and selection of actions (Lindeman & Verkasalo, 2005). Furthermore, motivational types related to openness to change are found on the opposite side of the circumplex as those related to conservation. Similarly, motivational types related to self-transcendence are located opposite to those related to self-enhancement. Despite SVS's being used commonly, Meglino and Ravlin (1998) suggest that there is no ideal solution for measuring values; however, ipsative

approaches have been considered most appropriate for studying values in decision-making situations, when people must choose between competing values, while normative measures may be better when studying the values of an individual or group. Now that we have looked at values and value structure, I will focus on the next entity, leadership, as it relates to values, as values-based leadership.

### ***Values-based Leadership***

A leader is a man who steps forward in a time of need—motivated not by ego or financial gain but by the sense of duty to benefit the society to which he belongs—then, when the task is completed, returns to his former life, no wealthier than when he began.

—Socrates

Despite change in technological and organizational forms, the study of leaders and leadership continues to be of major interest, as societies have evolved from nation-states to global economies (Ahn, Ettner, & Loupin, 2011). The common denominator with various models of leadership is values. And if one can call the new model “values-based leadership,” how can it be defined? O’Toole and Bennis (2009) define values-based leadership as the moral foundation underlying stewardship, decisions, and actions of leaders. They state that the three elements of an effective leader are vision, culture, and value resonating with the equivalent Roman themes of *fatum*, *pietas*, and *virtus*. Vision (*fatum*) requires imagination, courage, and resilience precisely because it is an envisioned future and requires change from the status quo. Culture (*pietas*) refers to the norms of behavior and shared values among a group, anchoring distributed decision making, and allowing the firm to direct behaviors

towards a common vision. And values (*virtus*) are the moral foundation underlying stewardship, decisions, and actions of leaders. Further, Ahn, Ettner, and Loupin (2011) identified the eight value elements of values-based leadership as integrity, good judgment, leadership by example, decision making, trust, justice/fairness, humility, and sense of urgency. According to Ahn et al., values can be personal, moral, social, and organizational, and they are dynamic and contextual.

Values-based leadership has also been researched by various management practitioners and organizational scholars. Popular business books have identified core values as one of the bases of business (Chappell, 1999; Collins & Poras, 1994; Fairholm, 1991). Charismatic and transformational leadership theorists have emphasized the role of shared values in motivating follower performance (Bass, 1985; Burns, 1978). *Leadership Quarterly* published a special report titled “Leadership, Followers, and Values” in the summer of 2001 (Brown, 2002). And values have been viewed as important for effective leadership for decades (Selznik, 1957), which leads to the relevance of Schwartz’s definition of values as “desirable, transitional goals, varying in importance, that serve as guiding principles in people’s lives” (1992, p. 6). Values-based leadership processes may possibly depend on the values that are in practice. Research by Schwartz (1992) suggest that values are organized and prioritized into systems and may vary in importance and conflict with each other. He suggests that values emphasizing achievement, profitability, and power often conflict with values that are oriented to the service of and caring for

others. Therefore, successful leadership may depend on the similarities and differences in values among leaders and followers (Brown, 2002).

Consistent with these researchers, Graber and Kilpatrick (2008) identified the following four characteristics in values-based leadership: a) awareness of one's personal and professional values, b) congruence with larger organizational values, c) awareness and understanding of both internal and external stakeholder values, and d) commitment to a values-based leadership (p. 179). Another concept of relevance is value congruence, also referred to as "values fit," which is increased commitment, satisfaction, and reduced turnover (O'Reilly, Chatman, & Caldwell, 1991). Value congruence has been associated with decreased conflict and increased cooperation (Schein, 1985). Studies have suggested that value congruence between leaders and their direct reports is an antecedent of leader-member exchange (Ashkanasy & O'Connor, 1997), a consequence of transformational leadership (Jung & Avolio, 2000), and a precursor to positive outcomes such as increased satisfaction and commitment (Meglino, Ravlin, & Atkins, 1989). Values are also a powerful media in organizational life, and their impact has increasingly been recognized over decades (Schein, 1985). Despite all these studies on value congruence, there has not been any research on the process to attain such value congruence in healthcare organizations. In my study, I have used the Rokeach Value Survey to study individual values of leaders, and the study explores further the value congruence of shared values among leadership and the rest of the organization.

Contingency models of leadership have championed the view that leadership style must consider the values of the group, and then the leadership value is crafted around those values to develop synergy between the leader and the followers. Values are at the core of who an individual is. They influence the choices a person makes, the people they trust, the appeals to which they respond, and the way an individual invests time and energy. Values are so deep-seated that one never actually “sees” the actual values; he or she sees the ways in which values are manifested, such as in opinions, decisions, attitudes, preferences, desires, and fears (Posner, 2010).

Leaders are also challenged to align themselves and their followers around a vision. Values are important because a leader, who articulates a vision, may need to hold values that are aligned with the vision. Fu et al. (2010) suggested that if the leader holds more individualistic or self-enhancement values, followers may not fully buy into the vision and may even feel betrayed by their leader, thus lessening the commitment factor. Van Schaik (1989) stated that people relate to a vision when it vibrates in harmony with their deepest personal values. A major gap in most current leadership theories is the lack of attention to identifying both leaders and followers as the people. The theories tend to focus on behavior or decision style, with relatively poor understanding of the values, needs, and motives that gives rise to the observed behavior. An assumption between the leader and follower has been that both will be able to identify the correct and ideal set of behaviors in a situation. The simplistic trait

and behavioral theories were replaced by the contingency theories that do offer a stable platform to look at the issues. However, the issues being quite complicated, one will require a more integrated, multifaceted, and systematic view of leadership process. The next major era of leadership research begins with the recognition that group and organizational performance are dependent upon the interplay of social systems (Wren, 1995). In addition to the issues surrounding values and values-based leadership, it is important to note that there have not been studies on values among leaders in healthcare and on how these values influence decision making and prioritization and assist with shaping the rest of the organization for successful performance.

### ***Leadership in Healthcare Organizations***

According to Ashford and DeRue (2012) organizations around the world are faced with a multitude of economic, social, ethical, and geo-political challenges that are complex and convoluted. At this time, the status quo is unsustainable and a “new normal” is essential. Similar to other service organizations, the healthcare environment has changed significantly in the past few years, leading to a more complex, challenging, and competitive structure. According to Armstrong (2006), the following realities continue to exist:

- Although there are plenty of resources on effective leadership, leaders are unable to articulate the principles underlying effective leadership.
- The ethics of leaders continue to decline, due to power struggles, narcissism, corruption, and inappropriate conduct, resulting in decreased patient safety.

- The rapid pace of change in healthcare process creates burnout among its leaders.
- Frequently, leadership development is not a top priority during economic downturn, limiting the growth of the leaders.
- Though senior leaders often cite values as a leading contributor to success, they have been considered as vague contributors due to inadequate studies with quantified hard data and measurable standards.

To achieve long-term sustainability, a healthcare organization needs to grow its community involvement and reciprocity. Therefore to fit into the community and achieve a degree of community goodwill, the organization should reflect and embody some measure of its community's values. Values are the foundation on which every organization is built. They shape every decision made, every conversation encountered, every deal made, and every change implemented (Values Compass, 2012). Values permeates all levels of the organization while creating an impact on the ways the organization conducts business, treats employees, and deals with customers and suppliers. It is essential for organizations to reexamine and instill sound values within their culture, thereby creating long term sustainability as indicated by Fu and Liu (2009). They further reiterate that underestimating the value of values can be a disaster for any organization. In this fast-paced culture, values must be the bedrock of good business, and smart leaders realize that compelling values back business success. Cameron (as cited in Caldwell, Dixon, Floyd, Chaudoin, Post, & Cheokas, 2012) states, "To merit the trust of organizational stakeholders, the leaders of

tomorrow's organizations must revise their standards, demonstrate their character, and meet the expectations of a cynical but increasingly complex world" (p. 175).

Overall leadership in healthcare is generally viewed in four sections, as noted by Schyve (2009) in Table 1.

**Table 1. Leadership in Healthcare**

<b>Leadership Structure</b>	Includes leadership responsibilities, governance accountabilities, the chief executive responsibilities, medical staff accountabilities, and the leaders' knowledge
<b>Leadership Relationships</b>	Includes the mission, vision and goals, conflict of interest among leaders, communication among leaders, and conflict management
<b>Hospital Culture and System Performance</b>	Includes culture of safety and quality, using data and information, organization-wide planning, communication, change management and performance improvement, and staffing
<b>Leadership Operations</b>	Includes administration, ethical issues, meeting patient needs, and managing safety and quality

Today in healthcare, with healthcare reform changes, federal budget deficit, and publicly available quality outcome data, no one can deny the need for change in the national healthcare process. To bring about this strategic change, healthcare leaders play an important role, which leads to the issue of values among senior executives and leaders. Consistent with literature review this far, leadership is recognized as the ability to influence, network, empower, and facilitate the followers. It requires creation of a revolution in safe, high-quality, cost-effective, and efficient care. There needs to be a focus on long-term initiatives such as recruiting, developing, rewarding,



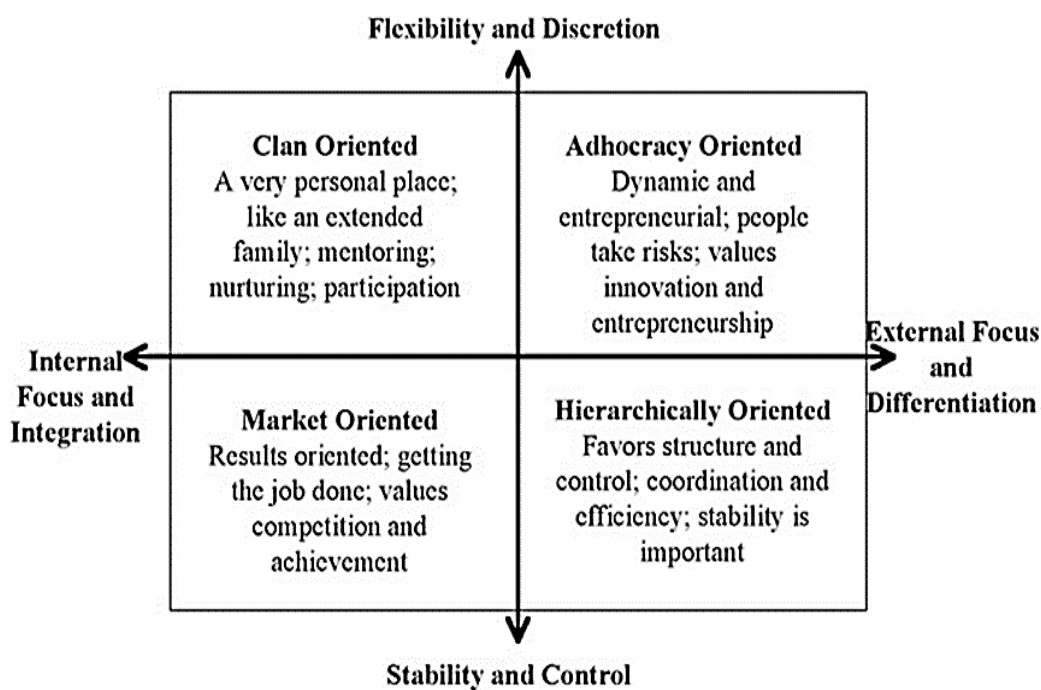
and retaining leaders at all levels. To achieve a long-term organizational sustainability, leaders need to build strong teams and should be empowered to drive and manage transformational change within their organization.

Additionally, leadership in healthcare organizations is both similar to and different from leadership in other organizations. Similar to other service industries, leadership must not only motivate, inspire, and uplift employees, but leadership should seek to motivate, inspire, and uplift patients and families. And studies have demonstrated that leaders' values matter for all sorts of outcomes (Fu et al., 2010). For healthcare organizations, outcomes would include excellence in organizational performance, culture of safety, stakeholder engagement and satisfaction, and organizational sustainability. Consequently, healthcare leadership essentially is a synergy of one's values, and as such, is as critical and integral as is the leaders' focus on high-quality clinical care and technical excellence (Clark, 2008). As a result, there is a constant need for alignment to self and to multiple stakeholders.

In defining leadership, Fernandez (2004) uses a quote from Confucius as an analogy: "A sovereign who governs a nation by virtue is like the north polar star, which remains in its place and the other stars revolve around it" (p. 26). Since the leadership framework I have used in my research involves the study of competing values among the healthcare leaders, I have described the competing values framework developed by Cameron and Quinn (1999) in the following few paragraphs.

## **Competing Values Framework (CVF)**

Cameron's Competing Values Framework is a theoretically grounded comprehensive approach to understanding and improving organizational and leadership performance by focusing on four action imperatives: competing, controlling, collaborating, and creating, as noted in Figure 2 (Fleenor, Smither, Atwater, Braddy, & Sturm, 2010). It also emphasizes the importance of the ends and means of achieving balance within each action imperative.



*Source:* Adapted from [contactcenterworld.com](http://contactcenterworld.com)

**Figure 2. Competing Values Framework**

CVF concisely captures the tensions between the different models, highlighting the paradoxes that managers face (Gifford et al., 2002). It creates a rich visual

representation of an organization's culture (Hartnell, Ou, & Kinicki, 2011). An important insight is that competing values, competing preferences, and competing priorities exist in any organization. It is difficult to understand how those competing values may become complementary. Although tensions naturally arise, every organization needs to pursue activities in all four competencies, though it will depend on strategic priorities, life-cycle development, and environmental conditions. According to Cameron, Quinn, Degraff, and Thakor (2006), there might be an imbalance, and the organizations need to be prepared to shift emphasis when the demands of the competitive environment require it. They also state that CVF drives the leaders' insight when two opposing ideas and concepts are simultaneously in action (*Janusian* thinking). It enables the leaders' sophisticated understanding of phenomena (cognitive complexity), thereby leading to value creation.

The main application for CVF is that it pays particular attention to employee perspective. It is consistent with a commitment-based management philosophy. It emphasizes transcending apparent paradoxes to identify win-win solutions (Wicks & St.Clair, 2007). Rather than focusing on customer and employee satisfaction, the CVF looks for ways to satisfy customer and employees while still addressing financial constraints and growth opportunities. It can also be used to assess both the culture of the organization and the competencies of individual leaders, thereby providing a clear link between strategy and implementation. CVF works best in service organizations like hospitals where the culture is based on group values (Obendhain & Johnson,

2004). The CVF approach embraces paradoxical thinking and looks for ways to transcend paradox and achieve objectives that initially appear to be in conflict (Garman, 2006). So far, I have outlined CVF in brief; I will add additional information in Chapter 5 while discussing the details of my study.

As noted in the introduction, beyond issues surrounding values and leadership, the next context in focus for my research is the decision-making process. I will provide an overview of the different theories, assumptions, and constructs in the field of decision making and examine its importance to leadership.

### ***Decision Making in Leadership***

Nothing is more difficult, and therefore more precious, than to be able to decide.

—Napoleon Bonaparte (Maxims, 1804)

Decision making within an organization has become a critical and most complex part of leadership. For the decision makers, the decision-making process is no longer a simple one where all the variables are available and well understood. There are too many considerations due to the importance of decisions to the individual, team, organizational, and the societal outcomes. Decision making by healthcare leaders is no different than decision making by leaders of other organizations because of its complexity and constantly changing environment. In the next few paragraphs, I will outline Vroom-Yetton's model of decision making, followed by Janis group think, and other researchers' theories on the process.

**Vroom-Yetton model**

Current research findings concerning follower participation in organizational decision making suggest that the degree of participation should vary with the particular problem or situation facing the decision maker. It was found that leaders who used decision making styles that agree with the Vroom-Yetton model have more productive subordinates (Paul, 1989). This model specifies five decision-making methods: Autocratic Type 1 or AI, Autocratic Type 2 or AII, Consultative Type 1 or CI, Consultative Type 2 or CII, and Group-Based Type 2 or GII. AI leaders solve problems using available information AII leaders get necessary information from subordinates and then make the decision alone. Followers' involvement is just providing information. CI leaders share the problems with subordinates individually rather than with a group and may or may not make a decision that reflects the subordinates' influence. CII leaders share the problems with the group collectively, obtaining their ideas and suggestions, and still may or may not make a decision that reflects subordinates' influence on the G-group or consensus decision. GII leaders share the problems with the followers as a group and seek ideas and suggestions without forcing their ideas, and they allow the group to make the final decision. The leader's task is to know when and how to implement each method as the situation requires.

**Groupthink**

According to Janis, "groupthink" can lead to faulty decisions (Janis, 1972). He defined groupthink as "a mode of thinking that people engage in when deeply

involved in a cohesive in-group, when the members' strivings for unanimity override their motivation to realistically appraise alternative courses of action" (as cited in Schoemaker et al., 1993, p. 63). Janis identified three layers of groupthink: key underlying causes, common symptomatic behaviors, and resulting decision-making flaws. The key causes include group cohesion, directive leadership, and ideological homogeneity. The common symptomatic behaviors include overestimation of the capabilities of the group, closed mindedness, and pressures for uniformity. The consequent decision-making flaws included inadequate contingency planning; insufficient information search; and biased assessments of risk, cost benefits, and moral implications. And all too often, the focus on decision making follows a very narrow, individual definition, concentrating on intellectual ability and thinking style, without looking at the interpersonal processes that support and underpin decision making.

