Moral Courage: A Requirement for Ethical Decision Making in Nursing Home Leadership

Shelley Kobuck

Follow this and additional works at: https://dsc.duq.edu/etd

Recommended Citation

This Immediate Access is brought to you for free and open access by Duquesne Scholarship Collection. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Duquesne Scholarship Collection. For more information, please contact phillipsg@duq.edu.
MORAL COURAGE: A REQUIREMENT FOR ETHICAL DECISION MAKING IN NURSING HOME LEADERSHIP

A Dissertation
Submitted to the Center for Healthcare Ethics
McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Shelley L. Kobuck

May 2015
MORAL COURAGE: A REQUIREMENT FOR ETHICAL DECISION MAKING IN NURSING HOME LEADERSHIP

By
Shelley L. Kobuck

Approved March 25, 2015

Gerard Magill, Ph.D.
The Vernon F. Gallagher Chair
Professor of Healthcare Ethics
(Dissertation Director)

Henk ten Have, M.D., Ph.D.
Director, Center for Healthcare Ethics
Professor of Healthcare Ethics
(Committee Member)

Joris Gielen, Ph.D.
Assistant Professor of Healthcare Ethics
(Committee Member)

Henk ten Have, M.D., Ph.D.
Director, Center for Healthcare Ethics
Professor of Healthcare Ethics

James Swindal, Ph.D.
Dean, McAnulty College and Graduate School of Liberal Arts
(Dean)
ABSTRACT

MORAL COURAGE: A REQUIREMENT FOR ETHICAL DECISION MAKING IN NURSING HOME LEADERSHIP

By
Shelley L. Kobuck
May 2015

Dissertation supervised by Gerard Magill, Ph.D.

Moral courage will no longer be an option for Nursing Home Administrators (NHA) to lead ethically with the projections for the future needs of healthcare services and the governmental involvement in containing the costs of care in the United States. The estimated increase in the 65 year and older population over the next 40 years and the accompanying impacts necessitate that healthcare will need to make significant changes from the care and services that currently exist. This growth in population of older adults will also be coupled with increased disability and declining resources. Due to these trends, persons in leadership positions in nursing homes are going to be increasingly faced with balancing competing needs and the equitable distribution of resources. For a leader to be able to function effectively within this healthcare environment requires moral courage in making the difficult decisions that are being presented. Healthcare has always
been posed with ethical dilemmas at times but the rapid changes and increases in need will not allow for occasional situations to arise that necessitate difficult decisions. These will become the norm for the daily operations for care delivery and the leadership of nursing homes must possess the ability to act courageously as an advocate for the patients and residents within the limited resources.

Like most other healthcare professions, NHAs are not proficiently trained to think in ethical terms, particularly on a day-to-day basis. In addition, there are inadequate ethical guidelines in the professional associations and licensing standards for administrators. Many NHAs do not possess the skills, knowledge, or character to enact moral courage. Without moral courage the residents and patients will not have the ethical representation by the leadership which poses a concern for upholding the best interests of the residents and patients who deserve to be treated with dignity and respect as valued and unique individuals. To think ethically requires education and skill development if not already intrinsic to the person. Ethical actions must follow through the decision making process and moral courage is the conduit for ethical leadership for the Nursing Home Administrator.

To understand these ethical concepts within the healthcare realm of nursing homes and the leadership perspective is to first review the background for this need for moral courage. The heart of holding a leadership position in any healthcare organization is to manage all operational aspects that provide and support the care of the patients and residents. The historical review of healthcare in the U.S. will look at the progression to the current implementation of healthcare reform which is necessitating decisions surrounding competing needs. This evolving healthcare situation is ripening challenges
for moral courage in the forms of limited education in ethics, conflicts of interest, and resource allocation. The typical scenario for ethical dilemmas has been deciding between patient and financial benefits however decisions will increasingly involve choices among competing patient needs when each patient could benefit. Past examples are summarized which outline poor ethical choices among healthcare leaders which will further support an increasing need for moral courage in decision making.

In healthcare moral courage is rooted in providing care to patients in a caring manner. The relationship between moral courage and patient care will be assessed by defining morality and courage. Courage will be further explored from a philosophical perspective within its defining qualities of gaining insight, being motivated to act with courage, and to experience a need to help another which connects it very appropriately to care. The provision of care is the core function of nursing homes which can get lost or forgotten within the organizational complexities. The NHAs who possess the attribute of courage can utilize it through acts of caring. This caring nature can be exhibited by going beyond the self for the leadership and recognizing the sanctity and dignity of all human life which can be displayed in morally courageous decisions. For NHAs to act ethically, they must recognize patients as persons first who are in need of care. To come from the point of the patient is the foundation for decisions, ethically, in which the leader must maintain a human connection. The ethics of care brings together several points that are paramount to ethical decision making for the leadership. This theory includes basic principles for moral development and the relationships between the patients and the caregivers. Although the ethics of care is relationship-based, ethical leadership is still bound to upholding the rights of the patients which are supported by traditional ethical
theories based in justice. The combination of the relationships with the patients, and being an advocate for their rights, aligns moral courage with caring actions.

Moral courage is the core of ethical leadership in nursing homes and starts with a review of determinates that contribute to the NHA leading morally. While there are contributors to strong ethical leadership such as values, competencies, emotional awareness, and accountability, there are also challenges that can lead to moral compromise. There are a variety of leadership styles which will be discussed along with secondary distinctions formulated on traits, which will offer differing approaches in enacting moral courage. Some styles lend themselves more readily to promoting an ethically grounded nursing home. Several models for ethical decision making will be explained which can be applied to morally courageous resolutions.

The actions and decisions of the leadership of all organizations define the ethical climate and their morally courageous decisions set the expectations for the rest of the organization to follow. The combination of written guidelines and the actions of the leadership flow into a level of trust. The nature of the ethical climate will be apparent through both internal and external means and in the value placed on the decisions surrounding quality of care and safety within nursing homes. Compliance and ethics programs serve as another level of support for providing positive ethical environments. These programs can offer nursing homes a constant mode of checks and balances to insure that an atmosphere is maintained which promotes moral courage throughout the organization.

A barrier for leaders to be effective in making decisions requiring moral courage is the need to comprehend and develop a level of competency to do so. Several strategies
will be covered that include ethics education, leadership mentoring, and case study reviews that can be utilized for training and development purposes. Also models for assessing and carrying out decisions based in moral courage will be explained as other resources for leadership development. The author also offers a model of moral courage for consideration.

For the future of nursing homes moral courage will become a requirement in executive leadership for ethical decision making in the best interests of patient care. Given the demographic changes that are evolving along with the anticipated growth and resource allocation, the challenges surrounding ethical dilemmas will become increasingly problematic. Leaders will need to be tethered to a virtuous foundation of courage and care that never loses sight of the patient as person with the sanctity and dignity in all human life. As decisions are navigated through moral courage, which is translated through behaviors and actions of the NHA, they will necessitate that the leadership have the ability to operate beyond self-interests. Where the competencies do not exist there will be a need for leadership development and an even greater need for strength of character among the highest levels of healthcare organizations to establish positive ethical climates. The NHA leaders beginning now and into the future will need to balance the care requirements against resource limitations and financial viability in a more demanding way than ever before in this ever-changing healthcare delivery system.
DEDICATION

This dissertation is dedicated to the memory of my father, John J. Kobuck, Jr., who first taught me the meaning of moral courage.
ACKNOWLEDGEMENTS

A special thank you for all of the support and encouragement I have received from so many and especially to:

❖ My husband, Thurman D. Gardner, and son, Alexander “Sasha” Gardner who continued to love me even with the stress and demands this program and dissertation placed on our personal lives.

❖ To my mother, Alice Kobuck, who has encouraged me all of my life.

❖ To my brother, John J. Kobuck, III, who continues to treat me like his little sister and keeps me humble.

❖ To Linda Drago who has served as a mentor to me since we first met on Duquesne’s Board of Directors.

❖ To the rest of my family and friends who forgave me for the long periods of time when they didn’t hear from me.

❖ To Dr. Gerard Magill who encouraged and supported my writings since I started as a student in the ethics program.

❖ To Dr. Henk ten Have who literally opened the world of healthcare ethics to me by introducing and supporting me in presenting research papers and attending trainings in other countries.

❖ To the Nursing Home Administrators I have had the honor of working with who lead with moral courage every day, especially to Amy Pietrolaj, Benjamin Neil, Robert Etchells, and Richard Valentic.
To the many nursing home patients and residents who were the reasons I was able to move past my fears in leading with moral courage.

And finally, to the Blessed Mother in the grotto who is my beacon of faith and hope, always.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iv</td>
</tr>
<tr>
<td>Dedication</td>
<td>ix</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>x</td>
</tr>
<tr>
<td>List of Abbreviations</td>
<td>xix</td>
</tr>
<tr>
<td>Chapter One: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>A. The Need for Moral Courage</td>
<td>3</td>
</tr>
<tr>
<td>B. Relating Moral Courage to Care and Caring</td>
<td>6</td>
</tr>
<tr>
<td>C. Moral Courage as the Core of Ethical Leadership</td>
<td>18</td>
</tr>
<tr>
<td>D. Moral Courage and Organizational Culture</td>
<td>24</td>
</tr>
<tr>
<td>E. Developing Moral Courage for Leadership Effectiveness</td>
<td>30</td>
</tr>
<tr>
<td>F. Conclusion</td>
<td>32</td>
</tr>
<tr>
<td>Chapter Two: The Need for Moral Courage</td>
<td>42</td>
</tr>
<tr>
<td>A. Defining Moral Courage</td>
<td>43</td>
</tr>
<tr>
<td>1. Morality Defined</td>
<td>43</td>
</tr>
<tr>
<td>2. Courage as a Virtue</td>
<td>47</td>
</tr>
<tr>
<td>3. The Power of Fear</td>
<td>48</td>
</tr>
<tr>
<td>4. Introducing Courage for Moral Decision Making</td>
<td>50</td>
</tr>
<tr>
<td>B. Demographics for an Aging Society</td>
<td>53</td>
</tr>
<tr>
<td>1. Age Trends and Projections</td>
<td>53</td>
</tr>
<tr>
<td>2. Forecasts for Medical Conditions and Care Needs</td>
<td>54</td>
</tr>
<tr>
<td>3. Reduced Workforce for Caregivers</td>
<td>55</td>
</tr>
</tbody>
</table>
Chapter Three: Relating Moral Courage with Care and Caring .............................................. 84

A. Fundamentals of Care ........................................................................................................... 86

1. Care as a Virtue ................................................................................................................... 85
2. Valuing the Person in Care ............................................................................................... 89
3. Compassion and Suffering ............................................................................................... 93
4. Recognizing Grief ............................................................................................................. 102

B. Moral Character for Caring .............................................................................................. 104

1. Beyond the Self ............................................................................................................... 104
2. Character Traits of Caring ............................................................................................... 106
   a) Sympathy ...................................................................................................................... 107
   b) Empathy ...................................................................................................................... 108
   c) Honesty ....................................................................................................................... 110
   d) Love ............................................................................................................................. 111
C. An Ethics of Care: From Obligation to Responsibility ........................................ 114

1. Moral Development of an Ethics of Care .................................................. 114
   a) Moral Development by Kohlberg ..................................................... 115
   b) The Voice of Gilligan ........................................................................ 116

2. Evolved Versions of Gilligan’s Voice ....................................................... 119
   a) Ruddick ......................................................................................... 119
   b) Tronto ............................................................................................ 120
   c) Noddings ....................................................................................... 120
   d) Held ............................................................................................... 121

D. Leadership’s Responsibility to Care and Rights ........................................ 122

1. From Responsibility to Care ................................................................. 123
   a) Relationships to Others ................................................................. 123
   b) Compared to Virtue Ethics ............................................................ 124
   c) Care Areas of Responsibility ......................................................... 125
   d) Moral Reasoning in Support of an Ethics of Care ......................... 128

2. Bound to Duties and Rights within Skilled Nursing Facilities ............ 133
   a) Duties ............................................................................................ 134
   b) Rights ........................................................................................... 135
   c) Exploring Traditional Moral Theories ......................................... 138

E. Aligning Moral Courage with Caring Actions .......................................... 148

1. Leadership Connectedness ................................................................. 148

2. Care as the Priority .............................................................................. 149

F. Conclusion ............................................................................................ 150
Chapter Four: Moral Courage as the Core of Ethical Leadership ........................................... 160

A. Determinants of Ethical Leadership .................................................................................... 161

1. Moral Competencies ........................................................................................................ 161
2. Values ................................................................................................................................. 163
3. Emotional Awareness ....................................................................................................... 165
4. Accountability for Self and Others .................................................................................. 168

B. The Slippery Slope of Moral Compromise ..................................................................... 172

1. Moral Relativism .............................................................................................................. 173
2. Principle of Cooperation .................................................................................................. 174
3. Obedience and Conformity .............................................................................................. 178
4. Groupthink ..................................................................................................................... 179

C. Leadership and Power ..................................................................................................... 182

1. Types of Power ................................................................................................................ 182
2. Followership .................................................................................................................... 185
3. Effective Use of Power .................................................................................................... 186

D. Leadership Styles and Viewpoints .................................................................................. 187

1. Leadership Styles ............................................................................................................ 187
   a) Directive .................................................................................................................... 188
   b) Transactional ............................................................................................................. 189
   c) Transformational ..................................................................................................... 191
2. Leadership Based in Traits ............................................................................................ 192
   a) Situational ................................................................................................................. 193
   b) Values-based ............................................................................................................ 194
<table>
<thead>
<tr>
<th>E. Models of Ethical Decision Making</th>
<th>198</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Realm-Individual Process-Situation</td>
<td>199</td>
</tr>
<tr>
<td>2. Magill and Devlin</td>
<td>200</td>
</tr>
<tr>
<td>3. Kidder’s Checkpoints</td>
<td>201</td>
</tr>
<tr>
<td>4. Purtilo and Doherty</td>
<td>203</td>
</tr>
<tr>
<td>5. Jonsen, Siegler, and Winslade</td>
<td>205</td>
</tr>
</tbody>
</table>

F. Conclusion .................................................. 207

Chapter Five: Moral Courage and Organizational Culture ........................................ 214

A. Determining Ethical Climates ............................................... 215

1. Victor and Cullen’s Theory ........................................ 215

2. The Role of Moral Agency in Leadership ...................................... 217

   a) Organizational Philosophy ........................................ 219

   b) Professional Ethics through Codes .................................. 220

   c) Regulatory Requirements ......................................... 222

   d) Policies .................................................................. 223

3. Trust ................................................................. 225

   a) Trust in Relationships ........................................... 225

   b) Theories of Leadership Trust ..................................... 227

B. Indicators of Ethical Climates ........................................... 230

1. Segments of Ethical Climates ........................................... 230

2. Measures of Ethical Climates ........................................... 232
a) Internal Ethical Climates ................................................................. 232
b) External Ethical Climates ................................................................. 234

C. Promoting Cultures of Quality and Safety ........................................ 239

1. Quality of Care ..................................................................................... 239
   a) Quality Assurance and Improvement Strategies.................................... 241
   b) Patient Quality Outcomes ................................................................. 242

2. Safety as a Function of Quality ............................................................ 243
   a) Defining an Ethical Culture of Safety .................................................. 243
   b) Medical Errors, Harm, and the Human Factor ...................................... 245

3. Strategies for Prevention ...................................................................... 247
   a) Working in Systems ........................................................................... 248
   b) Models of Risk Management ............................................................. 249
   c) Measuring Safety .............................................................................. 251

4. Moral Obligations for Errors ................................................................. 252
   a) Reporting ......................................................................................... 253
   b) Patient Notifications ........................................................................ 254

D. The Function of Compliance and Ethics Programs ................................. 255

1. Compliance Programs .......................................................................... 256
   a) A Historical Basis ............................................................................ 256
   b) The U.S. Organizational Sentencing Guidelines ................................. 257

2. Ethics Programs and Committees ......................................................... 257
   a) Consultations .................................................................................. 258
   b) Education ....................................................................................... 259
LIST OF ABBREVIATIONS

ACHCA – American College of Health Care Administrators
ACO – Accountable Care Organizations
AHRQ – Agency for Healthcare Research and Quality
AIMS – Advanced Incident Management Systems
AIT – Administrator-in-Training
CMS – Centers for Medicare and Medicaid
CQI – Continuous Quality Improvement
DRG – Diagnosis Related Groups
EI – Emotional Intelligence
GDP – Gross Domestic Product
HCUP – Healthcare Cost and Utilization Project
NAB – National Association of Long Term Care Administrator Boards
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
NHA – Nursing Home Administrator
HRO – High Reliability Organizations
JCAHO – Joint Commission for the Accreditation of Hospitals
LMX – Leader Member Exchange
MEPS – Medical Expenditure Panel Survey
OIG – Office of the Inspector General
OSHA – Occupational Safety and Health Act
PPO – Preferred Provider Organization
PPS – Prospective Payment System
PSDA – Patient Self Determination Act
QAPI – Quality Assurance and Process Improvement
RCA – Root Cause Analysis
RIPS – Realm-Individual Process-Situation
RUG – Resource Utilization Groups
TQI – Total Quality Improvement
VDL – Vertical Dyad Linkage
Chapter One: Introduction

Moral courage as a requirement for ethical decision making in nursing home leadership is the thesis that will be defended throughout this dissertation. Moral courage will be defined to establish the central theme for the argument. The demographics for the aging population and their care needs combined with the Health Care Reform Act of 2010 and healthcare’s need to reduce expenses, will support the increased requirement for moral courage in decisions.

Moral courage in relation to care and caregiving will position the argument from the point of the value of the patient as a person and the sanctity and dignity of all life which is the ethical substance to the need for moral courage as a requirement. The rights of the patient and the ethics of care will be balanced in the approach to the nursing home administrator (NHA) being the advocate within ethical decision making.

Moral competencies, values, emotional awareness, and accountability will provide the framework for determinants of ethical leadership. Types of moral compromise are covered which shed light on ways that movement away from ethical thinking can happen and can stifle acts of moral courage. Leadership styles and traits are deliberated with their impact on ethical decisions. The NHA’s decisions and the cascading effect they have on the ethical culture of an organization will be explained with an emphasis on quality and safety. These areas are clear indicators of the priorities within nursing homes and are specifically where moral courage will be needed in acting in the best interests of the patients.

With a thesis stating that moral courage is necessary, the final chapter offers strategies for developing courageous leadership skills and competencies through ethics.
education, leadership mentoring, and case study reviews. Several models for moral courage are also explored as they related to develop moral courage as a competency.

In nursing homes, ethics have been compartmentalized and are brought into the discussion such as when a dispute among family members arises regarding end-of-life decisions. What is missing is the understanding that all decisions become ethical in nature when the core business of an organization is caregiving such as in nursing homes. Thus an argument for moral courage as a requirement for ethical decision making from nursing home leadership is proposed. The nursing home administrator (NHA), by position, is designated as the leader of all operational areas and is where the ethical standards are established. There needs to be an expanded view of the responsibilities that come with all decisions when overseeing a nursing home. The residents and patients are entrusted to the care of the nursing home and the NHA has the responsibility to place them at the center of all decisions.

As nursing homes become more prominent players in the healthcare continuum with the significant increase in the aging population and a trend in reducing expenses, the need for ethical considerations will become even greater in determining the equitable distribution of resources. NHAs are not trained to think in ethical terms, particularly on a day-to-day basis, and there are limited ethical guidelines in the professional associations and licensing standards for NHAs. Many NHAs do not possess the skills, knowledge, or character to enact moral courage. Without moral courage the residents and patients will not have an advocate in the NHA and they deserve to be treated with dignity and to be respected and valued as unique individuals. To think ethically requires education and skill development if not already intrinsic to the person, however ethical actions must
follow through the decision making process and moral courage is the conduit for ethical leadership for the NHA.

A. Need for Moral Courage

Chapter Two begins with setting the foundation for the need for moral courage if it is to be argued as a requirement. Nursing homes no longer exclusively serve the long term chronically ill resident who comes to the facility to die. The nursing homes are seeing higher amounts of short term patients who stay days to months for rehabilitation and return to their homes. The needs for each group are very different and each brings a host of ethical dilemmas for the Nursing Home Administrator (NHA) to solve. For a healthcare leader, taking action often means to make decisions founded in moral courage.\(^1\) Moral courage serves as the basis for this dissertation and is viewed from its philosophical history of physicality to the transition to moral action within behaviors in taking the right actions for others. This virtue evolved physically but the fear remains as an obstacle to overcome. Today’s battlefield for the NHA is the in the growth of the aging population and the increase in longevity which will increase the needs for nursing homes with the governmental thrust of reducing healthcare spending. Non-governmental healthcare providers are also following this lead and there are differing opinions as to what constitutes the best interests of the residents and patients.

Moving away from the literal battlefield, courage became a moral approach to address concerns of right and wrong in ways that are acceptable within society.\(^2\) Combined with courage is the notion of morality which must be comprehended by the NHA before a moral dilemma can be assessed. The concept of common morality is that all humans have an intrinsic sense of the nature of moral behavior.\(^3\) As a virtuous leader,
moral courage is perpetual within decision making and for the NHA it will be reflected in communicating that the residents and patients are the point of concentration through behaviors and actions.\(^4\) Philosophically moral character is said to be developed with courage being the fundamental virtue that is followed by temperance, justice, and wisdom.\(^5\) Fear is part of courage but both need to be balanced in order for moral courage to be enacted for the right reasons.\(^6\) Courage in the moral sense is about being honorable and fearless, although fear is present, in doing the right things for the right reasons.\(^7\)

For any leader, not just the NHA, there is a requirement that the needs of others must supersede self-interests and the inability to do so creates barriers to enacting moral courage in decision making. Acting to benefit others, which are the patients and residents primarily, involves the consideration for their well-being as the main concern.\(^8\) Moral courage becomes a much stronger force in decision making as sacrifice, restraint, and selfishness are conquered.\(^9\)

This increasing need for healthcare services is driven by the increase in the aging population of people 65 years of age and older in the United States which is coupled with the increasing life expectancy.\(^10\) The largest growth segment in the U.S. was between 1946 and 1964 and that group will all have reached age 65 by 2030.\(^11\) Unfortunately with aging comes an increase in chronic and weakening conditions.\(^12\) At the same time the caregiving needs are rising, the pool of caregivers is declining as they are also aging.\(^13\) Significant actions must be taken to recruit and retain nurses into the workforce. The estimate is that the deficit could reach a million by 2020.\(^14\)

In looking at historical changes in healthcare, the nursing homes in the 1800’s started as almshouses as lower level healthcare alternatives for elderly, chronically ill,
and disabled persons. In the mid-1960s was the introduction of the Medicare and Medicaid entitlement programs by the government with provisions for the poor and disabled. The expense related to healthcare spending has increased significantly since the inception of the Medicare and Medicaid programs and is expected to reach $966 billion by 2018 with the rapid increase in the aging population in the United States.

Although the U.S. has unsurpassed healthcare services compared to other nations, access has been limited for this care. The Affordable Care Act of 2010 was passed to address this disparity. The key elements for change within this bill are to culturally change from an illness and medical model, to one of wellness and prevention.

Ethics education is not an area that is given any specific emphasis in the licensing core areas of knowledge or in the ongoing continuing education units. The topic is often used in relation to another area but the concentration as a subject to learn with any depth is minimal. Unfortunately, the lack of understanding of ethics as they pertain to the increasingly difficult nursing home management arena puts the NHAs at a disadvantage for entering difficult decisions with a sound grounding in ethics understanding. As an overall area for concern surrounding ethical dilemmas are conflicts of interest which address the admission and avoidance of conflicts and guidelines with consequences for violation. These conflicts arise when personal interests take precedence over the interests of others. The professional obligation is violated within the position of nursing home administrator by acting in the best interest for the self rather than for the residents, patients, and staff.

An additional difficulty related to conflicts of interest will be deciding on the distribution of limited resources when there are potentially benefits to be gained by
everyone in need. Such rules of supply and demand are tests to the conscience in resolving the means in which the patient needs are to be met. Resource allocation relies on distributive justice as a principle for guidance in deciding on a fair and equitable method for disseminating regulated resources which could consist of such things as supplies, equipment, services, or staffing. The notion of the right to health imparts an additional ethical dilemma and conscience in addressing the ideals of the moral importance of health, determining when inequalities within health are unjust, and formulating solutions when all needs cannot be met. Ideally, the NHA will be able to determine an appropriate level of care, not necessarily the best level of care, in terms of delivering a better quality of life while reducing healthcare spending. In situations of futility and the need for excessive resources, a cost benefit analysis may need to be incorporated into ethical decisions in determining reasonable benefits.

B. Relating Moral Courage with Care and Caring

As a virtue caring comes from associations among people, actions and competence within care. In cultivating close relationships with the patients the important elements are sympathy and compassion, loyalty, and love. This is a basic function within nursing homes and is a central factor and defining difference for healthcare leaders. A healthcare facility such as a nursing home has a moral duty to deliver care and the approach to caring has the capability to treat the patient as a person and not be viewed as an object known as merely a room number or a diagnosis.

Within professional caregiving are the caring functions of moral necessity, the involvement of compassion, a characteristic of humanness, an interpersonal relationship, and a therapeutic intervention. Care can be interpreted in several ways which includes
providing acts of care and engaging in the emotional elements surrounding motives, intentions, and the capacity to foster caring interactions with the patients. A caring person morally has the characteristics of caring for the normative correct matters and principles and caring in the appropriate way through feeling and competence. By the character of their profession, nurses are associated with care and caring. To completely provide care and care about the patients is to engage in moral courage in order to be able to accomplish the necessary actions for their well-being. As a leader in healthcare there is a responsibility to not lose the quality of caring within the delivery of care by attempting to be more efficient. This responsibility means to keep the patient as the central priority within the nursing home and to find ways to balance to the patient needs with the business needs.

The dignity for patients to be seen as individual persons who are unique and worthy of value is a challenge in any healthcare setting because the patient is in a vulnerable state due to the reliance upon others for care. Dignity is also coupled with respect which is connected to autonomy. Self-determination is a way for the patient to preserve dignity. The vulnerable position of the patient comes with less power than the caregiver or the NHA. The caregiver can exploit this relationship which can fall within the parameters for patient abuse or neglect. The NHA as the leader of the nursing home has the responsibility of utilizing that power in ways to support the dignity of the patients and residents. The caregiver does have power over the patient because of the dependency for care delivery. Furthermore, the leader separate from actual care delivery has an additional level of power over the patient in affecting that dignity be upheld or infringed. The dignity of a patient is lessened when their opinions and requests are
dismissed or judged by the nursing home staff.\textsuperscript{36} Residents with dementia are common examples of such indignation in that their loss of memory is sometimes misinterpreted as having no voice anymore regarding their preferences for any aspects of their lives. The emotions and individual needs of these residents still remain even in their confusion and deserve to be respected.\textsuperscript{37}

There are religious positions taken relating to the value of all persons and Pope John Paul II made the Catholic position very clear in \textit{ Evangelium Vitae} which upholds personhood, dignity, and the protection of all human life.\textsuperscript{38} Judaism takes the stance that all people are created in the image of God and that life is a sacred gift from God.\textsuperscript{39} When evaluating health disparities the needs of the individual person should override the sole advantages to society. The life and dignity of all humans is sacred and should guide the moral decisions that society should convey within Catholic social teaching.\textsuperscript{40} Secular healthcare leaders also have a duty to view the patients first as persons and to defend these essential values by advocating for them in morally courageous decisions.

Compassion is related to care and incorporates empathy and kindness directed at the needs of others instead of being directed to the self.\textsuperscript{41} As a virtue compassion is described as containing feelings of empathy that evolved from the suffering of others and includes being present with the patient.\textsuperscript{42} To truly help the patient is for the caregiver to have a complete comprehension of the cause for the suffering, and then to be motivated to provide relief.\textsuperscript{43} Although the NHA isn’t the person who will be engaged directly with the treatment of suffering and pain there does need to be a full comprehension by the leadership in order to truly understand the people who are going to be impacted by the decisions and whether or not they are morally based. Sympathy and compassion are
founded in the suffering of others and the value for such actions is in the character of those emotions. The relationship between the patient and the caregiver is one that is called a “transcendent horizon of significance” which is one of familiarity on a moral basis that discloses a shared practicality and understanding. Sacrifice is seen as atonement within suffering by some that assists with healing and permits a more insightful understanding of the patient by the caregiver. As a caregiver, being present for the patients necessitates help in managing their fears. The connection that the NHA has to the patients as persons is what keeps the decisions grounded in morality.

Suffering differs for each person and to understand the extent of suffering if to communicate with each individual to understand their specific needs for relief. Pain and suffering are directly related to the way in which the patient dealt with other difficult issues in their life and with their previous life experiences. The intensity is related to belief systems and suggests that a person has some power to formulate later life responses to suffering and death. Maintaining the dignity of the patient as an individual is a goal for nursing for patients who are suffering. Accompanying that goal is to provide physical and emotional support for the patient. Respect should be given to the patient to determine their own level of suffering as long as they are able to do so because the level of tolerance is very individualized. Like caring, compassion should be an obligation for all relationships and not just between the caregiver and the patient. A balance between the caregiver and the patient must be achieved by improving the quality of life for the patient. The goal for compassion is to achieve beneficence for the patient devoid of moral harm to the caregiver in determining the amount of personal sacrifice that is necessary in order to meet the standard of obligation for compassion.
In knowing the patients, the NHA must have the sensitivity to acknowledge the
grief that is being experienced due to the losses in their lives that accompany the nursing
home placement. Grief support is customary within hospice programs but little is done to
support the patient population in general. Elizabeth Kubler-Ross originated the stages of
grief that continue to be utilized which are: denial, anger, bargaining, depression, and
acceptance. Also, in addition to the stages the residents can also experience these losses
in terms of being real, imagined, or anticipated. These stages and types of loss could be
applied to every person admitted to the nursing home whether it is a temporary or
permanent placement. Such losses can include: independence, a previous lifestyle, a
home and all of the life-long belongings, relationships in the community, or pets to give a
few examples. The point is that the residents are in need of a significant amount of
emotional support which needs to be considered within the ethical decision making
process which is a contextual matter for the NHA.

Moral courage entails that a person be able to act on behalf of others and not just
remain concerned with self-interests. Accountability comes from the relational self.
Accountability is not only self-imposed but is a responsibility of the NHA for setting
expectations of others in the nursing home and insuring that they are met. When the NHA
acts in caring ways the expectation is modeled and should lead to replication throughout
the nursing home. Displaying a caring attitude is not restricted to the patients and
residents but can be directed at others in general such as the employees and family
members. From this stance, caring can be very effective and influential to the NHA in
positively changing the nursing home atmosphere. NHAs in their role as a caregiver
need to evaluate their own beliefs and fears and how their approach to delivering care is
influenced. The NHA must manage the reasons that motivate the staff to act on behalf of others rather than the self as well as examining personal motivations.

Sympathy provides the capacity for understanding others. By definition, sympathy is both a feeling and an attribute of the person who is able to have that feeling such as a caregiver who is able to experience the care needs with the patient. Compassion is a virtue and a form of sympathy however sympathy is not capable of altering the feelings that are communicated by the patient. Intersubjectivity is the caregiver’s ability to connect with the patient on a psychological level. Emotionally, this affects the caregiver in taking an ethical position towards the patient. There does need to be a respect for the autonomy of the patient in such circumstances because they may choose to not engage in the inaction with the caregiver even if it would be beneficial. Compassion includes sympathy in gaining insight into the suffering of the patients.

The relationships between the patients, and the leaders and caregivers, can improve significantly throughout the nursing home when empathy and compassion are merged. The feelings and viewpoints of others can be understood through empathy which is seen as a moral trait for caregivers. Empathy differentiates itself from sympathy by permitting a secondary experience and understanding of the feelings of the patient which includes an appropriate response. Sympathy may occur at the same time as empathy but is limited to having feelings of sadness and concern for the patient. Watson offered the Theory of Transpersonal Caring that allows for a more profound bond between the patient and the caregiver through a mutual understanding on an emotional level. However this bond can only occur if the caregiver has the capacity to enter into such relationships.
The most important element in caregiving is empathy which contains the fundamental areas of morals, emotions, cognition, and behaviors. As a significant feature in the helping relationship, empathy involves having an understanding of the patient’s feeling and being able to respond appropriately to those feelings. The development of a mutual relationship between the patient and caregiver through empathy allows the patient to be more forthcoming in expressing their needs which may not be easily noted. A close connection between the caregiver and the patient from the insight gained through empathy can assist with healing and is a personalized approach to the delivery of care.

Honesty can contribute to healing and the NHA can lead this approach within communication. Without honesty the nursing home can become consumed in misperceptions and confusion. The focus is taken away from patient care and mistrust impedes the development of relationships within the organization. The NHA may need to utilize moral courage as the means for communicating personally or may need to provide an atmosphere of safety for others to enact moral courage. There are risks that come with honesty, particularly when there is a negative or critical message to convey. In such instances the NHA can choose to set the example as a cultural expectation and show respect for the opposing opinions of others within the organization. Dishonesty must be understood as being a result of fear. Truthfulness must not be met with negative consequences or partnerships will not develop within the nursing home.

Love is connected to caring and as an emotion differs in strength which is determined by the relationship between the caregiver and the care-receiver. The patient needs are the priority in this professional relationship. Love allows the decision-makers
such as the NHA to recognize the patients through feelings. As a caregiver the NHA must be disposed to connecting to the patient interpersonally, engaging in developing professional knowledge and development that relates to the patient, and the courage to uphold and exemplify the best interests of the patients. To comprehend moral courage within the nursing home as a leader is to understand courage and care as virtues that motivate actions which are merged to express a response of caring.

The ethics of care proposed a very different methodology to moral reasoning from what had been previously offered. This theory evolved over time and advocated for equal positions between care and justice since both are significant in ethical considerations. The ethics of care came from a feminist perspective. The thought is that women are more inclined to care and caring in their ethical assessments when compared to men who are more geared to viewing situations in terms of rights and obligations. The foundation for an ethics of care engages the need for relationships and communication based in reality that supports attentiveness, responsibility, competence, and responsiveness.

The ethics of care is a one-step process in which there is an awareness of a need on the part of the patient and the determination of the appropriate action to take occurs simultaneously. This theory infers that the relationship between the caregiver and the patient pre-existed morally. The relationship between the caregiver and the patient are central in the moral reasoning with the ethics of care and include cognition, emotions, and action. These relationships evolved from caregiving and caring which are interdependent and use partiality in ranking relationships. This means that the
relationship places a higher value on the caregiver and patient relation when evaluated against another person who has no relational connection. 79

Being a virtuous person means to be a good person who is guided by virtues and values. Each person has a natural inclination to virtue or vice and according to Aristotle the goal is to stay within the mean of the two extremes. 80 Aristotle also taught that a virtuous person is constant in acting with virtue which comes from the fundamental character of the person. This theory is argued that there is difficulty in determining if the person was first moral or virtuous. 81 When comparing virtue ethics to right’s concerns, the position from virtue offers discernments in the moral character of the person as well as the use of emotion within the reasoning process and the situation is placed within context. 82 The relationship between the NHA and the patients should be based in moral values from both courage and compassion which is exhibited in the ethical soundness of the decisions that are being made. 83 The ethical and clinical factors for caring are joined when virtue ethics and care ethics are brought together in seeking decisions for the best interests of the patients. 84 Within the nursing department, the largest within a nursing home, the role of nursing as a profession is obligated to be morally accountable to their patients. 85 Being morally responsible is to be connected with a clear understanding of moral agency. 86

For the patient and the caregiver to have an open relationship there needs to be trust, respect, and mutuality. 87 Compassion combined with the relationship concept within an ethics of care promotes open expression within the relationship even when the patient is in a vulnerable position to the caregiver. 88
Both narrative ethics and casuistry offer opportunities for interpersonal communication by the patient that can lead to moral understanding. Specifically, narrative ethics provides a method which uses stories to gain insight into the patient’s current circumstances and past influences. The ethics of care combines the narrative with the context through beliefs, culture, emotions, and the communication style. Also, patterns of behavior are analyzed through past relationships and situations as they relate to the current situation in attempts to find solutions. Using narrative ethics permits patients to tell their stories which can assist in improving their well-being and redefine their current state in relation to their suffering. Practical reasoning is used in casuistry in noting similarities in previous cases as sources for determining decisions.

The caregiver must learn to care for the self in addition to the patients in order to be able to have the strength to be fully present with the patients in their suffering. Part of being a professional in healthcare, is to reinforce the belief that all humans, the patients and the staff, deserve respect, which includes self-regard. While the NHA is to keep the patients and residents as the primary considerations for decisions the care of the caregiver must also be a consideration so they can deliver the necessary care to the care-receivers.

The ethics of care and justice can be seen as being opposing views however as moral theories, the main difference is between obligation and responsibility. The positioning of autonomy is seen in an ethics of care as relational and in justice is seen as an individual. With an ethics of obligation the response involves determining the need of the patient and then to determine if there is the duty to respond. The foundation for this viewpoint is that the person or patient is automatically seen as needing to make an
independent decision without influence from another. There is an instinctive distancing from the person in the assumption for autonomy. The NHA relies on Resident Rights, in part, to guide decisions in respecting the autonomy of the patients. Upholding the human rights of others requires that empathy be enacted to move people into action. For healthcare leaders this movement to action may entail acts of moral courage.

The rights of patients are defended in several moral theories that are well established within ethics which will be explored. The first is utilitarianism which is the notion that the right action is the one that will benefit the most people. The outcomes of an action are examined when deciding on the ethical value of the action. The theory of Kantianism has the core precept that some actions are done out of duty which is what determines the action to be right or wrong. Kantianism focuses on the rules rather than factoring in the traditions and preferences of the individual as part of the decision making process. Also, morality is founded in reason and that the moral worth of actions is determined by the rules that are employed with the action.

Paternalism is a challenge for healthcare workers because they have been programmed to assist residents and patients to recover. There is great difficulty in allowing patients to make their own decisions when they are counter to the beliefs of the staff. There is an ethical dilemma in respecting the patient’s right to self-determination when the decisions may lead to poor outcomes. Often these decisions go against professional medical advice yet the residents and patients are permitted to make poor choices as adults. The nursing home mirrors this dilemma in which the NHA is to protect the residents from harm but is also to respect their decisions as adults.
Rights theories study the rights of all persons concerned within a situation in ways that defend and protect rights. Rights are seen as being both moral and legal. For the NHA, Resident Rights are also seen here as an element that serves as a guide in decision making as well from a regulatory requirement.

Principlism is made up of four principles which are respect for autonomy, nonmaleficence, beneficence, and justice. This theory is a common ethical framework for decisions however it is viewed as being more concerned with tasks and doesn’t consider the humanistic domains of the situation such as emotions or relationships. Respect for autonomy, which allows a person to make decisions and take actions founded in personal values and beliefs, is typically seen as the focal principle.

An ethical sensitivity towards the patients is required to understand when moral courage is necessary in acting ethically for the good of the patients. The combination of a comprehension of the patients’ vulnerability in their suffering and dependency along with the mutual relationships between the patients, and the caregivers and the leadership, are what makes up this ethical sensitivity. The NHA must be able to advocate for the needs and values of the residents and patient in the decisions that are made. For the direct caregivers, there must be an approach that includes both an ethics of care and one of justice. The inclination within moral courage is to be driven more by obligation and less by the consequences of the actions. Relationship development is combined with favorable actions that are exhibited throughout the nursing home by the NHA as the leader which establishes the expectation for others to follow.
C. Moral Courage as the Core of Ethical Leadership

Leading ethically conveys a comparison to spiritual, authentic, and transformational leadership.\textsuperscript{113} Having courage, moral potency, and being able to prioritize the key important concerns are common qualities of leaders.\textsuperscript{114} NHAs need to be able to acknowledge and comprehend the way in which their personal values play into their actions and decisions. They can then learn to make adjustments which focus on the needs and benefits of others such as the patients rather than self-interests.\textsuperscript{115} The effectiveness of a leader is linked to the possession of the spiritual values of integrity, honesty, and humility.\textsuperscript{116} These values are also ways to display core characteristics that lead to trust within the organization. Humility in itself permits the NHA to ask others for feedback to improve as a leader by accepting that perfectionism is not a reasonable expectation.\textsuperscript{117} Each individual has a basic belief system that determines which behaviors are more appropriate than others based on the circumstance. These values are entrenched in the heart of the person and may not correlate to the expected moral response by the organization. Because each person is unique these values will be prioritized in ways that differ among leaders. They are determined by personality, organizational situation, and the followership.\textsuperscript{118} Of note is that values and standards for the nursing home should not be confused as being the same; values determine the priorities for the nursing home and what is important and standards regulate the levels of acceptability.\textsuperscript{119} As a professional in healthcare, being caring toward the patients comprises compassion and empathy with competence in providing the care. Of importance is that the caring response remains within the professional limitations of the relationship.\textsuperscript{120} When the NHA is able to
respond to the patients in this way it sets an example for expectation throughout the
nursing home as to the way in which the patients are to be treated.\textsuperscript{121}

Nursing homes are highly emotional as are most healthcare environments because
of the negative situations that cause the need for the services. The staff and in particular,
the leader, must be able to respond appropriately within the context of their emotions.
Emotional reactions come from the interpretation of a particular event, person, or object
in relation to the outcome for the self or others.\textsuperscript{122} What that means is that the
interpretation is a significant part of the process because that is the piece that can alter the
response. The interpretation depends on whether or not the decision is relating to the
current situation or past situations for the individual responding. This is when the concept
of emotional intelligence (EI) is important in which the NHA would develop skills in the
areas of self-awareness, self-regulation, motivation, empathy, and social skills such as
leadership and conflict management.\textsuperscript{123} By developing these competencies the NHA
would be making decisions based on the needs of others rather than self needs. Usually
the decision maker is not aware that the reaction is based on self-interests but EI assists in
separating the personal from the professional concerns. Emotions and reasoning in
relation to each other are important as they apply to improving the clinical,
organizational, and employee outcomes within the perspective of the nursing home
leadership.\textsuperscript{124} Developing EI at all levels of healthcare organizations, starting with
student programs, would have a significant impact on the appropriate interactions
between the patients and the staff which would guide their decisions and actions
ethically.\textsuperscript{125}
Being able to manage emotions within the workplace gives the NHA an advantage in focusing on making decisions that are centered on the patients. EI is an effective part of leadership in which the reactions to situations are managed by understanding the emotional aspects of the personality through self-awareness. This approach allows the leader to accurately understand and respond to emotions rather than confusing personal issues with the current situation which can incorrectly influence the decisions. Dependable character and displaying good moral sense with emotional responsiveness such as that shown in EI can assist the NHA in ethical decision making.

Through the development of EI competencies the NHA is able to be much more effective as a leader within their relationships which can result in improvements in clinical care and the stabilization of the staff. Issues become less personal and more insight is gained into arriving at solutions to the problematic situations that are presented. The development of EI abilities can be very influential in a positive way. Rational reactions as the norm for responding rather than emotional ones can have a very negative influence depending on the type and intensity of the emotions. Both interpersonal and intrapersonal communications are vital in having the ability to connect with all levels of people within the nursing home. By approaching others with the appropriate emotion and attitude for the circumstance, the NHA will become much more effective as a leader. Within moral agency EI is experienced through motivation, perception, and reasoning. The emotions formulate an understanding of the self when compared to others.

For a nursing home to be ethically accountable the NHA as the leader must first hold himself accountable. This can be done through acts of moral courage and requiring consistency in responsibility in actions throughout the nursing home. Leading by example
is powerful in clarifying any confusion that might exist as to the expectations throughout the organization. Creating accountable nursing homes is the primary approach for developing trust throughout, which has the secondary benefit of improving employee satisfaction within the facility.\textsuperscript{131} For religious-based facilities, having a spiritual accountability to a higher power or a specific religious affiliation can be a source as well for motivating people to act morally.\textsuperscript{132} As the leader, when there is a failure to take personal responsibility for breakdowns in the operation and others are blamed for the problems, a cycle of victimization is started. Also, failing to address problems which includes these same behaviors if they originate in other places within the organization, contributes to victimization as well. This places the nursing home on a path of dysfunction and hinders the organization’s ability to move forward.\textsuperscript{133} There are also ethical implications for such behavior which clearly is not exercising moral courage.

The NHA must be able to foresee chances for corruption and abate it by developing the followership ethically, supporting a culture of compliance, and developing collective agreements for high moral expectations.\textsuperscript{134} Corporate incentives that indirectly encourage unethical behavior and self-interests have been blamed as contributing to the normalization of cultures of cheating within organizations. The media has also contributed to this slide in ethical conduct by promoting materialism and wealth.\textsuperscript{135} Through the establishment of ethically-based policies and procedures, codes of conduct and hiring strategies, the risks for immoral behavior can be diminished. The NHA has the most significant impact for setting the acceptable standards throughout the nursing home based on the leadership’s ethical conduct that is displayed.\textsuperscript{136}
Moral Relativism determines the right or wrong action to take which is based on the moral views of the person making the decisions. The morality of the decisions is influenced by the individual’s moral reference points. The principle of cooperation evaluates decisions that are always wrong in all situations and differentiates the level of culpability at either a formal or material level. Formal cooperation occurs when a person knowingly and willingly chooses to participate in immoral acts and material cooperation is an indirect and oppositional participation in immoral acts. Obedience and conformity often occurs by following the examples set by the authority figure in the workplace and the actions for the employee are justified as being obedient. Groupthink is the acquiescence of the values of individual persons to the values of the group. Like the four types of moral compromises cited, the problems arise when the decisions slowly move away from the established limits of morality. This notion of the slippery slope establishes a new level of acceptability that moves farther and farther from the initial point of morality until immoral acts become the standard.

The NHA has the capacity to motivate others to accomplish specific goals for the nursing home. There are several types of power and sources for influencing others that the leadership can use which can have either positive or negative implications. However, ethical leadership predicts the ethical results of followers in leadership perceived success, job satisfaction and commitment of the followers, and the propensity for reporting problems to higher levels of management. Leaders are much more influential with their employees when they utilize their personal power rather than their position as the NHA.
The directive style of leadership bases moral reasoning on the probability that the personal goals of the leader are attained primarily with some consideration given for the subordinates' involvement. This style is more concerned with the self-interests of the leader and is not aligned with morally courageous actions unless there is some benefit to the leader. The status quo is maintained in the transactional leadership style which is driven by tasks rather than vision. The subordinates are not developed in terms of their beliefs, values, thoughts, and attitudes and therefore, this style lacks in leadership attributes. The transformational leader has the ability to motivate others to exceed the expectations. Trust is employed and the behaviors of the leadership serve as examples to follow. A mutual goal is established and innovative thinking is encouraged. Respect and concern is shown for the needs of the individual employees which are determined and dealt with in a fair way.

Styles that are centered on traits include situational, values-based, and authentic leadership. Situational leadership functions on the three skills of: diagnosing the situation of the employee and task, flexibility for changing needs, and partnering with the employees for performance improvement. Decision making is affected by the situational elements of supervisory and performance pressure, autonomy in decision making, interpersonal conflict, and the nature of the problem. Like authentic leadership, values-based leadership is dependent upon the values of the leader to determine the ethical path that is taken. The values of the NHA would be identified, and their effect on the culture of the nursing home, which also realizes the distinctive aspects of healthcare and the high standards that are expected. Authentic leadership which seeks to utilize more ethical methods of management and leadership emerged out of the
increase in corrupt practices. Moral capacity, moral courage, and moral resiliency are the most important traits to develop for authentic leadership. Trust, hope, emotions, identification, and theories of identity are what authentic leaders use to develop positive attitudes and behaviors in their followers. Authentic leadership also requires that emotions are directed towards others and self-transcendent values. Models that are based on the relationships between the leader and the subordinates are the Vertical Dyad Linage Model and the Leader-Member Exchange Theory.

