DISSERTATION

A PHENOMENOLOGICAL INVESTIGATION OF COEXISTING VALUES IN HEALTHCARE

Submitted by

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ABSTRACT

Health care delivery in the United States has a storied history that has led the American public to expect that their Health Care Practitioners (HCPs) will pursue personal and professional values such as benevolence, equality and capability. A progressive set of events that dates back to the implementation of national health insurance for the elderly and the more recent emergence of events surrounding the implementation of the market-based solution in the Patient Protection and Affordable Care Act have led healthcare organization to become increasingly concerned with the pursuit of market values (e.g. competition; productivity). A review of relevant literature on the coexistence of personal, professional and market values in health care pointed toward a number of potential consequences that might emanate from this coexisting values phenomenon. The HCPs who practice at the nexus of this phenomenon are those who most directly experience such consequences and the aim of this study was to qualitatively explore and illuminate the lived experience of a selection of doctors and nurses.

Through an application of a co-constructive approach to inquiry it was found that those HCPs who participated in the study experience professional opportunities to express their personal value preferences, while also experiencing a paradoxical tension when it comes to leaving their patients feeling satisfied with their care experience. It was also found that the HCPs interpret their interactions with the pharmaceutical industry in a variety of ways, and that a HCPs exposure to market values is influenced by their practice area and the type health system they are working in. The vast majority of study participants practice within the same health care organization (system), and it was further found that these HCPs benefit from a quality of leadership and organizational support that enables the pursuit of their care value priorities. Study finding also point to the potential for adverse consequences (e.g. demoralization; burnout) in instances where HCPs are unable to fully realize their personal and professional value priorities. Study implications feature suggestions for practice, theory development and future research, and suggestions for those who might endeavor comparable qualitative research.

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CHAPTER 1 – INTRODUCTION

The American healthcare system has a long history based on a set of patient-centered values. These values are reflected in prevailing notions of medical professionalism (Arnold, 2002), and the mission statements of healthcare organizations (Graber & Kilpatrick, 2008). As a result, the American public has come to expect that their healthcare organizations will maintain a patient-centered orientation and that the Healthcare Practitioners (HCPs) within these organizations will personally and professionally pursue values such as benevolence, equality, and capability (Graber & Kilpatrick, 2008; Moyo, Goodyear-Smith, Weller, Robb, & Shulruf, 2015).

Events surrounding the implementation of the market-based solution in the Patient Protection and Affordable Care Act and the emergence of conveniently accessible and less costly alternatives to traditional care models have connected healthcare organizations to a set of values that differs from those that have historically been associated with care delivery. Ongoing changes in the care delivery environment have translated into a need for healthcare organizations to reconsider notions of customers, markets, and competition and develop new strategies that enable them to adapt. The broader healthcare system is now commonly described as a $3.3T industry and it is projected to account for 19.6% of U.S. gross domestic product (GDP) by the year 2024 (Keehan, et al., 2015). Market values emphasizing competition and productivity now appear as commonplace in many health organizations (Cameron & Quinn, 2011; Evetts, 2011; Freidson, 2001; Gabel, 2013; Light, 2010; Relman, 2007; Thorpe & Loo, 2003).

The pursuit of market values is considered by some to stand in opposition to those values that have traditionally guided the delivery of healthcare (Freidson, 2001; Gabel, 2013; Melia,

1995; Relman, 2007), whereas others point to the benefits that can be derived when such values are allowed to coexist (Evetts, 2011; Light, 2010; Martin, Armstrong, Aveling, Herbert, & Dixon-Woods, 2015). It appears that it has become commonplace for HCPs to work towards the realization of their personal and professional values (e.g. altruism; capability) while also attending to the business side of healthcare and the pursuit of the market values within (e.g. competition; productivity). This qualitative research project is intended to illuminate the experiences of a selection of HCPs who operate at the center of a phenomenon where there are expectations that their personal and professional values can coexist with market values.

This introductory chapter begins with an overview of the relevant literature that has informed this research and served to illuminate potential consequences that are believed to emanate from the expected coexisting values within the context of healthcare. A specific identification of the problem this research sought to address is followed by a discussion of my research interest. The purpose and significance of the proposed inquiry is then discussed and followed by an identification of the primary research questions that guided this inquiry. This introductory chapter also features an overview of the methodology, methods, and criteria that were used to ensure the quality of this phenomenological research. A summary of the research findings that were informed by the analysis of interviews with HCP study participants is offered next, and this chapter concludes with a brief overview of the implications that emanated from this phenomenological inquiry into the expected coexistence of personal, professional and market values in healthcare.

Overview of the Informing Literature

A prolonged review of informing literature was conducted in order to identify, interpret, and synthesize the values theories that ultimately guided the inquiry. The review of the literature

also served to identify potential consequences that are believed to stem from the expected coexistence of values in healthcare and explore what has been done in terms of efforts to research this current phenomenon. In this overview of the informing literature, I offer a general conceptualization of human values and a more pronounced conceptualization of the personal, professional, and market values theories that informed this study. This discussion is followed by an overview of the consequences that are believed to emanate from the interaction among these value types within the context of healthcare.

Human values and coexisting value types. This inquiry is based on a synthesis of human values concepts that were put forth, and advanced by numerous human values theorists (e.g. Kluckhorn, 1951; Maslow, 1959; Meglino & Ravlin, 1998; Rokeach, 1973; Schwartz, 1994; Williams, 1968). Kluckhorn (1951) and Maslow (1959) conceptualize human values as being goals towards which individuals and social entities strive; Rokeach (1973) posited that such goals may be immediate and/or long-term and they involve conceptions of what is individually and/or socially preferable. Schwartz (1994) built upon the view of human values as objectives and defined them as "desirable trans-situational goals, varying in importance, that serve as guiding principles in the life of a person or other social entity" (p. 21). In this inquiry, personal, professional, and market (all) value types were conceptualized as goals that serve the interests of an individual and/ or a collective entity. Given our tendency to pursue such interests, human values were also considered to be a source of motivation (Kluckhorn, 1951; Rokeach, 1973; Schwartz, 1994).

This investigation into expectations that certain values can coexist is further based on a general agreement that human values function as interpretive criteria (Kluckhorn, 1951; Rokeach, 1973; Williams, 1968) and that personal and professional, and market values types

may conflict or be compatible, depending on the degree of perceived similarity (Meglino & Ravlin, 1998; Parsons & Shils, 1951; Schwartz, 1994). In light of the view of values as goals and in consideration of the idea that some goals may be compatible whereas others conflict, human values are viewed as criteria for justifying actions and judging events that the HCPs encounter. Throughout the conduct of the study (e.g. data collection; write-up of findings), I sought to maintain an awareness that certain values may be espoused and those values may differ from those that are actually in use (Argyris & Schon, 1978; Meglino & Ravlin, 1998; Senge, 1990).

This inquiry is predicated on the view that *personal* values are a complex proposition involving cognition, affect, approval, and selection of behavior (Kluckhorn, 1951; Parson & Shills 1951; Schwartz, 1992). There is a common belief among values theorists that the pursuit of certain personal values involves internalized interpretations of how one believes they ought to socially behave (Feather, 1992; 1995; Meglino & Ravlin, 1998; Rokeach, 1973). An individual's value preferences may very well inform the choice to become a HCP and may be further refined through common socialization processes (e.g. medical training; patient interaction). It is believed that when a HCPs' personal values become internalized; they become standards (i.e. ideals) that guide their actions (Graber & Kilpatrick, 2008; Meglino & Ravlin, 1998). However, it is also important for us to consider that a HCPs cognitive and emotional experience with events may cause a reprioritization of personal values, depending on the context in which one is operating (Rokeach, 1973). In this investigation, personal values are conceptualized as dynamically functioning, and the values that are given priority by a HCP are believed to guide their selection among the various courses of action that may be available to them.

Professional values are commonly conceptualized as guiding the actions of a collective and are believed to promote smooth interaction between the members of the various medical

professions (Arnold, 2002; Schein, 1995). The espoused values of the medical professions were located in the literature related to sworn declarations (e.g. the Hippocratic Oath), codes of ethics (e.g. the American Nursing Association Code of Ethics) and the body of literature that is concerned with notions of medical professionalism. The review of studies and manuscripts that are based on professional declarations and notions of medical professionalism emphasize altruism as an overarching professional value. Benevolence, advocacy, non-maleficence, accountability, duty, and human dignity values are also commonly identified as being integral to the delivery of patient-centered, quality care. It was also found that newer medical professional values are coming to the fore. Values emphasizing the judicious use of evidence and collaboration among the various medical professions have been identified as being complementary to conventional care values and are viewed as being integral to addressing the challenges that are found in today's healthcare environment. The values found in medical professional declarations and notions of professionalism are often used as the basis for research that seeks to identify the value priorities of HCPs. This inquiry is premised on what appears to be a common belief, that within the context of healthcare, personal and professional values are intertwined and that both types of values guide the actions of HCPs (Dose, 1997; Moyo, et al., 2015; Pipes, Holstein, & Aquierre, 2005; Thorpe & Loo, 2003).

In their effort to identify the *personal and professional* values that are most relevant to HCPs, Moyo, et al. (2015) conducted a systematic review of the literature on values in healthcare. The researchers found the values of altruism, fairness, and capability to be predominant among HCPs. A secondary aim of the study conducted by Moyo, et al. (2015) was to map their findings on the personal and professional values of HCPs to the scientifically validated human values framework developed by Schwartz (1994).

The Schwartz (1994) framework (see Chapter 2, Fig. 2) features an identification of ten (10) specific human values (e.g. benevolence; achievement; tradition) and depicts a structural relationship among these values. In their structural model of relations among the personal and professional values of HCPs (see Chapter 2, Fig. 3) Moyo et al. (2015) also identify a set of 10 values that are specific to the medical professions and analogous to the values identified by Schwartz (e.g. benevolence = altruism). Like Schwartz (1994), the Moyo et al. (2015) model of structural relations among values positions the values that were identified as being most relevant to HCPs as compatible or conflicting. The models that depict the structural relationships among different values that were developed by Schwartz (1994) and Moyo et al. (2015) were used to further inform the study. An application of these frameworks was useful for distinguishing values by the motivational goals that are expressed and putting some structure around the infinite number of values that could be have been studied (Schwartz, 1994).

The current emphasis on *market* values in the American healthcare system can be traced back to the 1960s. The arrival of national health insurance for the elderly and the expansion of employer-financed health insurance in the late 1960s paved the way for the pursuit of market values within the arena of healthcare. During this era, profitability was essentially guaranteed and for-profit entities entered the healthcare space (Freidson, 2001). As new players have progressively entered the marketplace, competitive dynamics have become more commonplace. This trend has been complemented by a public policy agenda that led to the market-based solution found in the Affordable Care Act. Market values emphasizing competitiveness and productivity now prevail in an arena that is commonly described as a $3.3T industry, a marketplace where it is increasingly difficult to distinguish between not-for profit entities and their for-profit counterparts (Relman, 2007). In the conduct of the study, I adopted the view that

it has become increasingly commonplace for healthcare organizations to pursue market values in order to contain cost, realize collective viability, and promote long-term survival (Evetts, 2011; Handel & Gefen-Liban, 2003; Light, 2010; Martin, et al. 2015).

Counterbalance among coexisting values in healthcare. The pursuit of the professional values that are inherent to healthcare may very well be an effective counterbalance to the excesses and deficiencies that stem from the pursuit of market values healthcare. In this view, an emphasis on patient oriented, self-transcendent values serves to counteract the pursuit of market-oriented self-interest values (Freidson, 2001; Light, 2010; McNair, 2005). In the past, authors such as Freidson (2001) and professional organizations such as the American Board of Internal Medicine have called for a restoration of values such as altruism and accountability in response to the allegations of overtreatment, under-treatment, and excess charges that initially emerged in the 1970s. The simultaneous pursuit of care and market values serves the interests of healthcare organizations, in that it helps them adapt to the realities of the current healthcare environment (Heifetz, 1994; Martin, et al. 2015; Meglino & Ravlin, 1998), and work toward the realization of organizational viability. The findings from the literature that suggest that coexisting values may keep contrasting values in check (Freidson, 2001; Light, 2010), and a consideration of the range of values that inhere within the context of health care delivery is integral to ensuring the authenticity of this investigation (Lincoln & Guba, 1986a).

The consequences of coexisting values in healthcare. The review of the literature that took place prior to the conduct of the interviews not only served to inform a composite conceptualization of personal, professional, and market values, it also served to surface beneficial and problematic consequences when there are expectations that such values can coexist.

Beneficial consequences of coexisting values emanate from the current emphasis on evidence-based practice and the trend toward the use of inter-professional teams. The use of a base of evidence allows HCPs to realize capability and equality values while pursuing the standardization and efficiency that are commonly emphasized in organizations that are oriented towards markets (Light, 2010; Moyo, et al. 2015). When care is delivered via inter-professional teams, HCPs are able to pursue the collaborative values they appear to prefer (Brown, et al. 2014; personal correspondence). This method of care delivery is also believed to enable HCPs to collaboratively treat the vast majority of patient needs at a lower cost (Light, 2010), improve the quality of care (McNair, 2005), and provide a response to the global shortage of health professionals (World Health Organization, 2010).

A concern for problematic consequences such as nihilism and demoralization among HCPs also emanated from the search of the literature. There appears to be a common belief that the professional values that have guided the practice of medicine (e.g. altruism; non-maleficence) are irrevocably receding as the American healthcare system becomes increasingly commercialized (Freidson, 2001; Melia, 1995; Relman, 2007). While others (e.g. Rassin, 2008) have concluded that there are other reasons for a decline in altruistic values (e.g. narcissism), there appears to be a common concern that important personal and professional values are losing their influence (i.e. nihilism) as other values find their way into healthcare organizations.

The problematic consequence of coexisting values may be most directly experienced by HCPs, who are expected to uphold market values. In instances where their personal and professional values conflict with those of the market, it has been posited that these HCPs may experience demoralization and feelings of subjective incompetence (de Figueiredo, 2015; Gabel, 2013). It appears HCPs may also experience burnout when they are unable to reconcile their

personal and professional values (e.g. fairness; altruism) with opposing values (e.g. power; productivity) found in their work environment (Maslach & Leiter, 1997; Schwartz, 1994).

Healthcare executives may also experience problems when they attempt to infuse their healthcare organizations with market values. Studies that compare the conventional values found in healthcare to those of the market suggest that HCPs and healthcare executives may have different value orientations (Graber & Kilpatrick, 2008; Handel & Gefen-Liban, 2003; Thorpe & Loo, 2003). It seems that market values may be more difficult to attain in organizational environments where an orientation towards benevolence and universalism overshadows values that promote organizational self-interest. Such a challenge may pose a threat to organizational viability.

The Statement of the Problem

The review of relevant literature served to illuminate a problem that HCPs may experience. On one hand, we find the personal and professional values that HCPs appear to prefer (e.g. altruism; fairness). On the other hand, we find the market values that are increasingly espoused within healthcare organizations (e.g. competition; efficiency). The pursuit of business-oriented market values is considered by some to be a threat to the pursuit of the healthcare values that undergird patient-centered care (Freidson, 2001; Relman, 2007). It appears that when HCPs are unable to reconcile their personal and professional value preferences with market values that are emphasized within their organizations, they may experience feelings of demoralization and subjective incompetence, which are believed to contribute to burnout and the loss of personal and/or professional identity (de Figueiredo, 2015; Gabel, 2011; 2013; Relman, 2007).

The Research Interest

My interest in human values is both professional and personal. A long standing professional interest in human values that has been accompanied by research has led me to a place where I have adopted a conceptualization of values that positions them as interpretative criteria for selecting action (Williams, 1968; Rokeach, 1973; Schwartz, 1994); and like Connor and Becker (1994), I view values as being at the center of most organizational phenomena.

I have also adopted a belief that organizations are better served when they allow for a broad and diverse range of values to function (Heifetz, 1994). My interest thus extends from a professional belief that when it comes to interpreting and adapting to environmental events like those that are currently impacting the delivery of healthcare, the pursuit of a narrow and homogenous range of values may inhibit organizational performance and threaten organizational survival (Heifetz, 1994; Meglino & Ravlin, 1998).

According to van Manen (1990), "every project of phenomenological inquiry is driven by a commitment of turning to an abiding concern" (p. 31). A combination of personal experience and consultation with relevant literature led me to a set of three interrelated concerns that I bring to this study. First, I am concerned with the adverse and immediate impacts that HCPs experience when they are unable to exercise their personal and professional values (Gabel, 2013). Second, I am concerned for the possibility that the practice of healthcare may be adversely and irrevocably altered if market values emphasizing such things as risk taking and competitive advantage are over-emphasized at the expense of the important values that have historically guided the practice of healthcare delivery (e.g. benevolence and caring). Finally, I am concerned that healthcare options may become unavailable if healthcare organizations fail to acknowledge the market-based realities of today's healthcare environment. Given the conditions

in the current healthcare environment, it seems that all stakeholders would be better served if a broad range of values were allowed to function (Meglino & Ravlin, 1998). My commitment to what is a multi-faceted and complex set of circumstances is based on a concern for the multiple stakeholders who are impacted by the values phenomenon this study seeks to address.

My interest has also been shaped and refined through my own experiences. A past situation where my personal values did not align with those in my immediate environment led me to experience the type of demoralization and the feelings of subjective incompetence that Gabel (2011; 2013) describes. My interest is therefore also based on an abiding concern for others who might find themselves in situations where they find it difficult to express their value preferences. Perhaps it is no coincidence that my own value preferences cluster around an appreciation for and tolerance of different perspectives and the protection and enhancement of the welfare of people (Schwartz, 1994).

Finally, my research interest also stems from a genuine curiosity about the ways in which human values theory plays out within the complex context of healthcare. I approached this inquiry with the intention of finding out what it is really like for a selection of HCPs who seek purpose within the arena of healthcare. I am also interested in practical, contemporary matters and wish to understand better how the coexisting values phenomenon might be impacting the delivery of healthcare.

The Purpose and Significance of this Research

The purpose of this study is to illuminate the experiences of a selection of HCPs who are expected to uphold market values as they simultaneously seek to pursue their personal and professional value imperatives. The perceptions, interpretations, and experiences of those HCPs who choose their behaviors based on a prioritization of certain values comprise the data that was

used to provide a holistic rendering of the significance of the coexisting values phenomenon for the HCP participants.

It appears that no studies have qualitatively examined the interactions between business-oriented market values and the personal and professional values that HCPs appear to prefer. The literature that is focused on adapting values within the context of healthcare appears to be predominantly focused on emphasizing values associated with patient-centered healthcare in assisted living facilities. This inquiry is predicated on the belief that an investigation of coexisting values that is focused on the lived experience of HCPs will provide a useful source of rich and descriptive data (Holloway & Wheeler, 2013).

The inquiry also features implications for the disciplines of organizational behavior and business strategy. For instance, the organizational behaviors of HCPs appear to be driven by an orientation towards self-transcendence values as they focus on the immediate needs of patients in their care (Arnold, 2002; Gabel, 2013; Moyo, et al. 2015). For their part, healthcare executives are focused on the competitive aspects of healthcare and the longer term strategic positioning of the organizations in their care. Thus, the outward appearance of their organizational behaviors would suggest that they are driven by the pursuit of market values. While the literature does suggest there are benefits that can be derived from situations where a broad range of values are allowed to coexist (Meglino & Ravlin, 1998), the nature of these values can also result in forced choices between competing alternatives. The job of the healthcare manager or leader is complicated by the common coexistence of personal, professional, and market values. This study is intended to illuminate the organizational dynamics that extend from a complex values-centric reality and my purpose is to be useful and informative to healthcare's primary stakeholders, as well as those who operate in a comparable context. It is my hope that this inquiry provides

valuable insights into the merits and challenges associated with the pursuit of personal, professional and market values within the context of healthcare.

The Research Questions

This research aims to shine a light on the ordinary coexistence of personal, professional, and market values for a selection of HCPs and explore the significance of this phenomenon within the context of healthcare delivery. In order to realize this aim, the investigation involved an inquiry into *what* the HCPs who participated have experienced and *how* they have experienced a phenomenon that permeates healthcare organizations and the broader system. Three overarching research questions were used to guide this inquiry, and they are stated as follows:

1. What is the lived experience of HCPs with the co-existence of personal, professional and market values (textural and descriptive)?
2. How do HCPs experience the phenomenon of coexisting values (structural and interpretive)?
3. What is the significance of the coexistence of personal, professional and market values in healthcare for HCPs?

Overview of the Methodology, Methods and Quality Criteria

A thorough consideration of the philosophic axioms that guide various approaches to inquiry led to the identification of Interpretative Phenomenology as the research methodology that is best suited to this study of coexisting values in healthcare. The acceptance of Interpretive Phenomenology as a research methodology has its origins in the philosophies that were put forth by early phenomenologists. Edmund Husserl (1859-1938) was one of the first to suggest that a lifeworld, that of ordinary lived experience, could serve a source of valuable knowledge for understanding the nature of a phenomenon. Husserl also developed the concept of inter-subjectivity, where reality is constructed from the subjective interpretations of those who share

common experiences. HCPs share common educational and professional experiences that appear to shape their reality and the study was based on the belief that their experiences are one of the best possible sources of information for understanding the phenomenon of coexisting values in the healthcare context. Martin Heidegger (1889-1962) built upon the ideas of Husserl while highlighting his belief that humans are inherently interpretive beings. Heidegger posited that interpretation is the conduit through which reality is individually and socially constructed. He also suggested that our interpretations are rooted in a historical and social context like that which can be found in healthcare. Heidegger's emphasis on the incorporation of fore-structure also relates to this study, in that an application of the aforementioned values theory appears as integral to any meaningful interpretation of the coexisting values phenomenon. Husserl's ideas around what constitutes knowledge (epistemology) and Heidegger's beliefs with regard to how reality is constructed (ontology) bear directly upon this research, and their ideas have collectively informed the identification of Interpretive Phenomenology as the appropriate choice of methodology and the related methods (Lincon & Guba, 1985).

The lack of a clear set of steps for designing and executing phenomenological research within the Interpretivist Paradigm necessitated that I craft a flexible set of methods for use in the study. These methods were primarily derived from a synthesis of the methods suggested by Max van Manen (1991) and Paul Calaizzi (1978). Each of these authors has significant experience with the conduct of phenomenological research.

One of the steps recommended by van Manen (1991) involves orientating oneself to the phenomenon they wish to study. The process of orienting myself to the phenomenon of coexisting values included the aforementioned review of relevant literature and multiple discussions with both HCPs and administrators. These discussions ultimately led to the

identification of a site where the phenomenon is known to exist and those HCPs who agreed to participate in the study. The first section of Chapter 4 is dedicated to detailed introductions of the four doctors and four nurses who ultimately participated in the study.

Additional steps in the conduct of this inquiry included: 1) the acquisition of experiential accounts of lived experience from the HCP research participants via semi-structured interviews; 2) an identification of significant statements within each of the narrative accounts of lived experience; 3) a mining of significant statements for meaning; 4) a writing (and rewriting) of my interpretation of the meaning behind each significant statement; 5) analyzing and reflecting on those units of meaning in a search for in-case and cross-case themes; and 6) a writing (and rewriting) of research findings. These steps were pursued in an interrelated and flexible fashion, and the fusing of writing and reflection was key to data analysis. A detailing of methods that were used in data collection and analysis is offered in the middle part of Chapter 3.

The final portion of Chapter 3 is dedicated to an explication of the criteria that was used to uphold study quality. These criteria stem from the methodological placement of this phenomenological human science research in the interpretive paradigm. By adhering to specific methodologically based protocols, I sought to produce a study that is illuminating, trustworthy, and authentic, and an application of those (and other) protocols helped to ensure that this research was conducted in an ethical and legally sound manner (van Manen, 1990; Guba & Lincoln, 1989; Lincoln & Guba, 1985).

Lincoln and Guba (1985) define the trustworthiness of an interpretivist/ constructivist study in terms of "whether the findings of an inquiry are worth paying attention to" (p. 290). The trustworthiness of the current investigation has been bolstered through an application of relevant criteria developed by Lincoln and Guba (1985). I sought to realize credibility (truth value) by

involving myself in the inquiry for a prolonged period of time and checking my interpretations with both participants and peers. I also sought to enhance the truth-value of my findings via a synthesis of findings with relevant literature. I worked to promote transferability (applicability) by writing in a manner that invites a dialogic response, so that readers might recognize the HCPs experiences as their own and judge for themselves whether the findings are applicable to other contexts. I sought to ease transferability judgments via descriptions of the individualized and social context in which the HCPs practice. A multi-faceted audit trail was created to ensure the confirmability (auditability) of study findings and their implications.

Lincoln and Guba (1986a) define the quality criteria of authenticity in terms of whether an inquiry represents the realities of the stakeholders to that inquiry (fairness), whether individuals gain a more sophisticated and enriched construction of reality (ontological authenticity) and whether actors come to appreciate the value systems of others (educative authenticity). Study authenticity is further defined in terms of an inquiry's ability to facilitate and stimulate action (catalytic authenticity) and whether an inquiry can empower such action (tactical authenticity) (Lincoln & Guba, 1986a). Throughout all stages of the inquiry, I have sought to offer a fair (and balanced) representation of various viewpoints that extend from the presence of certain values. This approach worked in concert with the pursuit of educational authenticity and the related representation of differing interpretations so that stakeholders to this phenomenon might gain a deeper appreciation of the perspectives of others. I have strived to achieve ontological authenticity by providing all participants with the opportunity to gain a more sophisticated understanding of the coexisting values phenomenon. It is conceivable that some may act on a more sophisticated understanding and/or the research findings. If such action comes to fruition, I will have realized catalytic authenticity.

In terms of the ethics of the study, I sought to honor the obligation I have to the range of opinions and feelings that surfaced through the conduct of the inquiry. The ethical and legal obligation to protect the confidentiality of those offering their candid stories of lived experience is being upheld by keeping the participants identities and the organizational affiliations they have (or have had) concealed; and through the secure storing of sensitive study files (U.S. Department of Health and Human Services, 2009). Throughout all phases of the study, I have sought to honor the ethical and legal obligations I have to all the stakeholders who may conceivably be impacted by this investigation into the coexisting values phenomenon (van Manen, 1990). The application of the ethical and legal components of the quality criteria were integrated with the trustworthiness and authenticity criteria, and the integrated application of these criteria was integral to an arrival at research findings.

Overview of the Research Findings

An application of the theory identified in the search of relevant literature and the methodology, methods, and quality criteria informed the construction of five essential themes and thirteen sub-themes. It was found that that the HCPs who participated in the study experience 1) professional opportunities to enact personal value imperatives; 2) the paradox of patient satisfaction; 3) an association with the pharmaceutical industry; 4) varying levels of exposure to market values; and 5) quality leadership and administrative support. Each of these themes is intended to capture one essential aspect of the whole of the HCPs lived experience with the phenomenon. Within each of the essential themes is a sub-set of themes that are offered to capture the unique ways in which clusters of study participants experience the expected coexistence of personal, professional and market values within the context of their practice. A visual representation of the five essential themes and the thirteen sub-themes that were informed

by the analysis of the data derived from interviews with the HCPs who participated in the study is included as Figure 1.

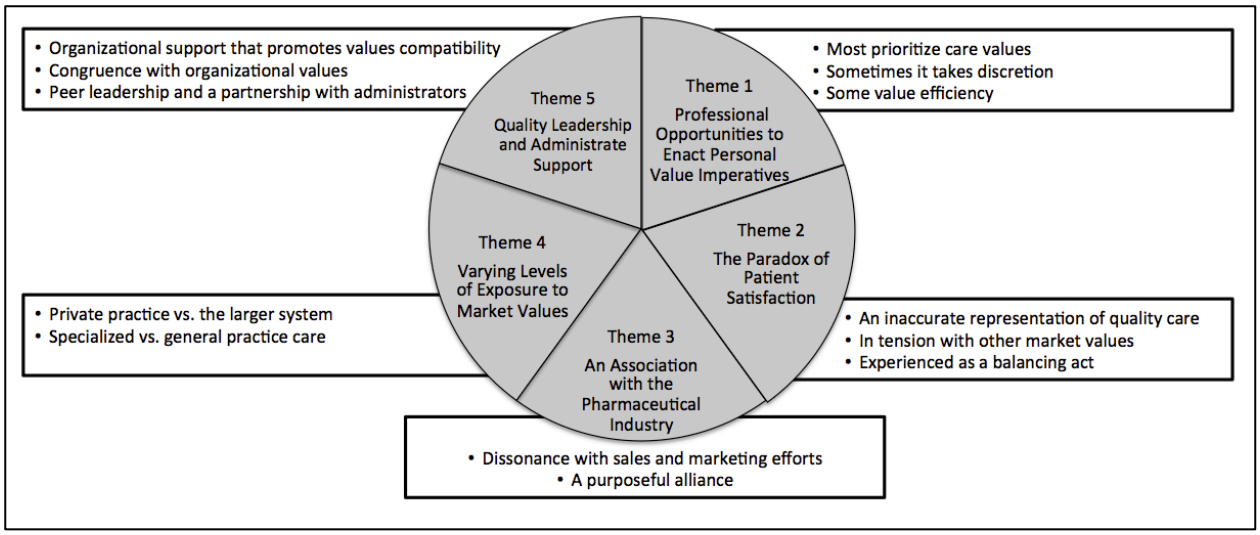

Figure 1. The five essential themes and related subthemes that were informed by the analysis of the data derived from the interviews with the HCP study participants.

The first theme that was informed by the analysis of the data derived from the interviews with the HCPs was that all eight of the participants pursue opportunities to enact personal values preferences within the context of their practice. It was found that the bulk of the participants prefer not to think of themselves as being in business and it is therefore of little surprise that most deemphasize the pursuit of values that have a market orientation. Each of the participants shared stories of their experience with the pursuit of care values and there was evidence of the altruistic, equality and capability values that Moyo et al. (2015) identified as being most relevant to HCPs. The participant interviews also served to reveal preferences for compassion, empathy, and honesty, and a propensity to put forth extra effort when it comes to the realization of care values.

It was also found that the professional pursuit of certain personal values may, or may not be, sanctioned by the health systems in which the participants worked. Two of the doctors who

participated spoke of a preference for a value that could be viewed as being oriented towards markets. For one of the physicians, a personal preference for efficiency seems to go hand-in-hand with what his system's administrators emphasize. Another physician described how his preference for efficiency and rationality stems from his in-depth knowledge of medical science (i.e. capability values). Two of the nurse participants spoke to how they have sometimes had to use discretion when it come to the pursuit of values that were not specifically sanctioned by the organization in which they work(ed). The stories that these two nurses shared illuminated how the pursuit of holistic care values and the exercise of faith-based values can compensate for the limitations of modern medical science.

The second theme that was informed by the analysis of the interviews was that the HCPs experience a paradox when it comes to the realization of patient satisfaction. It was found that the inconsistency that the HCPs experience stems from the ambiguity surrounding what constitutes patient satisfaction, and what constitutes the delivery of quality care.

Patient satisfaction data typically captured via surveys that have been developed as part of a progressive set of public policy actions on the part of the federal government. One of the physician participants spoke of receiving some the lowest satisfaction scores relative to others in his then current physicians' groups. His belief that patient satisfaction is an inaccurate representation of quality care and his statement that the broad system has an "imperfect method of assessment" (C.12), was echoed by another physician who participated in the study. She described how the current orientation toward patient satisfaction results in pressure to provide treatment that she would not ordinarily suggest, simply because her patients demand it. While Cleary (2016) suggests that an emphasis on patient satisfaction leads to positive patient outcomes, the experiences of these two physicians would suggest otherwise. Their experiences

are in keeping with a common belief that patients have been put into the role of being consumers (Junewicz & Yougner, 2016; Zgierska, Rabago, & Miller, 2014). It was found that treating patients as if they were consumers undermines HCP morale and their ability to exercise expert judgment. Junewicz and Yougner (2016) and Zgierska, et al.(2014) posit that when physicians are compelled to acquiesce to the requests of their patient it can result in interventions that are medically unnecessary and a level of quality that is sub-optimal.

Several of the HCPs spoke of the potential for conflict that is inherent to expectations that they simultaneously realize patient satisfaction and uphold what Avedis Donabedian (2003) termed *production-efficiency*. While most did convey an understanding that the goal of efficiently producing the goods and services that are used to provide healthcare is necessary for organizational viability, some shared stories that suggest that the orientation towards production-efficiency is leaving patients feeling unsatisfied. HCPs from across practice areas shared anecdotes which suggest that they are experiencing increasing level pressure to uphold these market values; the greatest level of pressure seems to be felt by physicians in general practice areas.

The interviews that I conducted with two of the doctors and two of the nurses served to reveal the judgment, skill and knowledge that is required to realize patient satisfaction while delivering quality care in a productive and efficient manner. The HCPs described routine situations where they are put in the position of having to weigh which of these values should be given priority. They conveyed an understanding that the delivery of quality care often requires one to deliver bad news and provide advice that is either unwelcome or will cause discomfort. It was found that negotiations are used to manage the tension between patient expectations and the delivery of care that the physician believes is the best course of action. Through the course of the

dialogue, it became clear that the HCPs leverage a combination of clinical knowledge and skill to uphold patient satisfaction. When they encounter the inevitable conflict with production-efficiency, they prioritize patient satisfaction "every time" (A.17). Taken together, the findings on the paradox of patient satisfaction suggest that we would do well to understand how the current emphasis on patient satisfaction might blur the line that distinguishes care values from market values.

The third theme that was informed by the data was that some of the HCPs experience an association with the pharmaceutical industry. The complex relationship between profit driven pharmaceutical companies and the broad healthcare system was evident in the stories of experience that participants shared. Some participants experience dissonance with the sales and marketing efforts of the industry, whereas others expressed value resonance with industry efforts to get patients needed medications.

Several of the HCPs have experienced a disassociation with the sales and marketing efforts of the pharmaceutical industry. One participant shared a story of how the sales tactics that were applied by a pharmaceutical sales representative failed to take into account her personal concern for patient outcomes and one of the doctors spoke of experiences with the advertising efforts of pharmaceutical companies and how those efforts sometimes work at cross-purposes with his preference for collaboratively evaluating all care options in partnership with his patients. Another physician who participated in the study appears to experience a far greater level of dissonance with the sales and marketing efforts of pharmaceutical companies. His experience with such companies had led him to conclude that the entire industry is uninterested in making people better.

There was significant difference in the way in which two of the nurses who participated have experienced the pharmaceutical industry. Each described a close working relationship with pharmaceutical companies, whereas they work to procure funding that allows their patient to receive medications they would otherwise not be able to afford. While such actions take these nurses further into the business side of healthcare than they would ordinarily like to go, they described how their efforts are justified by a desire to deliver compassionate care and the mutually reinforcing benefits that stem from their efforts.

The fourth theme to that was informed by the conversations with those who participated in the study goes to the varying levels of exposure that physicians have to market values. It was found that the type of system in which one practices influences how exposed a doctor will be to market forces. Those in private practice are likely to experience a greater level of direct exposure to market forces and therefore need to consider how those forces impact their ability to realize care values like providing open access to care. Those who practice in larger systems are more likely to be able to provide open access largely because of the patient volume that the bigger systems can accommodate.

It was also found that those who practice in specialized areas are less exposed to the market values of productivity and efficiency as compared to those physicians in general practice areas. When a patient schedules an appointment with their general care provider they often come with a series of health concerns that may or may not be related to one another. General practice providers are therefore expected to attend to a list of health concerns within a twenty-minute appointment window. The dueling expectations of their patients and their system administrators results in a proportionately higher degree of pressure on general practice providers. The conversations with two of the physician participants suggest that these providers are more likely

to experience the feelings of demoralization and subjective incompetence identified by Gabel (2011; 2013) and ultimately succumb to the burnout that has become an increasing concern for those who care about our care providers (Bodenhemer & Sinsky, 2014; Feldman, 2018; Lacy & Chan, 2018).