### **Schoemaker and Russo**

Previous research by Schoemaker and Russo (1993) suggested four general approaches to decision making, ranging from intuitive to highly analytical. Intuitive judgment is based on "gut feeling." However the difficulty in this process is due to inconsistency and distortion. Rules and shortcuts are often clever ways to approximate an optimal response without having to incur the cost of the detailed analysis. The difficulty is in the availability of industry-specific and generic rules. Importance weighting, like regression-analysis bootstrapping, allows the individual to articulate the weights, test them, and use them for future decisions. Value analysis

refines importance-weighting techniques by considering how factors affect broader objectives and how increases in the rating of a factor-add value. Some of the techniques include key objectives, nonlinear values, and expert opinion. Schoemaker and Russo (1993) further explain that using the right technique depends on the complexity of the situation as previously observed.

### **Brousseau, Driver, Hourihan, and Larsson**

Research shows that senior leaders analyze and act on problems far differently than their more junior colleagues (Brousseau, Driver, Hourihan, & Larsson, 2006). At lower levels, the priority is to keep everyone focused on immediate tasks and getting the work done. At higher levels, decision styles become more about listening than telling, more about understanding than directing. Brousseau et al. (2006) propose that decision styles differ in two fundamental ways: how information is used and how options are created. Information usage includes the maximizers, who mull over reams of data before they make any decision, which is usually costly in terms of time and efficiency, and the satisficers, who are ready to act as soon as they have enough information to satisfy their requirements. As for creating options, “single-focus” decision makers strongly believe in taking one course of action, while their “multifocused” counterparts generate lists of possible options and may pursue multiple courses.

Using the two dimensions of information use and focus, Brousseau et al. created a matrix that identifies four styles of decision making as noted in Table 2.

**Table 2. Brousseau's Decision-Making Matrix**

<b>Decisive (little information, one course of action)</b>	They value action, speed, efficiency and consistency
<b>Flexible (little information, many options)</b>	They focus on speed, but the emphasis is on adaptability.
<b>Hierarchic (lots of data, one course of action)</b>	Decisions should stand the test of time
<b>Integrative (lots of data, many options)</b>	They make decisions that are broadly defined and consist of multiple courses of action

Decision making for the integrative is not an event, but a process. Brousseau et al. (2006) claims people do not fall neatly into little boxes. Circumstances also influence the appropriate decision style. The leadership (public) mode, as the managers move up in ranks toward openness, diversity of opinion, and participative decision making, is matched by a step-by-step drop in the more directive, command-oriented styles. In the thinking (private) mode, there is a progression towards the maximizing style. The most successful executives become even more open and interactive in their leadership styles and even more analytic in their thinking styles as they progress in their careers.

### **Ben-Hur, Kinley, and Jonsen**

Other research in executive decision-making has shown that it is entirely natural for decision making groups, whatever their motivations and guidelines, to tend to suppress information flow, have more extreme attitudes, make more extreme



judgments, be less flexible in adapting their approach to changing circumstances, and yet have greater confidence in their decision (Ben-Hur et al., 2012).

Ben-Hur et al. (2012) identified three behavioral levers that can be used to create a culture in which ideas are properly debated, concerns are raised, and good decisions are made: knowing (understand the impact on information flow), saying (make sure people can say what needs saying), and sustaining (make it all sustainable). They also claim that using the three-lever approach transcends both process- and insight-based solutions by tackling the issues on multiple levels: individual ability, information flow within and between teams, team dynamics, and organizational culture.

### **Other research constructs**

Eisenhardt (1990) found that most leaders have recognized that speed matters in the case of strategic decision making. Fast decision makers use simple yet powerful tactics to accelerate choices. They maintain constant watch over real-time operating information and rely on fast, comparative analysis of multiple alternatives to speed cognitive processing. They favor approaches to conflict resolution that are quick and yet maintain a cohesive group process (consensus with qualification). Slow decision makers become bogged down by the fruitless search for information, excessive development of alternatives, and paralysis in the face of conflict and uncertainty.

According to Paul (1989), more recent literature reviews point out that forms of participation are functional when the following conditions are present:

- The leader has the authority to make a decision.
- The decision can be made without stringent time limitation.
- Subordinates have the relevant knowledge to discuss and implement the decision.
- Subordinates' characteristics (values, attitudes, needs) are congruent with the decision to participate.
- The leader is skilled in the use of participative techniques. An underlying theme of participative leadership is self-control.

Carroll (2002) suggested that the decision-making field started to embrace sensemaking along with calculation (Wieck, 1995), pattern matching as well as choice models in naturalistic decision-making (Zsombok, 1997), expressions of identity that underlie preferences (March, 1994), and construction or improvisation in social practice (Lave, 1998).

To conclude, at any moment on any day, most executives are engaged in some aspect of decision making: either exchanging information, reviewing data, coming up with ideas, evaluating alternatives, implementing directives, or following up. The way a successful leader approaches the decision-making process changes, as they move up in the organization. They learn new skills and behaviors and change the way they use information to create and evaluate options. As it relates to my research, I am interested in the dynamics of the senior leadership decision-making process, which involves key strategic organizational decisions. Thus far, I have detailed the three

main dimensions of my research, which are values, leadership, and the decision-making process.

### ***Summary***

Consistent with the content of values literature, the overview has highlighted a number of issues and debates within the field. Although values is a popular area of study that is conducted at multiple levels of analysis employing a variety of methodological approaches, the values literature has tended to focus on a limited domain. Most of the studies thus far have focused on values and value congruence among leaders and organizations. With limited research on the specific values of senior executives in healthcare and on the dynamics of the decision-making process, my research focus will be on the values and value structure of senior executive leaders using a mixed method research method. In the following chapter, I will describe the methods used in my research study.

## **Chapter 3: Methodology**

### ***Research Approach***

The intent of this qualitative study is to discover and explore the value structure shared by senior executives in a complex healthcare environment and the role values play during decision-making and prioritization processes by using the grounded theory approach. This chapter explains the research setting, the research participants, and the rationale for using qualitative method-grounded theory. Data collection, the analysis process, and limitations of the study are also described.

### ***Methodological Considerations***

#### **Organizational selection**

The site for this qualitative research study was purposefully selected to help the researcher understand the problem and the research question noted by Creswell (2009). The research was conducted with the president and all members of the senior leaders in the organization referred to as the executive team (ET) at a small community-based healthcare organization in the Midwest.

#### **Research question**

As noted by Strauss and Corbin (1998), a research question includes the specific query that is addressed by this research and sets the parameters of the project while suggesting the methods to be used for data gathering and analysis. To achieve a balanced degree of objectivity, the researcher needs to achieve a certain degree of distance from the research materials and represent them fairly, as demonstrated by the

researcher's ability to listen to the words of respondents and to give them a voice independent of the researcher. And to maintain sensitivity, the researcher needs the ability to respond to the subtle nuances of, and cues to, meanings in data.

The study examines the competing values that exist among senior executive leaders in one healthcare setting. The participants for the interview are the president and the vice-presidents (VPs) of a major healthcare system in Midwest. The study was initiated by interviewing the president, who was asked to state the four major decisions that were made within the executive team within the past year and half. It was followed by interviews with the VPs to recapture the perspectives from the decisions that were made. And through narration and storytelling, the researcher attempted to study the values verbalized and demonstrated during the process.

The following questions were taken into account as the data were analyzed:

- What values exist among senior healthcare executives?
- Are these values shared?
- Do the values compete with one another?
- If and when values compete, how are decisions, especially decisions critical to the organization, made?
- What are the other variables that influence the decisions?
- What are the dynamics observed during challenges in the decision-making process?

**Qualitative method**

Methodology is defined by Strauss and Corbin (1998) as a way of thinking about and studying social reality, while the methods are a set of procedures and techniques for gathering and analyzing data. The primary method for this study is based on the grounded theory approach developed by Glaser and Strauss (1999).

**Grounded theory**

Grounded theory studies are focused on discovering a theory or a framework, describing or explaining a phenomenon under investigation, by analyzing data collected via field investigations using techniques such as interviews, case study, and observations. In the grounded theory approach, a researcher does not develop any testable hypothesis or propositions. Instead, he or she formulates a general question about the phenomenon that is of interest to the researcher and waits for patterns to emerge. Thereafter, the pattern is used to theorize or explain the phenomenon in detail. Although grounded theory provides a general framework, data collection varies based on the topic of study, availability and accessibility to data, and the expertise and preference of the individual researcher (Ardichvili, Mitchell, & Jondle, 2009).

According to Strauss and Corbin (1998), qualitative research is any type of research that produces findings that are not arrived at by traditional statistical procedures or other means of quantification. It can refer to a research about people's lives,

experiences, behaviors, emotions, feelings, organizational functioning, social movements, and cultural phenomenon.

### ***Data Collection***

In this study, qualitative data were collected using the key-informant interviews method proposed by Kumar, Stern, and Anderson (1993). Key-informant interviews are used when the identified individuals are key players in the organization and have the wherewithal of the whole organization. The researcher used quantitative data collected from the Rokeach Value Survey to initiate the conversations during the semi-structured interviews, although the actual interview questions were based on decisions (Appendix B: Interview Protocol). And along with the RVS, the researcher added another question regarding Balance Score Card (BSC) for the interviewees in the survey. The question requested the senior executive leaders to rank the performance perspectives of BSC in the order of importance to each of them. The results in the survey were used as additional input while discussing the results from the study. A sample of the Rokeach survey and the contents of BSC are included in Appendix A: Rokeach Value Survey.

With regards to the interview, I started the process by interviewing the hospital president first. I requested him to narrate the four most important decisions that he made with his senior executive team in the past year and half. He identified them as a) implementation of a safety culture, b) reduction of cost in the healthcare business, c) implementation of lean thinking (a lean model), and d) a decision to employ

physicians. Then for each decision made, he answered a set of semi-structured questions as referenced in Appendix B: Interview Protocol (President opening question). I continued with data collection by requesting the VPs to elaborate on the same four decisions noted by the president. These interview questions are also included in Appendix B: Interview Protocol (Other senior executive team). I have outlined in brief each decision identified by the president to identify its relevance to the healthcare organizations with a response on the decision's effectiveness as identified by the participants in a scale ranging from 1 (*low*) to 5 (*high*).

#### Implementation of a safe culture

The new mandate in healthcare is improved organizational performance in terms of safety, quality, and service. Though many hospitals are still struggling to adapt to this new requirement, some hospitals are already in this journey of performance excellence. These organizations deliver high-quality, safe services to satisfied patients and caregivers and the community. The hospital that I researched identified implementation of the safety culture as a priority decision, based on the following reasons. The safety culture plan includes multiple policies, processes, guidelines, and procedures with a goal to decrease patient harm by 80% over the next five years, on the way to *zero patient harm by 2020*. And almost the entire executive group rated the current effectiveness of this decision with a median of 4 out of a possible score of 5.

#### Reduction of cost in healthcare

According to the American College of Healthcare Executives' annual survey of top issues confronting hospitals, financial challenges were reported to be the top concern



in 2013. With healthcare reform, federal budget deficit, increase in the cost of supplies, and skilled labor, it has become essential for healthcare organizations to do more with less. Hence “reduction of cost” through various means is a “must do” for all organizations. The participants in my research listed it as one of their strategic decisions, and although the decision has multiple tentacles, the specificity of the initiative in this context revolves around “hiring freeze” and “restructuring” efforts. With regards to the effectiveness of the decision, the median score out of a possible score of 5 was 4 among the participants.

#### Implementation of lean thinking

The current “do-more with-less” economy has created many job frustrations. More and more organizations are looking at efficiency tactics to address this deficit, while implementing standardized, repeatable processes. The inefficiency has been related to problems like waste, overproduction, repetitive processes, increased cycle time, and errors or faulty items. The participants in my study made a complex decision to implement the “lean model” to improve its processes, increase efficiency, and decrease waste, thus leading to improved quality, safety, and service. This initiative among the healthcare organizations was still considered innovative and risk taking because the long-term outcomes are not available in the literature. When questioned about the effectiveness of the decision, the participants’ median response was 3.5, and the explanation was that the initiative was in the early stages of implementation.

### Decision to employ physicians

Hospital executives and physicians have always been aware of their symbiotic relationship. This competitive yet complementary relationship has made hospital physician engagement an utmost challenge for the executives. But the need for greater integration between physicians and hospitals is of immense importance today because of increasing financial pressures for both groups. As patients, employers, and payers demand greater value and transparency with healthcare services, hospital executives and physicians recognize that a long-term, mutually successful relationship is essential. The participants from my research indicated that the decision to hire physicians and employ physicians groups was vital to their success and sustainability and was hence a strategic decision. This was the only decision for which the team rated the effectiveness with a median score of only 3 out of 5. Almost all of them identified the immediate necessity to amplify the speed to remain competitive within its environment.

### Interview protocol

A semi-structured interview was conducted with each participant. This interview had open-ended questions and lasted approximately 1.5 hours. The interview content was audiotaped and later transcribed. The protocol included the following:

- Interview consent form (Appendix C)
- A heading (date, place, interviewer, interviewee)
- Instructions for the interviewer to follow so that standard procedures were used from one interview to another

- The questions (typically an ice-breaker question, followed by a set of 4 to 5 sub questions that were related to the research question, and then a concluding question)
- Probes for the 4 to 5 sub questions, asking individuals to explain their ideas in more detail or elaborate on what they have said
- Space between the questions to record responses
- A final thank-you statement to acknowledge the time the interviewee spent during the interview

The rich qualitative interview data were coded according to the method outlined by Gioia, Corley, and Hamilton (2013). Coding is broadly defined as an analytic process through which data are fractured, conceptualized, and integrated to form theory. As noted by Gioia et al. (2013), “Studying social construction processes implies that we focus more on the means by which organization members go about constructing and understanding their experiences and less on the number or frequency of measurable occurrences” (p. 2).

### ***Data Analysis***

For the quantitative component of the study (Rokeach Value Survey results), simple descriptive analysis was undertaken. Measures of central tendency and dispersion are presented as mean (+/- standard deviation) if the values are normally distributed and as median (interquartile range) if they are non-normally distributed. For the

qualitative component of the study, the analytic method was qualitative analysis by grounded theory.

Grounded theory calls for three levels of coding first-order concepts, second-order themes, and aggregate dimensions. Per Strauss and Corbin (1998), coding is a dynamic and fluid process. Details of the different types of coding are explained in the next few pages. Upon reading the transcribed interview data, I developed 62 first-order codes (which included 21 *in-vivo* codes), and each one of them had a specific description. A description is the use of words to convey a mental image of an event, a piece of scenery, a scene, an experience, an emotion, or a sensation from the perspective of the person doing the depicting. I used Dedoose (<http://www.dedoose.com>), a qualitative analysis software application to organize the data and create subsets, called conceptual ordering, whereby the data were further organized according to a selective and specified set of properties and their dimensions. Properties are characteristics of a category, the delineation of which defines and gives it meaning, and dimensions give specification to a category and variation to the theory across the range along which general properties of a category vary. Conceptual ordering allowed me to focus better while looking for any emerging patterns, called theorizing. According to Strauss and Corbin (1998), “Theorizing is work that entails not only conceiving or intuiting ideas (concepts) but also formulating them into a logical, systematic, and explanatory scheme” (p. 21). A theory is a set of well-developed concepts related through statements of relationship,

which together constitute an integrated framework that can be used to explain or predict phenomena. As noted by Gioia et al. (2006), “The key question for us as model builders is how to account for not only all the major emergent concepts, themes, and dimensions, but also for their dynamic interrelationships” (p. 8).

Qualitative analysis is also done by clustering, where a diagram of relationship can be created from the codes developed. The inference data is used to theorize, and a pattern is created based on the general research question. As noted in Creswell (2009), it was an ongoing process by involving continual reflection about the data, analyzing reports, and writing memos. It also includes looking for themes or perspectives and generating categories of information. As detailed by Creswell (2009) below, a systematic approach was used with the qualitative data:

- Organize and prepare the data for analysis.
- Read through all the data.
- Begin detailed process by coding.
- Interrelate the themes and descriptions.
- Finally, interpret the meaning of themes and descriptions.

Gioia et al. state:

The intent of the findings section is to narrate an informative story . . . with the careful presentation of evidence . . . In the findings narrative, we devote space to explaining each emergent theme and/or dimension, but more importantly, we “zoom in” on the key emergent new concepts or themes and hold them up for examination as the core ideas of a given paper. (2013, p. 9)

In the following chapter, inspired by Gioia et al., I will present findings from my data analysis by creating integrated frameworks or models to explain the research phenomenon.

## Chapter 4: Results

### **Overview**

The results section encompasses the findings from this research based on the chain of evidence while including the validity and reliability of the research. It includes category concepts derived from open coding, axial coding, and selective coding. I have used multiple mini frameworks (Strauss & Corbin, 1998), or logic diagrams, to create a chain of evidence while presenting the finding in the form of a visual model. The results section also describes the quantitative indicator: the results of the RVS demonstrating the similarity of the participants' value index.