Models of ethical decision making are discussed in four approaches. The first is the Realm-Individual Process-Situation model views the process in the context of the realm, the individual, and the situation that the ethical concern falls within. Devlin and Magill offer a three-step method for determining the problem which is complemented by three steps for determining a resolution. Kidder’s Checkpoints progress through nine steps to arrive at a solution. Purtilo and Doherty offer a Process to a Caring Response which utilized six steps for ethical decision making, Jonsen, Siegler, and Winslade use a case analysis process that utilizes four areas for analysis in arriving at an ethical decision.

D. Moral Courage and Organizational Culture

The culture of any organization is a direct reflection of the leader. If the NHA complains about the culture within the nursing home and is not new to the organization, then he needs to reflect on his own actions and what they are communicating. The NHA typically doesn’t understand the power that he has as the leader to manipulate the culture by serving as the example that he wants others to follow. In short, the NHA as the leader
determines the culture of the nursing home by his own actions or inactions which are a reflection of his values and experiences.\textsuperscript{162}

The theory of ethical climates was introduced by Victor and Cullen and is based on moral development theories and the concept of ethical climates which are the cumulative ethical behaviors of an organization. As a group this ethical measure will fall on a continuum of moral or immoral actions as the norm in decision making.\textsuperscript{163} The degree of moral courage that is displayed by the NHA comes from this leader’s moral views and reasoning as it transfers into moral action.\textsuperscript{164}

The idea of moral agency needs to be understood that the nursing home is a moral agent, however the people within the nursing home, mainly the leadership, who make the decisions, determines the moral agency.\textsuperscript{165} These decisions place the nursing home’s moral agency on a continuum of rights and wrongs and duties and obligations.\textsuperscript{166} Therefore, the NHA needs to provide an environment to support virtuous decisions which start with the mission, goals, and policies.\textsuperscript{167} The NHA must be clear in establishing and communicating the ethical expectations of the nursing home because a person’s cultural experience teaches responsibility. However the beliefs for the causes of the behaviors are not necessarily correct in relation to the organizations ethical views.\textsuperscript{168} Communication regarding the mission, goals, policies, and actions needs to be positioned as a reflection of the ethical climate.\textsuperscript{169}

The organizational philosophy of the nursing home begins with the mission statement which communicates the values of the organization, and provides the basic ethical stance that serves to guide all actions.\textsuperscript{170} The governing body of the nursing home consists of the Nursing Home Administrator, the Medical Director, and the Director of
Nursing Services. The medical director and the attending physicians within the nursing facility are directed by the professional codes that are established by the American Medical Association.\textsuperscript{171} The nursing ethical code comes from the American Nurses Association.\textsuperscript{172} The Nursing Home Administrator must meet the licensing requirements of the state in order to practice which also outlines the conduct that is expected within the profession.

Developing trust is based on existing relationships even if they are not strong and are most determined by the connections that are made between the emotions and actions rather than to the results.\textsuperscript{173} Moral agency is the source of trust for the NHA. Trust is based in relationships and permits the leader to react morally to the resident’s needs.\textsuperscript{174} The NHA’s characteristics are essential in fostering and sustaining a trusting organization and courage is necessary in defending it against damaging actions.\textsuperscript{175}

Ethics for an NHA is often deciding between financial goals and resident needs. The changing healthcare environment is necessitating that cultures within nursing homes need to reflect positive ethical values that extend to all levels of the organization.\textsuperscript{176} There are measures for gauging the ethical climate of any nursing home and some are internal to the facility while others are external. The turnover rate of the staff is an indicator of concerns and can have negative effects on the quality of the care. Staffing levels and the amount of professional autonomy are reasons that influence nursing to leave an organization.\textsuperscript{177} Nurses indicate that they were most satisfied in workplaces that were caring and exhibited actions that were for the good of the organization and not individuals or a small group of the organization.\textsuperscript{178} Commitment to an organization by the nurses correlated directly to the strength of the positive ethical climate.\textsuperscript{179} Climates that
are primarily focused with cost control and efficiency can have an unfavorable effect on the quality of the care and services provided by the nurses. Climates where people are concerned most about their own welfare before others also has a negative effect.\textsuperscript{180} The most important factors in satisfaction and meeting the patient expectations were reliant on the emotional and human factors of the interactions.\textsuperscript{181}

The NHA must be concerned with the external ethical climate that is portrayed by the facility as well as the internal climate. A key way of reflecting this is through the compliance with the regulations and the Five-Star Quality Rating system has become a gauge for the general public to assist in the selection of a facility.\textsuperscript{182} When there are significant infractions in the regulatory requirements, sanctions can be imposed which can force a change in the moral judgment of the leadership.\textsuperscript{183} The involvement and contributions to the community is another critical area that communicates the ethical climate of the nursing home. Participating in social responsibility activities can develop trust as a healthcare provider.

Quality and safety are intertwined and are very clear indicators of the overall ethical climate of an organization and the priorities that are established. In healthcare in general there is a need to make significant changes in quality improvement processes for the level of quality and safety to improve to satisfactory standards.\textsuperscript{184} The very basics of quality care begin with the assessment of the patient in the admissions process and continue through discharge.\textsuperscript{185} Nursing homes have been struggling against negative perceptions of quality of care for a very long time. The Centers for Medicare and Medicaid Services (CMS) regulate quality of care and safety through survey inspections. CMS implemented a quality rating method in 2008 called, \textit{Five-Star Quality Ratings},
which is easily understood by the general public and assists in the selection of a nursing home. This rating system consists of three areas which are: health inspections, quality measures, and nursing staffing hours and incorporates safety factors as well.\textsuperscript{186} CMS encourages the use of QAPI (Quality Assessment and Performance Improvement) which is an assessment and analysis approach to understanding and preventing negative outcomes for the residents and patients.\textsuperscript{187} CMS provides a variety of resources to support improvements in patient care and safety areas.

Patient safety is viewed in relation to other objectives such as found in disaster planning, falls with injury, or medication errors. Detailed investigations including causal factors need to be analyzed through methodical actions for improvement.\textsuperscript{188} Safety within a healthcare setting has ethical associations and obligations to the patients.\textsuperscript{189} Moral courage is essential in matters of safety and quality in healthcare and even in the presence of fear the NHA must take the ethical course. Moral courage is a way of demonstrating advocacy for the residents and patients and supporting a culture of safety is central to ethical actions taken on their behalves.\textsuperscript{190}

The core competencies of leadership which are communication, professionalism, business acumen, and comprehension of healthcare create a culture of safety by the nursing home leadership.\textsuperscript{191} Creating openness for discussing safety and quality issues of concern, refraining from blaming individuals, providing the necessary reporting of the incidents to the proper agencies and the patient and family, and learning from the mistakes are the four elements for providing a supportive and ethical approach to safety.\textsuperscript{192} The NHA is responsible for overseeing these programs and is accountable for safeguarding the residents and patients.\textsuperscript{193}
A safety culture’s primary goal is to prevent harm from occurring within the nursing home however when an incident does occur then there needs to be a systematic method for preventing a reoccurrence. The models used should focus on the failures of the systems rather than on blaming people. The Advanced Incident Management System and Root Cause Analysis are examples of two such methods. Both of these approaches focus on systematic failures rather than placing blame on individuals. Another approach for accident analysis is the Swiss Cheese Model which has the idea that the holes are to shrink as barriers to safe practices are removed. Healthcare has standardized measures that speak a common language of care and safety improvement through structure, process, and outcomes. The NHA’s goal should be to run a high reliability organization by attaining consistency in safety.

Moral courage and moral obligation are partnered when medical errors occur. Courage is necessary to admit wrongdoing and at the same time there is a moral obligation to disclose to the patient that the error occurred. Ideally, the focus is on prevention but it is inevitable that there will be some kinds of errors and the hope is that these errors will not be serious because of the preventive programs that have been implemented. The ethical concerns surrounding disclosure should insure that no one is adversely affected for communicating errors. Unfortunately, many of the systems for reporting incidents continue to instigate fear of disciplinary action and are unclear in communicating the incidents for reporting.

Safety concerns related to the patients is an area that cannot be compromised and therefore courage is necessary for prompt action. By enacting courage the nursing home leader communicates safety as a priority for the organization which is imperative to
cultivate a culture of safety. This includes providing an open environment where people are not fearful of retaliation or blame. An atmosphere of learning from the mistakes to prevent future problems can only occur if that openness exists.\textsuperscript{201} The reality is that medical errors will occur but the general public expects perfection; that no mistakes should happen.\textsuperscript{202} The environment established by the NHA must be supportive of a culture that allows for the acceptance and reward for employees who fully disclose safety concerns. The leadership must endorse an organizational culture that does not censor information about errors and safety by direct or indirect means. The overall ethical culture of the nursing home will directly affect the priority that is placed on safety. If safety concerns are addressed urgently by the NHA then the precedence is being established for the importance of disclosing any areas of potential harm.\textsuperscript{203}

The Justice Department and the Joint Commission enacted the concept of compliance programs while the Joint Commission for the Accreditation of Health Care Organizations launched ethics programs.\textsuperscript{204} These were to work in an interdependent way to guide ethical decision making for the NHA and the caregiving team in support of the residents and patients.

E. Developing Moral Courage for Leadership Effectiveness

With a thesis surmising that moral courage is a requirement and not optional for making ethical decisions, then there must be a chapter dedicated to obtaining and developing moral courage in order to be an effective ethical leader. Part of developing moral courage is to look at the necessary competencies which are defined as features required for the job that have an element of behavior associated with them.\textsuperscript{205} Moral courage is exhibited in behaviors and many ethics programs focus on theoretical
knowledge and not on practical applications for utilizing the information in the day-to-day operations of a healthcare facility. In adults, such as NHAs, moral courage can be shaped beginning with moral action which can then be combined with sympathy and empathy. This in turn, creates selfless reactions which are necessary for moral courage to occur. Self-reflection through mindfulness is a key in comprehending moral responsibility as a healthcare leader. Ethical leadership can be measured through the social learning theory. Developing moral courage involves learning what moral courage is, practicing the use of moral courage, and then turning the practice into a habit so that acting with moral courage becomes an automatic approach to decision making.

Mentoring and the study of prior cases have been helpful in educating the concepts of moral courage. Mentoring reinforces the ethical behaviors of the leader and has the ability to teach others, however the available time to devote to mentoring activities determines the effectiveness. By combining past experiences and casuistry solutions for difficult patient situations can serve as effective training methods as well.

The components of moral capacity, moral courage, and moral resilience need to happen which are converted into actions and behaviors for the leader to develop moral effectiveness. The following are several approaches to measuring and enacting moral courage in a healthcare situation. These models can be utilized as part of a leadership developmental process with the benefit of impacting the ethical climate in a positive way. Each also can be applied from the point of care and caring actions in the decision making process.

Methods specifically noted for use for moral courage development begin with Rest’s Moral Skills Inventory which determines moral reasoning, moral integrity, and
moral courage. Lachman and her colleagues use the abbreviation of C.O.D.E. to remind them of the steps to enact moral courage with actions that equate to the letters which are: courage, obligation, danger, and expression. Kidder’s model has points for moral courage which are: Truth versus Loyalty, Individual versus Community, Short-Term versus Long-Term, and Justice Versus Mercy. Bandura’s Reciprocal Determinism uses the interconnectedness of the environment, thoughts, and behaviors along with the leader’s ability to self-regulate behaviors to control the behavioral effects and the degree of moral relevance. The author offers the Kobuck Model of Moral Courage which shows the progression of the development of moral courage on the part of the NHA as it moves into changing the ethical climate and culture for the nursing home.

**F. Conclusion**

For the future of nursing homes moral courage will become a requirement in executive leadership for ethical decision making in the best interests of patient care. Given the demographic changes that are evolving along with the anticipated growth and resource allocation, the challenges surrounding ethical dilemmas will become increasingly problematic. Leaders will need to be tethered to a virtuous foundation of courage and care that never loses sight of the patient as person with the sanctity and dignity in all human life. As decisions are navigated through moral courage, which is translated through behaviors and actions of the NHA, they will necessitate that the leadership have the ability to operate beyond self-interests. Where the competencies do not exist there will be a need for leadership development and an even greater need for strength of character among the highest levels of healthcare organizations to establish positive ethical climates. The NHA leaders beginning now and into the future will need
to balance the care requirements against resource limitations and financial viability in a more demanding way than ever before in this ever-changing healthcare delivery system.

---


120 Purtilo and Doherty, Ethical Dimensions, 25-43.
121 Pellicer, Caring Enough to Lead, 24-34.
127 Beauchamp and Childress, Principles of Biomedical Ethics, 30.
131 Mark Samuel, Creating the Accountable Organization (Katonah, NY: Xephor Press, 2006), 3-29


147 Aronson, “Integrating Leadership Styles,” 246.


160 Purtilo and Doherty, Ethical Dimensions, 99-112.
178 Chun-Chen Huang, Ching-Sing You, and Ming-Tien Tsai, “A Multidimensional Analysis of Ethical Climate, Job Satisfaction, Organizational Commitment, and Organizational Citizenship Behaviors,” Nursing Ethics 19 (2012): 513-529.
182 Centers for Medicare and Medicaid Services, “Improving the Nursing Home Compare Website: The Five-Star Nursing Home Quality Rating System,” 2008,


185 George D. Pozgar, *Legal and Ethical Issues for Health Professionals*, 2nd ed. (Sudbury, MA: Jones and Bartlett, 2010), 385.

186 Centers for Medicare and Medicaid Services, “Improving the Nursing Home Compare Website.”


192 Vincent, *Patient Safety*, 269-274.


201 Vincent, *Patient Safety*, 269-274.


209 Brown, Trevino, and Harrison, “Ethical leadership,” 117-134.
Chapter Two: The Need for Moral Courage

According to the Department of Health and Human Services, there are approximately 15,700 nursing homes across the United States with 1.4 million patients and residents.¹ Today’s nursing homes offer many services that were once only provided in hospitals and they have a significant amount of patients who receive care for short periods of time and return to the community. The person who is admitted for a brief stay is often referred to as a patient while longer term people are viewed as residents since the nursing home is deemed as their home in addition to being a healthcare facility. Still considered part of long term or post-acute care, nursing homes are characterized by having a selection of healthcare services that are individualized and coordinated. The goal is to obtain the highest level of functional independence and quality of life over an extended period of time by meeting the patient’s physical, mental, social, and spiritual needs.²

The nursing home as a healthcare institution is becoming more complex as its scope of services widens and the resources narrow. The nursing home administrator (NHA) will be faced with increasing ethical dilemmas which are not easy to solve and will require risk whether or not the choice is to act rather than to avoid the situation. To act is to make decisions founded in moral courage.³ Moral courage is first defined through establishing morality as a foundation with courage being viewed philosophically as a virtue. The accompanying emotion of fear will be followed by a discussion of moral courage as it relates to actions. The projected future of healthcare will look at trends for the aging population, forecasts for care needs, and the changes in the workforce. The history of healthcare will review a brief evolution of medical ethics in the United States.
with government programs that have impacted healthcare and the changes in the delivery of healthcare. The challenges for moral courage will explore the limited educational opportunities available for the NHA in ethics, conflicts of interest, and resource allocation. Several cases will be discussed from a variety of healthcare organizations which show ethical failures by the leaders. The need for moral courage for the leadership in managing nursing homes will begin by defining moral courage.

A. Defining Moral Courage

1. Morality Defined

In defining moral courage the concept of morality must first be understood. Morality is a notion in which everyone must have at least a basic understanding of the features before an assessment of a moral issue can occur. Morality has always been a condition of human behavior which accounts for the belief that all people have a sense of what it means to be moral. Once that has been established, the distinction of what constitutes morality’s existence can be found in what are characterized as moral rules and ideals.

A moral agent is a person who is able to differentiate between right and wrong and is able to resolve such conflicts through the use of ethical principles. The moral agent is expected to go beyond the knowledge and the skills of dealing with moral conflicts but also cares enough to act in support of an ethical result. A moral agent exhibits behavior that conveys concern for moral values as the final result. The NHA is a moral agent and it must be noted that in order for a person to be considered as such, he must be able to understand the rules of morality in order to be held accountable to the rules. All moral agents are aware that the first five rules of morality must be followed in which they must
refrain from taking actions against other persons which includes killing, causing pain, causing disability, depriving of freedom, or depriving of pleasure, unless there is a moral justification to do so. The second set of moral rules involves the acts of deceit, betraying a promise, cheating, violating the law, and failing to do one’s duty.\textsuperscript{7} Most disagreements on moral issues are based on the rankings of the issues in their perceived positive or negative impacts.\textsuperscript{8}

In comprehending the moral rules and ideals in more detail, the first five rules cover the five basic harms to a person and can often overlap when being applied to a situation. The first being, \textit{Do Not Kill}, is often interpreted as being the most severe because it involves the finality of death which also includes the permanent loss of consciousness within its interpretation. Although religious beliefs and their views on the value of life may differ in opinion, the persistent vegetative state falls within this category of death. The rule of \textit{Do Not Cause Pain} includes physical pain as well as mental pain and other forms of negative emotional responses such as anger, fear, repulsion, and grief. The intention on the part of the person violating this rule is important in determining the moral responsibility. \textit{Do not Disable} is often confused with the use of the word disability in the handicapped, but it is more wide-ranged and covers the aspect of not being able to do something that was done previously because of some action of another. The action needs to affect the person and not the situation of the person which would be covered by another rule. A condition that would not render this rule in violation would be an accident that caused the disability. \textit{Do Not Deprive of Freedom} is violated when a person is deprived of their freedom through a change in the environment or the loss of opportunity. This would also include physically restraining a
person as well as threats of punishment and extends into areas of discrimination. *Do Not Deprive of Pleasure* is when a person engaging in a pleasurable activity is stopped or denied because of some action taken by another. All of these rules can be applied to situations that are part of the normal daily operation of a nursing home. There are many types of losses through limitations of the disease processes and through institutionalization even when there are many considerations given for personal autonomy. The change in the environment by transferring from home to a hospital or nursing home automatically reduces the patient’s freedoms. Many of the pleasurable activities that a patient once enjoyed are not possible to engage in with the current medical state. The healthcare needs of the residents and patients that are cause for an admission to a nursing home present natural challenges to these rules, but the NHA has the responsibility to not allow additional harms to occur and to find ways to alleviate the harms that are factors resulting from the medical conditions.

The second set of rules involves deceit, keeping of promises, cheating, obeying the law, and doing your duty. Starting with *Do Not Deceive* is a form of lying but is wider in scope. The intention to deceive in other ways such as withholding information if the person has a duty to do so as well as the continuation of rumors that create false beliefs. *Keeping promises* involves both official promises such as a contract and ones which are made personally. This rule makes a distinction between justifying a violation and having an excuse for not keeping the rule of a promise. The excuse does not equal a justification because it would provide for an acceptable reason for not realizing the importance of upholding the rule. *Do Not Cheat* is essentially the act of being unfair. Unlike the other rules, this one is thought to only be acted upon in an intentional manner. *Obey the Law* is
to follow the laws of society in so much as they are laws for the good of others and are not morally unjustifiable. Lastly, the rule of *Do Your Duty* is to fulfill the obligations that a position or role that a person holds such as a nursing home administrator. This also includes circumstances when assistance is required, and can be provided within reason, there is a moral duty to provide the assistance. These rules are mostly a function of the leadership qualities in the NHA and the way in which the nursing home is managed. The NHA establishes the ethical culture that is created by morally meeting the obligations of the position.

Unlike moral rules which are obligatory, moral ideals are not required nor prohibited by common morality. They are actions that, although optional, are viewed as being morally praiseworthy. When ideals are attached to actions they are referred to as supererogatory acts which are closely tied to virtues. There are four points to this type of act which are: 1) optional, 2) they exceed the expectation of common morality, 3) they are intentional acts for the good of others, and 4) they can stand alone as morally commendable acts. Ideals, like rules, also serve to reduce or prevent harm to others and although they are not required, without them society would not thrive. From the viewpoint of common morality, there are many moral obligations or duties determined by the role in healthcare such as the NHA which are moral ideals.

The moral rules and ideals serve as guidelines for the decision making process. The five harms define what is to be avoided in the recommendations for actions while the second set of rules basically describes the obligations of conduct. The moral ideals and the supererogatory acts can be linked to the interactions and considerations given to the patient in the course of the decision making processes.
2. **Courage as a Virtue**

Virtues are seen as the foundational traits for moral character which is a starting point for leaders in healthcare. Courage as a virtue historically started as a physical action but has emerged into a moral one as areas of right and wrong needed to be addressed in socially acceptable ways. Courage is thought to be the cornerstone for the four cardinal virtues of prudence, justice, courage, and temperance because without it the other three are not possible.\(^\text{15}\) For the NHA moral courage is something that should be tested constantly and should become more apparent as the NHA increases an awareness of the ethical significance in every decision related to caring for vulnerable persons. The courage for the leader surfaces when the fear is overcome, and the fear in many instances surrounds conflict, which may be with employees, family members, or even residents.

Persistent courage along with integrity results in developing character which will need to be developed in healthcare professionals to act ethically. Lee and Elliot-Lee define the difference in the terms of integrity, courage, character, and ethics which are often used interchangeably. Integrity is representing what is right and has three parts which are: 1) to distinguish right from wrong, 2) to take the right action even if there is personal risk, and 3) to educate others through actions. Courage is the psychological and ethical power to endure danger, fear, or problematic situations. Courage is the impetus to act with integrity and turns integrity into a pattern of behavior. Character develops from continuous acts of courage and integrity which become automatic responses for defending morally wrong circumstances. Ethics can be formal written ethical codes or cultures that are informal and indicate the actual practices and values of an organization.\(^\text{16}\) The virtue of courage is not about self-interests but grows through self-
discipline, sacrifice, and overcoming selfishness. Morality is strengthened as courage is
developed.  

3. The Power of Fear

Where fear is concerned there should not be confusion that a courageous person acts regardless of fear and not because of fear. In Aristotle’s writings about virtues he explains courage as acting out of an appropriate level of fear for the right reasons. This fear is balanced through the principle of the mean and does not gravitate to the extremes for the situation which could be from fearlessness to cowardice. Courage is also powerful enough to conquer this fear to act morally. This view initially described courage as facing death on the battlefield but goes on to explain that courage resides in being noble and undaunted about doing the right things for the right reasons even when fear is present. For the courageous man, being fearful is to face a noble death or any circumstances for an immediate death. The nature of courage has differing degrees of fear that are determined on an individual basis which is also true for the situations that motivate confidence. Both fear and confidence are needed in acting with courage. There are many fears and some are associated with courage and others are not. This notion is described as enduring fears that are “for the right things, for the right motive, in the right manner and at the right time.” The nobility in courage is for the outcome of the action; the end result.

Both Aristotle and Nietzsche regarded actions of moral courage as being a continuation of the person’s past experiences rather than being decisions made in isolation. They saw acts of moral courage as being a constant in a person’s character and that these decisions were like links from one decision to the next that were seen as
defining moments. Such acts were not done as single and individual situations unrelated to each other. Friedrich, who was a controversial writer in the late 1800s, equated the development of character to an artist. Friedrich saw the past as being like raw material, such as clay to a sculpture that can be shaped to create the life and true self by identifying and enhancing their own personalities and character. Nietzsche acknowledged that each person has some aspects to their character that are already in place and will be difficult to change but with such things as focus, care, and discipline, a person can become who they truly are, rather than whom others want them to be.\textsuperscript{22}

Avoidance behavior can be a result of fear and is typically based on anticipatory fear which is in accordance with Bandura’s theory.\textsuperscript{23} Briefly, Bandura’s theory is a continuous process in which the environment, thoughts, and behavior interrelate in determining the behavioral outcome and its level of moral relevance.\textsuperscript{24} Theoretically, if the over-prediction of fear is a means to encourage avoidance behavior then there are fewer situations to disprove the theory. This behavior may prove to be practical in a short-term situation, but as a repeated pattern of behavior or a long term approach, it can become quite dysfunctional for the effective operations of an organization.\textsuperscript{25} For the NHA, an example would be in failing to address poor performance in managers. The fear may be displayed in reasoning through such concerns as the employee having worked for a long period of time for the organization, there is nobody to replace the employee, the employee is a nice person, or that employee is good at parts of his work. When this type of reasoning is employed by the NHA the avoidance behavior keeps the management team and the facility from operating at their highest potential. Also, the NHA never gets a chance to allay his fears and to see the good that can come from a person performing the
job well within all of the position’s requirements. These seemingly small failures multiply over time if allowed to continue and do eventually negatively affect the quality of the care of the residents and patients which is the core function of a nursing home.

4. Introducing Courage for Moral Decision Making

Moral courage is a human feature that is a prerequisite for all other types of moral behavior and is crucial to connecting beliefs to ethical action.\textsuperscript{26} The term, “moral courage,” did not become part of the English language until the 1800’s. The definition for moral courage that describes a close semblance to the experience of the NHA on a daily basis is, “the capacity to overcome the fear of shame and humiliation in order to admit ones mistakes, to confess a wrong, to reject evil conformity, to denounce injustice, and also to defy immoral or imprudent orders.”\textsuperscript{27} Being a leader and being the NHA is to stand alone in decisions. And like the ethical leader, moral courage is said to be the lonely courage.\textsuperscript{28}

Acting ethically always requires that one choose between benefits to the self, versus to others, and refusing to make this choice is what keeps people from acting with moral courage. Being affected by the well-being and rights of others requires the self to no longer be the main concern. Gini defines acts of moral courage as “the actor disregards concern for personal safety or well-being and exerts him or herself in the service of another.”\textsuperscript{29} The starting point for being ethical is to be receptive to the expressions of others first. Moral courage motivates to move people away from focusing on their own needs.\textsuperscript{30}

The healthcare leader will need to be able to successfully balance these self-interests in arriving at moral decisions for the patients. Moral courage occurs where
principles, endurance, and danger intersect in which there is an allegiance to the principles, an understanding of the risks, and the ability to tolerate those risks. Moral courage is motivated by the principles of the leader and is merely having the courage to be moral or ethical. For the NHA those acts of moral courage will most likely be in response to resident and patient situations. There are five basis moral values which are honesty, respect, responsibility, fairness, and compassion. An example within the nursing home which utilizes these values would be when an NHA has to mandate a nurse to work an extra shift which is unpopular because it is not optional and takes on a dictatorial tone. The NHA would display honesty in explaining the situation that is presented in relation to the level of care that is needed to meet the quality standards. Respect can be shown to the staff in the way in which he or she is approached regarding the situation and respect for the needs of the residents. The NHA has the responsibility to meet the regulatory requirements of the state Department of Health but is also required to meet the care needs of the residents and patients which may necessitate for more staff than the state requires. Fairness can be met by adopting a system for mandating employees to work extra hours which rotates the names of the employees so that the burden is shared equally among the qualified staff. Lastly, compassion can be shown to the staff by trying to continue to find another replacement even after the employee is scheduled to work the extra hours. Compassion is also being shown to the residents who deserve to have their care needs met adequately by having the necessary staff available.31

The military sought to learn more about courageous decisions and developed a system for measuring professional moral courage in the five categories of moral agency, multiple values, endurance of threats, going beyond compliance, and moral goals.32 The
same categories for measurements could also be applied to evaluating healthcare professionals. The essential objective of moral courage is to make difficult decisions for the right reasons even with the potential for negative consequences.

Moral courage for the NHA is to be able to defeat fear in defending his personal central values. The more common risks associated with the fear are humiliation, rejection, mockery, loss of job, or loss of social status. However, moral courage transposes values to actions. Many people are aware of their professional duties as an NHA but it is only through moral courage that knowledge is moved into action. Moral courage provides the pathway for an ethical response.\(^{33}\) Moral courage is permanent and is regarded as continuous in performance which will become a necessity in managing the challenges moving forward for patient care. People who inhabit positions of responsibility for vulnerable people such as patients should possess moral courage but it cannot be presumed to be true.\(^{34}\) Unfortunately there are good people who happen to be in NHA positions and at first glance they look like a good fit for the position. They have an advanced degree, are professional, and know the regulations, but the problems arise when they are unable to resolve conflicts and avoid situations in which difficult decisions need to be made; ones that require some level of moral courage. This type of person is known as a “good coward,” according to W.I. Miller in *The Mystery of Courage*. Miller further describes this individual as someone who runs from the battle when it isn’t necessary and repeatedly responds in the same manner.\(^{35}\)

Moral courage is also defined as a prosocial behavior but differs from helping behaviors in that the later receives positive responses rather than negative consequences. There are usually no direct benefits to the person displaying moral courage. Often the
person acting with moral courage is in a lower hierarchical or power position than the person with whom the action is directed towards. Moral courage comes from education and life experiences that formulate both wisdom and the wisdom to act with virtue.

B. Demographics for an Aging Society

1. Age Trends and Projections

To comprehend the magnitude of the growing need for healthcare services is captured in the estimated increase in the aging population. In 2012 the Administration on Aging projected that the number of people in the United States over age 65 will more than double by 2040 and the 85 and over group will triple from 2011 to 2040. In 2008 the U.S. Census Bureau concurred with the Administration on Aging projections of a rapid growth in the population in the same age groups, and by 2030 all of the “baby boomers” will have reached age 65. The number of older Americans by 2050 is to be 88.5 million which is mainly due to the aging of the baby boomer group born between 1946 and 1964 and through immigration. The number of people in the oldest age group, 85 years old and older, is estimated to be at 19 million by 2050 which is a 13.2 million increase from 2010. Another way of looking at the impact to healthcare with this rapid increase in age and life expectancy is through dependency ratios. These ratios are a measure of the age structure of a country and quantify the number of “dependent” persons within a population compared to the number of working persons. This is an economic analysis and for the U.S. in 2014, the total dependency ratio was 51% which is made up of a youth dependency ratio of 29.4% (age 0 to 14) and an elderly dependency ratio of 21.6%. The potential support ratio is 4.6 for 2014 and consists of the number of working age people (ages 15 to 64) per one elderly person. This is as a way to look at the
burden for assistance and this number will decline if the working age group isn’t replaced by the aging group.\(^40\) By 2050 the elderly dependency ratio is expected to increase to 37 however the period of greatest growth is between 2010 and 2030 from 22 to 35.\(^41\)

2. Forecasts for Medical Conditions and Care Needs

As was just explained, the dependency ratio is projected to increase from 67 to 85 from 2010 to 2040 which translates into a critical demand for care needs for this growing group of people.\(^42\) Since the early 1900s the U.S. has seen an increase in the life expectancy. What was age 50 in 1900 was at 76 for men and 81 for women in 2012.\(^43\) The increase in life expectancy brings both positive and challenging concerns and a longer life is accompanied by a longer phase of chronic and debilitating conditions, especially in persons 80 years and older which is the fastest growing segment in developed countries. Chronic conditions are irreversible and will not result in a full recovery. The attempts in care will be to manage the conditions rather than cure which includes an acceptance of the accompanying limitations. The types of chronic conditions for this age group will include dementia, depression, strokes, arthritis, and fractures. The care needs will include medical care and also assistance with activities of daily living which are bathing, eating, dressing, toileting and transferring from one surface to another such as from a bed to a wheelchair. Living longer is mainly due to medical advancements in reversing or eliminating disease processes, improving living conditions, and the control of infections.\(^44\) In having older adults assess their own health in 2012, 44% who were not in institutions gave themselves a rating of very good or excellent. When looking at this same data for older Americans in segments, African-Americans gave a rating of
25.8%, American Indians and Alaska Natives gave 29%, Asians gave 33%, Hispanics gave 29.7%, and white (non-Hispanic) gave 44.7%.45

3. Reduced Workforce for Caregivers

Coupled with this increased need is a significant decline in the availability of caregivers to provide the care. Nursing, the primary profession for caregiving, is declining in numbers at a time when the demands are increasing due to the onslaught of the “Baby Boomers’ moving into the 65 year old category.46 The American Nursing Association estimates that this shortage could reach the one million mark by the year 2020 if significant steps aren’t taken to reverse this trend.47 Since nursing became a profession in the 19th century there have been periods of supply and demand for nurses but the current scarcity is influenced by a wider range of causes. The reasons given for this downward trend are: fewer workers in general, the workforce is growing older which includes the nurses, the nursing profession is not desirable by the younger generation, there are more career alternatives for women, and the work environment for nursing is more difficult with fewer resources which has resulted in poor job satisfaction. Also contributing to the negative effects of the profession is the failure to expand recruitment efforts into a more diverse population, and the increasing accountability for a profession that has little authority and decision making power beyond the direct care of the patient.48 The age configuration of the U.S. will shift which will have a significant change in the working age range of 20 to 64. In 2010, 60% of the population was in the working age category but by 2030 there will be a 5% decline. The increasing immigrant influx in working age persons is thought to assist in counteracting the impact for the workforce.49
Nursing plays a vital role in advancing healthcare within the U.S. but as a profession they do not understand their role within the larger picture of healthcare. A fundamental approach to addressing this concern is to first understand the demographics that make up the profession. In finding solutions to improving this caregiving crisis is to first understand who the nurses are which begins through the collection and sharing of data. Strategies must be developed by policy makers, educators, healthcare facility leadership, and the government. One of the barriers to collecting this information is that data bases are kept by each state because of the licensing system and therefore, there is not one centralized area for information. Of importance to comprehending the nursing shortage is to recognize the effect and value nurses have on patient outcomes and that impact on the healthcare system as a whole.\textsuperscript{50}

C. Historical Changes in Healthcare

1. The Origins of Ethics in Healthcare

Since the beginning of the concept of medical ethics with Hippocrates and his noted oath for physicians, there has been an identified need for establishing parameters for the moral duties and obligations for persons providing medical care. The progress made through medical advancement and the increasing needs for care have been causes for conflict in the decisions that are being made.\textsuperscript{51} The basis for the ethical decision making process has been morality and its use in justifying the ethical positions taken.

Healthcare ethics which is the underlying issue to making courageous decisions had three identifiable and definable points in history in the U.S. which started with the early eighteenth century through to the Civil War, the Civil War period to WWII, and after World War II.\textsuperscript{52} Beginning in the eighteenth century through to the Civil War begins
the period in 1800 when only three hospitals existed in the cities of New York, Philadelphia, and Boston. As the first healthcare organizations, the financial donors made the administrative decisions for the operations of the hospitals which included the mission and values that would shape the ethical foundation and establish the ethical climates for these organizations. The patients treated were the working poor who were worthy of receiving proper care because they were deemed to be contributing citizens and were following the norms of the communities in which they lived. The people who were considered to be unworthy or undeserving were relegated to almshouses or poorhouses. The concept of almshouses was established during the early days of healthcare delivery and they were utilized for a century starting in 1830. Almshouses provided a lower grade option for care and assistance to the elderly, chronically ill, and the disabled. Until about 1850 there was minimal differentiation between hospitals and nursing homes and the system in the United States was patterned after the healthcare system in England at that time. The physician involvement was mainly limited to seeing patients in their private offices or making home visits to persons with the financial means to pay for the services. Religious orders sponsored some of the early hospitals which placed an emphasis on morality as a function of their medical and physical care. People of wealth received medical care in their homes. The philanthropists serving as board members upheld the mission and values. This early organizational structure in hospitals also incorporated the needs of the community which served to begin the concept of organizational ethics.

From the Civil War to WWII, the American hospital increased standardization and professionalization which served as a model for the current hospital structures.
Providing care for the worthy poor became less of a focus for hospitals as they moved toward becoming places that could offer higher technological options that could benefit all people regardless of their social standing. The mission of the hospitals began to change and the previously sole financial support of philanthropic means was now coupled with a payment for services option. These alterations in the mission and goals of hospitals also altered their values which transferred the emphasis from being morally and socially obligatory to one limited to the patients’ medical conditions. At the beginning of the 1900s, which continued for the next 50 years, was the separation of the short-term from the long-term patients in hospitals. With the drop in death rates due to advances in medicine and technology, acute care became distinctly different from chronic care. The primary services provided within the hospitals were surgeries which generated more revenue but also gave way to an ever increasing need for newer and better technology to support the success of those surgeries. Funding was becoming a driving force for hospitals which was increasingly shifting towards the needs and expectations of the communities and away from the needs of the indigent. Health insurance programs had begun in 1929 and continued to grow to offer an affordable solution for payment of the medical services. As an attempt to address the needs of the aging population, the New York Old Age Security Act of 1930 was enacted which led to the passing of the Social Security Act of 1935. This was to function like an insurance policy for the aged which provided a choice between staying home and going to a nursing home. Choices were being made even in these early days that required ethical decision making due to the limited availability and affordability of healthcare.
2. Government Policies and Programs

What seemed like the perfect solution to making healthcare available to all persons was the establishment of the Medicare and Medicaid entitlement programs of 1965 under President Lyndon Johnson. The former president, Harry Truman, was the first person to enroll in the Medicare program since he started proposing a universal healthcare system in the mid-1940s that evolved into the 1965 Act. This period of rapid growth for the government into healthcare added the National Institutes of Health as a response to the increasing demand for research in addition to the induction of these two notable programs. Medicare and Medicaid were the federal government’s first arrangement into funding healthcare for individuals. The nursing home industry really started to grow through these programs with the aide of federal funds for the care of the elderly which included provisions for the poor and disabled. The rules for participating in these programs formulated the guidelines for regulating and licensing nursing homes which have evolved into the contemporary skilled nursing facility operations.

Medicare expanded significantly over the ensuing years with few financial limitations for reimbursement. Originally, “reasonable costs” was the basis for payment for services but in 1982 a prospective payment system (PPS) was adopted to reduce the costs. This system was based on Diagnosis-Related Groups (DRG’s) in which the payments were determined by diagnoses. The DRG approach started in the hospitals and variations of it moved to other service areas. The nursing homes’ approach to PPS is through Resource Utilization Groups (RUG’s) which is a system for classifying residents according to the resources that are needed to provide the necessary care.
The timeline of other major governmental programs since the passing of the Medicare and Medicaid programs and prior to the Affordable Care Act of 2010 have been: Medicare Act of 1966 which funded home care, the first hospice in 1974, the creation of Diagnostic Related Groups (1983), the Nursing Home Reform Act (1987), the defeat of Clinton’s healthcare reform bill (1994), and the Medicare D law for prescription medications (2006).

When referring to costs in healthcare there are three meanings that can be taken. The first is really in reference to a “price” that is paid for services such as a physician visit, laboratory tests, or medications. The second perspective is noting costs on a national level which is an economic analysis of the utilization of resources for healthcare delivery. The third version is from the view of the providers of the services which includes such costs as labor, supplies, and capital costs for equipment and the physical plant. In the end, no matter which type of cost is being considered in healthcare, the expenditure in the U.S. is continuing to rise. In 2010, $509 million was spent on Medicare reimbursable services. To be more specific, 25% of the Medicare budget was estimated to have been spent on providing care and services for the last year of life of the participants in the program. On further analysis, 40% of the costs for that last year were spent in the last month of life for those Medicare participants. Medicare accounted for 12% of the federal budget. Shi and Singh attributed this to the medical model of healthcare delivery in the U.S. that focuses on cures and the practice of defensive medicine due to the prevalence of lawsuits.

Another significant cost factor must also be explored which is the financial impact on the assets of the patient and family. There is an incorrect assumption by most people
that Medicare will cover all of their healthcare costs, however there are deductible amounts and copayments.\textsuperscript{71} According to the “Official U.S. Government Site for Medicare,” the 2015 guidelines for a hospital inpatient stay is $1,260 deductible for days 1-60 and $315 coinsurance per day for days 61-90 within each benefit period. For skilled nursing facility stays the beneficiary pays nothing for the first 20 days of each benefit period and $157.50 per day for days 21-100, however there are qualifying conditions and the coverage will only continue if these are met. The 100 days of coverage is not a guarantee and if the patient needs to stay in a nursing home beyond the first 20 days, other payment sources will need to be used.\textsuperscript{72} In 2011, the older person spent on average $4,769 of their personal funds on health care which was not covered by any governmental or private insurance programs which is 12.2\% of their total expenses. This was an increase of 46\% from 2000 and consisted of 64\% for health insurance, 16\% for medical services, 15\% for medications, and 4\% for medical supplies.\textsuperscript{73}

A study conducted by the Mount Sinai Medical Center which issued its findings in the fall of 2012 found that 25\% of Medicare beneficiaries spend in excess of their total assets in healthcare expenses that are not covered by Medicare. These out-of-pocket expenses are incurred in the last five years of life and 43\% of his same group depleted all of their assets except for their main place of residence. Patients with dementia were the most expensive group for out-of-pocket expenses because they require specialized care that usually includes living arrangements designed to prevent unsafe wandering. The chronic nature of the dementia diagnoses does not qualify for skilled services under the Medicare guidelines unless there is an accompanying qualifying medical issue.\textsuperscript{74}
In reviewing the Medicare spending for $509 million in 2010, the main trends that were identified that added to the high costs for care were: 1) the large segment of the population that is aging, 2) the growth in the amount of people with the chronic conditions of diabetes, dementia, and obesity, 3) the increasing use of medical technology to extend life, and 4) the ethos of Americans in avoiding death. Social Security is expected to expand from $581 billion to $966 billion by 2018 with the aging of the Baby Boomer generation. The expected cause of this growth is that Medicare spending will almost double in that same time period.

The U.S. has the preeminent services available for healthcare compared to other nations. The physicians are highly trained and the most sophisticated equipment is available, but the health of the citizens is not reflected when compared to other developed nations. Not all Americans have access to this care. The cost is out of reach for many and according to 2005 data the health expenditure as a percentage of GDP (Gross Domestic Product), the U.S. was at 16.5 with the next higher being France at 11.0. With the oversight of healthcare by the government, the concerns are compounded with the addition of politically motivated decisions that are not in the best interests of the patients. Healthcare reform has come to the U.S. in the form of The Patient Protection and Affordable Care Act of 2010, which is the most comprehensive healthcare legislative action since the formation of Medicare and Medicaid in 1965. This Act has over 90 key requirements that are to be implemented between 2010 and 2019. The provisions are broken into ten categories and each will be listed with highlights of the provision. Title I. Quality, Affordable Care for All Americans expands healthcare insurance benefits for all Americans and bans pre-existing medical conditions as reasons for denying insurance.
Title II. The Role of Public Programs expands the Medicaid program requirements to be more inclusive to increase enrollment. Title III. Improving the Quality and Efficiency of Health Care preserves Medicare and expands healthcare services in underserved areas, and adds incentives for improving the quality of care. Title IV. Prevention of Chronic Disease and Improving Public Health develops a national strategy for wellness and prevention to reduce the amount of preventable diseases and disability. Title V. Health Care Workforce provides scholarships and loan repayment programs to increase the availability of healthcare workers for the future. VI. Transparency and Program Integrity provides more information to the patients for improved decision making and new disclosure requirements to reduce waste, fraud, and abuse. Title VII. Improving Access to Innovative Medical Therapies supports innovation and saves the consumers money which includes drug discount programs. Title VIII. Community Living Assistance and Supports Act (CLASS Act) offers a new alternative for financing long-term services in the event of a disability. Title IX. Revenue Provisions reduce the middle class taxes for healthcare, and Title X. Reauthorization of the Indian Health Care Improvement Act provides healthcare to American Indians and Alaskan Natives.80

In 2010 nearly 50 million Americans did not have health insurance coverage which is being addressed by expanding the Medicaid guidelines to permit greater access and by increasing access to private insurances through “exchange” programs established in each state.81 A major issue is the funding to endorse “Affordable Care” with the estimated cost over a 10 year period at $1.76 to $2.7 trillion which will be added to the existing National Debt.82 As part of the Affordable Care Act are pilot programs called Accountable Care Organizations (ACO’s) that challenge the professionals involved in the
delivery of care to populations of people to a co-fiduciary duty for the care. They are also charged with developing cultures that address potential ethical conflicts in a preventative way.\textsuperscript{83} The current concept of ACO’s is an approach to manage healthcare resources in a responsible way that improves the quality of care while controlling expenses. ACOs can offer a framework for the nursing homes along with other parts of the continuum of care to manage resources. The ACO structure can be combined with the moral responsibilities of each of the participating healthcare organizations to obtain and maintain a culture of beneficence.\textsuperscript{84}

These newer programs that are being piloted are forcing the varied care providers to work together which can result in mutual benefits of providing better care to the patient at a lower cost. In October 2014 the Improving Medicare Post-Acute Care Transformation Act of 2014, known as the IMPACT Act, established a quality measurement system for care outcomes for Medicare participants providing care in nursing homes, home health agencies, and other post-acute services. Centers for Medicare and Medicaid Services (CMS) plan to upgrade the \textit{Nursing Home Compare} data collection information for the Five-Star Quality Rating System which assists the consumer in evaluating and selecting nursing homes. The changes will include the verification of data through focused survey inspections, reporting the staffing levels from payroll information, improving the methodology for more improved accuracy in representing the facilities, improving the timeliness for states to complete the inspection information, and the expansion of the quality measures.\textsuperscript{85} This standardization of the care outcome data will be utilized primarily to assess quality, determine payment for services, and for discharge planning.\textsuperscript{86}
The Agency for Healthcare Research and Quality (AHRQ), within the Department of Health and Human Services, supports research that is aimed at assisting the general public in making better choices and to improve the quality of healthcare services.\textsuperscript{87} The Effective Health Care Program is the arm of the organization that partners with outside researchers to produce research reviews, original research reports, and research summaries.\textsuperscript{88} The Evidence-based Practice Centers fall under the research reviews to assist patients, healthcare professionals, and policymakers gain a better understanding of healthcare concerns.\textsuperscript{89} Two programs of the AHRQ are the Medical Expenditure Panel Survey (MEPS) and the Healthcare Cost and Utilization Project (HCUP) which have collected data that has been used to track and trend healthcare use and costs for research and policy development. The MEPS information has been used for: the study of the hardships case by out-of-pocket expenses, determining prescription drug costs by the elderly, profiling the uninsured, identification for sources for payment for healthcare services, and defining population segments for high healthcare utilization in specific areas. HCUP focuses on hospital inpatient utilization, associated charges, and demographic information by analyzing 80\% of the hospital discharges. Specifically, data is collected for reasons for hospitalization, the length of stay in the hospital, the medical procedures that were performed, and the detailed treatment that was administered for particular types of medical conditions.\textsuperscript{90}

3. Delivery of Care

Today’s healthcare environment needs to differentiate between the notion of medical care versus healthcare in which Americans wait until there is a need for care rather than focusing on preventing illness. This emphasis on illness rather than wellness
has greatly contributed to the trend of increasing healthcare costs in the U.S. which hasn’t necessarily resulted in a higher quality of the care that is being delivered. Largely driven by employers is the shift to wellness approaches by health plans. In an attempt to reduce costs, more of the responsibility has been given to the employees for their decisions related to their management of their own health and the costs or savings that comes with the results. The wellness approach engages the member in such activities as health fairs, health screenings, smoking cessation and weight management, in attempting to modify behaviors that contribute to poor health. According to the Centers for Disease Control, the top ten leading causes of death in the U.S. are: heart disease, cancer, stroke, respiratory diseases, injuries, problems related to Alzheimer’s disease, diabetes, influenza and pneumonia, kidney diseases, and blood poisoning through bacterial infection. Through wellness programs and lifestyles changes, many of these deaths could be prevented through reductions in such key areas of obesity and smoking. Taking this concept to the nursing home environment, there could be the possibility of reducing or delaying chronic diseases with the increase in life spans and the need for long term care. Even within the long term care residents, a wellness approach can be taken to keep the residents at the best possible level for independence and functioning which is also a regulatory requirement. To uphold this goal is an ethical approach to maintaining dignity and recognizing the sanctity of life through well-being.

The delivery of healthcare services has also been fragmented which means that the patient is receiving care and treatment in isolated and individual instances rather than through a coordinated approach in which the providers work together for the good of the patient. The fragmentation of care mirrors the way in which the services have been
reimbursed which has not offered financial incentives for healthcare professionals to work together. The Accountable Care Organizations are pilots programs to address this issue. A main cause for fragmentation is the law within the U.S. which dictates other aspects of the structure of the delivery system such as reimbursement. Specifically, the Medicare program pays separately by the type of service that is rendered so there are different payment systems for hospitals, nursing homes, home care, physicians, drugs, and outpatient services. This program has also perpetuated the medical model by requiring physicians to certify the services that are needed. Many of the private insurance companies have adopted similar guidelines to Medicare.