The fifth and final theme that was informed by the analysis of the data is that the HCPs experience quality leadership and administrative support that affords them the opportunity to pursue personal and professional value imperatives. It was reported that the leadership of the organization where the bulk of the HCPs work operates with an understanding that they can collectively realize higher levels of effectiveness when their HCPs are motivated to pursue their care-oriented values. The managers and leaders who occupy administrative roles in the organization where most of the HCPs currently work are those most likely to be concerned with the pursuit of market values, and these administrators are prone to enact policy that allows for the realization of care values.

Two of the HCPs drew a distinction between the type of leadership and support that they have experienced at various stages of their respective careers, and their preference for the more humanistic approaches to which they have been privy. One of these HCPS expressed a feeling of congruence between his personal and professional values and those emphasized by the organization. Several other HCPs also reported experiencing such congruence and all those who reported values congruence conveyed a sense of gratitude for the freedom to pursue their core values. The feelings of support and values congruency that were shared by participants were likely influenced by the fact that the organization is one where HCPs occupy leadership roles. The practices of putting HCPs in leadership roles and providing the support that is need to attain care values preferences while delivering messages that promote value congruence are in keeping

with those that were found in the nation's top performing academic medical centers (Chatfield, Byrd, Longenecker, Fink, & Gold, 2017). The implementation of such practices appears to inspire the common belief that the organization where most of the HCPs work is one that is led by competent administrators.

Overview of the Study Implications

The analysis of the data derived from interviews, along with a consideration of the multiple layers of context, suggests that the HCPs have significant experience with most of the values constructs that informed this inquiry. The research findings also point to a set of implications for practice, theory development, and future research. My experience with this research project resulted in a set of implications for others who might endeavor comparable research. Each of these sets of implications is discussed in detail in Chapter 5. This final section of Chapter 1 is intended to provide an overview of the implications that were informed by my analysis of the data that was gathered during interviews with the eight HCPs who participated in the study.

The stories and anecdotes that participants shared served as evidence that human values exist on both individual and collective levels, and that such values motivate actions on the part of individual HCPs and/or collective entities. Participants shared their personal and professional value preferences and discussed how they serve as criteria for interpreting, justifying, and judging events they encounter. For several of the HCPs, their values seemed to be most active when they were confronted with a value type that opposed their own values preference. Personal values preferences led many to the choice of becoming a HCP regardless of whether the values that were encountered earlier in life were perceived as conflicting or compatible.

Through the conduct of the inquiry, I found evidence that pointed toward how difficult it would be to distinguish between a HCPs personal values and those that might be classified as professional and there were clear preferences for the altruistic, equality, and capability values that were identified by Moyo et al (2015) as being most relevant to HCPs. However, there were notable exceptions, specifically in terms of preferences for values that were absent from the theoretical frameworks that informed this study. Preferences for holism, spirituality, and patient satisfaction values emerged as being quite relevant to those who participated in the study. The finding from this research also implies that certain values may not be as distinguished from one another as the theories that position certain values as working in opposition to one another would suggest (e.g. the pursuit of altruism is not necessarily working in opposition to the pursuit of capability values within the context of healthcare delivery).

The findings from the study also point toward the presence of beneficial and problematic consequences that emanate from expectations that personal, professional, and market values can coexist. The findings suggest that systems may realize increased levels of viability when HCPs use their capability values in ways that allow them to simultaneously realize efficiencies. However, there was also evidence that significant problems can occur (e.g. demoralization; burnout) when general care providers are expected to uphold productivity values.

The findings from this investigation point to significant implications for practice. Increasing levels of commercialization and an increasing level of policy-backed emphasis on patient satisfaction has allowed patients to become consumers. As a society, we would do well to view healthcare as being distinct from ordinary forms of commerce and honor the finding that HCPs prefer to not think of themselves as business people, but as care practitioners. HCPs often choose a practice area based on their personal value preferences and they undergo significant

training to develop the capabilities we expect. As patients, we should refrain from applying pressure that undermines the expertise that our HCPs have developed.

While the findings from this study suggest that burnout is mostly experienced by physicians in general practice areas, others points to research that indicates a significant increase in burnout across all specializations (Feldman, 2018), and feeling of demoralization among all of care providers (Sikka, Morath, & Leape, 2015). Taken together, these findings imply that policy makers and system administrators should pay careful attention to the pressure that is applied to our HCPs. The broad health system is reliant upon the motivation that the HCPs derive from the pursuit of their personal and professional care value preferences and it appears that the administrators consider their HCPs' pursuit of such values to be a source of competitive advantage**.**

System administrators would do well to put into practice the types of organizational interventions that have been found to be effective for enabling the pursuit of care values and addressing instances of HCP burnout (Lacy & Chan, 2018). For their part, HCPs should practice introspection and develop the self-awareness that may alert them to the warning signs (e.g. competing values; lack of control over their work; demoralization) and potential for burnout (Feldman, 2018; Lacy & Chan, 2018; Maslach & Leiter, 1997).

The conduct of this inquiry and the findings within also feature significant implications for theory development and future research. The stories and anecdotes that the HCPs shared served to reveal gaps in the values theory that was used to inform this study. Future efforts should be directed toward the development of theory that features a more detailed identification of the values that HCPs are expected to uphold. The finding that the pursuit of personal and professional values may motivate HCPs to engage in Organizational Citizenship Behaviors

(OCBs) also warrants attention. Future research should be directed toward a consideration of care values (e.g. altruism) as antecedent to OCBs, and how the motivation that is derived from a HCP's pursuit of his or her personal and professional preferences may be contributing to organizational effectiveness.

The findings on the increasing levels burnout among HCPs also suggest a need for more research. Future studies should be targeted toward an exploration of all potential causes of burnout, including expectations of productivity and the upholding of patient satisfaction, and any other market pressures that may be preventing our HCPs from realizing their personal and professional value imperatives. Additional studies should be directed toward developing an enhanced understanding of the leadership and administrative practices that may alleviate the potential for demoralization and burnout and how various forms of leadership (e.g. transformational; adaptive work) may help HCPs and their organizations navigate the ongoing changes in the broad health system. If the market-based solution to healthcare reform remains in place, future research should also be directed toward an exploration of the pursuit of competitive advantage and how the organizational pursuit of self-interest may or may not be contributing to the realization of the Institute for Healthcare Improvement's (2009) *Triple Aim* of improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of care.

This investigation of coexisting values in healthcare is the product of a prolonged engagement with human values theory and a thorough consideration of various research methodologies. In Chapter 2, I offer a more detailed interpretation of relevant values theories and descriptions of the consequences that were identified in my search and synthesis of the informing literature. Chapter 3 features a further explication of the philosophic tenants that informed the

choice of Interpretive Phenomenology as research methodology, and significant detail on the related methods and the criteria that were employed to ensure study quality. The application of methodology, methods and criteria were used to arrive at findings that are representative of the HCPs' experiences with the coexisting values phenomenon. Chapter 4 opens with an introduction to these HCPs and moves into a discussion on findings that is organized into the five themes that were informed by my analysis of the data. Chapter 5 features an enhanced level of detail on how the theory that informed this research was evidenced in the study and this dissertation concludes with a discussion on my experience with the research methodology and a detailed discussion of implications for practice, theory development and future research. It is my sincere hope that the following four chapters will be of benefit to all those who engage with the text.

CHAPTER 2 - LITERATURE REVIEW

Philosophers have struggled ineffectually with value problems for centuries (Hartman, 1959; Maslow, 1959). Researchers have conceptualized values as needs, interests, attitudes, traits, valences, cognitive events, organizational effectiveness indicators and the basis for shared norms (Amos & Weathington, 2008; Hitlin & Piliavin, 2004; Meglino & Ravlin, 1998; Williams, 1968). The scientific study of values in social systems is complicated by these relationships to related constructs (e.g. needs and traits) and their co-variability with one another (Connor & Becker, 1994; Rokeach, 1973). As an extension of their interwoven and dynamic properties, human values are often considered too subjective, too complex or too abstract to be isolated and objectively measured (Hitlin & Piliavin, 2004; Rokeach, 1985). This is not meant to imply we should ignore them; as human values are considered to be one of the main catalysts of human behavior (Kluckhorn, 1951; Rokeach, 1973). Values are also considered central to most organizational phenomenon (Connor & Becker, 1994); and an in depth understanding of the values theory that inheres in context is integral to understanding *how* the HCPs experience the phenomenon of coexisting values and *what* their experience has been with expectations that personal, professional and market values can coexist.

The purpose of this chapter is to offer a review of informing literature in order to 1) identify, describe and substantiate the relevant values theories that guided the inquiry (Hart, 1998); 2) explore, interpret and synthesize the informing theories in relationship to this investigation; 3) offer an interpretation of consequences that are believed to emanate from the coexistence of personal, professional and market values in healthcare systems; and 4) explore

what has been done and what needs to be done to further investigate the expected co-existence of personal, professional and market values in healthcare system.

In order to address the aforementioned purposes of this literature review, I examined both articles and books. Relevant articles were predominantly collected through electronic databases. Accessed databases include Academic Source Premier, Business Source Complete, Business Source Premier, Google Scholar, MEDLINE, PsycARTICLES, PsycINFO, Psychology and Behavioral Sciences Collection and SocINDEX. Databases were accessed through both the Colorado State University and University of Denver library systems. The search for relevant literature made use of numerous search terms that were used in combination with one another. Search terms included; individual values; personal values; employee values; values as motivation; organizational values; professional values; healthcare; healthcare systems; culture change, market culture; business values; healthcare providers; and healthcare practitioners.

Both theoretical and empirical articles on personal, professional and market values were considered for inclusion into the literature dataset (Whittmore & Knafl, 2005). Articles were screened and assessed for their usefulness in informing independent conceptualizations of personal, professional or market values, and for their usefulness in exploring relationships between these constructs. Articles that provided a general conceptualization of the relationships between the values constructs and those that addressed this relationship within the context of healthcare were considered for inclusion into the data set. Additional literatures were also selected into the data set when an author's body of work was routinely referenced and deemed integral to an informed conceptualization of the values constructs and/or the relationships between them.

The induction of books into the data set was undertaken when content was deemed essential to both understanding (Callahan, 2010) and deconstructing (Torraco, 2005) the theoretical origins of personal, professional or market values. For example, Parson and Shills (1951) are routinely referenced in the values literature as editors of the book *Towards a General Theory of Action*, in which numerous authors contribute manuscripts featuring unprecedented detail on theories of human values and their motivational properties. Books were also considered and selected into the data set if the text was routinely cited as one that explores the relationship between the constructs of personal, professional and market values. Freidson (2001), for example, is commonly referenced as an author who calls for a restoration of traditional medical professional values in light of the emergence of market values in healthcare. Books were accessed through the libraries at the University of Denver and Metropolitan State University of Denver.

My interpretation of the findings from the review of what I identified as relevant literature is offered in five parts. I begin with a general conceptualization of human values that is meant to explore the role values play in informing interpretations and motivating social behavior. This is followed by a discussion of professional values and those that appear in healthcare organizations. A discussion focused on the personal and professional values of HCPs is offered next. This is followed by a general conceptualization of market values and their place within healthcare organizations. Chapter 2 concludes with an identification of the consequences that emanate from the coexistence of personal, professional and market values in healthcare organizations.

A General Conceptualization of Human Values

A useful starting point for a general conceptualization of human values can be found in Rokeach's (1973) definition of human values which positions them as criteria used to adopt " an enduring belief that a specific mode of human behavior (or end state of existence) is personally or socially preferable to an alternate mode of behavior (or end state of existence)" (p.5). The Rokeach (1973) conceptualization of values, which extends from the work of earlier theorists such as Kluckhorn (1951) and Williams (1968), is important to consider in that it provides a foundation for understanding the pursuit of human values as phenomena where psychological and social preferences interact in ways that guide individual and collective interpretation(s) of environmental events.

An individual's personal values involve socially influenced conceptions of what is personally desirable and inform what that person believes they should strive for, as well as the emotions one experiences when selecting from the available modes, means and ends of individual action (Kluckhorn, 1951; Rokeach, 1973; Williams, 1968). A person's cognitive and affective experience with values is believed to refine their preferences for certain values (Parson & Shills 1951; Schwartz, 1992). There appears to be agreement that preferences for groupings (constellations) of comparable values transcend specific situations and at the same time, these preferred values are contextually reprioritized (Connor & Becker, 1994; Parsons & Shils, 1951; Rokeach, 1973; Rokeach & Ball-Rokeach, 1989; Schwartz, 1992; 1994, Schwartz & Bilsky, 1987, 1990). Depending on the social context in which an individual is operating, groupings of values that are personally preferred are activated and re-ordered for the purpose of selection of action (Parsons & Shils, 1951; Rokeach, 1973).

Abraham Maslow (1959), whose name has become synonymous with the motivating properties of a hierarchical progression of contextual needs, posited that personal needs are akin to personal values. Embedded in his well-understood theory of motivation is the idea that the attainment of periodic, lower-level needs are steps along the way toward the realization of the highest order personal value, that of self-actualization. He considered self- actualization, the common desire to realize one's full potential, to be the ultimate value. In this view, self-actualization is a far-off goal towards which all individuals strive. Rokeach (1973) preferred the name "terminal values" to "represent the super goals beyond immediate, biologically urgent goals" (p. 14). The view of ultimate values as a source of motivation was also endorsed by Kluckhorn (1951), who used the moniker "goal values" to describe "the aims and virtues which societies and individuals make for themselves" (p. 413). The review of the literature on values suggests that needs and values are interwoven motivational constructs and therefore collectively inform personal systems of action (Allport, 1958). It seems that regardless of the name used to describe them, these ultimate/ terminal /goal values serve a higher-order motivational function.

Once internalized, personal values function as "standards of conduct" (Meglino & Ravlin, 1998, p. 356), and a type of anchor that allows one to be true to one's self (Graber & Kilpatrick, 2008). Individual actions that are consistent with internalized notions of an ideal self promote a sense of inner harmony. Conversely, personal actions that are inconsistent with idealized values will result in feelings of guilt, shame or self-deprecation (Kluckhorn, 1951). While personal values are believed to have an enduring quality, they are also considered to be changeable under conditions that threaten individual self-regard (Brown & Trevino, 2009; Meglino & Ravlin, 1998; Rokeach, 1973).

Personal values are generally conceptualized as containing a unique quality of *oughtness* (Feather, 1992; 1995; Meglino & Ravlin, 1998; Rokeach, 1973). This term relates to individual beliefs about how one believes they should behave (Feather, 1992; Rokeach, 1973) and is based on "internalized interpretations about socially desirable ways to fulfill his or her needs" (Meglino & Ravlin, 1998, p. 354). For example, personal preferences for certain values may inform the choice to enter a healthcare profession because of the perceived benefits to society, as well as, a more selfish need to earn a living (Graber & Kilpatrick, 2008; Meglino & Ravlin, 1998; Thorpe & Loo, 2003). This inquiry is predicated on the idea that personal values are self-evident truths and that such values provide us with an individually sound basis for reasoning. However, it is also important to consider that within the context of healthcare, personal, professional and market value preferences all appear to be subject to the interpretative perceptions of others (Hartman, 1959).

It is generally accepted that when the pursuit of personal values is thwarted by the presence of other values in one's social environment, an individual will experience a state of internal tension (Lewin, 1951; Parsons & Shils, 1951; Schwartz, 1994; Schwartz, et al. 2012). Tension states created by conflict between coexisting values that are perceived as dichotomous are akin to psychological forces that block (vs. enable) progress towards a personal goal (Lewin, 1951). Parson and Shills (1951) referred to the forced choice among such alternatives as *pattern variables* and suggested that there are five pairs of pattern variable dichotomies that comprise the value system that determines selection of action. Regardless of what might be the correct number (or types) of pattern variables, such dichotomies are conceptually important to an understanding of human values and the personal motivation that derives from efforts to resolve tension states (Parsons & Shils, 1951). It believed that personal values-based motivation is most active when

an individual's value system is threatened by a value of the opposite type (Schwartz, et al., 2012). Such a situation will likely spur an individual HCP to resolve the tension created by the presence of opposing values. When persons, such as HCPs, are unable to resolve such tensions, it is believed that they will experience lower levels of personal satisfaction (Meglino & Ravlin, 1998).

In an effort to define a universal structure of relationships among human values, Schwartz and Bilsky (1987; 1990) conducted cross-cultural research and ultimately arrived at an identification of eight domains within which universal human motivations are expressed. In subsequent research, Schwartz (1992; 1994) refined the theory of universal values and expanded the number of motivational value domains to ten. Schwartz (1992; 1994) identified bi-polar value dimensions that bear some resemblance to the pattern variable dichotomies identified by Parsons and Shills (1951). However, Schwartz (1992; 1994) suggests that the set of ten universal human value domains can be summarized by viewing values as existing between just two bi-polar dimensions. One of these dimensions features a continuum of values ranging between the higher-order values of self-transcendence and self-enhancement (Schwartz, 1994). A second higher-order value dimension features a continuum of values ranging from conservationism to an openness to change (Schwartz, 1994). Schwartz's (1994) depiction of the structural relationship among the higher order value dichotomies and the underlying motivational value types is included as Figure 2.

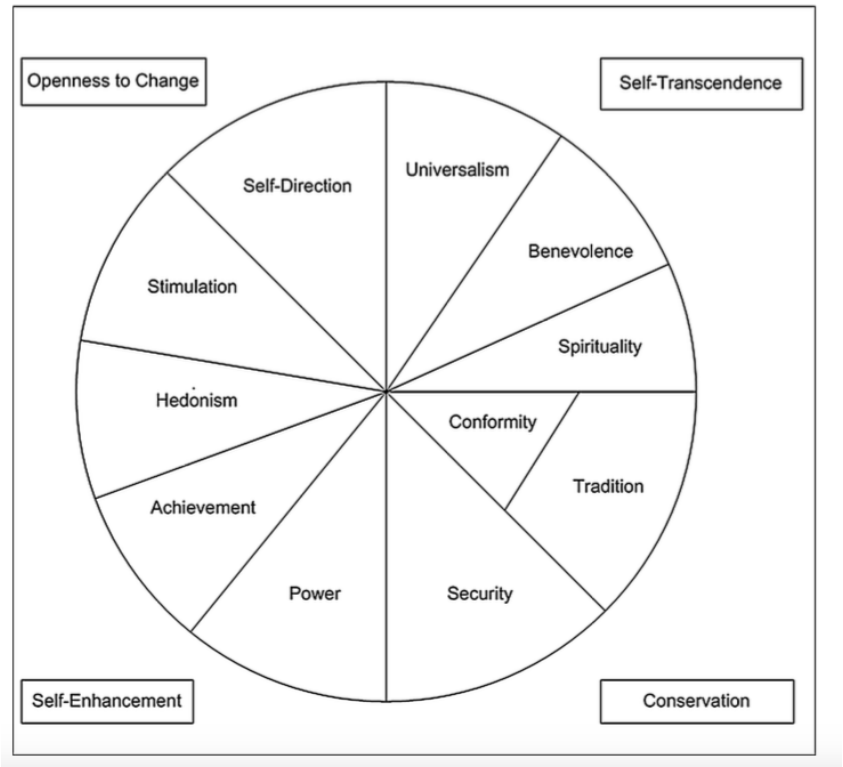

Figure 2. Schwartz (1994) structural model of relations among the motivational types of values, higher order value types and bi-polar dimensions.

As we can see in Figure 2, the four higher-order value classifications are located on the periphery of the circumplex model. The higher-order human values that exist at the opposite ends of each of these two continuums are conceptualized as opposite value types. Schwartz (1994) posits that within each of the ten universal value domains lies a subset of human values. While the number of values that could be studied appears to be infinite, the Schwartz (1994) model is useful in that it provides some structure and it grounds to the complex interrelationship among the countless number of combinations of value priorities.

Schwartz (1994) posits that the lines that partition the ten motivational value domains in Figure 1 are a matter of conceptual convenience and that there is overlap between the values in neighboring domains. Therefore, values in neighboring domains can more easily intermix.

Conversely, values that lie in more distant domains "should be discriminated clearly from one another" and "express opposing motivations" (Schwartz, 1994, p. 25). This part of the Schwartz (1994) theory is in line with what appears to be a consensus among other human values theorists; specifically that some human values are more compatible with one another and that other values conflict with one another (Kluckhorn, 1951; Meglino & Ravlin, 1998; Parsons & Shils, 1951; Rokeach, 1973; Schwartz & Bilsky, 1987; Schwartz, et al., 2012). For example, a healthcare organization's pursuit of market values may be in accord with the personal preferences of some individual organizational members, but contrast sharply with the professional values found in some healthcare professions.

An understanding of the distinction that Argyris and Schon (1978) and Senge (1990) draw between values that are *espoused* and values that are *in use* is also relevant to a study of the expected consistence of certain value types. This difference bears upon the inquiry in at least three ways. First, the literature on values in healthcare may espouse values that are inconsistent with those values pursued in practice (Moyo, et al. 2015). Second, when a healthcare organization espouses certain values (e.g. risk taking) they may be incongruent with those behaviors that it actually reinforces (e.g. safety; evidence based practice). Finally, the espoused/in use difference may also manifest itself at the level of the individual HCPs. "When an individual's values are different from those in his or her social environment (e.g. unit, organization), the values of the social environment may influence what the individual says, but may not accurately predict how he or she will actually behave" (Meglino & Ravlin, 1998, p. 356). It was important to acknowledge from the onset of the study that there would be ambiguity emerging from the various ways in which human values intermix, and varying interpretations of reality emerging from the complex interrelationships among and between different value types.

Schwartz (1994) defines human values as "desirable trans-situational goals, varying in importance, that serves as guiding principles in the life of a person or other social entity" (p. 21). The investigation of the coexistence of values in healthcare was predicated on Schwartz's (1994) definition of human values; and a synthesis of his values theory with that of others discovered in the literature review. In the conduct of the study human values were viewed as:

1. Interpretive criteria, rather than qualities that are inherent to an object.
2. Existing at the individual (i.e., personal) and collective (i.e., professional and organizational) levels.
3. Serving the interests of an individual and/ or some social entity.
4. Existing along a continuum of goal-based motivations that are anchored by dichotomous higher-order values.
5. Interwoven and dynamically functioning as standards for judging, selecting and justifying actions.
6. Conflicting or compatible depending upon the degree of perceived similarity.
7. Differing in terms of those that are declared (espoused) versus those that are practiced (in use).

Professional Values in Healthcare

Much like personal values serve as guiding principles for an individual, professional values serve as guiding principles for a collective (Schwartz, 1994). Kubsch, Hansen, & Huyser-Eatwell (2008) define professional values as "standards for action accepted by the practitioner and the professional group that provide a framework for influencing the behavior of the group" (p. 375). Such values serve the interest of a group and function as standards for judging and justifying actions taken by HCPs as members of the various medical professions (Schwartz, 1994).

Professional values are co-constructed through socialization processes that involve learning and internalizing values (Cohen 1981, as cited in Moyo, et al., 2015). While the process of learning values that are common to the healthcare professions may begin at any point in a person's life, a more formalized process of socialization takes place during medical education

and training programs (Kubsch, et al. 2008). Such programs are typically administered and delivered by existing members of the healthcare professions and these individuals often serve as role models for those in training (Freidson, 2001). Professional socialization is believed to have a homogenizing effect on professional values, and with that, bring some commonality to the values that a professional group emphasizes (Graber & Kilpatrick, 2008; Hofstede, Hofstede, & Minkov, 2010; Rokeach, 1973). The professional values of medical practice are articulated in the literature on medical professionalism and are formally expressed in professional oaths and codes of ethics.

Medical professionalism. Professionalism involves the pursuit of values and is generally conceptualized as a type of institutional logic that functions alongside other (i.e., managerial and market) logics within organizations (Freidson, 2001). The connection between logics and values is made clear in the writing of Thornton and Ocasio (1999) and Freidson (2001). Thornton & Ocasio (1999) define logics as "the socially constructed, historical patterns of material practices, assumptions, values and beliefs by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (p. 804). Logics provide the "formal and informal rules of action, interaction and interpretation" (Thornton & Ocasio, 1999, p. 804) and "these rules constitute a set of assumptions and values, usually implicit, about how to interpret organizational reality (Thornton & Ocasio, 1999, p. 804). Freidson (2001) refers to professionalism as *The Third Logic* and defines it as "an ideology serving some transcendent value and asserting greater devotion to doing good work, over economic reward" (p. 180). His writing on medical professionalism is routinely referenced by those who call for an emphasis on the self-transcendence (vs. self-interest) values that motivate the delivery of patient-centered care (Light, 2010; Relman, 2007).

In a comprehensive review of the literature on medical professionalism that spanned a 30-year period, Arnold (2002) found the value of altruism to be the most common among the medical professions. The attainment of the professional value of altruism involves putting others before self, while striving to aid those seeking the help of a medical professional (Arnold, 2002; Moyo, et al. 2015). Arnold (2002) also found that authors gave varying levels of emphasis to the professional values of accountability, duty, advocacy, service, social responsiveness and empathy.

In their qualitative study that involved a conceptualization of medical professionalism, Van De Kamp, Vernooij, Grol and Bottema (2004) found the values of altruism, accountability, respect and integrity to be frequent elements of definitions and descriptions of professionalism among physicians. According to Van De Kamp, et al. (2004) these exact qualities are incorporated into the Hippocratic Oaths administered in medical schools, which "suggests that some authors feel the term professionalism refers to the core values of the medical profession" (p. 700). The Florence Nightingale pledge, which was adapted from the Hippocratic Oath (Gabel, 2013), is the commitment made by nurses to uphold similar values to those found in the research of Arnold (2002) and Van De Kamp, et al. (2004).

Healthcare oaths and pledges. Professional healthcare provider oaths serve as a public declaration of the intended application of accepted professional values (Aquilar, Stupens, Scutter, & King, 2013; Gabel, 2013). Codes such as the International Council of Nurse's (ICN) Code of Ethics and the American Nursing Association's (ANA) Code of Ethics are also declarations and within these ethical codes we find the fundamental values that are espoused in the nursing professions (LeDuc & Kotzer, 2009). Such declarations provide "a guide for action

based on social values" (http://www.icn.ch/who-we-are/code-of-ethics-for-nurses) and involve a broader commitment to society at large (Van De Kamp, et al. 2004).

LeDuc & Kotzer (2009) used the ANA Code of Ethics as a basis for a study of professional values among nurses at various stages of their career. These researchers found a consistency of patient advocacy, health promotion and client safety values, regardless of career stage. In a comparable study, Rassin (2008) measured 20 values expressed in a code that is based on the ICN Code of Ethics. He found the professional values of human dignity, equality among patients and the prevention of suffering to be those given the highest priority by Israeli nurses. While these quantitative studies do offer a useful data point for understanding the values present in healthcare, there are limitations. The choice to base a quantitative study on a specific oath or a code of ethics will have a prescriptive influence on the professional values that are identified as important to the medical professions, and may favor those professional values that are emphasized as part of the medical tradition.

Numerous institutions have advocated for educating healthcare students as members of inter-disciplinary teams by focusing on the values that are common to all the medical professions (e.g. patient-centered care) (McNair, 2005). Training that includes a focus on inter-professional team development appears to be becoming a more common component of medical education. Brown, et al. (2014) conducted a qualitative study that looked at the values found in inter-professional oaths that were developed by student teams as part of their participation in an inter-professional leadership development course. Not surprisingly, they found the number one theme to be team orientation. According to Brown, et al. (2014) students "are beginning to develop the values that are precursors to collaborative practice" (p. 472). A recent survey of the preferred values of practitioners at a large healthcare system operating in the Rocky Mountain region

found a team orientation to be the second most preferred value among it's HCP employees, right behind fairness and just ahead of individual responsibility (personal correspondence). Taken together, these findings suggest that, within specific contexts, collaborative values may be becoming more commonplace.

The study of inter-professional oaths conducted by Brown, et al. (2014) specifically identifies research and evidence-based practice as part of a broader professional value classification of practice excellence. Evidence-based practice is a capability that involves integrating individual clinical expertise with the best external evidence from systematic research (Sackett, Rosenberg, Muir-Gray, Haynes, & Richardson, 1996), and was considered a medical milestone when it came into favor through a 1992 publication of the Journal of American Medical Association (Montori & Guyatt, 2008). Given its current and widespread application to medicine, the literature on professional values appears to comes up short in that it features a limited discussion on personal and/or professional value preferences that favor an evidence-base and the related motivational influence on clinical decision making.

Journal publications and books that are focused on medical professionalism, public declarations and ethical codes are valuable sources of knowledge when it comes to identifying and understanding the professional values found in medicine. A general consideration of such studies serves to highlight the real commitment that those in the medical profession have to individual patients and the expectation that society places on those who practice medicine. Self-transcendence values that focus on benevolent care for those patients with whom a HCP is in regular contact and a concern for the protection of society at large appear to have an enduring quality. Altruism and patient advocacy, along with other broader value oriented and ethical imperatives such as non-maleficence, accountability, duty, respect for human dignity and

equality appear to stand as the time-tested values of the medical professions (Arnold, 2002; Gabel, 2013; LeDuc & Kotzer, 2009; Relman, 2007; Van De Kamp, et al. 2004).

The review of the literature suggests that newer professional values are being emphasized in healthcare through efforts to use the best evidence to treat patients and deliver care via inter-professional teams. The process of assimilating medical professional values is considered "an ongoing dialectic of professional socialization that it is both reflective and dynamic, in that it involves interaction between the self and others in the environment" (Handel & Gefen-Liban, 2003, p. 482). It follows that medical professional values will be given different levels of emphasis as care delivery evolves. This inquiry featured an acknowledgement that the acquisition and application of medical professional values is informed by both tradition and ongoing changes in the healthcare environment (Graber & Kilpatrick, 2008).

The Personal and Professional Values of Healthcare Practitioners

Personal values involve social conceptions of what is preferable (Rokeach, 1973; Schwartz, 1994) and the presence of certain personal values appears to guide the choice to become a medical professional (Dose, 1997; LeDuc & Kotzer, 2009; Rassin, 2008; Rokeach, 1973). While some have sought to separately classify the personal and professional values of HCPs (see Handel & Gefen-Liban, 2003; Rassin, 2008), others have chosen to study them as one set of values (Moyo, et al., 2015; Thorpe & Loo, 2003). It is often difficult to distinguish between what is a personal value and what is professional (Pipes, et al., 2005), and in practice HCPs may also experience a comparable difficulty drawing such a distinction, as personal and professional are often intertwined (Dose, 1997). In the conduct of the literature review, it was also challenging to draw a clear conceptual distinction between the personal and the professional values of HCPs. As a result, the study was based on the premise that personal and professional

values are often “inextricably interwoven” (Pipes, et al., 2005, p. 329) and that “inevitably, values compel individuals to be and to act, both personally and professionally” (Thorpe & Loo, 2003, p. 89).

In an attempt to identify a universal set of values that guide decisions on patient care, Moyo, et al. (2015) undertook a systematic review of the literature on the personal and professional values of healthcare practitioners. A secondary aim of their study was to integrate the identified values into a comprehensive framework. The researchers used the previously identified Schwartz (1994) structural relationship among human values as the basis for an identification of the values that are most relevant to HCPs. The theoretical structural of relations among HCPs’ personal and professional values that was developed by Moyo, et al. (2015) is presented as Figure 3.

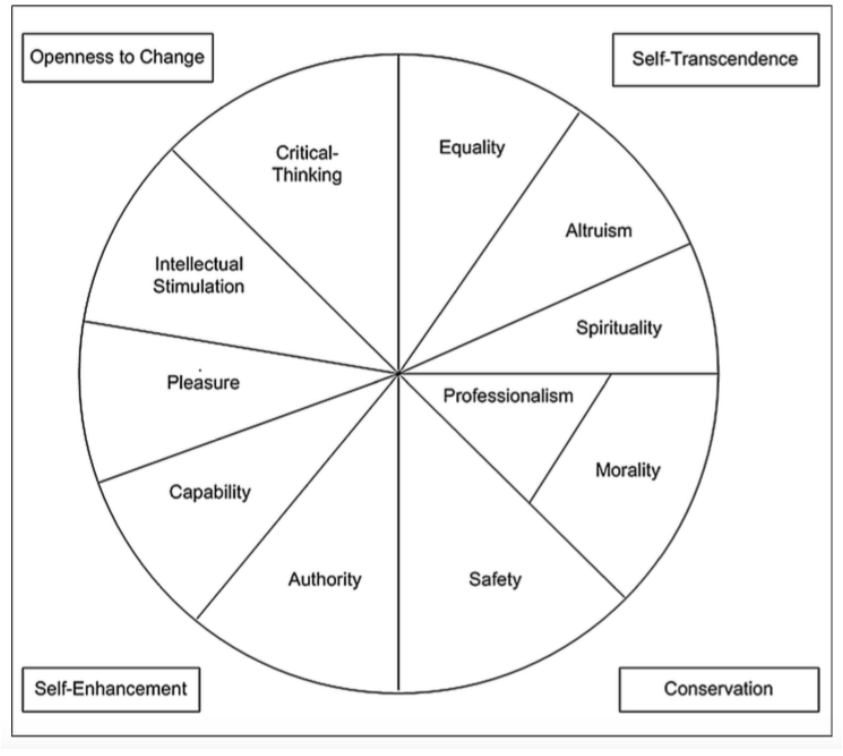

Figure 3. Moyo, Goodyear-Smith, Weller, Robb, & Shulruf’s (2015) structural model of relations among the healthcare practitioners personal and professional values.

Moyo, et al. (2015) found that the most relevant personal and professional HCP values, with the corresponding Schwartz value equivalent (in parenthesis), to be altruism (benevolence), equality (universalism) and capability (achievement). The finding that altruism and equality were the most frequently referenced values is in line with the orientation toward the self-transcendence values I discovered in the literature on medical professionalism.

According to Moyo, et al. (2015) the pursuit of the self-enhancement value of capability (achievement) values includes the pursuit of excellence, competency and knowledge. Despite the fact that Moyo, et al. (2015) purposefully omitted studies highlighting the values associated with evidence-based practice, an orientation toward the judicious use of evidence would also seem to be in line with the pursuit of capability values. The finding that capability values are common among HCPs also appears to be in line with the general conceptualization of values as goals that individuals believe they "ought" to pursue (Meglino & Ravlin, 1998; Rokeach, 1973; Schwartz, 1994) and the types of values that society expects it's medical professionals to enact (Graber & Kilpatrick, 2008).

The personal and professional values of HCPs that that Moyo, et al. (2015) identified as appearing less frequently, with their Schwartz (1994) equivalent (in parenthesis), were authority (power), intellectual stimulation (stimulation) and pleasure (hedonism). Moyo, et al. (2015) offer a plausible explanation as to why other values that are classified under the broader classifications of self-enhancement and openness to change appear less frequently in the literature. Values such as authority (power) and pleasure (hedonism) are usually not part of sworn oaths or published codes of ethics and "express motivational goals that conflict with some of the prominent values in the practice of healthcare" (Moyo, et al. p. 22).

Moyo, et al. (2015) acknowledge that a generic framework such as theirs may fail to account for all the values that are in play within the arena of healthcare. An integration of their findings with those of others suggests that a focus on ideological values (e.g. altruism; fairness) may limit our ability to holistically understand how other values may be impacting care delivery decisions. A conceptualization of coexisting values that is based on one framework may fail to adequately account for, or exclude, those values that an organization might espouse and/or those that find their way into organizations via forces that are present in the external environment (e.g. competitive; political; socio-cultural). The pursuit of the values identified as being paramount to the delivery of healthcare appear to be subject to the broader systems in which these values operate (Martin, et al., 2015). In this review of the literature, it was found that the pursuit of personal and professional values on the part of HCPs is likely to be impacted by strategically oriented market values that coexist within the current healthcare environment (Gabel, 2013; Freidson, 2001; Relman, 2007).

Market Values in Healthcare Organizations

Cameron & Quinn's (2011) research on organization effectiveness indicators led them to the development their own values framework, one that also acknowledges the dichotomous nature of certain values. In their Competing Values Framework (CVF), market organizations conceptually oppose clan (i.e., familial) organizations and are characterized by a dual orientation toward that which is external (vs. internal) and stability and control (vs. flexibility and discretion). The primary objectives of market-oriented organizations are "profitability, bottom-line results, strength in market niches and a secure customer base" (Cameron & Quinn, 2011, p. 44). The Market values that such organizations pursue are derived from models of competitive

economics (Handel & Gefen-Liban, 2003) and "the core values that dominate a market type of organization are competitiveness and productivity" (Cameron & Quinn, 2011, p. 44).