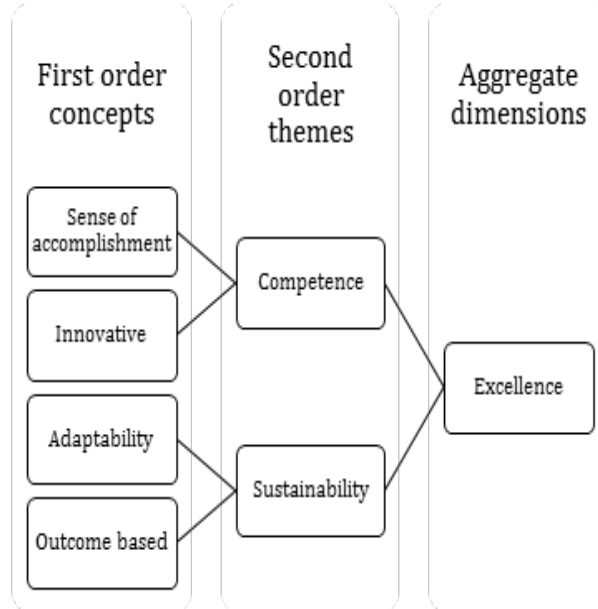
### **Open coding**

Open coding is an analytic process through which concepts are identified and their properties and dimensions are discovered in data. The researcher is concerned with generating categories and their properties while determining how these categories vary along their dimensions. Upon reading the interview transcripts and prior knowledge from literature review, I developed 62 value codes, including humility, gratitude, sense of duty, inclusive, common goal, adaptability, decisive, visionary, etc. The definitions of the value codes can be seen in Appendix D: Code Definitions. During this process, some of the value codes were *in vivo* codes. An *in vivo* code is created when “when the name of the code may be taken from the words of respondents themselves” (Glaser & Strauss, 1999, p. 105). Approximately 20 of the 62 codes were *in vivo* codes, such as partnership, trust, consensus, sustainability,

commitment, and optimism (the definitions of all the codes as aggregate dimensions are referenced in Appendix D: Code Definitions).

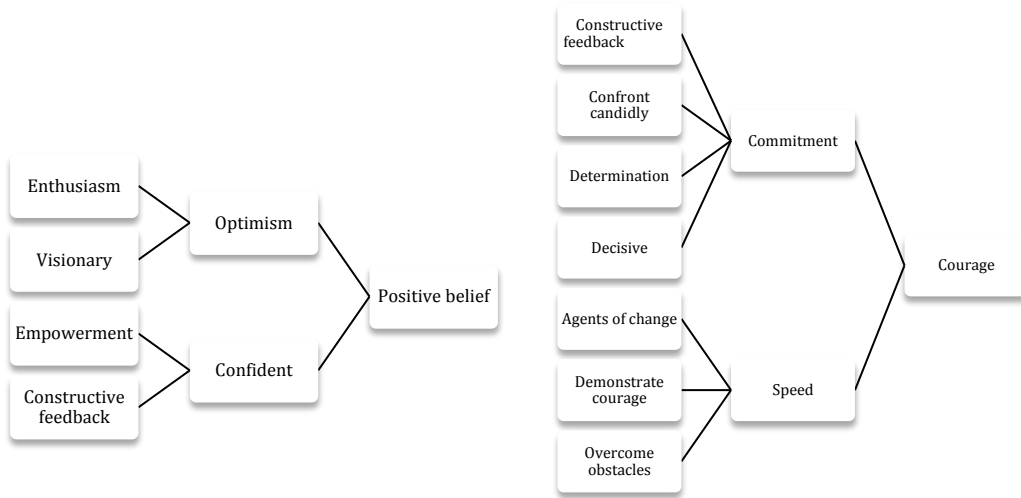
Though there are different ways of open coding, I used the line-by-line analysis. Strauss and Corbin (1998) describe this approach as the most time-consuming form of coding but often the most generative. Also, during this process, data are broken down into discrete parts, closely examined, and compared for similarities and differences. Events, happenings, objects, and actions/interactions that are found to be conceptually similar in nature or related in meaning are grouped under more abstract concepts termed “categories.” As a beginning researcher, the detailed lists of codes were overwhelming. Hence I took a closer examination of data for both differences and similarities, which allowed for fine discrimination and differentiation among categories. A category in qualitative research is also called “theme.” They are broad units of information that consist of several codes that are aggregated to create a central idea. Figure 3 shows an example of identifying a theme thereby creating a “data structure,” an approach based on Gioia (2012).



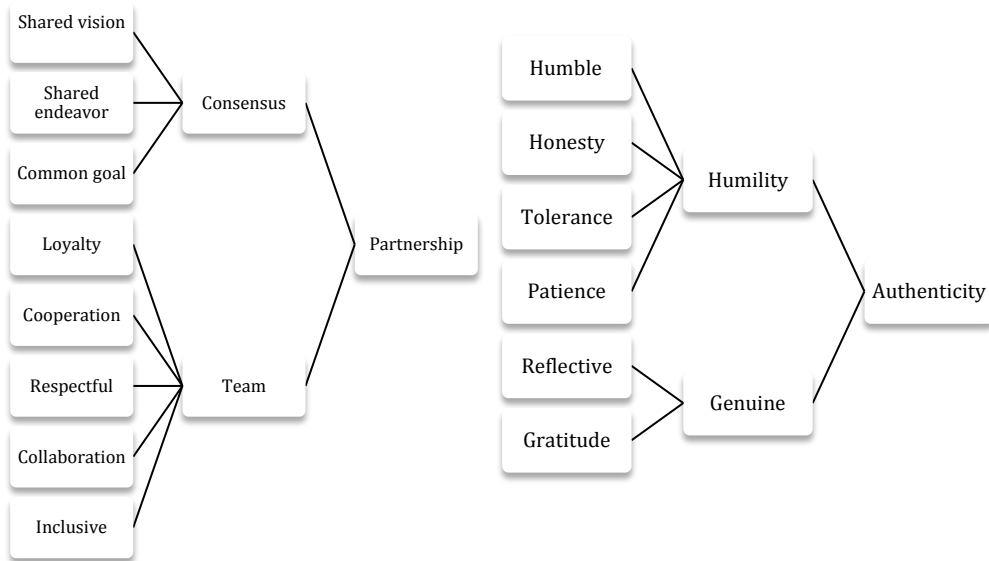


**Figure 3. Data Structure (Excellence)**

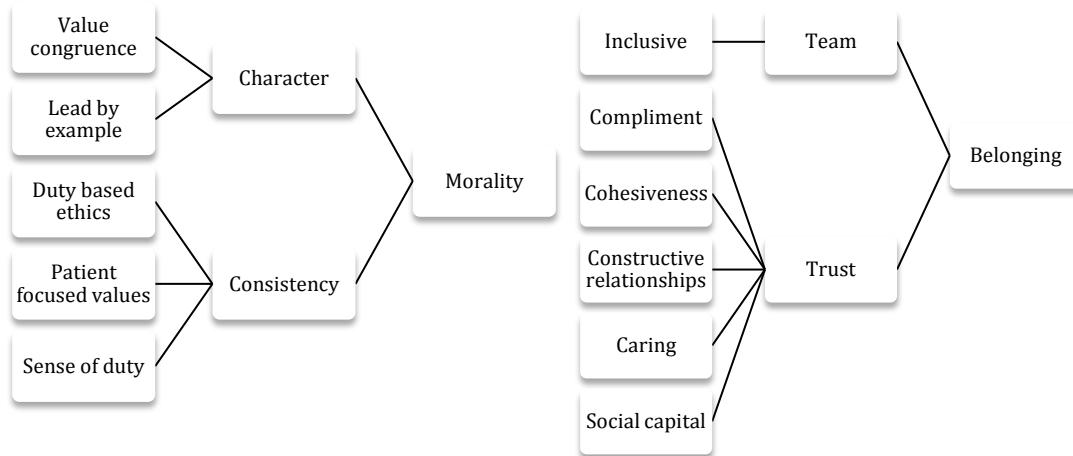
The data structures in Figure 3, Figure 4, Figure 5, and Figure 6 illustrate how the concepts were grouped to identify the themes, which led to the seven aggregate dimensions excellence, positive belief, courage, partnership, authenticity, morality and belonging.



**Figure 4. Data Structure (Courage and Positive Belief)**



**Figure 5. Data Structure (Partnership and Authenticity)**



**Figure 6. Data Structure (Morality and Belonging)**

Grouping these codes into categories enabled me to reduce the data to seven categories and then further reduce it to four major subcategories. Creswell (2013) describes this process as winnowing the data, reducing them to smaller, manageable set of themes thereby allowing me to create aggregate dimensions. I used this process of data aggregation with all 62 codes, resulting in seven aggregate dimensions, as noted in Figure 3.

### **Axial coding**

The purpose of axial coding is to begin the process of reassembling data that were fractured during open coding. In axial coding, categories are systematically developed to create a link with the subcategories to form more precise and complete explanations about phenomena. The actual linking takes place not descriptively but

rather at a conceptual level. The analyst looks for answers to questions such as why or how come, where, when, how, and with what results, which allows one to relate structure and process. A structure or condition creates the circumstances in which problems, issues, happenings, or events pertaining to a phenomenon are situated or arise, thereby setting the stage. Whereas process denotes the action/interaction over time of persons, organizations, and communities in response to certain problems and issues. To integrate structure and process and to gain an understanding of phenomena, I used an analytical tool called “Paradigm” as noted by Strauss and Corbin (1998). The basic components of the paradigm are as follows: a) Conditions: a conceptual way of grouping answers to the questions why, where, how come, and when; b) Actions/interactions: a routine or strategic responses made by individuals to issues, problems that arise under those conditions; generally answered by whom and how; c) Consequences: questions as to what happens as a result of those actions/interactions.

Similar to open coding, I recoded the data for repeated patterns of happenings, events, or actions/interactions that represent what people do or say, alone or together, in response to the problems and situations in which they find themselves. This process resulted in a phenomena led to the creation of four code families. A code family provides answers to generative questions: when, how, where, why, and with what results, while developing relationships of concepts within the data. Code families allowed me to handle mass amounts of data while generating both specific and *in vivo*

codes and quotations (latter is original text from the primary document). In total, I created five code families as identified in Table 3.

**Table 3. Code Families**

<b>Code Family</b>	<b>Description</b>
Situation	The four decisions, as identified by the president
Stakeholders	Leaders, employees, patients, community members, regulatory bodies
Values and norms	Values identified by the leaders, and the background norms that existed
Decision-making process	Both during consensus and challenges (agreement/disagreement)
Outcome	Effectiveness as identified and rated by the leaders on the four instances

Upon identifying the code families, I reviewed the data again to further explore the quotes that relate to each of the code family. This process led to *code scaffolding* (Di Virgilio, 2005 pp. 61–62) around the data, thus allowing sensemaking, conceptualizing of the primary phenomenon of research. Table 4 demonstrates an example of a code scaffolding application. I have used direct quotes from the participants to explain the values/norms, consensus, and outcome/effectiveness as identified by the participants.

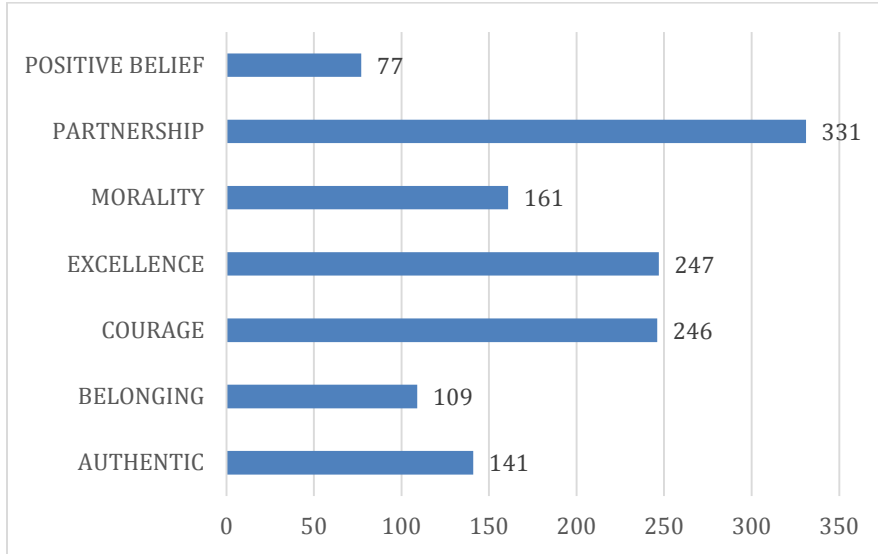
**Table 4. Code Scaffolding**

<b>Situation</b>	Implementation of safety culture
<b>Stakeholders</b>	Leaders, patients and community
<b>Values and norms</b>	“We are all here for the patients, it’s our service. And the last thing we want to do is lose the confidence of our patients and our community and our goal is to set up enough barriers or processes or can’t fails between the humans and the treatment to make sure that no harm is done.”
<b>Decision-making process</b>	“Obviously we are all here for our patients and our community. I don’t think we had any challenges within our team. The biggest challenge is trying to enroll other leaders in believing that we need to spend as much time talking about this.”
<b>Outcome</b>	“I am 100% on board with this, and in a scale of one to five, I would say it’s a four in effectiveness. We had a great safety culture to begin with, and this is trying to move the needle just a little bit further north.”

To keep the context and meaning relevant to the data, I continued to create memos simultaneously that were used during the axial coding process. And to further sort out the complex relationships among conditions, I followed Strauss and Corbin’s (1998) recommendation to develop the following labels to place on conditions: a) Causal conditions: usually representing set of events or happenings that influence phenomena b) Intervening conditions: those that mitigate or otherwise alter the impact of causal conditions on phenomena c) Contextual conditions: arises out of contingencies, which in turn must be responded to through an action/interaction. Analysis of categories is a process of deduction. Deduction is dependent on the researcher’s reading of the data content, along with assumptions about nature of life, literature reviewed, and the

discussions with the team. And at some point, per Strauss and Corbin (1998), the researcher reaches a point of saturation, where no new information emerges from the data, such as no new properties, dimensions, conditions, actions/interactions, or consequences.

As illustrated by Glaser and Strauss (1999), codes, code families, and memos are entities used to conceptualize, develop meaning, and build the story. They are key inputs for axial coding and pave the way for constant and theoretical comparisons. With the conditions in place, I created a pathway of event occurrence for one of the four instances, which aided in applying the same for others. The Dedoose software (<http://www.dedoose.com>) also helped me organize the top seven values from the data (as identified in Figure 7), where the X axis indicates the total number of values in the data among all the participants, the Y axis indicates the name of value, and analyzing the quotations led to a clarity of themes. The definitions of the following values are noted in Appendix D: Code Definitions.



**Figure 7. Frequency of Leaders' Values**

The relationship between the various concepts allowed me to create mini frameworks and conceptual diagrams. Mini frameworks are small, diagrammatic theoretical structures that arise as a result of coding among concepts and conditions. In this case, I was able to identify the inputs, leaders' prioritization process in decision making, and the outcomes, which led to the next process "selective coding."

### **Selective coding**

*Selective coding* is the process of integrating and refining the theory, thereby creating a larger theoretical scheme resulting in the research findings taking the form of theory. Integration is an interaction between the researcher and the data, an analytic gestalt, based on the evolution of thoughts derived from the immersion in data, and the successive findings from memos and diagrammatic representations. Upon analyzing the relationships of concepts, the researcher identifies and develops a



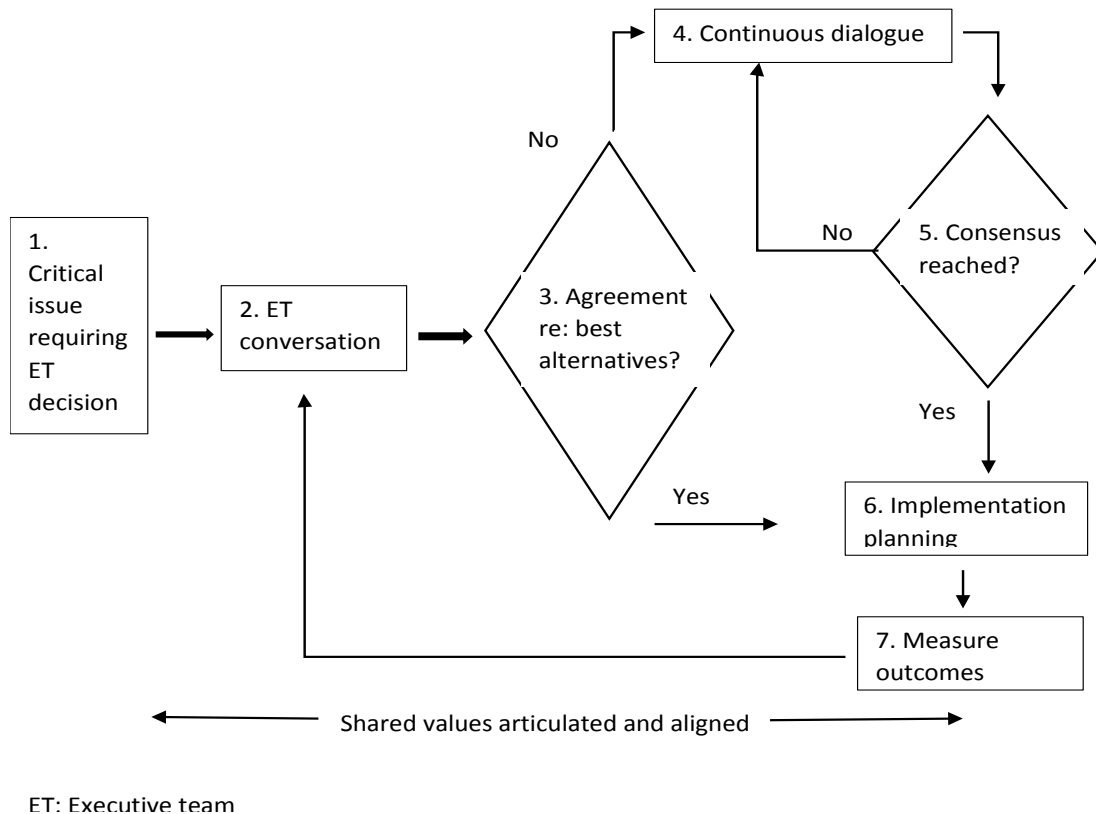
central core category, which might evolve from existing concepts or as a result of a conceptual idea that evolved from the collection of concepts. A category is an abstraction where the data is abstracted to several highly conceptual terms that represent the main theme of the research. I created a visual category diagram for each of the decisions addressed by the participants, as noted in Appendix E: Category Models (see Figure 15, Figure 16, Figure 17, and Figure 18). Per Strauss and Corbin (1998, p. 147), a central category has six criteria as seen in Table 5.