Health insurance was first introduced at the end of the 19th century exclusively to employers for the protection for the cost of care needs due to accidents in the workplace and for employee disability. In the early 1900’s two different provisions for healthcare delivery and payment were presented. Up to that time personal funds known as “out-of-pocket” were used to pay for healthcare. These two approaches consisted of a model similar to the health maintenance organization (HMO) which was a health insurance and a system for healthcare delivery and the Blue Cross Blue Shield (BCBS) plans who utilized selected hospitals and physicians. The Medicare and Medicaid entitlement programs were similar to the existing BCBS structure. As the governmental programs and privates insurances grew, healthcare was mainly being paid by third parties rather than by individuals through “out-of-pocket” expenses. The 1970’s saw the rapid increase in medical costs and the health insurances responded with the managed care model that monitored the utilization of resources. This era ushered in the preferred provider organization (PPO) and the HMO. Soon managed care organizations and health systems
were consolidating to obtain insurance plans and integrated delivery systems started to emerge. The utilization of services expanded to include medications, diagnostics, specialty physicians, and outpatient provisions. Disease management and high cost cases were closely scrutinized. The insurance industry’s attempt to manage and reduce costs garnered a strong negative reaction because it was the first time the patient was being told they could not have a service if it was deemed to be medically unnecessary. The emotional reactions escalated into allegations that insurers were intentionally denying services in order to increase their profitability for shareholders since many of these companies were now for-profit.96

In 2004 a statement for ethical principles was written for managed care companies to deal with the changing healthcare delivery system. There were four main areas addressed which were: 1) the relationships within healthcare should be truthful, respectful, compassionate, fair, and consistent, 2) there must be appropriate stewardship for the healthcare resources by all parties, 3) quality healthcare should be delivered ethically in an effective and efficient manner, and 4) patients must be notified and educated on the care and treatment possibilities and all financial and benefit concerns that involve the delivery of care.97 The keywords throughout these principles were: quality, truthfulness, respect, compassion, stewardship, resources, ethical, and well-informed, which are all words that are necessary for balancing the financial and care considerations for the patient in acting morally. The NHA is faced with making choices within the managed care arena in ways that will pose opportunities to act with moral courage. The decision to admit a patient to the nursing home who is a member of a particular managed care plan may call for considering the care needs against the payments even if the needs
of the patient can be met. There are regulatory considerations for such decisions but the financial impact must be evaluated. The NHA may also need to act as an advocate for the patient if the managed care assessment denies a service when the nursing home interdisciplinary team concludes that it is needed. All parts of the continuum of care are seeking ways to deliver care in an affordable manner and that also will involve systems of ethical checks and balances on each other in the form of advocacy for the patients.

For operating as a business, suggestions for administering managed care contracts with risk include: 1) identify the risks associated with the nursing home patient population, 2) assess the care delivery systems within the nursing home for operational effectiveness and efficiency, 3) recognize and deal with the risks of the competition, and 4) strategize for managing the financial risk to the nursing home.98 The point of discussing the risk with managed care contracts is to provide some background that will play into the morality of decisions that are made either by the managed care provider or the NHA. A model that permits the healthcare facility to focus on the clinical care within a managed care model involves a structured approach which is best used with assessing competing issues within the three concepts of: ideal which is the ideal situation for the patients, moderator which is when two aspects of care have to be modified to work with the other, and antagonist which is when one of the two parts within care are working even if the other is not. This model is successful in achieving quality care when all three concepts are functioning together for the good of the patient.99

D. Challenges for Moral Courage

The NHAs need to act with moral courage poses an initial obstacle due to the limited education and training specified by licensing agencies on ethics. The NHA is to
either obtain or develop the skills which are grounded in a basic understanding of ethics. The secondary considerations are that the evolving nursing home environment is rapidly moving in a direction whereas ethical dilemmas will become a normal day-to-day consideration which will bring about a stream of conflicts of interest which includes resource allocation. These key areas will be discussed preliminarily in the next sections with further expansions in subsequent chapters.

1. Education Limitations

NHAs are not specifically trained in ethics as a required area for coursework at this point in time. There are codes of conduct and ethics within some standards for the expectations within the individual states and associations but there is nothing in-depth. The National Association of Long Term Care Administrator Boards (NAB) is seen as the leading authority for nursing home administrators. NAB administers the national licensing examination that is required by most states in addition to the state examination. They have identified five domains of practice for the NHA which are: 1) resident centered care and quality of life, 2) human resources, 3) finance, 4) environment, and 5) leadership and management. Within these domains are detailed points to give further clarification and none mentions ethics as a consideration. However there are several references to quality of care and quality of life which involve ethical considerations for the patients and residents. A recent study by NAB has indicated that the core competencies for NHAs need to expand to further develop their professional growth in healthcare and to develop better careers paths in order to recruit a higher level of professional into long term care.\textsuperscript{100} Educationally, 32 states require a Bachelor of Arts degree, five require an Associate of Arts degree and 8 require “other” that is not
specified. Ongoing continuing education credits range from 15 to 25 and there are a few states with no ongoing education requirements. The good news, from Aristotle’s view, is that moral courage can be learned for moral virtues are developed through habitual use. Further development of moral courage will be discussed in Chapter Six.

2. Conflicts of Interest

The emerging healthcare situation is increasing the opportunities for NHAs to be tempted to make choices that may be morally questionable, particularly as they are trying to meet competing goals and directives. Conflicts of interest, which are a wide and generalized category, will require involvement in the disclosure of conflicts and prevention when possible, a regulation of actions, and consequences for acting in ways that cause harm. By definition, conflicts of interest arise when the self-interests of a person override the obligation to the individual’s profession. In a nursing home that involves the residents, patients, the facility, and the larger corporation if there is one, and the profession of nursing home administrator.

Although physicians are not a constant presence in nursing homes they continue to direct the orders that determine the key elements of the care under the leadership of the medical director. Financial conflicts historically did not begin with physicians but when such concerns arose they were initially self-regulated within the professional codes as ethical issues rather than legal ones. Within this profession, conflicts of interest evolved as the economic structure of the U.S. changed.

Capitalism is the main area of concern for conflicts within decision making within healthcare organizations. Within nursing homes this can be a core reason that could impact other areas of concern for moral leadership such as patient care and safety. The
structure within a capitalistic society contributes greatly to the potential for complicity. Guiding principles for incorporating morality into the decision making process involve principles of human dignity and rights as priorities.107 This concurs with conflicting concerns where the needs of patients have to be valued higher than financial incentives. The leadership of the nursing home has an obligation in areas of conflict in doing the right things for the residents and patients first, rather than basing the decisions on the costs or other discriminatory areas. The NHA is responsible for acting responsibly in such instances in providing guidance for appropriate actions.

Conflicts of interest occur when there are competing obligations to two or more entities and in meeting the requirements of one will result in not meeting the requirements of the other. Aside from the critical areas of conflict that involve direct concerns for the patients and residents are areas that are less obvious. Some of those “gray” areas for the NHA could include accepting gratuities and gifts which can become problematic with vendors who often offer such things as expensive meals or tickets to sporting events. The key in such a situation is that something of value was accepted with the intention to influence future behaviors which equates to bribery. Other more subtle issues could include such things as the model of company car provided for the NHA or the level of extravagance displayed in the remodeling of the administrative offices. There needs to be a constant assessment of situations in determining if conflicts of interest exist which then must be eliminated or disclosed so that preventative measures can be taken.108 Also within the nursing home, conflicts of interest can be found between the caregiving team and the patient’s family members however there is a common moral ground
between the two. The team members are obligated jointly to act in the best interests of the patient.\textsuperscript{109}

3. Resource Allocation

The overutilization of resources is a growing dilemma and by 2020 in the U.S. the gross domestic product expended by healthcare is anticipated to be at 20\% which is the highest globally.\textsuperscript{110} Resource allocation involves making choices as to where and how such assets as supplies or care are dispersed. Unfortunately, the available resources in nursing homes are fewer than in hospitals and consistently require that such choices be made by the leadership. The government funded programs have guidelines that are mostly based on economic or political reasons but such decisions require both a clinical and managerial collaboration to assess the greatest needs. Both, macro-allocation for groups and micro-allocation for individuals, need to be considered. Choices for individuals sometimes involve atypical life-saving services that are high in cost. In these cases the concept of futility can be a factor. In looking at the theory of futility the decision must include discussions surrounding the expected benefits of the treatment. When situations have been determined to be futile there is no hope of benefit from the continuation of treatment. Also included in this assessment is the appropriate utilization of limited resources and the costs that accompany them.\textsuperscript{111}

Resource allocation involves making choices between competing needs and often these choices are between two right answers. The underlying issues in any of these decisions will engage the values of the person making the decision and the values of the organization. The concept of resource allocation is based in the theory of distributive justice, also known as social justice, which serves as a basis for determining a fair
Distributive justice assists in determining ethical standards to justify the dispersal of resources. An aspect of making such decisions engages the principles of fairness and equity however compromises may be necessary if there are scarce resources. Rationing is a form of allocation of resources but is usually used in the context of extreme need.

A cost benefit analysis is an approach that is an economic measure but is not one that seems to be appropriate for an ethical situation because it presents a limited view. The financial impact is evaluated against the benefits but the dignity and personhood and value of a life are not part of the equation. These are the challenges in issues of futility and whether or not the excessive use of clinical resources gives a reasonable benefit.

The nature of the models for resource allocation has been focused on material resources with little attention given to the intricacies of the needs for healthcare. The most appropriate level of care in concerns of distributive justice offers both a better quality of life for the chronically ill as well as a reduction in expenses for healthcare. Palliative care has had positive results on placing the patient in the appropriate level of care and resource utilization which has resulted in lowering costs. Such a shift to chronic disease management moves away from a hospital treatment approach which is geared toward extending life to avoid death through the use of high-cost technological treatment options. In managing resources, maximization needs to occur for beneficial uses for the patients and an elimination of waste as an aspect of stewardship in leading a healthcare organization.

Medical resources are ultimately determined by the physician through their orders for care and services. As part of the governing body of the nursing home along with the
administrator and the director of nurses, the medical director oversees those physicians and can provide guidance to the attending physicians in managing and directing resources appropriately. Many of the NHA’s decisions that will gather criticism will deal with allocation concerns. As the statistics show, the healthcare needs are growing and the need to reduce healthcare costs is increasing as well. The decisions will involve choices in which one patient will be selected over another or one service of the facility will be reduced in order to maintain or obtain another. Utilizing a theory of justice in addressing the ideals of the moral importance of health, determining when inequalities within health are unjust, and formulating solutions when all needs cannot be met are the ethical dilemmas. Determining how the healthcare needs can be met fairly when all of them cannot be met is a question of moral authority for the allocation of resources.\textsuperscript{117}

4. Case Examples

Nursing Homes have endured a negative reputation since their beginnings in history which has continued to be perpetuated by the media. In a study of 1,562 articles published about nursing homes, 49.2\% were negative in nature while only 10.5\% were positive. The remaining 30.3\% were neutral. This study concluded that the prevalence of negative reporting has influenced the decision making of consumers for opting for other care choices if able and for affecting the governmental decisions as well.\textsuperscript{118} This type of negativity impacts the trust of consumers in nursing homes as healthcare providers. By being led to believe that poor care is consistently rendered and ulterior motives are the norm, the need for a higher level of ethical behavior is necessary. However, there are times when faced with competing needs and interests some healthcare leaders have made poor choices. Articles like the ones that follow contribute to the negative assumptions
associated with nursing homes. Unfortunately, there is not a clear understanding of the nursing home as a provider of healthcare services, nor the differences in the various services along the continuum of care which adds to the perpetuation of negativity. There is little media coverage for the positive aspects of nursing homes which is more the norm. Moral courage could have changed the course of these situations which are discussed in the following actual incidences.

In 2003 HealthSouth Corporation’s CEO and Chairman were charged with fraud for systematically overstating the company’s earnings by $1.4 billion. These actions of manipulation became the standard over several years and were intended to mislead investors into believing that Wall Street’s expectations were being met. At the time HealthSouth was known as being the largest provider on a national level for outpatient surgery, diagnostic, and rehabilitation services. In a case that garnered national attention in 2005, two nursing home owners decided not to evacuate their nursing facility during Hurricane Katrina which resulted in the drowning deaths of 35 patients. The owners of the facility were charged with negligent homicide for the lives that were lost and with cruelty to the infirm for the surviving residents. This incident was part of a much larger concern for Louisiana at the time which was the failure to properly plan for such a disaster which resulted in horrendous conditions throughout the state. The court acquitted the nursing home operators with a decision that was largely based on law however the family members of the deceased residents responded to the moral basis of the actions.

In 2012 there were three cases that happened with the first involving four ambulance operators in Houston, Texas who were accused of billing for the unnecessary
transportation of patients for a total of nearly $4 million. The requirement to bill Medicare for this type of transportation service is that the patients needed to be bedridden and transported to a hospital. This company used people who could walk independently and transported them to a mental health clinic, however they falsified the documentation in order to bill for the reimbursement from Medicare.\textsuperscript{122} Also in Texas, a physician was found to have enlisted homeless people as false patients to generate illegal Medicare and Medicaid claims for a total of $375 million. Approximately 100 claims a day were generated for services that were not needed or where never delivered. The Medicare guidelines which require physician certification for services was abused and involved nearly 500 home health companies.\textsuperscript{123} In Atlanta a nursing home operator was charged with fraud for accepting $3.2 million in reimbursement while the conditions and services of the three facilities failed to provide for the minimum standards of safety and care for the patients. The conditions in these facilities were deplorable with little air conditioning or heat, not enough food to meet the residents’ nutritional needs, and the physical buildings were deteriorating from lack of upkeep. The owner of these facilities failed to spend the Medicare monies for their intended use of providing care and services for the residents, and chose to keep the majority of it for personal use.\textsuperscript{124}

E. Conclusion

Nursing homes have had negative connotations since their inception as almshouses that provided care for the aged and unworthy.\textsuperscript{125} Having begun as an early hospital model in the United Kingdom, the nursing home has gone through many transformations in the last 25 years since the passing of the Nursing Home Reform Act (1987) in the U.S.\textsuperscript{126} The care and services provided has expanded significantly requiring
increased clinical capabilities and technology and a divide between the needs of the short
term resident who will return home after a few weeks at the nursing facility and the long
term resident who will make the facility their home for several years. With the reduction
in costs the patients are being moved to lower cost providers of care and therefore the
nursing homes are providing levels of care that was formerly administered by hospitals.
Even as a lower cost alternative to hospitals there continues to be a movement to reduce
the current reimbursement rates and to reduce the average length of stay which will both
result in declines in operating revenues to financially sustain a facility. Governmental
action had to be taken to reverse the trend in healthcare costs and this disjointed and
increasingly expensive system of care ushered in the Affordable Care Act of 2010. The
main point to enacting this law was to give more control to consumers for their healthcare
choices by expanding the limitations on insurance coverage, offering cost controls, and
providing for basic preventative care, physician choice, and emergency services. The
Affordable Care Act has or will impact all aspects of the nursing home operation with
moral challenges for the NHA over a 10-year period. The themes throughout the ten main
areas are quality, access, qualified workforce availability, employee benefits, increased
scrutiny through data collection and validation, affordability, efficiency, and prevention.
The NHA will have to be able to maneuver through the ethical confrontations that will be
created. There will be choices to be made involving risk amidst the chaos of the
perpetually changing healthcare industry. For the NHA to survive ethically is to have
reason and courage which are crucial to moral action.

1 Department of Health and Human Services, “Nursing Home Data Compendium 2013 Edition
Compliance/Downloads/nursinghomedatacompendium_508.pdf.
8 Gert, Common Morality, 145-146.
9 Gert, Common Morality, 29-40.
10 Gert, Common Morality, 40-51.
12 Gert, Common Morality, 22-26.
13 Beauchamp and Childress, Principles of Biomedical Ethics, 50.
21 Aristotle, Nicomachean Ethics, 68-75.
23 S. J. Rachman, Fear and Courage (New York: W. H. Freeman, 1990), 267-274
25 Rachman, Fear and Courage, 267-274.
The Fragmentation of Medicine: MIT Press, 2009), 37

Managing Illness to Promoting Health (2012), 2002,

Programs n.d., 2012,

https://www.govtrack.us/congress/bills/113/hr4994/text


“Accountable Care Organizations,” Issue Briefs, 2012

Executive Acions to Improve Quality of Care for Medicare Beneficiaries,

http://www.hschange.com/CONTENT/98996

http://effectivehealthcare.ahrq.gov/index.cfm/who-


Houle and Fleece, The New Health Age, 44-45.


69 El-Sayed, “Why is Medicare so Expensive.”

70 Shi and Singh, Essentials of the U.S. Health Care, 271-295.


73 Administration on Aging, “A Profile of Older Americans.”


81 Reid, The Healing of America, 244-251.


93 Houle and Fleece, The New Health Age, 44-45.


Medicare acquitted with $1.4 Billion Accounting Fraud,”


Aristotle, Nichomachean Ethics, 33.


Rodwin, Conflicts of Interest, 251-252.

Rodwin, Conflicts of Interest, 75-78.


Darr, Ethics in Health Service Management, 309-335.


Darr, Ethics in Health Services Management, 309-310.


R. S. Morrison et al., “Cost Savings Associated with US Hospital Palliative Care Consultation Programs,” Archives of Internal Medicine 168, no.16 (September 2008): 1783-1790.


E. A. Miller, D. A. Tyler, and V. Mor, “National Newspaper Portrayal of Nursing Homes: Tone of Coverage and Its Correlates,” Medical Care 78, no. 1, 2013, 78.


Chapter Three: Relating Moral Courage with Care and Caring

Healthcare’s central mission is to provide care and services to patients and the leadership of any healthcare organization has the moral responsibility to keep this mission as the focus. With the perpetually changing climate, the trend is towards increasing needs for care with decreasing resources to provide for those needs. Nursing homes have been operating within this environment for some time and are expected to continue to provide quality care with additional resource constraints. At this juncture is where the virtues of care and courage must come together in acts of moral courage to uphold the value of the patient as person in care. Moral courage has become a requirement in ethical leadership within nursing home management in representing the best interests of the patients and this chapter will focus on the reason for that need. Moral courage can no longer be an option in which indifference is an acceptable reaction to patient care necessities if ethical leadership is to prevail. Chronic illness has historically been the prevalent health situation for people admitted to nursing homes, however there is a portion of most homes that provide short-term rehabilitative services for patients who return to the community after approximately a month of treatment. That is the differentiator within the nursing home between using the term of patient versus resident. The resident is one who resides indefinitely within a nursing facility which frequently becomes the last home for those patients. With that type of patient, or resident, the nursing home transforms from a healthcare facility to a home which requires differing frameworks from which the leadership has to operate in the decision making process. The fundamentals of care will be covered through care as a virtue and the value of a person in care from the religious teachings of the sanctity of life and human dignity in
compassion and suffering. Grief will be discussed as it relates to losses experienced by the patient rather than just the limited view associated with death. The moral character of the leadership for caring will encompass the idea that the leaders must look beyond the self in order to care for and about others which includes the need for the traits of sympathy, empathy, honesty, and love. As the idea of moral courage moves from the concept of an ethics of care to the inclusion of the obligation and responsibilities to the patient, it will incorporate feminist views in Gilligan’s theory which expands into several variations from Ruddick, Tronto, Noddings, and Held. The key concept of relationships will be a focus within the ethics of care and the care areas within that theory. The responsibility of the leadership is to both the care of the patient and to upholding the rights of the patient. The key points to an ethics of care will be deliberated along with an exploration of traditional moral theories that are based in duties and rights which includes utilitarianism, Kantianism, paternalism, rights theory, and principlism. The final analysis will align moral courage with caring actions through the leadership’s connections in prioritizing the patient within the healthcare environment.

A. Fundamentals of Care

In healthcare, caring at its most basic level is in providing care to people as patients through acts of caring. Although care and caring are evident in all phases of life, this paper will limit them to the healthcare environs and the professional caregiver. Conceptions of care and caring will be reviewed to establish a fundamental understanding of the core for the leadership decisions requiring moral courage.
1. Care as a Virtue

Caring as a virtue is founded in connections among people, applications, and acts within the context of healthcare. Within care are the features that are most valued which are sympathy and compassion, loyalty, and love in developing close relationships with the patients. Initially, care can be seen as a completion of service tasks delivered by healthcare providers but as a virtue it goes well beyond that dimension which opens it up to emotional elements that enter into morality. This is the fundamental role of healthcare and is the defining difference for leaders in healthcare organizations. Mother Teresa described this concept about caring for the sick, “Don't only give your care, but give your heart as well,” Care is a duty for others especially when the need is evident. Care is often seen as an inconvenience and a chore that can be quite difficult, but through love that care is transformed into a duty to others in need. Providing care is not just for the body but also for the soul and being able to care for another is to show humanness. Caring is a virtue that evolved from the close associations of women and the care that they have traditionally given that involves emotion and a willingness to assist others. There is an interrelationship that involves care needs and the prevention of harm to others. Care is associated most with nursing and in healthcare Florence Nightingale is connected to courage as an example of acting selflessly in caring for others. She acted morally for the many soldiers who were her patients on the battlefields in the mid-1800s under dire circumstances while forging a path for all nurses to follow. As the founder of the modern-day nursing profession, she is seen as exemplifying moral courage by putting her patients’ needs before her own while taking significant risks in delivering care to the
frontlines of war. She is a role model for today’s leaders in teaching what it means to have moral courage on behalf of patients who are dependent upon leadership decisions.

A study by Morse showed that there are five basic positions of caring within healthcare which are: 1) a moral necessity, 2) an affect of compassion, 3) a human characteristic, 4) an interpersonal relationship, and 5) a therapeutic intervention. The moral imperative of caring is the heart of the other four functions within professional caregiving. A healthcare facility has a moral obligation to provide care, however the way in which the attitude of caring is enacted has the capacity to keep the patient within the realms of being a person rather than being relegated to that of an object. Care involves both the performance of acts of care as well as the emotions of care that include intentions and the ability to develop caring relations with the recipients of the care. The caring relationship must be shared between the caregiver and the recipient that involves an ongoing sensitivity to each other and the development of trust through cooperation. The need for a relationship between the patient and the caregiver is essential in order for true care to be provided and received. There are characteristics that make up a caring person in the moral sense. This starts with caring for the normative right objects and values and care in the right way through feeling and proficiency. There are two parts to the central meaning of care which are cognitive and emotional. Cognitive is to care about something and emotional is to express many associated emotions.

Nurses by nature of their professional roles are equated to care and caring actions and to fully care for and about the patient requires moral courage to perform for their well-being. The nursing home leadership must share in the responsibility of not losing the aspects of caring in delivering care in a more efficient manner. One of the more
controversial areas of managing a nursing home is in providing adequate direct care staff in the forms of registered nurses, licensed practical nurses, and certified nursing assistants. This group consists of the majority of the employees and they are the ones who provide the most important function within the facility. Also, this group makes up one the largest expenses which require it to be managed very closely for financial reasons. The challenge is in adjusting the staffing to meet the needs of the residents and patients while being fiscally responsible. The aspects of caring are what tends to be compromised when staffing levels are lowered. The time normally spent to connect with the patients and residents can be reduced to the completion of a series of tasks if the process isn’t monitored closely. Efficiency is a reality of cost containment but it cannot be addressed in isolation and will require balancing with the patient needs. As a leader the mission is patient care which must be communicated from the decision making authorities of a healthcare organization.¹³

Professional caring such as that of a nurse or the NHA entails responsibility to oneself and to the patients. The healthcare professional experiences feelings of caring as a perception of need in another person. These emotions that are elicited should lead to actions of care towards the patient. The caregiver as a person has a choice in determining whether or not to take caring actions, however as the healthcare professional there is a choice as well but there is also a professional and ethical responsibility to do so. In Aristotelian terms, the action in such circumstances should be morally committed.¹⁴ That moral commitment includes placing the highest value within the organization on the patient. Nursing homes are seen mainly as care environments while hospitals are seen as curing environments. Some see the care approach as ineffective because the goal is not to
remove the disease element. The goal is not to make someone live indefinitely, sometimes at all emotional and financial costs, in which death is seen as a failure.¹⁵

2. Valuing the Person in Care

For healthcare leaders to understand the need for moral courage is to fully comprehend the patient as the nucleus for all decisions. The value placed on the patient is clearly shown in the decisions and actions that are taken within an organization. This value identification for the patient is communicated in both religious and secular arenas as sanctity or sacredness for all human life. Human dignity is intertwined with this human valuation and is an essential basis for all healthcare services. Healthcare as a profession encapsulates elements of sacredness in the experiences between the caregiver and the patient. The beginning of lives, challenges in sickness, and the finality of the dying process. The sanctity of life is not limited to a religious perspective but can also be seen through a secular viewpoint.

One of the best teachers for learning to value the patient as a person is personal life experience as a patient.¹⁶ Pope John Paul II’s writing of Evangelium Vitae of 1995 clarified the Catholic churches’ stand on personhood, dignity, and the protection of all human life.¹⁷ “The Gospel of Life,” which is the literal translation of Evangelium Vitae, expresses the holiness and worth of all humans and the social responsibility of Catholics to care for the sick and poor of the world.¹⁸ Judaism also places great value on life and places much emphasis on procreation although they differ from Catholics in their belief in which personhood begins.¹⁹ The historic “Sanctity of Life” conference in 1966 bridged the idea of the sacred life from the religious and theological realm to the secular. Daniel Callahan surmised, based on the series of lectures, that humans must be the ones to
establish and implement the rules to protect and nurture the sacredness of that life which is equated to autonomy. Also from that same conference, Edward Shils, who was a presenter, supported that even in the shift away from religion and sanctity to autonomy, the human life is still sacred. The theories of both Callahan and Shils did not include the element of mental capacity into their discussions of autonomy but focused on the position of respect for the person. The respect for the person with advanced disease is foundational in the discussion around self-determination. The capability for making the wishes known in the current state are not possible, however they are still a person with value and therefore deserve to have their preferences honored from the “then self” even if through a surrogate decision-maker or other means.

Dignity for humans as patients in healthcare encompasses being worthy and of value, being unique and individual, and having rights as a human. Dignity is accompanied with the notion of respect that can be linked to autonomy and human dignity that can be maintained through such self-governing. Human dignity and social dignity provide two angles to dignity. The essence of being a human being is to have unconditional dignity which is inclusive of self-worth and self-respect. Social dignity is communicated through the acts of others and in relation to others. The behavior of the NHA towards the residents and patients communicates a message of social dignity. Dignity can be expressed in a negative way if by the NHA or staff member by walking into a patient room without knocking, not cleaning food off of the clothing after meals, or talking about a resident and not to the resident. Dignity is about treating the residents and patients as unique individuals first and as a patient or resident second. These are people, mostly adults, who happen to have a medical condition that requires nursing home care.
They should not be disconnected from all parts of their lives as they knew it before they entered the nursing home.

Dignity is attached to all humans and in healthcare the patient is placed in a position of vulnerability which increases the likelihood for instances in which dignity is violated. The caregiver does have power over the patient because of the dependency for care delivery. Furthermore, the leader separate from actual care delivery has an additional level of power over the patient in affecting that dignity be upheld or infringed. The challenge to individuals in their roles as patient is to have their dignity compromised by being dismissed or judged. This is played out regularly in healthcare facilities by referring to the residents and patients by some uniquely identifiable characteristic such as a diagnosis, room number, or an unbecoming term such as “the complainer.” This renders them as being of lesser value which can be seen with such persons with a diagnosis of a dementia. They progress through a steady decline in their cognitive skills that eventually affects their physical functioning as well making them totally dependent on others.

Caregivers can show a lack of compassion for these people and forget that in the midst of their confusion they are still people with feelings and individual needs. Parse offers a definition for dignity as being unconditional in its recognition of the uniqueness, respect, and assertion of the fundamental value. That definition does not segregate types of people but is all-inclusive.

From a religious perspective, both Judaism and Catholicism base the ideals of human dignity to the theological edict that man is created in the image of God and that life is a sacred gift from God. Another view on this same concept is that of alien dignity which means that it is not received from other humans but only from God. During
WWII Pope Pius XII spoke on human dignity from the aspect that government should protect human dignity by upholding their rights for the common good. Dignity can also be likened to equality from Kantian’s theory within justice that all humans have equal worth which is consistent with the magisterium of the Catholic Church for the value of all human lives. The physician-patient relationship defined from the time of Hippocrates places respect for the patient as a central idea of the professional oath in which the patient has become increasingly involved in the decisions for care. Physicians are part of the leadership of healthcare organizations but this idea extends beyond that profession and extends to other non-clinical managers.

Upholding the sanctity of life and human dignity is a requirement of an ethics of care in valuing the worth of the patients as individuals in carrying out decisions. People who are facing debilitating health such as those being admitted to nursing homes have the potential for their human dignity and societal value to be judged, misunderstood, or rejected. Their wishes are disregarded along with the person they were prior to the institutionalization. With the elimination of the person comes the elimination of their dignity. The requirements of the individual should supersede the exclusive benefits to the society, which could be the nursing home, when addressing inequalities. That nursing home could be viewed as the individual needs of each of its members for improved healthcare, which would be similar to Andorno’s concept of “collective dignity.” This concept looks at humanity in its entirety as having inherent dignity along with absolute respect for essential value. Within Catholic social teaching, life and dignity for all human persons is sacred and serves as the substance for the moral direction that society should follow. Healthcare leaders who are separate from religious-affiliated institutions
have an obligation to the patients as persons to support these basic values by representing them through morally courageous decisions.

3. Compassion and Suffering

Compassion is associated with care particularly in the profession of nursing and is difficult to define but it has an emphasis on the integration of empathy and kindness towards the needs of others rather than the self.\textsuperscript{36} Compassion as a virtue requires that it engage in both feeling and action. There is a rational choice involved and in this situation, it is in the relief of suffering.\textsuperscript{37} Compassion is a type of sympathy and is described as being a feeling as well as a quality of the person who is able to have that feeling. Compassion is a virtue whereas sympathy is not. The same standard is not met because compassion is unable to change the value of feelings that are expressed. The value is in the nature of the emotion for sympathy and compassion is a more advanced form of sympathy with its foundation in the suffering of others.\textsuperscript{38} Compassion is often misused as a principle rather than a virtue which reduces its meaning. When this happens it can be seen as using compassion as an excuse for not making a courageous decision and opting for an easy way out of a situation. However, as a virtue it helps to empathize with people who suffer although it does not give solutions to the suffering. Pain and sorrow are lessened for the patient through the compassion of friends because they share in the suffering through the love which comes with compassion. Both love and compassion create a sense of well-being in the sufferer which results in lightening the burden. Compassion cannot be separated from love.\textsuperscript{39}

As a feature, compassion exists at the heart of the moral life for all people and for the NHA to make ethical decisions for the operation of the nursing home requires that he
have compassion. As a professional caregiver such as the nurses, compassion is much broader in scope. The comprehensions of the patients’ feelings which are related to the disease process are not only involved but compassion also engages in the patients’ grief and fears, with the commitment to help. These feelings of compassion in the healthcare professional are utilized as a motivator for actively providing care. The caregiving activities should combine all of the qualities that make up the individual patient so that the whole person is being treated and not just a fragment.

Compassion is a natural complement to care and is carried out utilizing the principle of beneficence. This principle is defined as encouraging good and preventing harms which could be translated into promoting healing and preventing suffering. Empathy is incorporated in understanding the needs of others while compassion is focused on others rather than the self. Compassion should be an obligation that is required in all relationships and should not be limited to the patient and professional caregiver. Compassion can be extended to the family members and friends of the patient who are often suffering right along with the patient. Their compassion also comes from their feelings of caring in their close relationship with the patient. Compassion should also be extended among caregivers in support of each other and it should also be shown to the self at times. Each caregiver must establish limitations on the compassion that is shown in terms of the level of personal sacrifice that is necessary in order to meet the standard of obligation for compassion. The aim for the caregivers is to exert beneficence effectively for the good of the residents and patients without causing personal moral harm. When this type of balance is achieved it could be a means for improving the quality of life for the patients. The relationship between the patient and the caregiver
involves a moral familiarity with each other and can grow through compassion. They disclose reasonableness to each other and a mutual understanding of the world that is shared among all people at a higher level known as a “transcendent horizon of significance.”

Compassion as a virtue has feelings of empathy that comes with the suffering of others and involves the acts of being present with the patient. This mutual understanding of the caregiver with the patient is a function of being present with the patient.

The very nature of compassion is formulated in suffering and the starting point to understanding the source for its relief. The level of suffering is directly linked to the patient’s quality of life. The ability of the caregiving team to manage the suffering within acceptable limits will decrease the patient’s need to seek additional treatments and “cures” in attempts to alleviate the suffering. Compassion involves a more in-depth understanding of the person as a unique individual and makes it possible for others to decipher the patient’s level of suffering through words, actions, or observations even when the patient is the only one who truly knows the feelings behind the suffering. Gaining knowledge of the patient’s values and life experiences enhances insight which progresses a generalized understanding to one that is individualized. This process for increased comprehension of the patient engages compassion from a broad understanding by to one that is pinpointed to the specific needs of a specific patient. This intensity and comprehensive understanding of the patient will be the pathway to relieving the suffering.

If the caregivers had better insight into this concept they would understand some of the behaviors that are exhibited by the patients. Often times the repetitive actions such as ringing the call bell constantly or throwing a tray of food might be related to
suffering or fears. Sometimes they are one in the same. These irritating actions on the part of the patients which may cause more work for the very busy caregivers may be lessened through increased insight and acts of compassion.

Compassion is a cornerstone for healthcare professionals that offer a framework to enact the virtue through symptom management with a focus on the relief of pain and suffering. Within the nursing profession there is some debate as to defining compassion and the concern that the continuous progression of technological advancement for patient care interventions has taken the clinician farther away from the crucial caring interactions. This potential barrier of technology that was originally intended to improve the care and treatment of patients takes on a different view when dealing with irreversible chronic diseases and end-of-life care. The nurturing aspect of the nurses and all caregivers are what is most needed. The functions of the caregiver that enter into the areas of compassion involve recognizing the impact of the disease on the whole person and intervening to support and alleviate the conditions that can improve the circumstances. “Being there” for the patient is subjective but most important for the patient in chronic and terminal conditions.48

Part of being present for the patients is to help them manage their fears and fear comes with change.49 The nursing home patient has gone through many changes in the course of the illness that led to the medical condition they are now experiencing. Fear is likely to be a very strong emotion in most of the patients and they will deal with it in a variety of ways. Some will give no indication of a problem while others will be highly emotional and may even lash out at the caregivers. Suffering extends beyond pains and illness and incorporates hostility within a person’s being which explains some of the
negative behaviors that are exhibited.\textsuperscript{50} Pain and suffering are associated normally when the pain is severe, thought to be uncontrollable, or is chronic. The suffering for the patient is elevated when the perception is that there is little control over the pain. The fear that arises for the patient is an emotional factor that ties into the suffering that is projected into their future. They feel as if the pain and suffering are never going to be alleviated.\textsuperscript{51}

Suffering can be viewed from the perspective of personhood and the many facets that are combined to make up each individual are mirrored by the many facets that comprise suffering. Therefore the only way to know if suffering exists is to question the patient. The complexity of suffering is not clearly understood by healthcare providers which add to the exacerbation of suffering on the part of the patient. By being grounded in the core of personhood, suffering correlates with the actual or apparent decline in the person which increases the level of suffering. This decline does not only relate to the physical deteriorations but includes any emotional, spiritual, or social part of the person that is threatened by the possibility of becoming different.\textsuperscript{52} If the choice of the caregiver is to relieve suffering through compassion then there is a need to gain insight into the patient. A challenge to the relief of suffering is the need for many patients to remain independent even within their debilitating conditions. This demand to be self-supporting may make the patient resistant to allowing the caregiver to make the personal connections that compassion entails. In these instances support may only be able to be offered through silent acts of compassion.\textsuperscript{53} Sacrifice is seen within suffering as a way of atonement that can lead to healing and when experienced through caring allows the caregiver to have a deeper understanding of the world of the patient.\textsuperscript{54}
Within healthcare the goals of nursing for suffering patients is to maintain their dignity as unique individuals while providing physical care and emotional support.\textsuperscript{55} Compassion is the gateway to ensuring that the patient be respected as a unique individual in a dignified way even in the difficulties that arise out of their suffering. When suffering is acknowledged there is usually a goal for relief of the suffering, but because it has been coupled with pain as in “pain and suffering” it is confined within the parameters of the physical ailments of the patient. Without entering into other elements of personhood that might also be contributing to the suffering is to only address the care of a segment of the person.\textsuperscript{56} This goal transfers beyond the nursing perspective and should be an overarching objective for the organization as a whole. When utilizing such measures as those offered by the palliative care approach, to address suffering the goals incorporate the view that lessening suffering seems to be more applicable than improving the quality of life. That is because the quality of life is even less defined than relieving suffering and is also dependent upon social factors for identification which is separate from the needed medical care.\textsuperscript{57} Describing the level of suffering and when it reaches a point of intolerance is a very personal and individualized determination. The patient should be the one to make this decision however the physical and emotional conditions are much more difficult to assess when the patient is no longer competent and is unable to communicate the degree of suffering. At this point the physician and the surrogate decision makers must intervene on behalf of the patient.\textsuperscript{58}

Pain extends beyond the main physical causes and encompasses the emotional and psychological aspects of the person. Negative feelings such as fear and anger can cause an increase in physical pain that is being treated which can also be the source for
suffering that is separate from the physical factors. Pain is frequently difficult to manage because of the failure to evaluate the contribution of emotional distress. Cassel notes four means for ameliorating or removing suffering which are: living in the present, indifference to the situation, denial, and flexibility. By living in the present offers a break from the fear of the future which contributes greatly to suffering. Time is spent on what might happen versus what is happening now. By developing indifference to a stressful situation eases the person of the associated suffering. By denying the suffering is to develop the capacity to ignore certain behaviors and the reactions of people that are related to physical changes from the medical condition. The last method is to become flexible to the losses that have already happened. Maintaining the whole person is the goal since the sense of being incomplete or fragmented is at the root of suffering. This flexibility allows the losses to focus on another part of life. This will aide in restoring the intactness of the person thus reducing the suffering. Since pain and suffering are not one in the same, these four strategies are concentrated only on addressing suffering. The internal battle between personhood and the bodily disease of the individual patient determine that capacity to implement these recommendations.\textsuperscript{59}

This idea of the person should not be misunderstood as being limited to the features of the mind or the self. The consequences of not attending to the person as a whole are an increase in suffering for the patient because the person is fragmented which happens when the emphasis is on treatments or cures for a disease. Suffering is specific to each person and is associated with their values. Suffering is also formulated through individual life experiences therefore the patient should be questioned if possible to determine their level of existing suffering.\textsuperscript{60} In order to be able to see the person outside
of their role as a patient requires that the professional caregiver look at two key areas of compassion. The first is to have the ability and temperament to be able to engage with the patient so the individual nature of suffering is fully understood. The second is that upon comprehending the nature of the suffering the caregiver must have the desire to provide relief while living through it with the patient.61

Pain and suffering correlate to the reality and experiences of the patient and the intensity of both are directly attached to the incidents in the patient’s life that developed those beliefs. This position clarifies the reasons for such wide variations in the reactions by patients through pain and suffering with similar medical conditions. There is no systematic association of cause and effect with regard to these two areas however patients do have the ability to shape their future reactions to pain, suffering, and death by developing coping skills that can be carried into the future.62

Having the sensitivity for the patient’s need for understanding and the relief of suffering are paramount to genuine caring. Moral courage from nursing leadership may be necessary to represent the patient in obtaining the necessary resources to address these needs. Dealing with disability, illness, and death on an ongoing basis causes some caregivers to distance themselves from the caring aspects for patients. Care is being delivered from a task perspective but the caring attitude is not present and the patient becomes a diagnosis and not a person.63 This scenario can be played out with the leadership as well as at the bedside. The leadership must have a sense of compassion and sensitivity to the suffering of the patients and residents that flows into the morally courageous decisions that are made. This understanding can be attained in part by communicating directly with the patients. This can be accomplished by observation,
talking to the patients and their family members, and having a sense of the patient’s past. This connection to the patient transitions them more into the role of person who existed prior to the nursing home placement. By seeing the patients first in their role as persons, can assist in clarifying the need for the leader to act in situations that require moral courage. The executive leadership must have these direct interactions to the care recipients to be able to better understand the human considerations for ethical decision making.\textsuperscript{64}

Some NHAs may avoid interacting with patients who are dying or in pain because they are uncomfortable. Such situations can cause the personal fears to surface such as the fear of death which is prevalent in Western thought. Health professionals at all levels may react emotionally out of their own feelings of vulnerability and the natural reaction is avoidance. Western views also teach that suffering is not a normal life occurrence but rather is unexpected, tragic, and to be dreaded. Failing to actively engage with this facet of patient care limits the understanding of the NHA in fully comprehending the responsibilities of the position. If the NHA has developed avoidance patterns towards patients who are suffering or dying then the need to conjure up moral courage is in order. Direct contacts with patients who are in such declining states entail strength and courage along with attentiveness and a caring attitude in order to gain a more in-depth understanding of their circumstances.\textsuperscript{65} The healthcare provider in prompted to act in the best interests of the patient by having the ability to bond with the patient on an emotional and psychological level. Sympathy is fundamental to compassion and both encompass an understanding of the nature of suffering. The connectedness of the leadership to the
people as patients they represent is what keeps them grounded in making decisions from a morally courageous basis.

4. Recognizing Grief

Grief is a form of suffering that is clearly acknowledged with end-of-life and hospice care in its association with death however it seems to be a missing element in addressing the losses that come with nursing home placements. Significant junctures throughout life are often accompanied with significant loss. For the patient it may be the loss of independence, physical functioning, or personal belongings. This bereavement is a form of death to the patient and also requires processing through the emotions in learning to deal with a new reality of living. Elizabeth Kubler-Ross is an originator of one version of the stages of grief that have continued to be recognized since they were introduced in 1969. The five stages include: denial, anger, bargaining, depression, and acceptance. Denial is about thinking that the loss isn’t real; there is disbelief. Anger arises in many forms and can be directed at the self or others. Perhaps the patient failed to follow the physician orders that ultimately led to the debilitating situation which could have been avoided. The family members may be angry that their lives have been altered by a medical situation of a parent that will negatively impact their independence due to caregiving responsibilities. Bargaining is frequently coupled with guilt. This phase is identified with comments that are attempts to make deals to keep the loss from happening or to recover the loss. Depression is rooted in present time and is an appropriate reaction to loss. The final stage of acceptance is about being able to admit that the loss is real but does not necessarily mean the person isn’t still upset about the loss. Grief is about adjusting to change and going through a healing process. These stages are categories that
are generally experienced by many people but they also note that the response to loss is so personal and individual that there is no one way or right way for it to occur. Some people do not go through these stages in order nor do they experience all of them.66

By the time the patient or resident gets to the nursing home, especially if it is to be a permanent placement, there has been much loss in their lives. To gain more insight into the resident’s grief is to learn about the series of losses throughout the resident’s lifetime. If a review of the losses were assessed they might be extensive and include such significant events as: a son who was killed in war, the death of parents and siblings, the loss of a job or career, a house foreclosure, or the death of a spouse. There may also be a series of health related losses mixed in with the list as well which was probably the major factor which led to the admission to the nursing home. The more the caregivers know about the resident’s life the more understanding and supportive they can be to the resident. The information to be gathered in each of the losses would be the age in which the event happened, the feelings and behaviors that were generated from the event, the unanswered questions for the patient, and the impact the event had on the patient’s life in terms of changes. Getting an overall understanding of the losses within the patient’s life is a way of being able to help them to deal with their losses in order to move through the grief which is a form of healing.67

The nursing home administrator can have a significant influence on the course of patients during their stay at the facility by acknowledging the very reality of grief and supporting efforts to address it from the point of admission. These efforts should also be extended to the family members at that point as well because they are also experiencing loss as it is connected to the patient. A common experience for grief through loss is the
placement of a patient in a nursing home due to the advancement of Alzheimer’s disease. The progression of the disease process has been a slow loss of the person the family once knew who now may exhibit very different behaviors as if he is a completely different person. When this example is multiplied by the number of patients and family members in a facility, addressing grief in a supportive manner could have a substantial positive impact within the climate of the facility. The time spent in conflict borne out of grief could be spent on more positive activities geared toward the well-being of the patients.

B. Moral Character for Caring

For an administrator to lead ethically, he must be an advocate for the patient and must be able to comprehend with a deeper understanding of the significance of respect for the sanctity and dignity of each life. When the administrator communicates this through actions it can be very powerful and establishes a level of expectation throughout the organization. However, for this to happen, the administrator has to have a foundation for action based in moral character. For leaders within healthcare, moral courage needs to be intertwined with caring because of the responsibility for the patients. In some instances the leader is a nurse who is a professional closely associated with caring, however there are leaders who are not nurses and must be able to encompass caring characteristics that are evident in their decisions. One of the main points for the leader is to be able to have an understanding of the needs of others that are beyond self-interests.

1. Beyond the Self

Moral courage requires that a person move beyond the self because moral actions can only occur when engaging on behalf of others. Being courageous is to disregard concern for personal harms and for the good of another. An ethical leader will put the
well-being of others first even at the risk of his own self-interests. Taking risks for ethical reasons within the purview of moral courage is purposeful. In such instances, moral courage is a motivator for forward motion past personal needs which is the natural inclination in relationships to others. When the nursing home leader is unable to act ethically on behalf of the patients, they become secondary and their needs become insignificant. As the NHA there are requirements to uphold the rights of the residents and to provide for their well-being which will sometimes be accompanied by personal inconveniences, risks, and harms.\textsuperscript{68}

From the relational self originates a place for accountability.\textsuperscript{69} This accountability should not only be reflected in self-regulation but in the responsibility of setting clear expectations for others to follow. A leader who displays acts of caring can presume they will be replicated throughout the organization which is critical within healthcare. This caring is not limited to the patients but also to the employees who are either the direct caregivers or support those who are. From this viewpoint, caring can be very valuable and powerful to a leader in transforming the nursing home to a place in which the residents, patients, and staff feel valued and respected. Demonstrations of caring from the leadership are contagious and can permeate the entire organization over time. What we care most about is what expresses our essential values and the way in which we will lead. This personal value system is what guides the decisions of the NHA. To care is to be a leader. The converse which is that people who do no truly care cannot be leaders is to say that the person may be in a leadership position but will only manage and never actually lead others.\textsuperscript{70}
Leaders as caregivers must assess their own viewpoints towards their fears and vulnerabilities and the impact on their approach to care delivery. This insight allows them to act on the needs of others before their own and when this is done caring is exhibited. Caring for and about the patients are fundamental viewpoints that must be led by the NHA. The leader must not only examine his own motivations in actions but must also manage the motivations of his subordinates in acting for the good of others rather than the self.

2. Character Traits of Caring

One part of the leadership role as an NHA is that of a caregiver. Although this is not a direct caregiver position, the perspective of a caregiver and the attributes of caring need to be considered within decision making if it is to be ethical. The caregiver view is the moral compass from which these decisions are directed. The character traits of a person who is caring include sympathy, empathy, and compassion and in the vein of Aristotle, these are virtues which require that actions occur as well as feelings. The caregiver or the NHA as the leaders, must know the self as caring before knowing another as caring which can be the basis for the development of a culture of caring. Mayeroff’s caring components of knowing, patience, courage, honesty, hope, trust, humility, and experiencing a variety of viewpoints are an accumulation of descriptors of what it means to live a caring life. A caring approach has the ability to transform a nursing home.

