Understanding the Ethical Behavior of Healthcare Personnel: A Perspective of Human Resource Management

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ABSTRACT

Healthcare ethical behavior is an important topic in health industry. This study proposes a conceptual model and eight propositions from a perspective of human resource management, and provides with useful managerial implications for reference of management in healthcare. The proposed model suggests that healthcare ethical behavior differs among individuals, and is influenced directly by subjective norm, attitude, perceived behavioral control and ethical judgments, while also being influenced indirectly by idealism and relativism through the mediation of perceived behavioral control and ethical judgment. Last, conclusion and limitation of this situation are provided.

**Keywords:** Healthcare ethical behavior, subjective norm, attitude, ethical judgment, idealism, relativism.

INTRODUCTION

Medical ethics in healthcare have become an important part of society. The facet of medical ethics that is an applied science is finding its place in healthcare facilities and management (La Puma, 1990). However, there have been ethical dilemmas in healthcare as long as there have been sick or injured people looking for help from physicians and medical staffs (Ehlen and Sprenger, 1998). Unethical behavior in medical practice is concerned with ethical behavioral conflicts in the process of identifying, analyzing, and resolving the moral problems of particular patient’s care (La Puma, 1990). While ethical behavior in medical practice has been demonstrated to be beneficial to patients and medical staffs, unethical behavior has caused significant injury to them. Performing ethical behavior in healthcare by, for example, preserving patient confidentiality, medical staffs should respect patients’ autonomy, abide by their obligation to reciprocate patients’ trust, and preserve public confidence in the staff-patient relationship in healthcare (McNaughton, Mitchell, Hernandez, Padilla and Blandon, 2006). In a long run, patients who trust their medical providers to safeguard their secrets are more likely to seek prompt care for stigmatized health conditions and to disclose sensitive information necessary for appropriate treatment and diagnosis (McNaughton et al., 2006).

Healthcare has historically put emphasis on the confidentiality of the patient-physician relationship, stressing the importance of protecting the patient’s privacy (Carney, 2001). In recent years, the subject of medical ethics has put emphasis on the duties of the health staffs to protect patient confidentiality, to ensure informed consent, and to guard against the provision of medical services for reasons other than patient need (Ehlen and Sprenger, 1998). Ethical behaviors performed by the medical staffs may facilitate quality decision-making at all levels and they can be also helpful to shape the way management run the healthcare organizations. Thus, it is important to understand how individuals in healthcare perform ethical and/or unethical behavior.

It is the responsibility of the healthcare organizations to put into place security practices that safeguarded protected health information (Carney, 2001). Thus, those in areas of organizational integrity, legal, and human resource are being challenged to develop updated policies and to confront cases that may raise many new ethical questions for them as to what is the proper response to the growing number of breaches of patient privacy and electronic health record (Carney, 2001). For instance, even though ethical and human rights standards oblige providers to respect patients’ privacy, eighty percent of obstetrician-gynecologists mistakenly believed that reporting was required (McNaughton et al., 2006).

Examples such as breaches of confidentiality and the electronic community health record have been a frequently discussed in the popular press (e.g., McNaughton et al., 2006). Prior to the release of some regulations related to
medical privacy, healthcare organizations have struggled to establish a proper process for investigating breaches of confidentiality, specifically electronic breaches, and then to create a proper process of progressive guidance for addressing breaches (Carney, 2001). It has been posited that, while organizations continue to establish and implement more protective security measures, unethical behavior of medical practice will remain problematic in the 2000s and beyond. Hence, predicting behavior of medical ethics is a major objective of ethical theories in the context of healthcare, and some very useful theories for investigating unethical behavior have been proposed. For example, the theory of reasoned action, theory of planned behavior, and their extensions have been found very useful in predicting various intention and behavior (Madden, Ellen and Ajzen, 1992). These theories will provide a better foundation for researchers investigating unethical behavior of medical ethics.

The main purpose of this study is to develop a conceptual model and several propositions which are important to ethical issues in healthcare so that management may effectively plan appropriate strategies of human resource management in healthcare.

**THEORETICAL BACKGROUND**

A theory on which the line of ethical research is frequently based in the Theory of Reasoned Action (TRA) proposed by Ajzen and Fishbein (1980). TRA (Ajzen, 1991; Ajzen and Fishbein, 1980) has been extensively utilized as a theory to predict behavior. It is noted in a meta-analysis (Sheppard et al., 1988) that the model not only predicts ethical behavior well but also is helpful for identifying where and how to target strategies for changing the behavior.