According to Cameron and Quinn (2011), organizations began to bring an increased emphasis to market values in the late 1960s, as organizations increasingly faced "new competitive challenges" (p. 43). The increasing popularity of this organizational emphasis coincides with the 1968 arrival of national health insurance for the elderly and the expansion of employer-financed health insurance (Freidson, 2001). The resulting increase in the reliability of payments for medical services attracted private investment from those seeking profit (Freidson, 2001). Investor-owned enterprises arrived on the scene to exploit protected markets, where margins were high and it was nearly impossible to lose (Light, 2010).

Corporate business values such as competition, productivity, cost efficiency, achievement, and risk taking are alleged to have gained ever increasing levels of emphasis in healthcare and such values are believed to now undergird the delivery of care at many, if not most, healthcare institutions (Evetts, 2011; Handel & Gefen-Liban, 2003; Relman, 2007). The organizational missions and policies at such institutions reflect what Handel and Gefen-Liban (2003) termed "new business values" (p. 483). Relman (2007) posits that "most not-for-profit medical institutions act like their for-profit competitors" and it is becoming increasingly difficult to distinguish these two types of healthcare suppliers from one another. The selling of medical services by corporations has been sanctioned by a market-friendly, public policy agenda that is evident in healthcare reforms (e.g. the Patient Protection and Affordable Care Act) and for-profit healthcare entities are commonplace (Freidson, 2001; Noordegraaf, 2011).

While it is seems quite reasonable to expect that the delivery of healthcare would include notions of cost effectiveness and a consideration of resources (Melia, 1995), a reliance on market

values and the accompanying ascendance of competition among healthcare organizations carries with it significant implications for healthcare delivery. A focus on competitive advantage will tend to permeate decisions involving resource acquisition and allocation (Handel & Gefen-Liban, 2003; Scott, 2008; Thornton & Ocasio, 1999). For better or worse, the prevalence of market organizations, and the values that come with them, is believed to have permanently altered notions of medical professionalism.

Newer forms of medical professionalism that integrate the pursuit of market values are evidenced by the uptick in medical professionals who take up business roles within their organizations (Evetts, 2011; Noordegraaf, 2011). Further evidence of the connection between HCPs and business can be seen in the increasing numbers of those who seek a MBA in order to augment their specialized medical training (Scott, 2008). Such pursuits could simply be viewed as upward mobility strategies, but may also involve socially established ways in which one can pursue their more altruistic values. In this interpretation, HCPs may simply be adapting to changes in what has become a government sanctioned, $3.3 trillion industry.

Coexisting Values in Healthcare

The current reality of today's healthcare environment appears to be one where a range of personal, professional and market values are expected to function alongside one another. My synthesis and interpretation of relevant literatures served to identify some of the potential outcomes that come about when such values intermix. There appears to be a counterbalancing effect when values coexist, as well as consequences that can be categorized as beneficial or problematic. Each of these potential outcomes is discussed next.

Counterbalance among coexisting values. The finding that the altruism, equality and capability values are most relevant to HCPs suggests that HCPs place the highest priority on care (vs. market) values (Freidson, 2001; Moyo, et al. 2015; Relman, 2007). However, beginning in the 1970s and 1980s a more critical view of the practice of medicine arose as physicians came under scrutiny for an alleged use of expert knowledge for the purpose of achieving monopolistic economic gain (Evetts, 2011; Light, 2010; McNair, 2005). In this view physicians and their professional societies pursue a set of values clustered around economic self-interest, power and status and a related affinity for protecting markets via control from within (Evetts, 2011). While it could be argued that such a pursuit may still serve some patient interests; and that physicians were simply adapting to an environment where market values were coming to the fore, the practice features an orientation to a set of values that conceptually opposes those that are concerned with the enhancement of others (Relman, 2007; Schwartz, 1994). As evidence of overtreatment, under treatment and excess charges began to surface during the 1970s and 1980s it led insurance companies to engage in a "buyers revolt" (Light, 2010, p. 9).

The demands for economic value and accountability that came from such buyers were accompanied by other voices calling for a re-prioritization of values. In the mid-nineties the American Board for Internal Medicine (ABIM) began its Humanism Project which brought emphasis to values centered around altruism, while also emphasizing values such as respect for others, excellence, duty and integrity (Arnold, 2002). Freidson's (2001) writing in *The Third Logic* is considered the intellectual beacon for those who believe that the medical profession's service to political and economic interests cripples "their distinct moral position that considers their use of knowledge in light of values that transcend time and place" (p. 213). Those who agree with Freidson (2001) and the organizational efforts of the ABIM operate from the premise

that market values tend to crowd out the pursuit of important medical professional values and the social responsibilities that have traditionally guided the practice of medicine (Martin, et al. 2015; Sandel, 2013). The review of the literature served to identify a common belief that a restoration of values, centered around altruism and duty, could serve as an effective counterbalance to the excesses and deficiencies that appear to emanate from the pursuit of market values (Freidson, 2001; Relman, 2007).

While some have rallied for a return to traditional values, others have looked to an *increased* emphasis on market values as the ultimate arbitrator of social value (Light, 2010; Scott, 2008). It is interesting to consider how more perfect forms of competition might rectify market imperfections that extend from the alleged presence of self-interested players who seem to lack a societal frame (Light, 2010). It seems worthy to also consider that decreases in cost and increases in the quality of healthcare might occur if healthcare providers were unable to protect professional monopolies and patients were better able to access more complete information on prices, quality and services. While a reversal from the pursuit of self-interest values may be a challenge, a focus on the tensions that exist may very well serve as a mechanism for striking a virtuous balance between the excesses and deficiencies that appear to emanate from the pursuit of one set of values over another.

The *Triple Aim* represents a fairly recent initiative that seeks to create balance between the pursuit of care and market values. In 2009 the Institure for Healthcare Improvement posited that the simultaneous pursuit of 1) improving the health of defined populations; 2) the enhancement of the patient care experience and 3) a reduction in the per capita of cost of care could collectively lead us to "better models for providing healthcare" (p. 62). The language found in literature that advocates for the pursuit of the *Triple Aim* implies that there are benefits

that can be derived from the simultaneous pursuit of care and market values (Berwick, Nolan, & Whittington, 2008; Institure for Healthcare Improvement, 2009), and with that, it is important to consider other potentially beneficial consequences that can emanate from the concurrent pursuit of personal, professional and market values in healthcare.

Beneficial consequences of coexisting values. My interpretation of the literature on coexisting values in healthcare suggests that there are benefits that come about when the personal and professional values of HCPs are allowed to intermix with other values, including those of the market. The emphasis on evidence-based medicine and the more recent trend towards care delivery via inter-professional teams serve as examples of where the personal and professional values of HCPs can harmoniously interact with the market values that inhere in healthcare.

Evidence-based medicine (EBM) is defined as "the conscientious, explicit and judicious use of best evidence in making decisions about the care of individual patients" (Sackett, Rosenberg, Muir-Gray, Haynes, & Richardson, 1996, p. 1). Despite criticisms that the practice is a thinly veiled attempt to manage costs and erode professional autonomy, it seems apparent that routine care decisions call for the application of a common body of scientific knowledge. Such an application serves to address the adverse repercussions extending from variations in procedures, costs and quality (Light, 2010). A strong command of scientific knowledge and a preference for applying standards is an example of where the personal and professional values of capability and equality appear to effectively interface with the market values of standardization and efficiency. The practice of EBM has been enhanced by an increasing ease of access to published research and has evolved to include "an increasing emphasis on patient's values and preferences in clinical decision making" (Montori & Guyatt, 2008, p. 1814).

The emergence of care delivered by inter-professional teams is based on evidence that effective teamwork enhances the quality of patient outcomes and a need to adopt the market values of productivity and efficiency (McNair, 2005). This increasingly common approach to care delivery is intended as a response to the increasing demands of buyers who are now paying their own premiums (personal correspondence) and the presence of competitive industry players that offer standardized solutions to common healthcare needs (Christensen, et al. 2006). The practice involves the placement of increasing levels of responsibility on non-physician clinicians whose credentials and licensing is adequate for the delivery of lower levels of care (e.g. a prescription for an ear infection). In cases of ambiguity or increased levels of complexity, care decisions are likely to be made via consultation among the various members of inter-professional teams, where a physician serves as the team leader. This team approach to care is commonly referred to as medical home.

Integrated not-for-profit systems such as Kaiser Permanente and the Veteran's Health Administration have found "primary-care teams can treat more than 90 percent of patient needs with greater continuity and at lower cost" (Light, 2010, p. 277). An adoption of market values by healthcare entities has motivated good enough solutions to common ailments, improved access and reduced the cost of care (Christensen, et al. 2006). The economic realities that exist in the current healthcare environment highlight the importance of integrating the motivational aspects of personal and professional values with the practicality of market values in ways that allow for the viable delivery of quality healthcare (Evetts, 2011; Noordegraaf, 2011). It seems that inter-professional care delivery may provide a competitive advantage for those organizations where such care is commonplace, in that within these organizations we find teams of altruists (O'Reilly, Harreld, & Tushman, 2009). It is also noteworthy to consider that the World Health Organization

(2010) views the practice of inter-professional care delivery as being integral to addressing the global health workforce crisis and enabling a better response to local health needs.

Problematic consequences of coexisting values. It was found that an integration of the personal and professional values of HCPs with market values may be easier said than done. The literature on coexisting values in healthcare suggests that there are often consequences that are problematic. The trend towards a market-based system which celebrates values such as utilitarianism, competition and risk taking has caused some to raise concerns about the upholding of care values and the social commitment to patients and society at large (Freidson, 2001; LeDuc & Kotzer, 2009; Relman, 2007). It also seems that HCPs may experience adverse psychological consequences when their personal and professional values conflict with other values found in healthcare (Gabel, 2013). These consequences can make it challenging for anyone who may be seeking to infuse their organizations with market values.

In 1966, the American Medical Association (AMA) made a public declaration that "the practice of medicine should never be commercialized" (as cited in Relman, 2007, p. 2669)**.** Melia (1995) posits that an obvious change to the values found in healthcare has come about as the language of competition has nudged aside the more established discourse that is embodied in Hippocratic notions of duty and professional altruism. Like Melia (1995), Relman (2007) believes that moral considerations and ethical principles in medicine are overshadowed by market-driven values. He posits that "the fundamental ethos of medical practice contrasts sharply with that of ordinary commerce, and market principles do not apply to the relationship between physician and patient" (Relman, 2007, p. 2668). It appears that participation in what Arnold (2002) describes as "two potentially opposing social structures" (p. 508) has led some physicians to think of themselves as primarily being in business. There appears to be a shared belief that

when this happens "professional values recede and the practice of medicine changes" (Relman, 2007, p. 2668). Relman (2007) suggests that a major reason for the decline of professional medical values is the growing commercialization of the U.S. healthcare system.

The assertion that the medical professions may be losing their core values (i.e., nihilism) is often supported by pointing to the presence of industry-funded research and the significant influence the pharmaceutical industry seems to exert over clinical decision-making. It has been alleged that the pharmaceutical industry is largely responsible for the "commercial construction of medical science" (Light, 2010, p. 284). According to Montori and Guyatt (2008), "researchers funded by industry interpret their result differently and in favor of industry product" (p. 1816). This review of the literature points to a general agreement that the pharmaceutical industry also uses its financial resources to shape post-graduate and continuing education in ways that co-opt knowledge and research values (Light, 2010; Moyo, et al., 2015; Relman, 2007). Such practices obfuscate the use of an evidence base as a personal and professional value. It has been alleged that healthcare has become a market place where the pursuit of self-interest values "wastes up to 1 in every 3 dollars on administrative complexity, profits and unnecessary or unproven but overpriced procedures and products" (Light, 2010, p. 283).

Concern for nihilism also appears in the literature describing findings from studies of the values of nurses. In his study of nurse's personal and professional values, Rassin (2008) found that that altruism was ranked 12th out of the 20 measured values. He describes the relatively low ranking as "worrying" (p. 625). Thorpe and Loo (2003) suggest that nurses alter their perspectives toward the value of altruism when significant changes bring instability to the healthcare system. Gabel (2013) specifically points to recent changes in the healthcare system as an example of policy decisions that may threaten health professionals' orientation towards

altruistic values. Taken together the literature suggests that while the value of altruism does retain some legitimacy, it is perhaps less of a personal and professional motivator than it once was (Arnold, 2002; Martin, et al. 2015; Rassin, 2008) and that there may be systemic reasons for its reported decline (Gabel, 2013; Light, 2010; Relman, 2007).

Gabel (2013) suggests that problematic consequences may arise when HCPs experience difficulty acting "in an unencumbered and truly patient centered manner" (p.120). He suggests that these difficulties are a result of conflicts between the personal and professional values that HCPs prefer and the perceived values or practices that are present in the various components of the heath care environment (Gabel, 2013). Perceptions of a threat or loss to the personal and professional values that are perceived to be foundational to the healthcare professions are believed to result in feelings of demoralization and burnout among HCPs (Gabel, 2011; 2013).

In tracing the word demoralization back to its entomologic roots, Gabel (2013) finds that "it is associated with an individual's *moral* conduct, values, beliefs and goals and a loss of *morale* when important goals, needs and values are threatened or lost (p. 118). According to de Figueiredo (2015), demoralization may be viewed as consisting of two coexisting components: distress and subjective incompetence. He defines distress as "an unpleasant emotional experience of a psychological, social or spiritual nature that may interfere with the ability to cope effectively with a stressful situation" (de Figueiredo, 2015, p. 72). De Figueiredo and Frank (1982) define subjective incompetence as "a self-perceived incapacity to perform tasks and express feelings deemed appropriate" (p. 353). The market values that drive budget cuts, resource allocation decisions that reduce the quality or quantity of care, and inter-professional rivalries that stem from competitive dynamics, are all specifically mentioned by Gabel (2013) as conditions that increase the likelihood of demoralization.

Values conflict (i.e. value incongruence) can occur when HCPs "find it difficult to reconcile their values with what they perceive to be false, misleading or hypocritical values" (Gabel, 2011, p. 422). According to Maslach and Leiter (1997) conflicting values are considered to be one of the six areas that have been identified as contributing to burnout. Gabel (2011) points to multiple studies that suggest HCPs "may have an increased rate of burnout when they perceive that their ethical standards or values are not shared by the healthcare organizations with which they are affiliated" (p. 421). The pursuit of values that are geared towards maximizing revenues and limiting resource availability can be perceived by a HCP as antithetical to the practice of medicine and incongruent with their personal and professional value orientation (Gabel, 2011).

HCPs may also experience value incongruence between their personal values and those found in their organizations. Self-interest, or personal achievement values, may very well come into conflict with professional preferences for altruism. Professional notions of what it means to be collaborative may come into conflict with honesty and patient safety values when a HCP feels compelled to protect the welfare of their teammates (Arnold, 2002).

While HCPs within the various disciplines may have different views on the threat that market values pose to personal and professional values and may react differently to situations where there is incongruence with their own values, it appears that that an inability to professionally navigate such conflicts may result in consequences such as demoralization and burnout. Prolonged exposure to such consequences is believed to contribute to the loss of one's personal and/or professional identity (Gabel, 2013).

In their study of the personal and professional values of nurses and organizational values Handel and Gefen-Liban (2003) found that graduate nursing students ascribed the lowest levels

of importance to competition, risk taking and utilitarianism (i.e., the market values). Thorpe and Loo (2003) compared the values of undergraduate nursing student to those of business students and found that the future nurses in their study had significantly lower mean scores on economic and risk values. While studies that take into account recent changes to the healthcare system are warranted, these studies suggest that the values that are preferred by aspiring nurses differ from the market values that those on the business side of healthcare might prefer.

In drawing on the research of others, Graber and Kilpatrick (2008) suggest that physicians and healthcare executives each have different worldviews and that their professional identities are rooted in different professional values. A synthesis of this idea with those of Handel and Gefen-Liban (2003) and Thorpe and Loo (2003) raises interesting questions as to whether a realization of market values is within the scope of attainment for some healthcare organizations. While we know from history that some physicians have demonstrated an affinity for market values (Light, 2010), it seems that healthcare executives may find it easier to infuse their organizations with some values, (e.g. fairness; benevolence), as compared to others (e.g. risk taking; utilitarianism) (Graber & Kilpatrick, 2008; personal and confidential correspondence). Organizational efforts to aspire to certain values may also be complicated by conflicting messages that contribute to uncertainty, or confusion, with regard to what the organization truly values (Graber & Kilpatrick, 2008). An organization may espouse risk taking and adaptability in order to compete, but reward HCPs for the pursuit of capability values and a reliance on an evidence base when it comes to clinical decision making (Senge, 1990).

The problem of implementing market values also appears to be complicated by the presence of broader societal values. The American public, many of whom were raised in the faith-based traditions of selfless service and compassion, have deep-rooted expectations about

the provision of healthcare that may be at odds with a market orientation (Graber & Kilpatrick, 2008). Societal expectations that HCPs will pursue self-transcendence values are not uniquely American. When nurses in the UK's Royal College of Nursing threatened to strike some years ago they faced significant public backlash (Melia, 1995), much like that which doctors have experienced here in the U.S. beginning in in the 1970s. It seems the general public does not always approve of the exercise of market values when their doctors and nurses choose to collectively pursue them.

The review of relevant literature on the coexistence of personal, professional and market values in healthcare informed both a general conceptualization of human values and a better understanding of how certain values have come to be emphasized within the context of healthcare. The emphasis on market values that began emerge in late 1960s has provided the organizations that deliver care with both opportunities and challenges. The findings from this study (see Chapter 4) serve to reinforce the notion that those who operate at the nexus of care delivery (i.e. HCPs) are impacted by expectations that personal, professional and care values can coexist. However, before turning our full attention to study findings it is important to first explicate the methodology, methods and quality criteria that were applied to this phenomenological investigation of coexisting values in healthcare.

CHAPTER 3 – METHODOLOGY, METHODS AND THE QUALITY CRITERIA

The primary research questions that guided this investigation were rooted in a desire to explore and illuminate the experiences of a selection of Healthcare Practitioners (HCPs) with a complex phenomenon. These three overarching research questions were identified in Chapter 1 and are restated, as follows:

1. What is the lived experience of HCPs with the co-existence of personal, professional and market values (textural and descriptive)?
2. How do HCPs experience the phenomenon of coexisting values (structural and interpretive)?
3. What is the significance of the coexistence of personal, professional and market values in healthcare for HCPs?

The literature that informed the inquiry suggests that there are consequences that stem from the coexistence of personal, professional and market values in healthcare. According to this literature such consequences are directly experienced by the HCPs who operate at the nexus of the coexisting values phenomenon that this study sought to explore (Gabel, 2013; Relman, 2007). The development of an illuminating, trustworthy and authentic representation of the HCPs experience with the phenomenon required a careful and sustained consideration of various research methodologies.

According to Schwandt (2007) a methodology is a theory of how an inquiry should proceed and it involves a philosophical stance on what counts as valuable knowledge. A methodology and its underlying philosophy are principles that govern the use of particular methods. “The choice of method (or set of methods) should clearly depend on the problem under study and is employed (and given meaning) within a methodology that defines the object of study” (Schwandt, 2007, p. 193). A methodology not only informs a choice of method(s) but also

the quality standards that a researcher must adhere to in order for their study to be considered trustworthy (Glesne, 2011; Lincoln & Guba, 1998; Schwandt, 2007). The relationship between methodology, methods and study quality is therefore synergistic.

The arrival at a specific methodological approach, a related set of methods and the quality criteria that governed the conduct of the study was rooted in a thorough consideration of various philosophic axioms that ground approaches to researching lived experience (Holloway & Wheeler, 2013; Linclon & Guba, 1985). The purpose of this chapter is to 1) discuss the philosophic axioms inherent in different approaches to researching lived experience and how a consideration of these axioms led to the choice of interpretive phenomenology as the appropriate methodological location for the proposed inquiry; 2) identify the interrelated set of methods that were used to conduct the study and explicate their relationship to the proposed methodology; and 3) detail the criteria that were employed to govern the quality and ethics of this phenomenological investigation of co-existing values in healthcare.

Phenomenology as a Philosophy and Research Methodology

Phenomenology is both a philosophy and research methodology. The word derives from the Greek *phainomenon*, meaning appearance (Holloway & Wheeler, 2013). *Phenomenology* therefore, can be generically defined as the study of appearances (Holloway & Wheeler, 2013). Phenomenology has also been portrayed as the study of essences, the study of meaning, a science of consciousness, and as an exploration of human experience (Holloway & Wheeler, 2013; Racher & Robinson, 2002). Phenomenology, with its multiple definitions, is a conceptually complex proposition and its philosophic tenants are difficult to immediately grasp.

While there is no one best way to establish an understanding of the philosophic tenets of modern phenomenology, a logical starting point is to look to its origins. This section begins with

a discussion on the philosophic tenets of phenomenology as posited by Edmund Husserl (1859-1938) and Martin Heidegger (1889-1962). Many of the philosophic tenets of modern phenomenology are based on the beliefs of these two psychologists. Their respective positions relate to axioms about the nature of reality (ontology) and theories of knowledge and how such knowledge is justified (epistemology) (Dowling, 2007; Holloway & Wheeler, 2013). It is largely because of these heuristic properties that phenomenology has evolved to become an accepted research methodology in socially important areas such as education and healthcare (van Manen, 2007).

Just as ontological and epistemological beliefs shape assumptions for psychologists like Husserl and Heidegger, so too do they shape the assumptions about the nature of reality and truth made by phenomenological researchers (Guba, 1990). Such beliefs inform a researcher's world-view, or paradigm, which in turn informs the kinds of questions that a researcher might explore and how they go about doing so (Glesne, 2011). With this understanding of paradigms and how they inform various approaches to inquiry in mind, the second part of this section features a set of responses to questions commonly used to surface philosophic axioms for an inquiry (Guba & Lincoln, 2004). The responses to these questions include detail on the ontological, epistemological and methodological beliefs that the inquiry was based upon and their relationship to the study of coexisting values in healthcare. Taken together these considerations led to the identification of Interpretive Phenomenology as the appropriate methodological location for the study of HCPs experience with expectations that personal, professional and market values can coexist within the context of healthcare delivery.

Early phenomenology and its philosophic tenets. The philosophical origins of phenomenology can be traced to the writings of Edmund Husserl who is considered the first to develop phenomenology as a modern movement (Holloway & Wheeler, 2013). Husserl's concept of lifeworld has endured as one of the central tenets of modern phenomenology (Holloway & Wheeler, 2013). Lifeworld (i.e., the world of lived experience), involves the notion that humans may not take into account, or even notice, that which is commonplace, and that it takes phenomenological inquiry to examine ordinary lived experience (Holloway & Wheeler, 2013). Husserl's philosophic orientation is generally regarded as epistemic and he considered lived experience to be a fundamental source of knowledge for discovering the essence of a phenomenon (Dowling, 2007; Moustakas, 1994; Racher & Robinson, 2002).

Husserl drew much of his intellectual motivation from the work of Franz Brentano (1838-1917) and adapted Brentano's notion of intentionality (Dowling, 2007). Husserl took intentionality to mean "the essential feature of consciousness which is directed toward an object" (Holloway & Wheeler, 2013, p. 214), whereas "the act of consciousness and the object of consciousness are intentionally related" (Moustakas, 1994, p. 28). While Husserl does point to a relationship between the act of consciousness and the focal object of such consciousness, his thinking appears to be an attempt to draw a distinction between the mental (subjective) phenomena and physical (objective) phenomena (Moustakas, 1994).

Husserl believed that the essence or meaning of a phenomenon could only be understood by engaging in what he termed phenomenological reduction (Dowling, 2007; Holloway & Wheeler, 2013). The practice, which is commonly referred to as bracketing, involves an attempt to first clarify, and subsequently suspend, attitudes, beliefs, prior assumptions and presuppositions in order best understand the essence of phenomena (Dowling, 2007; Holloway &

Wheeler, 2013). For those being asked to recall lived experience this would involve a focus on pure phenomena, which is to render a description that is free of context and free of interpretation (Dowling, 2007). When those seeking to understand a phenomenon bracket they are attempting to suspend pre-understanding and conduct an inquiry that is free of judgment and free of interpretation (Dowling, 2007).

Husserl believed that, from an epistemological standpoint pre-reflective description, that is description without interpretation, represented the purest form of available evidence for objectively understanding lived experience (Dowling, 2007; Giorgi, 1992). He based his position on the earlier writings of Brentano, who was first to use the phrase descriptive phenomenology (Dowling, 2007). In this view of phenomenology, it is typically left up to others to interpret individual experience with a phenomenon. This emphasis on description is important to consider in that it can serve to convey specifically *what* an individual's experience with a phenomenon has been (Giorgi, 1992).

Whereas Husserl's philosophical beliefs are regarded as generally epistemological (what makes for knowledge of lived experience) his concept of inter-subjectivity can be classified as ontological. In this philosophic view of reality (ontology), the way humans make sense and meaning of their world is through co-creative, inter-subjective means (Holloway & Wheeler, 2013). Inter-subjectivity is the existence of a subjective reality that is based on common experiences and therefore shared by members of a community (Holloway & Wheeler, 2013).

While Husserl's philosophic beliefs seem to be largely influenced by the time in which he lived, his influence on phenomenology as a philosophy is irrefutable. His influence inspired numerous colleagues and students to pursue an understanding of the philosophy that grounds phenomenology. One of these students was Martin Heidegger.

Heidegger's beliefs are regarded as primarily ontological (Dowling, 2007). Heidegger's notion of *Dasein*, which is a concept of being, includes the belief that interpretation is intrinsic to human existence and it is through interpretation that reality is individually and collectively constructed (Dowling, 2007; Todres & Wheeler, 2001). Within his view of phenomenology we also find the belief that an essential part of being human entails the interpretive act of attributing value and significance to phenomena (Holloway & Wheeler, 2013).

The Heideggerian notion of phenomenology views every encounter as an interpretation rooted in historical and social context which, like the commonplace or the ordinary that is part of one's lifeworld, may be overlooked (Koch, 1995, as cited in Holloway & Wheeler, 2013); that is, until one has chance to reflect on such context. Heidegger believed that the depth of a human experience with a phenomenon could only be understood by holistically studying the context of lived experience (Holloway & Wheeler, 2013).

In his writings Heidegger addresses Husserl's epistemological emphasis on phenomenological reduction. Heidegger considered the induction of pre-understanding and theory to be an important part of inquiry into a phenomenon and termed this practice "fore structure of projection" (Giorgi, 1992, p. 132). Parker and Addison (1989c, as cited in Giorgi, 1992) appear to agree with Heidegger in positioning an application of pre-understanding as essential for guiding an accurate interpretation of a phenomenon. It seems that an inquirer's attempt to interpret experiences without the application of theory and/or some level of pre-understanding would be challenging (Lawn, 2006).

Like Husserl, Heidegger acknowledged the importance of descriptive phenomenology while simultaneously evolving phenomenology into an interpretive philosophy (Holloway & Wheeler, 2013). In *Being and Time* Heidegger takes the reader back to the etymological roots of

the word *phainomenon* to the Greek word *phaenesthai*, meaning, "to flare up, to show itself, to bring to light" (Large, 2008, p. 13; Moustakas, 1994, p. 26). In doing so, it seems Heidegger is encouraging us to use phenomenological inquiry, and our descriptive and interpretive abilities, to illuminate phenomena that might otherwise go unnoticed.

Interpretive phenomenology as research methodology. The epistemologically oriented philosophic axioms put forth by Husserl and ontologically oriented axioms put forth Heidegger have served to help us navigate the complexity of human interaction. Their ideas have led to the adoption of differing paradigmatic outlooks and the adoption of different methodological approaches to inquiry that inform the research of modern day phenomenologists such as Amodeo Giorgi (1992) and Max van Manen (1990).

Guba and Lincoln (2004) posit that all research paradigms can be characterized by the way their proponents respond to the three interrelated and sequential questions, which are as follows:

1. The Ontological Question: What is the form and nature of reality? What can be known about it?
2. The Epistemological Question: What is the relationship between knower (the inquirer) and the known, and what can be known?
3. The Methodological Question: How should the inquirer go about finding out whatever he or she believes can be known?

A thoughtful consideration of the axioms put forth by Husserl and Heidegger, and the questions proposed by Guba and Lincoln (2004) led to an arrival at Interpretive Phenomenology as an appropriate research methodology for the conduct of this study. This phenomenological investigation of coexisting values in healthcare was based on the *ontological* position that humans are interpretive beings who (individually and socially) create a reality that is bound by context, the *epistemic* position that a reflective and participatory merging of ordinary lived experience with apriori theory can serve as a source of subjective knowledge and the

methodological position that the best way to gain knowledge of the phenomenon is to dialogue with HCPs who have had experience with expectations that personal, professional and market values can coexist. A more detailed discussion of the ontological, epistemological and methodological positions that this study was based upon is offered next.

The ontological position. The inquiry was predicated on the Heideggerian axiom that humans are interpretive and meaning making beings; and as such, we self-create a personal reality that is based on our interpretations of our lived experiences (Lincoln & Guba, 1985). In applying this axiom to the current inquiry it follows that the participants' interpretations of their experiences with the coexisting values phenomenon served to inform their respective constructions of reality.

In the conduct of the study, it was also important to acknowledge that the reality that the HCPs share has been informed by social and historical influences. HCPs are subject to socialization processes that include common educational experiences and professional affiliation (Gabel, 2013; Mpatisi, et al. 2015); and they are subject to a long and storied history of healthcare delivery that carries with it a sworn responsibility (Brown, et al. 2014; Gabel, 2013; Graber & Kilpatrick, 2008; Handel & Gefen-Liban, 2003). The social and historical influences to which HCPs are exposed results in the co-creation and co-construction of an inter-subjective reality. This inter-subjective reality is shaped and refined as individual perspectives interact with the language and thoughts of those who share a common space in the delivery of healthcare (Glesne, 2011). It was therefore important to acknowledge that multiple realities exist and that such realities are bound by social, historical and local context (Guba, 1990).

The ontological belief that humans interpretively attribute meaning and significance to things is embedded in Heidegger's notion of being (Dowling, 2007; Holloway & Wheeler, 2013;

Todres & Wheeler, 2001). This idea is directly related to the study in that personal, professional and market values carry meaning (Gabel, 2013; Mpatisi, et al. 2015); and the significance that HCPs ascribe to these values informs *how* they experience the phenomenon of interest.

The epistemological position. The second interrelated question for considering a research paradigm has to do with an assessment of the nature of the relationship between the knower and the known and what can be known (Guba & Lincoln, 2004). In terms of what can be known, the study was based on the epistemic belief that within a HCPs world of the ordinary lived experience, there exists a fundamental source of knowledge for understanding the phenomenon of coexisting values (Dowling, 2007; Racher & Robinson, 2002)**.** In the conduct of the study it was important to consider that the coexistence of personal, professional and market values in the current environment of healthcare delivery has become commonplace (Light, 2010; Relman, 2007); and that the co-existence of such values may be taken for granted and go unnoticed in the ordinary world of healthcare delivery. An application of the epistemological belief that lived experience constitutes a valuable source of knowledge was useful for bringing attention to what might otherwise go unnoticed.

In using lived experience as a source of knowledge, it was also important to take into account the social and historical context in which the HCPs operate. According to the writing's of Heidegger, such context can also go unnoticed, unless we ask people to reflect on these influences (Holloway & Wheeler, 2013). In most of the interviews I was able ask the HCPs about the contextual influences on their values. By using a process of data analysis that involved a consideration of the contextual influences on the full range of values found in the study I was able to stay in integrity with the Heideggerian belief that the depth of human experience can only be understood by studying the context of lived experience (Holloway & Wheeler, 2013). The

application of Heidegger's beliefs regarding context allowed me to realize a more holistic understanding of the phenomenon.

Husserl's conception of the conscious experience with things (intentionality) as a reflexive source of knowledge for understanding meaning also warranted careful consideration in the conduct of the study in that; 1) values are often conceptualized as things and an objective and universal meaning of the nouns used to identify them remains illusive (e.g. benevolence means different things to different HCPs); 2) the values that HCPs (individually and collectively) hold inform how they perceive, live, judge and interpret not just things, but also events and other people; and 3) personal values are often conceptualized as existing below the level of consciousness. With these considerations in mind, the study was predicated on the belief that what can be known about the significance that a HCP ascribes to the phenomenon of interest is a product of their interpretation and the knowledge of this significance was surfaced by asking HCPs to reflect on their values and their relationship to their lived experience.

Husserl's epistemic concept of phenomenological reduction, or bracketing, was another area that was considered in terms of its relationship to the conduct of the study. A prolonged engagement with the study of values has equipped me with an informed understanding of values theory; and this research interest is what led me to an abiding concern for practical matters associated with the expected coexistence of values in healthcare settings (van Manen, 1990). It seems an attempt to interpret the experiences of HCPs in relation to the phenomenon of coexisting values without the application of theory and/or some level of pre-understanding would have been difficult, if not impossible (Lawn, 2006; Lincoln & Guba, 1985; Wilding & Whiteford, 2005). It also would not have been desirable. In a reference to the work of Denzin and Lincoln (2003), Wilding and Whiteford (2005) state that "to pretend that it is possible to

undertake any form of inquiry free of theoretical influence is nonsensical, and represents one of the major confusions in qualitative research" (p. 100), in that it assumes that we can separate ourselves from what we know and what we believe. The study involved an acknowledgment that all inquiry is theory laden (Lincoln & Guba, 1985), and I made strategic choice to integrate multiple conceptual frameworks into the questions that were ultimately posed to the research participants (Saldana, 2009). I believe a deeper understanding of the phenomenon of coexisting values in healthcare did come about as a result of the choice to incorporate my knowledge of values theory (Saldana, 2009).

By allowing my knowledge, beliefs and concerns to intersect with the ideas and experiences of participants we were able to engage in a deeper level exploration of the phenomenon of interest and merge perspectives in order to realize what Gadamer termed a *fusion of horizons* (Lawn, 2006). An interpersonal merging of my horizon with those of the HCPs who have had experience with the phenomenon of interest served to expand our collective understanding of its significance.

From an epistemological standpoint, the study was predicated on Heidegger's belief that pre-understanding and theory represents an important part of phenomenological inquiry, and the relationship between the knower and the known (and what can be known) was based on Gadamer's notion that understanding always involves a fusing of horizons (Dowling, 2007; Lawn, 2006).

The methodological position. The third and final interrelated question for vetting a research paradigm has to do with a consideration of how an inquirer goes about finding out what they believe can be known (Guba & Lincoln, 2004). This question was not taken lightly in that

it involves taking a philosophical stance of what constitutes legitimate knowledge (Dowling, 2007; Lawn, 2006; Guba, 1990).

With the overarching goal of illuminating the perspectives of HCPs in mind, I chose to dialogue with them about their experiences with expectations that personal, professional and market values can coexist (Glesne, 2011; van Manen, 1990). As the researcher, my role involved interviewing HCPs in order to access their reflective interpretations of the phenomenon of interest and interpreting myself, their narrative account of their experiences (Glesne, 2011). The interpretation of participant's narratives was mediated by relevant theory and my own experience with the study of human values (Wilding & Whiteford, 2005).

Such an interpretive approach, when combined with the aforementioned aversion to bracketing, might suggest that the study was located exclusively within the interpretive research paradigm. However, I did not wish to ignore the importance that description has when it comes to soliciting and rendering *what* a participant's lived experience has been with coexisting values in healthcare. It was for this reason that I incorporated elements from what has been identified as the *Duquesne* (descriptive) school of phenomenology. The approach to the study involved an acknowledgement of the overlaps and linkages between schools of interpretive and descriptive phenomenology (Holloway & Wheeler, 2013; van Manen, 1990). The study is perhaps best viewed as adhering to the *Dutch* school of phenomenology, whose adherents include Max van Manen. In the conduct of the study I chose to downplay a sharp distinction between description and interpretation and do practical, action-oriented phenomenological research (van Manen, 1990; 2007).