Ethical sensitivity allows for insight and compassion in responding to persons in caregiving situations. For ethical sensitivity to foster, the leader must be receptive to becoming involved in circumstances of suffering and uncertainty, have an internal
commitment to the patient, and obtain an understanding of the effect of the actions toward the patient which come from courage through feelings and beliefs. Ethical sensitivity for the NHA could be beneficial in making decisions with a more insightful understanding of the patients. The relationships between the nursing home leader and the patients which occurs within the framework of insecurity, distress from suffering and loss, and dependency. The NHA is able to identify, translate, and react in a meaningful way to the patient.

Interpersonal and intrapersonal skills can also play an important role in having the ability to communicate effectively through an appropriate use of emotions and attitudes. A professional response of caring involves compassion and empathy towards the patient while engaging competently within the professional parameters of the relationship. For a healthcare professional, caring becomes part of the character that is intrinsic to their being and is carried out in all of their interactions with the patient. There are three main reasons that account for a person’s orientation to prosocial values which are: a positive outlook towards others, interest in the well-being of others, and having a personal sense of responsibility for the welfare of others. There were many attributes that are ascribed to care and caring, however the list for further review will be narrowed to include the qualities of sympathy, empathy, honesty, and love. The key components of courage and compassion were covered in the previous sections so they will not be repeated.

a) Sympathy

Sympathy is a source for ethics because it allows for the ability to understand the condition of others. Sympathy is defined as being both a feeling and a quality of the person who is able to have that feeling. For a caregiver, to sympathize means to
experience the care journey with the patient. As was explained earlier, compassion is a type of sympathy and is a virtue but sympathy does not fit into that same category because it does not have the capacity to change the value of the feelings that are expressed. The value lies in the nature for the sympathy which could be for a positive or a negative emotion. Compassion is grounded in the suffering of others and is a higher form of sympathy. For the healthcare provider, compassion combined with sympathy as its foundation is the capacity to connect to the patient. This connection is accomplished through intersubjectivity which is the psychological relationship between the patient and the caregiver who share an interrelated commonality of understanding. This understanding may be subjective due to its interpretation on the part of each individual. On an emotional level sympathy influences the caregiver in acting in the best interests of the patient; however the patient can choose to not engage in the interaction. Sympathy is a core component of compassion and both possess an understanding of the nature of suffering.

b) Empathy

Empathy when combined with compassion has the ability to positively change relationships throughout the nursing facility with the most important recipient being the patients. Empathy allows a person to comprehend the feelings and viewpoints of others and is thought to be a moral disposition to working in healthcare. Empathy is fundamental to helping professions and relationships and positions the caregiver to effectively communicate. Empathy encourages ethical, virtuous, righteous, and noble behavior in the healthcare professional such as the NHA. Through empathy the golden rule is enacted at the top of the hierarchy in the nursing home with the NHA along with
effectual habits, genuine goodness, and exceptional character and qualities. That description may sound like an unrealistic expectation of any person, but the point is to show the power of empathy. Patients in their vulnerable states are in need of understanding and the organizational leader can achieve that through empathetic engagement. The qualities that distinguish it from sympathy are that empathy allows for an indirect experience of the feelings of the patient and sympathy permits the caregiver to have feelings of sadness and concern for the patient. Both may be present simultaneously but empathy requires an understanding of the feelings followed by an appropriate response to them. Watson’s Theory of Transpersonal Caring allows for a deeper connection of the caregiver to the patient through a shared understanding and emotion. This relies on the caregiver having the capacity to genuinely connect to the patient. There are three components to Watson’s Theory about caring which are: the carative aspects, the caring moment, and the transpersonal caring relationship which is mentioned here.

There are four elements to empathy which are moral, emotional, cognitive, and behavioral. Empathy is thought to be the most significant feature in a helping relationship. There are several aspects to it which involves having an understanding of another person’s feelings and being able to respond to those feelings. The interpersonal connection between the patient and the caregiver provides an atmosphere that allows the patient to be more expressive about their needs which may be in areas that are not easily identifiable by the caregiver. This level of insight can aid in the healing process resulting in improved outcomes for the patient. Empathy must be present within the delivery of care for patients to feel that they are being cared for as a person. As an interpersonal
competence, empathy is reliant upon the attitude and insight of the caregiver. Empathy is traditionally connected to the nursing profession but the non-clinical leadership needs to have a clear understanding of the perspective of the patients in order to act ethically on their behalf.

c) Honesty

The healthcare administrator can choose to create healing atmospheres through honesty in his actions. When it is absent the facility becomes tangled in misinterpretations and confusion which hinders connections among people. Moral courage may be needed to be able to express honesty within a work environment, especially in a hierarchical system when the feedback may be perceived as negative or critical. There is associated risk but if the leadership displays honesty and perpetuates a culture of honesty without fear of reprisal, then respect for the opinions can become a norm within the organization. Consequently, dishonesty is a byproduct of fear in expressing truths which has a negative consequence to developing partnerships with others. For trust to be developed and maintained there must be honesty, openness, consistency, and respect.

Honesty is a virtue that requires self-monitoring and can be argued against the basic healthcare concept of “do no harm” in that being honest can be painful to the self or others which can be used as an excuse for not dealing with difficult situations. This lack of honesty for the NHA can be seen in employee performance evaluations when they do not accurately reflect the actual performance of the employees. A failure to be honest with the employee does not offer them an opportunity to improve or develop personally and professionally. This lack of honesty has the secondary effects of keeping the nursing
home from reaching its potential in quality care and services. To be dishonest breeds mistrust in a leader. The NHA who is not honest will find that the facility will lose their faith in his leadership which will diminish relationships. Dishonesty involves manipulation and putting self-interests ahead of others. For information that is confidential and limits the leader’s ability to honestly share it with others will be dependent upon the way in which such situations are handled which will determine the perceptions of whether or not he is being open and honest. Honesty also includes promise-keeping and warns that making promises that are not kept are viewed the same way as dishonesty. Failing to be honest as the leader in the nursing home is disrespecting the dignity of those who are dependent on the NHA’s leadership decisions.92

d) Love

Love is seen as an emotion that is linked to caring. The intensity varies and is determined by the relationship of the caregiver to the patient however the needs of the patient remain the focus. Love is inferred by the ideals of caring for and to care about a patient. The type of love that is being described is one known as filia in Greek literature; a brotherly love such as one known in friendship and through expressions of affection. The relationship between love and caring is irrefutable and is commonly characterized in the phrase of “tender loving care.” Being able to care for another is to be humane which also implies the ability to show love. Being able to care for others does not permit the suffering of others.93 The heart is seen as the source for love and permits the decision-makers to know the patients through feelings and connectedness in a humanistic way. Where the “heart, mind, body and spirit” intersect and combine to formulate love, is when the healing process is promoted. Healing doesn’t necessarily mean curing or even
improving but being able to accept the current condition. The patients are in need of a
deepen interpersonal caring that may include love, especially in times of suffering, in
addition to the acts of care that are received. The heart is the path used to bond with the
patients through feelings and an understanding of their circumstances.  

Tillich talks of love as being the motivation to bring together those who are
separated. Each individual is maintained as both the object and subject of love. Love is a
motivator and exhibits its highest power by overcoming the disconnection of the self
from the self. Self-centeredness and oneness are surpassed with love.  
The acknowledgement of love can be a description of the caregiver and patient relationship in
which the caregiver must move past self-interests to connect to the patient. Caring from
an ethical view engages the virtue of love as a basis for action that is genuine. When love
is seen as being unselfish, unconditional, and altruistic in the caregiving setting, it mirrors
the concepts of caritas and agape. Caritas is one of charity and agape is love that is self-
sacrificing.

Going beyond the normal expectations of duties of the job as a healthcare worker
can be viewed as an act of love because if it giving more of the self as in being unselfish.
The theory is that engaging in acts of caring and love generate more acts of caring and
love. Love has the capacity to greatly alter a person and in healthcare this transformation
can be seen in the relief of suffering.  
The caregiver who is concerned about the well-
being of the patients can use love to enhance the state of the patient within the caregiving
relationship. This can also be true for the NHA within the caring relationship which is
based on the caritative ethic that consists of love, responsibility, and sacrifice. Caritas is a
love expressed through actions that is translated as being unselfish and altruistic and is a
theological virtue and agape is a natural and unconditional love. Love has been described as being unselfish which is aligned with moral courage in which neither can occur without moving beyond personal wants. Both also necessitate taking risks for the good of others.

Love is a subject that is often not acknowledged in the workplace because of its deeply interpersonal nature. However, in healthcare and particularly in nursing homes the patients often have become residents of the facility which has become their new home. With that longevity there are frequent long term relationships between the caregivers and the residents with accompanying inferences of agape and caritas. Both care and compassion are grounded in love in that care is seen as being the virtue that most closely looks like love, while compassion is inseparable from it.

Professionals involved in the delivery of healthcare are faced with opportunities daily to act courageously. Behind that courage is an obligation to act morally in support of people relying on the decisions of the leadership for their needed care which, hopefully, comes from a person who is predisposed to caring. The role of the leader within caregiving contains three features for caring which are: the willingness to connect interpersonally with the patient, the employment of professional knowledge and development, and the courage to support and represent the best interests of the patients. To understand moral courage within healthcare is to comprehend the virtues of courage and care that underlie actions which will then be combined to formulate a response of caring. The nursing home leadership cannot separate decision making from a caring attitude if they are to be ethical. The common themes in the virtues and attributes associated with caring call for gaining insight into the patients and residents through
knowing them as persons and acting morally on their behalf even if there are personal risks involved. Acts of moral courage can lead the way in setting examples for showing compassion, empathy, and respect to people who are not merely a diagnosis or a room number, but are individual and unique persons.

C. An Ethics of Care: From Obligation to Responsibility

The ethics of care encompasses the elements that are traditionally thought of as being carried out by the direct care staff of nursing and certified nursing assistants. However this approach can also be incorporated into the actions of the leadership of the nursing home. To briefly explain an ethical framework is being referred to which captures the essence of respecting the patients as individual persons and understanding their unique character and needs. The nursing home regulations have been supporting this for idea years and have formulated the concepts into the patient rights or resident rights as they are called in nursing homes. There are two moral theories that are going to be reviewed as they connect to the need for moral courage in ethical leadership which are the ethics of care and he ethics of justice. Theoretically they are thought to be at opposite ends of the spectrum, however they can complement each other and the nursing home leadership must be utilize both effectively in representing the patients and residents.

1. Moral Development of an Ethics of Care

Since the term feminism grew out of opposition to male dominance, the notion of feminine ethics emerged to encompass a moral reasoning that addresses the traditional norms while developing feminist ideals and values. Moral experience from a feminist view is to make conscious choices in assessing feelings and relationships within the situational contexts. Views on care derived from a feminist thought process, however
to understand the progression of this theory is to recognize the moral developmental theory of Kohlberg which served as a basis.

a) Moral Development by Kohlberg

Lawrence Kohlberg created a moral development theory beginning in the 1960s that was very different from previous viewpoints. Kohlberg was influenced by Piaget’s theory of moral judgment which had two stages for responding to moral dilemmas which changed at about age ten. The initial stage for younger children is to see rules as only being non-negotiable, being followed without question. As children grew older and in adulthood that position altered with an understanding that rules can change if everyone decides on the changes and the changes are used to guide cooperative existence. Kohlberg’s theory consisted of six stages that examined the ethical development within the progression of human development from childhood through adulthood. These distinct levels of ethical thinking moved from the child being mostly focused on the self with a gradual progression to care and concern for others within a just community. Kohlberg included the Obedience and Punishment Orientation (stage 1) which sees moral thinking as being directed from the adults and Individualism and Exchange (stage 2) which introduces the ideas of doing favors for each other and sees punishment as something that needs to be circumvented. Level II contains the next stage of Good Interpersonal Relationships (stage 3) which deals in meeting the expectations of others and embracing the conceptions of love, trust, and caring. Maintaining the Social Order (stage 4) is about morality within society which is progressing from the previous individual relationship. At this point the child has developed to function morally within the rules and authority of the community. Level III begins with Social Contract and Individual Rights (stage 5) which
is centered on defining a good society that allows for individualism within the social order that has been established. *Universal Principles* (stage 6) are seen as relating the principle of justice consistently among all people in an impartial way. Kohlberg had concern in differentiating these two stages based on his research model and had termed it as a ‘theoretical stage.’

b) The Voice of Gilligan

In 1977 Carol Gilligan proposed the notion of an ethic of care. Her theory was different from Kohlberg in that males tend to see morality from a rights dimension in a hierarchical view while females tend toward a responsibility and sensitivity to people in caring relationships. For that reason the two theories are usually seen at opposite ends of a continuum of justice versus care however Gilligan believed that one was not better than the other, rather, they were just different. Both are necessary and to operate at the highest level of moral development meant that the ethics of care and justice must be integrated.

Like Kohlberg, Piaget’s stages for development were a source for Gilligan as well as she formulated her theory of ethics. Working with Kohlberg, Gilligan noted that through research interviews the males were scoring higher than women in responses that were related to rational, objective, and principled reasoning. Theoretically, this reasoning increased as a person matured morally, however the women seemed to have difficulty moving past the third stage of *Good Interpersonal Relationships* which focused on love, trust, and caring. Also noted was that within the healthcare professions the difference between the duty and rights approach versus the relationship and caring approach was divided by the traditional roles for the medical profession and nursing. The physicians, who were mostly men at the time of the development of Gilligan’s theory, focused on
curing patients utilizing the four principles of principlism for decision making. The nursing profession, who largely consisted of females, concentrated on being caring and developing relationships with their patients that supported an ethics of care.\textsuperscript{108}

Gilligan’s model of moral reasoning was based on the premise that there is another approach that is different from the traditional ones that are founded on justice. This model consists of three levels and two periods of transition that serve as the basis for her ethic of care. Level One was called \textit{Orientation to Individual Survival} and the main issue is to preserve the self. Conflicts are limited to competing issues for the needs of the self and the concept of morality is also self-imposed. The first transition period follows and moves from \textit{Selfishness to Responsibility} and places the self with others. The attachment and association between the self and others creates a conflict of the competing needs of the self and others. This moral dilemma engages responsibility in determining the correct action that should be taken versus the one that is preferred for the self. The Second Level involves \textit{Goodness as Self-Sacrifice} which is the traditional position of women as caregivers. The cues are given from the social norms to sacrifice the self that is motivated by receiving approval from others. The transition that follows this moves from \textit{Goodness to Truth} and awakens women to the need to take care of the self in order to be able to care for others. Level Three is \textit{The Morality of Nonviolence} which is the struggle between selfishness and the need to be responsible to the self. This struggle is settled through the principle of nonviolence.\textsuperscript{109} Women wanted to see moral philosophy mirror what they do along with the attainment of moral insight however Baier challenged this view by adding that there are also men who support a movement in that direction as well.\textsuperscript{110}
Gilligan was criticized for offering a theory of partialism within the ethic of care which is in opposition to theories of justice. She was proposing a form of inequality and favoritism rooted in care and relationships which was very different from the traditional views. Partialism allows for differences in application of moral theories because it considers the specifics of a situation that may change the course of deliberation. Evaluating an ethical concern out of context is to not fully understand the problem. Relationships also play an important part of the context which, when considered, provide very individualized assessments and therefore individualized solutions. This approach is an abstract form of reasoning when compared to the more concrete interpretation of impartialism. The detachment of impartialism generates disinterest morally. Impartialism is based in rights and justice and is defined as people being treated equally. In treating patients, it is unjust to differentiate in the care for two relatively similar people which are supported in the nursing facility regulations. Partiality allows for the caring relationship with personal and emotional connections to surpass equality.

In a study by Kuhse et al. that identified the association between partial and impartial moral reasoning and gender was done with nurses and physicians. Several moral dilemmas were presented and the results did not show a significant relation between the types of moral reasoning that was taken compared to the gender or occupation. The hypothesis was that nurses, a historically female profession, would be more inclined to take a partialist “ethic of care” proposed by Gilligan while the physicians, traditionally male, would take the Kohlberg position of an impartialist “justice ethic.” One explanation for this shift in the results from the earlier research is due
to a weakening of stereotypical roles of the two professions especially as each profession has experienced an increase in numbers for both sexes.\textsuperscript{114}

Professionally, the NHA is caught between both of the approaches constantly. There are always the issues of resident rights and concerns of legal discrimination that comprise impartiality while the concerns for individuality, allowing for patient-choice, and promoting a caring environment don’t always interrelate in seeking solutions. Sometimes the best interests of the patients or residents are superseded by regulations or laws.

2. Evolved Versions of Gilligan’s “Voice”

Gilligan’s writing, \textit{In a Different Voice}, offered a very diverse approach to moral reasoning than what had been in existence. The notion of a female perspective gave to a new basis for ethical concepts.\textsuperscript{115} Since Gilligan’s introduction of an ethics of care others have taken her theory and altered parts of it to represent different views. The foundational element of being relationship-based remains but the applications of the theory have extended into more encompassing perspectives than was originally proposed.

a) Ruddick

Sara Ruddick (1989) evolved in the late 1980’s but in 1995 she saw a need to make changes to the ethics of care so that it could be applied to families and their moral encounters. Within the United States the ideas of justice have been seen as public territory while the family is seen as private which has been reasoned as allowing for exploitation within the family unit. Ruddick proposed that there was a way to rethink justice so that it could more readily support the family. Justice exists to address issues of inequality and was not written with the family in mind. Within the family, their
characteristics as a group developed through their relationships with each other which mimics the ethics of care which is also relationship based. Ruddick saw the feminist view of women’s work as Maternal Thinking which was the title of groundbreaking book she authored. She argues that the maternal perspective, although not limited to women, is the need for connections to others while giving and receiving out of love which can lead to peace.

b) Tronto

Joan Tronto (1993) defined an ethics of care from a global perspective that sees humans as a species and all of the activities that are enacted are to preserve, endure, and restore the world for optimal living. Her concept of the world involved the physical body, the self of the person, and the environments that are all interwoven and interdependent. Her criticism of Gilligan’s theory was due to the omission of the principle of justice and equality in the form of impartialism. Tronto added it to her model but limited it to the context of ranking levels of urgency in the needs.

Tronto proposed her model of care based on the notion that the patient and caregiver already have a moral relationship established prior to the experience of care being rendered. This model consists of two parts with the first being the phases of caring and the second are the fundamentals of caring. Tronto saw the ethics of care as developing a habit of care for the self and others. Her four elements continue to be recognized as the framework for today’s ethics of care.

c) Noddings

Nel Noddings (1998) supported Gilligan’s original concept of the ethics of care in that the moral theories based on justice were of a masculine slant and not conducive to
the traditional female thought processes for ethical reasoning. She did, however, place an emphasis on relational ethics. Noddings used the term of engrossment to describe the understanding that the caregiver must have about the care-receiver in order to provide proper and appropriate actions of care. Engrossment needs to be accompanied with motivational displacement for true acts of caring to occur because the knowledge of the patient should be combined with the needs of the patient so the knowledge is used properly. Lastly, recognition needs to be noted by the care receiver to the caregiver that a caring attitude was displayed. Noddings distinguishes the idea of natural caring as caring out of “want” from ethical caring in which care occurs because the caregiver “must” provide the care. She speaks of a natural caring which comes from a person’s desire of wanting to provide care which must precede the notion of an ethics in caring. She uses the analogy of a mother caring for her child in which the maternal instincts are to provide care to the child and the ethics of it do no enter until after that point. Noddings uses this point to expand her theory to show that there are intrinsic caring capabilities to all persons that is instinctual. Ethical caring can be done out of duty without the natural inclination toward caring being present.

d) Held

Virginia Held (2006) supports the ethics of care as a distinct moral theory with the focus on the relations of people rather than on the individual within rights. Like Tronto, she does recognize that justice is necessary in a caring environment. Held proposed that care ethics could expand the rights theories for an even stronger moral theory into the future as she extended her interest into its application for political and global relationships. Held suggested a reorientation to the mother and child relationship as a
structure for understanding the theory for caring about and valuing others. Her appeal was for moral theories to find equal worth for the traditional work of women in providing care when compared to the experiences of men.\textsuperscript{124}

In looking at the variations on the ethics of care the foundations remain the same with the need for relationships and communication for real-life issues that uphold the four elements for the theory: attentiveness, responsibility, competence, and responsiveness.\textsuperscript{125} The NHA’s duties are more in line with Tronto, Noddings, and Held in that they have the responsibility of supporting both the relational and rights areas for their patients. The ethics of care requires that the leaders be driven for the right reasons and by the care needs of the patients. The patients need to be seen as individual people rather than as a category of persons.\textsuperscript{126}

D. **Leadership’s Responsibility to Care and Rights**

The ethics of care looks to relationships, circumstances, and the issues that are exclusive to the individual patient in reaching moral decisions. Reasoning and perceptions are also a consideration and there is a level of sensitivity in this approach that is intertwined with caring that explores the virtues of love, compassion, sympathy, and empathy. In representing the patients the administrator must be able to balance the caring for and about the patient while upholding their rights. Although this approach is mostly associated with nursing care because that professional is charged specifically and professionally with providing care rather than medical treatment, it can also be utilized appropriately in other leadership roles within the skilled nursing facility.\textsuperscript{127}
1) From Responsibility to Care

An ethics of care grew from feminist viewpoints based on the idea that women are more predisposed to care and caring in ethical thinking than men. Traditionally, men come from a position of rights and obligations which were heavily influenced by early developmental conditioning as was presented by Kohlberg’s theory steeped in justice and rights. This focus for each gender established basic patterns of behavior in which boys were taught to disconnect with the emotions of others while girls were taught the opposite. This polarized conditioning set the stage for the ethics of care to advance from a feminist position. The ethics of care will explore the following: 1) relationships to others, 2) comparison to virtue ethics, and 3) care areas of responsibility.

a) Relationships to Others

The ethics of care that evolved over time suggests that there should be a balance between care and justice because of the importance of each. In order to support an ethics of care does not mean to discredit justice. Ideally, there would be cooperation between the strengths of the two. In providing care, the ethics of care, is a one-step process that answers the question, “How may I help?” This question encompasses the awareness of a need and the determination of an action to be rendered which occur simultaneously. The inference is that the nature of the caregiver and care-receiver relationship pre-existed on moral grounds. Relations are dominant in the moral reasoning progression and include cognition, emotions, and action. The notions of care and caring are primarily connected by an emotional tie also bound by cognition and emotion. In this context, cognition is in expressing a concern about something or someone of value and the emotions constitute the wide range of emotions because there is not a specific emotion associated with
care. These connections of thinking and feeling with care and caring, formulate a basis for relationships within the caregiving setting. Gilligan compares the relationship aspect between justice and care as one as that is self-defined through separation as in seeing others in relation to the self or one that is defined in relation to others through the connections that are made. Traditionally, the different ways that men and women construct their relationships pairs them with differing interpretations of the self and morality. These caregiving and care-receiving relationships are interdependent and the ethics of care utilizes partiality in prioritizing these relationships with the idea that the relationship places a higher value on a person when compared to another person who has no relational connection.

b) Compared to Virtue Ethics

Virtue ethics are centered on what it means to be a good or virtuous person. The natural tendencies or habits of a person will tend toward virtue or vice. Virtues are defined along with their vices and the goal is to stay within the mean of the two extremes. Aristotle’s teaching as was mentioned earlier, was that a virtuous person is consistent in their virtuous acts which originate in the core character of the person. Virtuous acts are formed through repeated actions forming habits. However, a criticism of these ethics is in determining which came first for the person: being moral or being virtuous. The virtue ethics compared to right’s issues offer insights into moral character and the inclusion of emotion into reasoning, with adjustments made for the situational context of the dilemma. From a helping perspective which is a function of the leadership’s decisions, the relationship with the patients should have a foundation of moral values which encompasses courage, compassion, and respect. Courage is to serve
as an advocate for the patient, compassion serves as a moral basis for providing care to another, and respect provides empowerment. Virtues ethics poses moral goodness against moral badness operating within a framework of context, attentiveness, and relationship.\textsuperscript{137} Virtue ethics when combined with care ethics bring together the ethical and clinical components with the caring actions for the good of the patients.\textsuperscript{138}

c) Care Areas of Responsibility

Tronto proposed her model of care based on the notion that all people, and in these instances the patient and caregiver, already have a moral relationship established prior to the experience of care being rendered. For the care provider the goals are in meeting the responsibility of care. This model contains two parts with the first being the phases of caring and the second are the fundamentals of caring. The ethical phases of caring includes: caring about, taking care of, caregiving, and care receiving. These do not have a specific order and can intersect. The nurse must identify the needs of the patient, recognize the caring responsibility, respond to the needs, and then follow up with the patient to determine if the actions were effective. These steps are also known as the nursing process which maintains the patient-nurse relationship when the steps are taken appropriately. The four elements of caring includes: attentiveness, responsibility, competence, and reaction of the patient.\textsuperscript{139}

*Attentiveness to Others* involves the identification of needs of the patient or family which requires a certain level of insight and comprehension of the patient’s situation.\textsuperscript{140} Nurses as the traditional caregivers, are professionally bound to be morally accountable to their patients.\textsuperscript{141} Engaging with the patient through intersubjectivity offers insight and understanding between the patient and the caregiver.\textsuperscript{142} Moral responsibility
is closely associated with a solid awareness of agency.\textsuperscript{143} For a caregiver to be attentive to the needs of others, demands that she be accountable to herself for inner moral development. This self-awareness and self-acceptance on the part of the caregiver moves the acts of caring to a higher level which becomes an art form. By being personally authentic, the caregiver can navigate the needs of the patient which results in automatic and appropriate caring responses.\textsuperscript{144}

\textit{Responsible Caring} occurs once a need has been identified which then becomes the responsibility of the caregiver to take action that is clearly outlined within the nursing code of ethics as a profession.\textsuperscript{145} Responsible caregiving requires the caregiver to nurture the self in order to have the strength to be fully present with the patient in their suffering.\textsuperscript{146} In healthcare the development of professionalism is to enact the belief that all human beings deserve respect which includes self-regard.\textsuperscript{147} There is much talk about treating the whole patient rather than segments of the person. When the caregiver is sensitive to her own needs and acts on them, then she will be able to care with the “whole self” which allows her to be kind, compassion and giving towards the patient. By caring with the whole self, the caregiver is able to care for the whole patient.\textsuperscript{148} The focus for the leaders is typically on acting morally for the patient but there is also a responsibility to morally consider the impact of decisions on the caregivers as well. Caregivers who are not properly cared for cannot deliver the necessary care in a caring way to the patients.

Compassion fatigue and burnout can be negative outcomes for caregivers who fail to consider their own needs. Overtime the constant exposure to caring for patients in high stress situations can cause the caregivers to disengage their feelings from their patients in order to protect themselves. Some caregivers also experience helplessness and anger in
watching their patients struggle with the debilitating conditions and the grief and bereavement that accompany the death of their patients. Nurses who experience these negative feelings also have cited system problems within the healthcare facility and personal problems as contributing factors. Physical and emotional fatigues are symptoms of both compassion fatigue and burnout and can affect the quality of the work of the caregiver. The idea of losing compassion or lacking in feelings related to caring for patients is difficult for many people in healthcare to admit and therefore they are reluctant to seek help.

*Competency in Providing Care* engages in areas of quality of the care that is provided. A certain level of competence in nursing practices is necessary for the nurse to administer proper care to the patient. Without the appropriate interventions the patient will not experience care as it should be. The caregiver must be capable of individualizing the care. Competency is the moral aspect to the quality in the care and there are moral consequences for failing to provide care as it should be. The demonstration of competent care is the equivalence to caring in the delivery of the care. Care in its intended practice within this theory is not met when it is delivered in the form of the completion of tasks without the connection to the patients and residents. Coupled with the clinical competencies is ethical knowledge which is interwoven with caring as a virtuous act. This ethical knowledge within the patient and caregiver relationship has a positive effect on the responses of the patient.

The last step of *Responsiveness To and From the Patient* is for the caregiver to evaluate the effectiveness of the interventions through interactions with the patient and family to insure that the care did meet the needs for the patient. The idea is that if the
steps to the phases of care and the elements of care are not implemented properly then the patient will not experience care in the ethical sense.\textsuperscript{154} The responsive relationship between the patient and the caregiver are grounded in the three areas of trust, respect, and mutuality. Respect is for both the self and others and trust is related to professional skills, qualifications, and competence. Mutuality entails cooperation between the caregiver and the patient in determine the needs of the patient\textsuperscript{155}

The ideals of an ethics of care permeate the issues formulated in the areas of compassion and suffering. The need for a relationship between the patient and the caregiver is essential in order for true care to be provided and received.\textsuperscript{156} The intersection of the virtue of compassion associated with suffering and an ethic of care through the relationship supports the open communication within the relationship which is mutually respectful even in the vulnerable position the patient has to the caregiver. The ideals of an ethics of care permeate the issues formulated in the areas of compassion and suffering. The need for a relationship between the patient and the caregiver is essential in order for true care to be provided and received.\textsuperscript{157} In developing this relationship the caregiver provides comfort to the patient in the form of holding a hand, providing a warm blanket, or listening to the patient’s fears. Comfort allows for healing and the ability to provide comfort measures can only occur within a relationship. These are not tasks to be done but are learned by the caregiver through personal relationship experiences.\textsuperscript{158}

d) Moral Reasoning in Support of an Ethics of Care

Moral reasoning in support of an ethics of care includes casuistry and narrative ethics and both share a sense of history in relational communication. Also known as case-based reasoning there is moral realism in these approaches.\textsuperscript{159}
Casuistry is a bottom-up approach of moral justification which uses inductive reasoning in the approach to decision making. Rather than relying on principles and theories, this method uses experience as a foundation for reviewing the outcomes of similar moral dilemmas. This method moves towards the norms but never fully embraces them and proponents of casuistry also support the idea that decisions can be made without the use of general norms. Casuistry is the use of practical reasoning in recognizing similarities in prior cases in arriving at decisions. Recommendations for using casuistry are: 1) use actual cases, 2) be very detailed and all-inclusive in gathering the information for review, 3) present a series of complicated cases, 4) place and emphasis that this is an analysis, and 5) maintain and awareness of the weaknesses of casuistry. This approach has been used for centuries and compares and contrasts case histories to make ethical judgments. The supporters of this methodology, known as casuists, are doubtful of the use of the systematic use of rules, principles and, theories, and use them sparingly. Typically, there is a norm that will tie one case to the next to support the relevance of using the precedent. Principles are not completely disregarded in casuistry but are the result of their association with the details of the case. A fault of this system of moral justification is that judgments that are not based on sound facts could continue to replicate unjust findings in future cases. Casuistry offers a capable option to ethical analysis for problem resolution. Casuistry is a method rather than a theory. The system for comparing cases goes through several stages. Moral principles are determined within the case and similar case examples are utilized to direct the actions for the current case. Criticisms are that the principles are decided post hoc which argues that
the first incident caused the second because it happened first and it supports the continuation of the status quo.¹⁶⁴

Narrative ethics offers an approach to moral understanding which engages in stories to fully understanding the situation. These stories explore the characters in the patients’ lives that are comprised of their relationships, the characteristics of those relationships, and the past experiences that they’ve shared.¹⁶⁵ Gilligan ties the narrative with context which proves a more tangible view of the situation of the patient. It encompasses the beliefs, culture, emotions, style of expression, and conditions over a period of time which will reveal patterns of action from the patient and within their relationships. The relationships of the past are linked to the present circumstances in finding resolutions for the future. Through the gathering of this information a platform for communication is established which is essential to an ethics of care.¹⁶⁶ Through these caring conversations the caregiver allows for the patient to reclaim their self-worth for well-being.¹⁶⁷

Caring is relational and necessitates a comprehension of the story of the patient by the caregiver to truly treat the patient effectively. To learn the story requires that attentive communication through dialog, listening, and analysis. The ethics of care process and the use of the narrative in moral reasoning are interrelated in that utilizing stories for moral solutions requires the attentiveness and contextualization found in this theory. Traditional theories don’t allow for the branching into areas outside of the rules which can limit the in-depth understanding of the patient. The nature of the narrative can be self-contained as a therapeutic intervention with the patient having the opportunity to tell their story and to have someone be attentive to them through listening which is an act of caring.¹⁶⁸
Allowing a patient to tell their story through narrative ethics is a way of helping them move out of their suffering which reframes their actuality. Story-telling for the patient is liberating and transforming. A person’s past experiences are often to root to their suffering and being able to communicate this information can help to move the person forward. The relationship that develops allows the patient to be cared for by the caregiver. Illnesses can be points in a life story or can define the life story of a person depending on the altering effects it has had on the life that the person previously knew. Change for anyone brings about emotional responses which can include fear and anxiety. The caregivers who are able to be supportive to their patients sensitively through discussion and listening offer a valuable aspect of care to the patient in developing the caring relationship. This relational element of caregiving also acknowledges the personal identity of the caregiver through narrative discussion.

Narrative ethics can be utilized if the choice of the caregiver is to relieve suffering through compassion then there is a need to gain insight into the patient. This approach delves deeply into the illness story of the patient and includes the individual thoughts and values that will impact the reactions to pain and suffering. This information must be gathered through intersubjectivity; a connection between the caregiver and the patient, that includes personal and cultural beliefs and not be a traditional history and physical approach. These stories are predominantly meant for the direct caregivers but they are also instruments that can assist leaders in gaining insight from the backgrounds of patients for more appropriate decision making. This insight can also play a factor in justifying the need for risk for engaging in decisions of moral courage. Care is an action and an attitude and caring engages the emotional element of the patient more fully
surrounding issues of comfort and support. The nursing home which does have long lengths of stay even for the shorter term patients allows for the relationships between the caregivers and the care-receivers to develop so that there can be a deeper understanding and experience for that comfort and support.¹⁷²

Narrative ethics is respectful of the individuality of the patient which recognizes the lived life. This approach can be used as a form of compassion for relieving suffering and offers a chance for healing of the patient through the intimate and vulnerable interactions with the health professional in expressing these stories of personal suffering. The capabilities for a healthcare professional to engage in such a relationship with a patient or resident requires empathy, an understanding of other cultures and religions, listening, the ability to interpret patterns of behavior, self-awareness and the ability to be open to accepting constructive criticism.¹⁷³

In looking at the variations on the ethics of care the foundations remain the same with the need for relationships and communication for real-life issues that uphold the four elements for the theory: attentiveness, responsibility, competence, and responsiveness.¹⁷⁴ These same areas could be applied to the leadership in their actions toward issues requiring moral courage. When looking at moral character in the leader there is the idea that the concept of obligation is the result of virtues and doing the right thing is an automatic response. The other thought is that some actions are done purely out of duty. The level of responsibility within the ethics of care shows similarities to common features of leaders who exhibit moral courage which are: 1) an assurance and conviction to taking the right ethical path without regard for their positions or relationships, 2) independent thinking, patience for delayed gratification, 3) willingness to accept a level
of personal loss and risk, 4) a high degree of determination and 5) perseverance. The person of moral courage also does not ask if an action is to occur but knows and follows through to completion. When comparing the approaches of justice and an ethics of care, they could be equated to the two differences between Gilligan’s emotional and automatic response to the care needs of patients in a virtuous manner which formulates the basis for an ethics of care. Kohlberg’s justice-based position on ethics is a clearer black-and-white approach that is based on rights which are duty-driven. For the leader, this virtue translates into moral courage and into the meeting of the care needs through compassion and empathy in an emotional sense. This does not necessarily mean that the action per obligation is wrong but that such decisions may be driven from a detached perspective of the patient.

2. Bound to Duties and Rights within Skilled Nursing Facilities

Moving from an ethics of care method to one of rights positions the decision making perspective for the NHA from one that is concerned foremost with the unique relational aspects of individual needs to one that is formulated on equality and fairness through individual rights. The first approach provides a closeness and insightfulness to the patient while the later distances the patients from others as decisions are based on specific guidelines. The ethics of care evolves more from the virtues and whether or not an action is good or bad and the moral theories of obligation address right versus wrong.

As moral theories the ethics of care and justice have the challenges and criticisms of the differences between ethics of obligation and ethics of responsibility. A key area for resolution between the two is the concept of autonomy which is relational within the
ethics of care and is seen as an individual within justice. An ethics of care sees patients as only being able to achieve autonomy within relationships with others and the ethic of justice sees autonomy as the rights of individuals to make their own choices.\textsuperscript{178} There are benefits to each of the approaches and the NHA has the responsibility of combining both in representing the patients and residents in beneficial ways.

a) Duties

The nursing home leadership has very clear duties that are outlined through the professional licensing boards, state and federal regulations, laws, and policies and procedures within the organization. The NHA is hired to manage all aspects of running the nursing home which includes meeting specific standards of conduct. Generally, the NHA provides oversight for personnel management, quality of care, physician relations, clinical care, food service, fiscal soundness, risk management, purchasing, and the physical environment.\textsuperscript{179} There are individual departments established with managers who report to the NHA who provide direct oversight to each of these areas. What has been listed are considered duties for NHA positions and could have been taken from a job description but when the ethical element is added to this list these areas are all viewed in relation to how the decisions surrounding each of these affects the residents and patients as the foremost concern. The American College of Health Care Administrators also has a list of duties contained in their \textit{Code of Ethics} that addresses the considerations for the residents and patients in carrying out the responsibilities which includes: 1) providing quality care within the available resources, 2) meeting the required laws and regulations, 3) protecting confidential information, 4) leading with integrity, 5) avoiding actions of
discrimination, and 6) not divulging professional or personal information to unauthorized persons.\footnote{180}

\textbf{b) Rights}

From a rights perspective, ethics based in obligation involves a two-step process for making decisions in responding to others. The first one is to determine the need that the person has and the second step is to determine if there is a duty to respond. This approach begins with a separation from the person of need with the precept that people are independent and autonomous beings as humans.\footnote{181} Human rights are intrinsic to being human and are founded in morality. Liberties subsist to protect persons from interference and are not attached to any claims on the person.\footnote{182} Within healthcare, rights are seen as entitlements to all patients however these rights must be able to be negotiated within competing needs and respecting the rights of others. That is, the rights of the individual must be balanced with the rights of the group. In a nursing home that concept might be played out in a situation in which a resident plays loud music late at night. While he has a right to engage in his interests, the other patients have the right to be able to sleep, so some type of compromise will need to be negotiated. There is confusion between using of the term of “rights” that is outlined in ethical codes as opposed to upholding the law. The first are guidelines for the way in which people are to be treated from a moral view and the later are requirements of the law.\footnote{183}

Well-being can be seen as a basic human right and according to Powers and Faden there are six dimensions of well-being within justice which consists of health, personal security, reasoning, respect, attachment, and self-determination. While one can live without any of these six areas they conclude that anyone who does not have at least
some semblance of each of these domains in their lives views it as being incomplete in terms of the wants and needs of the individual which comprise basic human rights. Each of these domains is morally significant. As indicators of a good life, justice has the obligation to assist in obtaining them. There are additional moral issues contained within each domain. Health in this instance incorporates a wide range of health issues related to both public health and clinical care and involves the distribution of medical services as an adjunct to obtaining or maintaining well-being. Personal security requires that a person be free from fear. That fear may be grounded in physical or emotional abuse or unsafe conditions surrounding a person’s environment which could be extended into additional areas of abuse and neglect within a nursing home. Living in constant fear from a variety of possible reasons will significantly impact the possibility of living a good life.

Reasoning includes having the cognitive capabilities to understand how each person should live and to determine the actions to take to achieve it. Within this reasoning is to be able to develop independent and critical thought processes. Respect is the person’s ability to feel that he is equal to others and is based in dignity and worth. As a condition of well-being, respect can take on several forms and can be linked to discrimination based on a person’s demographic affiliations outside of any specific causal factor on the part of the individual. Attachment is closely related to respect and goes beyond the traditional sense of justice in that it expands to include a person’s capacity to develop bonds of friendship and love. Further developed, attachment with the inclusiveness of emotional involvement, allows a person to develop the necessary connection to others as a vital aspect of well-being. Self-determination allows persons to lead their lives based on their own choices and values. The level of competency will play into the level of self-
governance. The famous philosopher, John Stuart Mill, describes self-determination as living one’s life “from the inside out.”

Patient rights, which are requirements within healthcare, are to support individual autonomy however they are not always known by the patient. When patients are aware of these rights and make decisions that are in conflict with the professional recommendations, they are often seen as being irresponsible rather applying their rights. Upholding the human rights of others requires that empathy be enacted to move people into action. For healthcare leaders this movement to action may include acts of moral courage. Residents Rights which is the nursing home version of the Patient Bill of Rights is fundamentally the ethical connection between the organization and the patients or residents. They exist in a variety of forms and have been issued through the American Hospital Association, the American Health Care Association, the Department of Veterans Affairs, The Joint Commission, and the American Civil Liberties Union.

Originally, rights for residents in nursing facilities evolved from the Federal Medical Assistance Law. They obligate the leadership to uphold the rights of each resident which is carried out through actions that include: freedom of choice, freedom from restraints, privacy, confidentiality, accommodation of needs, grievances, participation in resident and family groups, participation in other activities, examination of survey results, and the refusal of certain transfers. They were addressed again in 1987 through the Nursing Home Reform Act which required that a formal program be instituted in all facilities that included the monitoring and assurance that the rights were being enacted. The rights expand from being able to exercise rights within the nursing home but also include being a citizen of the U.S. The main point of these rights is to
acknowledge the patients as active and autonomous individuals who are able to make their own decisions while living within the healthcare facility or to allow for surrogate decision making if there are limitations in mental capacity or competency. These rights provide directives for the leadership in decision making. The leadership has to continuously remind the staff and family members of the importance of upholding these rights and being an advocate to the patients. The patient with chronic illnesses often feels isolated and continually battles for identity as an individual person which becomes a greater concern within institutional living. Given the limited and increasing reduction in reimbursement, the administrator has to try to maintain the individual identity of each resident while trying to meet their care needs and their personal preferences.

c) Exploring Traditional Moral Theories

Within healthcare ethics there are many theoretical guidelines that direct decision making as to the most appropriate actions to take based on the situation and the subject matter. This section will define five specific theories of utilitarianism, Kantianism, paternalism, rights theories, and principlism. These will be explained along with their relevance to ethics in caregiving matters.

Jeremy Bentham is the founder of his theory of utilitarianism which is based on maximizing happiness and has contributed significantly to the development of the allocation of social programs. The theory of utilitarianism is the concept that the right action to take is the one that will result in the best outcomes for the most people. As a form of consequentialism, it assesses the results of an action when deciding on the moral worth of the action. The consequences of all options for solutions are evaluated in
determining the best moral action. The most favorable solution provides for the greatest benefit.\textsuperscript{194}

This theory is based on utility which is the fundamental gauge of what is a right or a wrong action for utilitarianism. Contemporary philosophers increased the scope of the theory from the limitations of the objective of pleasure to include the concept of well-being which is comprised of such things as knowledge, success, and health. Even with these changes over time some philosophers continue to interpret the values of utility to be preferences of the individual person rather than being intrinsic. Utilitarianism is divided into two parts which are act and rule utilitarianism. In act utilitarianism the rules are circumvented in determining the consequences of the actions in each specific circumstance. The rules are closely obeyed within rule utilitarian for deciding the choices for the actions. The dictate that is supported by the principle of utility is determined to be the correct action to implement.\textsuperscript{195}

One of the criticisms when applying utilitarianism is that it is difficult to determine the greatest good of actions when working within the constraints of this theory. Historically, the utilitarian thought formulated the basis for public health since it seeks to provide the greatest benefit, however the allocation of limited resources has added a challenge in determining the greatest benefits.\textsuperscript{196} The same criticism could apply to the management of a skilled nursing facility in which the resident and patient rights are to be followed for the individual autonomy of the patients. However in supporting those individual choices, the rights of the group and the regulations governing the operating of the facility are often at odds with each other. This problem is particularly evident when the patient’s choices have the potential to cause some level of harm.
The writings of Emanuel Kant served as the basis for Kantianism. This theory is centered on rules but fails to include the traditions and desires within the decision making process. Kantianism believes that morality is theoretically based in reason and that a rule that is applied to actions determines their moral worth. In Kantian theory, one version of his categorical imperative is that a person is not used as an ends to justify the means.\(^{197}\) Kantianism which is also known as deontology has the core idea that some actions are obligatory which makes the actions right or wrong.\(^{198}\) Deontology is largely dependent on precedents and uses history in deliberating the right or wrong actions to take.\(^ {199}\) The use of casuistry which was previously discussed could be applied to this theory in arriving at a moral decision.

The criticism of this theory within healthcare is that autonomy does not consider others. However, it can be argued that this moral theory is inclusive within the categorical imperative of justifying the ends of the self and others. This interpretation is that through the use of sympathy and interdependence the common good can prevail over the interests of the self which allows for the idea of care to have Kantian application.\(^ {200}\) In looking at the categorical imperative from the nursing home leadership view is to see it as representing the dignity of every person.\(^ {201}\) No patient should be used as a means to something else but should be an end without being used for another accomplishment. The application of this theory to decision making situations within nursing homes may mean that no resident should be provided with unnecessary care in order to be able to bill at a higher rates of reimbursement; that the caregiving staff should not be reduced to levels that provide inadequate care; and that unsafe conditions of the physical plant should be
ignored to save money. The patient needs to be respected and the center of the considerations for all decisions.

In paternalism there is an ethical dilemma in balancing and respecting the autonomous decisions of the patients with the professional responsibility of encouraging their well-being.\textsuperscript{202} A challenge within healthcare is to allow for a patient to practice autonomous decision making when the choice made is in conflict with professional recommendations and values. As a result some caregivers are unable to step back and override their values with the patient’s by making the decision for the patient. Taken from the point of “knowing better” on the part of the caregiver, this approach takes on a parental stance.\textsuperscript{203} This method with patients can also be seen as an unethical form of caring because it oversteps the boundaries of the professional relationship.\textsuperscript{204} The obligation to protect patients is in conflict with respecting the patient’s right to autonomous decision making. The nursing home regulations are sometimes in conflict as well. The resident’s rights are strongly enforced but the sanctions are high for nursing home organizations when there are negative outcomes from the patient’s decisions. In extreme cases these sanctions can take on the form of large monetary fines called civil money penalties, revocation of operating and professional licenses, and personal legal liability on the part of the leaders of the nursing home.\textsuperscript{205} 

The role of paternalism is a balancing of the individual’s rights and the protection of the community as a whole which could be the entire population of a facility such as in a nursing home. Nationally, government involvement in making decisions in the best interests of society is often viewed negatively because it limits personal choices however the converse of that notion is to take a positive position of protecting the general
The dictates of paternalism run along a continuum that has a childlike control at one end and on the opposite side allows for some individual preferences. The paternalist in general imposes opinions and control over people by deciding what is best for the health and safety of individuals with minimal concern for autonomy. Because of the limitations on autonomous decision making and the perceived power of some healthcare professionals, paternalism is accused of manipulating health-related behaviors. The degree of decisions made for the patients may vary from one issue to another, however the argument related to paternalism is that in general more autonomy allows for more responsibility on the part of individuals.

The obligation to protect patients is in conflict with respecting the patient’s right to autonomous decision making. The nursing home regulations are sometimes in conflict as well. The resident’s rights are strongly enforced but the sanctions are high for nursing home organizations when there are negative outcomes from the patient’s decisions. In extreme cases these sanctions can take on the form of large monetary fines called civil money penalties, revocation of operating and professional licenses, and personal legal liability on the part of the leaders of the nursing home.