The TRA posits that behavior is a function of salient information or beliefs about the likelihood that performing a particular behavior will lead to a specific outcome. The TRA, which is rooted from social psychology, is based on the assumption that human beings are usually quite rational and make systematic use of the information available to them, and that people consider the implications of their actions before they decide to engage or not engage in a given ethical behavior (Ajzen and Fishbein, 1980). An exploratory analysis by Loch and Conger (1996) on one hundred and seventy four students has been conducted to examine the applicability of the TRA and to describe the ethical decision-making process in the issues of computer piracy and resource ownership, but it was found that TRA failed to describe the ethical decision-making process appropriately. Other researches have reached the similar conclusion (Randall, 1989; Randall and Gibson, 1990).

While TRA was developed and established based on the assumption that the behaviors were under full volitional control, a more extension of the model proposed by Ajzen (1985), the theory of planned behavior (TPB), explicitly incorporates perceived behavioral control as a predictor of behavior and intention. As described above, the appropriateness of TRA for ethics research has been questioned (Loch and Conger, 1996; Banerjee et al., 1998; Thong and Yap, 1998), probably because ethical decisions are complex and involve unpredictable factors that cannot captured with only two TRA constructs, the attitude toward a behavior and the subjective norm governing that behavior. For that reason, we may speculate (Chang, 1998) that the TPB might serve ethics research better since a third construct, perceived behavioral control (PBC), is included to the original TRA model.

As perceived behavioral control refers to the perceived control over a given ethical behavior or behavioral goal, it is one’s disposition that holds his or her beliefs concerning his or her capacity to perform a certain behavior. The more resources and opportunities individuals think they posses, the greater should be their perceived behavioral control over the behavior. As in the case of behavioral and normative beliefs, it is also possible to separate these beliefs and threat them as partly independent determinants of behavior. Compared to the TRA, perceived behavioral control as an exogenous variable is added in the TPB. Perceived behavioral control has both a direct effect on behavioral intentions and an indirect effect on behavior via intentions (Ajzen, 1985). Whenever individuals believe that they have little control over performing the behavior due to a lack of requisite resources, then their behavioral intentions may be low even if they have favorable attitudes or subjective norms regarding performance of the behavior (Madden et al., 1992).

**Conceptual Model and Propositions Development**

The proposed conceptual model of this study based on TPB, displayed in Fig. 1, is directly modified from Barnett,
Bass and Brown (1996) and Chang (1998), which have been originally demonstrated in the theory of planned behavior (Ajzen and Madden, 1986; Ajzen, 1991). The ethical judgment excluded in the previous studies of Barnett et al. (1996) and Chang (1998) is proposed herein due to its critical role to explore the ethical behavior of healthcare (Ajzen and Fishbein, 1980; Hunt and Vitell, 1986). More specifically, ethical behavior of healthcare is simultaneously influenced by subjective norm, attitude, perceived behavioral control and ethical judgment, while the ethical judgment is influenced by idealism and relativism.

The reason why this study is established based on TPB rather than TRA is because some investigations have suggested that TPB may be better than TRA for predicting human behaviors in certain domains of human functioning (Chang, 1998; DeVries et al., 1990; Kok et al., 1991). The TPB (Ajzen, 1985) expands the boundary condition of pure volitional control indicated by the TRA. This is accomplished by including beliefs regarding the possession of requisite resources and opportunities for performing a given ethical behavior.

The social component of Fishbein and Ajzen’s model is the subjective norm (Fishbein and Ajzen, 1975). Subjective norm is referred as the perception of an individual that most people who are important to him think he should or should not act a given behavior (Ajzen and Fishbein, 1980). The theory forecasts that the more an individual staff perceives that important others think he or she should engage in specific behavior of healthcare, the more likely the individual intends to do so (Fishbein and Ajzen, 1975). In the present study, subjective norm is considered to affect ethical behavior in healthcare (e.g., Chang, 1998) if the individual staff believes that significant others think he or she should engage in the ethical behavior, and if he or she is motivated to comply with those significant others (Lin, Tang, Chiu and Hsiao, 2005). Thus, the proposition is derived as follows:

P1: Subjective norm is positively related to healthcare ethical behavior.