Study Methods: Doing Interpretive Phenomenology in a Healthcare Setting

The absence of a clear and singular blue print for designing and executing phenomenological research within the Interpretivist Paradigm called for a thorough consideration of various methods described in literature. I used an integration of literatures to craft a flexible set of methods for the purpose of illuminating *what* the HCPs experience has been and *how* they interpret the expected coexistence of values in healthcare. Figure 4 is offered as a visual representation of the steps that were followed in the concurrent processes of data collection and analysis.

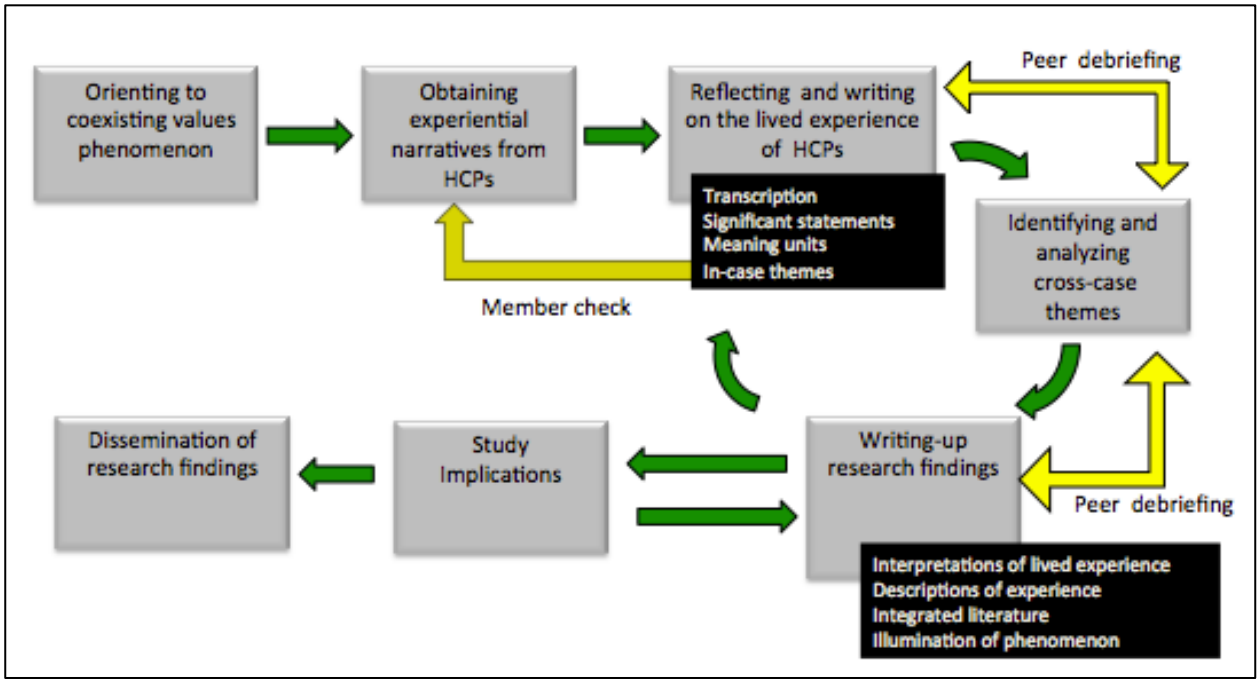

Figure 4. A visual representation of the steps that were followed in the processes of data collection and analysis.

This middle section of Chapter 3 opens with a discussion of how I became orientated to the phenomenon of co-existing of values in healthcare. This discussion also features information on participant/site selection and is followed by detail on how I obtained experiential narratives from HCPs who have had experience with the expected coexistence of values within the context

of their healthcare practice. The stories of lived experience that were offered by the HCPs were the primary source of data used for analysis.

The fusing of writing and reflection were essential to the process of data analysis and a rendering of the specific steps used in data analysis follows the aforementioned explication of how I obtained narrative accounts of lived experience. This segment of Chapter 3 concludes with a discussion of how an inclusion of theory-oriented interpretation and description is intended to promote an engagement with the write-up of the study findings.

Site and participant selection: orienting to co-existing values in healthcare. A base of knowledge with values theory served as the starting point for this study of coexisting values in healthcare. Personal experience with the delivery of training programs for healthcare professionals, attendance at speaker events and discussions with a variety of vested stakeholders allowed me to move from a person who has a general interest in values, to one who discovered a phenomenon that appears to be of concern to multiple stakeholders. These personal experiences were augmented with a consultation with relevant literature. Along the way I learned that there are beneficial and problematic consequences that emanate from the ordinary coexistence of personal, professional and market values in healthcare; and such values are expected to coexist in settings that range from small Federally Qualified Health Centers (FQHCs) that provide primary care to the rurally underserved, to large regional systems that offer comprehensive care to patients who reside in densely populated urban areas.

Selection of the research site. Since the phenomenon was known to occur in a variety of settings, I initially chose to stay open with regard to where I might conduct the study. Along with my goal of doing practical research came meetings with a variety of HCPs and organizational administrators who unanimously expressed an interest in my research topic. Gaining direct

access to participants, however, proved to be another matter. As part of a sustained effort that spanned six months, I ultimately made contact with an internal organizational development consultant who works for a large regional system that delivers comprehensive care. She confirmed the existence of the phenomenon within her organization and put me in contact with a high-ranking medical officer who facilitated access to the HCPs within the organization. The bulk of the interviews that I conducted took place at primary and specialty care facilities that are geographically dispersed across a sizeable area of the Rocky Mountain region of the Western United States and the opening portion of Chapter 4 features a more detailed description of the organizational context in which those who participated operate.

Selection of research participants. To be included as participants in the study HCPs were required to either hold credentials for the delivery of nursing care (i.e., Registered Nurses [RNs], Licensed Practical Nurses [LPNs] or Advanced Practice Nurses [APNs]), or be recognized by federal regulation as healthcare *providers* (i.e., Medical Doctors [MDs], Doctors of Osteopathy [DOs], Dentists [DDS], Nurse Practitioners [NPs], Physicians Assistants [PAs], Clinical Psychologists or Clinical Social Workers). The credentials were deemed important for identifying a selection of participants who are operating at the nexus of care delivery and responsible for making decisions around care directives.

The aforementioned medical officer provided a list of doctors who could be contacted with an invitation to participate in the study. The physicians on the list of potential participants were then contacted via e-mail. In order to generate a selection of participating physicians who have had experience with the phenomenon of coexisting values, the invitation included a two-page overview of the research project and messaging to confirm that these potential participants had lived experience with the phenomenon (Patton, 2002, as cited in Glesne, 2011). The two-

page overview of the study was pre-approved by CSU's Office of Research Integrity and Compliance Review (RICRO) and is included as Appendix A. Four of the seventeen physicians who were invited to participate agreed to do so and were subsequently selected into the study. Each of the doctors that were ultimately interviewed worked in discrete practice areas.

At the conclusion of each interview I asked participants to identify others they knew who might be interested in participating. Through the use of snowball selection I was able to generate a list of five nurses who could potentially participate. These nurses were also contacted via e-mail and they were invited to participate upon confirmation that they also had experience with the phenomenon of coexisting values. A total four were selected into the study. The four nurses represented three distinct practice areas. Detailed profiles of the four physicians and four nurses who ultimately participated in the study can be found in part one of Chapter 4.

Data collection: obtaining experiential narratives from HCPs. The methods for uncovering the phenomenon involved a qualitative exploration of *what* the eight HCPs' experience has been and *how* they have experienced this phenomenon. An adequate exploration of their experiences required that I seize opportunities to immerse myself in the lifeworld of the HCPs who were selected into the study (van Manen, 1990). I therefore visited with six of the eight participants in their place of work, and doing so allowed me to get into the midst of their working environment. By visiting participants in their places of work I was also able to absorb contextual information and the capturing of such information proved to be an invaluable compliment to the data collected via interviews with the HCPs who participated.

Narrative accounts of lived experience were solicited through the use of semi-structured interview questions that asked participants to share their personal stories and anecdotes (van Manen, 1990). These interview questions were derived from the three overarching (*what* and

how, nature and significance) research questions and they featured an integration of the theoretical frameworks that informed the study. The incorporation of theory into the dialogue with participants lent itself to an exploration of how the theoretical propositions that guide this inquiry and the lived experience of the HCPs might be interacting (van Manen, 1990). The general outline of the questions that were posed to study participants is included as Appendix B.

By employing a flexible approach to dialogue I was able to probe deeper into the participants' descriptions and interpretations of their lived experience (Marshall & Rossman, 2011), and pursue a fuller illumination of lived experience. During interviews I sought to engage with the HCPs as co-investigators in the study and I therefore chose to maintain an informal distinction between those who participated and myself (Gibson & Brown, 2009). This approach was based on the belief that all understanding is a form of dialogue (Hart, 1998) and through dialogue various interpretations were dialogically questioned, defined and re-defined (Hart, 1998; van Manen, 1990). My intent was to arrive at a "fusion of horizons" (Gadamer, 1989, as cited in Wilding & Whiteford, 2005, p.101) and a shared understanding of the significance of the phenomenon.

As method, interpretive phenomenology required that I maintain a sensitivity to the variety of interpretations that were encountered in the conduct of the study (Stake, 1995). I made a conscious effort to remain open to the nuances associated with these multiple interpretations in ways that only the *human instrument* is capable of doing (Lincon & Guba, 1985; Stake, 1995). As a data collection instrument, I was in a good position to take into account and interact with the range of personal, professional and market values that inhered in context (Lincon & Guba, 1985). As the sequence of interviews progressed I realized that I was able to gather more in the

way of useable data if I spent less time elaborating on theory and more time allowing participants to speak to the compatibilities and tensions that they experience.

Each participant interview was recorded and I personally transcribed the first two. Contrary to the benefits I thought I would realize at the time of my proposal, I found the act of personally transcribing recorded interviews to be of marginal value. A professional transcriptionist who had previous experience as an administrator within the field of medicine did the transcription of the remaining interviews. As each transcription was completed I re-listened to each of the audio recordings for the purpose of matching the audio recordings to transcriptions, and I made edits when necessary.

The process of data collection, transcription and the re-listening to conversations was not approached as distinct from data analysis (Gibbs, 2007); and the methods that were used for conducting these integrated steps were considered fluid and subject to experimentation and refinement (Gibson & Brown, 2009). The reflection that took place during interviews, transcription and in-case analysis, and during the time in between these concurrent steps, was the basis for continuous improvements to my approach to data collection and in-case data analysis.

Analysis: reflecting and writing on the lived experiences of HCPs. Colaizzi (1978) and van Manen (1990) each offer process guidelines that fuse writing and reflection for the purpose of analyzing the qualitative data that is captured through phenomenological inquiry. Colaizzi's (1978) seven-stage process is commonly applied to nursing research and is considered suitable for Heideggerian (interpretative) phenomenological research in that he acknowledges the use of interpretation in the process of data analysis (Dowling, 2007). Van Manen (1990) suggests a dynamic interplay among a set of six interrelated research activities and his approach is considered suitable for the proposed inquiry in that it downplays a sharp distinction between

description and interpretation. Although van Manen's (1990) method was created primarily for the purpose of conducting pedagogical research, he emphasizes a caring attunement to problems comparable to those this research sought to illuminate. Like van Manen (1990), Colaizzi (1978) encourages researchers to consider the needs of their own projects and both emphasize flexibility when using their recommended steps to analyze data. The research project featured an implementation of the recommended flexibility and involved continuously going back and forth between writing, reflection and the data.

The four steps I followed to analyze the data derived from interviews included; 1) an identification of significant statements from within written transcripts; 2) a mining of those significant statements for meaning; 3) an examination of interrelationships and uniqueness among meaning units for the purpose of identifying of in-case themes; and 4) an examination of interrelationships and uniqueness among significant statement and their underlying meaning for the purpose of identifying of cross-case themes. The steps in data analysis were sometimes pursued concurrently and each is now discussed in greater detail.

Extracting significant statements. This step of the data analysis was built upon the premise that some of the behaviors, observations and verbal expressions that are offered by participants contain data that speaks more directly to the phenomenon that one is investigating (Colaizzi, 1978). The identification of significant statements in this project involved a reading and re-reading of the transcribed text for the purpose of isolating those statement(s) or phrase(s) that spoke to *what* a participant's experience has been and *how* HCPs have experienced the phenomenon of coexisting values. Statements that appeared as essential to an illumination of experience with the phenomenon of coexisting values in healthcare were marked with yellow

highlights. An intensive reading, re-reading and identification of significant statements was repeated for each of the transcripted interviews.

Mining the data for meaning. After significant statements were identified and isolated, I sought to illuminate a deeper level meaning that may be underlying each of these statements (Colaizzi, 1978). The process involved a questioning of *what a HCP was saying* and *what was going on* within each of the significant statements (Gibbs, 2007). In this step of data analysis I sought to pursue a "deepened and more reflective understanding" (van Manen, 1990, p. 86) of the meaning behind behaviors, observations and verbal expressions that participants offered. I formulated a written interpretation for each significant statement and termed them meaning units (Colaizzi, 1978).

Meaning units were directly connected to significant statements on transcripts via the use of comment bubbles and alpha-numerically labeled so that they could later be traced back to specific points of discussion. A sample section of an annotated transcript (featuring an identification of significant statements and formulated meaning units) is offered Appendix C. As one can see in Appendix C the writing of meaning units allows for a deeper level exploration of underlying meaning, as compared to coding methods that seek to capture what an interviewee shares via the use of single term or short phrase.

Identifying and analyzing in-case themes. Themes were developed in order to identify repeating groups of ideas and unify the nature of each participant's experience into a meaningful whole. The arrival at a set of in-case themes began with a close scrutiny of in-case meaning units for uniqueness and interrelationships among them. Those meaning units that I identified as related were synthesized through a process that involved writing, returning to the transcripts to check my interpretations against participant narratives and a re-writing of meaning units when

necessary. Formulated meanings that were identified as interrelated, or representative of patterns of behavior, observations or verbal expressions, were grouped under a set of tentative themes (De Santis & Ugarriza, 2000). The identification of in-case themes involved a continued movement back and forth between information derived directly from interviews (data-driven theming) and the values theory that underpins this study (concept-driven theming) (Gibbs, 2007). I sought to refine tentative themes by printing out in-case meaning units on an index card, sorting them and then resorting them into themes. I exercised great care and invested a considerable amount of time to ensure that the identified themes were not detached from the lived experience I sought to illuminate; nor weighted in favor of the theoretical constructs the inquiry was based upon (Colaizzi, 1978; Gibbs, 2007).

Upon completion of the identification of in-case themes participants were sent an annotated interview transcript and a separate document that featured a listing of in-case interview themes and a sub-listing of the meaning units that informed the identification of a given theme. Participants were asked to check my interpretation of the narrative they offered in order to ensure it was an accurate representation of their lived experience with the expected coexistence of personal, professional and market values within the context of their practice. The process that was used to member check findings is further explicated in part 3 of this chapter and it can be found in the discussion on the steps that were taken to ensure the trustworthiness of the inquiry.

Identifying and analyzing collective themes. The research methods that were originally proposed called for an identification of themes that occur frequently in the text so that they may be aggregated and organized into clusters of themes that reflect the shared experiences of *all* participants. The process of identifying cross-case themes began with the placement of individual in-case themes and their underlying meaning units on to index cards. An attempt to

sort these cards into cross-case themes resulted in the identification of just one cross-case theme. It became clear that it would be necessary to go back into the data from interviews, and seek some additional clarity around what constitutes a theme in phenomenological inquiry. The identification of themes as fasteners upon which we hang phenomenological descriptions offered by van Manen (1990) and the "analytic process of winnowing down themes" (p. 140) to what is essential as suggested by Saldana (2009) served as the basis for the identification of cross-case themes.

The alphanumeric codes that I developed for tracking significant statement and the accompanying meaning units proved invaluable for managing the voluminous number of data points from across the eight interviews. The coding scheme allowed me to efficiently locate specific statement and meaning units as I went back and forth between the data and the writing up of themes. Taken together these steps allowed for the identification of a set of five overarching themes that are reflective of the participants collective experience with the phenomenon. The simulated removal of themes was done as to assess whether the omission of a theme would fundamentally diminish a readers ability to fully understand the participants' experience with the expected coexistence of values in healthcare (van Manen, 1990).

Writing-up of research findings. As noted in the lead into the discussion on methods, the steps that were employed in data collection and analysis were not approached as discreet from one another. The research activities involved an interpretive and descriptive process of writing (and re-writing) of findings that explored in rich detail, the depth and significance of the HCPs lived experience with the phenomenon (van Manen, 1990). The process of going back and forth between the parts of the study and the whole of the study (van Manen, 1990) and the parallel process of writing (and re-writing) of findings allowed for the development of themes

which are intended to represent my interpretive understanding of the eight participants lived experience with what is at once a common and complex phenomenon. Chapter 4 features an inclusion of theory-based interpretation and rich description of lived experiences so that those who interact with may see their own experiences in those of the HCPs and transfer the finding to contexts that are comparable to the one in which the HCPs operate (Lincoln &Guba, 1985). Before turning our full attention to the Chapter 4 findings it is important explicate the criteria that was used to ensure study quality and this final section of Chapter 3 is offered to a discussion of those quality criteria.

Criteria for Ensuring Quality in the Conduct of the Study

The standards that govern the quality of this phenomenological inquiry are based on its methodological placement in the interpretivist paradigm. By adhering to quality criteria associated with the constructivist/ interpretivist paradigm and phenomenological human science research, I sought to ensure that the inquiry is illuminating, trustworthy, authentic and that it addresses relevant ethical and legal considerations (Glesne, 2011; Lincoln & Guba, 1998; Schwandt, 2007; U.S. Department of Health and Human Services [HHS], 2009).

This third part of Chapter 3 opens with discussion on how I worked to illuminate the significance of the co-existing values phenomenon, as experienced by a selection of HCPs. A discussion on how I addressed the trustworthiness criteria proposed by Lincoln and Guba (1985) follows. The discussion on trustworthiness features an integration of relevant human science research practices borrowed from van Manen (1990), and it is followed by a description of how I sought to account for the range of social and political stakeholder interests and values that inhere in the study via an adherence to the constructivist/ interpretivist quality criteria of authenticity (Lincoln & Guba, 1986a; Schwandt, 2007). A discussion on how I upheld a concern for ethics

and effects for those that might be impacted by the study follows. This third and final part of chapter 3 closes with an acknowledgment of my voice and my personal values, and how each contributed to the study.

Illuminating the significance of lived experience of HCPs. Through the conduct of the study I sought to shine a light on the ordinary coexistence of values in healthcare as experienced by a selection of HCPs. I approached the study with the understanding that any significance that HCPs might attribute to the phenomenon would likely be hidden, or perhaps even veiled (van Manen, 1990). Description aimed at revealing the significance of lived experience involved an interpretation of the HCPs' interpretations (van Manen, 1990). Throughout the conduct of the study it was important to acknowledge that all descriptions are a form of interpretation and heed the ways in which van Manen (1990) believes phenomenological descriptions can fail to illuminate lived experience.

As a novice phenomenological researcher with a passion for values theory it was important for me to be cognizant of any temptation to reflexively default to descriptions that have the character of theoretical abstraction (van Manen, 1990). Such a default had the potential to alienate me from a relational understanding of the participant's experience with the phenomenon and obscure my ability to illuminate its significance for HCPs (van Manen, 1990). While theory was integrated into the dialogue with participants, I took strides to ensure that the descriptions of lived experience that are offered in Chapter 4 are a pure representation of participant's experience, and not weighted towards the theory that informed this research project.

In order to assure a quality illumination of lived experience my goal was to provide a nuanced and holistic rendering of its significance for the consumers of this research. I sought to reach such a rendering by 1) considering the meaning and the significance of words that the

HCPs used in their stories of lived experience; and 2) how these stories speak to the significance of the phenomenon that is being investigated.

Considering the significance and meaning of words. As research method, phenomenology requires sensitivity to the subtle undertones and meaning of language (van Manen, 1990). Words that HCPs perceived as ordinary are born out of lived experience (van Manen, 1990). Within the context of healthcare there are commonly used words and phrases that convey a specific and sometimes deeply rooted meaning. For example, to say one engages in *patient-centered care* might suggest an approach to healthcare that incorporates values of altruism, equality and morality. As an outsider looking in, it was essential to maintain sensitivity to idiomatic phrases, and to consider the deeper meaning and origins of the words participants chose to use (Van Manen, 1990). Certain phrases emerged in conversation and I was better able to interpret the HCPs experiences by giving contextual consideration to terms such as *patient satisfaction, productivity and efficiency*.

Considering the parts and the whole. In order to best understand the significance of the phenomenon it was essential to oscillate between a focus on the parts of the study and a focus on the totality of the study (van Manen, 1990). This process has been termed the hermeneutic circle (Schwandt, 2007). For Heidegger the hermeneutic circle, with it's part/whole consideration, is in operation in the formulation of our everyday understanding of the world (Lawn, 2006). In this view fore-structure, or pre-understanding (the whole) works in tandem with our understanding of that which immediately presents itself to us (the part). Our pre-understanding is constantly in play and evolves based on new reflections and new interpretations (Lawn, 2006).

As researcher, I sought to remain open to reflective insights and evolve my ability to understand, interpret and describe the significance of the phenomenon of co-existing values. The

study involved an ongoing and repeated consideration of the words and stories of individual participants; and a search for what they could tell me about the specific dimensions of the phenomenon, and how those words and stories might inform an understanding of the whole of the phenomenon (Wilding & Whiteford, 2005).

Promoting trustworthiness. Lincoln and Guba (1985) define the trustworthiness of an interpretivist/ constructivist study in terms of "whether the findings of an inquiry are worth paying attention to" (p. 290). These co-authors developed a subset of four quality criteria that were adapted from the conventional /positivist paradigm (Lincoln & Guba, 1985), and these criteria are commonly used to assess the trustworthiness of interpretive inquiries such as this one (Lincoln & Guba, 1986a). The criteria and their conventional equivalent (parallel in parenthesis) are as follows: Credibility (paralleling internal validity), transferability (paralleling external validity; generalizability), dependability (paralleling reliability) and confirmability (paralleling objectivity) (Lincoln & Guba, 1985; Guba & Lincoln, 2004). A careful consideration of these quality criteria led to the identification of dependability, and its conventional parallel reliability, as being outside the scope of an inquiry that seeks to surface knowledge that is bound by time and context (Guba & Lincoln, 2004; Lincoln & Guba, 1985).

A discussion on how I worked to ensure credibility and transferability features an integration of quality criteria identified by van Manen (1990), and is followed by a description of the steps that I took to ensure the confirmability of findings.

Ensuring credibility. Lincoln and Guba (1985) define credibility as the establishment "of truth of the findings of a particular inquiry" (p. 290). In the conduct of the this inquiry I sought to realize credibility by 1) involving myself in the inquiry for a prolonged period of time; 2) testing

my descriptions with participants and peers; and 3) integrating relevant literature (Lincoln & Guba, 1985).

Prolonged engagement. As a researcher who was not an insider to the world of healthcare it was imperative that I go beyond a surface level orientation to the phenomenon of interest and immerse myself in the lifeworld of HCPs. The delivery of training programs and the conversations with multiple stakeholders to the healthcare system afforded me the opportunity to deeply absorb the social, political and historical context that might have otherwise been overlooked. An understanding of such context was viewed as essential in that it has influence over the description that the HCPs offered and the interpretations they make. A prolonged engagement with the lifeworld of HCPs was approached as an opportunity to create a foundation of trust and assure them that their confidences will not be used against them (Lincoln & Guba, 1985).

As noted, the study was conducted with the aim of "rising above my own pre-conceptions" (Lincoln & Guba, 1985, p. 303) that extend from my knowledge of values theory. A prolonged engagement with the lifeworld of HCPs served to address the challenges associated with subjectively interpreting their descriptions and interpretations.

Just as it is possible for me to introduce distortions, so to is it possible for participants to introduce their own. The truth-value of my research was bolstered by a prolonged exploration of the research questions that guide this inquiry in relationship to the responses that participants offered. The research project involved a significant investment in time spent interviewing, reflecting and writing so that I could identify the patterns of interpretation and action that speak to the significance of coexisting values as experienced by HCPs.

Testing descriptions and interpretations with participants and peers. A member check, where descriptions and interpretations are tested with those from whom I collected the data, represented a crucial step in ensuring the credibility of findings (Lincoln & Guba, 1985). In order to substantiate the claim that my reconstructions and interpretations of lived experience are true representations of the HCPs intended meanings, it was essential to provide the participants with the opportunity to react to them (Lincoln & Guba, 1985). Each of the participants was given the opportunity to verify the accuracy of my descriptions and interpretations, and further clarify the intended meanings that were contained within their stories of lived experience (Lincoln & Guba, 1985). An arrival at the truth-value of findings was approached as a matter of agreement with the study participants (Borland, 2004).

In order to further ensure credibility, my interpretations, themes and hypotheses were tested with people who have an understanding of my topic (Lincoln & Guba, 1985). Intermittent debriefs with individual HCPs who were not research participants was a welcome source of feedback and dialogic insight. Ongoing debriefs with my advisor, Sue Lynham, were particularly useful for refining my approach to data collection and analysis. Debriefs with other individuals who were not directly involved in my study, served to clarify and refine next steps in a methodological approach that was intentionally fluid (Lincoln & Guba, 1985).

Consulting relevant literature. Consultation with relevant scholarly literature was essential to the identification of the informing theories and potential problems this study sought to explore. A prolonged engagement with phenomenological literature provided me with exposure to different approaches to phenomenology and enabled me to identify the methodology that will guide the proposed inquiry (van Manen, 1990). The data analysis and identification of study implications featured a continued integration of scholarly literature so that I could operate

from an appropriate knowledge base (Hart, 1998), and maintain an awareness of the latest knowledge on my topic (Creswell, 2009). Literature was also used to integrate the lived experiences of HCPs with current ideas and theories. The integration of literature allowed me to transcend the limits of my immediate interpretive sensibilities and further test my interpretative insights up against those of experts (van Manen, 1990).

Inviting a dialogic response and enabling transferability. Lincoln and Guba (1985) define transferability as "the extent to which the findings of a particular inquiry have applicability in other contexts (p. 290). In order to promote transferability to other contexts, I have sought to realize what van Manen (1990) has termed "dialogic textuality" (p.151). To accomplish this I have aimed to offer interpretations and description that are oriented, strong, rich and thick (Lincoln & Guba, 1985; van Manen, 1990).

In my writing I have sought to create text that is oriented and strong by not separating my interest, concerns and the theory that underpins this inquiry from the lived experiences of the HCPs (van Manen, 1990). The goal is to bring the reader into the stories of lived experience so that they might recognize their own experiences with values; if I have been successful in doing so, I will have enabled the reader to see what their own experiences have in common with those of the HCPs who participated in the study. I have sought to capture stories of lived experience and explore their full experiential ramifications by providing rich interpretations and thick descriptions (van Manen, 1990).

"Thick description" (Lincoln & Guba, 1985, p. 125) involves the inclusion of an appropriate amount of contextual information so that others who engage with the text can make their own judgments with regard to the transferability of findings. The information on individual and shared context that is offered in the opening segments of Chapter 4 is meant to promote a

dialogic response from those who interact with the text. I have sought to enable transferability by specifying everything I believe the reader needs to know to understand the findings, so that they can make their own assessment as to whether these findings fit within another context (Lincon & Guba, 1985).

Maintaining confirmability. Confirmability is defined as having the ability to verify the data used to substantiate interpretivist / constructivist knowledge claims (Lincon & Guba, 1985). Confirmability of the data used to arrive at study findings has been realized through the creation of an audit trail. The audit trail consists of the maintenance of specific artifacts as suggested by Halpern (1983, as cited in Lincoln & Guba, 1985) that include:

1. Recorded data, field notes and any other raw data obtained through unobtrusive means.
2. The products of data analysis. These products include unitized information, write-ups of notes on the setting(s) and notes related to the development of thoughts, creative insights and working hypothesis.
3. An alphanumeric coding system. Significant statements and the accompanying meaning units were tracked via a coding system that can be used for tracing descriptions and interpretations back to specific points in the conversations with the research participants.
4. The products of data synthesis and reconstruction. Such products include notes relating to the identification of themes, tentative findings that emanate from the interpretive nature of the inquiry and a final report.

The maintenance of these records has been the key to systemizing, relating and cross-referencing the volumes of data captured through the conduct of the inquiry (Lincon & Guba, 1985).

Promoting authenticity. Study authenticity stems from the interpretivist/ constructivist axiom that there are multiple realities, and that such realities are the product of individual and social construction. In constructivist/ interpretive oriented research, authenticity is defined as the representation of the realities of stakeholders to an inquiry (Lincoln & Guba, 1986a). This study features social and political implications for a broad range of stakeholders who are impacted by

the co-existence of values in healthcare. Given the methodological location of the study and the idea that "interpretation is not simply an individual cognitive act but a social and political practice" (Schwandt, 2007, p. 12), it follows that the five authenticity criteria put forth by Lincoln and Guba (1986a) and later advanced by Guba and Lincoln (1989) warranted significant attention.

In the proposal to conduct this research it was posited that the study would address the authenticity criteria of 1) the provision of balanced view that presents all constructions and the values that undergird them (fairness); 2) an expansion of individual (and group) consciousness (ontological authenticity); 3) an increased understanding and appreciation of the interpretations of others outside the immediate stakeholder group (educative authenticity); and 4) the stimulation and facilitation of action (catalytic authenticity). The address of the fifth criteria identified by Lincoln and Guba (1986a), tactical authenticity, was not initially proposed because, in its original form, the study did not aim to emancipate any particular stakeholder group, nor suggest any tactics for doing so. A detailed discussion of how I pursued the authenticity criteria that were originally proposed and how I came to realize the importance of tactical authenticity is offered next.

Fairness. This study is based on the well-supported belief that within healthcare there exists a situation of value-pluralism, where different interpretations of the current phenomenon emerge from different value systems (Lincoln & Guba, 1986a). In the review of the literature I discuss how varying constructions are likely to extend from an emphasis of differing values and differing foci (e.g. healthcare providers vs. healthcare administrators). Prior to and during the conduct of the study I purposefully sought to interact with members of key stakeholder groups and solicit interpretations of the phenomenon that are reflective of a range of interests and

beliefs. These efforts included attendance at speaker events and direct conversations with health system administrators. While it was not feasible to interview representatives from all stakeholder groups, the presentation of study findings is representative of a consideration of different value and belief systems and how those differing systems play into the consequences the inquiry seeks to illuminate.

Ontological authenticity. As the researcher I aspired to conduct the study in a manner that afforded interested participants (including myself) the opportunity to hold a more sophisticated and informed understanding of the phenomenon of co-existing values (Lincoln & Guba, 1986a; Guba & Lincoln, 1989). In order to realize this aspect of study quality, I have maintained documentation that shows evidence of advances in my interpretive understanding of the phenomenon. The coded transcripts and notes from data collection serve as evidence of advances in the participants understanding of the phenomenon (Guba & Lincoln, 1989).

Educational authenticity. In addition to promoting a more sophisticated understanding of the phenomenon among HCPs, it was also important to promote an appreciation of interpretations that are rooted in value systems that are different than those of HCPs (Lincoln & Guba, 1986a). An incorporation of the values of others (e.g. patients; healthcare administrators; policy-makers; society at large) was considered integral to the study. I further sought to realize educational authenticity via an integration of literature that highlights the goals and values that various stakeholder groups pursue. An appreciation of interpretations that stem from values that are different from those of the HCPs was incorporated into the study. The write up of the findings in Chapter 4 and the implications in Chapter 5 are offered as evidence of educational authenticity (Guba & Lincoln, 1989).

Catalytic authenticity. Interpretive phenomenology allows for the development of a thoughtful and attentive awareness of significance and often results in the creation of "action sensitive knowledge" (van Manen, 1990, p. 21). Given that the study was designed to illuminate HCPs experience, it is conceivable that the findings could stimulate action that addresses issues stemming from the pursuit of competing values in healthcare (Guba & Lincoln, 1989; van Manen, 1990). While none of the participants have reported such actions, changes to the status quo could come about as reconstructions are formed and individuals are stimulated to act on them (Guba & Lincoln, 2004). Reactions to what was found through the conduct of the study will become more likely upon its publication. Evidence would likely come in the form of testimony from members of stakeholder groups who commit themselves to action that emanates from an exposure to the proposed inquiry (Guba & Lincoln, 1989). However, this information may only be retrievable after the passage of time (Guba & Lincoln, 1989).

Through the conduct of the study, I intended to honor and address the quality criteria that are considered appropriate for Interpretive Phenomenology. An adherence to the standards proposed by van Manen (1990) coupled with the trustworthiness criteria that are suggested by Lincoln and Guba (1985) was incorporated to ensure that my findings are worthy of attention. The address of the authenticity criteria was fostered via inclusion of the interests and values of the multiple stakeholders who may be impacted by the phenomenon (Lincoln and Guba, 1986a). While I did not originally see a need to be concerned with tactical authenticity, or a political agenda that advocates for any one (or more) stakeholder group(s), the study findings did point to implications that are worthy of further-consideration and I will return to suggested actions in the (Chapter 5) conclusion of this dissertation manuscript.

Upholding a concern for ethics and effects. Given the wide range of values that inhere in context, it was essential to preserve a concern for ethics and effects throughout all phases of the study (Guba & Lincoln, 2004; van Manen, 1990). The inquiry was designed to illuminate both complimentary and competing values and *not* predicated on a stance that any one set of values is more important than another, but at the same time one cannot ignore the moral principles that guide the practice of medicine (van Manen, 1990). Throughout all phases of the study, I have sought to uphold an ethical obligation to all interested stakeholders. These stakeholders included the organization where the bulk of the HCPs came from and those HCPs who were co-investigators in the study (van Manen, 1990).

It was important to maintain awareness that an inquiry such as this one could surface feelings ranging from a captive discomfort to a liberated release (van Manen, 1990). The empathic nature of the chosen methods allowed for adjustments that were based on subtle shifts in the demeanor of participants. It is possible that there may be lingering effects on the HCPs involved in the study. While it is not possible to predict, or perhaps even detect, such reactions, it is essential to maintain an awareness that they may occur (van Manen, 1990).

An early stage consideration of the research project in relationship to the legal guidelines for human science research suggested that the project met the U.S. Department of Health and Human Services (2009) criteria for Exempt #2. The proposal to conduct the study in accordance with Health and Human Services (2009) Exempt #2 criteria was approved by Colorado State University's (CSU) Research Integrity and Compliance Review Office (RICRO) on January 12, 2017, and the letter of approval from CSU/ RICRO is included as Appendix A. The informed consent of the HCPs who participated in the study was obtained prior to the conduct of any scheduled interviews. The document that was used to obtain informed consent of those

participating in the study was developed from a template furnished by CSU/ RICRO and it is included as Appendix B.

Throughout the conduct of the inquiry, the privacy and confidentiality of research participants has been maintained via the use of pseudonyms (pseudo-names). The key that has been used to connect pseudo-names to actual identities is maintained in a place that is separate from electronically stored data (Creswell, 2009). Audio recordings of participant interviews are stored under lock and key and will be deleted upon the successful defense of this dissertation research. All electronic files that are associated with the proposed inquiry are stored behind a password protected user interface.

A conscientious and careful effort was taken to ensure that any disclosure of the human subjects' responses will not reasonably place them at risk of criminal or civil liability, or be damaging to the subject's financial standing, employability or reputation (Health and Human Sciences, 2009). The data that have been used in the final write-up of the study have been scrubbed to ensure that there is no discernable reference to the identity of individual participants and organizational affiliations participants currently have, or have had.

In the conduct of the study it was also important to consider the ethical implications and effects on other stakeholders and the research site(s) (Creswell, 2009; van Manen, 1990). The necessary permissions from all conceivable gatekeepers were obtained prior to the commencement of data collection and interviews were conducted at times that minimized the impact on the responsibilities that the HCPs held.