Paternalism within the nursing home encounters the binary situations which are the patient who is at the facility for a short stay versus the long term resident who has made the facility their home, will be influenced differently in allowing others to alter their decisions in the disguise of being in their best interests. The truth is that competent residents and patients are allowed to make “bad” decisions which are based on the values of the healthcare professionals. Paternalism is a parent-child relationship and limits the opportunities for responsible behavior for the individual resident or patient. The NHA
can be an advocate for the patient even if there is a personal value conflict. A possibility for dealing with the conflict is a term known as “nudging,” which suggests that the patient’s wishes and the professional recommendations be identified and encouragement be given to move in the direction that will be less harmful to the patient. This strategy known as soft paternalism becomes less necessary as trust develops with the patient.210

Rights theories have a foundation in protectionism which has an ultimate goal of moving the person toward empowerment and autonomous decision making that results in their best interests. Protectionism is to protect vulnerable persons who are unable to safeguard themselves and to protect vulnerable persons as a way of assisting them to become empowered.211 Through ethical analyses the right’s theory explores the rights of all parties involved, both defending and protecting rights. Legal and moral rights are two very distinct rights but are sometimes confused with each other. Both are supported by normative structures with the first being in law and the second in morality.212

Right’s theory would support the rights of patients, even when there is an inability to actively participate in the process. The rights of the patient must be upheld on the part of the substitute decision-maker based on the legal view of the right to autonomy, privacy, and the freedom to make independent choices.213 This position was further clarified through the Patient Self-Determination Act (PSDA) which was put into effect in 1991 and requires that all hospitals and nursing homes must complete three tasks for all admitted patients which are: 1) to inform patients in writing of their rights regarding the selection and refusing options for care and treatment, 2) to ask if there is an advance directive with a note made to the patient’s medical record along with an attempt to acquire a copy, and 3) to inform, in writing, of the healthcare facility’s policies on these
matters. The traditional paternalistic decision making by physicians was shifting to the rights of the patient and the PSDA recognized this strong need for patients to be actively involved in their medical decisions which included making futuristic plans in advance of needing them. There are two types of formal decisions of this nature known as advance directives and they are treatment directives and proxy directives. The treatment directives are also known as living wills which outline the type of care that the patient would want which is put in writing in the event that the patient is unable to make a decision in the future. These are general guidelines for the wishes of the patient and can’t possibly cover all of the potential situations that might arise. The proxy directives are also known as a durable power of attorney and designate another person to make decisions on behalf of the patient if the patient unable to do so.

An important aspect the individual right for autonomy is informed consent and in order for a patient to make a decision there is an absolute need for this condition to be met. The conventional route of informing the patient is through the physician communicating the diagnoses, care options with the prognosis, and the potential side-effects associated with the treatments. For a patient to make a free and voluntary choice there has to be a clear comprehension of the medical condition. The leadership of the nursing facility has an obligation to insure that these rights are being enforced with the residents and the patients and accommodations need to be made to effectively communicate the information. The NHA may be called to defend the rights of the residents and patients in a variety of forums which may be with the family members who have taken opposing positions on an issue. In such instances moral courage may need to
be the avenue necessary for the defense of the patient while working to bridge the gap of
differences.

The four principles that make up principlism are: respect for autonomy,
nonmaleficence, beneficence, and justice, and provide a framework for ethical decision
making that is seen as being more task-based without considering the emotional and
relational aspects of ethical dilemmas.\textsuperscript{217} Edwards equates the elements of principlism to
be congruent to an ethics of care within the context of nursing.\textsuperscript{218} The principle of respect
for autonomy is often viewed as the most important of the principles and permits a person
to make decisions and take actions based on their own values and beliefs.\textsuperscript{219} Within
healthcare it includes giving consideration to maintaining a person’s autonomy even
within their disabilities. The respect feature encompasses respects in treatment of the
person as well as the actions taken towards the person. An individual’s rights and choices
are respected until the rights of others are negatively impacted such as causing serious
harm. Within informed consent which falls within this principle requires that information
be properly and completely disclosed to the patient so the individual can make choices
according to his or her own wishes, having a full understanding.\textsuperscript{220}

Nonmaleficence prohibits the causing of harm and it clearly delineates its
differences in the moral rules and ideals which allow for degrees of importance and
seriousness in ranking the types of harms.\textsuperscript{221} Nonmaleficence is supported by the moral
rules of refraining from killing, causing pain and suffering, disabling, wrongdoing, and
welfare deprivation.\textsuperscript{222} The principle of nonmaleficence prohibits the causing of harm and
it clearly delineates its differences in the moral rules and ideals which allows for degrees
of importance and seriousness in ranking the types of harms.\textsuperscript{223} Beneficence is to promote
good while preventing or relieving harm and is connected closely to compassion and caring. Beneficence might give the impression that it is in support of the ethics of care however the element of moral obligation places it in a position of rights and justice.\textsuperscript{224} The argument for this principle is that it falls within the range of moral ideals which merely suggests rather than requires the actions that are to be taken, however there are moral obligatory rules that support this principle as well. The moral ideal suggests that actions are to be taken, however the moral obligatory rules are requirements.\textsuperscript{225} That is to say that the prevention and relief of harms is a requirement and promoting the welfare is suggested.\textsuperscript{226} Fairness, equality, and entitlement are contained within justice and a further expansion on this principle factors in discrimination within equality and the allocation of resources within the properties of distributive justice.\textsuperscript{227} In general this principle has been criticized for being deficient in providing direction for actions for application and has been perceived as an ethical checklist within principlism. Justice is a moral ideal rather than a rule and therefore, encourages compliance as opposed to requiring it.\textsuperscript{228} In short, it simply supports that equal persons should be treated equally.\textsuperscript{229} Within moral courage the tendency is to be more geared to commitments based in rules rather than consequences and is driven more by the obligation than by the outcomes of the actions.\textsuperscript{230}

The role of the NHA in overseeing the care provided to the patients explains the obligation of incorporating compassion within the professional expectations. There needs to be an ongoing acceptance by the NHA that they have the responsibility to provide a healing environment for the patients. Healing is to provide care through the virtues of compassion and mercy. The self-image of the patient is fragmented by the illness from the disease and it is through healing that mends the pieces into the whole person. The ego
and the body are rebuilt. Healing can evolve out of compassion even when used for chronic and irreversible diseases if processed through the principles of beneficence, justice, and respect for autonomy in the choices related to the care and treatment plans specific to each patient.\textsuperscript{231}

Within moral courage the tendency is to be more geared to commitments based in rules than consequences because moral courage overcomes the fear and risks associated with the actions. Moral courage is driven more by the obligation, than by the outcomes of the actions which for the ethical leader in healthcare the obligations are the patients and residents.\textsuperscript{232} Although the ethics of care requires less structure and more connection to people through relationship development, it doesn’t completely disregard the need for rights-based theories. In general the use of utilitarian or Kantian theories by an NHA would be necessary in their role of upholding the rights of the patients however they will not adequately support an ethics of care. There would be more likelihood that moral courage would be necessary to dispute the application of utilitarian, deontology, and principlism ideals on many issues related to the care of the patients.

There has been much research done that proved that both an ethic of care and justice approaches have been effective in solving moral dilemmas.\textsuperscript{233} The difference between the two methods of moral reasoning is that they are comparing a “care” moral orientation to a “justice” moral orientation.\textsuperscript{234} As a healthcare leader, a mixture of the discussed theories for reasoning should be employed based on the nature of the dilemma. Within healthcare facilities, utilitarian thought might be more readily applied when considering decisions that will impact a large group of patients living together. There are many obligations that fall within the purview of leadership responsibilities and
precedence is often used to guide future decisions from a deontological stance. However, with the changing demographics and healthcare reform, the past may not serve future decisions well. Paternalism is most likely to remain a challenge for healthcare leaders who have traditionally been trained to protect the patients within their responsibility. This approach can be a starting point for assessing a safe situation and moving to a balance that includes patient’s preferences. Lastly, the four elements of principlism are incorporated on a regular basis within the decision making process for healthcare leaders. The primary focus is to prevent harm to the patients but protecting rights, promoting well-being, and supporting autonomy should be incorporated into day-to-day operational actions.

E. Aligning Moral Courage with Caring Actions

The administrator must lead the charge in prioritizing the needs of the patient for the healthcare organization that is shown in not only words but in moral and ethical actions as well. This ethical sensitivity combines an understanding of the vulnerability of the patient in their suffering and helplessness with the reciprocal relationships of the patient and the professional caregivers and leadership. All of these aspects enter into the need for moral courage by the leadership in decision making that is in the best interests of the patients.

1. Leadership Connectedness

As had been previously discussed, the leadership must have an understanding of the needs of the patient as a person that goes beyond the medical care in order to represent their best interests. The NHA is in a position to make decisions that affect every aspect of the patients’ world within the nursing home. This leadership position must
understand that helping relationships need to be developed with the residents and patients. The NHA must cultivate an understanding of the nursing home from the perspective of the patient from actually knowing the patient rather than through assumptions. This cannot be accomplished from the confines of an office but must be developed through constant interpersonal interactions with the patients in all phases of their dependency on others for care.\textsuperscript{236}

To make ethical decisions within a care environment such as a nursing home requires that the leader be caring in attitude. While that may be subjective by definition there are nine areas that have been identified by the Center for Nursing Leadership that factor into caring as a competency for leaders. These competencies are: 1) truth holding, 2) intellectual and emotional self, 3) discovery of potential, 4) journey toward knowing, 5) diversity towards wholeness, 6) appreciation for ambiguity, 7) knowing something of life through experiences, 8) holding varied viewpoints without judgment, and 9) keeping commitments to oneself.\textsuperscript{237} In summarizing these points there is a theme of honesty, trust, insight, life experience, self-awareness, and acceptance of differences. This openness in thought can assist the leader in taking actions that are more firmly rooted from the perspective of the patient. Some of these areas were addressed earlier within this chapter while others will be addressed in subsequent chapters. However, the significance of these key areas for connecting to the patients a can justify repetition as they relate to operating from a position of moral courage.

2. Care as the Priority

Healthcare leaders cannot ignore the diminishing funding for healthcare especially in nursing homes, which impacts the amount of time that caregivers can spend
with their patients. With less time available for direct contact, the human element of caring is diminished. While some may attribute this trend to a focus in driving profits for corporations, the general governmental reimbursement has been declining at the same time as the need for care and services is greater.\textsuperscript{238} With the two forces, resources and need, moving in opposite directions, the leadership must seek ways to keep the patient and the care central to the mission of the organization which will require moral courage. For the leader to represent the needs and values of the patient and the caregiver there needs to be a combined approach for both the ethics of justice and care.\textsuperscript{239} The rights of the patients are supported by the leadership which can also come from the context of the situation and the relationships of the patient as noted in the ethics of care. Both the absolutes of law and rights and the more ambiguous guidelines for caring are used. The leader as the moral agent enters into relationships of mature care with the patient and the caregivers. Mature care is determining a balance in care for the self and for others and between reason and emotion. Both reason and emotion must be present but not let one prevail to the detriment of the other.\textsuperscript{240}

F. Conclusion

The bottom line for a healthcare leader is not a financial one. The bottom line is whether or not the patients and residents are considered as the core of all decisions. To understand care is to understand all of its facets. There is providing care, as actions, and there is to care for, as in the attitude. As a leader, to be able to fully comprehend the aspect of care is to have the characteristics of being caring. Those characteristics allow for the leader to see the relationship of their decisions from the perspective of the patient. Being a healthcare administrator is a very powerful position. Unfortunately many do not
embrace that power and fail to see the impact of their actions as being good or bad. They do not connect that every action communicates what is important or not important throughout the organization. The NHA as the leader of the nursing home truly does lead by example and can expect to see his own behaviors replicated throughout the organization. Although behaviors and their relationship in determining an ethical climate will be discussed in a subsequent chapter, it cannot be ignored when deliberating the power of an administrator's behavior in communicating the importance of keeping the patient at the center of all decisions.

Providing care is the core of healthcare but it is in caring that the human element is transformed into the sacredness of life and the focus on establishing dignity for those patients. The patients must first be seen as individual persons who have been placed in a position of vulnerability in their need for care from others. That basic precept places all of the leadership within a healthcare organization in positions as caregivers in indirect ways. These caring characteristics of compassion, empathy, honesty, and love filter into the decision making process and when there are conflicting needs, they are paramount to driving actions which require moral courage. As leaders the orientations to care and justice must both be interconnected in making moral decisions. The relationships and contexts must be evaluated along with the rights, regulations, and laws that consider the dependency and vulnerability to support each individual person as a patient. To understand the moral responsibility the leadership has to their patients is to look at Logstrup’s summary from *The Ethical Demand*:

“By our value/attitude to the other person we help to determine the scope and hue of his/her world; we make it larger or smaller, bright or drab, rich or dull, threatening or secure. We help to shape his world not by theories and
views but by our very being and attitude toward him. Herein lies the unarticulated and one might say anonymous demand that we take care of life which trust has placed in our hands.”

Although the demand is not anonymous for the nursing home administrator, the actions that are taken by such a leader must have a clear understanding and acceptance of the power and responsibility that is possessed within the position. To consider the best interests of the patients and residents, or to act with indifference, will determine the course for outcomes within the nursing home. These actions will establish the value of the unique individuals seeking care and the caring attitudes that are expressed towards them. Courage will be necessary to keep the patients at the center of the decisions and the leadership can be their greatest advocate. Moral courage enacted by the NHA for the care of the patients and residents sets the foundation for which all other actions will follow.

5 Beauchamp and Childress, Principles of Biomedical Ethics, 36-38.
15 ter Meulen, “Ethics of Care,” 40-41.
26 Post, Compassionate Care, 130-131.
42 Beauchamp and Childress, Principles of Biomedical Ethics, 38-40.
48 Davison and Williams, “Compassion in Nursing.”
71 Chochinov, “Dignity in Care,” 756-759.
72 Crisp, “Compassion and Beyond,” 233-246.
81 Wele, “Sympathy as the Basis of Compassion,” 482-485.
89 Sears, *Humanizing Health Care*, 77-84.
93 Dowling, “Exploring the Relationship,” 1289-1292.
120 Lachman, “Applying the Ethics of Care to Your Nursing Practice,” 112-116.
133 Beauchamp and Childress, *Principles of Biomedical Ethics*, 36-38.
137 Armstrong, “Towards a Strong Virtue Ethics,” 120.
139 Lachman, *Applying the Ethics of Care to Your Nursing Practice*, 112-116.
140 Lachman, *Applying the Ethics of Care to Your Nursing Practice*, 112-116.
148 LaSala, “Moral Accountability,” 423.
151 Lachman, Applying the Ethics of Care to Your Nursing Practice, 112- 116.
152 Tronto, Moral Boundaries, 133-134.
154 Lachman, Applying the Ethics of Care to Your Nursing Practice, 112- 116.
155 Tarlier, Beyond caring, 230-241.
156 Held, The Ethics of Care, 51-53.
157 Held, The Ethics of Care, 51-53.
160 Beauchamp and Childress, Principles of Biomedical Ethics, 376-381.
162 Beauchamp and Childress, Principles of Biomedical Ethics, 376-381.
171 Welie, “Sympathy as the Basis of Compassion,” 479-484.
172 ter Meulen, “Ethics of Care,” 46-47.
174 Tronto, Moral Boundaries, 126-137.
176 Beauchamp and Childress, Principles of Biomedical Ethics, 32-33.
177 Armstrong, “Towards a Strong Virtue Ethics,” 120.

Beauchamp and Childress, *Principles of Biomedical Ethics*, 350-351.


Beauchamp and Childress, *Principles of Biomedical Ethics*, 350-351.


Ten Have and Welie, “Justifying the Practice of Euthanasia,” 161-162.


Edwards, “Is there a Distinctive Care Ethics?,” 184-191.


Beauchamp and Childress, *Principles of Biomedical Ethics*, 103-105.


Larrabee, “Gender and Moral Development,” 112.

Beauchamp and Childress, *Principles of Biomedical Ethics*, 197-199.


Beauchamp and Childress, *Principles of Biomedical Ethics*, 241-244.


Kuhse et al., “Partial and Impartial Ethical Reasoning,” 226.

Weaver, Morse, and Mitcham, “Ethical Sensitivity,” 607-618.


Chapter Four: Moral Courage as the Core of Ethical Leadership

When representing vulnerable people such as in a leadership role in a nursing home there is an ethical responsibility to do the right thing on behalf of the residents and patients. Within that role is to fully comprehend the needs of the people who are being served so that their interests can be properly represented. For leaders that is only a small part of their responsibilities and therefore there are other duties and obligations that will have competing needs. At this juncture, the leader will be faced with making choices that will garner both positive and negative reactions depending on whose needs are being met. At that point moral courage steps in to keep the facility operating on a sound ethical course. Moral courage is generated from the character and values of the leader and surfaces from the core of ethical leadership. Being a leader isn’t just who a leader is but it must also include a discussion about what the leader does. These areas will be examined throughout this chapter. Elements that contribute to ethical leadership will be viewed through moral competencies, values, emotional awareness, and accountability for the self as well as others. Ethical leaders must guard against the gradual decline and shifting of moral standards which can occur in the areas of moral relativism, the principle of cooperation, through obedience and conformity, and groupthink. The position of the nursing home administrator is one of power since it is at the top of the hierarchy within the nursing home, however the way in which the NHA uses that power with the followership will contribute to the ethical direction of the nursing home. There is a variety of leadership styles that will be defined which includes several that are based on traits and they will be explored in relation to the wide-range of circumstances that can occur within a nursing home at any given time. The discussion will look at the
predominant styles that are more closely associated with supporting the NHA in leading ethically and for acting with moral courage. With decision making being the source for the actions that carry out moral courage, five models of ethical decision making will be studied in concluding the chapter.

A. Determinants of Ethical Leadership

Again, it must be repeated that the ethics of the nursing homes are formulated by the actions of the leaders combined with their character traits and their propensity for being virtuous. The decisions that are made are a product of their ethical beliefs or values. This streamlines the expectations throughout the organizations with the leaders modeling the behavior that is to be mirrored. Anyone who has worked within the nursing home industry is aware of facilities that repeatedly and consistently produce poor outcomes in many key areas. The occupancy is low, the satisfaction surveys indicate discontent, the staff turnover is high and there are inclinations of distrust at all levels. While many are dumbfounded as to how the state of the operation became engulfed in a negative vortex, the answer is rather clear. There are problems with the leadership; the nursing home administrator. There is a failure to lead ethically. More detailed explanations of potential areas contributing to such ethical declines will follow in moral competencies, values, emotional awareness, and accountability.

1. Moral Competencies

Moral competence is based on values and is the key competence for being an effective leader. Like courage as a virtue, moral competence is the one from which the other competencies, emotional, social, and cognitive, evolve if the outcomes are to be beneficial to others. Accepted universal principles are applied to personal actions
consistently resulting in behaviors congruent with ethical leadership. An emphasis is placed on the leader’s intellectual capacity to establish ways in which to take actions that are both right and good.\(^5\)

Moral competence consists of two levels in which there must be the maintenance of knowledge and having the capacity to reason regarding specific problems. There needs to be an orientation to act in altruistic ways as well as to be able to assess moral issues rationally. Within moral competence altruism and moral judgment have to be developed. Referring back to Kohlberg from Chapter Three, moral competence is described as a skill to dispute moral concerns and to be able to make moral choices. According to Yates, the decision making process is a form of moral competence which incorporates the skills of formulating decisions, evaluating beliefs and values so as to combine them into logical options for selection, and having a higher order understanding of personal abilities.\(^4\)

Giltinane cites Winkler and Grimm (2010) in noting some of the common attributes of leaders are having courage, ethical strength, and an aptitude for prioritizing.\(^5\) Moral reasoning is an aspect of moral competencies and is the ability to make decisions about issues that are either right or wrong or good or bad. Ideally, the NHA would be able to find common areas of good among the disputing persons which would make for more positive outcomes. Such skills for moral reasoning can be developed over time.\(^6\)

Competence is the NHA’s ability to perform the duties of the position as an administrator which are set against standards of practice. They are clear directions for successful job performance.\(^7\) Within healthcare the addition of the moral aspect to the core job functions establish the basis for exhibiting a caring attitude toward the patients and leading ethically. Moral courage is seen as a competency because leaders need to be
able to grasp it in the workplace in order to be able to handle ethical concerns with a moral response.\(^8\)

First as an NHA there must be a mastery of the competencies for the position. A leader will have difficulty commanding the respect of his followership without being able to successfully employ the basic responsibilities of his job. In addition to those basic job skills are moral competencies which consist of virtues and principles such as compassion, empathy, and courage. For an administrator to be able to act with moral courage in representing the patients and residents, he must be able to articulate and act on values to develop moral competence. By repeatedly practicing expressions and actions steeped in values will develop moral courage as a moral competency over time.\(^9\)

2. Values

Ethics within the nursing homes are formulated by the actions of the leaders combined with their character traits and being virtuous. For nursing homes the leaders are the administrators, and the decisions that are made are a product of their ethical beliefs or values.\(^10\) Values influence the way in which an organization is managed.\(^11\) Although those values may be written and displayed within an organization, the personal values and characteristics of the leadership are more influential in operationalizing a set of values throughout the organization and the two may or may not be congruent.\(^12\)

Leaders must learn to recognize and process their personal values so they develop an understanding of how all of their actions and decisions require adjustments to benefit others rather than just the self.\(^13\) Studies indicate that there is a connection between the effectiveness of a leader and the possession of spiritual values such as integrity, honesty, and humility.\(^14\) Humility allows the leader to move away from the ideal of perfectionism
and actively pursue feedback.\textsuperscript{15} Values are rooted in the core of a person and are beliefs that there are specific behaviors that are more appropriate than others. These beliefs do not insure that correlating actions will follow even when they serve as directives for actions. The prioritization of values will differ among leaders, which is reflective of personality, organizational situation, and the subordinates.\textsuperscript{16} Values should not be misunderstood as standards, for values determine the priorities and what is important while standards determine levels of acceptability.\textsuperscript{17}

Virtues, a form of values, are centered on what it means to be a good or virtuous person. The natural tendencies or habits of a person will lean toward virtue or vice. Virtues are defined along with their vices and the goal is to stay within the mean of the two extremes.\textsuperscript{18} Historically, Aristotle’s teaching was that a virtuous person is consistent in their virtuous acts which originate in the core character of the person. However, a criticism of these ethics is in determining which came first for the person: being moral or being virtuous.\textsuperscript{19}

Within the nursing home it is important for the leadership to have a sense of caring as a value because they are making decisions for a vulnerable group of sick and debilitated people. The professional response of caring involves compassion and empathy towards the patient while engaging competently within the professional parameters of the relationship.\textsuperscript{20} When the leadership communicates this through actions it can be very powerful and establishes a level of expectation throughout the organization.\textsuperscript{21} However, for this to happen, the leadership has to have a foundation for action based in moral character.
3. Emotional Awareness

Emotional reactions evolve from the interpretation of the event, person, or object and the relevancy of the result to the self or others. Emotional Intelligence (EI) involves developing proficiencies in the five areas of: self-awareness, self-regulation, motivation, empathy, and social skills such as leadership and conflict management. The relationship between emotions and reasoning are of great interest in its potential application for improving the clinical, organizational, and employee results within the purview of leadership.

Emotional intelligence (EI) is an effective aspect of leadership in which the leader processes the ability to manage his own reactions to situations by understanding the emotional elements of the personality through self-awareness. Although this idea has mixed responses due to the difficulties for measurement, it is a way for leaders to correctly comprehend and respond to emotions. For the NHAs to guide the nursing homes morally, they need to be dependable in their character while exhibiting good moral sense with emotional responsiveness such as that shown in emotional intelligence.

The NHAs who possess the skills of EI are able to deal effectively within their human relationships which can contribute to improvements in clinical care and employee stabilization. The need for and the development of skills surrounding emotional intelligence could have a very positive influence on the caregiving environment when rational reactions are employed rather than emotional ones. Interpersonal and intrapersonal communication can also play an important role in having the skill level to connect with others effectively through an appropriate use of emotions and attitudes.
Emotional intelligence plays into moral agency through motivation, perception, and reasoning with the emotions forming an understanding of the self in relation to others.\(^{29}\)

The leader who exhibits competent skills in EI provides a work atmosphere that promotes self-awareness to recognize and build upon strengths while addressing weaknesses. The skills for advancing this level of insight can be developed from prior experiences. The insight that the leader exhibits through EI can aide in gaining credibility and respect as a leader and foster improved communication and relationships within the organization. Key elements for the leadership are incorporated into EI which includes professionalism and self-regulation.\(^{30}\)

Nursing facilities are highly charged with emotions as are most healthcare facilities due to the nature of the need for the services. The patients and their families are dealing with debilitating conditions that has caused significant change in their lives and frequently includes death within the nursing home. The employees are attempting to manage the workload while trying to address the needs of these patients and their family members which can be quite stressful. The leaders who possess the skills of EI will be able to effectively manage the conflicts that can emerge from these circumstances.

Conflict Resolution is a skill that relies on a balance between emotions and rationality. Conflict will occur frequently within the nursing home and may arise from any number of sources; residents, family members, and employees are a start. Again, in healthcare environments there are a lot of emotions that are being expressed directly and indirectly and the degree of the reactions are not necessarily proportionately related to the nature of the issue. The NHA must be able to enter into these situations with the skills to lead to resolutions. One thing that is certain is that conflicts cannot be ignored, although
there are many NHAs who may try. The issues will not go away and may get worse if they are allowed to continue without being resolved. These are times when fear may be present but it has to be overcome with actions through moral courage. The NHA is not alone in feeling fear because for conflict to exist there needs to be opposing values and a threat of some kind that is accompanied by fear. The attitude in managing conflict is focused on the feelings and values of all parties involved and not just one person’s agenda. Like moral courage and ethical leadership, conflict management requires that the focus for ethical actions is placed on others and not on the self.

There are three stages to conflict resolution which are: 1) encouraging effective communication among the involved parties, 2) assessing the components of the cause for discourse, and 3) assisting with the solution to resolve the conflict. To be successful, the NHA must be able to manage his personal emotions and attempt to do the same with all persons involved in the conflict. Successful conflict management incorporates appropriate conflict resolution methods within the three stages which should provide for an emotionally intelligent process. Enacting moral courage can follow similar guidelines by approaching the adversary as an equal human rather than reducing them to some category of villain or monster. Moral convictions can be maintained even when acting with emotional awareness. The justification for dehumanizing and judging others because they are representing an oppositional position will be difficult to support on ethical terms even in situations requiring moral courage. Both Aristotle and Nietzsche saw acts of moral courage as being continuous in a person’s character so the moral character that respects and advocates for the patients and residents should be the same moral character that treats all humans with respect.
4. Accountability for Self and Others

   Ethically accountable organizations begin with the leaders holding themselves accountable while acting with moral courage in addressing the same level of responsibility across the organization. This streamlines the expectations throughout the organization with the leaders modeling the behavior that is to be mirrored. Accountability is primary in establishing trust and improving employee satisfaction within the workplace. Holding employees accountable necessitates that consequences be established for those who do not meet the obligations for their job positions which can negatively impact the success of the facility. By ignoring the negative behaviors of employees and allowing them to continue without consequence, the NHA is actually empowering them to continue to work against the goals of the nursing home. In an industry of limited resources the leader is allowing people to be paid to sabotage the successful operation of the facility which is certainly not in the best interests of the residents and patients. Samuel’s attributes eight components that consistently support the effective use of accountability in organizations. Adapting them for the nursing home, they are: 1) establishing a clear vision with the key priorities so everyone knows what they are working towards, 2) the management team must all share in taking ownership over the key priorities and not limit them their specific areas of responsibility or department, 3) linking the execution of the goals to the performance of the managers so the results can be achieved, 4) being persistent in stopping dysfunctional behaviors within the facility which are barriers to achieving the goals, 5) creating an atmosphere of transparency by surfacing problems and conflicts for resolution so the facility can move forward, 6) thinking in terms of contingency plans in anticipating potential problem areas so the
recovery can occur quickly and effectively, 7) consistently monitoring key indicators for measuring the progress toward the goals so there is an ongoing understanding of the status of the results by the whole management team, and 8) acknowledging successes to reinforce positive behaviors and to recognize the accomplishments that can be achieved when everyone is working towards the same goals and maintaining personal and organizational accountability.  

Failing to take personal accountability results in entering a cycle of victimization in which problems are not addressed and blame is placed on others. Behaving as a victim is a refusal to take personal accountability. Entering the loop of victimization means that the problem is ignored, denied, blamed on someone or something else, rationalized away, resisted, or distractions are created to hide from the problem. Emotions that accompany victimization are guilt, resentment, and mistrust and they eventually have negative effects on the person’s interpersonal relationships. However, there is a way out of this line of thinking and it begins with realizing that being a victim is a choice. Once this happens, then that recognition can be followed with: owning the problem, being forgiving of the self, examining the self and the contributions to thinking as a victim, learning from the experience, and taking action to change the situation that led to the state of victimization. When a person can work through the process to get out of a mindset of victimization, then personal accountability can surface.  

Victimization is often seen among members of the staff within nursing homes as they blame other departments for problems, make excuses for being late for work, resist care delivery changes for the good of the residents, and ignore the directives given by their supervisor. When these types of actions occur, the NHA must adhere to the guidelines just reviewed and be persistent about stopping
dysfunctional behaviors for the good of the facility and the care of the residents and patients. Functioning in the mode of victimization serves as a distraction from focusing on providing quality care as the priority.

Another view of accountability is to connect it to a higher power through a spirituality or religious faith. This avenue is thought to be a key in motivating people to display moral acts. People within this approach who feel they have a calling, which is an intended purpose for a person’s life, may have more of a motivation to act with moral courage. A calling to a profession tends to be accompanied with personal integrity which allows for the willingness to take personal risks in supporting the right ethical actions.37

While there are many guiding directives within a healthcare facility, there are still instances when the leader of an organization chooses to ignore using them in dealing with problematic areas. The accountability to the self and others is not being administered. Jean-Paul Sartre offers three explanations in which the leadership may choose not to address issues of potential conflict. The categories for these three approaches are under the heading of self-deception and they are: willful ignorance, systematic ignoring, and rationalization. Willful ignorance is purposely avoiding information because if a problematic situation is acknowledged, then it will have to be addressed, which may entail making difficult decisions. This could play out for the NHA with the example of failing to conduct patient or employee satisfaction surveys for helpful feedback, delegating tasks involving conflict to members of the management team such as meeting with an angry family member, or spending much time in the office and not conducting rounds throughout the facility to assess the status of the operation. Systematic ignoring is being aware of a situation but ignoring it through blocking and distractions which avoids
taking accountability for making decisions. The NHA can enact this by being too busy to deal with situations; filling the daily work schedule with activities that create barriers and excuses. The third technique is rationalization which relies on excuses for not taking responsibility to act on the information. For the NHA this approach can take the form of blaming others for the situation which is taking the victimization route. This can be seen with family members who frequently complain. Rather than looking at each complaint as having the potential for at least some truth to it and requiring further investigation, the NHA may invalidate the family concerns with such comments as, “He complains about everything,” “They’re never satisfied with anything,” or “Just ignore them. They take up too much time with complaints.”

Being accountable as the leader of the nursing home means to be responsible for the care of patients and all that supports the delivery of this care. The failure to address potentially damaging or harmful situations through accountability enters the realm of moral decisions. The administrator must lead the charge in prioritizing the needs of the patient for the nursing home that is shown in not only words but in moral and ethical actions as well. Being accountable to the self and others is to have moral courage. Being accountable to the residents and patients is to deal with difficult and uncomfortable situations. The NHA, by license, is responsible and accountable for all activities within the nursing home. Choosing to ignore potentially significant concerns within the nursing home is not only a failure in ethical leadership but is a failure in acting in the best interests of the residents and patients who are to be the center for all decisions.
B. The Slippery Slope of Moral Compromise

Leaders must anticipate opportunities for corruption and take action to mitigate it through developing individuals, promoting a culture of compliance, and creating social contracts surrounding high moral expectations. A culture of cheating has developed as a norm within many workplace cultures which has been largely fueled by corporate incentives that indirectly promote unethical actions and self-interests as well as the status of materialism and wealth that is generated by the media. The risks for unethical behavior can be minimized by the establishment of policies and procedures, codes of conduct, and hiring guidelines that are ethically-focused. However, the ethical conduct of the leadership has the greatest impact for communicating the acceptable actions throughout the organization. A measurement tool called the Personal Ethical Threshold (PET) is a questionnaire that assists with identifying ways in which organizations can place barriers to acting with moral courage. The ten questions measure moral intensity against situational pressure to determine the point at which a person is likely to violate his or her ethical principles. Moral intensity captures the perception of the ethical importance of the issues to others; the costs associated with a violation. The greater the moral intensity to others should incite an increased likelihood for acting with personal moral principles through moral courage. The situational pressure is concerned with self-interests and factors that influence a person to act in ways that violate personal moral principles. The personal costs are compared to the benefits of the actions and the chances for unethical behavior increases when there is greater personal loss by following moral values or greater personal gain by abandoning them. Engaging in moral courage increases
or declines in a parallel manner as these assessments are applied to the situation for action.43

Four explanations for moral decline are presented in this section and explain the potential for the nursing home to gradually move in a negative direction. The NHA must be aware of each of these areas and be vigilant in monitoring the trends for such activity.

1. Moral Relativism

Wrongdoing as the standard for doing business has developed within many workplaces and has gradually gained acceptability because “everyone is doing it.” Moral relativism holds that taking the right or wrong action or in determining what ought to be done within a situation is qualified by a moral view however this moral view can be interpreted in many ways.45 Moral relativism can be subdivided into three types. The first is normative ethical relativism which depends on customs, traditions, and standards for acceptable conduct, and varies from place to place such as in different countries. Contextual relativism comprehends that there are commonly acceptable moral practices that are seen as being right or wrong for everyone however the utilization of these practices may have differing outcomes as the situations change. The third, methodological relativism, describes the concerns most closely related to moral compromise in which specific groups set their own standards of acceptability. The leadership in such situations determines the acceptable moral practices within the organization and the followership accepts the standard even if it is morally wrong.46 The values of the leader drive the decisions and if that person has a tendency to lie under pressure and work beyond the rules and guidelines of the healthcare facility then the norm for acceptable behavior and actions will decline.47
For the NHA moral relativism may be an issue that has to be dealt with as it can occur within segments within the nursing home. There may be cliques of employees or residents that exclude others based on their moral practices. A particular shift or unit of workers may conduct their assigned duties in ways that completing the tasks quickly rather than completing them thoroughly for the benefit of the patients. Any new employee who is assigned to that shift of workers may have difficulty acclimating to the group if their norms are not in sync. The NHA will need to take action to address practices that are in conflict with the needs of the residents and patients in such a scenario. Hopefully, they would also be in conflict with most other employees of the nursing home. The morals of that particular group of workers who are not providing care properly are not aligned with the expected morals of the facility. The NHA must act on behalf of the residents for many reasons but a basic one is their right to proper care and depending on the tasks being excluded could involve dignity issues as well. Obviously, there may be some moral courage involved in confronting a group of employees even when the hierarchy is involved but the foremost issue requiring moral action is for the quality of care that is being given.

2. Principle of Cooperation

The principle of cooperation comes out of Catholic moral teaching and involves maintaining identity and integrity when dealing with others. This principle separates right from wrong and good from evil and recognizes that simply by living in the world is to be exposed to wrongdoing, however being removed as much as possible should be the goal and this principles gives guidance in the parameters for ethical conduct. The principle of cooperation originated as directives for maintaining moral actions when encountering
others who are acting immorally. Decisions are evaluated that are always wrong in all situations and differentiates the level of culpability at either a formal or material level. This distinguishes between premeditated participation in a decision and the participation in a decision that was unintentional for the outcome that occurred.\textsuperscript{49} Within healthcare organizations today there are more services and providers who work in partnerships than ever before and need to be concerned that their corporate values are not being compromised through these relationships.\textsuperscript{50} The nursing can have contractual arrangements with such services as pharmacy, food suppliers, medical equipment providers, physicians, managed care companies, transportation, temporary staffing agencies, and the list continues. The principle of cooperation infers agreements with the wrongdoing of another. Actions are evaluated that are always wrong and differentiates the level of culpability at either a formal or material level.\textsuperscript{51}

Formal cooperation requires that a person knowingly chooses to participate in actions that are undeniably immoral which are primarily performed by another party. Depending on the nature of the action it can also be illegal but that is not a condition within this moral charge. Formal cooperation can be subdivided into the areas of an explicit moral act which is clearly intentional and an implicit moral act which has an immediate agreement to participate in the act of wrongdoing. These actions need to be carried out willingly and intentionally.\textsuperscript{52} Formal cooperation is morally wrong and signifies that the person cooperating is in agreement with the wrongful action that is being conducted by the other party.\textsuperscript{53} Hamill refers to items of formal cooperation as “cooperation of intention” and “substantial cooperation in action” which clarifies the definition of taking on the wrongdoing of another.\textsuperscript{54} An example would be an NHA who
knowingly charges patients for supplies and services not provided. The monthly invoices are altered for the patients who pay privately and have large amounts of savings. These actions are justified by the NHA because he believes that it really isn’t hurting these residents because they have lots of money and really won’t miss it. The motivation for wrongdoing is the NHA’s need to increase the reimbursement rates because he needs to generate more revenue for the nursing home so he will be sure to qualify for his annual bonus. The business office manager is aware of the actions of the NHA and submits the bills to the residents knowing that it is ethically wrong. She is aware of the guidelines for the company’s compliance process to report ethical concerns. In this case the business office manager met both criteria formal cooperation by participating willingly and intentionally.

Material cooperation is an indirect participation in an illicit act. There is an unwillingness to be involved in the objectionable act of another party. Both the intention of the other party and the request for the immoral act are opposed. A caution is that the proximity to immoral acts in these cases of material cooperation, can give the appearance of formal cooperation and caution should be used when agreeing to collaborate with other organizations or individuals. Material cooperation is further clarified through immediate and mediate levels of participation. Immediate material cooperation occurs when the cooperator participates in a morally wrong act with another person. Mediate material cooperation is cooperating in an indirect way in which the action does not directly contribute to the wrongful act and is also referred to as non-substantial cooperation. Material cooperation will be explained using the same scenario in which the NHA wrongly alters resident invoices to increase reimbursement. The business office manager
is a new employee to the nursing home and this is her first experience in processing invoices. She has relied on the NHA to train her in learning the details of her job. The NHA explains that she will be taking over the alteration of the monthly invoices because he doesn’t have time to continue to do it and promised her a bonus to meet the goals he has set. The business office manager refuses to participate. She has completed the company’s compliance training program and has indicated to the NHA that she is very trustworthy and would never participate in any kind of unethical or illegal action within the responsibilities of her position. The NHA indicated that he understood her position. Later he requested the password to her computer stating that he was required to keep a list of these for all of the managers. After a few months she realized that the NHA has been accessing the patient invoices on the weekends and sent separate invoices for additional services and supplies. She doesn’t agree with the illicit acts of altering invoices but has inadvertently participated in material cooperation. Although there was no intentional wrongdoing, the association gives the appearance of supporting the illicit activities.  

The prospects for the future climate of healthcare environments position the leaders for encounters associated with cooperation. In the world of limited resources and reduced reimbursements the threat of violating the principle of cooperation is a threat to NHAs in choosing to respond ethically. Entering into relationships that operate in unethical ways which allows them to offer reductions in expenses might be cause for the NHA to choose to look the other way. By rationalizing immoral behavior for the good of the patients as a whole through obtaining additional resources, violates this principle. Also, the Kantian categorical imperative fails to support this justification in which the
end does not justify the means. Throughout the discussion of the principle of cooperation there are repeated points when alarms for moral courage are sounding. The temptations presented to the NHA will continue as the resource allocation issue grows but if the NHA’s moral values are sound then as a morally courageous person he will remain uncompromised.58

3. Obedience and Conformity

Conformity is defined as the external alteration of actions or thoughts due to an external pressure which can be from a person or other object. This pressure can be from real or imagined persons and is often done with rational thought. Also known as rational conformity, this approach includes compliance, abidance, and obedience and formulates narrow conformity which is when a person’s actions and thoughts are congruent with the majority. Irrational conformity happens when changes are made irrationally which can be termed as “herd” behavior. Usually this is also rational thought within this approach as well but there may have been some misperceptions in the rationalization.59 Obedience when paired with authority results in positive feedback to the subordinate when the behaviors exhibited mimic the authority figure. The authority that is derived from a higher hierarchical position has a stronger influence in motivating the subordinate to act in the preferred manner. The actions on the part of the subordinate are seen as being obedient as opposed to being compliant.60 Milgrim conducted the infamous studies on conformity and obedience in the 1960s involving painful electric shocks, which concluded that under certain circumstances all people possess the possibility for engaging in evil acts.61 Haslam and Reicher concede that people do not blindly follow their leaders in participating in evil acts but do so because they associate with them and justify their
actions as being honorable. There has become a cultural acquiescence of moral failure and a deficiency in values that has been repeatedly played out in the media with such examples as Bernard Madoff and Enron.

This type of behavior can be found in the nursing home among departments particularly if there are long term employees. Conformity can be a factor in contributing to high turnover rates for new employees who are unable or unwilling to conform to the group particularly if the group is engaging in unethical activities. Such occurrences could include taking short-cuts in the delivery of care to so there will be more time to spend on smoking breaks or to reduce the workload. Another example might be for the dietary staff to skip the extra step of properly sanitizing the dishes so they can leave work earlier. This could put all of the residents at risk for acquiring some form of communicable disease. In these scenarios, conforming to the group is more important than concerns about the potential impact on the residents when the actions are counterproductive. The employee who enters such a work situation may not agree with the shortcuts being taken but may find it difficult to confront the situation morally. The risks are great as a new employee who has not developed any trusting relationships at this point in the workplace. Perhaps the process for reporting compliance and ethical concerns was discussed in the new employee orientation program. In that case the employee may use that as a means to enact moral courage if there was an understanding of the professional ethical obligations within the job which is accompanied by the courage to address the problem.

4. **Groupthink**

Working together as a group has the possibility of accelerating accomplishments within an organization when combining the skills and knowledge of the individuals
however if not managed properly destruction can also occur in the same manner. In 1972, Irving Janus proposed a theory to explain the process that occurs when individuals conform to the values and ethics within a group which he coined as “Groupthink.” Janus’ research, which was refined over a period of time, determined that groupthink is likely to happen if a group’s members are highly unified, have little to no external involvement with professionals knowledgeable in their organization, limit their internal examination and assessment for new ideas and information, are managed through a directive style of leadership, and readily follow the recommendations of the leader and the more powerful members of the group.65

This group process for decision making has associated risks for negative outcomes due to the cohesiveness of the membership. The goal is often more on meeting the time constraints rather than exploring a full range of information in determining the most appropriate decision. Part of the limitations of information within groupthink is the reticence of members to disclose their opinions if they are different from the majority of the members. This silence then leads to conformity and self-imposed censorship.66

Turner and Pratkanis offer a variation on the Groupthink Model which they call a Social Identity Maintenance (SIM) Perspective. They recommend three possibilities for deterring groupthink within an organization which are: 1) principles for structuring the discussion within the group, 2) establishing processes to promote the ideas of all members of the group, and 3) the utilization of techniques that assist in guiding the decisions.67 The results of these studies, although limited, do cause concern for the potential for immoral actions of the leadership and the effects throughout an organization.
There are many nursing homes in smaller rural communities which tend to have long tenure among many of the employees, management team, and even the administrator. Having 20 or more years of employment within a single facility is not unusual. Oftentimes these are people who grew up in the same communities and socialize outside of work. More than likely such a group would tend to think similarly. They may also be comfortable being told what to do rather than participating in decisions. If such a facility had little or no oversight from an external corporate structure the potential is very high for groupthink to occur. That is not to say that high quality care is in question or immoral actions are occurring. The situation presented could mean that the facility is operating at a status quo rather than being in a state of continuous quality improvement. A new person introduced into this facility might find it very hard to be accepted if they are not from the same community or have another common connection. An NHA who has been the leader for an extended period of time has the capacity to lead or manipulate the group. If that person leads ethically then compliance issues should be minimal, however if that person leads in a style that compromises morals then there will be serious concerns for the well-being of the residents and patients.

Part of leading and decision making involves compromise and compromises can be made while still maintaining an ethical stance. The problems arise with the slippery slope concept in which the decisions gradually move away from an established threshold of morality which defines a new norm within a group of people. Each of the four areas presented had the potential to cross the threshold from morality to immorality and the leadership could steer the direction based on his values. Moral courage may be required to redirect each of these areas when the ethical standards for the nursing home are
deteriorating. There was the element of group pressure within these areas form compromise and research shows that this is a situation that is likely to engage in moral courage. The NHA’s responsibility is to be actively engaged in the details of the operation and to develop a level of trust that would make it difficult for unethical conduct to continue to go unchecked among individual members or groups of people for long periods of time. In addition, the NHA needs to provide an atmosphere in the nursing home which encourages displays of moral courage by welcoming and being open to receiving reports of problems.

C. Leadership and Power

Power within an organization is the leader’s ability to be able to motivate or influence others to accomplish specific actions or goals. As a healthcare executive the NHA can use power in either a negative way which was outlined in the previous section, or in a positive and ethical way. Ethical leaders will use their capacity to influence and motivate their followership to act in the best interests of others and in healthcare that would be the patients and residents.

1. Types of Power

The leader can operate from several types of power and according to French and Raven (1962) each varies in the way in which the subordinates are influenced and the results that are expected. The source for influencing others can be obtained through commitment, compliance, and resistance. There are two categories of power which are: position power and personal power. Position power comes with the job meaning that the position or rank that the person holds is the source of the power rather than through any attribute that is specific to the person holding the position. Personal power comes from
the specific person’s ability to influence others and this power can also be attained through relationships. Position power includes the power classifications of coercive, reward, and legitimate. Personal power includes referent and expert power.74

*Coercive power* is established through negative reinforcement and requires that the leader impose the consequences of threatened punishments. This can be used as an effect for failing to meet an expectation and is not seen as being overly harsh if the terms were communicated to the follower in advance. This approach is useful for getting a fast response, increasing obedience, and as a disciplinary action. The downside is a decline in job satisfaction by the followers, the trust and commitment are negatively affected, and the effect is gradually lost. *Reward power* is based on giving something of worth to others. The reward must be meaningful to the receiver to serve as a motivator. If not, it could have the opposite effect. Like coercive power reward power works well for increasing obedience. Other benefits are seen are an increase in performance for short periods of time, a focus on the main concerns of the group, and there is a cultural acceptance. The negative effects are seen in lower job satisfaction than other forms of power, the potential for an increase in expenses depending on the types of rewards given, and an inconsistency in improving job performance. *Legitimate power* is grounded in the position that a person holds and not to the person. The degree of power correlates to the level of the position within the organization and the perception of the position by the subordinate. The NHA is the highest ranking position in the nursing home and if he asks some housekeepers to clean a room they will do what is asked because it is an acceptable request within their job duties. They may not like the person in the NHA position but they respect the position. The benefits of legitimate power are that it is culturally
acceptable, improves efficiency, gains obedience, and engages the whole organization.
Job performance and satisfaction may decline with this reward and it may eventually lose its usefulness. *Expert power* is the opposite of legitimate power in that it is determined by the person and not the position. The power is associated with the person’s capacity to influence others through provisions of information and skills. Within the nursing home this might be the receptionist or secretary who has access to all of the information that flows to and from the NHA along with the potential for her to be able to influence that position due to the working relationship. The activity director can fall within this category with the residents based on her skill level for providing enjoyable events. This form of power results in high degrees of follower job satisfaction and performance and expends very little emotional energy. The adverse side is that gaining this type of power can take some time to develop; it requires that the needed knowledge and skills are present, and the effect can decline with excessive utilization. *Referent power* is founded in being a role model and engages admiration, and feelings of affections, esteem, and respect. This power is gained through nurturing and develops over time but can be damaged if the follower perceives that he is being exploited by being asked to make excessive concessions. If this occurs the person in power may need to re-establish the relationship by adapting her behaviors. The NHA may find this situation with a top performing manager who has been developed and promoted under his leadership and is asked to repeatedly take on addition work assignments. Over time the respect and admiration this manager had for the NHA may decline if the situation isn’t managed properly. Referent power is effective in increasing job satisfaction and performance but it does take some time to develop and can decline if overused. Having the necessary
knowledge for the job and developed interpersonal skills are components of this type of power.\textsuperscript{75}

Several types of power have been explored and the NHA has experienced the most if not all of these. Having the ability to control and influence many followers places the NHA in the midst of many activities and situations constantly, however when circumstances call for moral courage there is a strong sense of isolation and being alone in those decisions.\textsuperscript{76} To be an ethical leader often requires the NHA to stand alone in his convictions.