**Table 5. Criteria for choosing a Central Category**

<b>1</b>	It must be central, that is, all other major categories can be related to it.
<b>2</b>	It must appear frequently in the data. This means that within all or almost all cases, there are indicators that point to that concept.
<b>3</b>	The explanation that evolves by relating the categories is logical and consistent. There is no forcing of data.
<b>4</b>	The name of the phrase used to describe the central category should be sufficiently abstract that it can be used to do research in other substantive areas, leading to the development of a more general theory.
<b>5</b>	As the concept is refined analytically through integration with other concepts, the theory grows in depth and explanatory power.
<b>6</b>	The concept is able to explain variation, as well as the main point made by the data; that is, when conditions vary, the explanation still holds, although the way in which a phenomenon is expressed might look somewhat different. One also should be able to explain contradictory or alternative cases in terms of that central idea.

According to Strauss and Corbin (1998), there are several methods in developing a core category. It is a process of moving from description to conceptualization. I

reread the original interview content, looking for an emerging thought or idea. Being a practitioner, as well a research student, I was looking at details and unable to visualize the core category. I brainstormed with my dissertation chair, who helped me to look at the large abstract picture, rather than the details. With this level of analysis, I created visual representation of the sequence of stories. According to Strauss and Corbin (1998), the integrative diagrams represent data and major concepts rather than the details, but they flow with a logic approach, require minimal explanation, and thus lead to the central category diagram in Figure 8.



**Figure 8. Central Category Diagram**

Based on the data, identified in box 1 that all four critical issues required decisions to be made at the executive leader level. Upon making the decisions, the executive team continued to discuss the details in recurrent conversations, as noted in box 2. In those conversations, they contemplated the best alternatives (box 3). If they agreed on a best option, they proceeded with planning and implementation (box 6). If they disagreed during conversations, the leaders continued with further dialogue (box 4), indicating a presence of shared values and norms based on interview data, which led to consensus (box 5). In the absence of consensus, the team continued with discussion and dialogue, a cyclic pattern until consensus was reached (box 5). Upon reaching consensus, the team started with planning and implementation of the decision, while measuring effectiveness by outcomes. Despite positive outcomes, the team continued to have ongoing conversations, dialogue, and discussion to improve processes as evidenced by the diagram. In the event of negative outcomes, the team engaged in a similar process with additional discussion to revise the strategy. The central category diagram (Figure 8) represents this process as dynamic and cyclical in nature.

During the entire process, the leaders articulated their shared values and demonstrated their alignment to personal values as evidenced by the following quote:

I am thrilled to work in this organization. When you talk about values, the biggest thing is, it is in alignment with my own values; and that's probably the most attractive thing about the work that I do. It's the manner in which we do it that resonates with me . . . so while we are looking at managing costs, it's more than managing. It's really a

reduction, and the thoughtful review of where is it going to come from so that we don't compromise quality, service and we remain true to those organizational values

As a way to support the diagram, I looked back at the memos and concepts, while answering the following leading questions from the interview data. The interview questions listed below were designed to seek a response, though not questioned directly. The actual interview questions are included in Appendix B: Interview Protocol.

- What values exist among senior healthcare executives?
- Are these values shared?
- Do the values compete with one another?
- If and when values compete, how are decisions, especially decisions critical to the organization, made?
- What are the other variables that influence the decisions?
- What are the dynamics observed during challenges in the decision-making process?

Decision making is also a complex yet dynamic process. According to complexity theory, it “is concerned with the behavior of systems with seemingly irresistible escalation in their intricacy and the cumulative impact of this evolution” (as cited in McKenna & Martin-Smith, 2005, p. 824). Social behavior is unpredictable, and interaction among the team members is complicated. But Maier (2005) stated that the

concept of a group's "acceptance of decision" as a variable points out the importance of satisfying the needs of the group, as well as in achieving the organizational goal (p. 43). And this acceptance of decision as a team is called consensus. Consensus is difficult to achieve unless the team develops trust and loyalty in their relationship. Collaborative endeavors require conversation, discussion, and contemplation from all participants about the nature of their roles and others (Kim & Strudler, 2012).

Based on the central category diagram, the leaders during decision making are involved in a series of discussion and dialogue. Because they are making critical decisions, the leaders have both agreements and disagreements. To reach consensus, they engage in conversation that is influenced by their norms, assets, and limitations; organizational strategy; priorities; and available resources. Some external factors that possibly influence this process are the organizational culture and values, which are beyond the scope of this study. The process appears to be a dynamic and fluid process that is ongoing to create consensus among the team members.

As suggested by Creswell (2013), I will present segments of actual data by quotes and vignettes in the following few paragraphs to show the relationship of the data to my category diagram. The quotes will demonstrate the dynamics, including discussion, dialogue, and conversation observed during the decision-making process. They also reveal the presence of other factors, such as a leader's articulation and the alignment

of values and norms, both during consensus and during challenges of the four decisions.

#### Implementation of the safety culture

In the healthcare industry, the prominent external variables includes the healthcare reform, pay-for-performance or values-based healthcare, and population health. There is a drive towards quality improvement, safety, and patient-centered care in all levels of providers. The following quote from one leader describes the reason for making this decision a system strategy as well as a mandate.

Implementation of the safety culture: the reason I left that one for last is, I'm not so sure how much of that was an actual choice. So I guess what made the decision important, is the fact that the Institute for Healthcare Improvement came out and showed, how many people were being killed in hospitals every year. Approximately 100,000 Americans die by mistakes in hospitals every year. People just never get on a plane assuming that, you, God forbid, I should be on the one that's going to crash. I don't think people enter a hospital thinking, I'm going to end up with an infection, someone's not going to pay attention to me, I'm going to be overmedicated, I'm going to be under-medicated, and something is going to happen to me, and I'm going to die. I don't think people do that. I think people assume they're going to come into hospitals, and everything is going to go perfect and take care of them. Our goal here is to reduce harm by 80% in the next five, on the way to zero patient harm in 2020.

The above quote also indicates the expectation of the stakeholders of increased safety in the hospitals as well the data indicating a need for change. Going further, as noted by another leader, the implementation of safety culture was a “no brainer” and aligned with organizational mission, which demonstrates the leaders' values and norms.

Specifically we've been on a journey, a Good to Great journey for many years. And that Good to Great journey emphasizes providing an exceptional patient experience marked by superior health outcomes. And you cannot maintain that superior outcomes if you are not all over safety and really making that a focus. I think health outcomes is the number one, it is the product we make at our organization, and certainly, safe care is an important part of that product.

Though the leaders demonstrated a high level of consensus with this decision, as most of them referred to it as “the right thing to do,” they did mention a few challenges.

The leaders employed the tactic of “discussion and dialogue” while reiterating their shared vision and implemented a methodology that they could all agree. The following quote also describes their reference to their hierarchical structure during decision making:

With regards to safety, we had to make some decisions around the reporting structure and where that best fit. So that was challenging. We also had to make a decision on what level in the organization that role needed to be at, whether it was a director or manager. And that got resolved through consensus. We do a lot of challenging of each other and discussion back and forth, and then we land on a decision. And, we're all pretty familiar with supporting whatever decisions are made because we make them as a team, and we all then live by the decisions that we make.

#### Reduction of cost

Healthcare in recent years has been going through profound changes, requiring organizations and leaders to be resilient, adaptable, and innovative while being mindful of the individual, professional, and organizational practices. The industry-related rapid changes in the environment have led the healthcare industry to be mindful of its long-term sustainability, and the major decisional consideration has been “reduction of cost.”

The following quote describes the impact of external healthcare changes on decreasing cost and developing a systematic, process-oriented culture.

So reduction in cost, yeah, this is a decision that's vital for what's going on in our industry. Arguably, there's been changes in the environment that requires hospitals and healthcare providers to ultimately provide a lower cost option. Patients are now much more financially responsible for their healthcare than they ever were, which means no one cared what they paid, because you just paid a copay. Now with co-insurance and other products out on the market, how we compete is largely based on our cost structure, meaning in order for us to sustain ourselves, we're getting paid less for the same services that we've been providing from different payers and our other end-point customers

The organization's internal strategy for addressing this decision was by implementing a restructuring process. According to the leaders, this decision had multiple challenges because of its impact on strategy, resources, and a design process. The following quote describes how the leaders' alignment with values, despite stressful decision-making challenges, played a major role and led to a consensus.

I am thrilled to work in this organization. When you talk about values, the biggest thing is, it is in alignment with my own values; and that's probably the most attractive thing about the work that I do. It's the manner in which we do it that resonates with me . . . so while we are looking at managing costs, it's more than managing. It's really a reduction, and the thoughtful review of where is it going to come from so that we don't compromise quality, service and we remain true to those organizational values. . . I still remember this, very vividly when we talked about our first round of cost reductions, probably when we had to really get serious about this, when was it, a year ago last February. I remember the president teeing up the conversation and then one of the VP saying, now how do we do this with respecting our MVP and our behaviors of excellence? I mean, we're going to be dealing with people's jobs and their lives. . . .But we very carefully



and purposefully looked at all the data to determine, what our current state was and what the target state was, knowing the changes that are coming, and putting plans in place to ensure that we can sustain our financial position and at the same time living our mission, values and philosophy. And the most priority is taking care of those patients that we serve.

Consistent with the central category diagram in Figure 8, the leaders incorporated discussion and dialogue with this decision, but their commitment to their stakeholders stayed at the forefront of this decision, which indicates their values of partnership and belonging as noted in one leader's comments: "With regards to cost, it's sustainability. And when our mission is to serve our community and serve those patients, we cannot continue to serve our community if we go broke and this hospital closes."

These quotes indicate that the leaders have made strategic decisions based on the external and internal industry related variables, while being mindful of the individual and organizational values and mission. The next decision as identified from the data is on the lean model.

#### Implementation of lean thinking

To counteract the changes in the environment, the organization engages in strategic planning process and implements innovative tactics. In this research, the leaders describe going through an organizational journey, to improve the service culture, excellence culture, and now a process culture. The following quotes describe the

organizational strategy in this journey but also clearly describe the values-based norm that exists in the culture as these decisions are implemented.

As it relates to Lean, the values that drove that were associate engagement and stewardship. So there's a couple ways to take costs out. Unfortunately, the most common way to take cost out is across-the-board expense reductions, which lock in the inefficiencies and the current way we do things. We chose a method where our associates and physicians will actually help us to design out waste so we can improve our outcomes at a more affordable cost.

As noted by Ardichvili et al. (2009, p. 450), leadership—most notably senior management—must embody the values in a way that is compelling for all stakeholders. The above quote clearly indicates the perspective of a senior leader's alignment of values and mission. In the presence of challenges, the tactics used in this decision were the methodology, but the senior leaders' involvement in the process by making it a priority was a significant attribute, which is as detailed below:

Each of us committed to our place in terms of executive sponsorship, our place in terms of role modeling, with Gemba time and being involved in the report-outs and, again, just being present in a way that showed the rest of the team that it is a priority.

The final decision implemented was the hiring of physicians and employment of physician groups.

#### Decision to employ physicians

The example below describes the leaders' consensus process during one of the other key decisions, employing physicians. The following quote describes their

disagreements during the process and how they implemented the tactic of prioritization to move ahead with the decision.

Purchasing the practice, and employing the physicians, to ensure that we have fiscal viability going forward . . . I don't want to say it's the challenges among the executive team, as much as it's amongst the system. And who do we go after first, how many do we buy, where are they located, those kind of things.

Although disagreements existed, the team demonstrated its mindfulness of the value of partnership in this decision.

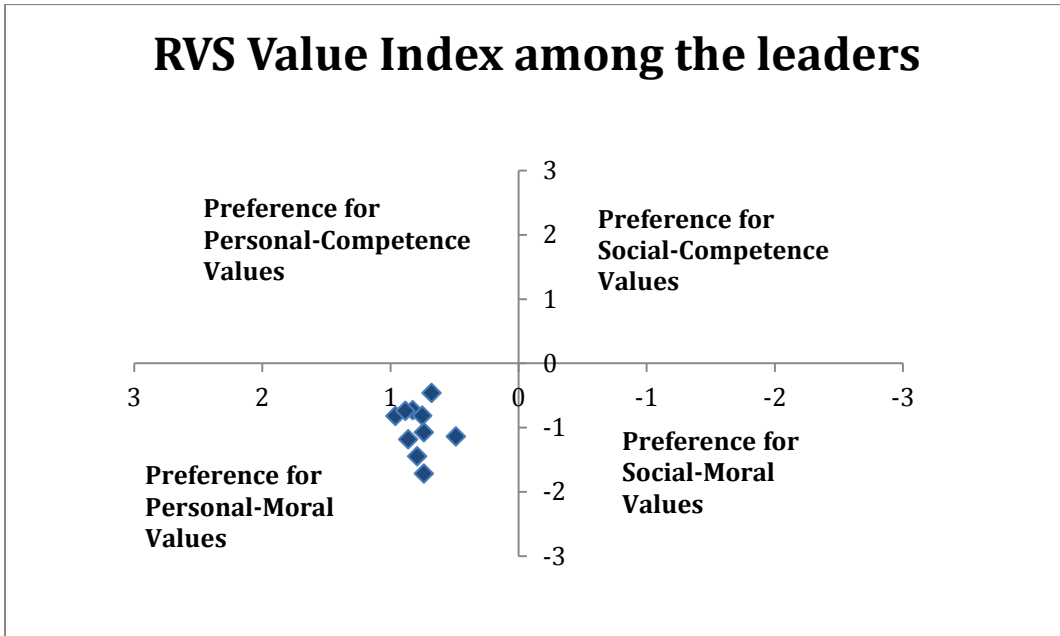
Employing physicians, the nature of healthcare is such that probably five years from today, the vast majority of physicians will be employed by either a multispecialty medical group or a not-for-profit hospital. So we want to be able to offer our doctors the option of being employed. And employing doctors, really is the value of partnership. We cannot provide great healthcare without physicians who are economically and professionally successful, so partnership really drove that decision. . . . The whole idea of the value of partnership with our physicians. We've always done that with our independent physicians, but now looking at the changing environment and needing to partner in a different way with our docs beyond our PHO into an employment relationship. . . . If we are going to continue to be an organization that is financially viable, we are going to have to hire physicians.

Apart from the qualitative results, I used Rokeach Value Survey with all participants prior to key informant interviews. The result from the quantitative aspect of the study follows.

### **Rokeach Value Survey (RVS) results**

Additional important findings from the quantitative component of this study were the results from the Rokeach Value Survey. As noted in Chapter 3, I had sent the RVS to

the participants prior to the interviews. The data were used to initiate the conversation during the key informant interviews, leading to a rich qualitative database. The results from RVS indicated a strong preference for “personal-moral values,” which means that the leaders have a personal commitment to values instead of to an external authority. These personal-moral values, usually considered virtues or good personal qualities, were a key finding in this research. A unique and unexpected result was that all the participants from the study scored the same, as seen in Figure 9 with similar orientation of values.



**Figure 9. RVS Value Index of the Participants**

There appears to be synchronicity within the leadership teams on their individual value proposition, which could justify the reason for high consensus among the team.

The sample size was predominantly of similar ethnicity, while the gender

participation was 6:4 (female: male). Because the values were not normally distributed, median (interquartile range) is presented for all question items as noted in Table 6. For terminal value score, a positive sum indicates a “personal” orientation, and a negative sum indicates a “social” orientation. The individual distribution of terminal and instrumental values for all the participants is included in Appendix F: RVS Results (see Table 7 and Table 8).

**Table 6. Distribution of Terminal and Instrumental Values on Rokeach Value Survey among ET, 2013**

<b>Parameter</b>	<b>Mean (<math>\pm</math>S.D.)</b>	<b>Median (25<sup>th</sup> &amp; 75<sup>th</sup> centiles)</b>
Terminal Value (n=10)	0.77 ( $\pm$ 0.13)	0.77 (0.72, 0.87)
Instrumental Value (n=10)	-0.95 ( $\pm$ 0.22)	-0.98 (-1.1, -.74)

The similarity in results creates the possibilities of various questions: Is this a unique setting? Is it an artifact of healthcare institutions-hospitals? Is it the culture of this specific hospital? Or is it the culture of this specific group of leaders? The results also raise the question of whether the hiring practices, promotion/succession practices, leadership development processes, and performance management systems were influential. The literature review showed that RVS was used globally, although most uses were studies related to college students, adolescents, teachers, politicians, gender, generation, and nationality differences and none were specific to leaders in healthcare.

Garavan, Saha, and Cseh (2008) suggested in their study that Canadian line managers with high “personal values” orientation influenced decision making and had minimal impact on training and development. As noted above, a literature search did not reveal any other studies related specifically to business leaders in healthcare. In the following few paragraphs, I will use direct participant quotes and anecdotes to indicate the presence of such values and norms within the executive team.