Acknowledging voice and values. Just as it is important to give voice to the values of stakeholders, so to is it important to acknowledge the voice and values of the researcher. In keeping with the characteristics of the interpretive paradigm, I served as the primary data

collection instrument (Lincoln & Guba, 1985). While I am not a HCP, I aspired to get into the midst of the lifeworld of HCPs and explore what I perceive to be a common situation. As a passionate participant in the investigation into coexisting values I was active in the co-construction and re-construction of interpretations (Guba & Lincoln, 2004). The phenomenological descriptions that I offer in Chapter 4 will always be *one* among many interpretations and are not meant to "exhaust the possibility of yet another complementary, or even potentially richer or deeper description" (van Manen, 1990, p. 27).

Values have been central to the inquiry from the time it was conceived. As the inquirer, my personal values, which have been shaped and refined through my experiences, informed the choice to focus on the problem of demoralization and feelings of subjective incompetence as experienced by HCPs (Lincoln & Guba, 1985). However, the reason for focusing on such a problem not only relates to an abiding concern for those who are unable to express their values, but also the personal belief that organizations are better served when they give all organizational members the opportunity to voice their values. I operate from the belief that the pursuit of a narrow and homogenous range of values may actually inhibit organizational performance and/or threaten organizational survival when it comes to interpreting environmental events like those that are currently impacting the delivery of healthcare (Meglino & Ravlin, 1998). So, the inquiry has not only been influenced by the personal, professional and market values that inhere in context (Lincoln & Guba, 1985), but also my personal values, which center around the protection and enhancement of the welfare of all people and an appreciation for and tolerance of different perspectives (Schwartz, 1994).

With the detailed explication of the methodology, methods and quality criteria in place, we can now turn out attention to Chapter 4, and the findings that were informed by my analysis of the data derived from the dialogue with the HCP research participants.

CHAPTER 4 – FINDINGS

An application of the methodology and methods that were detailed in Chapter 3 were used to arrive at an understanding of 1) *how* the HCPs who participated in the study experience the expected coexistence of personal, professional, and market values; 2) *what* their experience has been with the coexisting values phenomenon; and 3) the significance that the HCPs ascribe to other's expectations that they simultaneously uphold their personal and professional value preferences alongside the market values that are commonly emphasized within the current healthcare environment.

A prolonged engagement with, and analysis of, the data derived from the interviews that were conducted with the HCPs informed the identification of five essential themes. It was found that the HCPs experience 1) professional opportunities to enact personal value imperatives; 2) the paradox of patient satisfaction; 3) an association with the Pharmaceutical Industry; 4) varying levels of exposure to market values; and 5) quality leadership and administrative support. Each of these themes is meant to capture one aspect of the HCPs collective experience and within each one is a set of 2-3 sub-themes that are meant to capture the unique ways in which clusters of study participants experience expectations that personal, professional, and market values can coexist within the context of healthcare. A visual representation of the five essential themes and the thirteen sub-themes that were informed by the analysis of the data derived from interviews with the HCPs who participated in the study is included as Figure 5.

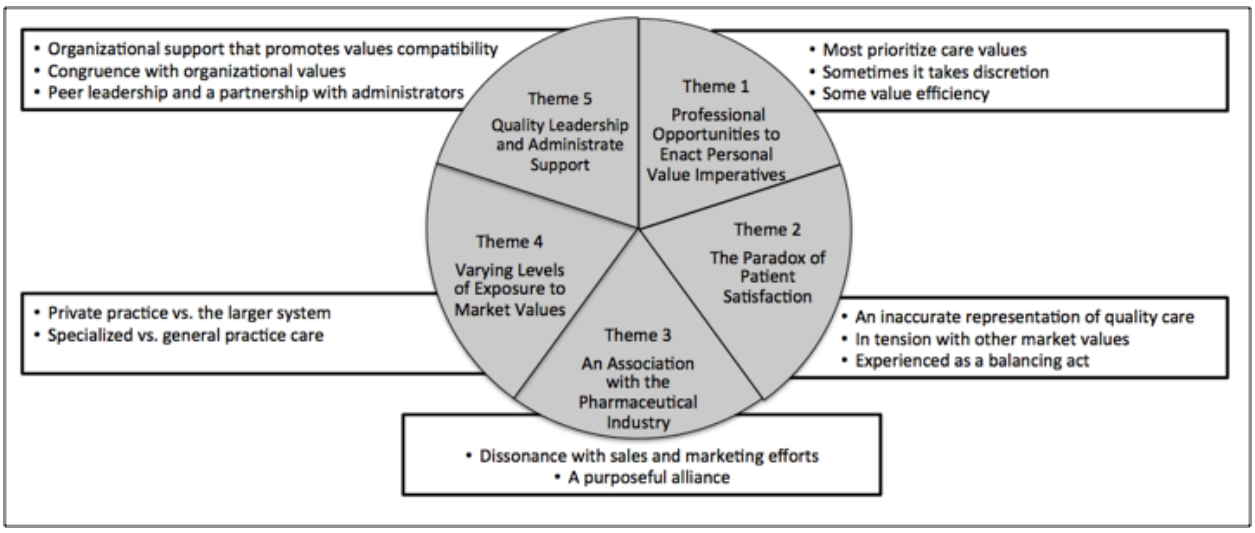

Figure 5. The five essential themes and related subthemes that were informed by the analysis of the data derived from the interviews with the HCP study participants.

Heidegger posited that the depth of human experience with a phenomenon could only be understood by holistically studying the context of lived experience (Holloway & Wheeler, 2013). A thorough understanding of *how* the HCPs experience the expected coexistence of personal, professional, and market values and *what* their experience has been with the phenomenon necessitates a thorough understanding of context. A description of the organizational context that the vast majority of the participants share is essential for arriving at a fuller understanding of experience and enables the possibility of transferability of the research findings to other comparable settings (Guba & Lincoln, 1989; 2004; Lincoln & Guba, 1985).

Seven of the eight study participants work for a large healthcare system that operates across a broad geographic area in the Rocky Mountain Region of the Western United States. The system is comprised of several large hospitals and an extensive network of clinics that are located in both densely and sparsely populated areas. The seven participants who work in this system are engaged in specialized and general practice care that is delivered to a population residing in a relatively rural area.

The system is one where revenues are primarily derived from insurance reimbursements for the products and services delivered by the HCPs. The presence of third party health insurance and the related reimbursement payment structure results in a type of business transaction that is distinct from the more direct forms of interaction that typically occur between those who sell a product or service and their customers. This contextual nuance was illustrated by one of the participants when he spoke of how rare it is for "a physician to interact directly with the patient over the cost of something" (A.10). The transactional elements of care delivery are further obscured by the presence of other business entities that have a stake in the healthcare industry (e.g. the makers of devices; the pharmaceutical industry) the presence of these entities plays directly into what HCPs experience and how they interpret their life world.

Just as it is important to understand shared context, so too is it important to understand individual context. It is largely for this reason that a portion of Chapter 4 is dedicated to an introduction of the eight HCPs who participated in the study.

Participant Introductions

To realize the aim of promoting an understanding of individual context, each of the participant introductions features the identification of personal value preferences and in some cases, a description of how experiences that occurred earlier in life informed individual value preferences. Such context is important to consider, as those experiences led many of those who participated in the study to become a HCP. Each introduction also features a discussion that is intended to begin the process of illuminating individual lived experience with expectations that personal, professional, and market values can coexist. Such experiences can impact a HCPs disposition and each participant introduction concludes with my interpretive description of each

HCPs disposition toward their role within the system and/or the broader context of healthcare delivery.

Protecting the confidentiality of those who voluntarily participated in the study necessitates that both the individual identities and the organizational affiliation(s) of the participants be concealed. The names that appear at the onset of each of the individual participant introductions that follow are pseudonyms (pseudo names) and the organizational affiliation that is common to seven of the eight research participants is simply referred to as *the system*, or the *large system.* Concealing the identity of the participants also required the maintenance of the confidentiality of their specific practice areas, as the combination of personal background, value preferences, and practice area might serve to inadvertently disclose the identity of individual participants. Practice areas are simply referred to as either a *specialized practice* or *general practice.* As we will see, the bulk of the experience that participants bought to the study comes from practice in specialized areas. Participant introductions are offered in the same order in which individual interviews took place, beginning with Doctor Anderson.

Doctor Anderson. The first interview I conducted was with Doctor Anderson, a mid-career physician who practices as a member of a larger physician group. He and his colleagues treat patients who suffer from a disease that calls for them to deliver a combination of urgent and routine follow-up care. They deliver clinical care via a centralized location and through a number of small satellite offices located in rural municipalities. In addition to maintaining a clinical practice, Doctor Anderson also oversees a specialized medical procedural center for which he has lead responsibility for its financial viability and successful delivery of high quality care.

During our conversation, Doctor Anderson shared his perspective that care and market values have to be compatible "or else I don't think healthcare in the United States as it currently exists would work" (A.19). He emphasized that for a health system like his to remain viable, it is essential to look at healthcare from "a business point of view" (A.19). For Anderson, such a point of view involves significant concern for the market value of efficiency. He confirmed that he values efficiency, both personally and professionally, and during our conversation he shared his belief that "the best (healthcare) system is the most efficient system" (A.19).

Doctor Anderson also sees the viability of his system as being dependent on an awareness of the interests of the various market players found in healthcare (e.g. the makers of pharmaceuticals and devices; insurance companies; hospitals). He described the logic he applies to his fiscal responsibility for the procedural center as being comparable to the fiscally conservative approach he takes toward his personal finances, and he provided an explanation of how that logic applies to his negotiations with vendors:

> I do my very best to get the lowest price on (devices)….It's because I think the right way to deal with someone over a business frame is to approach it with how do I get this cheapest device for the cost and you know, how do they not make a whole bunch of exorbitant money. Which in the big picture is what I think we want to avoid in healthcare. Is that everybody takes a big chunk off the top (A.7).

It is evident from this statement that Doctor Anderson is concerned with how the pursuit of profitability factors into the high cost of healthcare. There was also evidence of a preference for patient advocacy in this line of conversation, as he further stated that he would put an increased emphasis on a fiscally conservative approach in negotiations with vendors if he believed that patients were directly impacted by the costs of the medical devices he purchases.

While Doctor Anderson does believe that his system provides world-class care, he also believes that the broader system is coming up short when it comes to providing access to care, in

that "we don't provide it to all people" (A.39). His experience has caused him to arrive at the conclusion that the system in the U.S. would be the best in the world if everybody got "the same level of care as those that have private insurance, or government sponsored insurance" (A.39). Yet, in the same line of conversation Anderson expressed that he experiences a paradox when it comes to insurance coverage, in that patients are dis-incentivized to access care because of the high deductibles they are obligated to pay. While he does experience an inconsistency with access, Doctor Anderson appreciates that the insurance reimbursement payment structure provides an incentive for those in his practice area to engage in the development of innovative approaches to care delivery.

When asked if he personally interprets healthcare as a business, Doctor Anderson replied by saying "it will be nice if you could keep the business side out of it" (A.4); yet, he also appears to willfully acknowledge the present realties of the broader environment and seems intent on helping his system realize success within that environment. While he made no specific mention of his attitude towards his current roles and responsibilities, he conveyed an air of confidence and optimism; I interpreted his disposition toward his position and the system in which he currently works to be quite favorable.

Nurse Britt. The second interview that I conducted was with Nurse Britt. Comparatively, she is in an earlier stage of her career and has taken an interesting and unique path to her current practice in a specialized area. After pursuing several different undergraduate majors, she earned a degree in health and exercise science. After spending some time exploring different career avenues related to her undergraduate degree, she decided to go to nursing school. Upon her completion of nursing school, she experienced challenges securing a position and was eventually

hired by her personal physician to work temporarily as a medical assistant. That same specialized care physician eventually hired her as a RN.

Her specialized practice area differs from internal medicine and other specialized practice areas in that it involves frequent and sustained interaction with adult patients who have been diagnosed with chronic conditions. Much of Britt's patient contact takes place over the phone and she described her work as being focused on triage and working with patients to manage their condition (s). Through the course of our conversation, it became evident that Nurse Britt personally values being a patient advocate and helping and supporting others.

Nurse Britt has witnessed her physician's (and the clinic's) transition from being in private practice to becoming part of the larger system. Through the course of our conversation Nurse Britt questioned whether the financial goals and the productivity that the large system emphasizes are of benefit to the patients she serves. She experiences a moderate level of organizational pressure to move through patient interactions at a quick pace, while simultaneously leaving those patients with the feeling that their needs have been met; she has also experienced minor negative consequences stemming from the duality among personal/professional and market value priorities.

The larger system with which the specialty care clinic is now associated emphasizes broad and open access for all patients, regardless of the severity of their condition. Nurse Britt described how this mandate strains the clinic's ability to exert expert judgment when it comes to triaging patients, and prioritizing whom the physician sees. She questions whether some of the treatments for which the patients come in are necessary and whether the money that goes into healthcare is really improving patients' lives. By the same token, Nurse Britt conveyed an understanding that the system needs to maintain certain levels of productivity to remain viable.

Nurse Britt takes it upon herself to follow-up with patients in instances where the physician does not have enough time to listen to all that the patient wants to share. She stated:

> I feel like I'm in a very special and unique situation. I do see patients during the day, but it's a little bit spread out and I can make my phone calls when I have the time. So, I can call a patient and follow up from an appointment and let them talk. And really get their point across (B.6).

She appears to enjoy a collegial and trusting working relationship with the physician for whom she directly works. At the close of our interview, I asked Nurse Britt if there was anything else I should know about the phenomenon of co-existing values in healthcare, and she replied by telling me that I should know "I really love my job. Kind of found my dream job which is something that I think a lot of people don't get to say" (B.25).

Doctor Carney. Interview number three was with Doctor Carney, a physician who has enjoyed a long career as a researcher and provider in both general and specialized practice areas. The interview opened with a considerable amount of discussion focused on Doctor Carney's eclectic background. He described himself as a "baby scientist" (C.1), a very bright, but non-school oriented kid. Despite the claim that he almost did not make it out of high school, Doctor Carney went on to study microbiology and earned his Ph.D.; medical school and significant experience as a researcher followed. In parallel with this experience, Doctor Carney developed an interest in complementary approaches to scientific medicine. His most recent research efforts featured an integration of the social sciences and eastern philosophies into alternative approaches to care delivery. He is in the latter stage of a long and varied career and currently practices in a specialized area where he treats patients with chronic conditions.

Through the course of our conversation, Doctor Carney recalled huge differences between what had transpired in the past and what takes place in the current healthcare environment. He attributes the significant differences in today's environment to a

"corporatization" (C.8) that stresses efficiency and marketing efforts to promote the idea of a perfect life; each of these places an undue burden upon physicians.

Doctor Carney described himself as having an orientation towards communist/ socialist ideals and in the past, he has accepted less in the way of compensation to work in systems in which no one is turned way. The value he places on equality was further evidenced when he drew a distinction between "the Cadillac level of care" (C.24) that some receive and his personal beliefs surrounding universal access to care:

> Healthcare is a right and everybody should receive the same healthcare, no matter what you make. Just like a fireman comes to your house to put out the fire. Policemen are there when you need them. Doctors should be there (C.24).

During our interview, Doctor Carney lamented the amount of money that systems spend on administrative overhead, which consists of resources that he believes could be allocated toward care for more people:

> Again, I just think healthcare is a right and I don't see why we should be spending a third of what we spend on administrators. So how many millions are we spending to market, in the country as a whole?... It's been estimated we spend 30 to 35% of healthcare dollars on administration. That includes all of that, not taking care of people (C.30).

His experience has led him to the belief that a single payer healthcare system would allow his organization to allocate resources away from administrative overheard and toward taking care of people.

Although he was critical of the broader health system, Doctor Carney conveyed a favorable impression of the systems management. He experiences far less posturing and less ego than he did at earlier stages of his career, and he appreciates that his current management team has enacted policy that serves to effectively balance care and market value priorities. Doctor Carney intends to retire from practice within the next few years and dedicate a greater percentage of his time to the pursuit of his aforementioned research interests.

Doctor Davis. The fourth interview was with Doctor Davis, a provider and researcher who is at a relatively earlier stage of his career. Davis knew from a young age that he wished to be a physician and his experience with higher education reflects this desire. His undergraduate program involved pre-acceptance into medical school and he went on to do his residency and a research fellowship at one of the nation's most well regarded medical institutions. During the latter years of his experience at this institution, he developed expertise in the administrative aspects of conducting research. His combined experience has led him to his current practice, which integrates two specializations and management of a team that conducts related research. Doctor Davis has been in his current position for two years.

Doctor Davis described the current environmental emphasis on patient volume as being unfortunate, in that it does not favor smaller practices that seek to provide open access to care by accepting Medicaid. He appreciates that his system (employer) has the administrative resources to provide open access to care and that it insulates its providers from the ramifications of the prevailing market pressures. Davis described the value of providing equal access to care as paramount and he feels fortunate to be part of an organization where others take on the responsibility of the maintenance of organizational viability.

Doctor Davis adopted a less optimistic tone when he described the efforts to realize productivity via a narrow focus on specific care needs (in both specialty and primary care) as an impediment to delivery of comprehensive care. However, as we will see, he has also observed colleagues encounter adverse repercussions stemming from the challenges associated with trying to be all things to all patients. Doctor Davis is better able to realize the productivity that the current environment demands by practicing within the scope of an economically viable

specialization. He also described the pressure to stay at the upper levels of the spectrum of efficiency that he experiences as more intrinsic, than community driven.

Through the course of our conversation, it became evident that Doctor Davis personally values time spent with his young family. He also values self-direction (autonomy), intellectual stimulation, and the sense of achievement that his team's research agenda affords. He values collaborating with his research team and patients when evaluating their care options. He experiences the system in which he currently works as one that allows for the realization of the values that are important to him and he described his current position as the ideal situation.

Nurse Emerson. The interview with Nurse Emerson was the fourth one I conducted. She was the only study participant who was not currently associated with the system by which all of the other participants were employed.

Nurse Emerson is in the mid-to-late stages of a multi-faceted career that began with her experience as a childbirth educator and lay midwife. She described her choice to become a registered nurse as one that was rooted in pragmatism, an interest in science, and "wanting to be an advocate" (E.45). She believes that others choose nursing for the same mutually reinforcing benefits that drew her to the profession.

Emerson's first position as a RN was in a pediatric setting, a role where she felt she could advocate for both families and infants, and "be a guardian of (the) normal" (E.2). While Nurse Emerson has been a Registered Nurse for 32 years, she has also worked in a variety of other positions that are reflective of her advocacy and autonomy values, as well as her interests in holistic care. She values mindfulness practices, and her career choices and stories of professional interactions with both patients and colleagues reflected this personal value orientation.

During our conversation, Nurse Emerson stressed the importance of engaging in dialogue that serves to illuminate the importance of the personal values that nurses bring to the work environment. Her belief that care values and market values can coexist was expressed in an optimistic tone:

> So, I think it's important to have the market values and personal values intertwined. They're not going to match 100% but I think the closer we get - the more likely the systems going to improve… It's going to be better for society (E.70).

At the time of our conversation, she was actively seeking her next career opportunity. I learned after our interview that she had accepted a new position that appears to be perfectly aligned with her personal and professional value preferences.

Nurse Francis. The sixth interview I conducted was with Nurse Francis. Her path to her current position in specialty care began in the area of general (medical/surgical) care delivery. Structural changes prompted Francis to make a reluctant move from general practice into a specialized practice area that involves a high rate of mortality. She was surprised to find the new specialized practice area to be very fulfilling and she continued to work in that particular specialty for over 20 years.

She shared that she considered it a privilege to be able support her patients through difficult processes, but eventually the work began carrying over into her off hours and she shared how her care for others began to take an adversarial personal toll. She shared a story of a pivotal event, in which an experience with a young patient threatened her personal and emotional well-being. At that point, she decided to make the switch to her current practice area, which does not put her in the position of having to "say goodbye to as many of (her) patients" (F.2). Nurse Francis currently delivers care to those who are afflicted with chronic conditions and are suffering pain as a result.

Through the course of our conversation, it became clear that Nurse Francis cares for others in a self-transcendent manner and that she values benevolence and equal access to care. Nurse Francis also prioritizes the value of honesty in her patient interactions. Her intent to be transparent with those in her care is tempered by her empathic and compassionate nature and she cites a strong faith in God as having a significant influence over her personal value priorities.

An early experience with expectations that required Nurse Francis to uphold the market value of efficiency was illuminated in her narrative account of an interaction she had when practicing in a small, specialized care clinic. Pressure to cut supply costs that was applied by a low-level, small clinic administrator was experienced as peculiar, and she described the use of materials needed to deliver care correctly and effectively as "a cost of doing business" (F.27). She considers certain expenditures to be justified by the ethos of doing no harm and feels that they are necessary to maintain patient trust. In her current role, Nurse Francis experiences only subtle pressures to control costs and very little pressure to uphold productivity. Nurse Francis identified the physicians in her current system as those most likely to experience administrative pressure to uphold productivity.

While she may not personally experience pressure to uphold market values as directly as other HCPs, her long career as a nurse has led her to a place where she has gained an appreciation for what it takes to maintain a viable practice. Nurse Francis credits her current system's administrators for creating the conditions that allow her to take actions that are in the best interests of her patients. She considers herself fortunate to be practicing in such an environment.

Doctor Gabriel. The seventh interview that I conducted was with Doctor Gabriel. A positive experience with care she received during her formative years caused her to develop an appreciation for the maintenance of human dignity, and that experience led to her decision to become a physician. Upon her completion of medical school, Gabriel entered into an internship and then went on to become a doctor with the U.S. military. She described her position within the military as being one of the best jobs you can have in that particular branch and the responsibilities she held were varied. After several years in that role, she chose to stop moving and entered into a residency. This led Gabriel to her current position as a general practice provider, a position that she has held for several years.

Doctor Gabriel's concern for the maintenance of human dignity is related to the value she places on providing patients with a positive impression of their care experience. She values being well liked by her patients and seeks to retain them by providing them with the comprehensive care they are often seeking. Her intent to establish ongoing and trusting relationships with her patients was evidenced when she stated that, "I try to be very honest with patients and I want them to be honest with me" (G.7).

Of all those who participated in the study, Doctor Gabriel appears to be the participant who is most directly impacted by the presence of market values. When asked if she experiences the presence of market values such as productivity, efficiency, and competition, Gabriel responded in the affirmative by saying, "completely" (G10). She went on to describe how her compensation is structured and how the related calculations reflect an organizational intent to uphold productivity. Doctor Gabriel described the compensation structure as being detached from the significant time and effort that she and another general practice provider put forth. She also considers the compensation system to be in tension with patients' expectations of the

comprehensive level of care that they seek, as well as the time and money they have invested to access the care she delivers.

Doctor Gabriel described some of her interactions with her patients as being a comparatively lower level source of values conflict. Her patients sometimes seek treatments that she would not professionally recommend and she shared how this often conflicts with her intent to leave patients feeling satisfied with their care delivery experience. In such instances, Doctor Gabriel works to "make patients understand I'm listening to them and that I want what's best for them" (G.49).

At the time of her interview, Doctor Gabriel had recently faced the possibility of a pay cut and at the same time, committed to a major personal expenditure. She was scheduled for, and looking forward to, an upcoming meeting with the system's administrators where she would be discussing her concerns regarding the perceived imbalances in her compensation structure. She intended to open the upcoming meeting with the administration by conveying her love for the clientele (patients) and expressing how much she appreciates the administrative support she receives. Despite the varying levels of values conflicts that she experiences, Doctor Gabriel stated, "where I work, I am very happy" (G.10).

Nurse Harris. The eighth and final interview I conducted was with Nurse Harris. The path to her current position as a nurse in a specialized practice area began with an early childhood fascination with the care that her mother and grandparents received in hospital settings. The subsequent arrival of her first child caused her to become interested in the scientific and biological aspects of care delivery. When Nurse Harris personally experienced the labor and delivery nurses who attended to the birth of both her children as being uncaring, it "solidified where (she) went out of nursing school" (H.8). After graduating, she worked for a time as a

labor and delivery nurse, and landed a position doing triage in a general practice clinic. Her current position in specialized care involves prolonged and repeated interaction with patients afflicted with chronic conditions.

In addition to her earlier experiences with care delivery Nurse Harris cites her parents (upbringing), spouse and religious affiliation (faith in God) as also having a significant influence on personal value priorities. She identified the value of doing no harm as a given and related it to the importance of engaging in practice excellence.

Nurse Harris described her higher order personal preference for the delivery of compassionate care as one that is not necessarily shared by all members of the nursing profession, whereas others nurses pursue a more objective, data-based approach to patient interaction. She drew a sharp contrast between a data-driven approach and her own preference for becoming immersed in the details of her patient's lives. She went on to acknowledge that her preference for an interpersonal approach to compassionate care may not be to conducive to the productivity that others seek; she shared that the exercise of her preferred approach increases the likelihood of conflict with market values. However, she has experienced the values that have been espoused by the organizations in which she has worked as being compatible with her own:

> I've never so far had anything in my behavior or my thought process or my what I do that would conflict with it. So, it's not a big deal to me. But, if it ever did come to - you need to do these things for this reason and it conflicted with what my personal beliefs are in terms of who I am as a nurse and who I am as an individual and what that patient needs. I would have issue with it. And, probably it would cause me - I don't think I could work in an environment where it was asked that I do something that went against my values whether I felt like it was dangerous or whether I felt like it was putting too high a priority on money (H.24; H.25).

This significant statement is not offered to suggest that Nurse Harris is free from any consideration of the influence that market values have on care options. Towards the latter stages of our conversation, she expressed a concern over increases to the cost of healthcare and how

such increases can diminish available options for patients. She conceded that an over-emphasis on market values has been an unspoken concern of hers and she predicted that "if we're basing or making decisions on market values I can see that ultimately there will be a conflict. It's coming" (H.44). Nurse Harris experiences very little power in terms of her personal ability to influence the future direction of broad-based healthcare policy. She therefore chooses to focus her efforts in those areas where she can make a direct and positive impact on her patients, both in terms of protecting their personal finances and providing them with compassionate care.

Nurse Harris claims to have fallen into each nursing position she has held since completing nursing school and stated that she has loved every one of them. She believes that she is currently in a position where she can be of the most value to both her patients and the system in which she is practicing. While Nurse Harris could retire at any time, she plans to continue working for as long as she feels she is making positive contributions. She described her current role as a "unique honor" (H.6), and she openly shares her enthusiasm for her position: "I was just telling one of the doctors that I have the perfect job. You see these people get better. And you bond with them. And, of course, they have ups and downs. But mostly they get better" (H.6).

Like others who participated in the study, Nurse Harris' personal value preferences played a significant role in her decision to become a healthcare professional. This discovery is in keeping with the notion that the presence of certain personal values (e.g. benevolence; equity; the upholding of human dignity) informs the choice to become a medical professional (Dose, 1997; LeDuc & Kotzer, 2009; Rassin, 2008; Rokeach, 1973). The data derived from the HCP interviews also suggests that the personal values of those who participated in the study are enduring (Rokeach, 1973); the first major theme that was informed by the analysis of the data

speaks to the variety of ways in which the HCPs seek to professionally realize the personal values that matter most to them.

Theme 1 - Professional Opportunities to Enact Personal Value Imperatives

The first and most readily apparent theme to be informed by the analysis of the data was that all study participants seek out opportunities to enact personal values preferences within the context of their practice area. As one would expect, the bulk of the study participants expressed personal values that are commonly associated with the delivery of healthcare. It was further found that the care values that some practitioners prefer to exercise were not necessarily sanctioned by the organization in which they worked, and that others value efficiency. A visual representation of the theme Professional Opportunities to Enact Personal Value Imperatives and its related sub- themes in relationship to the four other themes informed by analysis of the data is included as Figure 6.

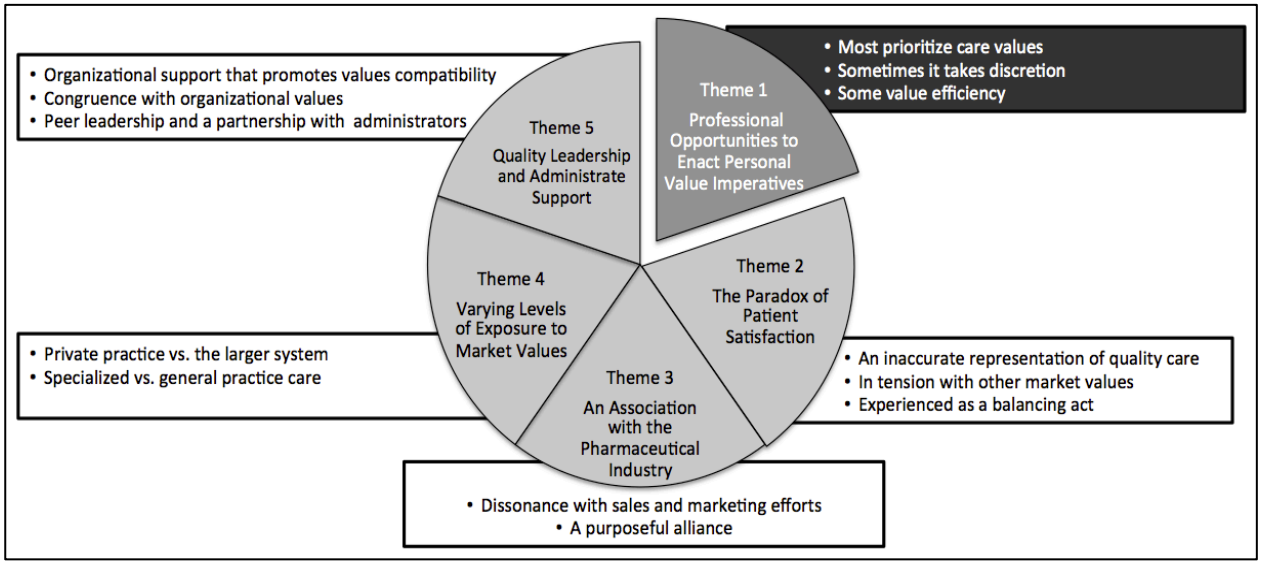

Figure 6. A visual representation of the theme Professional Opportunities to Enact Personal Value Imperatives and its related sub- themes, as one part of the findings informed by the analysis of the data derived from interviews with research participants.

While some do pursue values that could be construed as having a market orientation, all those who participated in this study view themselves to be care providers, and not business people. Before turning our attention to the specific discussion on how the HCPs seek out opportunities to apply their personal values preferences it is important to first consider some additional context, specifically in terms how the HCPs view themselves as actors in the broader system that they are a part of.

Doctor Anderson has observed that practicing physicians "don't like to say you're running a business, they're providing healthcare" (A.24). He shared his belief that "most people when they're going to medical school and thinking why do you want to become a physician, get all your training, aren't thinking about how the market factors will affect what they do" (A.34). He has further observed that very few physicians incorporate market metrics into their thought processes when identifying their goals over time.

Doctor Gabriel's view of the broad system is also rooted in the general experience of physicians. She views the orientation toward productivity and its relationship to how physicians are compensated, and what can ultimately be billed back to insurance companies, as working in opposition to "direct patient care where you just take care of whatever needs to be taken care of in the time that you need" (G.51). Doctor Davis has a more reserved take on the current environmental emphasis on productivity and described it as more important to others than it is to him. While Davis did acknowledge that he takes satisfaction in seeing the system promote itself and grow its market share, he also stated that if those things conflicted with time spent with his family, the pursuit of market values would take a backseat.

Doctor Carney offered his perspective on the broader system and chose the term "corporate climate" (C.30) to describe the current environment as one in which individual

healthcare systems "have to be competitive and have to sell themselves" (C.30). He stated that it "would be nice" (C.29) if his system administrators would be less concerned with the pursuit of market values. Given his self-avowed orientation toward communist/socialist ideals, it was not a surprise to find that he would prefer more of the financial resources in his system to be allocated toward "taking care of people" (C.30); he believes that this would be more likely "if we had a single payer system" (C.29).

Through the course of the analysis of interviews with the physicians, it became evident that they would all prefer an environment where the pursuit of self-interest was less prevalent and where the market values of competition and productivity had less of an impact on their system and their work as providers. The perspectives of the physicians who participated in the study were reflected in the words of Doctor Anderson when he opined "in an ideal world they (physicians) wouldn't be (in business)" (A.24).

The conversations I had with the nurses who participated in the study also revealed an aversion to an emphasis on market values. Nurse Emerson's "experience has been that most people at the nursing level can see through market values that are just offered sort of in a glitzy, advertising way" (E.22). She has observed that "there's internal resistance" (E.22) and that nurses will go through motions of documenting that they are implementing the market- oriented values because they are forced to, not because they really embody them. Nurse Emerson's observation was reinforced by another nurse participant who quipped that she has a tendency to discount those values that are orientated toward productivity, while embracing those that emphasize care. It was found that the vast majority of the HCPs put the most weight onto the pursuit of care values.

Most prioritize care values. When asked about his personal and professional values, Doctor Davis spoke of what he can and cannot control and how he chooses to focus his efforts on the preservation and enhancement of the welfare of those patients with whom he is in direct contact:

> I think that what drove me to go into this profession, (and what) provides professional satisfaction (is that) I think I can do good for people...I contribute to that…. I can't control what cards people are dealt –but if we take that and serve that patient and their family as best as we possibly can. To improve their quality of life and of course to extend their life. But even if we can't affect that, we want their quality of life to be good and for them to connect with family and whatever that is for that person. Whatever value that is for that person that matters to them. We help them to achieve that and to provide that. That is number one (D.6).

The altuisitc (benevolent) approach to care that Davis identified as a top priority was also identifed by Mpatisi, et al. (2015) as the personal and professional value that is most relevant to healthcare practitioners.

The upholding of human dignity for all patients (termed equality) is the value that Mpatisi, et al. (2015) identified as being second-most relevant to heath care practioners. For Doctor Gabriel, working toward the preservation of human dignity is paramount, given the state of vulnerability in which many of her patients may find themselves. She drew a connection between her personal value orientation and how it informs her practice:

> So, in any kind of particular time like that…. so, if anyone is going through a terrible time with depression or cancer or anything like that where they feel really vulnerable - I really try to work on making them feel comfortable, making them feel like it went as well as it could go and making them want to feel like they could come back and see me again (G.4).

While Gabriel does pursue a preference for making patients feel comfortable with accessing care and wishes to leave patients with a positive impression of their care experience, she also values honesty. She also spoke of her ongoing efforts to create an environment where her personal preference for honesty is reciprocated (i.e., patients trust her and she trusts them).

Nurse Harris' ongoing interactions with patients who suffer from chronic conditions has provided her with the opportunity to further define her preference for delivering compassionate care, as evidenced by a significant statement she offered:

> The whole thing that these patients go through when they have a chronic non-curable disease - they have to cope with that. And, you help them with that and you help them feel normal and feel valued and help them learn that they're valuable in whatever state. And, that's personal. I don't think that's necessarily nursing across the board. I think that's years of experience and humbly coming to the reality of how much we affect our patients. The power that we have over them. And, that, I think, took years of experience (H.11). I don't think they teach that to people. I don't think you're born with that. I mean part of that - you're born with compassion or you cultivate compassion maybe is what I should say. And, it becomes important. Compassion is kind of what drives me to try to understand what best helps them (H.12). Besides fixing their disease. What other pieces do they need while they are here in my area (H.13)?

It is generally accepted that personal values are shaped and refined though socialization processes akin to the one that Nurse Harris described (Meglino & Ravlin, 1998; Rokeach, 1973). Her extensive experience with treating chronic illness appears to have had a comparatively greater influence on her personal preference for compassion and holism, as compared to other nurses, as well as any training that involves a primary focus on treating only the physical manifestations of an illness.

Nurse Britt shared a recent experience with a patient that speaks to her preference for a supportive approach to helping patients come to terms with the reality of managing and living with chronic conditions:

> He had just moved here a couple of years ago. Was in a new relationship, kind of starting new and then got this diagnosis…. he had a hard time accepting the diagnosis and was very hesitant to do all of the things that the doctor had suggested. So, I did spend some time, more time, specifically when he was having trouble…There was a process that needed to happen of like, yeah you are doing this on your own, but we're going to help you. And it's normal that some help is needed because this is a very difficult, and very individual diagnosis (B.8).