2. Followership

In looking at a variety of views as to what makes a leader effective is that they are creative, have a vision, and lead by example. Through these areas the leader is able to communicate their vision to positively influence the followership in embracing the vision themselves as they pursue the example established by the leader.\textsuperscript{77} The follower is heavily influenced by the apparent authenticity and integrity of the leader because this is perceived as dependability of the leader. Such attributes as integrity, self-awareness, and beliefs must be identified by the followers for them to be persuasive.\textsuperscript{78}

An organization’s outcomes are affected by the leader’s perceived authenticity in leader enactment which is made up of both physical actions and the sharing of stories. While leader enactment is a strong determinant of authenticity, life storytelling only contributes in part to the assumptions of the authenticity of the leader.\textsuperscript{79} Leading by example is the chief means that authentic followers are developed by their leaders. This is strengthened by environments that support ethical, caring, and inclusive actions. The relationship between the leader and the follower are defined by transparency, trust, well-
intentioned goals, and the development of the followers. High moral standards are established by the leader and are communicated throughout the organization through actions and words for others to emulate. The relationship that is cultivated between the leader and followers gains insight and self-awareness for each and they begin to understand the symbiotic connection they have to each other. The followers endorse the leader when the difference between who they are and what they do is stabilized.⁸⁰

Ethical leadership forecasts the ethical results of followers in leadership through perceived success, job satisfaction and commitment of the followers, and the propensity for reporting problems to higher levels of management.⁸¹ The importance of this relationship cannot be emphasized enough in determining the practices through behaviors throughout an organization. The follower gives commitment, effort, and energy to the organization under the guidance of the leadership however there are certain debts the leader has to these followers which are: recognition, appreciation, dignity and a sense of fulfillment.⁸²

Within the leader and follower relationship the leader can impact the moral courage of the follower through social learning and role modeling. This can be accomplished through observation of the leader in situations requiring the need for moral courage and with repetition the follower begins to gain the confidence to develop the competence. By living the moral values through actions the norms are established for the followers in doing what is right.⁸³

3. Effective Use of Power

The research indicates that successful leaders utilize their personal power to influence action from the followers rather than using their position. These leaders also
use their power in an understated manner that minimizes the focus on the hierarchical differences. Effective leaders are able to influence others to support them in attaining their goals even when there is not a direct supervisory relationship. They do not use their position or title as a means to get what they need however attempting to dominate others may get a temporary result. Approaches for increasing their level of professional expertise, through their accomplishments and achievements, and through developing power in others, are all ways that a leader can increase their power in ethical ways.

Setting the ethical tone for an organization through moral courage is an exchange between the leaders and the followers. The roles of managers and leaders are not interchangeable because each has a different set of skills and responsibilities within an organization.

D. Leadership Styles and Ethical Viewpoints

The style of leadership that governs a healthcare facility establishes an atmosphere throughout. There is a wide range of types that will be presented and some are more appropriate for specific situations while others may be more prone to creating caring environments. The areas that determine ethical leadership that were covered earlier in the chapter, moral competence, values, emotional awareness, and accountability, will factor into the style that is dominant for the leader. Also, the nature of the organization will respond differently to the various types of leadership and some are more aligned with the needs of healthcare facilities such as a nursing home.

1. Leadership Styles

The nursing home administrator who governs the nursing facility determines the way in which the priorities of the organization are communicated and implemented which
translates into the decision making and the ethical culture. Leadership styles do make a
difference in the behaviors found throughout an organization and the leadership style that
is primarily used by the leaders of the nursing home also impact the culture which will be
covered in the three leadership styles of directive, transactional, and transformational
along with the styles based in leadership traits.

a) Directive

The leader within the directive style communicates very clear expectations for
assignments which includes what to do, how to do it, and when it should be completed.
The communication mainly flows in one direction.\textsuperscript{87} The directive approach to leadership
is mainly focused on the decisions being made by the leader in order to meet personal
goals. Moral reasoning with this style is based on the likelihood that the personal goals of
the leader are achieved with varying degrees of consideration for the involvement of the
subordinates. There are four levels of directive leadership which are ranked from the
most autocratic to the least and are: 1) \textit{Benevolent Autocratic} which makes all of the
decisions for the subordinates which are grounded in self-interests, 2) \textit{Consultative}
gathers input from the subordinates but the leader makes the final decision, 3)
\textit{Participative} encourages the subordinates to suggest solutions for decision making and
the leader maintains the right to determine the ultimate resolution, and 4) \textit{Consensus} also
encourages the subordinates to suggest solutions but the final decision is based on the
consensus of the group rather than being made by the leader.\textsuperscript{88}

The directive method of leadership would not support a focus of care and the
patient on the part of the leader. The self-serving nature of this approach is in contrast to
the ideal of caring which is based on meeting the needs of others. Although there are
instances within the nursing homes when this style would be appropriate, it is a style that was compatible with some of the concepts of moral compromise. Virtuous acts and having courage to act against adversity are not about self-interests. Courage grows through self-discipline, sacrifice, and overcoming selfishness and morality is strengthened as courage is developed.\textsuperscript{89} This leadership style is based more in self-interests and does not translate well for an NHA who enacts ethical leadership through moral courage or for a morally courageous organization.

b) Transactional

Transactional leaders are not concerned with the personal needs of the employees nor do they develop the employees.\textsuperscript{90} The transactional leadership style is one that maintains the status quo and at its most basic description is bartering between the leader and the subordinate. The term “managership” was coined by Conger and Kanungo (1998) to describe this style because they assert that there are no leadership qualities in this relationship because the subordinates are not being developed in their beliefs, values, thoughts, and attitudes. Rather than being vision driven, this style is more task-focused. There are three approaches that employ this mindset to management which are: 1) contingent reward, 2) management-by-exception, and 3) laissez-faire leadership. Contingent reward is the rewarding of agreed-upon tasks upon completion. Management-by-exception is to focus on correcting areas of responsibility by a subordinate that are not meeting the expectations of the leader. The third, laissez-faire, is when a leader fails to carry-out the duties of the position.\textsuperscript{91} The transactional approach is effective when there are timelines that need to be met or in situations that require that specific duties must be completed quickly under the dictates of the leader such as an emergency situation. There
is much structure within this method which develops team members in such a way that many do not perform well independently. Of note is that task-focused styles of leadership correlate to low levels of job satisfaction with nurses which is not the attitude that a positive ethical environment seeks to have in the delivery of care to their patients. This style would be effective for the nursing home for specific instances in accomplishing tasks with all of the regulations and requirements for providing care and services. For the nursing home leadership it further enforces the power of their values since it does not develop them in the subordinates.

Moral courage can be practiced effectively within transactional leadership with limitations, particularly in areas such as safety issues where the tasks for such things are audited and serve a purpose in the best interests of the patients. Situations of dispute with the potential to harm patients may call moral courage into action on the part of the leader. Under this style of leadership a negative aspect that can occur is the potential for patient care to be treated as tasks and the idea of receiving care and being cared for as a whole person is lost. Also, the heavy use of “bribes” may contribute to decisions being made for self-gain in contributing to slippery slope areas of concern.

In healthcare moral courage must be developed within leadership and throughout the organization that is inclusive of beliefs, values, thoughts, and attitudes. If ethical leadership is to have moral courage at its core then transactional leadership is not the most conducive approach. Also, task-focused styles of leadership correlate to low levels of job satisfaction with nurses which is not the attitude that a positive ethical environment seeks to have in the care delivery to their patients and residents.
c) Transformational

Ethical leadership imparts a similar interest in the moral aspects of leadership comparable to spiritual, authentic and transformational leadership. Sivanathan and Fekken utilize the studies of Bass and Avolio in discussing transformational leadership which is defined as a leader having the capacity to motivate others to exceed the established goals. The four qualities found in this style are: 1) trust and imitation of leadership behaviors, 2) driven by a mutual goal, 3) encouragement of innovative thinking, and 4) concern and respect for the needs of the individuals who are identified and addressed in a fair manner. This is a charismatic style of leadership that can have both positive and negative outcomes depending on the motivation of the leader. Howell’s study (1992) showed that charismatic leaders who personalized their drive could be done for self-gratification, unfair implementation, and exploitation. Socialized charismatic leaders were the opposite which is in line with the traditional thought behind transformational leadership. Transformational leadership is viewed as generally being an ethical approach due to its focus on empowerment that is the vehicle for developing the beliefs, attitudes, and values of the followers in developing their autonomy and self-esteem. The management of workplace diversity requires an inclusivity and respect for people with differing perspectives which is supported in this style. A concern with transformational leadership is that immoral acts would be defensible because they are a true reflection of the leader.

Transformational leadership is viewed as a very effective form of leadership to support the development of courage in the followership. This style promotes professional growth in leadership qualities for the followers through empowerment and matching the
goals of the followers to those of the leader and the organization. Development promotes
the motivation of the followers to perform rather than being influenced by the leader.
Repeatedly the transformation style results in development and performance that exceeds
the expectations. Within a nursing home that is lead through a transformational style the
propensity for expanding the boundaries of performance positively in a constant
improvement mode can be seen as acts of courage to tread into new territory for the good
of the organization.\textsuperscript{101} If these challenges to the status quo are sound ethically then that
courage displayed by the NHA is transposed to moral courage.

One of the roles of the leader within a healthcare organization is to establish a
positive ethical climate which is reliant upon trust. A person who is trusted consistently
exhibits the right actions habitually which establishes the character as a model for others
to follow.\textsuperscript{102} This style of leadership naturally builds trusting relationships between the
leader and the followers. Giltinane notes that Malloy and Penprase (2010) proposed that a
transformational type of leader can improve the care delivery through staff engagement
and higher levels of accountability through empowerment.\textsuperscript{103} A concern with
transformational leadership is that immoral acts will be defensible because they are a true
reflection of the leader.\textsuperscript{104} Transformational leadership is closely associated with an ethic
of care rather than an ethic of justice.\textsuperscript{105} This style most closely matches the philosophies
of a morally courageous organization.

2. Leadership Based in Traits

Within the leadership styles are variations that can alter the influence with the
organization. Situational factors that may affect decision making include: supervisory and
performance pressure, autonomy in decision making, interpersonal conflict, and the
nature of the problem. The following styles of leadership are trait-based and will begin with situational leadership.

a) Situational

Situational leadership was developed by Paul Hersey and Ken Blanchard and operates on three main skills of: diagnosis which assesses the situation of the employee and the task, flexibility to be able to adjust to the varying needs, and partnering with the employee for improving performance. The main premise is that for leaders to be effective they need to be able to adjust their styles of leadership to correlate to the situation. The balance of both a directive and support approach needs to be maintained. An evaluation of the competence of the followers is necessary to determine the level of direction and support that will be needed. As the employees are developed the level of involvement by the leader should diminish. There are four leadership styles within this model which are divided into directive and supportive behavior categories and are: coaching, directing, delegating, and supporting. The development level for the followers is determined by the assessment of their commitment and competence for specific tasks.

Situational leadership necessitates flexibility for movement from one approach to another which is dependent upon the intricacies that have to be addressed. This style is based on the relationships between the leader and followers. The type of leadership is also known as a contingency approach because there is always an alternate approach waiting to be used if the current one isn’t the most appropriate. As the situation changes, so does the leadership style.

Situational leadership is a good match for operating a nursing home with the constant need to adjust to changing situations within any given day. Flexibility is also
conducive to any organization whose primary reason for existence is to care for people. There are critical life-saving events, many tasks that must be accomplished, and a high degree of emotion, inclusion, and needs management. The four styles contained within this model could all be applied within the operation of a nursing home as the best approach depending on the types of actions that are needed from the leader.

b) Values-based

Values-based leadership identifies the values of the leader and the organization and their impact on the culture of the organization but also recognizes the unique aspects of healthcare and the high expectations of the general public. Traditionally, employees have not been rewarded for supporting the values of an organization which can have a negative effect by causing a decline in the level of motivation and commitment in the workplace. Recommendations to improve this trend are outlined in four main areas that are geared towards the needs of healthcare organizations which are: 1) acknowledge the values of the facility as well as personal values, 2) establish the expectations for values of the corporate oversight structure if there is one and determine the values that can be applied within the facility, 3) determine and integrate the values of the internal customers if possible, and 4) proceed with leading with a values-based approach.109

This style has the power to motivate and inspire the followers and encompasses being decisive, trustworthy, visionary, and self-sacrificing. Because of the shared core values, there are expectations for high performance.110 Within values-based decision making it is important to engage the mission of the organization and devise a system for clearly staying within the parameters of that mission. Conflicts can occur in improperly interpreting the mission.111 The core principles of values-based leadership are: self-
reflection, balanced perspectives, self-confidence, and humility. Famous people who have embraced the principles of this approach and are also noted for their acts of moral courage are Mahatma Gandhi, Mother Teresa, Martin Luther King, Jr. and Nelson Mandela.112

In supporting the concept that the values of the leadership ultimately drive the decisions, the values-based leadership style may also be effective when combined with other leadership styles. Aligning the values with the decision making process should guide the NHA in an ethical direction as a leader. Although conflict will continue, such an approach could be an additional support for incorporating moral courage in the daily decision making. If the nursing home is grounded in ethical values then the discourse surrounding moral courage may be lessened.

c) Authentic

A focus on authentic leadership has been in response to the surge in corporate corruption and seeking ways to develop skills for more ethical approaches. Leadership development is an aspect of style however the concept needs to be clearly defined with the establishment of measures.113 Authentic leadership is described as having deep insight and self-awareness of thought processes and personal values and morals as well as for others. There is a comprehension of personal behaviors as perceived by others, strengths, knowledge, and the contexts that encompass these issues. The authentic leader communicates confidence with a positive attitude while maintaining high moral character.114 Authentic leaders shape positive attitudes and behaviors in their followers through trust, hope, emotions, identification, and theories of identity.115
Emotions directed towards others and self-transcendent values are essential for authentic leadership.\textsuperscript{116} The values that are associated with authentic leadership are those that are right and just for all persons involved and positive other directed emotions are categorized into the areas of: appreciation, gratitude, and goodwill. These leaders are able to function at a higher moral intensity because of their clear awareness that their actions are motivated to go beyond the needs of the self which are combined with positive emotions that are also motivated for the good of others. This method of leadership necessitates that actions are a reflection of the person’s internal thoughts and feelings on a consistent basis.\textsuperscript{117}

Authentic leadership was a response to the need for ethical leadership and the recognition of the increased challenges within society.\textsuperscript{118} That rationale parallels the argument for requiring moral courage in decision making for ethical leadership. Also which supports the argument that the three most important elements for development within authentic leadership are moral capacity, moral courage, and moral resiliency.\textsuperscript{119}

The changing landscape for healthcare which combines increased needs with decrease resources creates dilemmas for the NHA in managing and leading nursing homes within ethical parameters and incorporating a leadership style that mirrors the concerns could be an added support for keeping the patients and residents at the center of decisions.

d) Relational Leadership Theory

The relational leadership context combines relationship development with actions throughout an organization and sets the example for others to follow. There are two views to this theory which are the entity and relational perspectives. The entity approach emphasizes the characteristics of individuals as they participate in interpersonal
relationships, which is a more traditional approach to relationships. The relational perspective interprets leadership as a process of social construction in which the relationship develops from the associations and interrelations between organizations and their employees. Both of these perspectives see leadership as a social process.\textsuperscript{120}

The relational leadership model of the Leader-Member Exchange (LMX) Theory is the most well-known example of a relational leadership model and grew from the Vertical Dyad Linkage (VDL) Model. The relational leadership style moved away from the traits and character of the leader and the subordinates that is more common, to the relationships which are noted in the VDL which is divided into an in-group and an out-group.\textsuperscript{121} LMX is used to assess relationships between leaders and followers in the areas of ability, benevolence, and integrity.

There were four stages which evolved in arriving at the LMX theory which start with the VDL Model which validated the differences in the work units. The VDL research noted that the leaders cultivated differing relationships with the various members of their team who reported directly to them. The second stage of research validated the differing relationships in terms of the organizational results. Stage three focused on the Leadership-Making theory through an examination of the development of the relationships between the leader and member. Stage four researched the Team Making Competence Network of combining teams of two into a larger group. The research looked at the correlations between the leadership arrangement and the arrangements of tasks and the nature of the relationships that grew from interdependent structures.\textsuperscript{122}
This approach also contains some of the key elements that can contribute to a positive work environment through the nature of the interrelationships. Like the transformational style, there is an emphasis on developing followers and the significant responsibility of the leader’s actions which are duplicated by the followers. Also, like the ethics of care the relationship is a core function of the approach that is viewed in context. The context within the relational leadership style joins the development of the relationships with actions which set expectations for others to mirror. If these relationships and actions are morally grounded then this style of leadership would provide a structure for ethical leadership to succeed.

Ideally, a leader is able to move throughout the leadership styles using the most appropriate method depending on the circumstances. The constant changes within nursing homes do call for the NHA to make quick changes particularly with the responsibility for the welfare and safety of patients who are a vulnerable group. For example, a directive style would be necessary to manage an emergency such as an evacuation for a fire in the nursing home, a transactional approach would be appropriate for implementing a training program for all employees by a specific date, and a transformational method would work for reorganizing the nursing department and engaging the nurses in the process with their suggestions.

E. Models of Ethical Decision Making

Frameworks for decision making provide directions which result in improved resolutions. The approach selected for use may depend on the nature of the decisions that are to be made, however these models serve as structures for arriving at decisions that are based on sound ethical reasoning. The nursing home with the wide range of care
needs and services provides for ongoing debates regarding ethical dilemmas. With such circumstances as chronic conditions associated with aging, end-of-life decisions, and resource allocation, the manner for arriving at solutions cannot be regarded as insignificant. High ethical values must be maintained on the part of the leadership who are spearheading these decision processes. Properly following these models will minimize the opportunities to compromise morals on the part of the leadership whose personal values might not be within the ethical parameters for the organization. There are many models that serve as strategies for ethical decision making and four of them will be covered in the next section.

1. Realm-Individual Process-Situation

The Realm-Individual Process-Situation (RIPS) is a model of ethical decision making that was developed originally for physical therapists but can be transferable to other areas of healthcare management. This model replaces previous methods that were seen as limited in perspective for the changing needs in healthcare. The RIPS approach incorporates the features of the process which are the realm, the individual process, and the situation that the ethical concern falls within. This is then followed by a series of four steps for resolving the ethical dilemmas which are: 1) recognizing and defining the ethical issues, 2) reflecting on and translating the information that was collected in the first step, 3) making a decision as to which action is the correct one to make when faced with two “right” decisions, and 4) implementing the decision followed by an evaluation and reassessment for its effectiveness. Of note is that step three is not necessary when there is a clear right and wrong decision so it can be skipped and the process then moves directly to the final step.¹²⁴
The RIPS model has an emphasis on gathering information to fully understand the problem by reflecting on it. The translation of the data can place the problem in context as resolutions are determined with a follow-up step to assess the effectiveness.\textsuperscript{125} RIPS minimizes some of the problems with other decision making models by not skipping over necessary action items to get to a solution. By recognizing the organization and societal issues rather than just looking at individual or interpersonal issues gives a much wider perspective in arriving at a decision. Considering the moral motivation within this process could provide for evaluating the values of the leadership within the organization particularly if self-interests are involved.\textsuperscript{126} Clearly, if self-interests are a factor in properly utilizing this process then enacting moral courage will also be problematic. Moral courage is consistent with moving beyond self-interests and is a requirement for representing and defending the best interests of the residents and patients.

2. Devlin and Magill

Devlin and Magill describe their decision making process as a three-step approach that identifies the problem which is then accompanied with three steps for resolution. These stages for identifying the problem start by assembling a group of people who can view the situation from many perspectives and can contribute to gathering the necessary data. The utilization of root-cause analysis is employed to correctly detect the problems which will then require the establishment of goals. In arriving at a resolution, the possible solutions are assessed and ranked to determine which of the selections will best address the needs of the situation. A plan for implementation is developed and the effectiveness of the process is decided through a follow-up evaluation.\textsuperscript{127}
The Devlin and Magill approach seeks more information at a deeper level which is similar to the traditionally feminist ideology of including the emotions, needs, and the conditions surrounding the situation which are assessed in arriving at the most appropriate solution.\textsuperscript{128} This model incorporates the use of a ranking system which is a way of prioritizing care for the patients who are most in need.\textsuperscript{129} While it could be manipulated to support an ethics of care, the use of a ranking system is one of justice. Of note is that Tronto did incorporate that aspect into her proposed ethics of care as a way of prioritizing care for the patients most in need.\textsuperscript{130} There is flexibility within this paradigm that is grounded in principlism and virtue ethics. Although the leadership’s values may be virtuous, this process provides a systematic approach to limit the influence of those specific values from superseding the process.\textsuperscript{131} 

Devlin and Magill’s model, when used within a nursing home, limits the leader from imposing personal values into the deliberations due to its orderly approach. Although the intent for the NHA may be altruistic, he may not even realize that he is basing his decisions on his own values and not the patient’s. In actuality, the actions are self-serving and can create self-imposed boundaries on being able to act with moral courage on behalf of the resident or patient. Moral courage is about acting in the context of relation to others and can’t be accomplished with placing the self as the priority. Ethics cannot be enacted in isolation but needs to be associated with the rights and well-being of others.\textsuperscript{132}

3. Kidder’s Checkpoints

Rushworth Kidder, an ethicist, developed the checkpoint methodology as a means to organize ethical dilemmas and systematically work through the steps to arrive at a
solution. Kidder’s Checkpoints progress through nine steps that start with gathering information, noting situations that have two right solutions, and ending with retrospective analysis of the decision that was made.133

Kidder’s methodology is meant to organize ethical dilemmas and systematically work through the steps to arrive at a solution. The steps are: 1) determine that there is an ethical problem that needs to be solved, 2) determine who is the best person to address the problem, 3) Collect the pertinent factual information to the situation which includes details, 4) assess for right versus wrong in arriving at a recommendation or decision, 5) assess for right versus right which happens when two essential values are involved in the ethical dilemma, 6) apply the ethical standards and perspectives with the most appropriate principles for the concern, 7) determine a third possible solution which may involve a compromise or a creative approach, 8) arrive at a decision, and 9) re-examine the decision that was made and the learnings that came out of that specific experience. In step four, Right versus Wrong, Kidder further categorizes the tests for assessment. The titles may seem somewhat humorous but the point is made for a more practical evaluation. The stench test checks for a “gut” reaction. The front-page test evaluates the level of comfort or discomfort that would exist if the decision was printed in the front page of a newspaper. The Mom test determines if the decision would go against the moral code of someone you care about. If the decision passes each of these tests then the process can move to the next step. Step five also delves deeper in evaluating the dilemma. There are four sub-categories that assess in the areas of: 1) truth telling versus loyalty to others and institutions, 2) personal needs versus the needs of the community, 3)
short-term benefits versus long-term negative consequences, and 4) justice versus mercy.\textsuperscript{134}

Kidder’s process supports the argument that decision making is directed by personal core values and morals which are either seen as ethical decisions or moral temptations.\textsuperscript{135} Kidder also acknowledges that the moral dilemmas can be complex and that courage may be required to make a decision based on the information that is provided within the process. Furthermore, he notes that moral courage would be needed by the leader such as the NHA, to actually implement the decision that was made.\textsuperscript{136}

4. Purtilo and Doherty

Purtilo and Doherty’s Process to a Caring Response is an approach that provides a means to making useful choices that progress to a professional, ethical, and caring response to patients. There are six-steps in this decision making analysis of ethical problems which has the intended outcome for a caring reaction. This methodology asserts that the healthcare professional has a duty to provide a caring response to the patients at all times and must be the primary focus of all actions. The six steps for arriving at an ethical decision are: 1) gather relevant information, 2) identify the type of ethical problem, 3) use ethics theories or approaches to analyze the problems, 4) explore the practical alternatives, 5) complete the action, and 6) evaluate the process and outcome. When starting this process the professional needs to “reflect thoughtfully” with “logical judgment” as the authors describe. The challenge is to take the pieces of information that are mixed with emotions and fill in the missing areas. In addition to collecting the data surrounding the current situation there must be an understanding of the life situations for the patients that may be impacting the current situation. This aspect is formulating the
narrative of the patient. Moving to the second step is in identifying the type of ethical problem.

An ethical problem and an ethical dilemma are not interchangeable in that the dilemma consists of two or more correct actions, however both cannot occur. In choosing to take one action over the other is to take an ethically correct action but failing by not also being able to take the other correct action. Also, for an ethical dilemma to exist an ethical conflict and ethical conduct must be present. In stage three the ethical theories that outline principles, duties, rights, and consequences are the formulas that are used for analysis and guidance in taking ethical actions. As noted from Chapter Three, the moral theories include utilitarianism, Kantianism or deontology, or rights theory to name a few. Step four requires the healthcare professional to study the practical options for the resolution. Guard against staying with a familiar solution rather than exploring other possibilities. Looking at alternative views in creative ways may offer a solution that was never considered. Step five finally requires that an action occur. Some actions may be controversial and failing to act may cause harm as well. These are instances that require moral courage when taking the ethical course may be accompanied by risk. The last step is to assess the steps that were taken and the effectiveness of the final outcome for the patient. Reflection is a way for professional growth in learning from mistakes as well as successes so that the patients can continue to be represented and supported with caring responses.

The method is very concerned about the type of engagement the clinician has with the patient which is established in the title. Throughout the process attention must be given to the interactions with the patient so they come from a position of caring. This
method offers a constant reminder of who are the central figures in the deliberations which are the patients and the residents.

5. **Jonsen, Siegler, and Winslade**

Jonsen, Siegler, and Winslade’s Case Analysis Process utilizes four topics to collect information and analyze the situation which includes: medical indications, patient preferences, quality of life, and contextual features. *Medical Indications* covers such areas as the diagnosis, prognosis, care and treatment plans. The facts of the medical characteristics are reviewed within an ethical framework. The principles of beneficence and nonmaleficence are contained in this step. *Patient Preferences* respect the patient’s autonomy and establishes the patient’s preferences for the course to take for resolution. The patient’s values and the evaluation of the benefits and burdens of the individual preferences as they relate to the ethical dilemma are presented. *Quality of Life* is a difficult term to evaluate because it has individual meaning. The patient and the other parties associated with the resolution should define each of their views in the meaning to Quality of Life and the potential effects of the preferences of the patient. The principles of beneficence, nonmaleficence, and respect for autonomy are addressed in this step. *Contextual Features* are determined as they affect the solutions to the case. Each area being considered must be assessed for its significance to contributing to a comprehensive understanding of the issues and the resolution to the problem. The principles of loyalty and fairness are contained in this step. This model works well if the question to be answered is positioned as a trial statement which is a suggestion surrounding moral responsibility within a given situation. Attached to these statements is an ethical obligation to act. An example of such a statement would begin as, “The best ethical
approach is to…” The statement is then analyzed against the four quadrants. Ideally the decision for resolution is completed within the first two quadrants. This process is unique in analyzing the context which includes geriatric teams in healthcare and their positive or negative influence on the ethical decision making procedure.

This method acknowledges the right to self-determination for the patient and allows for flexibility in establishing the personal definition for quality of life. By placing the process within a contextual framework both the preferences and quality of life will be able to be comprehended more easily from the patient’s perspective if the patient is able to be actively engaged in the process. A potential challenge for the patient will be in stating a position that may be in conflict with other family members or even the staff who may be inclined to take a paternalistic stance. The leader in these types of circumstances may need to pull from inner strength to be able to respond to a difficult ethical decision and that inner strength is moral courage.

There were five models presented and each had a focus that may be more appropriate for specific types of ethical problems which required resolution. Simply, through the utilization of an ethical decision making process places the NHA on a moral path for deliberation. Choosing these approaches offers the opportunity for the NHA to act as an advocate for the patients and residents and within these methods there are provisions to assess the ethical issue from both a rights and care perspective. There are considerations for fairness, rights, and respect for autonomy with possibilities for narrative insight which includes relationships and a contextual perspective. For there to be a need for processes to assist in deliberating ethical dilemmas means that there are decisions to be made that do not have easy solutions.
F. Conclusion

Leadership is defined with such phrases as: inspiring or motivating others to take action, providing support, and guiding subordinates to share values and a vision toward achieving common goals. Having certain competencies may contribute to the foundation for decision making but the values of the leader as a person are what primarily influence the decisions in the nursing home and ultimately the outcomes for the patients. There were four concepts of compromised morals discussed which described a variety of ways that an organization can gradually move on a continuum from right to wrong. However, the leadership has the power to influence the actions of others which can shift the moral direction either way.\textsuperscript{146} Many styles of leadership were covered and although there are appropriate uses for all of them, the transformational leadership style captured the essence of the moral leader who is driven by virtuous actions within personal values. The leadership styles based in traits all could contribute to developing and maintaining nursing homes as ethical environments. As specific processes for ethical decision making, the five examples gave clear guidelines for directing the decisions. However, the leader who engages in these approaches must never lose sight of who is the center of the debate and who must be represented and protected and the position of NHA has the moral obligation to do that. In looking at each section covered and the various scenarios within the nursing home, the leadership has the power to drive the ethical decisions by formulating the foundation based on their own values. As Aristotle taught, character develops from repetition and forming habits; therefore the more moral courage is displayed the more likely it is to become ingrained in the culture of the organization.\textsuperscript{147} To have the responsibility of leadership in healthcare inherently means to have to make
difficult decisions. To deliberate is to take positions that will create discord and risk and when those are present then the ethical leader will use moral courage as his strength.

32 Moss, The Emotionally Intelligent Nurse Leader, 187-205.


Magill, Moral Compass for Cooperation, 138-141.


Hamel, Cooperation: A Principle that Reflects Reality, 80-82.

Magill, Moral Compass for Cooperation, 138-143.

Hamel, Cooperation: A Principle that Reflects Reality, 82.


Northouse, Leadership Theory and Practice, 9-11.

79 Anna Elisabeth Weischer, Jurgen Weibler, and Maite Petersen, “‘To Thine Own Self be True:’ The Effects of Entactment and Life Storytelling on Perceived Leader Authenticity,” *The Leadership Quarterly* 2, no. 2 (April 2013): 170-181.
82 Pellicer, *Caring Enough to Lead*, 143.
83 Hannah, Avolio, and Walumba, “Relationships between Authentic Leadership,” 564.
87 Northouse, *Leadership*, 139-140.
98 Aronson, “Integrating Leadership Styles,” 244-246.


110 Hackman and Johnson, Leadership, 307-308.


136 Johnson, *Meeting the Ethical Challenges*, 250.
140 Beauchamp and Childress, *Principles of Biomedical Ethics*, 333-367
143 Russell Burck and Stanley Lapidos, “Ethics and Cultures of Care,” in *Ethical Patient Care*, eds. Mathy D. Mezey et al. (Baltimore: Johns Hopkins University, 2002), 54-56.
146 Fuqua, Payne, and Cangemi. "Leadership and the Effective Use of Power."
Chapter Five: Moral Courage and Organizational Culture

The nursing home leadership determines the culture of their organizations however they often don’t realize the level of responsibility and control they have over establishing and changing these cultures. The terms of “walking the talk” and “leading by example” are management phrases that have been utilized repeatedly but when understanding the contributing factors of such actions they are significant to organizational cultures and ethical climates. In establishing and maintaining a positive organizational culture within the constant changes of healthcare, decision making will be challenged repeatedly to establish high ethical standards within nursing home management. Moral courage as a factor in ethical leadership is thought to be the prominent virtue that influences other virtuous acts. The need for such unwavering actions is supported by values that extend beyond the leader in confronting adversity. This moral responsibility for the overall operation of the nursing facility takes on the “courage of conviction” in acting for the good of the patients. The discussion will begin with a review of ethical climates and Victor and Cullen’s noted research that formulated the concept. The role of moral agency will cover organizational philosophy which is characterized by the mission, vision, goals and policies. Professional codes, regulatory requirements, and policies as guidelines for directing the actions of the leadership will complete this section. The importance of trust with the leadership is examined within the relationships at all levels. The three approaches for measuring trust will be viewed as they relate to establishing a positive ethical climate and the need for moral courage in maintaining trust. Indicators of the ethical climate will be included which are comprised of the three segments of artifacts, espoused beliefs and values, and basic underlying
assumptions along with the internal and external ethical climates. These measures are signs of the ethical environment within the healthcare facility and this section will be limited to areas that are common within nursing homes which are patient satisfaction, employee job satisfaction and turnover rates, regulatory results, and social responsibility. The promotion of cultures of quality and safety as the foundational areas for keeping the patient at the center of decisions is evidence of the ethical organizational culture which is reliant upon moral courage. Quality assurance and improvement strategies and patient outcomes will be covered primarily as quality of care concerns. Safety as an aspect of quality will be explored through developing cultures of safety, strategies for prevention, medical errors and the moral obligation for dealing with errors properly. Lastly, the need for compliance and ethics programs within the healthcare environment are examined for guidance and support that the “right” things are being done within legal, regulatory, and ethical standards for the good of the patients and residents.

A. Determining Ethical Climates

When there is an egregious occurrence in any organization there are always surprised reactions as to how such an event could happen. A key answer to this question has a foundation in the ethical climate of an organization which will begin to be explained with Victor and Cullen’s theory.

1. Victor and Cullen’s Theory

Culture within an organization is directly attached to the values along with the experiences and attitudes of the leadership. The culture can be manipulated by the leaders by living out the desired values through actions and decisions that are supportive. Victor and Cullen (1988) developed a theory based on Kohlberg’s moral development stages
which linked their concepts to the term of *ethical climate* which is the culmination of the ethical behaviors of an organization. There were three clearly defined ethical standards within this theory and the rationale used in the decision making process. An Ethical Climate Questionnaire was developed as part of this theory which measures the ethical climate at both the individual and organizational levels. Nine possible categories of ethical climates are suggested when comparing the ethical criteria against the locus of analysis. The ethical criteria are made up of Egoism, Benevolence, and Principle which closely resemble Kohlberg’s moral theory ethical standards of self-interest, caring, and principle. The locus of analysis consists of Individual, Local, and Cosmopolitan. The table below shows the nine ethical climates when combining the criteria with the locus of analysis (Figure 1).

<table>
<thead>
<tr>
<th>Ethical Criteria</th>
<th>Individual</th>
<th>Local</th>
<th>Cosmopolitan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egoism</td>
<td>Self-interest</td>
<td>Company Profit</td>
<td>Efficiency</td>
</tr>
<tr>
<td>Benevolence</td>
<td>Friendship</td>
<td>Team Interest</td>
<td>Social Responsibility</td>
</tr>
<tr>
<td>Principle</td>
<td>Personal Morality</td>
<td>Rules, Standard Operating Procedures</td>
<td>Laws, Professional Codes</td>
</tr>
</tbody>
</table>

Victor and Cullen deduced that the first of these two dimensions, the type of ethical criteria, is the moral philosophy that is prevalent within an organization in decision making. The theory asserts that benevolent persons are less prone to following rules and principles and that persons more steeped in principle are less caring about others. The second dimension, locus of analysis, assesses the predisposition of individuals within the organization to making decisions based on self-interests, joint interests for the company, or to societal interests beyond the organization. The comparative relationships measured within the Ethical Climate Questionnaire were: Caring, Law and Code, Rules,
Instrumental, and Independence. Obviously the area identified as “Caring” plays strongly into the nursing home setting and the establishment of a culture that exhibits a concern for the effects of decisions on others. Moral courage evolves from the leader’s moral positions and reasoning as it moves into moral action. The moral action is the connection to the development of the ethical climate which permeates the organization in a positive way. Without the courage to ground the decisions morally, a decline in climate will ensue which will eventually result in negative outcomes.

2. The Role of Moral Agency in Leadership

Moral agency for healthcare organizations is the capacity for making moral decisions based on universal values of right and wrong. Organizations are considered to be moral agents but it is the people within the organizations who determine the decision making actions. As in the nursing home the decisions that are made by each person cumulatively establish the guidelines for acceptability for decisions. The moral character of these individuals regulate the level of morality that is practiced in making decisions and also determines the placement of an organization’s moral agency on a continuum of rights and wrongs and duties and obligations. The structure provided within the nursing home needs to support virtuous decisions through its mission, goals, and policies. More specifically, the four main areas that are combined to establish moral standards include: 1) the setting of goals and a mission that will guide the individuals that make up the nursing home, 2) the guidelines of the facility in the form of policies and procedures are established through a collaborative approach among members of the organization, 3) through moral evaluation by other organizations and the larger society in which they
function, and 4) through accountability in meeting or failing to meet the expectations and the methods in which they are used, moral or immoral, in conducting their actions.\textsuperscript{12}

Virtue and character ethics are accentuated in the moral agent. Such attributes as trustworthiness, honesty, and benevolence endure within the moral character of the agent which indicates the morality of the actions rather than vice versa. The decisions that are made determine the moral character of the individual. Having an intrinsic sense for the moral actions to take is a natural instinct for some people however the most appropriate moral response can be learned as well. For the leadership’s character to be morally aligned with the organization, the organization must provide a supportive framework for virtuous decisions. The mission, goals, policies, and actions must be integrated in communicating a positive internal and external ethical climate as an outcome.\textsuperscript{13} A person’s cultural experience during rearing teaches responsibility, however the beliefs for the causes of the behaviors are not necessarily correct which supports the need for the leadership to determine the expectations through their actions and in developing others.\textsuperscript{14}

Care rather than medical procedures are the core services within a nursing home and the clinical leadership’s moral agency is a driving force behind the decisions of the direct caregivers. This is especially critical when considering that the majority of the direct caregivers in this healthcare setting do not fall within a professional designation but are certified as nursing assistants who take their cues from the leadership.\textsuperscript{15} When looking at moral courage within the context of moral agency it is deduced to a position of confrontation that is taken between two or more moral agents. This confrontation can be direct or indirect. These moral agents in opposition are approached as subjects rather than as objects to prevent decisions based on the leader’s own means to an end.\textsuperscript{16} Nurse
leaders as representatives of the direct caregivers determine the moral standards for quality care. By position they have the power to influence the work and care environments through moral courage so their staff can also function as moral agents through ethical practice.\textsuperscript{17}

a) Organizational Philosophy

A nursing home must first arrive at a philosophical position for conducting business which evolves into the mission statement, vision, and values for guiding all aspects of the organization. Ideally it will limit potential conflicts by clearly establishing parameters for operating.\textsuperscript{18} Mission statements assert the values of the nursing home and are used for motivational purposes and for establishing an external perception.\textsuperscript{19} They serve as the foundational moral position of the organization from which all actions should be derived.\textsuperscript{20} As a motivational tool mission statements can improve organizational performance.\textsuperscript{21} By these statements reflecting the core values of the nursing home they will be able to connect them to the future and the ways in which change needs to occur to meet the vision.\textsuperscript{22} The key importance in these assertions is that what is written to define the ethical position of the organization is reflected in actions of the leadership. The moral agency of the leadership enacts the organization’s mission, vision, and values, and these provide the framework for an organization to follow. The administrator, either officially or unofficially, serves as the chief ethics officer of the nursing home in establishing the moral agency. Through leading by example, these core beliefs will instill trust throughout the management processes of the organization.\textsuperscript{23}
b) Professional Ethics through Codes

As mentioned previously, the three leadership positions within a skilled nursing facility consist of the medical director, the director of nursing for clinical care who is usually a registered nurse, and the nursing home administrator. Each of these positions has professional ethical codes that incorporate standards for conduct which become part of the development of the moral agency and ethical climate of the facility.

The medical director and the attending physicians within the nursing facility fall within the professional codes outlined by the American Medical Association (AMA). Ethical issues have been explicitly noted by the AMA since the 1990s to clarify the conduct that is expected of the medical community in practicing their profession. The standards that are covered in the *Principles of Medical Ethics* include basic ethical standards for the patient and physician relationship, examples of common ethical concerns with suggestions for resolving, and reports on current ethical topics of concern. These standards of conduct maintain that the physician must acknowledge that the first concern is to the patient, then to the general community, healthcare colleagues, and finally, to himself. The AMA has also issued the Council on Ethical and Judicial Affairs which covers the basic rules for the patient-physician relationship.24

The ethical code for nurses comes from the American Nurses Association and is made up of nine principles which start by acknowledging that all professional interactions must be done with compassion and respect recognizing the individuality, dignity, and value in every person. Other key elements of the code includes that the primary focus is the patient, promotion of advocacy, adherence to nursing practice, supports quality healthcare, continuous learning, and upholding the integrity of the profession.25 Within
the nursing home the nursing leadership position is the moral compass for the direct
caregivers as they encounter issues related to policies and procedures, the availability of
resources for care, and conflicting loyalties. This nursing leader needs to use the role in a
positive way to encourage ethical nursing practices.\(^{26}\) The purpose of this code for nurses
can be summarized in three points: 1) to provide ethical rules to direct behavior, 2) that it
applies to all aspects of nursing roles in research, patient care, and in education, and 3)
that the nature of being a nurse places them in an ethical position within the general
public. Morally, the code makes the nurse responsible and accountable for the individual
actions within the nursing practice.\(^{27}\)

The Nursing Home Administrator (NHA) must meet the licensing requirements of
the state in order to practice which also outlines the conduct that is expected within the
profession. Since these are mandated by each state, there is a wide range of topics
covered within these codes however specific ethical guidelines are not prevalent. The
American College of Health Care Administrators (ACHCA) has a *Code of Ethics* that
lists four areas of expectation and are stated that the NHA shall not: 1) disclose protected
patient information unless required by law or for public protection, 2) falsify professional
qualifications including the provision for services beyond the qualifications, 3) engage in
conflicts of interest or activities that could impact the patients or facility in a negative
way, and 4) condone unethical behavior.\(^{28}\) The ACHCA also has additional guidelines
that were issued in 2004 entitled, *Principles for Excellence for Leaders in Long-Term
Care Administration*.\(^{29}\)

Today’s nursing home leadership utilizes professional ethics in their traditional
form of adhering to their ethical codes however they find themselves in circumstances for
conflicts of interest and commitments. The moral agency defined through the mission, vision, and values, expects all working internally and externally with the organization to remain within those parameters. Two of the main areas for ethical conflict requiring moral courage for the leadership within nursing facilities are the caregiving needs of the patients versus meeting the financial goals. The reality of cost containment and resource allocation is necessary in order to distribute these resources over more patients which are cause for ethical dilemmas.  

\(^{30}\) 

\(c)\) Regulatory Requirements

The Centers for Medicare and Medicaid Services (CMS) is the overarching regulatory body for nursing homes at the federal level for the certification for participation in these governmental programs. State departments of health function as the primary enforcement agency in the capacity for licensing.  

\(^{31}\) The formerly known Health Care Financing Administration (HCFA), it transformed into CMS in 2001 as part of reorganizing the Health and Human Service Department. While still under the HCFA umbrella the Nursing Home Reform Act of 1987 was passed which established three goals for improving nursing homes which were to determine standards for quality care nationally, develop a system for assuring and monitoring resident rights, and to institute a consistent process for evaluating that nursing homes are meeting the regulations for providing quality care.  

\(^{32}\) The Department of Health (DOH) in each state regulates and licenses the operation of nursing homes in coordination with CMS who certifies facilities for participation in the Medicare and Medicaid programs. They enforce both the federal and state regulations through unannounced inspections and cite the nursing home for any
areas of deficient practice. Each deficiency is graded according to the scope and severity of the problem which is based on the amount of patients involved and the potential for harm. The more severe and widespread a problem is results in more severe penalties for the nursing facility. This can include monetary fines, decertification for receiving Medicare and Medicaid funding, and the closure of the facility. Plans of correction are required for any areas cited and follow-up inspections are conducted to insure that improvements have been made. The Office of Inspector General (OIG) is the enforcement agency for Civil Money Penalties for severe nursing home violations. The OIG’s mission is to uphold the integrity of the programs provided by the Department of Health and Human Services and to protect the health and welfare of the recipients of those programs. Obviously, the DOH exercises significant control over the nursing home operations but the leadership continues to control the moral agency in the approaches that are taken in meeting these regulatory requirements.

d) Policies

The policies within a nursing home are what connect the mission and vision of the organization to the plans and structural operation of the facility. The policies should be a reflection of the goals and philosophy of the organization so they can carry these ideologies throughout the organization at all levels. Within healthcare organizations there are challenges in actually writing policies because ethical issues need to be given directives. Winkler offers suggestions for writing policies on controversial medical practices that may have moral disagreement. This process mirrors political processes rather than an authoritarian approach that typically accompanies policies that are not morally controversial in nature. Recommends are that five points be met in developing
the policies which include: 1) representation of the professionals who have expertise to solve such an ethical dilemma, 2) utilize a deliberate process to build a consensus on the appropriate actions to take on the issue, 3) make the rationales for the decision available to the healthcare professionals so they understand the reason behind the decision, 4) include an objection for conscience since there will be professionals who disagree with the policy, and 5) implement the policy and evaluate its effectiveness. Since the policies are a direct reflection of the values of the organization, failing to match the two in morally controversial issues could subject the organization to engaging in morally illicit activities through the principle of cooperation.

The policies should be a reflection of the goals and philosophy to be communicated through actions throughout the organization at all levels. They serve as the connecting element for the mission and vision to the strategy and the structure of the nursing home. Policies are the guides for implementing the moral agency of the organization and are the application of the mission, core values, and philosophy. Policies and procedures reflect the safety and compliance values of an organization. If there are problems in those two areas then there should also be an assessment of the policies with an emphasis in areas of high risk. Since policies are also a function of the moral agency of the organization the evaluation needs to objectively assess if the current policies are reflective of the mission, vision, and core values of the facility.

Specific to patient care, policies and procedures can be completed in an evidenced-based process which is necessary for them to be built on best practices. This method also promotes safety through the integration of evidence. Consistency in the delivery of care to the residents and patients is also supported with this approach.
The leadership must manage and coordinate a vast amount of information and activities in the operation of nursing homes which is a characteristic of healthcare. The nursing home industry is a highly regulated business that necessitates the adherence to specific procedures. These various regulations are intended to represent the best interests of the patients and require interpretation and enforcement led by the administrator of the nursing facility. The ethical compliance of all of the external regulatory agencies and codes are based on the philosophy and practices of the nursing home that is established through moral agency and is set forth in the mission, vision, and values.\textsuperscript{40}

3. Trust

Trust comes from the actions of the moral agent on the part of the leader. Within healthcare trust is a process that is based in relations and allows the healthcare professionals and leadership to react morally to the people who are being served.\textsuperscript{41}

a) Trust in Relationships

Existing relationships are a key element in developing trust even if the relationship is not a strong one. Trust is most determined by the emotions that a person connects to actions that are taken rather than to the results.\textsuperscript{42} The characteristics of the leadership are vital in developing and maintaining a trusting organization which must include having the courage to protect it against damaging actions.\textsuperscript{43} This building of trust for the organization can be done by providing quality services, being responsive to all customers of the organization, and by developing a brand identity that will be associated with trust.\textsuperscript{44}

Clinically, trust is essential to the ethical climate of an organization and to the well-being of patients. Research shows that patients who do not trust their physicians
who direct their care will be skeptical about following their care regime. This could negatively impact the patient outcomes which in turn can cause the clinicians to become disturbed about non-compliant patients. The same could hold true for the NHA as a person of authority in the nursing homes. This can become a cycle that plays out negatively for all involved. The solution then goes back to moral agency and the need for the organizational ethics to provide a framework that will nurture trust throughout the healthcare facility. This will serve as a foundation for the healthcare professionals to be more comfortable in making the decisions that are best for their patients and in carrying out the clinical elements for their care.