Fishbein and Ajzen (1975) divide the beliefs antecedent to behavioral intention and behavior into two conceptually distinct dimensions: behavioral and normative. The behavioral beliefs are postulated to be the underlying influence on an individual’s attitude toward performing the behavior, whereas the normative beliefs affect the individual’s subjective norm about performing the behavior. Thus, information or salient beliefs affect behavior either through attitudes or through subjective norms. As noted by Fishbein and Ajzen (1975), exogenous variables of the model are hypothesized
to affect behavior indirectly through the mediation of attitudes or subjective norm. Attitude towards behavior in healthcare can be defined as a person’s general feeling of favorableness or unfavorableness for a particular ethical behavior in healthcare (Ajzen and Fishbein, 1980). Considerable ethical attitude research literature has established that attitude is a reliable predictor of behavioral intentions and subsequent behavior (Ajzen and Fishbein, 1980; Ajzen, 1991).

P₁: Attitude is positively related to healthcare ethical behavior.

Perceived behavioral control is defined as “people’s perception of the ease or difficulty of performing the behavior of interest” (Ajzen, 1991). Behavior that is not under complete volitional control requires their performers to have certain resources and opportunities for performing them (Lin and Ding, 2003a). The perceptions of performers concerning whether they have these resources will likely affect their behavior, as well as their subsequent success or otherwise (Lin and Ding, 2003a). Consequently, perceived behavioral control has a positive association with ethical behavior in healthcare.

P₂: Perceived behavioral control is positively related to healthcare ethical behavior.

Ethical judgment in healthcare can be seen as the degree to which a medical behavior in question is considered morally acceptable by an individual (Reidenbach and Robin, 1990). The theory of reasoned action (Ajzen and Fishbein, 1980) implied that individuals’ judgment in healthcare may influence their medical behavior in healthcare. Consistent with this perspective, many previous studies regarding ethical issues suggested that ethical judgment and ethical intention and behavior are important components of the ethical decision making process (Cherry and Fraedrich, 2000; Thong and Yap, 1998). Numerous research presented that ethical judgment significantly influence the behavioral formation. Most empirical studies related to ethical decision making found that individuals who judge an action to be highly ethical are more likely to perform the ethical behavior (Ajzen and Fishbein, 1980; Hunt and Vitell, 1986). Consequently, the ethical judgment can be proposed to be significantly linked to ethical behavior in healthcare.

P₃: Ethical judgment is positively related to healthcare ethical behavior.

It has been argued by Forsyth (1980) that differences in the classical ethical philosophies may be parsimoniously illustrated by two constructs, including relativism and idealism (Lin and Ding, 2003b). It was proposed that these two constructs, when applied to individuals, describes their ethical ideology (Forsyth, 1980).

Ideological differences in ethics have been examined and assessed as a potential explanatory variable for differences in ethical judgment of an individual staff across different industries (Lin and Ding, 2003b). The empirical results in previous research suggest that individuals who differ in idealism and relativism approach ethical problems differently, and usually obtain different conclusions concerning the morality of particular behavior in their profession (Barnett, Bass and Brown, 1994; Forsyth and Berger, 1982; Forsyth, 1980; Forsyth and Nye, 1990; Stead, Worrell and Stead, 1990). Individual ideologies and judgment about the ethical behavior in healthcare may be associated in two critical ways. First, differences in ethical ideology may affect the way individual staffs process information about problems involving medical ethics (Forsyth, 1985). Second, degree of sensitivity to unethical matters may differ among individuals with different ideologies (Forsyth, 1981).

Based on the rationale above, different kinds of ethical ideologies would be anticipated to have a direct influence on both the perceived behavioral control and the ethical judgment of individual employees in healthcare. In particular, idealists are strongly concerned for the welfare of others, and therefore are likely to evaluate the possible damage unethical behavior may cause to others (Lin and Ding, 2003b), and to consider behavior highly unethical if it has the potential to harm the well-being of their patients. In addition, idealists may judge that complying with ethical codes in healthcare is an acceptable solution to safeguard organizational interests against unethical wrongdoing (Lin and Ding, 2003b). Besides, healthcare staffs who are highly sensitive to patient well-being will be more likely to perform ethical behavior as an ethical means of safeguarding the interests of the organization in healthcare. For example, it was found that individuals believe peer reporting to be more ethical when the wrongdoing has the potential to harm the organization of healthcare (Trevino and Victor, 1992). Consequently, idealism is proposed to be positively associated
with perceived behavioral control and ethical judgment in healthcare.