This statement is reflective of Nurse Britt's sustained intent to exercise empathy, while compensating for the limited amount of face time that the specialized care clinic's physicians have with patients. When she perceives that patients have been unable to fully express their concerns during a scheduled appointment with their physician, she makes use of slack time to make follow-up phone calls. Britt's efforts go above and beyond that which is required in her current role as a RN and the motivation to put in the extra efforts to make the follow-up calls stems from her personal desire to be helpful, supportive, and empathic (Schwartz, et al., 2012).

Sometimes it takes discretion. It was found that the values that two of the nurses prefer were not specifically emphasized or sanctioned by the organization in which they worked. Nurse Emerson and Nurse Francis described how a subtle application of values they have found to be important to care delivery worked to augment approaches endorsed by the organizations in which they have worked.

Nurse Emerson works toward the goal of not only caring for the physical body, but the patient as a whole. She described a preference for holism as being a thread throughout her career and discussed a history of discreetly applying her preference for holistic care in organizational environments where such values were not sanctioned:

> I'm a Holistic Nursing Association member and the values they have there are things that I've had to sort of sneak in (emphasis given) to my nursing practice because they weren't part of the institution's values. But they were very important to me and they were important in gaining trust with patients and helping them to facilitate informed decision-making (E.16).

While the system that Nurse Francis currently works in would not be considered faith-based, she operates from the belief that her own faith in a higher power brings benefits to the patients in her care, and she spoke of events where there was a tacit reciprocation of such values:

> I have strong faith in God and I believe that those values are helpful for every area of my life. I would not dream of pushing my values onto someone. But I certainly want them to

> benefit from my care and those values. So, I definitely feel like it would be wrong to push my values. I do believe that there will be benefits that they may not even realize where the values are derived from…And patients will hold your hand and ask you to pray for them. I mean it's amazing without me having to say anything…They just, I think there's times they just realize they need more than what we can give them and they're just kind of crying out for any help that can be provided (F.11; F.12).

Similar to Nurse Britt's follow-up phone calls, Nurse Francis's exercise of faith-based values and Nurse Emerson's pursuit of holism appear to compensate for (and be a complement to) the limitations of modern healthcare delivery.

Some value efficiency. The value of efficiency was found to be one that is not only emphasized by system administrators but is also preferred by HCPs like Doctors Anderson and Carney. On the day of our interview, Doctor Anderson had recently been reflecting on the pursuit of clinical efficiency and stated:

> I was thinking to myself today that the best system is the most efficient system and efficient means full or busy, right? And so, if you had an efficient assembly line you have a widget going past you every one minute, no matter what. If you wanted to have an efficient clinic you have a patient every fifteen minutes in the clinic no matter what. And you could say that the patients who need thirty minutes need two fifteen minute slots blocked out. But, if you have fifteen minutes to do here and then nothing to do for fifteen minutes, then you're inefficient, and you're going to find that your productivity is less than what the administration wants (A.11).

In the follow up to our interview Doctor Anderson confirmed that the value of efficiency is one he personally aspires to realize. When a patient consultation goes long he is cognizant of the expectations that the next patient may have:

> But the next patient keep in mind, has expectations as well. One of their expectations might be that they're going to be seen in a timely manner. One might be that they get a full fifteen minutes with the doc (A.15).

These two significant statements are reflective of an alignment between personal preferences for efficiency and Anderson's intent to honor the expectations of both patients as well as those of his

system's administrators. Doctor Anderson reported that he makes up for lost time by dedicating his personal time (e.g. lunch hour) to the maintenance of medical records.

Doctor Carney spoke to past experiences where his propensity to be efficient worked in combination with his knowledge of medical science and his Myers-Briggs type stylistic preference:

> I think I had a kind of scientific bent to things so I tend to be efficient. I am an INTP. As a rational, I'm very much a bang, bang, bang. I'm interested in you as a person but I'm not a chit-chatter (C.10)

While I personally experienced Doctor Carney as being quite amicable, he stated that his exercise of rational efficiency has been a source of dissatisfaction among patients who have sought his care. It is also noteworthy, however, that both Doctors Carney and Anderson appear to be pursuing the capability values that were identified by Mpatisi, et al. (2015) as being the third most common among HCPs; some patients might prefer a provider who is able to leverage their expertise to deliver care in a rational and efficient manner.

Doctor Anderson pointed out that patient expectations of the amount of time they get with physicians "will change from patient to patient" (A.22). Nurse Harris shared a relevant observation that stems from her long career as a HCP:

> I'll tell you - it's really interesting - we have some doctors that will take 40 minutes with a patient and some doctors that will take 10 minutes with a patient. There are patients who will prefer one over the other. And it's not always going to be the doctor that takes more time. So, doctors have styles. Patients have styles. Nurses have styles. And, usually, they end up aligning with each other when they have similar styles (H.60).

The alignment of preferences that Nurse Harris describes speaks to how the personal values of HCPs and patients can ultimately align when patients have a choice among care providers, and how such an alignment can translate into a positive experience for patients.

The conversational interviews with all those who participated in the study served to reveal a predominant orientation toward care values and reinforce the idea that the personal and professional values of HCPs are intertwined (Dose, 1997; Mpatisi, et al., 2015; Pipes, et al., 2005; Thorpe & Loo, 2003). The notion that it would be difficult to conceptually distinguish between those values that are personal and those that are professional was perhaps best described by Doctor Davis who said "they're so ingrained to be able to with a knife, cut them apart, would be very hard" (D.9).

When aggregated, the values-based contributions of HCPs are very important to healthcare systems in that they serve to improve organizational effectiveness (Organ, Podsakoff, & Makenzie, 2006; Perreira & Whaitney, 2016). Doctor Anderson's preference for efficiency and his willingness to sacrifice his lunch hour to maintain it can contribute to the creation of a more positive outcome for multiple system stakeholders. The values-based efforts that he and Nurses Britt (helping/supporting), Emerson (holistic) and Francis (faith-based) put forth are discretionary and they appear to provide patients with an increased level of satisfaction with their care experience. However, it was also found that there is some inconsistency with regards to what it means to have patients who are satisfied with their care experience.

Theme 2 - The Paradox of Patient Satisfaction

The second theme that was informed by the analysis of the data captured through participant interviews pertains to an inconsistency between the broad system emphasis on patient satisfaction and other values that are commonly emphasized in care delivery. It was found that two of the physicians who participated in the study experience patient satisfaction as being an inaccurate representation of quality care and that efforts to realize patient satisfaction are at odds with the pursuit of productivity and efficiency values. It was further found that the need to

balance patient satisfaction with quality and production efficiency often rests on the shoulders of HCPs. Figure 7 is offered to highlight the theme of The Paradox of Patient Satisfaction and its related sub-themes, as one part of the findings from the analysis of the data derived from participant interviews.

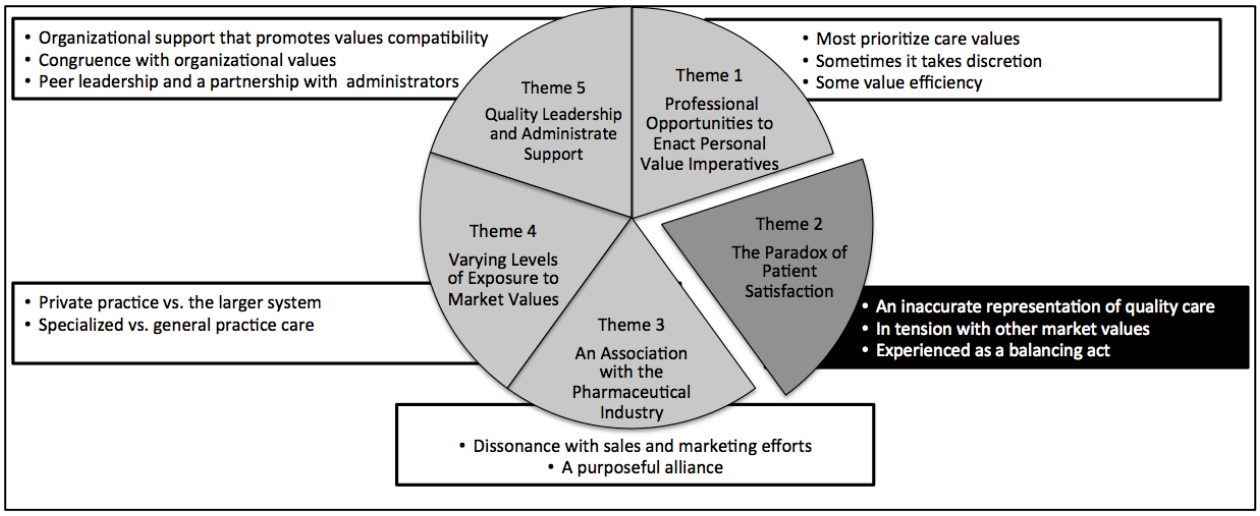

Figure 7. A visual representation of the theme The Paradox of Patient Satisfaction and its related sub- themes, as one part of the findings informed by the analysis of the data.

The origins of the current emphasis on patient satisfaction in healthcare are part of the reason that patient satisfaction has multiple meanings. A stream of research that dates back to the late eighties suggests that patient satisfaction is closely correlated with compliance with care directives, quality care indicators, and improved health outcomes (Cleary, 2016; Zgierska, Rabago, & Miller, 2014). Others claim that patient satisfaction has undergone a transformation from a care-centered approach to a market-oriented goal of *customer* satisfaction with hospital and clinical care experiences (Junewicz & Yougner, 2016; Williams, 1994). The alleged transformation of patient satisfaction to a market-oriented goal has been attributed to an increased level of commercialization in healthcare and federal policy that fiscally incentivizes

the pursuit of perpetually higher levels of patient satisfaction (Junewicz & Yougner, 2016; Voss, Cable, & Voss, 2000).

Patient satisfaction levels are commonly captured through surveys that were developed through a progressive set of federal policy actions. Hospitals are now required to report survey data that demonstrates that their patients are satisfied in order to receive their full Medicaid reimbursements. The Centers for Medicare and Medicaid services websites publicly report and compare data for both hospitals and individual physicians, and a majority of physicians have reported that their compensation is linked to patient satisfaction ratings (Junewicz & Yougner, 2016; Zgierska, et al., 2014).

According to Junewicz and Yougner (2016), there are several ways in which patients can be satisfied and the clearest path is when patients are provided with "medically necessary care that actually improves their health outcomes" (p. 43). A far more nebulous way in which patients may realize satisfaction occurs when they receive interventions that they or their families want or even demand (Junewicz & Yougner, 2016). It has been asserted that such requests sometimes result in interventions that are medically unnecessary and may negatively affect health outcomes (Junewicz & Yougner, 2016; Zgierska, et al., 2014). Quantitative research conducted by Zgierska, et al. (2014) found that a majority of physicians view patient satisfaction as a poor surrogate measure of the quality of medical care, and the experiences of two of the physicians who participated in this study are in alignment with the notion that patient satisfaction and quality care are not always synonymous.

An inaccurate representation of quality care. Doctor Carney spoke of experiences earlier in his career in which he received some of the lowest satisfaction scores as compared to others in his then current physicians group. He attributed his lower satisfaction scores to his

aforementioned preference for a rational and efficient approach to care delivery. While those in his care may have preferred a more interpersonal approach, it is important to consider that those patients may very well have benefitted from Carney's application of his knowledge of medical science.

Doctor Carney has more recently experienced an inability to help those who are afflicted with pain that has no known cure. He stated, "the hardest problem is when I can't help somebody, those with incurable pain, the drug seekers" (C.18). He has made it "a practice not to give out narcotics, period" (C.18) and he believes that "a lot of patients don't like that. They need their pain meds" (C.18).

He describes the challenges that he experiences as being further exacerbated by the marketing tactics of corporate America. "I think Madison Avenue itself, they're advertising as if everybody should be thin, rich and have no pain. Have a beautiful life. Drive a beautiful car, and people, I think, believe that" (C. 21). The combination of incurable disease, patient demand for narcotics, and the marketing efforts of the pharmaceutical industry have made it difficult for Doctor Carney to achieve patient satisfaction, and this has led him to the conclusion that "the (broad) system has an imperfect method of (physician) assessment" (C.12).

Doctor Gabriel also experiences patient satisfaction and the related metrics as a source of pressure to prescribe medications she would not ordinarily suggest. She is routinely confronted with situations where she experiences "some sort of urge to make sure you're giving them the meds they want so that they're satisfied" (G.18). She makes a concerted effort to suggest alternatives, but often encounters resistance on the part of her patients, particularly from those that are older and have been on certain medications for a significant length of time. Doctor Gabriel described such instances as an internal source of conflict and one of the most unpleasant

aspects of her position as a provider in general practice; she would likely choose alternatives "if they weren't going to fill out a survey" (G.18). Her experience serves as an example of how patient satisfaction data captured via a consumer style survey places a very real pressure on physicians to provide interventions they would not otherwise recommend. The conversations with Doctors Carney and Gabriel serves as evidence of how the patient-centered care and the shared decision-making that were once essential elements of patient satisfaction have evolved to become a customer-oriented approach to care delivery that can actually "undermine the expertise and morale of physicians" (Junewicz & Yougner, 2016, p. 50).

In tension with other market values. Productivity is an overarching value in organizations with a market orientation (Cameron & Quinn, 2011), and administrators in many healthcare institutions emphasize increasing levels of efficiency in order to foster organizational viability. Avedis Donabedian (2003) coined the term *production efficiency* to encompass the goal of efficiently producing the goods and services that are used to provide healthcare. He also referred to this type of efficiency as *managerial efficiency* because it stems from "organizational and managerial decisions in which practitioners do not play a decisive role" (Donabedian, 2003, p. 10).

While most study participants did convey an understanding that *production / managerial efficiency* is necessary for organizational viability, several participants spoke of the potential for conflict with patient satisfaction. Doctor Anderson acknowledged that his personal preference for efficiency and the managerial intent to realize productivity has the potential to conflict with the satisfaction of his patients' expectations of the specialized care he delivers. In a similar vein, Doctor Gabriel spoke of fellow general practice providers whose patient satisfaction scores go down when they seek to realize productivity by staying within scheduled appointment windows:

> A lot of the doctors that do well on their RBU's are seeing patients every 10 to 15 minutes. They're just knocking them out. But satisfaction goes down. When you do that, patients don't necessarily feel like you spent a good time with them that they wanted (G.14).

Gabriel's personal preference is to take the time necessary to address all of the care her patients seek and code the visit accordingly.

According to Donabedian (2003), the participation and consent on the part of practitioners is necessary for *production/managerial efficiency* to be realized. Doctor Anderson appears to be an active participant as evidenced by his statement that "the best system is the most efficient system and efficient means being full or busy" (A.11), and that if "you're inefficient and you're going to find that your productivity is less than what administration wants" (A.11). While Nurse Britt appeared to be a bit less eager to consent to the *managerial efficiency* that Donabedian (2003) identified, she spoke of her part in an intervention that reflects a managerial intent to realize production efficiency:

> I uh, did more or less get in trouble for spending so much time with patients on the phone. Um, a couple years into my position. Just as far as hours allotted to each doctor, and their staff go, I was going over, um. So, I did have to meet with my manager and come up with ideas on how to make my phone call shorter, get to the point quicker and still make the patient feel like I wasn't rushing through the conversation (B.7).

Nurse Britt has not only personally experienced some pressure to conform to production efficiency; she has also witnessed an increased level of administrative pressure that was applied to the physician she works for as they collectively transitioned from a smaller clinical practice to the larger system. Nurse Francis has similarly observed a progressive level of administrative pressure on physicians to conform to production efficiency, as evidenced by a significant statement she offered:

> I think that there's pressure put on them to take care of a certain number of patients and they do at the most efficient level possible. I think they're under a lot more pressure the past few years than I've ever seen in healthcare. That's changed a lot (F.36).

An additional way in which a system can realize efficiency is by distributing care (and resources) among different classifications of patients based on some typology such as age, or type of illness (Donabedian, 2003). Donabedian (2003) termed this approach *distributional efficiency*. Patient dissatisfaction emanating from the pursuit of *distributional efficiency* was evidenced in the narrative account of an experience that was offered by Doctor Anderson. He spoke of an organizational structural trend toward the use of hospitalists, whereas the doctor a patient sees in an office is different from the one they will see when admitted to the hospital. Doctor Anderson does not personally see this trend as antithetical to quality, but described the use of hospitalists as a source of dissatisfaction among patients:

> I think it's very good healthcare, don't get me wrong. Patients don't perceive it as so. But you have a specialist in the hospital who just takes care of hospital patients all the time and you have a specialist in the outpatient center who just takes care of their outpatients. I think they're more specialized and probably do a very good job. It's not a patient satisfier by any means, that they don't see their same physician in the hospital that they saw in the clinic (A.31).

While such an approach may serve to make efficient use of specialized expertise, the loss of continuity appears to be a source of patient dissatisfaction. Interestingly, only two of the six participants who practice in specialized areas referenced the potential for dissatisfaction with the *distributional efficiency* (segmentation) that is inherent in the delivery of specialized care, and none of participants described their own specialized care patients as being dissatisfied.

Experienced as a balancing act. The interviews that I conducted with two of the doctors and two of the nurses served to reveal the knowledge, judgment, and skill that is required to strike a balance between the pursuit of efficiency, the delivery of quality care, and the realization of patient satisfaction.

During our conversation, Doctor Anderson shared a story of a same-day occurrence of being behind at the clinic because a patient who had been stuck in traffic showed up 10 minutes late for their appointment. The patient noticed an anatomic model in the examination room and began to ask questions that Doctor Anderson deemed to be unrelated to his condition. He apologized for not having the time to answer the patient's questions and moved on to the next patient. It was found that Doctor Anderson is routinely put in the position of gauging expectations, having to weigh those factors that are most relevant to a patient's needs, and responding in ways that leave the patient feeling as if they got the attention they deserve. He stated that he prioritizes patient satisfaction "every time" (A.17).

Conversations with two of the nurses who participated in the study are in line with the common understanding that the delivery of quality care may involve some level of physical, mental, and emotional discomfort for patients (Junewicz & Yougner, 2016). Nurse Emerson described healthcare as sometimes involving situations "where we're actually inflicting pain in order to facilitate healing" (E.4). A significant statement from the interview with Nurse Francis speaks to her experience with the mental and emotional pain that may accompany the delivery of quality care:

> I think there's sometimes you do have to share hard things when you tell a patient that's having a lot of joint pain that even if they could lose 10% body weight it would be very, very helpful for them. You know it's painful for them to hear that, it's hurtful (F.7).

Both nurses deliver news that is sometimes difficult for patients to receive and they exercise their personal value preferences in doing so. For Nurse Francis, this involves her stated preference for honesty and for Nurse Emerson this involves "promoting as much humanism as possible" (E.4). From these interviews, it was apparent that both nurses are motivated by their personal value

preferences and that both are able to skillfully deliver care that may cause discomfort as they simultaneously seek to realize patient satisfaction.

A personal preference for reciprocal honesty is also part of Doctor Gabriel's practice and her pursuit of this value has come into conflict with patient satisfaction. She shared multiple stories of primary care patients who come with questionable rationale for treatments that might not be in their best, long-term interest. Doctor Gabriel is keenly aware that she can simultaneously realize productivity and patient satisfaction by acquiescing to patient demands:

> I can easily see patients quickly and say here's your drug, come back and see me if you have any more problems. You know, you can just appease them and they're usually kind of satisfied for a while until it doesn't get better but that's not really the proper way to do things (G.34)

Instead Doctor Gabriel takes the time to discuss the realities associated with potentially harmful treatment options and address the multiple needs of her primary care patients. She shared a story of a patient who would ordinarily see another physician in the system, but was able to get on her schedule for a twenty-minute appointment and get care for a number of issues:

> And he said you know what? In twenty minutes you have fixed or helped me with these problems that I've had for years and my doctor doesn't get the time to get to it. So, he was really satisfied. He changed over to my clinic and started being my patient (G.35).

Through an analysis of our conversation, it became clear that Doctor Gabriel applies a combination of clinical efficiency, discretion, and negotiation skills to her significant efforts to leave patients feeling satisfied. The accounts of lived experience that were offered by Doctor Anderson, Nurses Britt and Emerson, and Doctor Gabriel are illustrative of how HCPs are routinely put in the position of weighing the relative importance of personal values, patient satisfaction, and quality care and how they strive to achieve what Doctor Gabriel termed "a balance" (G.19).

The findings from the conversations with the vast majority of the study participants are in keeping with the notion that patient satisfaction is a "term that remains poorly defined" (Junewicz & Yougner, 2016, p. 43). The experiences of the HCPs who participated in the study suggest that the current orientation toward patient satisfaction works at cross-purposes to the delivery of quality care and various forms of efficiency that are needed for system viability.

Some researchers do acknowledge that patient satisfaction survey data can "facilitate positive change and quality improvements initiates in healthcare delivery that are responsive to other needs" (Zgierska, et al., 2014, p. 438), whereas others view it as a mere proxy for customer satisfaction. Those who are critical of the current emphasis on patient satisfaction suggest that such an orientation may cause practitioners to be reluctant to deliver bad news, provide good care that will cause discomfort, and advice that is not welcome (Cleary, 2016; Junewicz & Yougner, 2016). It was found that many of those who participated in this study seek to uphold these elements of healthcare quality via an application of their values, knowledge, and skill.

It is important to acknowledge that the system in which seven of the participants work is subject to a broader societal orientation toward certain values and goals (Donabedian, 1966; 2005); and that "a lot of things are based" (B.17) on the aggregated results of that "little quiz on how your appointment went" (B.16). We would do well to realize that the pressure to uphold satisfaction, quality, and efficiency largely rests with our HCPs' ability to balance these multiple and competing priorities, and that the relationship between a HCP and their patients should be viewed differently from the business-to-consumer relationship commonly found in competitive markets (Parsons, 1975).

Theme 3 - An Association with the Pharmaceutical Industry

The third theme that was informed by analysis of the data serves to highlight the various ways in which participants have come into contact with the pharmaceutical companies and how they interpret their experience with the industry. It was found that some experience dissonance with the sales and marketing efforts of pharmaceutical companies, whereas others openly engage with the companies within the industry when they perceive such interaction to be mutually beneficial. A visual representation of the theme An Association with the Pharmaceutical Industry and its related sub-themes is offered as Figure 8.

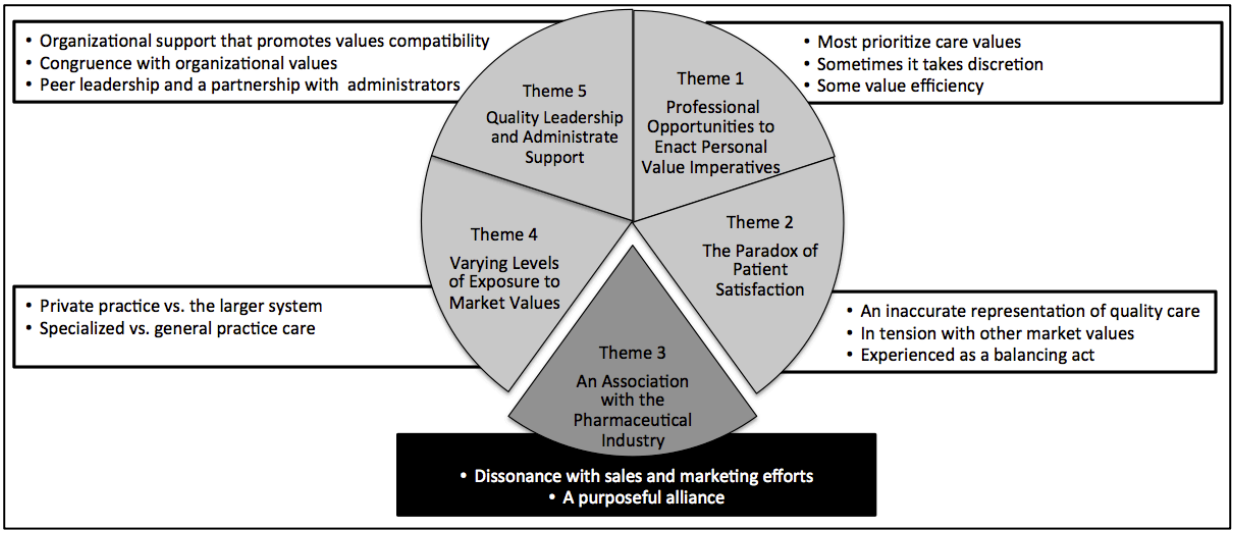

Figure 8. A visual representation of the theme An Association with the Pharmaceutical Industry and its related sub-themes, as one part of the findings informed by the analysis of the data.

To best understand the different ways in which HCPs experience their contact with the industry, it is worthwhile to first consider two of the contextual perspectives that were shared by research participants and draw a relationship between those perspectives and what was discovered in the initial review of the literature on coexisting values (Chapter 2).

The existence of the industry players who pursue their own interests (e.g. the pharmaceutical industry; the makers of medical equipment and devices) were identified by

Doctor Anderson as the reason why it is necessary for the system to maintain a business orientation and why healthcare is considered a business. Anderson posited that the view of healthcare as a business is predominant in most systems that exist around the world, even those that have a single payer, whereas it is typically a government that pays for the products and services that profit-driven entities provide. During our interview, he opined that "it would be nice if you could keep the business side out of it" (A.4), but he sees that as impossible given the ubiquitous presence of industry players who view healthcare as a marketplace with profit potential.

The presence of the pharmaceutical industry and its pursuit of profit has been identified by some as one of the main reasons why the cost of healthcare continues to escalate, and there is some agreement that the pharmaceutical industry uses its financial resources for the "commercial construction of medical science" (Light, 2010, p. 284).

Doctor Carney's perspective is aligned with the allegations that that have been levied against the pharmaceutical industry. He pointed to the identification of pain as a vital sign as an example of where he has experienced the pharmaceutical industry as having an undue influence over medical research.

Dissonance with sales and marketing efforts. Nurse Britt shared a story of a recent encounter that served to illuminate how her value orientation served as the basis for a quizzical interpretation of the actions of a vendor who worked for a pharmaceutical company. The product that the vendor was attempting to sell was a monitor that could capture data that would be very valuable for the physicians in Nurse Britt's specialized practice area. The doctors were very interested so Nurse Britt was charged with pursuing the purchase. The sales representative offered an introductory special that would necessitate the purchase of five of the monitors, one

device over the number that was needed to cover the four clinics on behalf of which Britt was negotiating. She described the sales representative as "very pushy and trying to sell *me* on saving money" (B.24). Nurse Britt recalled her reaction:

> I remember looking at one point and saying, it's saves who money? She goes, well you, the system. And I said it's not saving the patient money, we're going to charge them the same. And it's not saving me any money. I'm just the nurse, I'm about clinical outcomes (B.24).

The experience that Nurse Britt had with the sales representative speaks to how the value she places on outcomes supersedes any significant concern for the cost of resources. It seems the sales person would have been more effective if they focused on the benefits to the patients, rather than defaulting to an appeal based on cost savings. Nurse Britt's story also serves to highlight how there is often no apparent relationship between the costs that health systems incur and the costs their patients are ultimately obliged to pay.

Doctor Carney personally experiences the pharmaceutical companies as being uninterested in making people better. Carney described their stated concern for the promotion of well-being as "lip service" (C.22) and his experience with research and specialized practice has led him to perceive the industry as being comprised of "reptilian corporations" (C.22) whose job "is to make money" (C.22). Doctor Davis has adopted a softer view and sees the industry as only partially responsible for increases to the cost of care. He has observed that the industry is often vilified for being responsible for such increases because "they are big and not in the room" (D.12).

Doctor Davis' current combination of research and practice puts him in contact with the pharmaceutical industry, and this may be part of the reason he has adapted a comparatively softer view of the industry. Through the course of our conversation, he conveyed an enthusiasm for the promise that his work holds and gratitude for his opportunity to pursue capability values.

However, like Nurse Britt, Davis has experienced some level of dissonance with the marketing efforts of pharmaceutical companies.

As he was watching the Super Bowl with his family, an advertisement for one of the drugs that he has researched came across the airwaves and he conveyed that he found the experience to be peculiar. He described the experience as "mind-boggling" (D.21), not only because a pharmaceutical ad aired during the biggest advertising spectacle of the year, but also because the action that was suggested ran counter to his experience with the manner in which people typically discover that they need access to the specialized care his clinic delivers.

While Doctor Davis experienced the Super Bowl advertisement as an oddity, he has also had experiences in which he perceived the marketing efforts of the pharmaceutical industry as effective. He spoke of encounters with patients who bring in a grocery store magazine that features drug advertisements that have the appearance of being a two or three-page editorial;

> People come in and say I want this. You look at it and it looks like the rosiest treatment in the world. And it's extremely promising and I'm very, very excited about it. But it has a ton of side effects and people can die… from the treatment. And that's not mentioned anywhere in this rosy, you know, I'm not sure what magazine it was in (D.25).

It is ultimately up to Doctor Davis to highlight the reality associated with all treatment options and he is sometimes placed in the position of having to recommend more proven alternatives that have fewer side effects. As noted in his introduction, Doctor Davis seeks to maintain a collaborative reproach to evaluating care options with his patients and like others who participated in the study, he also appears to realize the mutual benefits of his collaboration with the pharmaceutical industry.

A purposeful alliance. The drugs that are used to treat patients in the practice area that Nurses Francis and Harris share come at an extremely high cost. When the high cost of medication prevents their patients from being able to access necessary care, these two nurses

work to procure financial resources for them. Nurse Francis provided a general overview of the efforts that she and Nurse Harris undertake:

> I think the group of nurses that I work with - they are all very diligent and try to get them (patients) funding wherever we can. And so, we're kind of, even though we're nurses, we end up diving deeper into the financial piece than what we actually enjoy but sometimes we're able to get people started on their medication and get them going. And, that's really encouraging to the patient. And, it's fulfilling to us because if, you know, see the patient later and they're no longer dealing with pain and they're able to take on their life again and do the things that they want to do. That's pretty encouraging (F.16).

One avenue through which these nurses can secure funding is through the co-pay assistance programs that pharmaceutical companies offer. Nurse Harris described how it works:

> So, what that means is if - we'll use an easy amount of money - if you have an insurance company - and they say you have to pay your deductible first. And then after you pay your deductible, we'll pay 80%. So, let's say this costs $2,000 (I'm just pulling a number out of my head) and your deductible is $1,000. So, first you pay your $1,000 and then of the $1,000 that's left, we'll pay 80%. So, they're going to pay $800 but there's a $200 gap. The drug companies will pay that less $5 (H.1).

Nurse Harris went on to describe how drug companies will sometimes go beyond providing co-payment assistance and even donate drugs in instances where a patient's insurance policy will not cover the cost of drugs that are needed to maintain the patient's quality of life. The interviews with Nurses Francis and Harris featured a significant amount of discussion around the ways "that these very, very expensive medications become accessible to patients who we call our underinsured" (H.2) revealed a significant involvement with the business aspects of healthcare on the part of these two nurses.

When asked if nurses are more prone than doctors to working directly with patients as they navigate the cost of their care, Nurse Francis indicated that there is a difference, which she attributed to working with patients "on a more personal level" (F.20). It was found that both she and Nurse Harris are afforded the opportunity (and take the time) to become immersed in the details of their patients' lives. Their approach is based on a common desire to "understand what

best helps them, besides fixing their disease" (H.12) and it goes well beyond getting to know the names of their patients' grandchildren. Nurse Francis offered a recent story of an encounter with a grandmother that is illustrative of how her interpersonal approach to care delivery works to bring the financial circumstances their patients encounter to the surface:

> They tell us things like I've got a daughter who's schizophrenic who lives in a home and I'm raising her 4-year old child. And, I'm only working part-time because I'm trying to raise this child and take care of my daughter who's schizophrenic. And (they) say, I don't have the money for this medicine. And you look at them and go - you need this medicine so that you can continue to take care of everybody. And then you think OK, what kind of resources can I help find to get this person so that they can take care of their family, so that they can continue with their lives… (this grandmother) couldn't afford her medication. So, we worked and worked to get her on her medication (F.21).

When Nurses Francis and Harris encounter a financial need, they take action. Nurse Francis shared another story that speaks to her own tendency to act, even if the ultimate source of payment is uncertain:

> There was a young man who desperately needed the medication. He was living with his mother. His mother was disabled. He was like 18, 19 years old. He was a very young man. He was making nothing - $16,000 a year or something …. So, obviously he couldn't pay toward it very much… they got him on Medicaid right away, but they still couldn't come up with that other 20%. So, with that we were able to get free drugs from the company. As it turned out, Medicaid actually ended up paying for it…The insurance ended up taking care of it. But we didn't think it was (going to) in the beginning. But, you know, we did get the treatment going kind of in faith a little faster than what we would have - but he was in critical condition and really needed the treatment (F.23).

While Nurse Harris believes pharmaceutical companies "truly do want their product to be accessible to people, to everyone" (H.3), she also understands that they are motivated by profit. When those patients that do have insurance coverage have reached their annual co-payment maximum, the financial dis-incentive for accessing care that these patients may encounter has been removed, and the patients' insurance carrier is now obligated to cover the cost of ongoing drug treatments. In these instances, both the pharmaceutical companies and the system benefit.

Nurses Francis and Harris operate with an understanding of the mutually reinforcing benefits that stem from their actions, as evidenced by a significant statement offered by Nurse Francis:

> You know, every time we help the patient financially we're actually helping the company and helping ourselves stay employed when it comes right down to it. Because we're providing these services for our patients - if the patients can't afford to get the treatment they can't afford to keep the nurses on. And, they can't receive the treatment that they desperately need (F.22).

Both nurses also use their expert knowledge of insurance plans and the related payment structures to provide continuity of care to those patients who wish to stay on course with the specialized care they deliver. "Sometimes it's just a matter of advising them on what type of insurance they need to buy with the next sign up period" (F.19). Nurse Harris shared how her patients often call to ask her "where would you go, what insurance would you pick...which one (plan) do I pick that would give me the option to stay here?" (H.63).

Nurse Harris described the financial aspects as a "huge part of healthcare" (H.4) and she considers the efforts that she and her collogues put forth to be an essential component of their patients' wellness:

> So, if we're just treating the patient's disease and then they have to figure out how to pay for this treatment - I mean, that's a part of their wellness. Emotionally and, if we bankrupt them in our attempt to make them better - sometimes that's a terrible thing. So, it's part of taking care of the whole patient - you're helping them understand the financial piece (H.4).

Through the course of dialogue, it became clear that the reluctant willingness to engage in the business side of care on the part of Nurses Francis and Harris is motivated by an intent to care for the whole person (holism) and compassion for those who are desperate to receive the specialized care they deliver. Their actions are further justified by the mutually reinforcing benefits that emanate from their collective efforts. While others may be slightly less willing to

accept the realities of the healthcare marketplace, most of the participants show evidence of a willingness to adapt.

Theme 4 - Varying Levels of Exposure to Market Values

The fourth theme that was informed by the analysis of the interview data relates to the varying level of exposure to market values that physicians encounter. It was found that the type of system a physician works in will typically dictate how directly that doctor experiences market values. It was also found that those practicing within a scope of a specialized practice area are afforded more cover from market values relative to their general practice colleagues. Figure 9 is offered as a visual representation of the theme Varying Levels of Exposure to Market Values and its related sub-themes, as one part of the findings from the analysis of the data derived from interviews with the HCPs who participated in the study.