Within nursing homes trust must not only occur among supervisors and their employees but also among the patients and the care providers and the facility leadership. In both instances there are differing levels of power in the two people involved in the relationship. There is often an assumption that the relationships between the patients and the healthcare professionals who provide the care are one of trust. Trust is necessary in a relationship in which a vulnerable individual depends on the other for significant assistance through caregiving however it is not automatic and must be earned. Trust depends on both parties taking risks in trusting each other in order for it to grown. There are three phases for developing trust in relationships which are: 1) the situation must be one in which trust is needed and requires the vulnerable party in the relationship to be entrusting to the other, 2) a perception of the one person in the relationship assesses the level of trust of the other through characteristics and situations, and 3) one member of the relationship manages to overcome the difference in the power base with the other in order to establish a mutual goal of trust between the two parties.45
A challenge within healthcare is the struggle to balance the caregiving needs of the patients with the financial obligations and limitations. The ability for the nursing home to manage these two areas impacts the trust of the community which they serve. The facility goals are the principles which guide the actions and decisions of the NHA that set the groundwork for establishing this trust. Pearson, Sabin and Emanuel offer a system that can be translated for use in nursing homes for looking at ethical quality. This design is for use with the type of healthcare concerns found within the U.S. and the main areas are: 1) systems that are inclusive of the ethical principles relevant to medicine and healthcare such as those found in principlism, 2) systems that conform to the regulatory requirements and integrity in their integration into the operational areas of the facility, 3) operationally managing the competing financial needs with the ethical obligations to the patients and the community, and 4) promoting the inclusion of the physicians and patients in the decision making process. Basically, these dimensions contain the fundamental definition of organizational ethics in the key areas that need to be addressed for ethical quality to exist within a nursing home as they move through competing ethical values.

b) Theories of Leadership Trust

Having a culture of trust can lead to a more productive workforce and in healthcare that could mean better outcomes for the resident and patient care. Changing a culture and developing trust are adjustments that can take some time. Having approaches to establish a baseline by assessing the current trust culture in a facility can be done by using a measurement tool such as the Perceived Leader Integrity Scale and the Organizational Culture Inventory. The leader Member Exchange Theory which was reviewed in Chapter Four is not specifically a measurement tool but is an approach to the
relationships between the leaders and the followers which requires interpersonal evaluations between the two levels.

The Perceived Leader Integrity Scale identifies seven behavioral domains that are indicators for moral integrity which are: 1) training and development, 2) resource and workload distribution, 3) truthfulness, 4) illegal discrimination, 5) following the policies and procedures, 6) maliciousness, and 7) self-protection. These areas were selected as being common to the leader and subordinate relationship without specific considerations for the type of work that is being done. They measure a combination of the perceived behaviors the leader exhibits toward the subordinate and the subordinate’s observations of the leader’s interactions with the other workers. These domains reveal a high internal consistency and validate the theoretical models for associating with other variables. Integrity in dealing with others is evaluated as well as self-serving behaviors. This tool is used to provide feedback to the leader and is limited to the evaluation of one person who is the immediate supervisor of the subordinate completing the questionnaire. The results did note that there is a significant correlation between job satisfaction and perceived trust and integrity in the organizational leadership. Because this method is generic to any type of business and is completed by individual subordinates who are rating their direct supervisor, there could be a great deal of helpful information obtained for the leader in improving behaviors. This increased self-awareness may help NHAs adjust their responses, particularly if they are being misunderstood rather than being based in a value system that doesn’t match the goal of placing the residents and patients as the priority.

The Organizational Culture Inventory by Cooke looks at three different groups based on cultural norms and the ways in which people interact with each other which are
further divided into four areas for a total of twelve cultural types. The first category, *Constructive Norms*, includes achievement, self-actualizing, humanistic/encouraging, and affiliative which serves to support behaviors for job satisfaction. The second category, *Passive/Defensive Norms*, addresses support for the employees and behaviors related to security. This includes approval, conventional, dependent, and avoidance. The third category of *Aggressive/Defensive Norms* supports the completion of tasks and behaviors associated with security and includes oppositional, power, competitive, perfectionist. The types of organizational cultures that are described in the *Constructive Norms* group would be most conducive to the nursing home environment with the emphasis on teamwork, constructive criticism, value quality, and encourages creativity and professional growth among the members.

As discussed in a previous chapter, the Leader Member Exchange Theory is a model of interpersonal trust within leadership positions and subordinates. This model is a form of relational leadership and offers a better understanding of the quality of the relationships and how trust develops between the levels within the workplace hierarchy. The level of trust arrives through the evaluation by each party of the other on abilities, benevolence, and integrity. This, in turn, will influence their behaviors towards each other in their performance.

Moral courage is a function of moral agency which is an underlying determinate in establishing the trust within any organization. The nature of nursing homes is to serve a population of highly vulnerable older and disabled persons who require the leadership to act as their advocates. The leadership, particularly the nursing home administrator, is placed in a position for constant conflicts of interests by being responsible for the many
operational aspects which can have competing goals and the way in which those competing goals are prioritized and communicated through actions or inactions will be a determinant of trust. Of note is that failing to take any action within these conflicts can be seen as cowardice while making a decision of “no” can be an act of moral courage.\textsuperscript{50} Although such situations are cause for difficulty they cannot be used as an excuse for not being responsible in finding solutions. The leadership must summon up their moral courage to continuously work at creating and maintaining a positive ethical climate of trust throughout the organization.\textsuperscript{51}

\textbf{B. Indicators of Ethical Climates}

Ethics in healthcare has mainly been concerned with clinical dilemmas but as patient welfare becomes increasingly interwoven with financial concerns there is a need for developing a culture that reflects positive ethical values throughout the nursing home.\textsuperscript{52} The ethical view of an organization is not kept within the walls of the healthcare facility but extends to anyone who comes into contact with the organization either directly or indirectly.\textsuperscript{53}

1. Segments of an Ethical Climate

Ethical climate is a defining outcome of the culture of an organization and can be segmented into three areas for analysis which progress in gaining increased insight with each level. The first cultural level, \textit{Artifacts}, is the most obvious and consists of what is observed in the processes, structures, and behaviors however it is very difficult to interpret the meaning behind these observations. This level engages the senses of what is seen, heard, and felt when engaging with a new group or culture.\textsuperscript{54} For the nursing facility this could be the experience of a newly admitted patient or a recently hired
 employee. They note the physical building, décor, professionalism of the staff; interactions of the caregivers with the patients, follow-through on requests, or the published mission statement. The second level is *Espoused Beliefs and Values* which are largely abstract and also encompass the goals and aspirations of an organization. In evaluating these beliefs and values it is necessary to distinguish them from being compatible with the core assumptions that influence performance, being part of the philosophy of the organization, or as being excuses or visions for the future. These can include the ethical guidelines that are communicated to the members of the organization to follow in specific circumstances and can be at odds with other artifacts and behaviors.55 For the nursing homes these could be to replace missing clothing for an upset resident when the laundry was done by the facility although the policy states the opposite. The circumstances surrounding the specific situation may be altered for ethical reasons to doing the “right” thing. The third level, *Basic Underlying Assumptions*, reflects the favored beliefs and assumptions of the group put into action by the individuals. These responses as solutions to situations are repeatedly selected and gradually become the norm for the group. Once embedded in the culture they are difficult to change.56 The danger to an organization is when the underlying assumptions develop in a morally unsound direction. Acts of moral courage will be necessary among the group members to redirect the culture which is not an easy task and must be lead from the top levels of the organization. A negative example of this for the nursing home would be for medical record entries to be backdated by the nurses when they run out of time during the shift to document on the correct day. A delay would reduce the financial reimbursement
for the facility due to a late entry. The rationale used is that the care was delivered that is being documented so there really isn’t any harm in “fudging” the date.

2. Measures of Ethical Climates

As was noted earlier, the leadership ultimately determines the ethical climate of the organization which branches out into internal and external impressions. While there are many indicators for measurement for these two areas, only a few select ones will be addressed in the next section.

a) Internal Ethical Climates

Common gauges utilized in nursing homes are patient satisfaction, employee job satisfaction, and employee turnover rates. There are some national databases available and the 2011-2012 National Research Survey of Customer and Employee Satisfaction was administered through the My InnerView program for skilled nursing facilities. The customer section collected responses from residents, patients, and family members on 22 encounters within the areas of quality of life, quality of care, and quality of services. The patient areas were divided between short stay and long stay since the experiences and goals were very different between the two types. The most influential determinants of satisfaction were the care and concern of staff, competency of staff, allowance for the choices and preferences of the patient, and the responsiveness of the management. In a study in healthcare settings that were not nursing homes concluded similarly that the most important factors in satisfaction and meeting the patient expectations were reliant on the emotional and human factors of the interaction.

The employee engagement section of My InnerView gathered feedback for the leadership in the areas of resources, relationships, and commitment. The areas that were
most important to employees in shaping their level of satisfaction were the care and concern of the management, attentiveness of the management, and assistance with job stress. The number one issue for the employees was the same as that for the residents and patients which was the care and concern that was shown to them as individuals. The employees were seeking care and concern from their leadership and the patients were seeking it from the staff which links nurse and direct caregiver’s job satisfaction to the satisfaction levels of the patients and residents.59

The turnover within the nursing profession has been problematic for decades which, with the nursing assistants, make up the majority of employees in nursing homes. The ethical climate within an organization is a strong factor in nurses changing jobs or leaving the profession altogether. Reasons that influenced this were staffing levels and the amount of autonomy they were able to have regarding their nurse practice.60 The perceived ethical climates of nurses were linked to job satisfaction and their commitment to the organization. They were most satisfied with a caring type of ethical climate which resulted in behaviors that benefitted the organization.61 As the ethical climate moved more in a positive direction the greater the commitment was by the nurses to the organization.62 The research also shows that when the leader and follower have similar views on moral reasoning, the followers are more satisfied and committed to the workplace which results in lower turnover.63 Climates that are mainly concerned with cost control and efficiency can have an adverse effect on the quality of the care and services provided by the nurses as does an instrumental climate where people are concerned most about their own welfare before others.64
The internal areas covered as measures of an ethical climate clearly show a direct line back to the character of the leader. Just looking at the patient and employee satisfaction factors shows the burgeoning effect that can go in either a positive or a negative direction from the actions of the leader. These studies give credence to the adage that happy employees make happy customers, or in this case, it would be that satisfied nurses are caring and compassionate towards their patients which also results in satisfied patients. An influence in the satisfaction levels is the leadership integrity and courage to take moral actions which sets examples for all to follow. Within moral courage is also courageous followership which is the trickledown effect from the leadership. Courageous ethical followership results in the subordinates’ willingness to take responsibility for their own actions on behalf of the organization, to serve the leadership, to challenge the leadership in ethical decisions, and to participate in transforming the organization to be the best that it can be. The ultimate act for courageous followers is to find the courage to leave an organization if the ethical principles do not meet their standards of acceptability.65

b) External Ethical Climates

NHAs need to be concerned with their ethical climate outside of the organization as well as the internal operations. This is how they are perceived within the community and society at large which can be the reputation of the facility. Nursing homes have been perceived negatively since their inception as almshouse which adds an automatic barrier to the perception of their external ethical climate. There are two common ways for nursing homes to be evaluated which are through their regulatory results and their involvement with the community through social responsibility.
For nursing facilities, the Centers for Medicare and Medicaid Services (CMS) established a rating system in 2008 to assist consumers in evaluating nursing homes on standards that are similar to hotel ratings which is familiar to most consumers. This system is called the “Five-Star Quality Ratings,” and divides the facility operations into three categories which are: health inspections, quality measures, and nursing staffing hours. A combination of these areas determines an overall rating for the nursing center. The rankings are from one to five stars with five being the highest and are comparing a particular nursing home with the average ratings throughout the state. There are specific criteria which must be met. This information is available on the CMS website called Nursing Home Compare which began in 1998 and includes other resources to aid in choosing a nursing home. There have been a wide range of criticisms of this system in which consumer advocacy groups complain that the attention is placed on compliance rather than the quality of care which is where the real areas of concern lie. The nursing home providers argue that the results are based on very limited timeframes and do not give an adequate representation of the facility. Providers also object with the use of a bell curve measurement methodology that places 20 percent of a state’s nursing centers in the lowest rankings and only 10 percent are ranked at the highest level. With a goal of improving nursing homes in addition to assisting the consumer in decision making, such a system will always keep a group within a category of poor performance which may not be an adequate representation. Basically, this approach serves as a report card for each nursing home. The details related to the quality outcomes available for review have been very difficult for most consumers to understand it in relation to their specific concerns and needs for selecting a nursing home. Despite
the concerns about the website it is heavily utilized by both healthcare professionals and the general public and the difference of a star in the overall rating can impact the business of the facility negatively. In some instances, poor regulatory performance can result in sanctions that are imposed for failing facilities which can cause a change in the organization’s moral judgment. Unfortunately some leaders need to be forced into doing the right thing rather than leading with moral courage as a consistent and normal practice.

The ethical climate of an organization can be established within their communities through their involvement and contributions through social responsibility. The engagement in activities of social responsibility will serve to develop an image of trust that the organization has as a healthcare provider. The concept of social responsibility programs has a variety of definitions and for the purposes of this discussion the ethical theories presented by Garriga and Mele will be used which target doing the right thing for improving society. These approaches encompass the ideals of fiduciary duties of an organization based on a moral theory, human and labor rights and respecting the environment as being universal, sustainable development which is aligned with the company’s goals and strategies and the social needs of their communities, and for the common good of society since businesses are all part of the societies in which they serve. Nursing homes sponsoring programs or actions that contribute to the social well-being of the community in its present circumstances can impact the future in positive ways. Healthcare organizations providing indigent care to the uninsured is seen as an expectation within their communities. The challenge is in managing the financial responsibilities for viability with the contributions to persons with little or no medical
insurance. In order to be a good steward for the community the engagement across the continuum of care allows for a more equitable distribution among service providers while meeting the public needs.\textsuperscript{72} For nursing centers accepting participants in the Medicaid program is often seen as a form of indigent care since the reimbursement rates are typically the lowest amount which doesn’t always cover the costs of the care. The Medicaid program is administered at the state level so there are variations of the systems and criteria for payment determinations.\textsuperscript{73} Nursing homes historically began as places to provide for the less fortunate in the communities they serve. This continues to be an important part of their mission as they seek to be an extension of the family in providing care within these communities. The social responsibility can include providing benefits to the community within the framework of the organizational assets, to provide for the needs of the patients without discrimination, and to protect the resources that are given to the facilities to manage appropriately whether through private or public avenues. In offering benefits to the community the nursing home may vary depending on whether the status is for-profit or not-for-profit. They are not necessarily at polar opposites which are typically assumed. The level of uncompensated services is an expectation for nonprofit nursing homes however it is the moral agency within an organization that determines this level.\textsuperscript{74} In making these kinds of decisions the patient needs to remain the focus and the treatment of residents may not be selectively better or worse for reasons that are discriminatory in nature. When looking at the general welfare of the nursing home, the stewardship of the resources is critical.

The role of nursing homes is to provide care and services to vulnerable persons who are compromised for a variety of reasons rendering them dependent as patients or
residents. The nursing home is no exception to this and encompasses all of the complexities of operating within a healthcare organizational structure which makes it difficult to function within a positive ethical climate on a consistent basis. Within this vulnerability there are detailed sensitivities that are required within a nursing home that surround ethical obligations which include: 1) statement of the commitment in the goals of the organization, 2) display a social understanding of healthcare, 3) identify as a core goal of the organization that all people who are served must be treated with dignity, 4) make financial allowances so as to compensate for the provision of care and services for persons unable to pay, 5) build in approaches that assist in balancing the profitability of the organization against the allocation of resources and the needs of the vulnerable people, 6) develop procedures and programs that specifically address the requirements for the vulnerable persons, and 7) make requirements for vulnerable populations to be involved in the advancement of programs and services to validate that the appropriate needs are the focus. Also, participating in the community activities through the variety of philanthropic activities and organizations maintains an ongoing involvement and willingness to be engaged in helping wherever there are needs.

Seeking and receiving feedback from external sources will take courage, particularly if the public impression is a negative one, but it is a trait of strong moral leaders. The leadership has a responsibility to improve areas of concern for the good of the patients and part of the process is seeking information from people who can give insight and a clearer understanding of the issues. The moral agency of the leader directly impacts the ethical climate of an organization and if the leadership is ethically sound then the internal and external climates should be positive ones. This type of leader is one
who is virtuous at their core being which forms their perceptions and behaviors and is steadfast and consistent although the situations may change. They will act with moral courage, always.77

C. Promoting Cultures of Quality and Safety

A clear gauge of moral courage by the leadership in healthcare is the way in which quality and safety concerns are addressed which translates into the ethical climate. The governance is where the moral agency will be realized in prioritizing quality improvement in all areas of the operation. Extensive changes must be made in the way that quality improvement is managed if the outcomes for quality and safety are to improve to an acceptable level in healthcare organizations.78

1. Quality of Care

The basic and fundamental points for quality care begin with a complete and concise review of the patient’s history and physical that includes all aspects of the patient’s medical condition along with the non-medical areas that impact the situation. A plan of treatment will be developed from this information along with the ongoing care needs and plans for transitioning to another level of care or to discharge home.79 Moving from the specifics of each patient are essential areas of readiness that need to be in place for improvement in quality to occur. These are in connecting the data of poor results to the clinical processes and communicating, educating, and implementing the actionable items consistently throughout the organization.80 Care is typically associated with the roles of nursing and Jameton surmises that nurses serve as the moral center of healthcare. The conflict arises when the morally correct thing to enact from the nursing perspective is not achievable due to organizational constraints.81
The nursing homes are rated in quality according to the Five Star Quality Rating program which was explained earlier in this chapter. In an effort to improve this system the IMPACT Act of 2014 was passed to establish standardized assessment data for quality, payment, and discharge planning for post-acute services that participate in the Medicare program.\textsuperscript{82} The changes to *Nursing Home Compare*, the website where the nursing home ratings are located, include the expansion of focused survey inspections to validate the information that is reported for resident assessments and quality measures. The staffing levels will be reported quarterly rather than annually and will be verified with the payroll system. The methodology for scoring the ratings will mainly use the information that is verified rather than the information that is self-reported by the nursing home. The number and type of quality measures included in the rating system will increase and the state inspectors will be required to meet specified timeframes for completing their facility surveys.\textsuperscript{83}

There are three domains that contribute to the measurement of healthcare quality which starts with *structure* which supports the *processes* for the final results called *outcomes*. More specifically, the structure provides the foundation which includes the healthcare organization’s capability to provide the treatments and services and all the resources that support the delivery of care. These are the “resource inputs’ and the list outlining this domain for a nursing home would be extensive but it is comprised of such things as equipment, buildings, staffing, licensing, and training. The process domain incorporates the actual delivery of the care to the patients and residents. Both the interpersonal component of care and caring and the technical aspects of care are included. Examples of these are: compassion, empathy, communication, diagnosis, treatments, and
costs. Basically, every interaction with the patient or for the patient falls within this area. The outcomes are the results of the delivery of the care and can consist of recovery, death, satisfaction with the care, and the discharge status.  

a) Quality Assurance and Improvement Strategies

The Affordable Care Act is requiring healthcare organizations to move from an auditing approach found in quality assurance to a process improvement one which is referred to as QAPI (Quality Assurance and Performance Improvement). CMS was tasked with developing and providing the technical tools for educating and assisting the nursing homes with this transition. The key point for utilizing performance improvement as an approach is to be constantly assessing the processes to meet or exceed the standards for quality care in a preventative way. The culture needs to permeate the entire nursing center in which all levels are identifying situations that need improvement. There are five elements to the QAPI process which are: 1) design and scope, 2) governance and leadership, 3) feedback, data systems and, monitoring, 4) performance improvement projects, and 5) systematic analysis and systematic action. Ongoing input should be encouraged from the patients, the family members, and the staff so that a wide range of viewpoints can be included in the process.

Other approaches to quality improvement are TQM (total quality management) and CQI (continuous quality improvement). Both TQM and CQI must include the allowance for employee engagement and supportive resources. TQM and CQI together focus on the customer, the structured processes, and participation throughout the organization at all levels. The emphasis is on determining problems within the systems of the organization rather than placing blame on individuals, using data-based problem-
solving solutions, using cross-functional teams, empowering employees to act on identified problems, and focusing on both the internal and external customers.\textsuperscript{89}

Critical or clinical pathways are methods that are focused on the outcomes of the patient and were primarily developed for case management of the patients. These are guidelines for care and treatment interventions with expected results for specific diagnoses that are correlated with timeframes. The goals for using these pathways are to decrease costs, improve the quality of the care with consistency thus reducing errors, and increasing communication among the various disciplines involved in the care.\textsuperscript{90} The culture within the workplace is critical for improving the quality of care in nursing homes. The staff will be more committed to the nursing home and engaged in providing quality care to the residents if the leadership empowers them to influence the circumstances within their work situations.\textsuperscript{91}

b) Patient Quality Outcomes

For nursing homes a quality outcomes standard for care is found in the \textit{Quality Measures} component of the Five-Star Quality Rating System. This category has four purposes and starts with providing information about the care in selecting a nursing home. The information is also made available to consumers for communicating the quality of care to existing residents and family members. Quality measures give guidance in determining focus areas for discussion with the staff of the nursing home and provide data to the facility in developing their plans for quality improvement activities. These measures do not assess individuals but are an indication of the status of the physical and clinical conditions of the residents as a group and are divided into short and long stay groupings.\textsuperscript{92} The 2013 Quality Report from the American Health Care Association
showed that the quality measures from 2011 to 2012 improved in most of the categories. There were 13 data points for long-term residents and five for the short-stay patient. The area with the greatest improvement was pain management.93

2. Safety as a Function of Quality

The prevention of harm to patients has been an edict since ancient times with Hippocrates, yet it has continued to be a significant cause for debate as healthcare organizations seek to find ways to eliminate medical errors and harms to patients. The nature of medicine is fundamental to safety risks and needs to balance potential harm in attempts to gain benefits for the patients or residents.

a) Defining an Ethical Culture of Safety

Historically, medicine moved from a heroic approach to one in which physicians actually caused disease with their treatments before realizing that medical errors needed to be addressed. Patient safety is frequently seen as a primary guiding principle in healthcare institutions however, it cannot be a stand-alone goal and must be viewed within its relation to other objectives. Close scrutiny must be accompanied by methodical actions for improvement.94 Creating a culture of safety is one that has ethical implications of obligation to the patient from both a practical and professional standpoint.95 Safety is of paramount importance in the nursing home environment and in establishing a culture of safety Wachter clearly describes three necessary points for establishing this culture which are: the reporting of errors, the predilection for blaming, and a priority for improving patient safety.96 That notion is further expanded by Vincent as he refers to the work of Weick and Sutcliffe (2001). They describe culture in general in six sections: 1) common assumptions made throughout an organization, 2) these common beliefs are
developed within the organization, 3) these common beliefs are a result of having to change to address a problem and to integrate the changes within the organization, 4) the common beliefs have proven to be effective for continuation, 5) the common beliefs are taught to new affiliates of the organization, and 6) the common beliefs are thought to be the accurate view of dealing with the area of concern. These steps provide the framework for changing a culture and Vincent notes four features when focusing on safety which are: openness, blame, reporting, and learning. The ethical principles of beneficence and non-maleficence are intertwined with safety cultures in that they are both concerned with doing the right thing for the patient in preventing harm. They are also steeped in the basic concept of safety which is to act for the benefit of others and to prevent harm. Organizationally, healthcare combines its many facets to coordinate the services and the providers in such a way that each individual patient is receiving the intended care and treatment. In order for those processes to occur precisely there needs to be an assurance in each step which is directed toward preventing harm. The challenge is in engraining that edict throughout an organization so that it becomes intrinsic in the way of thinking and acting. In such a critical area as safety the idea of moral disengagement could be deadly. Self-sanctions need to be enacted personally for the leadership to recognize the accountability and the responsibility they have for the lives within the nursing home.

Since 1970, the Occupational Safety and Health Act (OSHA) have dealt with safety in the workplace and closely monitor healthcare organizations. The three main areas that are addressed through this act are to meet the OSHA standards, cooperate in inspections, and maintain the required records. The employer is expected to provide a workplace that is safe and free of hazards while the employees are expected to follow the
OSHA standards. The Life Safety Code arises from the National Fire Protection Association and includes national fire safety and building standards within healthcare. Nursing homes are inspected annually for meeting the standards of the Life Safety Code which include such areas as fire protection systems, hazardous areas, emergency power, and the construction standards for the buildings.

Moral courage plays a large role in patient safety with courage being founded in ethical risk-taking behaviors even with the presence of fear. The leadership is responsible for the oversight and directions of these programs of accountability and has made a commitment to their communities to safeguard these people. There is a duty within this courage by the NHA to emphasize this notion within and outside of the organization. Moral courage is a manifestation of advocacy for the patients in doing the right thing and safety is at the core of action for the patients.

b) Medical Errors, Harm, and the Human Factor

An important factor to realize in errors that are the result of human involvement is that humans integrate information about their environment, translate it, and then act on it. The key understanding is that all three of these functions are reliant on the individual’s point of reference causing different reactions to the same situations. There is a break between the person’s view of the situation and the decision for response and the complete facts of the situation.

When actual harm is caused it is from not giving appropriate care, giving inadequate basic care, or having some type of mistake occur from an appropriate care or treatment intervention, which have a wide range from a small abrasion to death. The propensity for risk is increased by experience meaning that the more a person is exposed
to a potentially risky situation the greater the risk for a negative outcome. Risk is influenced by the perceptions of the risk as well. The level of control to avoid the risk, the probability for a negative outcome, and the type of danger all play into the perceived risk which is tied to human behavior.¹⁰⁶

Training and enhanced communication is necessary to improve a culture of safety. There are proven strategies for improving errors through teamwork. Four fundamental areas for focus start with the leadership of the organization making safety a priority and clearly communicating the expectations to all persons. The leadership must continuously discuss and exhibit safety through actions and keep it the focus on attaining and maintaining the level of importance that is required. Using examples from other industries allows the healthcare team to translate the improvement opportunities in the examples into their own setting; ideas are moved into action. Utilizing simulations for developing a safety culture have conflicting views as to their relevance but the context of the training and the seriousness of the need for improved safety will give direction on its appropriateness. A positive outcome for simulation is a quick buy-in for changing the culture. The final approach is that the trainings need to be ongoing. Expecting to keep any initiative a priority requires that it be continuously discussed and evaluated.¹⁰⁷

The human activity within healthcare institutions is looked at as: routine operations, maintenance activities, dealing with unusual occurrences, and resourceful activities. Each individual has a unique perception of the situation based on experiences, beliefs, and values which serve as a filter for interpreting the actions to take in a situation. This filter will mirror the degree in which a culture of safety is embedded within the organization and when errors do happen they are classified according the type of error.¹⁰⁸
Within a culture of safety human errors need to be seen as chances to learn however they require that they be admitted which has been hindered by legal actions and threats to careers.

Simply by communicating and teaching expectations for safety to healthcare providers does not insure that cultures of safety are effectively in place. There are ways for nursing homes to monitor that the requirements are carried out properly and when an error does occur, there are processes to determine the causes and adjust for future avoidance. When focusing on human error, the notion that the human condition incorporates error into human nature, then the way for compensating is in the utilization of systems for abating mistakes.\textsuperscript{109}

3. Strategies for Prevention

To develop a culture of safety there needs to be four fundamental areas for focus which are: making safety a priority, using examples from other industries as analogies, utilizing simulation for training, and providing ongoing trainings.\textsuperscript{110} There are such errors that are termed as “never events” by the National Quality Forum (2004) and although rare, are in the realm of worst-case safety errors such as death in a bedrail, surgery on the wrong body part, or a patient suicide. The event categories are broken into: surgical, product or device, patient protection, care management, environmental, and criminal.\textsuperscript{111} Within hospitals the characteristics attributable to the best patient safety outcomes were those that were developed by the Joint Commission for the Accreditation of Hospitals (JCAHO). This organization implemented patient safety criteria in 2003 and tied accreditation to them. Some of the areas emphasized were computerized physician order entry, the existence of formalized patient safety programs, conducting safety rounds and
inspections, implementing policies for specific safety concerns, and the utilization of data in safety programs which is available in aggregate for leadership decisions making.\textsuperscript{112} The JCAHO’s 2014 National Patient Safety goals covered such issues as using medication safety, identifying patients correctly, and preventing infections.\textsuperscript{113}

a) Working in Systems

The goal of a safety culture is to ultimately prevent medical errors from occurring but when harm is done then there needs to be a systemic approach to preventing reoccurrence. Thinking in systems is an increasingly necessary competency for healthcare professionals as they manage the many functions that must come together correctly for proper care delivery. Nursing homes as a delivery system is very complicated and within that framework decisions are constantly being made at all levels that have ramifications for patient safety. Complexity Theory is an approach that can be employed to sort through such situations as a culture change for safety. Simply put, large organizations such as in healthcare are constantly changing, are unpredictable, and rely on interdependency among many people to accomplish the mission of providing care. Such an organization does not follow a linear path but has activities that are moving in all directions to accomplish the purpose. There are three levels for utilizing this theory: simple, complicated, and complex, which is determined by the type of solution that is needed. The main rules for this theory which are adapted for healthcare are: 1) the relationships between the departments are more important than the departments themselves, 2) the healthcare organization is constantly changing, 3) the professionals within healthcare are often independent decision-makers, 4) inconsistency and ambiguity are the nature of healthcare, 5) problems can be improved if the trends causing them are
understood, 6) problem solving can be accomplished with minimal alteration, 7) big improvements can be made even with simple changes, 8) behaviors within an organization show trends in action, and 9) change is easier to be realized when behavior patterns are affected.\textsuperscript{114} Thinking complexly is thinking in terms of processes that require ongoing review rather than seeing individual actions within defined time periods. Individual components of care are brought together that must interact together in a relational way that is good for the patient.\textsuperscript{115}

b) Models of Risk Management

Risk Management programs are to improve resident safety and quality and ensure compliance with legal, regulatory, and policy requirements through risk detection, evaluation, and prevention. The scope of a program is facility-wide and includes risk assessment in all areas of the organization. Quality and safety are addressed interdependently for the protection of the patients, visitors, staff, and the assets of the facility. The increase in lawsuits within healthcare and against nursing homes has placed more focus on managing risk and the identification of areas that are more prone for legal activity. The positive aspect of this focus is that the quality of the services is also impacted in a positive way. Some the areas that receive high litigation attention are: falls with injuries, chemical restraints when medications are misused to sedate a patient, nutrition and hydration resulting in malnutrition and dehydration, pressure ulcers, medication errors and the use of multiple medications.\textsuperscript{116} The Nursing Home Administrator is responsible for implementing and enforcing the risk management components.
Two such models for risk management are the Advanced Incident Management System (AIMS) and Root Cause Analysis (RCA) which is utilized by the Veterans Administration National Center for Patient Safety. Both of these methods focus on systematic failures rather than placing blame on individuals. AIMS give an all-inclusive approach to reporting errors with connections to the process improvements that emerge. Concepts of deconstructing occurrences are used with the integration of safety, quality, and risk management.\textsuperscript{117} RCA consists of a team who are closely linked to the processes and systems that are being evaluated. The goal is to obtain accurate information that led to the error and to follow a specific process that includes a problem statement, root causes that contributed to the event, flow charts, and cause and effect diagrams. The final step is to develop root cause statements that show why the event happened. Human contributory actions must be preceded by a cause.\textsuperscript{118} James Reason offers an approach that is widely used called the Swiss cheese model (SCM) for accident analysis.\textsuperscript{119} The Swiss cheese model is based on the idea that the holes in the cheese represent holes in a process for errors to slip through. The analysis and improvement processes are to result in closing or making the holes smaller to reduce or eliminate the amount of errors that can get through. Blaming is not the focus in this model and the goal is to limit the opportunities for error. RCA concepts are used in this model as well which go to the core of the problem resulting in the implementation of changes to the processes.\textsuperscript{120} Other such examples of culture changing activities in safety are the use of the checklist and record reviews. The checklist accomplishes much in its simplicity by offering standardization, reinforcing proper procedures, and providing a secondary review that the safety-focused activities are in place. In serving as a reminder the
checklist has avoided many serious medical errors that could have happened needlessly. Of importance to note is that checklists alone do not change the culture of safety but are one approach. Systematic record reviews are also used to monitor safety in a particular point in time or as a study over time. The use of an identifier known as a “trigger tool,” which can be a word or action, is linked to a possible adverse activity which is located within the medical record.

The professionally developed training programs of TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) and Health Workplace Intervention both suggest ways to get a team to develop a mindset for providing quality care and patient safety. Health Workplace Intervention is a team building process for designing and implementing a vision of a healthy workplace. There is a defined past, present and future vision for the work unit in establishing the plan with the idea that the strengthening of the team improves the commitment of the team to each other, increases job satisfaction, and creates a safer care environment for the patients. TeamSTEPPS, was developed through a combined effort of the Department of Defense and the Agency for Healthcare Research and Quality to provide education to improve the functioning of teams in the provision of care. The curriculum covers leadership, situation monitoring, mutual support, and communication which are combined to remove obstacles that contribute to safety concerns. Through the development of these core competencies the team is able to be more flexible as they work together to achieve the desired outcomes.

c) Measuring Safety

Measuring safety in nursing homes is not an easy task due to the many elements that enter into a disease and illness process. Harms can be caused by the disease as well
in the attempts to cure which are not always known for some time. Determining indicators to measure are difficult because of these factors with the addition of events of error being uncommon, the numbers of people at risk for harm are difficult to determine, and because self-reporting is the main way of communicating errors. Regardless of the challenges, the approaches taken to measure safety, like quality, are through structure, process, and outcomes and many healthcare professions have standardized measures that speak a common language of care and safety improvement.126

High Reliability Organizations (HRO) gained the reputation with the airline industry as becoming almost mistake-free in their pursuit of safety. HRO’s share common foci in having a fixation with failure, a commitment to identifying potential safety problems and developing prevention measures, and a sensitivity to the safety concerns of the frontline staff which would be the direct care workers in the nursing homes. The idea of HROs has evolved with safety culture development for healthcare organizations127

The Institute of Medicine published To Err is Human and Crossing the Quality Chasm in 1998 which discussed the significant need for improvement in safety and quality within healthcare.128 This study estimated that at that time there were 98,000 deaths in hospitals annually due to medical errors and served as a wake-up call to everyone in healthcare that there needed to be an emphasis on safety and prevention.129

4. Moral Obligations for Errors

In 2004 the World Health Organization World Alliance for Patient Safety commenced for promoting cultures of reporting errors for learning and future prevention.130 Medical errors will occur due to human nature and at the same time the
general public believes that no medical mistakes should occur. Medical errors will occur because there are no perfect humans or perfect systems however there is an obligation to minimize the scope and severity of harm or the potential for harm within the nursing home. A main factor in improving the safety within the facility it to know that a problem exists which involves the reporting of safety concerns.

a) Reporting

Trust in healthcare institutions is compromised regarding the inconsistencies for reporting errors. In addition to the prevention of medical errors there should be a focus on the ethical concerns surrounding disclosure so that professionals are not negatively affected for truth telling. Organizations must establish cultures that allow for open, honest, and transparent communication of adverse events. The current systems for reporting still incite fear of disciplinary action and are unclear in communicating the incidents for reporting. In addition there is little understanding as to how to analyze the data to use in the prevention of unsafe practices. The probability for a health professional to report unsafe practices is significantly influenced by the support of the supervisor such as the NHA in the nursing home, and the role identity. Role identity occurs when the position at work becomes adopted as part of the self. The strength of the role that has been assumed will determine the behavior that is exhibited. The stronger the role identity, the more likely the person is to report unsafe practices. Nursing homes have mandates for reporting that are determined and managed by each state which includes the notification of professional licensing boards for some types of incidents. These requirements can create barriers for the NHA in attempting to eliminate the “blaming” aspect of reporting in creating a culture of safety. Obviously, reporting
unsafe practices or actual incidents resulting in harm require moral courage. Some of the risks involved may be the loss of a job or a nursing license for a co-worker but that must be weighed against the effect the actions have had or could have on the patients and residents. In an environment that has a strong ethical climate with a culture of safety, there would be no question as to the correct actions to take. The NHA has the ethical responsibility to insure that both are well established within the nursing home.

b) Patient Notification

Errors will happen within the complex systems of nursing homes but how they are handled is critical to meeting the moral obligation of the organization and promoting trust in the relationship with the patient. The patient deserves to know the truth and a sincere apology is necessary in taking full responsibility and respecting the patient, however it can’t stop there and requires that solutions for future prevention must be taken.\textsuperscript{136} Apologizing is difficult for many, but it takes moral courage to do so, particularly with the litigious environment in healthcare. When delivering a genuine apologizing, there are general elements that should be included which are: 1) recognition of the harmful incident, 2) communication of regret or sympathy, 3) accepting responsibility, 4) making amends, and 5) providing follow up communication.\textsuperscript{137} Healthcare professionals have a fiduciary duty to report medical errors but there is often a conflict between protecting the organization and to the patient’s right to know.\textsuperscript{138} Failing to disclose medical errors to patients cannot be justified ethically.\textsuperscript{139}

Courage instigates action which is crucial to patient safety.\textsuperscript{140} With this courage the nursing home leadership must create a culture of safety through the use of the core competencies of: leadership, communication, professionalism, business acumen, and
comprehension of healthcare.\textsuperscript{141} In addition to the competencies is also the cultivation of a culture that provides for openness and fairness, assessing situations rather than simply placing blame, rewarding the reporting of problems, and learning from errors to provide for future improvements.\textsuperscript{142} Moral courage is required to admit wrongdoing but when the safety of patients is at risk there is a moral obligation. The leadership must endorse an organizational culture that does not censor information about errors and safety by direct or indirect means. The culture of safety is directly linked to the organizational culture created by the leadership which promotes the value in the disclosure of safety concerns.\textsuperscript{143}

D. The Function of Compliance and Ethics Programs

The initial concepts for compliance and ethics programs came out of the Justice Department and the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) respectively. These initiatives were in response to the increasing need to address patient care concerns with business practices through organizational ethics and the growing fines for fraud and abuse within the healthcare system. In an attempt to take proactive steps to mitigate the potential for accidental or intentional violations, organizations began to incorporate ethics and compliance programs. Such fines could be reduced if such programs were in place and were established according to the federal standards. Compliance and ethics programs can be instituted separately or combined, however if divided the concern is that there will be two entities working on similar areas of concerns with differing agendas.\textsuperscript{144} For explanatory purposes compliance and ethics programs will be presented individually in the next section.
1. Compliance Programs

a) A Historical Basis

In 1997 the Office of the Inspector General (OIG) distributed guidelines for the establishment of compliance programs to deter fraud and abuse within the Medicare and Medicaid programs. The point was to enforce the state and federal laws however the compliance programs needed to incorporate both ethical and service into the framework to be principled and focus on a high level of patient care. Title VI within the Affordable Care Act refers to *Transparency and Program Integrity* to address compliance and ethical concerns. For compliance programs, that will mean addressing fraud and abuse and enforcing new disclosure requirements. Compliance programs also recommend some form of anonymous reporting avenue for wrong-doing to eliminate the fear of retaliation. For the nursing home this requirement is typically administered through some form of “Hotline” that is investigated by personnel designated as corporate compliance officers.

Within skilled nursing facilities compliance programs continue to be involved in the Medicare and Medicaid programs and the potential for fraud and abuse which was the original OIG directive. Where physicians are concerned, they only partially address the issues of physician conflicts of interest. The Anti-Kickback Act of 1972 was established to deal with fraud related to physicians referring to services that will increase their income through incentives from ancillary companies or through direct ownership. The Stark Law (1989) prohibited physicians from self-referral for services such as laboratory or home health services. The Civil Money Penalty Law assesses fines to physicians if the
previously stated laws are violated and the amounts are based on the severity of the actions.\textsuperscript{148}

b) The U.S. Organizational Sentencing Guidelines

In 1991 the U.S. Organizational Sentencing Guidelines came into effect for corporations, partnerships, labor unions, pension funds, trusts, non-profit entities, and governmental units. These outline the punishments for misdemeanors or felonies for criminal conduct within organizations. Although organizations cannot be imprisoned, their punishments can consist of fines, probation, requirements for making restitution, and publicly disclosing their wrong doings.\textsuperscript{149} The U.S. Sentencing Commission recommends oversight at the highest levels of the organization, 2) the use of due care in assigning discretionary responsibility, 3) effective communication of the compliance expectations to all levels of the organization, 4) establishment of systems to allow for monitoring, reporting, and investigating suspected compliance violations, 5) consistent application of the guidelines, and 6) appropriate and effective systems for responding to instances of determined violations and prevention of future occurrences.\textsuperscript{150}

The compliance program within the nursing home is tasked with the prevention of illegal activity and the proper development and implementation of the program must be accurate and thorough. For the programs to be effective they must be supported at the highest levels of the organization which means the NHA at the facility level, and be embedded in all facets of the operation on a daily basis.\textsuperscript{151}

2. Ethics Programs and Committees

Ethics programs can take on either a regulatory slant or one that is based in values. The first is more of a compliance view and tends toward an emphasis on meeting
established criteria, rules, and employee behavior. A values approach is geared towards the advancement of shared values within the organization and ethical objectives.\textsuperscript{152} Years of research has concluded that organizationally, ethics is primarily concerned with difficulties surrounding integrity, responsibility, and preferences in decisions.\textsuperscript{153} Within nursing homes the ethics program is usually found in an ethics committee, if one exists, that is mainly concerned with patient care and rights issues.

a) Consultations

Ethics Committees originated from the President’s Committee in 1983 for the purpose of consulting on difficult clinical decisions, providing education on ethical topics, and formulating policies and procedures from an ethical perspective.\textsuperscript{154} Ethics committees as a forum for discussing ethical dilemmas grew from 26\% to 60\% during the period of 1983 through 1986 and are present in some form in most healthcare institutions today.\textsuperscript{155} The case that determined the need for ethics committees for guidance in ethical decision making was the landmark case of Karen Ann Quinlan which set a precedent for the right to die. At the age of 21 Karen Ann was placed in a persistent vegetative state (PVS) after consuming alcohol and drugs and was placed on a ventilator. The New Jersey Supreme Court ruled in favor of removing the ventilator at the request of the parents with support of the Catholic Church. Karen Ann continued to live for another 9 years in a nursing home until she died of pneumonia.\textsuperscript{156} Until the mid-1980s there were few ethics committees that had been established initially following the Quinlan case. The Catholic hospitals, however, had been operating with such a system since the 1940s under the name of “medico-moral” committees.\textsuperscript{157}
The core areas for knowledge for consultation as established by the American Society for Bioethics and Humanities for ethics consultation are: 1) moral reasoning and ethical theory, 2) typical bioethical issues and concepts that are addressed in ethics consultations, 3) healthcare systems operational areas that includes managed care and government structures, 4) clinical framework such as medical terminology and common medical problems, 5) information about the healthcare facility where the consultation is occurring, 6) specific policies about the healthcare organization related to the ethics committee, 7) beliefs and viewpoints of the patient and others involved in the dilemma as well as the organization, particularly if there is a religious affiliation, 8) applicable codes of ethics, professional conduct, and guidelines of accrediting bodies, and 8) health law as it pertains to the situation and the ethics committee.\(^{158}\)

Ethics Committees within healthcare organizations have typically convened to address ethical dilemmas surrounding end-of-life issues but as the role of this group is seen as being able to expand into areas that have an ethical impact on the organization such as managed care and the Health Insurance Portability and Accountability Act (HIPAA) regulations.\(^{159}\) The top four factors most important for the success of an ethics committee according to a national survey (2001) is: participation, communication, skills, and composition.\(^{160}\)

b) Education

The educational component of the ethics committee is the most lasting and provides the foundation for being able to thoroughly and knowledgably conduct consultations and develop policies for the organization. Ethics education is not limited to the committee functions but is carried out into the daily work environment and raises the
level of moral competence. The educational programs are to increase the strength of the ethics committee members but this element is also charged with providing ethics training throughout the healthcare organization as well as the community. Utilizing a variety of approaches to facilitate learning for the staff will increase their interest. Present relevant information to the different positions and departments throughout the facility. Incorporate this training into existing meetings and communications on a regular basis so the importance of ethics is conveyed and the message is consistent. Topic examples for education are: confidentiality, HIPAA, conflicts of interest, advanced directives, patient self-determination, codes of conduct, patient abuse, and reporting requirements for ethical violations.¹⁶¹

Nursing homes do not yet have ethics committees in place with any regularity. Ethical dilemmas that involve differences between family members and the patient of a serious matter such as determining end-of-life issues may be discussed by bringing together the administrator, director of nursing, medical director, and perhaps an attorney. A specific process geared toward bringing ethical dilemmas to resolution is not likely to be used. For skilled nursing facilities that are located within hospitals or are part of a hospital system are more likely to have access to a committee as a resource or have a better understanding of the process. The educational role of an ethics committee could be very beneficial to developing the interdisciplinary team in nursing homes by assisting them in expanding their knowledge of ethical concerns. There could also be an increase in awareness for including ethical thought into decisions and assessments of situations. Knowledge can be a requirement for moral courage to be enacted. If there isn’t an understanding that a circumstance is ethical in nature then there cannot be an
understanding of the need to take moral action. One of the most influential ways of teaching moral courage is through the actions of the leader of any organization and the NHA can use the ethics committee as a more formalized approach that can provide supplemental information. For moral courage to become entrenched in the nursing home culture the employees need to gain a level of practical knowledge and skills that become habitual and are unhesitatingly available.  

c) Policy Development

A function of the ethics committee can be to develop or review policies and procedures for the organization. The purpose is to incorporate ethical considerations within the policies which will serve to ally the clinical and operational areas in the establishment of their moral agency. Problems that arise from clinical issues sometimes originate in other organizational areas such as billing practices for care delivery, physician paternalism and nondisclosure, access to care, and utilization review. The ethics committee can take three positions regarding their involvement in policy development which are: to be receptive to participation, to be an advocate for policy development, and to be a mandatory part of the policy development process. The receptive approach to participating is to be open to giving policy advice which is typically in non-clinical areas because expertise is usually needed for clinical evaluations. As advocates, the ethics committee may realize that a new policy or a change to an existing policy is needed and the appropriate process within the organization is followed for consideration. This may be an issue that evolves through the course of consultation or from interactions and feedback from the educational sessions. Whatever the means, the committee has a sense of obligation to submit the proposal for change. The third position
for mandatory involvement in policy may be a factor of the institutional process or policy that requires some or all non-clinical policy changes to be evaluated ethically through the ethics committee.\textsuperscript{164}

The ethics committee could also adopt the notion of seeking opportunities throughout the organization that minimizes the risk for unethical activity by developing core values that guide the organization which was covered within moral agency.\textsuperscript{165} The compliance and ethics programs can be incorporated into establishing an ethical culture within the organization.\textsuperscript{166} In the heavily regulated world of nursing homes there is an ongoing need for ethical education and policy and procedure review. These compliance and ethics programs can provide ongoing support for the leadership in maintaining moral courage within their decision making capacities that translate into a positive ethical climate. The most basic and mutually shared value of all professionals in healthcare is the care of the patient. Bringing together members within the nursing home to discuss areas of discourse can serve to provide support throughout the organization for ethical behavior which will include modeling moral courage on the part of the leadership.\textsuperscript{167}

E. Conclusion

The NHA establishes the moral agency for the nursing facility. This is portrayed throughout the nursing home through the actions that are separate from the messages that are communicated through the mission, goals, and vision of the organization. Whether moral agency is displayed through the processes within an organization or through the individual choices of the people who represent the organization, it comes down to the moral judgment that translates into the conduct.\textsuperscript{168} The leadership of nursing homes must be vigilant about promoting a culture that encompasses the ideals of a virtuous
organization. Trust is a concern for the nursing home industry based on historical roles for the healthcare facilities and the continuous negativity that is represented through the media. The leadership needs to be keenly aware that its conduct must be linked back to the mission and must be connected to the ethical decision making process.\textsuperscript{169}

When looking at the challenges in managing the rapid changes in healthcare, the nursing home leadership is faced with finding ways of working with fewer resources while the needs of the patients’ continue to increase. Character will need to be cultivated through persistent courage with integrity in order for these healthcare professionals to act ethically.\textsuperscript{170} The members within the nursing home make up the moral agency that is directed by the organizational philosophy, professional codes, and regulatory requirements. The measures are clear indicators of the direction of the ethical climate which must be built on a foundation of trust which is critical in developing a positive ethical climate and moral courage helps to build this trust. Foundational areas in nursing home management that require strong ethical approaches are those creating cultures for quality and safety. Moral courage must be in a heightened state of alert in maintaining these two areas, and moral courage succinctly asserts that the leader is not only moral but is also courageous by the behaviors that are exhibited.\textsuperscript{171} The message was repeatedly noted that the highest levels of any organization must foster the prioritization for ethical actions. Moral courage is most certainly a requirement in ethical leadership in nursing home management which has been shown to be highly influential on the ethical climate and culture development. To quote Miller who said that, “Courage is one of those things that can only be properly attained by doing it. To get courage, be courageous.”\textsuperscript{172}

\begin{flushleft}
\end{flushleft}

Spencer, Mills, Rorty, and Werhane, Organization Ethics, 15-30.