### **Values and norms**

According to Schein (2010), the culture of a group is a pattern of shared basic assumptions learned by a group as it solved its problems of external adaptation and internal integration, which has worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. There are three different levels of culture: artifacts, espoused beliefs and values, and basic underlying assumptions. Values are the social principles, goals, and standards that cultural members believe have intrinsic worth. They define what the members of a culture care about most and are revealed by their priorities as evidenced in the following quote.

Again, we all can name MVP as those values, excellence, stewardship, compassion, partnership, and equality is the simplest way to value that, to be respectful of people’s culture and religious traditions, diversity. I think additionally, there are values that are in play that might not be spoken as clearly.

With the following quotes and summary, I propose that the leaders set the stage and create an environment where the senior leaders use values and norms to assist with

key decision making. As noted in Figure 9, and as evident from the following direct quote by the president, it is obvious how he sets the stage during key decision making while creating an organizational climate that nurtures values.

I would like to add that much of America has gone through great challenges since June of 2007, when the recession started. And although the recession technically ended in June of 2009, here we are, four years after that, and there's still 7.6% of Americans without a job. Illinois' unemployment rate just ticked up again to 9.2%. Chicago's unemployment rate is 10.4%. I do agree with Jim Collins' observations in his book *Great by Choice*, the new normal for the world and for America is more instability, more unpredictability, more challenges in the business world. And so my commitment, from a value's perspective, is to do everything that I can, from a basis of fairness, compassion and wisdom, and to the extent that when people do lose jobs, to help them find work elsewhere within the system, and if not here, even outside of the system. So the nature of healthcare is simply going to become more challenging.

It is evident that all decisions are made by explaining the context, through storytelling, rhetoric, and social cues, while making a connection to the individual and organizational values and mission. Two senior leaders in the organization refer to his context as follows:

The messaging from the president of the entire organization has included, not only are we first and foremost a clinical enterprise, but now it's, we are first and foremost a safe clinical enterprise, so again, that whole vision and messaging around patient safety. So the values in that really are around excellence, you know, providing excellent care for our patients.

Nonetheless, the high-level communication both from system and our organization helps the decisions, even the very difficult ones, become as effective as possible because of the way in which our leadership, particularly our president, sets the context, communicates the context,

and then how the decisions come as a result of the context that he's described.

During my interviews with the participants, I noticed that the leaders' model the positive behavior so that the members of the organization are made aware of the priorities, which results in an alignment of values and mission. The following quote exemplifies the role modelling by senior leaders:

Each of us committed to our place in terms of executive sponsorship, our place in terms of role modeling, with Gemba time and being involved in the report-outs and, again, just being present in a way that showed the rest of the team that it is a priority.

Apart from role modeling, the senior leaders participate in a series of discussions and dialogue during decision making to create consensus. Flood (2000) found that the leadership style of the CEO was related to perceptions of team effectiveness. He argues that a leader who motivates his team to transcend his own self-interest to achieve the common goals of the organization is usually effective in getting consensus among his senior executive team. In doing so, the team finds meaning and purpose to its work. In this research, the presence of values among the senior leaders is evident from the following direct quotes, and the common goal for the team is reduction of cost.

I still remember this, very vividly when we talked about our first round of cost reductions, probably when we had to really get serious about this, when was it, a year ago last February. I remember the president teeing up the conversation and then one of the VP saying, now how do we do this with respecting our MVP and our behaviors of excellence? I mean, we're going to be dealing with people's jobs and their lives.



Labor is our biggest cost in healthcare, and so I think the value of compassion has been critically important as we went into our redesign of some areas last summer. I think we put our MVP right up there in the front of it all and tried to make decisions with compassion in mind for the people that, serve our patients and what those changes would be like for their lives.

As mentioned before, Schein (2010) also indicated the presence of norms in organizational culture. Norms are expression of values. They are unwritten rules that allow members of a culture to know what is expected of them in a wide variety of situations, including how to coordinate their behavior with that of others. Norms communicate expectations regarding different types of social behavior, and the social behavior related to consensus was discussed in the past few paragraphs. Based on literature, the norms that produce the greatest success will survive. This research offers evidence of a senior leadership team background norm that appears to have developed because of intimacy and shared leadership, not because of authority, as seen in the quote below.

How the team went about making those decisions, again, was to really have an open conversation and dialogue. One of the things I like about our executive team is the very open, frank, honest conversation. And everybody is able to bring their best stuff to the table to say, here's why I think we should go in this direction or that direction. So the talent pool, the multiple voices, and even to draw in voices sometimes I find myself speaking, trying to give voice to those who are not at the table, you know, what about our charity care patients, what about our detox patients?.

From this quote and others from the interview transcripts, I identified three leadership norms: transparency, collaboration, and commitment. I will give two examples of direct quotes to denote the three leadership norms in the team. Transparency, in this case, relates to a tendency for open and direct communication among the team as identified in the following quotes.

All the way up to the president of the hospital who, builds, works toward that consensus, and then, results in a decision that he makes that we will then support. And, the transparency of that has been extremely gratifying for me because I've worked for places where it's not been transparent how decisions get made, or when they are made, what is it that was decided and what now is expected as a result of that decision?

And I see our exec team as a safe place for people to be able to raise the flag and say, wait a minute, let's look at bigger picture and what are we doing and what are we trying to achieve. And our president, I value his leadership because he is very comfortable with that. He wants people to be able to say, wait a minute. Have we thought of this, or have we thought of that?

Collaboration is referred to the process of working together in a group to achieve or create something. According to Schwarber (2005), effective leaders recognize that shared decision making is about conversation. It is important for the team to sit down and talk with each other, bringing valuable information and ideas to the dialogue, not as a superior to subordinates. The following quotes capture this sense of collaboration and cohesion within the team.

The fact is that I work with an incredibly talented team here. And just as you have indicated with the four different strengths that people have, I think it's because of that balance of who we are here on this team that we've been very, very thoughtful and deliberate about how

these costs have been rolled out to this organization to not upset the applecart while trying to look at the longevity of our organization.

Knowing that from past, seeing the work from past decisions allows me to be very hopeful and optimistic how future decisions will be handled. There's a great amount of consistency that I have witnessed on the exec team on how all decisions are made.

Leadership team here, I don't know if anybody else mentioned it, we've got some leadership coaching. And part of that was just trying to, do some personality inventories and things that say, well, here's the kind of person I am, and here's how I'm going to relate to my peers on the exec team. And we're not all alike, so we start to say, okay, here's this strength of yours that will really help us with this decision. Or here's what I need, maybe, because I don't have that strength to be part of the conversation. I need this part explained to me, or you need to give me some time to do it. And if I reflect on that, as you say, then maybe I'm also saying, I'm probably not the only one. So who else here at the table or in our institution would benefit from?

The third norm that exists within the team is the presence of commitment. It is the sense of duty among the leaders with a higher purpose to achieve common goals and ensure the long-term success of the organization. The following quotes demonstrate the sense of commitment among the senior leaders.

I think it was an underpinning that is universal across the exec team in terms of, you know, our promise to our patients that when they walk into this place of healing, we're going to make every effort not to harm them as well.

The second piece of that, in terms of reducing cost, much of it's in labor. And the one thing that I do like about this organization, it's a much more humane approach, once we've identified that we need to reduce labor costs and then targeted who those people are, the way that they're handled, and the amount of notice that they get. The support they get following, in terms of helping them find another position, either within the system or in the community. That is very values

driven. That's consistent with our MVP, to say that, you're not just a digit on a spreadsheet. You're a human being. We get it, and let us help you, even though, you no longer have a job with us.

And to me, that all again comes right back to the patient who's going to get our very best, compassionate, respectful, dignified care as a person created in the image of God. So the why of this for me always comes back to our mission, values, and philosophy.

I feel privileged to be part of this system, because it is one of the leading healthcare organizations in America dedicated to reforming healthcare by moving our healthcare delivery model from a fee-for-service (volume-based model) to a values-based model where we can improve outcomes and do it at a more affordable cost. And we want it to be sustainable, a Baldrige concept...and our organization is a forerunner in population health management, and that's where healthcare is going.

### **Validity and reliability**

Rudestam and Newton (2007) contend that qualitative researchers tend to forgo the use of terms such as validity and reliability because they found that “these concepts [are] linked to objectivistic research and that they are inappropriate for naturalistic inquiry” (p. 112). Though to create trustworthiness of the research process, they recommend attending to the above entities in a convincing way. Reliability in qualitative research refers to the possibility of replicating the study under similar conditions. It refers to achieving consistency with the coding of raw data and ensuring that any reader will understand the themes and arrive at similar conclusions. And validation refers to trustworthiness and credibility of the data.

The researcher demonstrates reliability of the data, as noticed by the consistency with data collection, transcription, and coding process of all participants. The data coded

from the transcripts was also validated by interpretive validity, where the first-order codes were created by the researcher developing concepts derived from a constant comparison of interview data from the transcripts. The coded information was further assessed for intercoder reliability by two independent coders—PhD cohort students not related to the study—and my dissertation chair, all of whom used the same set of codes for the same blocks of data. The guide to intercoder reliability checking can be referred to in Appendix G: Guide for Intercoder Reliability Checking. In a similar approach to Miles and Huberman (1994), the coders were provided with 10 similar pages of randomly selected interview transcripts, which resulted in an initial average of 77% intercoder reliability using the following formula.

$$\text{Reliability} = \frac{\text{number of agreements}}{\text{total number of agreements} + \text{disagreements}}$$

Conducting a peer debriefing and having a conversation with all the intercoders, who were unfamiliar with the context, and clarifying their differences and inferences to the code and data, raised the final reliability to 96%. Following Miles and Huberman (1994), I completed intra-coder reliability with an accuracy of 93%, comparing the coding I did on the first dozen pages of transcripts to the coding I did a few days later on the same material.

Being well aware of the organization, due to tacit knowledge, and having the opportunity to interview each participant for approximately 1.5 hours helped validate the study. Since the sample is small, generalizations to similar participants and

organizations will be based on readers' perspective. To further validate the diagrammatic representation, I shared my central category diagram from Figure 8 with two of the interview participants and my dissertation chair, who had also been part of the intercoder reliability from this research. They agreed that the categories fit logically with the core category, and the diagram conceptualized the interpretation of the research theme.

### ***Research Limitations***

The main limitation is assumed to be that the researcher is also a practitioner in the environment of study. Although familiarity of the data could be a possible bias to the study, conceptualization from the content should be evident. Rather than being a limitation, the researcher's familiarity with the content, environment, and the leaders themselves could also be considered as a strength in this study. Another possible limitation is that the research participants were purposefully selected from one healthcare organization, which could be considered to be a narrow participant pool, and concepts cannot be generalized to the other healthcare leaders and organizations. And as always another limitation to consider is the possibility of "social desirability bias" wherein respondents give replies that are seen as socially acceptable, that tend to put them in a favorable light, or that they give answers that one might want to hear. A significant weakness as to the validity of the study is that the researcher conducted the study in only one organization, with no comparison to organizations of similar value alignment or misalignment.

Although the above limitations should be considered, many elements of the study design were included to ensure relevance and high quality of the data. For example, peer debriefing and member checking were done to demonstrate the researcher's study conclusions are grounded in the data. Additional checks—such as interview questions validated for appropriateness by experts in the field, professional transcription, careful documentation, and analysis—were done to ensure high quality of data and the inference being reliable and valid.

## Chapter 5: Discussion

### ***Introduction***

I began my study seeking to understand the values of one executive healthcare team and how these values impact their decision-making process when dealing with critical issues. I was especially interested in what happens in times of disagreement. During these times, I expected to find differing or competing values among executive team members (Cameron & Quinn, 1999) and wondered how they would be resolved or if they could be resolved. I was surprised to discover that all participants in this study share the same values; a finding supported both by quantitative and qualitative data. I then looked more closely at the decision-making qualitative data and discovered values-based implicit and explicit norms of behavior that were positively impacting the decision-making process. In this chapter, I propose that this healthcare organization's success, as measured by goal achievement, is partially a result of senior leadership's shared values and their values-based behavioral norms. To explain this proposition, I refer to the literature on civility tactics by Pearson, Anderson, and Porath (2000), competing values framework by Cameron et al. (2006), and the leadership model described by the Malcolm Baldrige National Quality Award process.

### **Workplace civility**

Pearson, Anderson, and Porath (2000) describe workplace *civility* as “behavior that helps to preserve the norms of mutual respect at work; it comprises behavior that are



fundamental to positively connecting with another, building relationships, and empathizing” (p. 125). According to Van Bergen, Bressler, and Collier (2012), the key component of civility is dialogue and openness to others. The discussion and dialogue involves the exploration of self as well as learning from others. It implies articulation of one’s values, priorities, and assumptions as much as learning what might be values by others in the team. Consistent with above literature, the key tactic used by the participants included dialogue and discussion, while affirming their priorities. Robert and Lester (2006) state civility in workplace also includes mutual respect, a quality that requires the participants to remain transparent with sharing views as well be open to listening to others’ views. It permits disagreement among the team’s beliefs and practices, but it limits the ways in which this disagreement can be pursued based on respect for the person (Kim & Strudler, 2012). Values of tolerance and respect can be seen as first-order codes in this study.

To justify further, the tactics used by senior executive leaders from my research are listed below. I will detail the presence of *civility tactics* with direct quotes from the participants, thereby connecting the evidence.

#### Discussion/dialogue

Discussion and dialogue is an ongoing process among the senior leaders, as well with their direct reports, as identified in the following quote by one of the leaders:

How the team went about making those decisions, again, was to really have an open conversation and dialogue. One of the things I like about our executive team is the very open, frank, honest conversation. And

everybody is able to bring their best stuff to the table to say, here's why I think we should go in this direction or that direction. So the talent pool, the multiple voices, and even to draw in voices sometimes I find myself speaking, trying to give voice to those who are not at the table, you know, what about our charity care patients, what about our detox patients?

#### Role model

The senior leadership shared their values by various means such as social cues, rhetoric, and storytelling, thus creating an environment of positive leadership amongst the team. The following quote from a leader demonstrates this tactic.

Nonetheless, the high-level communication both from system and our organization helps the decisions, even the very difficult ones, become as effective as possible because of the way in which our leadership, particularly our president, sets the context, communicates the context, and then how the decisions come as a result of the context that he's described.

#### Leaders' values

There was a high degree of synchronicity among espoused and enacted values in the team. As noted previously, the participants engaged in seven common sets of values evident during the decision-making process of critical issues and exemplified in the following two quotes:

And to me, that all again comes right back to the patient who's going to get our very best, compassionate, respectful, dignified care as a person created in the image of God. So the why of this for me always comes back to our mission, values, and philosophy.

Again, we all can name MVP as those values, excellence, stewardship, compassion, partnership, and equality is the simplest way to value that, to be respectful of people's culture and religious traditions, diversity. I think additionally, there are values that are in play that might not be spoken as clearly

Leaders' strengths

The leaders stated that they had various formal assessments that increased their awareness of each other's assets and limitations. One participant described the importance of leaders' strengths as follows:

Leadership team here, I don't know if anybody else mentioned it, we've got some leadership coaching. And part of that was just trying to, do some personality inventories and things that say, well, here's the kind of person I am, and here's how I'm going to relate to my peers on the exec team. And we're not all alike, so we start to say, okay, here's this strength of yours that will really help us with this decision. Or here's what I need, maybe, because I don't have that strength to be part of the conversation. I need this part explained to me, or you need to give me some time to do it. And if I reflect on that, as you say, then maybe I'm also saying, I'm probably not the only one. So who else here at the table or in our institution would benefit from?

Resources available

Their prioritization during decision making was dependent on the internal and external resources. Even during a disagreement, the participants demonstrate mindfulness of organizational and system resources:

I think, we handled that by making sure that we had proper resources. You know, we now have a lean department. We hired sensei. And we had a systematic approach for rolling this out to our leaders so that, all leaders have been trained in this and are continuing to be trained.

Project design

Their decision was also based on the scope of each decision, and its impact on the organizational strategy. The leaders related to strategy as a tactic in the presence of disagreement, as observed by one leader:

As it relates to Lean, the values that drove that were associate engagement and stewardship. So there's a couple ways to take costs out. Unfortunately, the most common way to take cost out is across-the-board expense reductions, which lock in the inefficiencies and the

current way we do things. We chose a method where our associates and physicians will actually help us to design out waste so we can improve our outcomes at a more affordable cost.

### Identify priorities

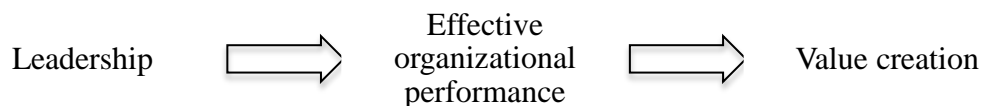
It was obvious from the quotes that the leaders had a clear understanding of both the system and the organizational strategy and that their prioritization was based on strategy, opportunities, and resources. The following quote describes the leaders' using priority as a tactic during challenges in decision-making process.

But we very carefully and purposefully looked at all the data to determine, what our current state was and what the target state was, knowing the changes that are coming, and putting plans in place to ensure that we can sustain our financial position and at the same time living our mission, values and philosophy. And the most priority is taking care of those patients that we serve.

So far, I have outlined the civility tactics used by the senior executive leaders during decision-making. The next theoretical alignment is the relationship of research findings to CVF, as described below.