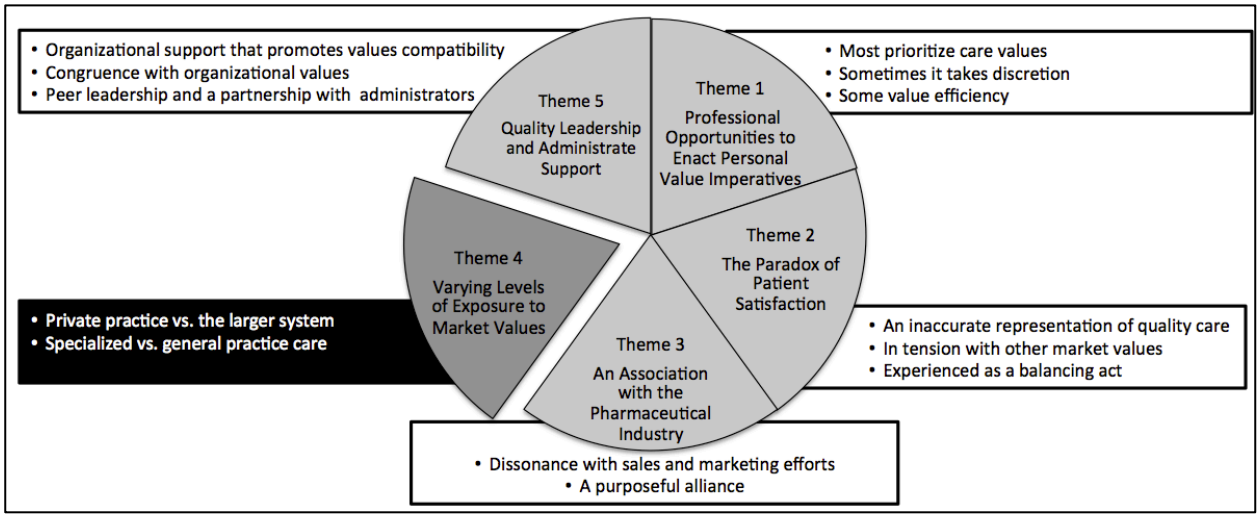

Figure 9. A visual representation of the theme Varying Levels of Exposure to Market Values and its related sub-themes, as part of the findings from the analysis of the data.

Private practice vs. the larger system. It was found that being in private practice requires that a physician maintain a greater awareness of business matters than those who practice in large systems. According to Doctor Anderson:

> In medicine you have private practices, which have all forms of business responsibilities. Can they pay their employees, can they pay for their bills and can they pay for their building? And you have others who are employed by another entity in our case (the system), and a physician's employment group within that…. So fewer (business) responsibilities when you're employed by somebody else (A.3).

Anderson later spoke of how "If you were going to go and say I am going to start my own practice you clearly have your eyes wide open that you're running a business, too" (A.35).

Doctor Davis shared a like-minded perspective and at a very early stage of our conversation, spoke to how "in this decade – it's becoming more challenging to run a clinic and private practice for a (small) specialty group" (D.1). He conveyed a sense of loss as he went on to say "that private practice is harder now" (D.7) and described how "practice wise, financially, the volume unfortunately, is key" (D.7). Davis lamented that the current reimbursement payment structure makes it difficult for the small practice provider to treat whoever might seek out their services, whereas "if you are a smaller practice you have to make decisions as to whether you're going to avoid loss and things like that, particularly in primary care" (D.7).

The conversations with Doctors Anderson and Davis served to illuminate how "market influences are different depending on your employer type" (A.35), and both appear to benefit from the size and scope of the large system in which they work. Doctor Davis expressed gratitude for being able to "treat whoever walks in the door …the same way" (D.8) and went on to elaborate on the support he receives from a system-wide group that operates outside of his immediate practice area:

> If they (patients) don't have insurance, or they are under insured we have a team that makes sure we can get that covered. Whether that's through grants, or charitable giving, or we can write it off, or whatever. That gives me a lot of satisfaction that I can say you can have the Cadillac of insurance vs. no insurance and I'm trying as hard as I can to treat you exactly the same. That's a big value I have (D.8).

The administrative support that the large system provides affords Doctor Davis the opportunity to realize his values priorities, while also protecting him from market forces to which he would be exposed if he were in a smaller practice. In his current position, he is not faced with decisions around being able to take only "so many Medicaid" (D.7). Doctor Carney also expressed similar appreciation for the cover the larger system provides when he said "we take everybody; Medicaid, everybody. We make more money here just because of the way the system works" (C.32).

Another facet of the system involves insurance reimbursement structures. Doctor Anderson described how an attention to such structures contributes to his system's viability:

> If you do a procedure that is reimbursed at a low amount, but the procedure takes a lot of time. If you only do those procedures then you couldn't have a viable practice. But when you look at the big picture you can do long extensive procedures that have a low reimbursement, by making up for it with other things through give-and-take. There are other shorter procedures that have high reimbursement (A.23).

The ability to strike a balance among a portfolio of services was described by Doctor Anderson as being integral to the simultaneous pursuit of care and market values. It seems that an ability to strike such a balance within a smaller practice would be a fortunate happenstance.

Perhaps the most revealing insights regarding the protections that the large system affords rests with what the physicians who participated in the study did not say. Not one expressed a concern for competitive pressure from any other providers, either from within or outside of the system. Doctor Carney was the only one to even acknowledge the presence of competitors. The individual he spoke of was actually renting space from the system and his office was located in the same building as Doctor Carney's, just one floor above.

Specialized vs. general practice care. When asked whether or not he sees commercialization in healthcare as obfuscating or co-opting the values that have historically underscored the delivery of care, Doctor Davis responded by saying "I think the biggest one is the time spent with the patient. The patient-physician relationship. I think the biggest assault is in Primary Care" (D.43). Doctor Davis went on to reference how physicians have historically been depicted on TV and how the idea of taking ninety minutes with a patient is completely out of the question:

> And, the commercialization has just changed things. It's trained out of us when we're in training. You focus on -- you know the number of times I heard my mentor say "I'm a (specialist). We'll call someone else to answer that question. Let's talk about your (immediate condition). When you're in clinic or rounds. We become very siloed. Like I am supposed to spend 15 to 20 minutes with my patient, focus on my (specialization), the rest of it is someone else's problem. I think there is a lot of pressure for that - which I really don't like (D.45).

Doctor Anderson shared a similar observation that extends from his role as a specialized care provider who practices in the same area as Doctor Davis's mentor:

> There are many physicians in this world who will say I took care of the healthcare problem they walked in with. Didn't take care of all that ancillary stuff. I saw a patient who walked in and wanted to talk about their toe pain, and their dizziness and their itch. We were there to talk about their (specific condition)" (D.22).

Anderson went on to describe how the more focused approach to specialized care delivery can leave patients with a less-than-favorable impression of their care experience.

Doctor Davis has witnessed the potential for burnout that results from efforts to perpetually honor the notion of what a provider has historically been expected to be (all things for all patients). He spoke of a fellow specialty care provider who also works in his clinic:

> I think she's getting burnt out because she tries to be the Primary Care, the Oncologist, the Cardiologist, the Endocrinologist. Everybody. She tries to be that classical - what a doctor was. That has a high value for her - she tries to do that as much as possible. When I have to cover for her, or when any of us have to cover for her patients – it's maddening

> because we can never live up to that bar. They have this expectation that we're going to take care of everything under the sun (D.47)

Other stories that Doctor Davis shared suggest that the likelihood of productivity related to burnout increases when one is practicing in the area of primary care. Davis described adverse repercussions that he witnessed in a friend:

> …one that I grew up with…When (people) asked who they should see for primary care?...he was the guy… the person everyone wants to see because he tried to be that ideal primary care doctor, (he was) the community's doctor, incredibly successful…. He was getting so much pressure to see more people, be quick…he felt that he couldn't interact with patients. He burned out to the point where he ended up quitting, he just couldn't take it anymore, gained 100 lbs. He now works at a urgent care clinic where he can focus on one issue at a time, has lost about half the weight, essentially collecting a paycheck because he is not yet at retirement age (D.50)

Doctor Davis went on to share a more recent example of another friend in general practice. In this instance, he learned that his friend was experiencing self-doubt "because he was getting pressure to see more people and just felt like he couldn't. The feelings that were expressed by his friend caused Doctor Davis alarm, in "that somehow (this) was an inadequacy that he had, as opposed to an unreal expectation" (D.52). Doctor Davis went on to note a trend that he attributes to the increased emphasis on the commercialization and the market value of productivity:

> A lot of residents come out now in Primary Care, the newer docs…. When they see a patient – they are trained to deal with one thing. And in their charts and notes there is no mention if the patient has had (a life-threatening illness), there's no mention of side effects (from treatment). They come in because they have a cold. And it's about the cold and it's as if the rest of it doesn't exist. So, I'm saying this as if I'm old, and I'm not, but that's not good medicine (D.53).

The ability to realize the simultaneous pursuit of care and market values appears to come easier to those in certain specialized practice areas. Patients who schedule visits with general practice providers often walk in with a number of unrelated health concerns and there is typically an organizational emphasis on patient volume. It is often incumbent upon the general practice provider to work to efficiently address multiple concerns within short appointment windows,

while also being expected to realize the productivity. The testimony that was provided by Doctors Davis and Gabriel suggest that these pressures are having adverse repercussions on general practice providers.

It has been found that burnout effects up to 60% of those in general practice (Lacy & Chan, 2018), and of all the HCPs who participated in this study, Doctor Gabriel seems to be the one who is closest to burnout and the demoralization that is believed to accompany it. As noted in Chapter 2, Gabel (2011; 2013) asserts that feelings of burnout and demoralization among HCPs can occur when the personal and professional values that are perceived to be foundational to the healthcare professions are threatened or lost. Doctor Gabriel's words point to an inability to reconcile her personal and professional value preferences with other factors in her environment, an absence of fairness, and a lack of control over her work, all of which have been identified as factors that contribute to burnout (Maslach & Leiter, 1997). Organizational interventions are considered to be one of the more effective ways to combat physician burnout (Feldman, 2018) and the system in which Doctor Gabriel practices appears to be one where its practitioners benefit from high-quality leadership and administrative support that recognizes the importance of caring for those who provide care for others.

Theme 5 - Quality Leadership and Administrative Support

The fifth and final theme that was informed by the analysis of the interviews with the HCPs pertains to a favorable view of the system's leadership and an appreciation for the level of support that system administrators often provide. The study participants experience the system's leadership as being effective at providing a level of support and conveying messaging that enables compatibility among personal, professional, and market values priorities. A visual representation of the theme Quality Leadership and Administrative Support and it sub-themes in

relationship to the other themes that were informed by the analysis of the data is offered as Figure 10.

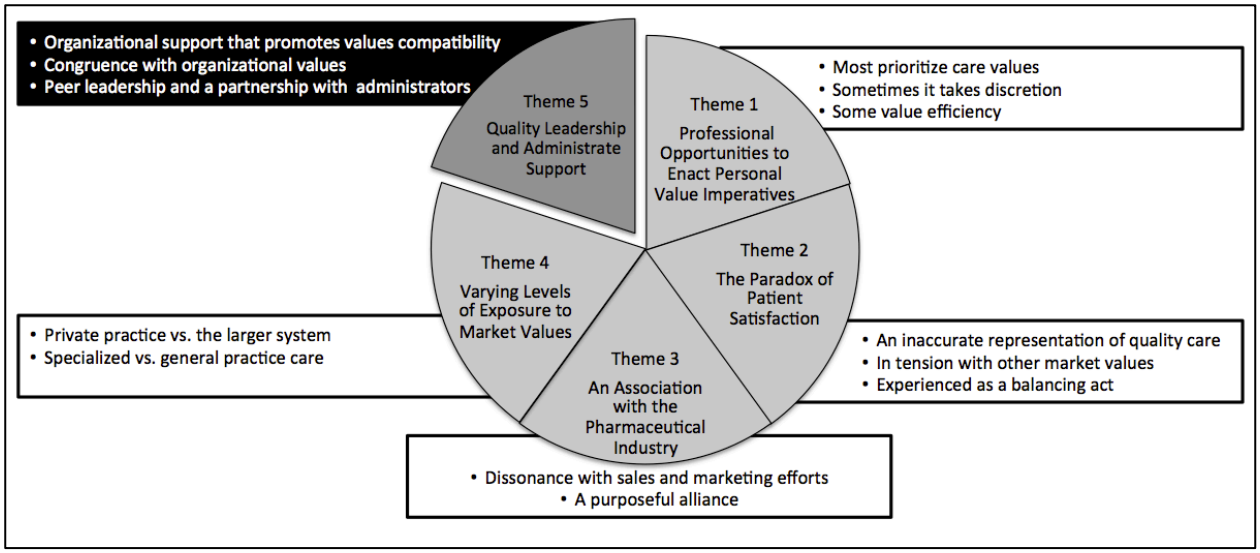

Figure 10. A visual representation of the theme Quality Leadership and Administrative Support and it sub-themes, as part of the findings that were informed by the data analysis.

When asked if she directly experiences market values, Nurse Francis identified her managers as those most likely to be concerned with upholding such values. She went on to describe how the business-oriented administrators in the system have a different expertise and focus than that of medical practitioners:

> I think they are tasked. It's obvious that they're tasked with watching the money but they - when you put it in context of what is right for the patient? I've had good managers and they seem to get that and back off a little bit and do what's appropriate (F.14).

The different value orientations that administrators and practitioners bring have been a source of minor conflict for Nurse Francis, but she believes the managers in her chain of command are focused on the right things, in that they allow for the prioritization and application of care values over a concern for market values. She described those that have risen in the chain of command to roles in senior management as individuals "who actually want to do the right thing and take care of the patient" (F.33). Nurse Francis named a specific manager who she holds

in high regard, and she considers herself fortunate to work for such "awesome" and "stellar people" (F.32).

Organizational support that promotes compatibility among value priorities. When asked if he has experienced the expected coexistence of personal, professional, and market values as being compatible, Doctor Carney also responded by identifying a specific leader who he holds in high regard. He went on to describe the administrators throughout the system as being adherents to the practice of "service leadership" (C.27) and prone to enact policy that makes "life easier on the docs" (C.25). He gave a specific example of where he was assigned two scribes who are responsible for the maintenance of electronic health records (EHRs). It has been found that doctors ordinarily spend between 21.5% to 49.6% of their time in the exam room on the computer maintaining EHRs (Asan, Smith, & Montague, 2014; Montague & Asan, 2012); 87% of physicians identified paperwork and administrative responsibility as being a leading cause of work-related stress and burnout (Bodenherimer & Sinsky, 2014). A team approach to documentation and the maintenance of EHRs has been identified as one of the main ways in which healthcare organizations can improve the work life of clinicians and staff (Bodenherimer & Sinsky, 2014). Doctor Carney is a proponent of scribes and described the administrative allocation of resources as being beneficial in terms of improving both efficiency and his ability to be more present with his patients. Bodenherimer and Sinsky (2014) cite two studies that suggest that the approach is associated with "greater physician and staff satisfaction, improved revenues, and the capacity to manage a larger panel of patients" (p. 575).

Nurse Francis echoed the sentiments of Doctor Carney by stating "we are making eye-to-eye contact which is probably (something) in healthcare (that is) becoming lost" (G.37).

However, her optimism was somewhat tempered, as she went on to say that "in switching to this they're (physicians are) expected to take on, do more appointments, see more patients" (F.38).

There was a significant contrast between how some participants experience administrators in the larger system and how they have experienced administrators during events that had transpired in other organizations at various stages of their careers. Doctor Davis shared a story about the arrival of his first-born and being told to be back to work before his wife was released from the hospital. He described the experience as a significant conflict between the value he places on family and the administrative expectation that he return to work. Davis expressed a feeling of being merely a foot soldier and he ultimately left a prestigious position that most physicians would envy.

Nurse Emerson told a similar story about a stark contrast between a mechanistic approach to management and compassion for her familial obligation; in which a nurse manager threatened to charge her with patient abandonment if she chose to attend to her grade school-aged daughter who was suffering from a 104-degree fever. Another early career experience with the same Nurse Manager served to highlight a stark contrast between managerial intent to realize productivity and compassion for both herself and the lost life of an infant. Nurse Emerson described that specific experience with her then-manager as "harsh" and "dehumanizing" (E.9).

Nurse Emerson shared several other stories of past adversarial encounters with organizational administrators. She described one administrator's attempts to drive efficiency as inefficient, and an impediment to established patient and inter-professional relationships. In another instance, she experienced the swift and symbolic actions to amass power on the part of a new CEO as being detrimental to what was previously a supportive and meaningful team environment. The hierarchical structures that were put in place by that administrator were

described by Nurse Emerson as antithetical to collaboration and distinct from informal forms of leadership that stem from earning trust and respect.

In the latter stages of our conversation, Nurse Emerson shared a story of a more positive experience with a manager who understood that anyone who comes into contact with patients has the opportunity to compensate for the time pressures that nurses and doctors ordinarily encounter:

> That manager was amazing - he told his workers – who, some of them didn't even have high school education, many of them were not English as their first language - the people who were pushing the brooms and cleaning the rooms. He told them to talk to the people when you go in there and smile, and say have a nice day and thank you and was there anything you need?... and it helped people feel better and chemically, neuro-chemically, we know that when people are happier they heal faster (E.72).

Emerson went on to point out that while nurses do ordinarily want to spend time with patients, it is also important for them to have an occasional respite from the demands of patient interaction. Her collective experience has led her to the belief that it is important to care for those who care for others.

Congruency with organizational values. For Doctor Gabriel, administrative support and value congruence appear to go hand-in-hand. She stated that, "It's very important to me that my organization supports me and that we have the same values about what we want for patient care. That's very true" (G.47). Doctor Gabriel believes the system is one where there are good intentions and experiences congruency among the care values that are espoused and those values that are in use (Argyris, 1974). Doctor Davis also experiences congruency between his core values and those that are pursued within the larger system. He spoke to the benefits that are derived from being part of such a system and how administrative support structures ensure universal access to care:

> What I love about this group (system). I treat whoever walks in the door; I treat them all the same way. If they don't have insurance, or they are under insured we have a team that makes sure we can get that covered (D.8).

Like Doctor Davis, Doctor Carney also expressed an appreciation for the system's policy of providing access to care for anyone who seeks it. The setting enables the realization of their shared preference for equality and is experienced as being quite different from one that has a more pronounced orientation towards profitability.

Both Doctors Carney and Davis described their specialized practice within the larger system as being akin to a private practice. Davis expressed gratitude for the administration's willingness to allow him to pursue his personal preference for autonomy:

> When you join a hospital system, it could be viewed as a big bureaucracy with a lot of people telling you what to do and I would not care for that. I think I've been given incredible freedom and flexibility…to do the research I'm passionate about, but still (I) am running my own practice within a hospital system… I think I get the best of both worlds (D.5).

The freedom Davis is afforded appears to be a source of motivation. He considers himself to be fortunate to work in a situation he described as rare, relative to others who practice in other large systems. The narrative account of the transition to the larger (current) system that was offered by Nurse Britt was more in keeping with the sacrifice of autonomy that Doctor Davis described as commonplace. She described the physician that she works for as now "having all of these people above her who are making calls on her practice" (B12). However, in the same line of conversation, Nurse Britt also spoke of experiencing alignment with the values and goals of the newer, larger system.

While Doctor Davis did acknowledge that administrators value productivity, he also expressed gratitude for having a compensation system that does not incentivize over treatment. He believes this practice removes any subtle, or sub-conscious personal motivation to over treat

patients that those in private practice might experience. Doctor Davis described the compensation practices as "very-very good" (D.54), and conducive to the ethos of doing no harm.

Congruency among the values that an organization practices and those of its organizational members is commonly referred to as person-organization fit (P-O fit) and its benefits are well established. When values are in alignment, organizational members have been found to realize a higher degree of satisfaction, a reduced intention to quit and they are more likely to put forth extra effort (Edwards & Cable, 2009; Kristof-Brown, Zimmerman, & Johnson, 2005). In a recent study that was specific to healthcare, Risman, Erikson and Diefendorff (2016) found that nurses' perceptions of P-O fit were a significant predictor of their job satisfaction and the quality of patient care.

The findings from the interviews I conducted with the HCPs who participated in the study suggest that they experience congruence between their personal and professional value preferences and the care values that the system emphasizes and supports. The freedom to express a range of personal and professional values and the benefits to the organization are reflected in a significant statement that was offered by Nurse Francis; "I feel like they've allowed me to practice what my core values are. I think they see some value that I really do care about the patient and I'm glad to go the extra mile when needed (F.40). Her statement speaks to an apparent understanding among system administrators. They appear to understand that the system's organizational effectiveness is enhanced when its healthcare practitioners are given freedom to enact their personal and professional value preferences.

Peer leadership and a partnership with system administrators. It was found that the system where the bulk of the study participants work is one in which administrators seek to foster a close working relationship with the HCPs. According to Doctor Anderson:

> We have a system that works very well. We have physicians working with administrators to ensure good access to high-quality care, that is innovative…we (also) have physicians who are in administrative roles and are doing a lot of strategic planning (A.36).

The practice of having physicians in leadership roles is in keeping with what Chatfield, et al. (2017) have found to be an effective practice in the nation's top performing academic medical centers. According to these researchers, physician involvement in leadership is the best way to foster their buy-in, and the practice helps to "ensure that leadership is seen as a partnership between administration and care providers" (Chatfield, et al., 2017, p. 377). Chatfield et al. (2017) also identify the practice of developing strategy in conjunction with those who will enact it as being essential to the realization of a shared vision. While Doctor Anderson does give partial credit to the financial incentives that are provided by the current insurance reimbursement payment structure, he described the physician-administration partnership in his system as contributing to his practice area's ability to "ensure good access to high-quality care that is innovative" (A.38).

Nurse Emerson echoed the call for peer leadership that others consider to be effective. She opined that if care and market values are to coexist, there "needs to be more *nurse* leaders" (E.69). Emerson has witnessed her fellow nurses' efforts to uphold care values and productivity and she described them as those who best understand "the pulse of what's happening on a day-to-day basis" (E.69). Nurses are the largest segment of the healthcare workforce and they spend the greatest amount of time in delivering patient care as a profession (Institute of Medicine, 2011); the idea that Nurse Emerson put forth has resonance with other appeals for nurse

leadership. The Institute for Medicine (2011) calls for nurses to "be fully engaged with other health professionals and assume leadership roles in redesigning care" and Bisognano (2016) sees nurses as being "crucial to healthcare system transformation" (p. 423). Larkin, Swanson, Fuller and Cortese (2016) posit that a successful reform of the US health system will require all HCPs to see themselves as people who have "the power to do something about it" (p.137), and as individual leaders who enact transformational change.

The purpose of this chapter was to present a detailed and in-depth illumination of the research participants' experience with expectations that personal, professional, and market values can coexist within the context of their practice. The combination of a descriptive and interpretive approach to this phenomenological inquiry and a thorough consideration of individual and social context informed the identification of five essential themes. It was found that the HCPs experience 1) professional opportunities to enact personal value imperatives; 2) the paradox of patient satisfaction; 3) an association with the Pharmaceutical Industry; 4) varying levels of exposure to market values; and 5) quality leadership and administrative support. It was further found that there are nuances in the ways the HCPs experience these essential themes; the subthemes that were organized under the essential themes were offered to capture such nuances.

The descriptions of experience that the participants provided inform a response to the research question number one (What is the lived experience of HCPs with the co-existence of personal, professional and market values?). The responses to the question of *what* individual participants have experienced suggests that bulk of the study participants share a common experience with expectations that care and market values can coexist, and an organizational environment that allows for the pursuit of personal and professional care value preferences.

The participants' interpretations of their experiences with expectations that personal, professional and market values can coexist informed a response to research question number two (How do HCPs experience the phenomenon of coexisting values?). The exploration of *how* they experience the phenomenon suggests that the presence of market values leads the HCPs to judge the actions of profit driven entities and that care values serve as the basis for justifying interaction with these market players. Many of the HCPS who participated in the study experience compatibility among their personal and professional values and the market values that are present in the current healthcare environment, whereas others experience varying degrees of conflict.

The findings from this research also serve to inform a response to research question number three (What is the significance of the coexistence of personal, professional and market values in healthcare for HCPs?). It was found that the phenomenon is most *significant* for those who are in small private practice and for those in general practice; as it is they who are most likely succumb to the feelings of demoralization and burnout that have been identified as problems that emanate from the expected coexistence of personal, professional and market values within the context of care delivery. The study of the HCPs experiences with other's expectations that certain values can coexist within the arena of healthcare point towards significant implications, and these implications are discussed in detail in Chapter 5.

CHAPTER 5- IMPLICATIONS

The investigation into *how* the HCPs experience expectations that personal, professional, and market values can coexist and *what* their experience has been with the phenomenon led to a set of findings that feature possible implications. This final chapter is offered as an exploration of those possible implications and begins with a discussion on how the theories that guided this inquiry are reflected in the experiences of the eight HCPs who participated in the study. A discussion of implications that stem from my experience with Interpretive Phenomenology follows, and is offered for those who might conduct studies comparable to this dissertation research. Chapter 5 concludes with a discussion on possible implications for practice, theory development, and future research, as well as a summary of this research project.

Associations with the Informing Theoretical Frameworks

The study was informed by numerous theories and the consideration of a range of perspectives. The human values theory applied to the study was representative of a synthesis of numerous pieces of literature that were published over the span of a 70-year period. The theory that was used as the basis for the conceptualization of the personal and professional values of HCPs also emanated from an inductive approach, and was heavily influenced by the research of Moyo et al. (2015). Cameron and Quinn's (2011) work was the primary source for the market values theory that informed the study. The theory that formed the basis for an exploration of the consequences that may emanate from the coexisting values phenomenon was also representative of a synthesis of numerous perspectives. The stories and anecdotes that the HCPs shared often served as confirmation of these theories and there were several instances in which the aforementioned theories were disconfirmed.

The theory of human values. The conceptualizations of values put forth by the likes of Maslow (1959), Parsons and Shils (1951), Rokeach (1973), Schwartz (1994); Schwartz, et al. (2012) and Williams (1968) were synthesized and used as the basis for the human values theory that informed the study. The conduct of the current inquiry served to reaffirm and illuminate the presence of numerous human values theory constructs.

The theoretical belief that values serve as interpretive criteria was revealed when participants self-identified their personal value preferences, and then went on to describe their perceptions of the broad environment (e.g. corporate climate; concern for high cost of care) and the organization in which most of them work (e.g. focused on the right things; concerned with the productivity imperative). In instances where an individual's personal values were perceived to be similar to those emphasized in their environment (e.g. efficiency) the HCPs indicated that they experienced compatibility among value priorities. Conversely, when the HCPs interpreted values that were environmentally emphasized as working at cross-purposes with the values they hold (e.g. patient satisfaction vs. capability values) they experienced conflict.

Evidence that the HCPs' values function as interpretive criteria for judging and justifying certain actions appeared in several areas. Two of the HCPs reported that their preferences for improved patient outcomes was the basis for *judging* events where the pharmaceutical industry sought to market and sell its products; two of the nurses *justify* the direct interaction they have with the industry under the auspices of providing access to care for patients who would otherwise not be able to afford it, and the mutually reinforcing and system-wide benefits that emanate from their efforts.

The conceptualization of human values as having the unique quality *oughtness* (Feather, 1992; 1995; Meglino & Ravlin, 1998; Rokeach, 1973) was evidenced in Nurse

Emerson's story of how she chose to become a nurse. She described how her choice was not only based on her preference for advocacy, but also pragmatism. As a newly single mother, she perceived a career in nursing as representative of a socially desirable way in which she could fulfill her own needs (Meglino & Ravlin, 1998).

Through the course of the study, it was also found that some of the HCPs values are most active and more likely to be a source of motivation when they encounter values that are opposed to those they prefer. Nurse Harris' description of her negative experience with labor and delivery was described as a primary source of motivation for life-long efforts to pursue compassionate care. Doctor Gabriel's effort to meet with administrators and work with them to restore fairness to the compensation system to which she and others are subject serves as a second example of where there was an affront to a value preference and the associated events inspired action on the part of a study participant. The experiences that these two study participants shared also speak to how values are shaped and refined through socialization processes. Each described how previous experiences with care delivery put them on course to become a HCP; and Nurse Harris spoke to how her preferences for compassion has been continuously shaped and refined via her ongoing interaction with the patients she cares for.

The finding that Nurses may not be apt to ascribe to an organizational emphasis on market values is reflective of an observation put forth by Meglino and Ravlin (1998). The anecdotes that were shared by Nurses Emerson and Harris suggest that when an individual nurse's values are different than the market-oriented values that are present in their environment, the values of the social environment may have some level of influence over what a HCPs says but are not likely to be an accurate indicator of how that HCP will behave. The stories these nurses shared also suggests that some HCPs may engage in what Stormer and Devine (2008)

termed “facades of conformity” (p.112), specifically when there is a gap between the personal and professional values that HCPs prefer and the values that a healthcare system espouses (Argyris, 1974).

The conduct of the study served to affirm that human values exist on the individual and collective (i.e., professional and organizational) levels and that such values are a source of goal-based motivation for both individual actors and the collective entities. It was found that the collective actions of those with broad responsibility for the system are not only oriented toward the collective pursuit of care values, but also patient satisfaction values and the market values of productivity, efficiency, and competition. While some individuals may attribute varying levels of importance to care and market values, we can infer that the concurrent pursuit of such values serves the collective interests of the systems’ primary stakeholders. The individual HCPs shared numerous stories of how their personal values informed their approach to care delivery (e.g. exercising compassion; holism; efficiency) and when aggregated, these stories largely spoke to the pursuit of self-transcendence values (i.e., benevolence; universalism) that are often synonymous with notions of professionalism within the practice of healthcare.

The theory of the personal and professional values of HCPs. In Chapter 2 it was posited that it would be conceptually difficult, if not impossible, to distinguish between the personal and professional values of healthcare practitioners (Dose, 1999; Moyo, et al., 2015; Pipes, et al., 2005; Thorpe & Loo, 2003). The experiences that were shared by all HCPs suggest that their personal and professional values are inextricably linked. This linkage became evident early in the series of interviews, specifically when Doctor Anderson spoke of exercising his preference for efficiency and Nurse Britt spoke of how her personal goal of helping and

supporting others plays into her practice. Several others spoke of how their personal values informed their choice to become a HCP.

In her review of the literature on medical professionalism Arnold (2002) found the value of altruism to be the most common among the medical professions. Moyo, et al. (2015) reached a similar conclusion in their own literature review when they identified altruism as being the value that is most relevant to HCPs. In their efforts to align their findings with those of Schwartz (1994), Moyo, et al. (2015) equate altruism with benevolence, and numerous participants expressed personal/professional preferences for the values that Moyo, et al., (2015) categorize under the broad heading of altruism (e.g. helping, empathy; compassion). Many of the participants also expressed preferences for the category of values Moyo, et al., (2015) identified as being the second-most relevant to HCPs. The intent to realize equality surfaced via the emphasis that some study participants placed on advocacy, equity, socialism, and human dignity values (Moyo, et al., 2015). Capability values were identified by Moyo, et al. (2015) as the set of values that are third-most relevant to HCPs and through the course of the study, it became clear that several of the participants valued the exercise of competence and the development of new knowledge through the pursuit of research.

While the accounts of lived experience that participants shared suggest a fair degree of alignment with the values that were identified by Moyo, et al., (2015) as most relevant to HCPs, there are two notable exceptions. First, several of the nurses revealed a preference for, and application of, the spirituality values (faith in god; holism) that Moyo, et al., (2015) identified as occurring less frequently in the literature. Given the absence of a broad acceptance of spirituality values, it is reasonable to infer that this is why two of the nurses spoke of the need to discreetly apply such value preferences. The second exception pertains to the capability-based, clinical

efficiency that two of the doctors prefer to exercise. While Moyo et al. (2015) do discuss how the pursuit of capability is one of the more relevant values to HCPs, there is a notable absence of a reference to any preference for efficiency values and how efficiency may be interacting with the pursuit of capability values.

In Chapter 2, it was discussed how Moyo et al. (2015) derived their theoretical structure of HCP value relations from the Schwartz (1994) structure of relations among universal value domains; and how for example, capability values are a derivation of the achievement values identified by Schwartz (1994). In both models the capability (achievement) values that were claimed by study participants are conceptualized as working in opposition to the self-transcendence values (altruism; equality; spirituality) that many of the participants also claimed. The findings from this study imply that self-transcendence (care) values and capability values may not be as dichotomous as the Moyo et al. (2015) would indicate; in that many of the participants simultaneously pursue such values and only one (Doctor Carney) reported adverse personal consequences stemming from an intent to concurrently uphold care and capability values.

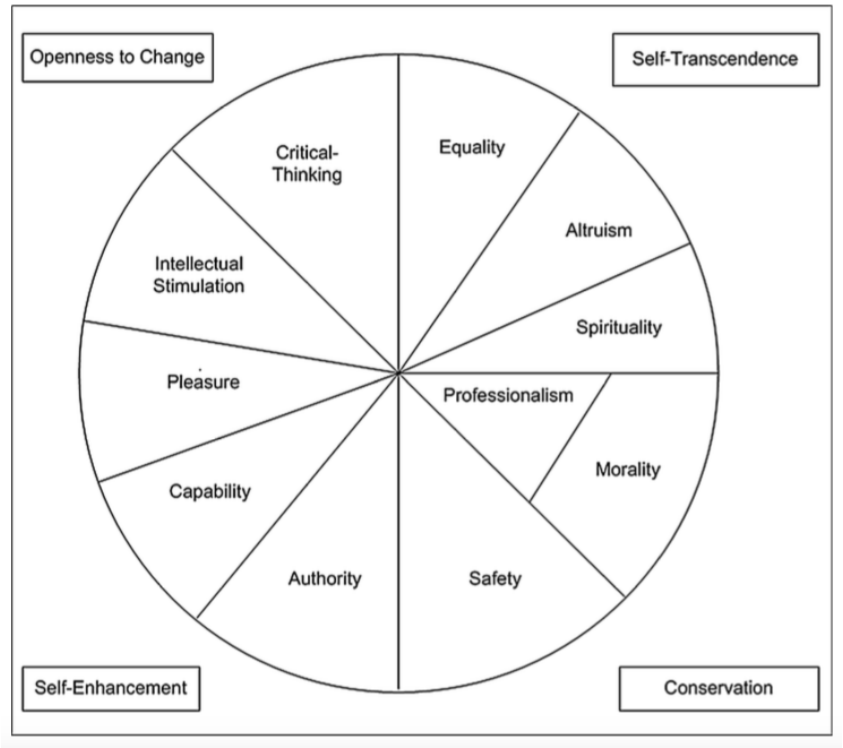

Figure 11. Moyo, Goodyear-Smith, Weller, Robb, & Shulruf's (2015) structural model of relations among the healthcare practitioners personal and professional values.

The theory of market values. The third theory that was used to inform the study came from the work of Cameron and Quinn (2011). Given the ample amount of literature on human values and the personal and professional values of HCPs, it was decided that only the market values piece (one of four parts) of their Competing Values Framework was needed to initiate the study. As previously noted and as the name would suggest, the Competing Values Framework is also based on the notion that certain values work in opposition to one another and these two researchers position organizations with an orientation towards markets as being conceptually opposed to those that resemble a clan. According to Cameron and Quinn (2011) the clan organization appears more like an extended family, than it does an economic entity. The authors posit that market-oriented organizations are predominantly concerned with the external environment and transactions with suppliers, customers, and regulators; the goal in such an

organization is to conduct transactions with these constituents in ways that create and sustain competitive advantage.

According to Cameron and Quinn (2011) the core values of a market-oriented organization are competition and productivity, and such values are believed to permeate organizational culture. The conversations with those who participated in the study served to reveal that they experience a low-level competitive pressure and moderate degree of productivity pressure. Only Nurse Britt and Doctor Carney spoke of the existence of a specific competitor, and neither indicated feeling any concern for its existence. Cameron and Quinn (2011) suggest that a focus on rivalry and differentiation accompany the external orientation of a market organization. A significant statement that was offered by Doctor Davis served to further distinguish the system from the market type that Cameron and Quinn (2011) describe when he spoke of how little there is that differentiates his clinic from others that offer the same specialized care in other systems. Through the course of the study, it became evident that the primary responsibility for "being competitive within the market" (C.27) rests with the system's administrative leadership. From this finding, it is reasonable to infer that the orientation of the system's administrators is rooted in professional values that differ from the vast majority of the HCPs who participated in the study (Graber & Kilpatrick, 2008); and that the market value of competition does not appear to permeate the operations of the system in the manner in which Cameron and Quinn (2011) suggest.

The one participant who appears to most directly experience the market values of productivity and competition is Doctor Gabriel. At an early point in our conversation, she described the system's productivity- based compensation system and how it uses comparisons to national productivity averages as a basis for calculating her salary. Doctor Gabriel spoke directly

to how this causes her to experience competitive pressure and how in any given year she may take a pay cut, or receive a bonus, depending on how she stacks up against national productivity averages.