Spencer, Mills, Rorty, and Werhane, Organization Ethics, 146-150.

Pearson, Sabin, and Emanuel, No Margin, No Mission, 26-27.

Darr, Ethics in Health, 380-383.

Darr, Ethics in Health, 384.

Storch et al., “Listening to Nurses’, 7-16.


Spencer, Mills, Rorty, and Werhane, Organization Ethics, 84-91.

Leiyu Shi and Douglas A. Sigh, Essentials of the U.S. Health Care System (Subury, MA: Jones and Bartlett, 2010), 246-248.


Allen, Nursing Home Administration, 518-521.


Spencer, Mills, Rorty, and Werhane, Organization Ethics in Health Care, 148-149.


Spencer, Mills, Rorty, and Werhane, Organization Ethics in Health Care, 148-149.


46 Pearson, Sabin, and Emanuel, No Margin, No Mission, 153-166.
48 Alice E. McDonnell, “Administration Within Long-Term Care,” in Geriatric Health Services, ed. Alice E. McDonnell (Burlington, MA: Jones and Bartlett, 2013), 9-11.
51 Spencer, Mills, Rorty, and Werhane, Organization Ethics, 130-135.
53 Spencer, Mills, Rorty, and Werhane, Organization Ethics, 92-93.
55 Schein, Organizational Culture, 25-27.
56 Schein, Organizational Culture, 27-33.
61 Chun-Chen Huang, Ching-Sing You, and Ming-Tien Tsai, “A Multidimensional Analysis of Ethical Climate, Job Satisfaction, Organizational Commitment, and Organizational Citizenship Behaviors,” Nursing Ethics 19 (2012): 513-529.
73 Allen, Nursing Home Administration, 306-309.
74 Darr, Ethics in Health Service Management, 357-359.
75 Pearson, Sabin, and Emanuel, No Margin, No Mission, 100-101.
76 Huang, You, and Tsai, “A Multidimensional Analysis,” 513-529.
77 Johnson, Meeting the Ethical Challenges, 69-71.
79 George D. Pozgar, Legal and Ethical Issues for Health Professionals, 2nd ed. (Sudbury, MA: Jones and Bartlett, 2010), 385.
84 Shi and Singh, Essentials of the U.S. Health Care System, 289-293.
90 Shi and Singh, Essentials of the U.S. Health Care System, 294.
97 Vincent, Patient Safety, 269-274.
98 Runciman, Merry, and Walton, Safety and Ethics in Healthcare, 157-158.
100 Allen, Nursing Home Administration, 334-337.
101 Shi and Singh, Essentials of the U.S. Health Care System, 246.
102 Peter J. Buttar, Principles of Long-Term Health Care Administration (Gaithersburg, MD: Aspen, 1999), 9-14.
105 Runciman, Merry, and Walton, Safety and Ethics in Healthcare, 112-113.
106 Runciman, Merry, and Walton, Safety and Ethics in Healthcare, 29-51.
107 Wachter, Understanding Patient Safety, 264-269.
108 Runciman, Merry, and Walton, Safety and Ethics in Healthcare, 112-162.
109 Runciman, Merry, and Walton, Safety and Ethics in Healthcare, 109-110.
110 Wachter, Understanding Patient Safety, 264-269.
111 Vincent, Patient Safety, 105-106.
117 Runciman, Merry, and Walton, Safety and Ethics in Healthcare, 197-199.
118 Runciman, Merry, and Walton, Safety and Ethics in Healthcare, 206-217.
121 Wachter, Understanding Patient Safety, 269-271.
122 Vincent, Patient Safety, 104-105.
126 Vincent, Patient Safety, 96-102.
127 Wachter, Understanding Patient Safety, 255-258.
166 Pentz, “Core Values,” 225-234.
168 Charles Garofalo and Dean Geuras, Common Ground, Common Future, Moral Agency in Public Administration, Professions, and Citizenship (Boca Raton: Taylor and Francis, 2006): 142-144.
Chapter Six: Developing Moral Courage for Leadership Effectiveness

In moral courage attention is drawn to “righting” a wrong that has not been addressed and can mean that there are no other supporters who are willing to agree with the stance taken which may also result in social disapproval.¹ Purtilo offers that today’s healthcare arena is perpetually changing and therefore it is paramount that healthcare professionals understand what moral courage is, its importance within healthcare, and the need for it to be revealed when encountering ethical dilemmas.² Skills and competencies as an NHA are needed to be able to address potentially controversial concerns and this often means standing alone as the leader. To be able to function as an ethical leader is to progress and mature in asserting moral decisions. Understanding and acting with moral courage is not an automatic response for some people and they require training which may come through educational programs, mentoring, or evaluating case studies. The development of the NHA can be further enhanced by using models of moral courage as guidelines.

A. Leadership Skills and Competencies for Effectiveness

Competencies were addressed in Chapter Four with an emphasis on moral competencies, however to discuss the development of leadership skills and moral courage, it is appropriate to revisit them. To being, there needs to be an understanding of the difference between skills and competencies. Skills are acquired through intentional, methodical, and continual use involving cognitive, technical, and interpersonal skills. They are learned abilities for implementing job functions. Competencies include skills but go beyond that with the addition of behaviors, knowledge, and proficiencies to be able to utilize skills. These allow for the effective use of skills through patterns of

270
continuous performance. In short, skills explain “what” is to be done in a job and competencies explain “how” to complete the job requirement.³

1. Skills

There is a skills-based leadership model that looks at three main components which are individual attributes, competencies and leadership outcomes. This approach focuses on the capabilities that are necessary for effective leadership rather than just exploring the tasks of the job which would be the NHA in this instance. Individual attributes includes cognitive abilities, motivation, and personality, and leadership outcomes consists of effective problem solving and job performance. The middle section of this model, competencies, is the one for more emphasis within this section of the chapter. Competencies are comprised of skills in problem-solving and social judgment and knowledge surrounding the responsibilities of the job. Problem-solving engages creativity in the process of arriving at solutions. Social judgment skills include the ability to understand the nuances of people and social structures and how to appropriately navigate within those interactions through perspective taking, social perceptiveness and social performance. Knowledge is directly linked to the problem-solving capacity for an NHA, for without a reasonable degree of knowledge related to healthcare and nursing home operations, there will be limitations in finding appropriate solutions to problems.⁴

2. Competencies

Competencies are defined as features required for the job that have an element of behavior associated with them.⁵ Confusing management and leadership competencies is common although the skills necessary for leadership are different from management.⁶ A directory for competencies for healthcare administrators was developed that consist of
300 competencies which are divided into the five domains of leadership, communication which included relationships, professionalism, business knowledge and skills, and healthcare knowledge.⁷

There are basic tenets to dealing with people and situations in productive ways that lead to acceptable solutions even if there is disagreement. Mastering such skills pulls from a variety of areas within competencies. While there have been many books written about the skills and abilities a leader needs to attain to be successful, an early writing that has stood the test of time in outlining guidelines. Written in 1937, How to Win Friends and Influence People by Dale Carnegie, places the competencies for leadership in a very rudimentary way. In four parts he sums it all up in: 1) techniques for handling people, 2) how to be likeable, 3) how to influence people to your view, and 4) how to be a leader. The outcome of all of the points he makes in the book are formulated into nine principles that comprise the area of human relations. Carnegie incorporated an ethical slant to changing people’s attitudes and behaviors through the development of interpersonal skills.⁸ Being an NHA is to deal with people from all angles and on any day that could include residents, patients, employees, vendors, family members, regulatory agencies, community members, and doctors. The list could go on but the point is that finely developed interpersonal skills are a significant attribute. Being likeable certainly allows for the NHA to be more approachable in formulating relationships and being able to engage more easily with others. The “likability factor” may allow more access into obtaining information earlier in potentially problematic areas. Influencing others to follow directives is a requirement if the facility is to move forward, however that is assuming that the direction is an ethical one. Lastly, being a leader is not an option for
NHAs. To be merely a manager will reduce the operation to be task driven which will not contribute to achieving the full potential of the nursing home which provides an ethical and caring atmosphere.

In the constantly changing healthcare environment there are new challenges presented every day and the leadership competencies that are needed to be successful today are different from the past. A survey conducted by Hartman and Crowe (2002) surmised that there are five necessary skills for leaders to be effective which are: 1) developing a strategic vision, 2) establishing goals for translating the vision into actions, 3) formulating a strategy to achieve the goals, 4) implementing the strategy, and 5) assessing the implementation process and outcomes with adjustments to the plan if necessary. Peter Drucker noted that managers seem to view effectiveness and efficiency incorrectly and clarifies that the difference is in “doing the right things and doing things right.” Often times much effort is placed in accomplishing tasks that shouldn’t be done at all.

Recent research has shown that the Administrator-In-Training Program (AIT) is an essential element in the development of leadership skills and competencies necessary for a nursing home administrator to be successful. There is a wide range of training and educational requirements for NHA licensing which is determined by each state and the AIT program entails that an NHA candidate completes on-the-job training for a period of time under the guidance of a preceptor who is a licensed NHA. Although the concept is a good one, the quality of the training is not always adequate to prepare a person to run a nursing home successfully, although the requirements for obtaining a license may have been met. Two important factors in acquiring the necessary skills and competencies are
the attitude toward learning in the facility where the AIT takes place and the experience of the preceptor. The features of training locations for AITs that influence the quality of the training and preparation for success as an NHA are: 1) the quality of the preceptor related to experience as an NHA, experience as a preceptor, the number of years at the specific facility where the training is occurring, and professional involvement, 2) the attitude of the facility towards the AIT program in that there is a continuous learning environment, the department managers are competent and able to provide quality training within their specific areas, and organizational support is provided for professional development, 3) the importance of culture change is stressed and there is participation in the Advancing Excellence in America’s Nursing Homes initiatives, and 4) there are various levels of care and services offered at the training site in addition to the skilled nursing facility such as dementia care, assisted living, and community-based programs.\textsuperscript{11}

The Advancing Excellence campaign was established in 2008 for the specific purpose of providing resources for improving the quality in nursing homes.\textsuperscript{12}

**B. Strategies for Developing Courageous Leadership**

NHAs completed self-assessments in a study related to their preparedness for the position of leading a nursing home. The results showed that they preferred to be trained in more formalized methods through Administrator-in-Training programs, bachelor degree curriculums, and mentoring for entry-level competencies and skills. They were less inclined to prefer training for developing these competencies through “on-the-job training, previous job experience, and self-study” options.\textsuperscript{13}

Brandstatter and Jonas propose moral courage to be a necessary competency for anyone who is considered to be a bystander in today’s society. They note that moral
courage is shown in extreme situations as well as smaller scale expressions. People may want to act in morally courageous ways but may not know how to do so. There is an interruption between a person’s feelings of wanting to react in morally courageous ways but the behavior does not follow the feeling. Therefore, they offer two training programs for developing moral courage which are the Gottinger Zivilcourage-Impuls-Training (GZIT) and the Zurcher Zivilcourage Training. These trainings are theoretically similar and have a goal of making people more sensitive to violence within neighborhoods, offering methods for getting involved in the situations, and increasing attentiveness to be aware of potential situations requiring actions of moral courage. These programs last between one and for days and exercises are conducted with the participants to differentiate between perceived and actual helping behaviors which are based on an adaptation of the Latane and Darley model of helping to a model for bystander intervention in which opportunities for enacting moral courage are added. Rules of conduct within the group are presented and role playing and mental simulation techniques are also used to develop competencies resulting in moral actions.14 The adapted Latane and Darley’s model for bystander intervention could be further adjusted for use in a nursing home setting with the NHA. The model consists of five questions which are asked as part of the learning process for developing moral courage. If the answer to each is “no,” then no acts of moral courage are taken. The following adaptation is an NHA example:

*The ethical issue identified is:* Due to illness and vacations the required staffing ratios for the nursing department for the direct care of the residents and patients will not be met for the evening care unless more staff is obtained from other sources.

*Question 1:* Does the NHA perceive that there is an ethical situation?
**Question 1:** Does the NHA perceive adequate staffing levels for care as an ethical issue?

**Answer 1:** No, because he is in a hurry to leave work at the end of the day and doesn’t check with the Nursing Department to see if there is adequate staffing to provide care.

**Question 2:** Does the NHA perceive adequate staffing levels for care as an ethical issue?

**Answer 2:** No, because he sees staffing challenges as just another function of managing a nursing home and doesn’t perceive it as an ethical concern. Having employees not show up for work for a variety of reasons is frequent. The NHA is not seeing the consequences of the situation which could compromise the quality of care for the residents and patients.

**Question 3:** Does the NHA feel responsible for insuring that there are enough caregivers in the facility to meet the needs of the residents and patients?

**Answer 3:** No. The Director of Nursing Services is responsible for her department and his attitude may be that the Nursing Department needs to solve their own problems.

**Question 4:** Does the NHA decide on a specific way to respond to the ethical situation?

**Answer 4:** No. The NHA may not know of any other solutions to get staff and doesn’t want the conflict of making nurses come to work when they are not scheduled or to mandate staff to stay which is very unpopular for employees. He could also have this reaction even if he doesn’t perceive the situation to be an ethical one.

**Question 5:** Does the NHA take actions to address the staffing situation?

**Answer 5:** No. There may be a lack of competence in that he doesn’t connect ethical concerns to his behavior of leaving the nursing home without verifying the enough caregivers were available to meet the needs of the residents.

This example shows the failure of an NHA to engage in moral courage when opportunities were presented. By not perceiving the ethical nature of day-to-day concerns that occur in operating nursing homes is to miss opportunities to represent the best interests of the residents and patients through moral courage. If the answers had been “yes,” followed by an appropriate action, then moral courage would have been enacted in each of the five steps. This five-question process assesses the level of development for
the NHA with the goal of understanding and utilizing moral courage in appropriate circumstances.

1. Ethics Education

Hawkins and Morse cite many studies that support that courage is progressive in nature and can be taught and learned as an ethical obligation and a requirement by leadership positions such as the nursing home administrator. There are three guiding principles and strategies to fear in minimizing the risk in moral courage which are: 1) increasing the chance for success, 2) decreasing the potential for loss, and 3) decreasing ambiguity. For leaders to be able to steer through this fear is to develop skills that will enable them to act with moral courage in order to be effective within ethical leadership. Many ethics programs focus on the teachings of theories and principles but do not offer much practical application for assimilating this knowledge into the daily clinical environments. In adults moral courage can be created starting with the elements of moral action combined with sympathy and empathy which creates selfless reactions. Mindfulness, which involves self-reflection, is instrumental in understanding moral responsibility as a healthcare professional. Noddings attributes the source for human caring, which translates into moral courage, as coming from the feminine essence of being cared for. This method is based in care ethics and relies on relationships and circumstances. The social learning theory is seen as a way to assess ethical leadership since there has been very little direct research done on the topic. Lee and Elliot-Lee propose that developing moral courage begins with the three words of Learn, Do, and Be. The first step is to learn what moral courage is, second is to practice using moral courage, and then over time, such actions will become habits in actions.
A study by May, Luth, and Schwoerer (2013) looked at the effects of the completion of a course on ethical decision making in business which could increase the confidence in the participants skill level to deal effectively with ethical issues in the workplace, elevate the importance of ethics in the workplace, and increase acts of moral courage in the workplace. The study found moral effectiveness to be essential to moral courage because self-confidence and confidence in a person’s professional abilities is necessary for leaders to take the risks associated with moral courage. The findings of this research indicate that ethics education can have a positive effect on moral courage even with a brief course of training.24

2. Leadership Mentoring

Mentoring is seen as a valuable approach to cultivating positive leadership behaviors however the mentor must be skillful as a coach and have available time to nurture the relationship.25 A significant area for developing managers into leaders is to establish an atmosphere that promotes critical thinking which requires that personal assumptions are questioned and reviewed in attempts to find better ways for addressing areas of concern. The mentor or teacher must be accepting of differing viewpoints and creative ideas.26

Both the mentor and the mentee, who is the NHA, play active roles in the learning process which includes sharing the responsibilities for reaching the goals that are to be achieved. In this instance, that would be the development of moral courage. The NHA gradually becomes self-directed in carrying through the teachings as he moves from being dependent on the mentor initially to becoming independent. The phases of the mentoring relationships include preparing to be a mentor, establishing the agreement
between the mentor and the mentee so each understands the parameters of the relationship, enabling growth through learning, and ending the agreed upon relationship because the skills have been developed to a level for independent use. The four areas don’t necessarily occur in a linear fashion but are a cycle that is determined by the behaviors of the learner and there is not a clear ending of one phase before moving to the next. The third phase is the most significant because that is where the growth occurs and requires that there be a mutual trust within the relationship in order for the learning to develop.  

The atmosphere of the nursing home has to be one that promotes acts of courage and the dual-processing approaches that are termed as being either “hot” or “cold” are models that are likely to result in courageous acts. The “hot” version of dual-processing models are the ones in which moral courage is formulated from an automatic “gut” reaction. The actions are automatic with little regard for the danger involved. There are three versions within this intuitive group which are: Social Intuitionist Model, Chronic Accessibility Model, and the Expert Decision Model. The Social Intuitionist Model is thought to be an instinctive reaction of survival of ancient origins that is based on familiar situations. These are then modified for the current circumstances. With the addition of rational thought a person is able to adjust a reactive behavior to one that is more deliberate. The supervisor of the NHA can give guidance to this impulsive reaction by facilitating an appropriate social response through active discussion. The Chronic Accessibility Model involves chronically accessible ideas of courage and situations which require that acting with moral courage is a duty. This type of behavior can frequently be found in positions that rescue others such as firefighters. The Expert
Decision Model occurs from knowledge and experience that is developed over time by purposely engaging in a dangerous task. As an example, the NHA may develop such a skill by dealing with difficult physicians over time. Negotiation and interpersonal skills may develop with confidence to be able to challenge the physicians’ decisions with moral courage. The “cool” or more rational approach to moral courage can be developed in NHAs by fostering patience and urging them to rationally think through the situation before acting and be less impulsive. Like the “hot” methods, these can be taught by talking through the possible courageous approaches to the problems. To further the learning is to evaluate the actions retrospectively to determine what was effective and what can be done differently in the future.  

3. Case Study Reviews

The idea of using case reviews as methods for learning can be used to retrospectively review a wide range of topics and concerns within the nursing home from specific patient clinical studies to a process for leadership decision making. Developing the format for learning in this mode can draw from theories of action learning, reflective practice, and narrative examination. This method allows for more input into the process of arriving at solutions which can also be used to train the students, which would be AITs and NHAs. Benefits to using case studies in teaching are that they provide a strong foundation for improving skills in problem solving and decision making. They serve to assist in integrating, assessing, and applying concepts to actual situations which turn abstract ideas into real-life skills. By experiencing situations engaging in acts of moral courage through case studies, the NHA can begin to understand the ethical concerns in
even the seemingly insignificant situations and the needs for moral intervention from the position of NHA.

Action learning is an approach that uses a type of case study in teaching in that the process reviews actions that have been taken and analyzes them in terms of the effectiveness of the solutions. There is a retrospective element as that in a case study review. Action learning is an approach to teaching that looks at solving actual problems. Actions are taken and then followed by reflecting on the results for improved performance. The components of action learning are: problem, group, questions, action, learning, and coaching. There must be a sense of urgency surrounding the problem which is then restated by the group. The group is small and consists of four to eight persons with differing backgrounds. Their task is to formulate a variety of strategies for resolving the problem and then determine and implement the most appropriate course of action. The points within the group are to include members who have knowledge of the issues related to the problem and have a willingness to help others in learning. Action learning focuses on questions, which makes it different from other learning methods that tend to focus on finding solutions. Through questions the group is able to gain a comprehensive understanding of the problem which generates creative and innovative tactics for resolution. Once actions are taken then the learning begins by assessing the effectiveness of the actions. This insight expands the quality and range of the learnings which begins the process of questioning again. The learning within this approach is equally important as resolving the initial problem. The group will devote specific time to learning that will be facilitated by the coach. The coach also points out distinct learning opportunities throughout the steps in this process. Action learning deepens and widens the base of
knowledge at a very fast pace which is transformation to the individuals and to the group.  

This process could be used in developing a group of NHAs or by an NHA for developing the nursing home management team in acting with moral courage. Problems occurring within the facility could be reviewed in which moral courage was used or could have been used and reflecting on the outcomes for improved future responses. As an ongoing group, this process for learning could develop the individual team members as well as develop the management team as a group. If the NHA has the capacity to coach this process it could be pivotal in transforming the ethical culture of the nursing home.

C. Models for Moral Courage in Care

As was mentioned earlier, in order to develop moral effectiveness in leadership the components of moral capacity, moral courage, and moral resilience need to exist that translate into actions and behaviors. Moral courage can be developed by promoting the NHA’s self-confidence to be able to move moral intentions into moral actions. Training in moral courage can increase the NHA’s feelings of effectiveness that improves performance as a leader. This competency can be further reinforced through coaching the NHA through moral dilemmas until there is a comfort level for the NHA to operate independently in similar situations.

Kohlberg’s model for moral development was also covered that discussed the progression of stages and levels from childhood through adulthood and is regarded as one of the most noted approaches to surveying a person’s moral background. Kohlberg’s version of moral development also has served as a basis for other theories that are covered in this dissertation. The following are several approaches to measuring and
enacting moral courage in a healthcare situation. These models can be utilized as part of a leadership developmental process with the benefit of impacting the ethical climate in a positive way. Each also can be applied from the point of moral courage in care and caring actions in the decision making process.

1. The Moral Skills Inventory – James Rest

James Rest developed a Moral Skills Inventory that measures the four components of: moral sensitivity, moral reasoning, moral integrity, and moral courage. Moral sensitivity is having awareness that there is an ethical component of a situation, having the ability to determine if an ethical response is needed or is appropriate, and the inclination to respond morally. Moral reasoning is also termed as moral judgment, and Rest used the three levels for moral reasoning of: preconventional grounding which is the lowest level and is concerned with self-interests, conventional is the second level which assumes group norms, and the highest level is postconventional reasoning which engages in theoretical ethical principles and is concerned with doing good for others. Moral integrity is tied to the essential characteristics of a person and their tendency to act morally. The prioritization of values is also contained in this section. Moral courage is defined by Rest as containing the skills of moral action such as conviction, perseverance, toughness, and “effective engagement.” Another way of understanding the four areas of behavior associated with the Moral Skills Inventory is to see the basic points as: 1) identification that a moral problem exists, 2) determining the normative approach and assessing the appropriate actions, 3) evaluating the various possible solutions against the moral values and selecting the preferred option, and 4) implementing the selected plan of action.
Rest, like Carol Gilligan, was a student of Kohlberg’s and based his inventory on Kohlberg’s moral development theory. Rest’s response to criticism of Kohlberg’s model was to alter the approach to reasoning by adding the concept of patterns founded in memory. The notion is that people respond to situations from past similar experiences and they can improve upon the responses as they become more familiar with the circumstances. Rest also altered the last stage of *Post-Conventional* so that there was a more global view of the ethical perspective of a shared vision of an ultimate society which could act in the best interests of everyone with respect to their rights and protections.  

Rest went on to devise the *Defining Issues Test* (DIT) for measuring moral development. Six situations were provided and the respondents had to select answers that best represented their personal views and the process they used in arriving at their decisions. The six situations were matched to the moral development levels which are then scored. The DIT model has been used extensively and a sampling of the findings show that: 1) the ability to reason morally usually improves with age, 2) moral judgment is improved with ethics education, 3) when ethical education stops then moral development fails to continue to grow, and 4) ethical leaders can expand the moral judgment within their followership by encouraging them to function with higher levels of ethical behavior patterns.  

The Moral Skills Inventory and the Defining Issues Test could be used to assess moral development of NHAs for establishing a baseline and for growth. Particularly with the DIT, since the results of that test indicate that improvement has been shown in moral judgment through the intervention of ethics education and training, which then can be
passed on to the followership throughout the organization. The NHA would be more inclined to act with moral courage which would affect the culture of the nursing home in a positive way by improving the ethical climate.

2. C.O.D.E. – Vicki Lachman

Vicki Lachman, a noted author on moral courage in healthcare, proposes an acronym to assist healthcare professionals, namely nurses, in remembering four steps to practicing moral courage in an effective way. Using C.O.D.E., the letters are defined as: *Courage* to objectively evaluate the situation as requiring moral courage, *Obligation* to take the right action on behalf of the patients in ethical matters, *Danger* management of the fear to act courageously, and *Expression* which is taking the necessary steps to enact moral courage.\(^{38}\) The acronym of CODE is one familiar to the nursing profession so it is easily remembered and it also elicits a high level of importance for response. The acronym reminds healthcare professionals of their responsibility to be advocates for the patients which helps in working through their fears so that they can take action in the form of moral courage.\(^{39}\)

Courage is a virtue and is aligned with practical wisdom according to Aristotle. As one of the four core virtues, courage, is the one that allows for the other three to occur which are temperance, justice, and wisdom.\(^{40}\) For the health professional to act with moral courage, moral wisdom must be present which involves moral perception, moral sensitivity, and moral imagination. When translated, this means that this is insight that an ethical situation exists, the recognition of issues within the caregiving context exist and are addressed, and empathy is displayed for the patient in the situation. Professional codes outline the obligations healthcare professionals have to their patients which
requires moral courage in order to be able to uphold their responsibilities to the patients. A danger to being able to act with moral courage is in the healthcare professional knowing what that means and knowing how to respond in a morally courageous way. Many people do not possess the knowledge and skill level which is seen as failing to be “ethically competent.” Some people simply refuse to engage in situations of conflict. Expression and action as the last step engage confidence in communication through assertiveness which may include negotiation. This step can be hindered when professionals feel that they are not in a position to express their opinions or that they are not comfortable to challenge current situations due to their personality constraints. Lachman suggests that in addition to using the C.O.D.E. approach to formulate the steps to action with moral courage, that a series of questions be answered with each step in planning the response if there is time to do so.41

This approach could very easily be used by an NHA in being able to comprehend the process for enacting moral courage by using the acronym and reviewing and answering the questions that accompany each step. The questions formulated by this approach for overcoming fear are: 1) identify the risk you want to take, 2) identify the situational fear you experience, 3) determine the outcome you want and what you have to do to achieve this outcome, and 4) take action. 42 As an example, if the NHA is concerned about terminating a long term employee who is disruptive in the workplace, the answers to each question might be as follows: 1) Terminate the nurse who has worked at the nursing home for twenty years, 2) This employee is a large man who has issues with anger and may become physically abusive during the termination meeting. This employee has a family member who is in charge of discharge planning at the main referring
hospital and may send the majority of the patients being discharged from the hospital to
other nursing homes which will cause a negative financial impact to the facility. 3) The
preferred outcome is to terminate the employee in a way that is dignified for the
employee and safe for the NHA and others, and there will be no negative financial
impacts on the facility. The NHA will prepare notes of what he wants to say during the
termination which clearly outlines the reasons for ending the working relationship but
also includes the appreciation for any positive aspects during the person’s employment. A
witness to the meeting will be present and a security guard will be notified to be in the
area of the NHA’s office during the termination in the event there is a physical response
from the employee. A meeting will be scheduled with the hospital just to see if there are
any areas for improvement on the part of the nursing home in strengthening that
relationship, and 4) Schedule the date and time for the employee to be terminated. The
idea is that over time acting with moral courage will become autonomic with practice, but
by breaking the tasks down into steps, the fear can be lessened when there is a very clear
plan. Behaviors leading to moral courage can be taught through this approach which will
assist in developing skills that allow NHAs to act on behalf of the patients and residents.


Kidder’s model for moral courage consists of three interconnecting circles with
the titles of danger, endurance, and principles. The principles necessitate an obligation
that coexists with being cognizant of the danger associated with supporting the principles
and the commitment to enduring that danger. The point where all three of these attributes
overlap is where moral courage resides. The addition of principles to danger and
endurance is what differentiates moral courage from physical courage. Physical courage does not require values although they can be present.  

In addition, Kidder classifies moral courage within the headings of motives, inhibitions, and risks in his analysis of various viewpoints. Motives for moral courage are inclusive of duty, a strong moral principle, personal beliefs, and an interest in addressing unfairness and inequality. The inhibitions which are linked to these motives divide into two types of limitations which are counterfeits and obstacles. The counterfeits are made up of deliberate actions and self-satisfaction on the part of the wrong-doer. Obstacles contain the opposing notion of moral cowardice, failure to accept responsibility, and a need to be liked. Risks engage in negative responses to the morally courageous acts which can be ostracism, demotion, suffering, and criticism. Kidder deduces that there are four paradigms offered for moral courage and understanding ethical dilemmas which are: Truth versus Loyalty, Individual versus Community, Short-Term versus Long-Term, and Justice Versus Mercy. Ethical dilemmas tend to fall within one of these four categories and understanding the foundations for each of these provides a framework for understanding.

Kidder’s checkpoints were discussed in Chapter Four as a method for ethical decision making. The model of the intersecting circles provides another aspect for
understanding and applying moral courage. The NHA can use the model as a simplistic
guide to think of moral courage in the three areas of principles, danger, and endurance in
learning to assess the needs for moral action and follow it in learning to utilize moral
courage.

4. Reciprocal Determinism – Albert Bandura

Albert Bandura poses Reciprocal Determinism within social learning theory as a
continuous process in which the environment, thoughts, and behavior interact. In addition
to this are the influences of the individual’s self-regulatory processes for perceiving,
evaluating, and regulating behavior. Combining these elements of Bandura’s theory
interrelate in determining the behavioral outcome and its level of moral relevance. Rather
than the traditional two of behavior coming from persons and situations, this view
includes three elements. These elements interact as reciprocal determinants and consist of
the interrelation between behavior and environmental conditions, personal and
environmental conditions, and personal and behavioral conditions which flow in either
direction. The three areas do not share equal power. They will differ from one person to
another and in different circumstances. The use of the term determinism represents the
creation of effects by events. Behavior is affected by the environment however the
environment can be conjured up as well by the individual. The self-regulatory aspects of
this theory do not manage behavior but provide references to thought patterns associated
with perception, evaluation, and behavior regulation. There are three components to self-
regulation which are self-observation, judgmental process, and self-response.46

This theory explains why a person behaves in the manner that he does. The
traditional theories were that behaviors were generated from within the individual or by
external forces. However, Bandura proposed a different approach in that new information and behaviors are learned through observation which includes the study of the behaviors of others and the consequences of those behaviors. This triangular model of interaction is an appropriate one for the NHA to learn and act with moral courage. Observation can occur through mentoring and in simply watching the behaviors of leaders of ethically sound facilities. The reciprocal aspects of behavior, the environment, and the cognitive areas match well with the ideas of moral courage which are identified through cognitive and internal functions, are driven by behavior, and have an impact on the environment. The reciprocal components keep the moral courage moving among the individuals and the nursing home.

5. Kobuck Model of Moral Courage

This author’s approach to developing nursing home administrators is based on many years of experience and not on quantitative research findings. Over a 20 year period of functioning as both a nursing home administrator and as the supervisor of administrators there have been approaches used in identifying and developing NHAs that have resulted in significant successes in the delivery of quality of care and meeting the financial goals of the organizations. A competence that was pivotal in being able to achieve both was the NHA’s capacity to act with moral courage. The concept wasn’t necessary clear in the beginning of the supervisor and NHA relationship but over time the expectation became a habitual characteristic. Many of the author’s approaches were similar to the points made throughout this dissertation. Character and attributes form the foundation in selecting a nursing home administrator. The NHA must demonstrate passion for doing the right thing for the residents and patients in a caring way. A sense of
fearlessness is displayed with responsibility and not recklessness as Aristotle describes in the mean. These NHAs must be self-motivated and questioning the status quo at all times.

As the supervisor there must be a willingness to allow for responsible errors within the teaching process of moral courage. Many times an NHA knows that there is something “not right” with situations but they don’t know what to do about it beyond that gut feeling. Assistance is needed in identifying the ethical issues and in determining options for action. Support should be provided to the NHAs for moving from their comfort zones into areas that stretch their abilities to act with courage. If possible, the supervisor should never allow an NHA to fail during this development phase which could further strengthen the fear that accompanies moral courage. Learning should not involve the breaking of a person’s spirit but should involve enhancing the spirit through motivation and professional growth. Each time the NHA is permitted to expand their comfort level in enacting moral courage, self-confidence is also expanded. Acts of moral courage need to be exhibited by the supervisor to establish the expectation and to teach through examples. Reviewing acts of moral courage and missed opportunities in retrospect permits learning from actual situations. The NHA should always be asking if there was anything that could've been done differently or better in dealing with moral dilemmas. The “aha” moments are motivating to both the supervisor and to the NHA as successful ethical interventions occur. The more the NHA leads with acts of moral courage the more this competency will become ingrained as a standard for the NHA’s leadership style. Acting with moral courage will be necessary for both significant issues as well as small concerns in support of the notion that all decisions become ethical within nursing homes because of the responsibility for and to the residents and patients.
Eventually, the NHA will view all decisions with ethics as the point of reference. Developing moral courage as a nursing home administrator is to spiral from a general understanding to a more specific one. With each complete rotation of the spiral comes the addition of depth and understanding. The frequency increases until moral courage becomes pinpoint clear and becomes habitual. The relationship between the NHA and the supervisor factors into the ability for moral courage to be enacted. There must be trust between the NHA and the supervisor that provides a safety net until the competency is mastered. In building confidence, the supervisor must be trusting in the competencies of the NHA and believes that capacities for the appropriate actions exist. The NHA must trust the supervisor in believing that direction is being given in a way that is within his scope of capabilities. Discussing the decisions for moral actions in advance, if there is time, provides an ongoing opportunity for learning through immediate feedback. The interactions with the NHA are not to micromanage, but to listen to the rational thoughts behind the decisions and to give guidance or reassurance when needed. Acts of moral courage are accompanied by fear and sometimes very high emotion. The supervisor must allow for the expression of the emotions that accompany the fear and provide an atmosphere that permits the NHA to express the emotions openly within the supervisor and subordinate relationship. The rule established by the supervisor is that the NHA can express negative emotions to the supervisor but not at the supervisor.

One point of caution is in determining the motivations for actions. What sometimes looks like moral courage is not and is a disguise for acts of self-interests. Some NHAs will make the difficult decisions for the good of others while others make those difficult decisions for personal benefit. In the latter case, moral courage may seem
to be occurring but the actions are actually motivated by personal gain. Both may occur from the action and an example would be as follows: The NHA terminates a nurse for repeatedly failing to contact the physician immediately regarding significant changes in the patients’ conditions. She has worked at the nursing home for 25 years and her salary is the highest in the department with her overtime pay. With this change, an unsafe practice that could harm the patients is eliminated, and the NHA will reach the goal of his bonus for reducing the expenses in nursing salaries. The ethical question is whether or not the action was taken primarily for the good of the residents or for increasing the NHA’s personal income. The motivation will determine if moral courage was a factor in the decision or if I was merely self-serving. When an NHA’s actions fall within this “gray” zone the supervisor will need to monitor the actions closer and provide further guidance. For an NHA to consistently make decisions on the precipice of unethical behavior will have further consequences which could begin the slippery slope for amoral decision making. This would deteriorate trust throughout the organization which begins the decline of the internal and external ethical climates.
Kobuck’s Model for Moral Courage begins at the base of the largest circle where moral courage is developed. Virtues, values, and attributes of the NHA enter that point with the guidance and support of the supervisor as the mentor. The understanding of moral courage is broad and somewhat undefined for the NHA initially. As the understanding of moral courage grows the comprehension becomes more clear and narrower in scope as to what, when, and how to respond to the ethical concerns. Simultaneously, acts of moral courage begin to occur in the decision making process. With each act of moral courage there comes a complete rotation on the spiral towards the goal of moral courage becoming a competency for ethical leadership. Also, with each rotation on the spiral is movement away from the self and an increase in comprehension and self-confidence for the NHA to work through the associated fear. This process continues until the moral courage competency reaches the *Transition*. The transition point is where the clarity and action for moral courage for the NHA have become ingrained in the leadership style and the benefit of leading with moral courage begins to permeate the organization. The more moral courage is enacted the more the positive ethical climate grows. Moral courage acts like a fuel for growing and sustaining a positive ethical climate within the nursing home and pushes the spiral outward thus creating an ethical culture. However, if acts of moral courage begin to decline then the spiral beings to retract, moving away from the positive climate towards the negative climate, and from acting for others to acting for the self. Moral courage must constantly breathe life into the ethical climate for growth and maintenance. An ethical climate in the nursing home, or in any organization, cannot occur without moral courage from the leader.
Once the NHA has developed the competencies and trust and has shown evidence of understanding the ethical implications of the responsibilities with the position, the supervisor can step back and allow the NHA to fully lead ethically. That doesn’t mean that there is no involvement by the supervisor. There always needs to be systems for checks and balances which are the reasons for compliance and ethics programs. The relationship of the supervisor and the NHA will change from one of teacher and student to one of professional peers for discussions. The hierarchy for the chain of command within the organization remains but the relationship will change.

D. Conclusion

Moral courage is permanent and is regarded as being constant in performance which will become a necessity in managing the challenges moving forward for patient care in nursing homes. Moral courage can be taught and learned even if it isn’t an inherent trait of the NHA. The NHAs can develop skills and competencies which in turn strengthens their capacity as a leader. There were a number of approaches explored that can be used to acquire competencies supporting moral actions. For NHAs moral courage is crucial to becoming effective as administrators who drive the ethical climates within their nursing home through moral decision making. Developing the ability to act with moral courage is to move from the self to others, never losing sight of each individual patient and resident and their importance.

Environments supporting moral courage cannot become stagnant. Continuous acts of moral courage energize ethical climates and moral courage establishes the foundation and the ethical direction. Once moral courage becomes habitual in the administrator's leadership approach, then the impact of the actions begin to take hold in affecting the
organization as a whole. Ethical thought and action begins to be duplicated throughout the nursing home changing the culture into an ethical one with the patients and residents as the priority.

9 Lachman, Ethical Challenges, 237.
16 Lachman, Ethical Challenges, 6-76.
49 Hawkins and Morse, “The Praxis of Courage,”, 266.
Chapter Seven: Conclusion

The arguments for concluding that moral courage is a requirement for ethical decision making in nursing home leadership will go back to the beginning in comprehending the nature of moral courage and why it is so important in nursing homes. Although they are significant contributors to moral dilemmas, the rapid and substantial growth in the aging demographics in the U. S. and the governmental involvement in reducing healthcare spending are not the primary reasons. The need for moral courage is for the benefit of the residents and patients who must be the priority in all decisions in any healthcare organization and in particular are the nursing homes which have been the focus in this dissertation.

A. The Heart of Need

The heart of this argument is formulated on the concerns for the needs of the patients and residents who are dependent on the nursing home leadership to make ethical decisions. These debilitated persons are entrusted to an organization as recipients of care and services with the assumption that no harm will be caused. Healthcare environments have many moving parts within the delivery of care and the services that support that care which includes the interactions among departments within the facility as well as with external providers. There has to be one person who is at the helm directing all of the operations and is the designated protector of the best interests of the patients and residents, and that is the nursing home administrator. In keeping the residents and patients as the core focus, the value that is placed on them in the hierarchy of importance considers the affects to them in all concerns within the decision making process. The way in which the patients and residents are valued is not just an issue for dignity but also
entails upholding their rights. The NHA must manage both the ethics surrounding care as well as the rights in justice as factors in ethical decision making.

Providing care is one aspect of interacting with the patients and residents but the manner in which it is provided is equally important. While all of the tasks associated with caregiving may be met by administering medications, attending to the activities of daily living, and conducting therapeutic exercises as examples, but if caring isn’t included with those caregiving tasks then the needs have not been met. Caring is a key element in developing the relationships between the healthcare professional and the residents and patients, and caring is communicated through compassion, empathy, honesty, and love. That is not just the nurse and the patients and residents, but also includes the NHA and the patients and residents, for the caring response resides within the professional realm of the relationship.\(^1\) The NHA should challenge that patient hood becomes personhood, and that providing care is translated into caring.\(^2\) Moral courage isn’t engaged in making just the “big” decisions but is also conjured up in what may be seen as very small instances in the course of an administrator’s day. The administrator must connect to the people who are going to be consistently impacted and least able to defend themselves in decisions that aren’t reflective of their needs. The relationship of the NHA with the patients and residents can influence the use of moral courage.

Moral courage may be about having the courage to be vulnerable enough to show emotions of caring. Moral courage may also be about such issues as being afraid of death but finding the courage to sit with a dying patient. The range for needing moral courage as the leader of a nursing home is wide because the opportunities for its use are far reaching due to the complexities of nursing homes as organizations. Moral courage may
be required to cancel the contract of major pharmaceutical company because they refuse to change their delivery times causing delays in treatment, it might be used to confront a physician because his philosophy for prescribing pain medications isn’t congruent with standard hospice practices, or it may be necessary in supporting a patient’s autonomous decision when the family members disagree and threaten the facility with legal action because their wishes didn’t supersede the patient’s decision. Compassion exists at the center of the moral life for all people and therefore, for a nursing home administrator to lead ethically with moral courage requires that compassion towards the residents and patients be present.³

B. Leading to a Moral Culture

There were some key elements that resounded throughout this dissertation which is that ethical response is only in relation to others. Moral courage does not exist within self-interests. Acts of caring do not exist within self-interests. Ethical leadership engages with followership, however, areas of moral compromise are primarily focused on the self. The nursing home administrator is the beacon for the nursing home and the guidance of the signals can be ones of warning or inspiration which transforms the ethical climate. The power of ethical leadership for improving all operational areas of the nursing home is inordinate but few NHAs realize the potential. The dots are not connected from the behaviors of the NHA to the corresponding actions and atmosphere that prevail throughout the nursing home. All NHAs should be introspectively assessing their contribution to the ethical cultures in their nursing homes. If the facility is showing positive results in such areas as employee and patient satisfaction and quality care then the self-assessment should determine the actions that correlate to the positive results so
they can continue. If the outcomes are negative with dissatisfaction and poor care then the evaluation in one to determine behavior changes from the leadership. If an NHA is complaining about the way in which people are behaving and the negativity within his facility then he only needs to look into a mirror to determine where the change needs to start. Trust is a significant feature of an ethical culture. Trust is also the foundation for all interpersonal relationships and the NHA is “ground zero” for where trust throughout the organization originates.4

C. Learning to Lead Morally

When the point of developing moral courage as a leadership competency has been achieved, the change in perspective can be an evolution for the NHA both personally and professionally, which then drives the ethical transformation of the nursing home. Developing necessary competencies for moral courage is to explore features required for the job that have an element of behavior associated with them.5 Moral courage is revealed in behaviors however training in ethical areas typically consists of gaining theoretical knowledge rather than on practical applications that could be used in real-life circumstances in operating a healthcare facility.6 Moral courage can be produced by beginning with moral action which incorporates sympathy and empathy, all of which create selfless reactions which are necessary for moral courage to occur.7 To be able to act with moral courage involves learning what moral courage is and practicing the application of moral courage which then transitions the practice into habitual acts. In becoming a habit, moral courage becomes an automatic response in decision making.8
D. The Habit of Moral Courage

Moral courage is enduring and is regarded as continuous in performance which will become essential in managing the challenges that currently exist and are expected to progress in the future for resident and patient care in nursing homes. Professionals who inhabit positions of responsibility for vulnerable persons such as residents and patients should possess moral courage but it cannot be presumed to be true. The need for moral courage has been identified through the aging demographics, delivery of care needs, governmental involvement, and day-to-day challenges to the NHA. The central need for moral courage has been covered in care and caring for the residents and patients of nursing homes through the fundamentals of care, moral character for caring, obligations and rights for the NHA to care, and aligning moral courage to caring actions. As a core of ethical leadership for the NHA within nursing homes, the involvement of determinants of ethical leadership, concerns for moral compromise, the use of power in followership, styles and ethical viewpoints of leadership, and models of ethical decision making have been studied. Moral courage and the influence of the NHA on the organizational culture of the nursing home has been traced through the development of ethical climates, the promotion of cultures of quality and safety, and the guiding role of compliance and ethics committees. Finally, the need for developing moral courage in the NHAs, if it isn’t pronounced within the possessed competencies, is necessary for effectively and ethically leading the nursing home through strategies for learning and models of moral courage. Moral courage is most certainly a requirement for decision making in ethical nursing home leadership if the residents and patients are to be the priority within facilities. By position, NHAs are entrusted with advocating for quality care for the residents and
patients, through caring, and honoring the dignity and sanctity of all human life, even in the most debilitating physical and cognitive states. The NHAs ultimately establish these values throughout the nursing homes and their decisions must always be in the best interests of the residents and patients above all else.

Looking at nursing homes as a point in the continuum of care has particular concerns that create challenges for leading ethically. The NHA must be able to lead through those challenges in defense of dignity, rights, and humanistic compassion for the needs of the residents and patients. Therefore, moral courage is truly a requirement for the nursing home administrator to be able to consistently make decisions that are ethically grounded. To be morally courageous means to stand firm in one’s moral convictions even when there may be no supporters. William I. Miller succinctly summarized the notion in the comment, “Moral Courage is the lonely courage.” So, for nursing home administrators, who understand the magnitude of their responsibilities and the requirement to lead ethically through acts of moral courage, be prepared to stand alone.

---

Bibliography


Borhani, Fariba, Tayebe Jalali, Abbas Abbaszadeh, and Aliakbar Haghdoost. "Nurses' Perception of Ethical Climate and Organizational Commitment." *Nursing Ethics,* September 2013: 1-11.


Chassin, Mark R. "Improving the Quality of Health Care: What's Taking So Long?" *Health Affairs* 32, no. 10 (October 2013): 1761-1765.


Clark, Paul R. "Building Healthier Workplaces and Providing Safer Patient Care." *Critical Care Nursing* 32, no. 3 (July-September 2009): 221-231.


—. *The Virtue of Care.* 2003. (accessed December 9, 2011)


Huang, Chun-Chen, Ching-Sing You, and Ming-Tien Tsai. "A Multidimensional Analysis of Ethical Climate, Job Satisfaction, Organizational Commitment, and Organizational Citizenship Behaviors." Nursing Ethics (SAGE) 19 (June 2012): 513-529.


Levinson, Daniel R. Nursing Home Enforcement: Collection of Civil Money Penalties.


Paulus, Paul B. "Developing Consensus about Groupthink after All These Years." Organizational Behavior and Human Decision Processes 73, no. 2/3 (1998): 362-374.


Weischer, Anna Elisabeth, Jurgen Weibler, and Maite Peterson. "'To Thine Own Self be True:’ The Effects of Enactment and Life Storytelling on Perceived Leader Authenticity." *The Leadership Quarterly* 2, no. 2 (April 2013): 170-181.