P3: Idealism is positively related to perceived behavioral control in healthcare.
P5: Idealism is positively related to ethical judgment in healthcare.

In contrast, relativists believe that it is impossible to make accurate ethical judgment regarding individuals’ behavior without knowing all the specific circumstances behind the behavior, and thus are less likely to judge behavior harshly (Forsyth, 1980, 1981, 1985). Besides, relativists are less likely to reveal their perceived behavioral control. Previous research found that non-relativistic individuals were less likely than relativists to violate a societal norm for personal gain (Forsyth and Nye, 1990). This raises the possibility that relativists may be more inclined than non-relativists to engage in self-beneficial unethical behavior (Lin and Ding, 2003b), and are more likely to perform unethical behavior. Consequently, employees’ relativism is negatively linked with perceived behavioral control and ethical judgment in healthcare.

H3: Relativism is negatively related to perceived behavioral control in healthcare.

H5: Relativism is negatively related to ethical judgment in healthcare.

CONCLUSIONS

The findings of this study suggest that healthcare ethical behavior differs among individual staffs, and such behavior is influenced directly by individuals’ subjective norm, attitude, perceived behavioral control and ethical judgments, as well as indirectly by idealism and relativism. Meanwhile, HR management may be able to influence healthcare ethical behavior directly or indirectly through the above constructs. For instance, management can attempt to prescribe responsibility, by strengthening idealism to enhance positive ethical judgment in organizational codes of conduct, which may help create an environment that is more conducive to good ethical behavior. Efforts to re-educate staffs about healthcare ethical behavior as an in-role rather than an extra-role behavior are worthwhile for patients’ well-being. Many measurements for organizational control, such as patients’ “hotlines” are likely to strongly influence individual decisions on whether to behave ethically. Management should also highlight the serious consequences if staffs perform unethical behavior.

A patient satisfaction survey for medical staffs in terms of their ethical behavior may be conducted to gather insights about customer concerns, needs, anticipations and complaints. The information of the survey should be compiled and transcribed into verbatim reports that are distributed to all department heads on a monthly basis (Mercier and Fikes, 1998). This kind of survey is helpful for identifying ethical problems in healthcare. The survey can be conducted via postal mail, telephone or e-mail following patients’ discharge from the healthcare organizations. It is necessary to respond to every negative comment made by a patient in case there exist serious ethical problems.

Medical staffs should make quality care and service realized by conforming healthcare ethics. Staffs are anticipated to act on behalf of patients with skill and sensitivity. Continuous improvement in ethics is anticipated to be an integral and routine part of the job of everyone in healthcare. Support staff, as well as the healthcare staffs, should be included in improvement teams and work groups for practicing medical behavior in accordance with ethics. Educational courses related to ethics in clinical processes, certifications, management, and performance should be provided to everyone in healthcare. It is important to note that training of work groups or teams on the tools and technique of quality improvement for ethical measurements should be done on a just-in-time basis.

Ethical committees may be established for contributing to healthcare policies and providing an open forum for multidisciplinary discussions of ethical issues (La Puma, 1990). In addition, medical staffs may ask healthcare ethicists for help in case they bump into ethical dilemmas. Healthcare ethicists have a staff obligation to effect morally permissible outcomes; their role as liaison may appropriately include persuasion instead of coercion (La Puma, 1990).
LIMITATION AND FUTURE RESEARCH

The propositions proposed herein make up the first research limitation. Given that the model developed in this paper benefits healthcare management practice, empirical studies may supplement this study with statistical tests from either a cross-sectional or longitudinal design. However, empirical research might have its own weaknesses, such as a potential common method bias in the use of a questionnaire to measure all constructs and limited generalizability due to cultural and national diversity. In addition, albeit this study found that healthcare ethical behavior may be influenced simultaneously by several antecedents, more research needs to be carried out to empirically test the proposed model of this study. It is also important to test the validity of the model across different occupational fields. Note that the real workplace situation involves more complicated external impacts (e.g., politics, communication), so the different scenario and scales for future research should be designed and developed to fit different research subjects, and further testing on employees in the real healthcare workplace can also be the complementary research of this study. Future research could be instructed at examining directly the relationship between a change in attitudes and the corresponding ethical behavior, and the impact that staffs’ age has on each of them.

REFERENCES