### **Competing Values Framework (CVF) in healthcare**

CVF emerged from studies analyzing the factors that cause organizations to have highly effective organizational performance. Cameron et al. (2006) created a widely accepted model (Figure 10) to explain the concept of competing values.



*Source:* CVF-creating value in organizations, Cameron et al. (2006, p.6)

**Figure 10. Cameron's Model**

This model indicates that fostering a successful leadership improves organizational performance and leads to optimal value creation. The framework helps leaders to work more comprehensively and consistently improving organizational performance and value creation. According to Cameron et al. (2006), all organized human activity has an underlying structure. Organization connotes patterns and predictability in relationships; hence, identifying the underlying dimension is the key function of CVF.

The competing values framework identified in Figure 2 is based on two core dimensions—an internal and an external focus—and two attributes—a flexibility and stability attribute—creating a two-by-two quadrant. The four quadrants represent opposite or competing assumptions. From a practitioner perspective, the labels on the quadrants are collaborate, control, compete, and create.

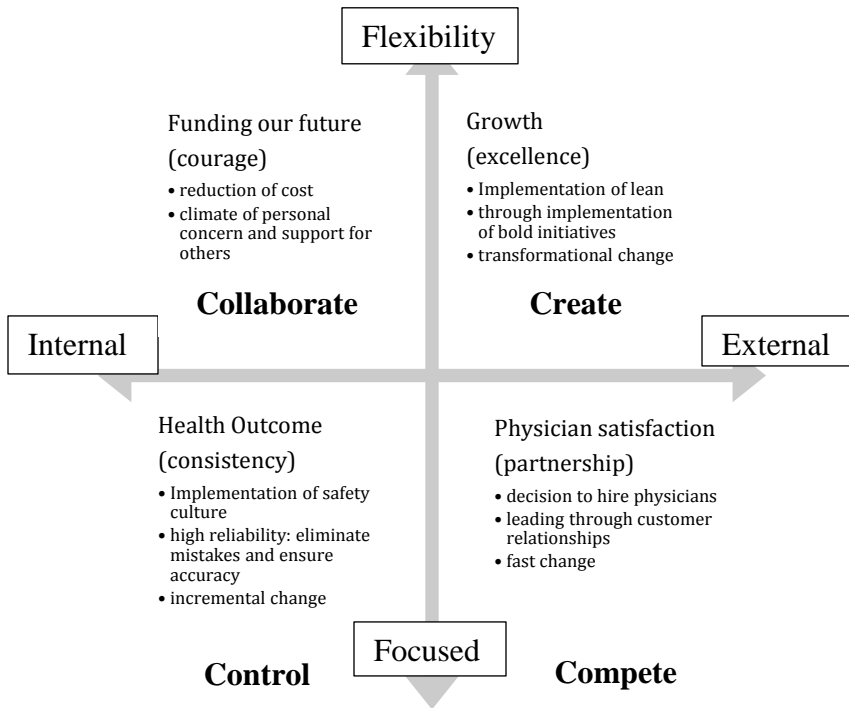
The framework highlights the need for congruence among individual dynamics, organizational dynamics, and different types of outcomes associated with value creation. It represents the way people evaluate organizations, process information, learn the environment, organize and lead others, create value, and cluster organizational elements, and what people see as good, right, and appropriate. It also makes clear that achieving valued outcomes in each of the quadrants is crucial for

organizational effectiveness over the long term. The competing elements in each quadrant give rise to the presence and necessity of paradox (Cameron et al., 2006, p. 11). The framework is extremely useful in organizing and interpreting a wide variety of organizational phenomena, such as outcomes, strategy, culture, core-competencies, leadership communication, decision making, motivation, human resource practices, quality, and employee selection.

In this study, I have used the framework to study the decisions made by senior leadership based on their individual values and the resultant outcome. From the perspective of the CVF, I have three data points from my research that I would like to overlay on the CVF framework. On an individual level, the four leading values identified among the leadership team are partnership, excellence, courage, and morality. From the leadership level, the four decisions made by the executive team (based on interview data) are implementation of safety culture, reduction of cost, implementation of lean, and decision to employ physicians. And at an organizational level, as noted in Figure 14 (Appendix A), the leading four weighted performance metrics from the BSC survey results are physician satisfaction, growth, health outcome, and funding our future.

Cameron et al. (2006) argued that every organization needs to pursue activities in all four competencies, although not all four quadrants must be emphasized equally. The distribution depends on the demands of the competitive environment and the agility to

shift emphasis as needed: “Paradoxical organizations and leaders tend to pursue simultaneous contradictory strategies at the same time, leading to success and value creation on a long run that far exceeds the norm” (Cameron et al., 2006, p. 158). Upon analyzing the impact of the above three data points in relation to the framework, I created the following model in Figure 11, which explains the leaders’ diversified value system, their importance to performance perspectives, and the decisions made within the organization. It suggests that all quadrants are pursued simultaneously even though the emphasis on each quadrant varies in accordance with the interview data.



**Figure 11. Conceptual Model**

In the *Collaborate* quadrant in Figure 11, the decision was reduction of cost, an internal organizational strategy with a flexible focus. The pillar identified is funding our future in the organizational scorecard. The leaders discussed the reduction of cost decision as a continuous process with an ongoing need and change in various segments. Although the important entity discussed by all the leaders was the hiring freeze implemented to reduce cost, the leaders' commitment (subcategory code courage) is evident in the following quote:

In terms of reducing cost, much of it's in labor. And the one thing that I do like about this organization, and where I worked for 12 years before was in a for-profit, and they didn't use this methodology. They said, X amount of FTEs are gone, look at who's most senior, or whatever, and boom. People come in, they're told they're without a job, goodbye, don't let the door hit you on the way out. Here, it's a much more humane approach that, once we've identified that we need to reduce labor costs and then targeted who those people are, the way that they're handled and, the amount of notice that they get. The support they get following, in terms of helping them find another position, either within the system or in the community. That is very values driven. That's consistent with our MVP, to say that, you're not just a digit on a spreadsheet. You're a human being. We get it, and let us help you, even though, you no longer have a job with us.

With regards to the *Control* quadrant, the decision was the implementation of a safety culture as an internal organizational strategy extremely focused in its approach. This strategy offered no flexibility because of the high need for reliability in its dimension. This decision requires that the organization ensures accuracy in safety and avoids errors. It is considered an incremental change because the goals are to decrease harm by 80% in the next five years and to zero patient harm by 2020. The value code



identified with this quadrant is morality (subcategory codes sense of duty and patient-focused values). The following quote identifies the value congruence among the leaders, and the BSC performance metric associated with this quadrant is health outcome (safety).

The implementation of safety culture, what made the decision important? Well, first of all, since we are a clinical enterprise, ensuring that we care for our patients in a safe manner is absolutely critical, and it's nonnegotiable. We need to make sure that we're doing everything for our patients. I think it's the right thing to do, and we should be doing it. I believe, in all of our leadership's mind, it's not a question of should we but how much should we focus, and yes, we're very focused on our mission values and philosophy, and this is in support of that. But it's also the right thing to do for the people that we're responsible for.

The next quadrant is the *Compete* quadrant: the decision reflected here is the hiring of physicians. Because of the speed in its focus, it is considered a fast change, and it is also a strategy that was implemented to be positioned positively against the market competitors. The decision came about because of the external environmental changes, and the value identified with this quadrant is partnership. The goal with this decision is to create a customer/stakeholder relationship, and the pillar reference in BSC is physician satisfaction, as identified in the following quotes.

Employing physicians, the nature of healthcare is such that probably five years from today, the vast majority of physicians will be employed by either a multispecialty medical group or a not-for-profit hospital. So we want to be able to offer our doctors the option of being employed. And employing doctors, really is the value of partnership. We cannot provide great healthcare without physicians who are economically and professionally successful, so partnership really drove that decision.

The whole idea of the value of partnership with our physicians. We've always done that with our independent physicians, but now looking at the changing environment and needing to partner in a different way with our docs beyond our PHO into an employment relationship

If we are going to continue to be an organization that is financially viable, we are going to have to hire physicians

The last quadrant is the *Create* quadrant. The decision emphasized here is the implementation of lean culture. Although very few healthcare organizations have implemented lean successfully, it was a bold and innovative initiative for this organization. The value code in use is excellence (subcategory codes innovation and sustainability). Because of its process-oriented methodology, a transformational change is expected as the organization flourishes in the long term. The organizational pillar referred to is growth in the BSC. The following quote describes the rational thinking behind the lean implementation.

As it relates to Lean, the values that drove were associate engagement and stewardship. So there's a couple of ways to take costs out. Unfortunately, the most common way to take cost out is across-the-board expense reductions, which lock in the inefficiencies and the current way we do things. We chose a method where our associates and physicians will actually help us to design out waste so we can improve our outcomes at a more affordable cost.

We've got to succeed within Lean to make the work more rewarding and more value-added for the people that are here. I mean, it's a fact of life. Actually, I shouldn't feel too sorry for myself because with the exception of healthcare and higher education, every industry in America has had to go through this. So we are 25 years overdue for a cost reduction journey. So shame on us if we feel sorry for ourselves.

According to Cameron et al. (2006), different competing values, preferences, and priorities exist in every organization. Effectively managing the contradiction and stress among these entities can create value and lead to exceptional organizational performance. Leaders could be either task oriented or people focused, but effective leaders usually demonstrate a capacity to integrate both (customer satisfaction and process simultaneously), as noted in the previous quotes. Cameron et al. (2006) has also referred to a concept called *cognitive complexity*, where the leader possesses a sophisticated understanding of a phenomena that resides in the person's mind. It is usually referred to as "both/and" thinking and not "either/or" thinking. Through the following quotes, the research participants exhibit the high-level and effective process of cognitive complexity.

It isn't just about reducing cost, it's about reducing and taking waste out and reducing cost in a very thoughtful way so that you don't harm your outcomes. Some people might say if you're reducing cost, that's going to hurt your efforts on safety. But I think the job of senior leadership is not to live in an either/or world, either cost goes down or safety improves, but it's a world where we create both, greater safety for our patients, and we do it in a more cost-effective enterprise.

Now is that profit margin value greater than our value for compassion, or different from our value of stewardship, or aligned with our value for excellence? So I think that's where the conversation, how those values play in is to have that open conversation that I mentioned earlier to say, how do we really engage and it's not an either/or value, it's a both/and, but how do we emphasize the both/and?

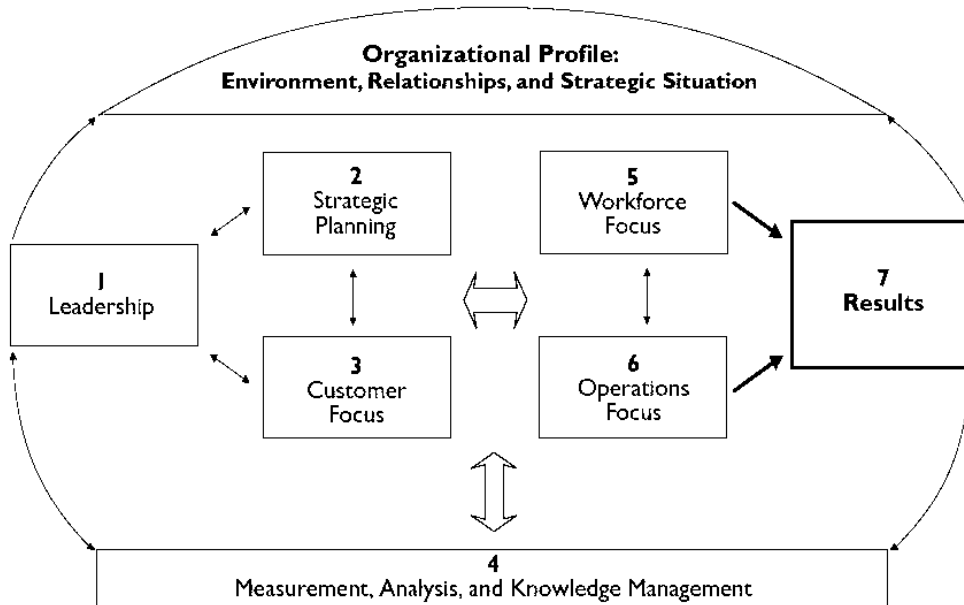
Cameron et al. (2006) contend that creating both/and thinking is one of the key strategies that leads to value creation. The next finding from this research indicates

that in the presence of an effective decision-making process, the leaders demonstrate a leadership approach similar to the Baldrige criteria, as detailed below.

### **Leadership in a Baldrige-winning organization**

The new mandate in healthcare is improved organizational performance in terms of safety, quality, and service. Though many hospitals are still struggling to adapt to this new requirement, some hospitals are already in this journey of performance excellence. These organizations deliver high-quality, safe services to satisfied patients and caregivers, while keeping the cost low enough to enable them to thrive financially despite low reimbursements. These organizations have clearly followed sound organizational theories and benchmarked against their counterparts even from other industries. Their success is stable and consistent because of evidence-based best practices and outcomes. And these organizations are the recipients of Malcolm Baldrige National Quality Award (MBNQA) in their sector. The award applicants complete a 50-page application responding to the Criteria for Performance Excellence's seven organizational elements: leadership; strategic planning; customer focus; measurement, analysis, and knowledge management; workforce focus; operations focus; and results, as seen in Figure 12.

**Baldrige Criteria for Performance Excellence Framework  
A Systems Perspective**



Source: [www.baldrige21.com/Baldrige%20Model.html](http://www.baldrige21.com/Baldrige%20Model.html)

**Figure 12. Baldrige Framework Model**

Based on the results from a rigorous, standardized process and on the feedback from the examiners, the judges select a winner every year. Although the Malcolm Baldrige criteria are designed to be non-prescriptive, this national framework for performance excellence offers important guidelines for leaders to incorporate into their organizations.

The organization that I researched was a MBNQA recipient, and as noted below in the following quote, the leaders refer to it as one of their achievements and process in their organizational journey.

You know, we had Good to Great 1.0, which was Studer looking at our key stakeholders. Then Good to Great 2.0 was our Baldrige and looking at how systematic are we, and do we have those systematic repeatable processes that will lead to consistently great care. So lean then was a perfect follow-up to that, as Good to Great 3.0, now looks at, how are we going to eliminate waste while, we provide value to our customers. So I think that the real decision was not so much are we going to do this, because it was a logical next step.

The Baldrige criteria for senior leadership outlines vision, values, and mission as the first multiple requirement, followed by legal and ethical behavior and sustainability.

It is defined by best practices resulting in exceptional outcomes as compared to national standards. The participant's organization has clearly achieved marked success, as demonstrated by winning the Malcolm Baldrige National Quality Award and numerous other recognitions for excellence and performance. This result is made available, based on the tacit knowledge of the researcher, as well as public records.

The inference is further attested by the following quote from the president that represents the optimism and resulting success of the organization.

We are first and foremost a safe clinical enterprise. I am absolutely enthusiastic about the work we are doing here. By the way, Truven a company that evaluates hospitals, has rated our organization's safety at the 100<sup>th</sup> percentile. And the exciting part about healthcare is that we do have an opportunity to reinvent healthcare, and I think both our organization and the system are at the leading edge in America of doing that. And that gives me some real pride and excitement, inspite of the fact, that there are many, many challenges in the future.

As identified from my research, the senior leaders in my sample demonstrate a high level of personal value congruence and alignment to mission and values. And their winning the award is an indication of organizational excellence leading to organizational sustainability.

Based on the research, it is evident that when leadership shares a common set of values, it is replicated at all levels of the organization and thus creates a values-driven organization. The following quote from one leader reveals his mindfulness to values and norms.

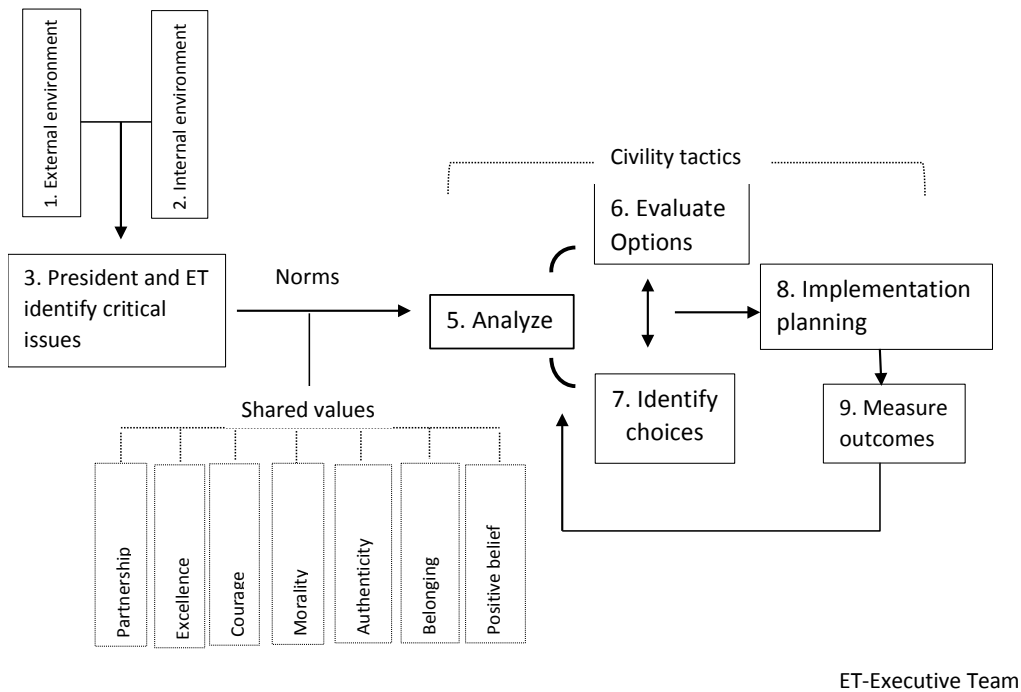
I don't know if this is the scope of your research or study, but I think of it a little bit, I hear about values as part of institutional leadership. I mean, a lot of people can claim values, but they don't really say, which ones are good and which ones are not good? They just say, we're mission based or we're value based. And say, if that value to be the best at such and if it has a negative impact on someone else, do you care about that? And, so for me, it's a little bit of coming back again to my lens which is our faith-based mission, values, and philosophy out of the Judeo-Christian base. So where they come from matters as much to me, and perhaps more so, than that we have them. I think you have, it's important to have them, obviously, as your consistency or organizational compass or directional, what have you. But, what's the source of it? So, I might say, it's a value of the institution to be kind to people. Why? Well, it's good business, or is it because Christ first loved us? Oh, that's a little different. Again, that people come to work, they may not, and are not required to share that particular basis of a value, but it's really powerful when somebody does come to work and says, this is my ministry, it's more than a job. It's my vocation. Well, why? Because, God called me to this. Oh, is that different than somebody else who feels real passionate about their work? Maybe in the outcomes it doesn't matter too much, but I think, ultimately, it matters.

### ***Revisiting My Initial Research Question***

My research focused on the following questions: What values exist among senior healthcare executives? Are these values shared? Do they compete with each other? If and when values compete, how are decisions, especially decisions critical to the organization, made? My research suggests that instead of having competing values, the leaders from this research demonstrate three characteristics: they have a preference for personal-moral values as evidenced by RVS, a common set of shared values and norms as evidenced by the qualitative data, thus leading to alignment with the mission and vision of the organization. In addition, I suggest that when these conditions exist, certain behavioral norms of civility develop that facilitate decision making, prioritization, and implementation planning, which leads to the achievement of organizational goals.

Based on the results from my study, I propose that the leaders in this study exhibited a set of normative behaviors called civility tactics that guided them in the decision-making process to achieve consensus. As a result, the leaders were able to contribute and adapt to the needs of all four quadrants in the competing values framework, despite multiple priorities. By employing civility tactics and allowing the values and norms to influence decision-making, the leaders are effective, as confirmed by their achievement of the Malcolm Baldrige National Quality Award in the healthcare sector. Figure 13 depicts the results from my research.





**Figure 13. Values-Based Decision-Making Process**

In the decision-making model shown in Figure 13, the president and the senior leaders initially identify critical issues that have an impact on the organization based on internal (box 1) and external (box 2) environmental variables. A key input to the internal environment is the influence of shared values and norms within the

leadership team, as identified in the central category diagram (Figure 8). After identifying variables, the ET analyzes the situation, evaluates options, and identifies alternatives (box 5–8), leading to implementation planning. During this stage, to achieve consensus, the leaders engage in a few normative behaviors called civility tactics, such as dialogue/discussion, role modeling, influence of leaders' values and strengths, and identification of available resources and priorities. Research data indicates that this process is cyclical until consensus is achieved. Effectiveness of decisions is measured by the organizational outcome (box 9), which continues to be reanalyzed (box 5) for new options and choices leading to further decisions and systematic processes.

The external variables as outlined by the research are strengths, opportunities, limitations, and uncertainty in healthcare. The internal variables are organizational mission, vision, leadership values and norms, strategy, and past performance. Based on the results from this study, the seven common sets of leadership values are partnership, excellence, courage, morality, authenticity, belonging, and positive belief. Norms that are in play include transparency, commitment, and collaboration.

Effective leaders role-model and articulate their values through rhetoric, social behavior, and dialogue and discussion, thus employing various civility tactics to achieve consensus during decision making. This demonstration of value congruence creates synchronicity at all levels of the organization, while simultaneously creating

an organizational norm. In essence, the alignment of shared values and norms with the application of civility tactics appears to be the key factors that influence complex decision making among the senior healthcare executive leaders in this sample. It is important to note that these decisions were not discrete time-based short-term decisions; instead, they were ongoing critical management issues encountered by senior leaders, leading to constant change and added conversations within the organization.

The findings from the study also support the notion of Graber and Kilpatrick's (2008) four characteristics for a values-based leader: a) awareness of one's personal and professional values, b) congruence with larger organizational values, c) demonstration of awareness and understanding of both internal and external stakeholder values, and d) commitment to a values-based leadership (2008, p. 179).

The study also supports the assumption noted by Fu and Liu (2009) about creating organizational sustainability and creating successful outcomes through values. In the following chapter, I have suggested future possibilities and recommendations to my study, with a brief note on my personal learnings from the research.

## Chapter 6: Research and Reflection

### *Recommendations for Future Research*

Although I started the study researching competing values among healthcare leaders, I discovered that all the leaders in my sample have similar, not competing, values and a strong preference for personal-moral values. These values contributed to the development of behavioral norms that facilitated the decision-making process and helped ensure successful organizational outcomes. The findings from this one healthcare organization study suggest other questions and the need for further research.

From the above inference, a number of other questions arise from this study: Is this an artifact of a healthcare setting, or is it unique to this hospital or this system? Would the data be richer with other research methodologies, such as a case study or ethnographic study? Also, since the hospital that I researched was a not-for-profit institution, it would be interesting to repeat this study in for-profit institutions, which have different goal priorities. There are a number of other considerations: Is civility tactics a result of shared values? What could go wrong, in situations when decisions need to be made, when the team is not aligned? Does diversity in values among the team lead to richer decision making?

This research could be extended to address the following questions: Did the organizational values influence the leaders' values, or did the leaders' personal values

attract them to work in this organization? Were the leaders' values influenced by the healthcare environment, or did their personal values attract them to healthcare? The study would be richer with increased numbers of participants and with different ethnic groups. Conducting similar studies with leaders from non-healthcare organizations or with Malcolm Baldrige Award recipients only, both within healthcare and in other sectors, might offer new insights. For organizations with extremely different values, what are the implications for their leadership team?

The study has a significant practitioner implication in the areas of hiring, performance management, leadership development, and succession planning. The study results possibly suggest that investment in value alignment of leaders will benefit the organization's outcomes. The study results demonstrate that the presence of the following seven predominant leadership values could be positively related to successful organizational outcomes: partnership, excellence, courage, morality, authenticity, belonging, and positive belief. The study has also clearly indicated that senior leaders with strong alignment to values and mission will bring about synchronicity and value congruence at various levels of the organization, thus leading to successful outcome.

As noted in the leadership literature, different leadership perspectives have values as a common denominator: level 5, charismatic, transformational, principled, and servant leadership. But with rapid changes and turbulence in today's healthcare, it is

imperative for senior leaders to have a strong focus on values, for exceptional organizational performance, excellence, and sustainability.

### ***Personal Learnings***

From a practitioner perspective, academic and scholarly work is a challenging task, yet a rewarding experience. It is a paradox, and never realized, until one experiences the course over time. The research has surely instilled and increased my love for learning. I have learned to read the articles in their entirety instead of the abstracts and results. Being in a practitioner setting, I find avenues for application of the various theories while I continue to admire the dedicated theorists and contributors to the field of leadership.

I am hoping the access to a workplace and the availability and awareness of academic resources will inspire me to continue research, thus benefiting the field of leadership as well the workplace. And above all, I had the privilege to experience the richness of qualitative research, and discern the words of Albert Einstein: “Not everything that can be counted counts and not everything that counts can be counted.”

## Appendix A: Rokeach Value Survey

Please rate each of the values on these two pages in terms of their importance to you by entering the appropriate number (1 = of lesser importance, 7 = of greater importance). Think about each value in terms of its importance to you as a guiding principle in your life. Is it of greater importance to you, or of lesser importance, or somewhere in between? As you work, consider each value in relation to all the other values listed on each chart. Work slowly and think carefully about the importance you assign to all the values listed below. When you're done, follow the scoring and plotting instructions that appear below and at the end of the survey.

Terminal Values	Of lesser importance			Of greater importance			Number	P Scores	S Scores
	1	2	3	4	5	6			
A comfortable life	1	2	3	4	5	6	7	0	
An exciting life	1	2	3	4	5	6	7	0	
A sense of accomplishment	1	2	3	4	5	6	7	0	
A world at peace	1	2	3	4	5	6	7		0
A world of beauty	1	2	3	4	5	6	7		0
Equality	1	2	3	4	5	6	7		0
Family security	1	2	3	4	5	6	7	0	
Freedom	1	2	3	4	5	6	7	0	
Happiness	1	2	3	4	5	6	7	0	
Inner harmony	1	2	3	4	5	6	7	0	
Mature love	1	2	3	4	5	6	7	0	
National security	1	2	3	4	5	6	7	0	
Pleasure	1	2	3	4	5	6	7	0	
Salvation	1	2	3	4	5	6	7	0	
Self-respect	1	2	3	4	5	6	7	0	
Social recognition	1	2	3	4	5	6	7	0	
True friendship	1	2	3	4	5	6	7	0	
Wisdom	1	2	3	4	5	6	7	0	
<b>Total</b>								0	0

P - S = T (Terminal Values)                      0.00

P total/53 = P Score    0.00

S total/18 = S Score    0.00

A positive Terminal Value Score indicates a "personal" orientation, while a negative sum indicates a "social" orientation.

<b>Instrumental Values</b>	Of lesser importance			Of greater importance				Number	C Scores	M Scores
	1	2	3	4	5	6	7			
Ambitious	1	2	3	4	5	6	7		0	
Broadminded	1	2	3	4	5	6	7		0	
Capable	1	2	3	4	5	6	7		0	
Cheerful	1	2	3	4	5	6	7			0
Clean	1	2	3	4	5	6	7			0
Courageous	1	2	3	4	5	6	7			0
Forgiving	1	2	3	4	5	6	7			0
Helpful	1	2	3	4	5	6	7			0
Honest	1	2	3	4	5	6	7			0
Imaginative	1	2	3	4	5	6	7		0	
Independent	1	2	3	4	5	6	7		0	
Intellectual	1	2	3	4	5	6	7		0	
Logical	1	2	3	4	5	6	7		0	
Loving	1	2	3	4	5	6	7			0
Obedient	1	2	3	4	5	6	7			0
Polite	1	2	3	4	5	6	7			0
Responsible	1	2	3	4	5	6	7			0
Self-controlled	1	2	3	4	5	6	7			0
								Total	0	0

C total/36 = C Score 0.00      C - M = I (Instrumental Values)      0.00  
M total/30 = M Score 0.00



Plot your Terminal Values Score on the horizontal axis and your Instrumental Values Score on the Vertical Axis.

Use Insert, Shapes, Line to draw the lines.

Draw a vertical line for the Terminal Values Score.

Draw a horizontal line for the Instrumental Values Score.

Mark the point of intersection between the two scores.

Terminal Values Score: 0.0

Instrumental Values Score: 0.0

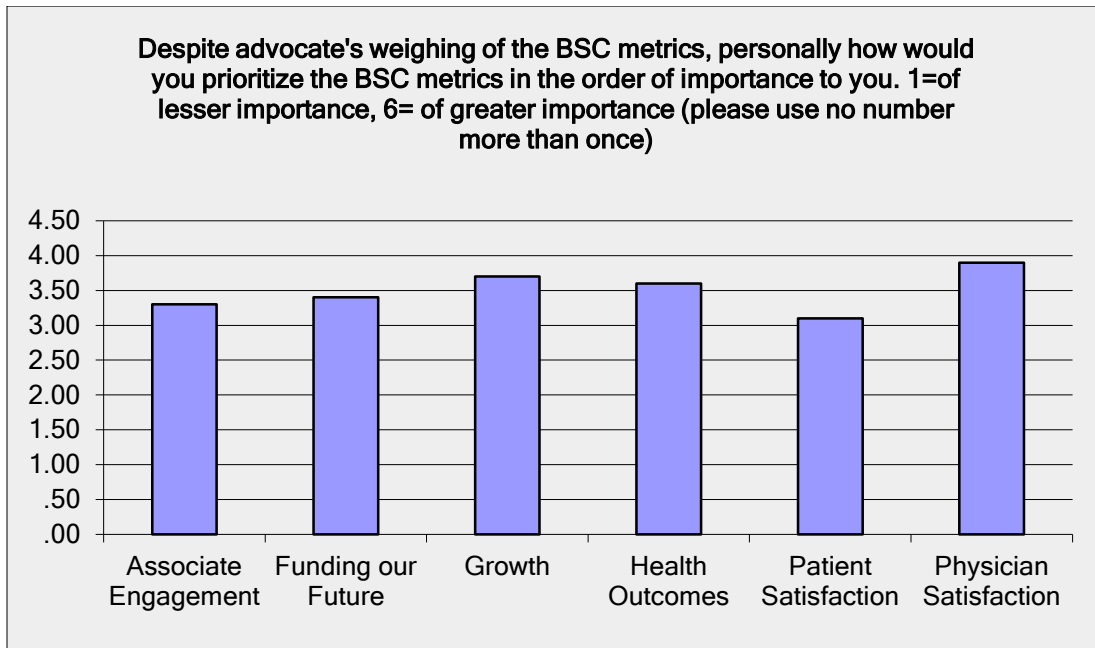
**Terminal**

		<b>Personal Values</b>							<b>Social Values</b>														
<b>Instrumental</b>	Competence Values	Preference for Personal-Competence Values							+7	Preference for Social- Competence Values													
									+6														+5
	Moral Values	+7	+6	+5	+4	+3	+2	+1	0	-1	-2	-3	-4	-5	-6	-7	Preference for Social- Moral Values						
		Preference for Personal-Moral Values							-1	-2	-3	-4	-5	-6	-7								

### **Balanced Scorecard Performance Indicators**

As part of the survey, the participants, were requested to rank order the priority of balanced scorecard metrics in the order of importance to them, despite the corporate weighing of each indicator.

- Associate Engagement
- Funding our Future
- Growth
- Health Outcomes
- Patient satisfaction
- Physician satisfaction



**Figure 14. BSC Priorities**

## Appendix B: Interview Protocol

To begin with, I would like to give you a brief introduction on my topic: Though all of us agree that values play a major role in our personal and professional life, I am attempting to study the competing values that arise among senior executive leaders, and how do they get resolved or do they? I would like to listen to your personal experiences and perspectives that would take me through this path on your values. I would like this to be a ‘conversation’ instead of a formal interview. Please feel free to interrupt me anytime or clarify any questions you might have.

### President opening question

You’ve told me before, about how you ended up in your current position as GSAM president. Though can you tell me, what’s most attractive to you about your work? Why do you like, what you do?

Next, I would like to ask you about the four most important decisions you and your senior executive team had to make within the last year and a half.

Specific questions about each of these decisions:

1. What was the issue or opportunity you were trying to address?
2. What made this decision important?
3. How did your team go about making the decision?
4. What role did values play in the decision-making process?
5. What challenges did you encounter and how did you resolve them?
6. How do you feel about the decisions?
7. How long did it take to make these decisions (among the four)?
8. Were the decisions effective, i.e.: satisfactory (scale of 1-poor,3-avg,5-good)
9. Is there anything else you’d like to say about this decision?

### Other senior executive team

Can you tell me a little bit about, how you ended up in your current position? What’s most attractive to you about your work? Why do you like, what you do?

Next, during my interview with \_\_\_\_\_, we discussed four significant decisions made by senior executive team. I would like to get your perspective on the decision-making process used for each of the following instances \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

Specific questions about these decisions include:

1. What made this decision important?
2. How did the team go about making the decision?
3. What role did values play in the decision-making process?

4. What challenges did you encounter and how did you resolve them?
5. How do you feel about the decisions?
6. How long did it take to make these decisions (among the four)?
7. Were the decisions effective, i.e.: satisfactory (scale of 1-poor,3-avg,5-good)
8. Is there anything else you'd like to say about this decision?

I appreciate your time and support. As a reminder I will be transcribing it, would you like a copy of the transcript?

## Appendix C: Consent Form

### ***Sample Email to Potential Participant***

A sample of an email to potential participants is as follows:

Dear \_\_\_\_\_

My name is Prem Mony and I am currently a doctoral student pursuing a doctorate in Values-Driven Leadership at Benedictine University in Lisle, Illinois. The subject of my doctorate is on values, and value structure among senior healthcare leaders. The title of my dissertation is: *Competing values in Healthcare leadership*.

I am writing because I would like to invite you to participate in this research based upon your demonstrated expertise and excellence as a successful healthcare leader. Your participation would ideally involve 30 minutes of your time to complete the questions on the survey monkey and a minimal of 60 minutes for face-to-face interview. These interviews would be conducted at your convenience, with regard to both time and location. The general interview questions will be provided to you in advance for your review. If you are amenable your participation might also include answering a limited number of follow-up questions for purposes of clarification if necessary.

The research has been approved by the Institutional Review Board (IRB) of Benedictine University and the bona fides of the project and the research will be provided for your review.

The timeline for the research involves conducting the interviews between the months of June, July, August, and September of 2013.

This research will add to the body of knowledge about the “Value structure of senior Healthcare Leaders and how do they work together.” This research could potentially assist with a greater awareness of the how and why of leadership training and development among hospital executives. Though specific to healthcare, the leaders’ value concepts could be applied to other fields as well. I am available to answer any questions you might have about this research and can provide supporting documentation as mentioned above.

Thank you in advance for your consideration of this request.

Sincerely,  
Premalatha (Prem) Mony

## ***Informed Consent Forms for Participants***

### Informed Consent Forms for Participants in the study of values

To:

From: Premalatha (Prem) Mony

Subject: Informed Consent to Participate in Study

Date:

Dear \_\_\_\_\_

My name is Premalatha (Prem) Mony, and I am a PhD student at Benedictine University. I am researching on the topic, "Competing values in Healthcare leadership." This research will add to the body of knowledge about the Value structure of senior Healthcare Leaders and how do they work together. This research could potentially assist with a greater awareness of the how and why of leadership training and development among hospital executives.

Thank you for your willingness to participate in the interview. Your participation is voluntary. You do not have to answer any questions you do not want to answer. If at any time you do not want to continue with the interview, you may decline. Your time and involvement is profoundly appreciated. The entire interview will take approximately one hour. To maintain the essence of your words for the research, I will record the information. At any time you may request to see or hear the information I collect.

The interview will be tape-recorded and the interviewer will take notes. This is done for data analysis. The tape will be transcribed by the interviewer and kept confidential in a password-protected computer.

Excerpts from the interview may be included in the final dissertation report or other later publications. However, under no circumstances will your name or identifying characteristics appear in these writings. If, at a subsequent date, biographical data were relevant to a publication, a separate release form would be sent to you.

I would be grateful if you would sign this form on the line provided below to show that you have read and agree with the contents.

---

Signature above

This study is being conducted in part to fulfill requirements for my Doctor of Philosophy in Values-Driven Leadership in the Center for Values-Driven Leadership at the graduate school of Benedictine University in Lisle, Illinois.

Sincerely,

Premalatha (Prem) Mony  
Benedictine University

This study is being conducted in order to provide data for a published dissertation study as well as additional publications such as articles. The study has been approved by the Institutional Review Board of Benedictine University. The Chair of Benedictine University's Institutional Review Board is Dr. Alandra Weller-Clarke. She can be reached at (630) 829-6295 and her email address is [aclarke@ben.edu](mailto:aclarke@ben.edu). The faculty person who will be responsible for disposal of the information from this research is Dr. Marie E. Di Virgilio. She can be reached at (630) 829-6225 for further questions or concerns about the project/research.

Sincerely,

Premalatha (Prem) Mony

***Informed Consent Form for Transcribers and Coders***

Informed consent forms for transcribers and coders in the study of values

To: Potential transcribers and coders in the study of Values on the date of:

\_\_\_\_\_

From: Premalatha (Prem) Mony

Subject: Informed Consent for Participation in the study of Values for Mony's  
Dissertation Research

Date \_\_\_\_\_

Dear \_\_\_\_\_

My name is Premalatha (Prem) Mony. I am currently pursuing a doctorate as a PhD student at Benedictine University. The subject of my doctorate is on values, and value structure among senior healthcare leaders. The title of my dissertation is: Competing values in Healthcare leadership. This is a request for informed consent for your participation in this study. Your participation will include transcription or coding of the interviews within the study.

It is important to note that there is the possibility that there will be identifying information provided from this research. Your name may be presented in connection with transcriber or coder within the study. The research will be used specifically for the purpose of the dissertation and could also be used for other publications such as articles or a book.

This study involves confidential information. Specifically, all the data content from the study including from the interviews and any additional statements from the participants or the researcher must be considered as confidential and proprietary by you. Your signature on this informed consent form acknowledges the confidential nature of the material you will be accessing as part of your involvement in this research. Your signature also signifies your agreement that you will not disclose in any way, at any time in the present or the future, to anyone apart from the researcher (Premalatha Mony), any of the information or content of this study. Your signature additionally signifies that you understand that failure to abide by the confidential and proprietary nature of this consent form could subject you to legal or other consequences for breaching your agreement to maintain confidentiality regarding this study.

Data from the study will be stored on a computer disc and transmitted to a Benedictine university faculty member for secure and ultimate disposal after a period of seven years. Dr. Marie E. Di Virgilio is the Benedictine University faculty member



who will secure and ultimately dispose of the information. Her information is at the end of this form.

I hereby consent to participate in this research under the conditions listed above. My consent is formally indicated by my signature below.

I would be grateful if you would sign this form on the line provided below to show that you have read and agree with the contents. Please return it by email to me at [Premalatha@aol.com](mailto:Premalatha@aol.com). An electronic signature is acceptable.

---

Your signature or electronic signature above  
(If you have problems with the electronic signature please call me at: 630-697-2354)

This study is being conducted in order to provide data for a published dissertation study as well as additional publications such as articles or a book. The study has been approved by the Institutional Review Board of Benedictine University. The Chair of Benedictine University's Institutional Review Board is Dr. Alandra Weller-Clarke. She can be reached at (630) 829-6295 and her email address is [aclarke@ben.edu](mailto:aclarke@ben.edu). The faculty person who will be responsible for disposal of the information from this research is Dr. Marie E. Di Virgilio. She can be reached at (630) 829-6225 for further questions or concerns about the project/research.

Sincerely,

Premalatha (Prem) Mony

## Appendix D: Code Definitions

**Authentic:** Real or genuine, not copied or false, while demonstrating humility, honesty, and gratitude

**Courage:** Demonstrating a commitment and determination to do something that is difficult/ dangerous, or in the face of adversity, as noticed in change agents

**Excellence:** Demonstrating extreme high quality, leading to organizational wealth and sustainability

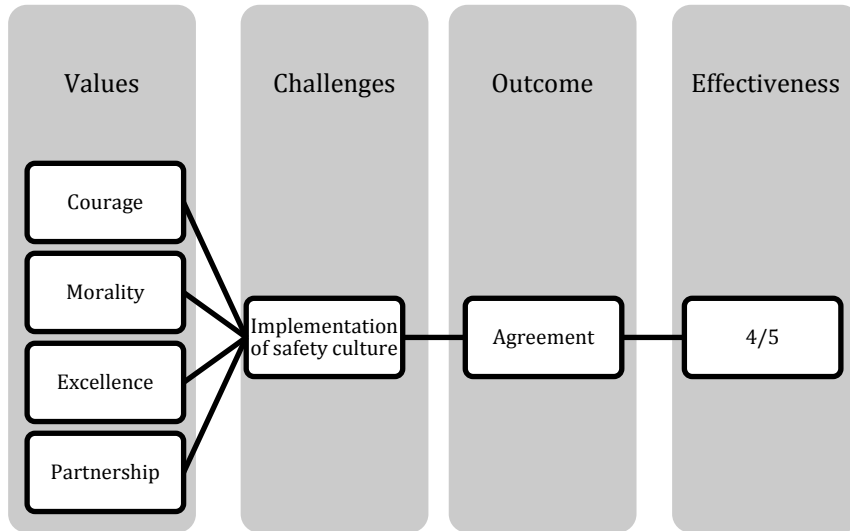
**Morality:** Concerning or relating to what is right and wrong in human behavior, demonstrating value congruence in words and actions

**Partnership:** A relationship involving close cooperation and collaboration between individuals working towards a common goal and shared vision

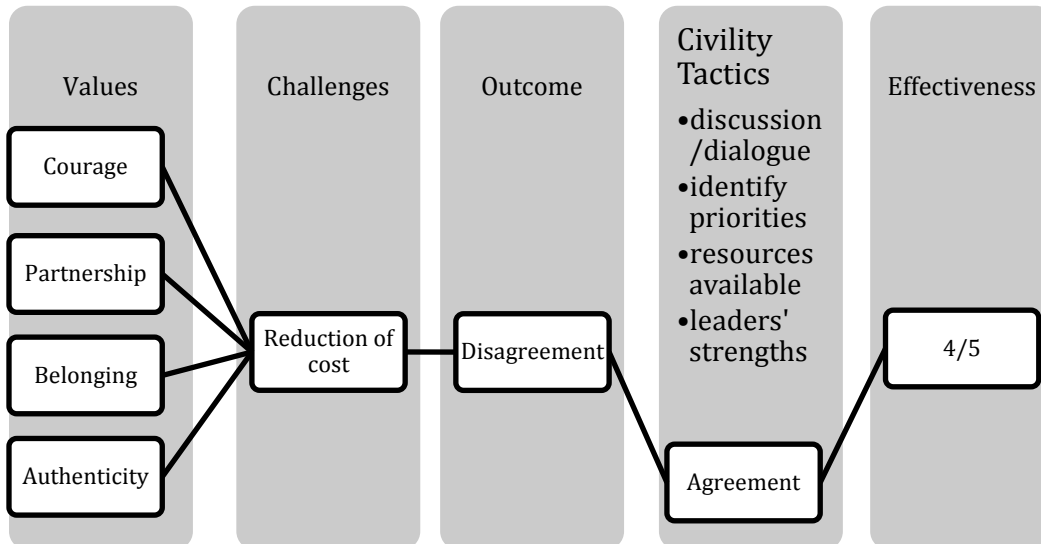
**Positive belief:** Feeling or belief that good things will happen in the future, while being confident and optimistic.

**Belonging:** Close or intimate relationship and working jointly with others or together leading to a social capital

## Appendix E: Category Models



**Figure 15. Decision: Implementation of Safety Culture**



**Figure 16. Decision: Reduction of Cost**

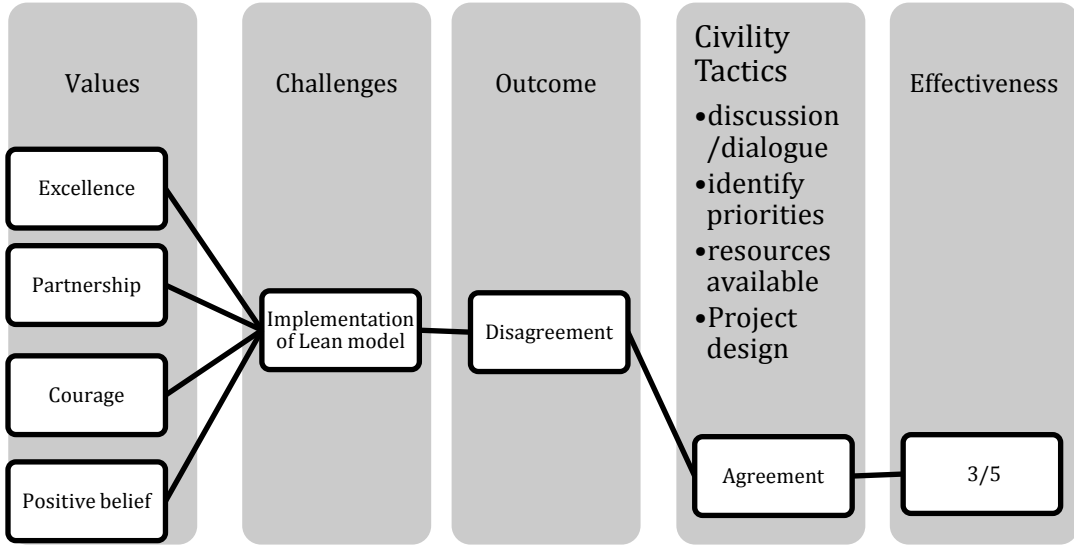


Figure 17. Decision: Implementation of Lean Model

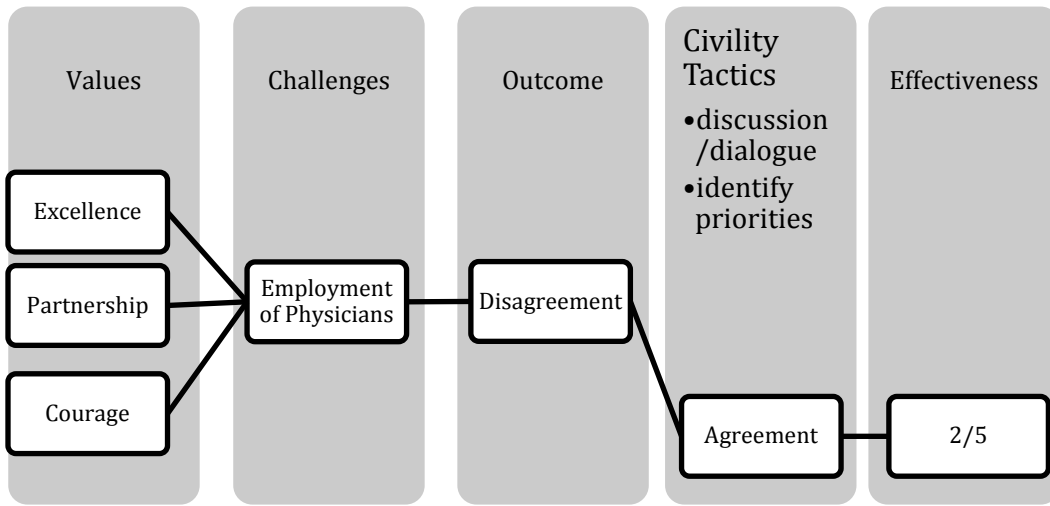


Figure 18. Decision: Employment of Physicians

## Appendix F: RVS Results

**Table 7. Distribution of Terminal Values by Rokeach Value Survey in a Select Sample of Senior Healthcare Executives**

Item	Median (25 <sup>th</sup> & 75 <sup>th</sup> centiles)
A comfortable life	6.00 (4.75, 6.25)
An exciting life	5.00 (5.00, 6.87)
A sense of accomplishment	7.00 (6.00, 7.87)
A world at peace	4.00 (3.75, 5.25)
A world of beauty	4.00 (4.00, 6.00)
Equality	7.00 (5.75, 7.00)
Family security	7.00 (6.75, 7.00)
Freedom	7.00 (5.50, 7.00)
Happiness	6.00 (5.00, 7.00)
Inner harmony	6.00 (4.75, 7.00)
Mature love	6.00 (5.75, 7.00)
National security	6.00 (4.00, 6.25)
Pleasure	5.00 (3.75, 6.00)
Salvation	6.00 (4.50, 7.00)
Self-respect	7.00 (6.00, 7.00)
Social recognition	4.00 (2.75, 5.00)
True friendship	6.00 (5.00, 7.00)
Wisdom	7.00 (6.00, 7.00)

**Table 8. Distribution of Instrumental Values by Rokeach Value Survey in a Select Sample of Senior Healthcare Executives**

<b>Item</b>	<b>Median (25th &amp; 75th centiles)</b>
Ambitious	6.00 (5.00, 7.00)
Broadminded	6.00 (5.00, 7.00)
Capable	6.50 (6.00, 7.00)
Cheerful	6.00 (5.00, 7.00)
Clean	4.00 (2.75, 5.00)
Courageous	6.00 (5.75, 7.00)
Forgiving	6.00 (4.00, 6.25)
Helpful	6.00 (5.50, 7.00)
Honest	7.00 (6.00, 7.00)
Imaginative	5.00 (4.75, 6.00)
Independent	6.00 (5.00, 7.00)
Intellectual	6.50 (4.75, 7.00)
Logical	6.00 (5.00, 6.25)
Loving	6.00 (5.00, 7.00)
Obedient	4.50 (3.75, 6.00)
Polite	6.00 (5.00, 7.00)
Responsible	6.50 (6.00, 7.00)
Self-controlled	6.00 (4.75, 6.25)

## Appendix G: Guide for Intercoder Reliability Checking

To study the competing values that exist among senior healthcare executives.

Overview: This document guides the process of coding data collected for a qualitative study on the values described by the executive leaders while relating to the four major decisions made within the past year and half. Through narration and story-telling, the researcher attempts to study the values verbalized and demonstrated during the process.

Research Context: The participants for the interview are the President and the Vice-presidents of a hospital from a major healthcare system in Midwest. The study was initiated by interviewing the president, who was asked to state the four major decisions that were made within the executive team, followed by the VPs to recapture the perspectives from the decisions that were made.

Research Questions: The researcher is interested in understanding the competing values that exists within senior executive leaders in a healthcare organization. Things you might look for-but should not be limited by-include:

1. Are the leaders able to articulate the values that he/she possesses?
2. What are the different values expressed both directly and indirectly?
3. Does these values play a role or guide them in the decision-making process or during the implementation of the decisions?
4. Has there been a change in the values with the various decisions?
5. Are there any consistency of values across the four decisions?
6. Do you notice a leadership style that is predominant among these leaders?

Directions:

1. Familiarize yourself with the research questions.
2. Read each passage from the transcript
3. As you read the passage, think about the research questions: what values do you see that are verbalized/demonstrated while going through the four decisions.
4. For each passage, please note your observations about the values.
5. Save the document, add your initials to the document name. For example: 'codevalidationPM' –in which, the document name is codevalidation and PM represents the coder's initials.

Please contact Prem Mony if you have any questions regarding this process.

## Glossary

AOMJ	Academy of Management Journal
ASQ	Administrative Science Quarterly
BSC	Balanced Score Card
CMR	California Management Review
CMS:	Centre for Medicare and Medicaid Services
CPAD	Cost per Adjusted Discharge
CVF	Competing Values Framework
FTE	Full Time Exempt
HBR	Harvard Business Review
ISO 9000	International Organization for Standardization
LBDQ	Leader Behavior Description Questionnaire
LMX	Leader Member Exchange
LOS	Length of Stay
MBE	Management by Exception
NHS	National Health Service
ROI	Return on Investment
RVS	Rokeach Value Survey
SPSS	Software Package used for Statistical Analysis
SVS	Schwartz Value Survey
TQM	Total Quality Management



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