The more common ways in which the HCPs experience a market orientation stems from the presence of values that bear a relationship to the productivity and competition values that Cameron and Quinn (2011) identified as market values. Efficiency is a close cousin to productivity, as indicated by Donabedian's (2003) use of the term *production-efficiency* to denote the goal of efficiently delivering healthcare in ways that management prescribes; a number of participants spoke of either a personal preference for, or organizational expectation that, they deliver production-efficiency.

In the theme addressed in Chapter Four, The Paradox of Patient Satisfaction, it was discussed how the current, broad-system emphasis on patient satisfaction is sometimes experienced as a thinly veiled proxy for the market value of customer satisfaction (Junewicz & Youngner, 2016; Williams, 1994). When a patient is dissatisfied and their insurance coverage allows for a choice among providers (and systems) they will likely choose to seek care via a provider and/or system that is in competition with the one where most of the participants practice. These circumstances are well understood by HCPs like Doctors Carney and Gabriel and they experience pressure to acquiesce to the wishes of their patients and deliver care that may be unnecessary, or different from what they would otherwise suggest. The paradox for Doctor Gabriel is that she wants her patients to have a positive care experience. Those who advocate for the current emphasis on patient satisfaction point to research that has found that it correlates with care quality indicators and that it is predictive of better health outcomes (Cleary, 2016).

The concern for transactions with customers and suppliers that Cameron and Quinn (2011) identify as characteristic of market-oriented organizations bears a connection to Doctor Anderson's description of why healthcare is viewed as a business (i.e., the presence of self-interested industry players). It can therefore be inferred that there would be a justification for the prioritization of market values throughout the system where the bulk of the HCPs practice. However, the pressure to focus on the transactional elements of care that HCPs reported appears to be self-directed and any pressure to compete with other systems (or other providers) is experienced as tacit. When compared to the feelings of organizational support and the favorable outlook of leadership that participants described, it suggests that the vast majority of the participants experience the system in ways that are more akin to Cameron and Quinn's (2011) notion of a clan, where "shared values and goals, cohesion and participative-ness" (p.46) are the norms.

The theories of the consequence of coexisting values in healthcare. The fourth and final informing framework is representative of a synthesis of multiple perspectives on how the personal and professional preferences of HCPs interface with market values. In the latter part of Chapter 2, it was discussed how the coexistence of these values can lead to a variety of consequences. The conduct of the study served to reinforce that the coexistence of personal/professional and market values can lead to both beneficial and problematic consequences.

Beneficial consequences. In Chapter 2 it was suggested that both health systems and patients may benefit when HCPs 1) use a base of scientific evidence to efficiently deliver care; and 2) work productively as members of inter-professional teams. While none chose the term evidence-based practice, it was found that the majority of the Doctors and most of the nurses use

their strong command of scientific knowledge and a related preference for applying standards in ways that allow them to realize *clinical efficiency* (Donabedian, 2003). The bulk of the HCPs appear to use clinical knowledge, judgment and skill to "prescribe and implement care that does not include harmful, useless or less effective remedies or methods" (Donabedian, 2003, p.10). This finding suggests that many of the HCPs are using their capability values in ways that allow them to simultaneously realize efficiencies and effectiveness, and therefore contribute to system viability.

The pursuit of the collaborative values that accompany the increasingly broad use of inter-professional care delivery teams is another avenue though which health systems can realize efficiency (and productivity). Although they did not use the term inter-professional, the collaboration that was described by Doctor Davis and Nurse Emerson as preferable did cut across the traditional roles and responsibilities held by those in the systems in which they have worked. The pursuit of collaborative values does appear to have a positive impact on health outcomes (Light, 2010; World Health Organization, 2010). However, none of the participants drew a pronounced connection between their preference for collaborative values and how such values might be contributing to efficiency and productivity.

An unanticipated way in which the presence of market values appear to enhance health outcomes emanated from the conversation with Doctor Anderson, specifically when he spoke of the incentive to innovate that accompanies the insurance reimbursement payment structure upon which his system relies. Nurse Emerson also appears to be a proponent of the coexistence of care and market values, but only when the pursuit of efficiency does not dehumanize patients and practitioners.

Problematic consequences. The review of relevant literature that was conducted prior to the execution of the study revealed a concern that market values will supersede care values (i.e. nihilism) and that HCPs may experience adverse personal repercussions when the pursuit of care values is thwarted by the presence of market values (Gabel, 2011; 2013; Light, 2010; Montori & Guyatt, 2008; Relman, 2007). The study served to reveal that some of the HCPs experience a significant level of concern for nihilism and there was evidence that some physicians do experience adverse personal repercussions that stem from an inability to realize their personal and professional value preferences.

A significant portion of the conversation with Doctor Carney was focused around his belief that the pursuit of market values has already changed the practice of medicine and that care values are becoming sacrificed as the broad healthcare system increasingly embraces corporatization. Observations that Doctor Davis shared regarding the increasing emphasis on patient volume, and how it has become difficult for a small practice provider to offer care to underserved population in their communities, also imply a sense of loss. The statements offered by Nurse Harris suggest that while we might not be there yet, a clash between care and market values is on the horizon and inevitable.

Toward the latter part of our interview, Doctor Davis spoke of how a fellow specialized care colleague and other general practice providers that he knows try to be all things to all patients. His stories served to illuminate how honoring the notion of what some expect our care providers to be has contributed to the adverse repercussions (e.g. burnout; demoralization) that Gabel (2011; 2013) identified as characteristic of physicians; specifically when they are "confronted by what they perceive to be overwhelming work demands and/or threats to their own value orientations" (p. 421). The stories offered by Doctor Davis served to reinforce the theory

provided by Gabel (2011; 2013). Gabel's (2011; 2013) theory was also evidenced in the frustrations that were expressed by Doctor Gabriel, and her words suggest that she may be on the cusp of burnout.

The data from the interviews did point towards evidence of conflict among and between market values, whereas the expectation that the HCPs uphold patient satisfaction came into conflict with system-wide expectations of efficiency and productivity. However, conflict between care values was not found. While two of the nurses spoke to having to discreetly pursue holistic and faith-based values, there was no appearance of problematic consequences stemming from the co-existence of such values and (other) care values. From this, it can be inferred that conflict among care values appears to be less likely than conflict among market values.

The application of the theories that guided the inquiry served as a sound basis from which to solicit stories of lived experience. The analysis of the HCPs' experiences implies that while market values do have an influence over their actions, most of them are able to pursue care values in ways that bring them personal satisfaction. When there is a perceived imbalance among personal/professional and market values priorities, the HCPs who participated work to restore balance; when they choose to do so, they are appreciative of the administrative support they receive.

My Experience with Interpretive Phenomenology

Guba and Lincoln (1981) suggest that there are three desirable qualities of humans as data collection instruments and that we bring seven characteristics to interpretive/constructivist forms of inquiry. This portion of chapter 5 is dedicated to a reflection upon my experience with Interpretive Phenomenology by looking at it though Guba and Lincoln's (1981) discussion of the characteristics and qualities of humans as data collection instruments, and it concludes with three

additional reflections of my own volition. The thirteen categories of reflection that comprise this section feature considerations, implications, and suggestions for those conducting research that is comparable to this phenomenological investigation of coexisting values in healthcare.

Reflections on the seven characteristics of the human instrument. Guba and Lincoln (1981) posit that the idea of a human as a data collection instrument is distinct from quantitatively oriented data collection tools in at least seven ways. As humans, we bring to our research endeavors 1) a responsiveness; 2) an adaptability; 3) a holistic emphasis; 4) an ability to process data immediately; 5) an ability to expand our knowledge base; 6) opportunities to clarify and summarize; and 7) opportunities to explore atypical and idiosyncratic responses (Guba & Lincoln, 1981). A discussion of how these seven characteristics played into the current study is offered with the hope that my reflections will be applicable to those who endeavor upon qualitative projects comparable to this one.

Responsiveness. According to Guba and Lincoln (1981), the human-as-instrument is both interpersonally and environmentally aware and can therefore sense and respond to the personal and environmental cues that are offered in the process of phenomenological inquiry (Lincoln & Guba, 1985). My personal experience with the characteristic of responsiveness has led me to suggest that as researchers, we should embrace how this human quality plays out in the various stages of our inquiries.

Physicians are notoriously busy people and from the onset I wanted to be responsive to this aspect of the study. In order to realize that intent, I had prepared a set of notes that would enable me to provide a quick reset of the theory that informed the inquiry and a set of semi-structured questions to guide my first interview. I felt well prepared for my planned conversation with Doctor Anderson. As we sat down for our meeting, my notion of physicians as busy people

was reinforced, as Doctor Anderson was in the midst of several important tasks that relate to his role as a specialized care provider. As the interview proceeded, Anderson appeared to immediately grasp the theoretical constructs that served to guide the study and his words served to demonstrate his rapidity of thought. I worked to respond in kind, while asking for specific illustrations of his experience where I could. In this particular instance I personally experienced responsiveness as a double-edged sword; I sought to honor Doctor Anderson's stylistic preferences while sacrificing opportunities to probe more deeply in certain areas. Fortunately the interview was not a loss, as it did contain useful pieces of lived experience and later served to be an excellent source of data for understanding context.

The review of the transcript of the interview I conducted with Nurse Britt also prompted some reflection on responsiveness and a heightened level of self-awareness of its importance. During this conversation, Britt displayed patience and seemed to be interested as I described the theory that undergirded the inquiry. Upon reviewing the transcript, it became apparent that Nurse Britt was being courteous and that the discussion on theory ate up a great deal of valuable time. It was clear that this time could have been better used to allow Nurse Britt to share more of her experiences with expectations of coexisting values. From that point forward, I sought to have the participant to do most of the talking and tacitly wove theory into the conversations when I interpreted the participants' narrative account of their experience to be related to the theoretical constructs that informed this inquiry. The importance of refining one's attentiveness to the behavioral and social signals that research participants offer cannot be understated; the approach at which I ultimately arrived proved to be an effective mechanism for the co-construction of knowledge of the phenomenon of coexisting values in healthcare.

Adaptability. As humans we are "virtually infinitely adaptable" (Lincoln & Guba, Naturalistic Inquiry, 1985, p. 193), and as a data-gathering device we are capable of the concurrent collection of data on any combination of a number of things (e.g. body language; intonation; a collection of books on a shelf; artifacts that speak to the values that an organization seeks to uphold).

Throughout the implementation of the study, I did my best to collect data that went beyond the stories that participants offered. I noted signals that indicated careful consideration of word choice (e.g. speech cadence) and intonations that served to signal the relative importance of specific point that a participant was choosing to make. While I am quite sure that I missed some of the signals, an awareness of them served as the basis from which I was able to make ongoing adjustments to my approach to dialogue with participants.

Similar to responsiveness, the importance of collecting data from sources other than the words of participants cannot be underemphasized. An attention to the artwork that adorns a lobby, the commonality of a logo, and the documents that remind the HCPs of the values that the system upholds served to enhance my understanding of the context in which the HCPs practice.

Holistic emphasis. The human as a data collection instrument is the only device known to be able to holistically grasp the multiple and interacting elements of context (Lincoln & Guba, 1985); and "the infinite variety of constructs" (p.132), that are available to them (Guba & Lincoln, 1981).

The notion of infinite constructs, each interacting with one another (Guba & Lincoln, 1981), is particularly relevant to this study, in that the number of values a human instrument could study is infinite (Schwartz, 1994). While the identification of certain values was useful for the initiation of the study, it was just as important to stay open to the emergence of values that

did not fit neatly into the theoretical constructs that formed the basis of this inquiry. The finding that some HCPs prefer efficiency (considered to be a market value) and how it works in tandem with capability serves as an example of where it was important to depart from a strict adherence to a priori theory and consider the ways in which the values constructs interact.

Another example of where I was able to leverage a holistic emphasis involved the induction of market values constructs that go beyond the competition and productivity values identified by Cameron and Quinn (2011). A prolonged consideration of recurring discussion around patient satisfaction and a literature search which uncovered its multiple meanings proved to be integral to a more complete illumination of others' expectations that the HCPs uphold market values. The induction of relevant literature served to reveal that the HCPs who participated are not alone when they experience patient satisfaction as a tacit representation of competition values. It seems unlikely that an alternate instrument would have served to collect such data, and it is somewhat ironic that the level of a patient's satisfaction with their HCP is measured via a survey instrument.

Knowledge base expansion. It is certainly safe to say that my personal awareness of the coexisting values phenomenon has grown from the time the study was proposed. As noted earlier in this chapter, I approached inquiry with some propositional knowledge of the beneficial and problematic consequences of coexisting personal/professional and market values, and how such values might serve as an effective counterbalance to one another. On the heels of experiencing the relief that accompanied the identification of research participants came a feeling of apprehension when I realized how little I truly knew about their world of lived experience. I attribute the deepening of my knowledge base mostly to the immersion that came with visiting

participants in their places of work, the writing and reflection that accompanied the data analysis, and the integration of relevant literature.

The contextual data that I captured in the lobbies and offices of the clinics was far more useful than the bits of peripheral data that I captured while sitting in the coffee shops where I met with two of the nurses. The identification of significant statements and the interpretative process of writing and re-writing the meaning units was key to deepening my understanding of the tacit meaning behind the words that the HCPs offered.

The writing of meaning units also served to help identify patterns in the data. When it became evident that efficiency and patient satisfaction were recurring themes in the data, I consulted with relevant literature. The concurrent pursuit of research activities of immersion, writing and reflection, and the integration of literature served to help me make sense of the complexity that was inherent to this study, and each contributed to the expansion of my knowledge base.

Processual immediacy. According to Lincoln and Guba (1985), we, as humans, are the only type of data collection instrument with the ability "to process data just as soon as it becomes available, to generate hypotheses on the spot and test those hypotheses" (p.194) with participants. My experience with the conduct of the study is in keeping with this belief. As noted earlier, prior to conducting the first interview, I had pre-scripted a quick overview of informing theory and a set of questions to ask participants. While I do believe that the first two interviews did yield useful data, I felt the quality of data that I was able to capture was enhanced as I let go of the more structured approach to the conversations I had initially adopted. The dialogue that I enjoyed with Doctor Carney (my third participant) was pivotal. It was at this point that I was able to adopt a presence that enabled a more responsive form of participant engagement; whereas, we

were able to integrate his experience with my knowledge and generate ideas that were tested and refined through a back and forth exchange of ideas. From that point forward, it felt as though I was able to more effectively partner with participants on the co-creation of knowledge with the phenomenon and I worked to refine this approach throughout the course of the remaining interviews.

The opportunity for clarification and summarization. The dialogue that I had with Doctor Carney not only served as an illustration of the importance of processual immediacy, but it also provided an opportunity for clarification and summarization. This benefit was realized from a very early stage in the series of participant interviews, as evidenced in an excerpt from the transcript of the conversation with Doctor Anderson (see Figure 12).

Anderson: So fewer responsibilities when you're employed by somebody else (A.3)

CS: Sure, um, as compared to running your own private practice.

Anderson: right

CS: Sure, um if I am understanding you correctly then, your interpretation would be that healthcare is in fact a business?

Anderson: yeah it would be, maybe unfortunately. It will be nice if you could keep the business side out of it, right, (A.4) but you certainly can't when you have all the players that are involved. You have hospitals, you have insurance companies, you have the US government, right, and you have physicians, industry - the makers of Pharma and devices. SS A.5

Time Stamp = (4:15)

CS: than OK we, we could likely agree that, for the purpose of an organization remaining viable it's very important to maintain some sensitivity or some awareness of X

A: absolutely, I think that's well stated.

Figure 12. An excerpt from the transcript of the interview with Doctor Anderson.

The excerpt in Figure 12 from the conversation with Doctor Anderson serves as a good example of our "unique capability of summarizing data on the spot and feeding it back to respondents for clarification" (Lincoln & Guba, 1985, p. 194). It is important to also consider that in phenomenology, our participants are co-researchers and the verification of a shared understanding works both ways. The Figure 13 excerpt from the dialogue with Nurse Harris serves as an illustration of how such an understanding was established in the conduct of this inquiry.

> Harris: …I don't think I could work in an environment where it was asked that I do something that went against my values whether I felt like it was dangerous or whether I felt like it was putting too high a priority on money. (H.25) Do you see what I'm saying?
>
> CS: Every time? 100% of the time? Your personal values that appear to be oriented towards care would trump any attempt, pressure that might be applied on you to
>
> Harris: I guess every time I would question it. (H.26) I have …I think I have a breaking point - a line that I wouldn't cross and I think every time I would evaluate that. (H.27)

Figure 13. An excerpt from the transcript of the interview with Nurse Harris.

The opportunity to explore atypical and idiosyncratic responses. The significant statements that appear in Figure 5 (H.25; H.26; H.27) are typical of what one would expect to get in response to an inquiry into the expected coexistence of values in healthcare. However, other significant statements that participants offered were atypical. Often these responses came from those whose role or specialized practice area provided them with a unique perspective on the phenomenon (Guba & Lincoln, 1981). I found these types of responses to be difficult to neatly categorize into themes (Lincoln & Guba, 1985), yet extremely valuable for informing a thorough understanding of lived experience with the phenomenon of coexisting values. I would encourage those who endeavor this type of inquiry to work towards the inclusion of the broad range of responses you will likely receive and "not chop off the tails" of the distribution, as some of the

one-off in-case responses you are likely to receive will be integral to a fuller illumination of phenomena.

The desired qualities of the human instrument. Guba and Lincoln identify three specific qualities that they consider desirable for "'human instruments" (p.138). The qualities of empathy, a willingness to talk and listen to those who can provide unique insights, and the ability to deal with psychological stressors come from a cumulative body of wisdom acquired by those who have conducted studies with a methodological orientation that is comparable to the one used in this study (Guba & Lincoln, 1981).

On being empathic. The quality that Guba and Lincoln (1981) identify as most applicable to investigations such as this one is empathy, as it "is essential to the study of human behavior" (p.140). My own ability to understand the personal feelings of those who have encountered co-existing values conflict is based on an experience I discussed in Chapter 1, where I felt unable to reconcile my personal value preferences with those that were present in that professional environment.

My ability to understand and relate to those who appeared to have adapted, or be less impacted by the phenomenon was enhanced by a consideration of the authenticity criteria identified in Chapter 3. Throughout the conduct of the study, I sought to maintain a balanced view that represented a variety of constructions of reality and the values that undergird them (fairness) as well as an increased understanding and appreciation of the interpretations of stakeholders other than the HCPs who participated (educative authenticity) (Lincoln & Guba, 1986a). The adoption of a dialogic perspective was informed by an ongoing consultation and review of relevant literature, and the practice of talking about my study to anyone who would listen.

On talking and listening. My ability to empathize with the range of interpretations that are inherent to the coexisting values phenomenon came from a willingness to talk to those who represent a variety of perspectives. A series of meetings I had with system administrators who were seeking to infuse their healthcare system with an understanding and application of market values was immensely useful, as were the series of conversations I had with those who work with federally funded community health centers. My ongoing conversation with a physician who coaches other providers who are contending with demoralization and burnout has also been instrumental to my efforts to "fully, equitably, and honorably" (p.142) represent a variety of viewpoints (Guba & Lincoln, 1981). My sustained efforts to talk and listen to those who can inform the study findings is motived by a desire to present a study that is trustworthy and credible (Lincoln & Guba, 1985). While the conversations with those who have informed the study have been uplifting, the isolation and ambiguity that also accompanied this research is quite another story.

On dealing with psychological stressors. The isolation, loneliness, ambiguity and data management challenges are just a few of the stressors that are likely familiar to those who have endeavored to conduct an inquiry such as this one (Guba & Lincoln, 1981), and my experience was no different. The ambiguity that was inherent to the study and extended hours that I put in are two of the more significant sources of stress that I encountered.

I routinely came across data points that contradicted one another. It was sometimes valuable to push through a given instance of data ambiguity by writing and rewriting interpretations and descriptions, but it was typically more valuable to put an idea aside and take the time away from writing to process it. For me, an enhanced level of clarity often came about during the times that I was away from my desk.

Another source of the ambiguity I experienced came from the lack of clarity around the process (steps) for conducting this type of inquiry. When the execution of the steps I proposed resulted in ambiguity or confusion, I found it useful to go back to the literature and bring in ideas I had not considered during the proposal stage. The synthesis of new ideas with those I had originally conceived was key to breaking through an impasse I encountered during the process of cross-case theming. The induction of new literature was also key to working through the ambiguity around what it means to leave patients feeling satisfied.

While the struggle has certainly enhanced my knowledge and abilities as a researcher and educator, the extended hours have resulted in an inevitable sacrifice of time. Since the time I started my Ph.D. program I have gotten married and we have been blessed with the arrival of two amazing daughters. During this time, I have also lost a grandmother, an aunt, an uncle and a beloved best friend. It is likely that the time I have spent in this program has been prolonged because I took the time to be at my late Uncle's 50th wedding anniversary and make those last trips to see my Grandmother and my good friend. For this I have no regret, and my advice to those with extended families is to do the same. Take that road trip, as you can never anticipate how quickly things will change. The work will certainly be there when you get back.

The value of the understanding and support that I have received from my wife and two children cannot be understated. If I were to do one thing differently it would be to decrease the amount of stress that this endeavor has placed on them via the establishment of workspace outside of our house. I would also recommend the development of an extended network of colleagues who have executed on this type of research. The plan for any future writing and research project is to involve and collaborate with others who are in the same professional space.

Some additional reflections and recommendations. Through the conduct of the study I came into three additional reflective discoveries that do not squarely fit into Guba and Lincoln's (1981) seven characteristics of the human instrument and the related qualities they identified as being desirable. These discoveries extend from the challenge I experienced when recruiting participants, when interviewing participants, and when attempting to analyze the large quantities of data that were acquired in the conduct of the study. Considerations and suggestions are offered in each of these areas.

On the recruiting of participants. Like most people, the participants I chose to interview were limited in the amount of time they could dedicate to an interview and the subsequent verification that my interpretations were an accurate representation of their lived experience. Even with professional experience and good contacts in the realm of healthcare, the process of generating a list of potential participants consumed an unanticipated period of four months' time. Securing a list of participants was just as much a product of tenacity as it was good fortune, whereas a loose tie in my extended network was willing to lend a supportive hand. However, even with some level of executive sponsorship, only about 25% of those physicians on the list agreed to participate. Scheduling and meeting with the four physicians who agreed to participate consumed another four months' worth of time. As noted in Chapter 3, the four nurses who participated in the study were recruited by asking these physicians if they knew of any others who might be willing to participate in the study (i.e., via snowball sampling).

I would encourage those who take up this type of inquiry to be realistic when it comes to participants' time and your own time. It seems likely that you will rarely get as much time with your participants as you might like and it is important to realistically consider the demands that you might be placing upon your participant's time. If you are fortunate enough to have multiple

meetings with participants, take the time in between to review your transcripts. Come to any second meetings with a clear sense of the areas you would like to explore in greater detail and give your participants some prior notification on the specifics of your follow-up plan. When it comes to your own timeline, please do consider that accessing participants will more than likely take quite a bit longer than you might like or anticipate.

On the market values construct. Several of the study participants seemed to experience difficulty conceptually distinguishing between markets, marketing, and what constitutes a market value. None of the participants in this study shared direct experience with competition, but all appeared to have some experience with more tacit representations of competitive pressure. Any future research that explores the interface between the personal, professional, and market values within a health system would benefit from a clearer conceptualization of what might be considered a market value within the context in which the participants operate.

For future inquires that seek to explore HCPs' interpretations of the business side of care, I would suggest that the researcher(s) base their conceptualization of market influences on a softened (more conversational) version of Thornton & Ocasio's (1999) notion of logics. It seems that a focus on the "the socially constructed, historical patterns of material practices…by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton & Ocasio, 1999, p. 804) would yield deeper insight into how HCPs experience expectations that they pursue market-oriented behaviors, as they simultaneously seek to attain their personal and professional care value priorities. A focus on logics may also be useful for developing a clearer and mutually agreed upon conceptualization of patient satisfaction.

On the management of data. The conduct of this study resulted in a copious number of data points, some of which conflicted. The identification of significant statements was a useful first step in managing the volumes of data derived from individual interviews. The practice of writing (and re-writing) meaning units fostered familiarity with the data, and the meaning units themselves served as the basis for identifying the in-case themes that were member-checked with participants.

The alphanumeric system that I developed for tracking significant statements and the accompanying meaning units proved invaluable for managing the voluminous number of data points from across the eight interviews. The tracking scheme allowed me to efficiently locate specific statements and meaning units as I went back and forth between the data and the writing up of the five themes that form the essential structure of the phenomenon. I found that my ability to organize data was further enhanced when I chose to put the alpha- numeric codes and a short description of the meaning behind significant statements onto sticky notes. These sticky notes were posted on large sheets of blank paper and then organized and re-organized into broad themes and sub-themes. Figure 14 is offered as an example of how the alphanumeric codes and the accompanying summarization of the meaning units were organized under the theme of the Paradox of Patient Satisfaction and its three sub-themes. The physical representation of the data depicted in Figure 6 was also useful for "parking" potential connections between data and established themes, and for capturing data that cut across themes. The sticky notes that appear at an angle in the lower right corner of Figure 14 are examples of data points that were parked in order to prevent them from becoming lost during the process of data analysis.

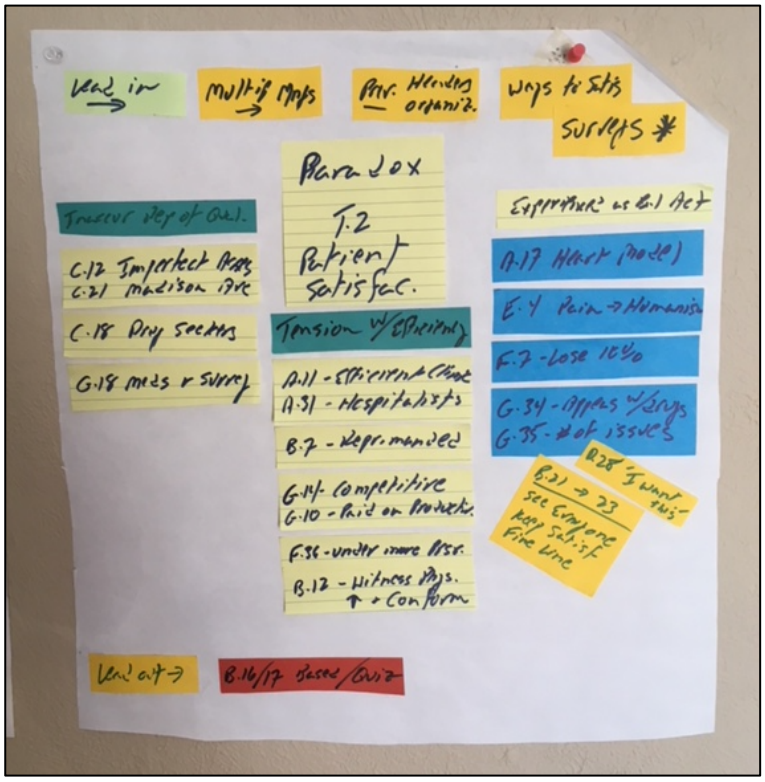

Figure 14. A visual representation of the alphanumeric system used for organizing meaning units that served as a useful data management tool.

It is my sincere hope that the preceding reflections upon the characteristics of the human instrument, the desired qualities of the human instrument, and the discoveries I have made may be transferrable to studies comparable to this one. A fortunate few will be conducting sponsored research that has been requested by others. For most of us, the research we are conducting is based on an interest we have and is of our own creation. Like those that have gone before me, I experienced moments of self-doubt, mostly stemming from my place as an outsider. Such doubts were amplified when one of my participants referred to my study as "academic". However, my doubts were assuaged during moments like the one I experienced in casual conversation with Nurse Britt, when she said "I am glad you're doing this". I would encourage those who undertake inquiry that is meant to illuminate that which is commonplace and ordinary to be

confident in your resolve, even when confronted with the inevitable doubts about the merits of your study.

I found the people I interviewed to be extremely interesting, each in their own right and I can say without any doubt that the experience of conducting this research has allowed me to become more attuned to the social and behavioral signals of other individuals. This Phenomenological Investigation of Co-Existing Values in Healthcare has made me a better researcher and educator in ways that I could not have foreseen prior to embarking upon the study.

Implications for Practice, Theory Development and Future Research

The arrival at a set of findings involved a careful consideration of the individual and social contexts in which the participants practice and these findings point to implications for practice, theory development and future research. This part of Chapter 5 begins with a discussion on practice implications for society at large and then moves into practice implications for administrators and HCPs who find themselves in situations where care and market values are expected to coexist. This section of Chapter 5 concludes with a number of suggestions for theory development and future research that would serve to fill the gaps in our understanding of this coexisting values phenomenon.

Implications for practice. The findings from the study suggest that we would do well to view healthcare as distinct from ordinary forms of commerce and our HCPs as something other than business people. This idea that we should view the relationship between a patient and their physician as different from relationships found in competitive markets is not a new one. Some time ago Parsons (1975) saw fit to point out that while yes, the relationship should be viewed as a two-way street, it is "asymmetrical" (p. 257) given that practitioners "bring expertise in health

matters, gained through training and experience" (p. 257) and they have a unique fiduciary responsibility to provide care for those in need. Over the years, market values have continued to gain influence over healthcare, prompting Williams (1994), and others to question the validity of patient satisfaction as a measure of quality care. The current policy-backed emphasis on patient satisfaction appears to have allowed patients to more fully step into the role of consumer and this raises serious questions as to whether such an emphasis is undermining the expertise of our HCPs (Junewicz & Yougner, 2016; Zgierska, Rabago, & Miller, 2014). As stakeholders to a system on which we as a society depend, we need to proceed with an awareness of the pressures that market demands are placing on our physicians.

The findings from this study suggest that the system where the bulk of the participants work is reliant upon the motivation that the HCPs derive from the pursuit of their personal and professional care value preferences. It appears that the administrators consider their HCPs' pursuit of such values to be a source of competitive advantage, as evidenced by one participant's description of messaging that emphasizes "to be competitive in this market, we (the HCPs) have to give the best patient care" (H.50).

The significant statements that were offered by multiple participants suggest that the system's administrators maintain a dual orientation toward a concern for the competitive environment and concern for the HCPs. The interviews with Doctors Carney and Gabriel and Nurses Emerson and Harris suggest that certain administrators practice service leadership, whereas they work to make sure the HCPs' highest priority needs are taken care of (Greenleaf & Spears, 2002), and "assure that people get the resources they need to do their jobs" (Autry, 2001, p. 20). The employees in the system appear to benefit from competent leaders that support the

workforce in ways that are known to reduce stress and the likelihood of burnout (Lacy & Chan, 2018).

The stories of experience that the HCPs shared suggest that their experience with the expectations that they contain costs and leave patients feeling satisfied is more favorable when their administrative leadership provides support and delivers messaging that is care-value resonant. It seems other system administrators would do well to work towards the adoption of what has been termed the quadruple aim, where they work to improve the work life of HCPs, while also improving the health of populations, enhancing the patient experience of care and reducing the per capita cost of care (Bodenhemer & Sinsky, 2014; Sikka, Morath, & Leape, 2015).

While the findings from this study and the research of Bodenhemer and Sinsky (2014) imply that that burnout is most prevalent among general practice providers, Feldman (2018) points to research that indicates a significant increase in burnout across all specializations. Sikka, et al. (2015) take it a step further by suggesting that "burnout not only affects physicians" but all HCPs. Sikka, et al. (2015) posit that there has been a loss of joy and meaning at work for HCPs. This was reflected in a significant statement offered by Doctor Carney:

> So a lot of people I see are kind of mechanical. They just go in every day, just trying to keep up. And, they are not introspective about what drives them morally, ethically and the only thing that I see is that people become uncomfortable. So they may be more irritable, they may not be functioning quite as well. But unless they take the time to explore who they are in relationship to the system they are working with…..They don't actually pull back; they don't spend time looking at who they are at multiple levels in order to see why there is a discrepancy. And they don't feel so good (C.7).

Carney's statement suggests that some HCPs do not take the time to look inwards and assess whether or not they are living their values. While the treatment effects of organizationally directed efforts to intervene in instances of burnout have been found to be effective (Kriemer,

2018; Lacy & Chan, 2018), it is also important for HCPs to practice introspection and develop self-awareness (Feldman, 2018), as well as practice the self-care they preach to their patients who are caregivers to others (Feldman, 2018; Lacy & Chan, 2018).

Implications for theory development and future research. The integration of theories of human values, the personal and professional values of HCPs and market values served as a useful point of departure for the conduct of the study. However, the conversations with HCPs and the subsequent analysis of the data derived from interviews served to reveal some gaps in the theories that guided this inquiry. An integration of the gaps in theory with other findings in this inquiry points towards a need for future research in several areas.

Moyo et al. (2015) based their theory of the personal and professional values of HCPs off of the 10 universal value domains originally identified by Schwartz (1994). Moyo et al. posit that the values they identified in their literature search are those that are most relevant to HCPs. Through the conduct of the study, I came into values that the HCPs considered relevant (e.g. patient satisfaction; efficiency; health) that were not clearly accounted for in either the Moyo et al. (2015) framework, or the market values construct that was borrowed from Cameron and Quinn (2011). As noted in the previous section, some participants had some level of challenge grasping the concept of a market value, suggesting that market values such as competition may be less relevant to them as actors in systems where others attend to strategy. Taken together, these findings suggest a need to develop a more comprehensive theory that encompasses all, or at least most of, the values that are most relevant to HCPs. Ideally, such a theory would address the potential for conflict among those values; and future research should be directed at empirically validating any theory that explicates the values that are relevant to HCPs.

Through dialogue it became clear that the actions of the HCPs who participated are motivated by a desire to attain personal and professional value priorities. In Chapter 4, it was suggested that for some, the pursuit of such values and the related actions fit with the definition of Organizational Citizenship Behaviors (OCBs) offered by Organ, et al. (2006); which holds that such behaviors are "discretionary, and not directly or explicitly recognized by the formal reward system" (p. 3) and when aggregated they "promote the efficient and effective functioning of the organization" (p. 3). Perreira and Whitney (2016) consider OCBs to be important to health systems because they "contribute to the efficient use of scarce resources and increase organizational productivity" (p .148).

In their effort to fully define OCBs, Organ, Podsakoff, and Mackenzie, (2006) tell the story of a "Good Samaritan" (p. 2) that one of the authors encountered earlier in his career, and the authors raise questions as to whether OCBs are the same as altruism, and whether an OCB can be defined by its motivation. Given that the self-transcendent pursuit of altruism is often viewed as one of the main sources of values-based motivation among HCPs, it seems that we would benefit from future research and the development of theory that explores the relationship between personal and professional values of HCPs and OCBs. Future research projects should also explore the personal and professional values of those in the caring professions and whether those values are antecedents to OCBs. It seems the field of Organizational Behavior (OB) would benefit if the study of values were to advance from a focus on the act of valuing to more in-depth exploration of values-based motivation.

As noted in Chapter 4, several of the factors that were identified by Maslach and Leiter (1997) as contributing to burnout surfaced in conversations with two of the physician participants and there is widespread concern for the established increase in burnout within the

healthcare professions (Feldman, 2018; Gabel, 2011; 2013; Kriemer, 2018; Lacy & Chan, 2018; personal correspondence). The proposition that increases in HCP burnout are the result of increasing levels of commercialization in healthcare, as put forth by Gabel (2013), is based on his extensive experience as a pediatrician, psychiatrist and professor of psychiatry. While Lacy and Chan (2018) do draw an implied connection between burnout, work stress, and the prevalence of market matters at the level of the broad health system, it appears that few if any studies have sought to quantitatively explore a relationship between an orientation towards markets, a HCPs inability to realize their personal and professional value preferences, and burnout. The serious consequences that emanate from increasing levels of burnout (i.e. demoralization; depersonalization; substance abuse; suicide) suggest that studies should explore all potential causes of burnout, including expectations of productivity and the upholding of patient satisfaction, as well as any other market-based pressures that our HCPs may be experiencing.

The participants in the study reported an appreciation for the competency of the system's leadership, the support they provide, and the related opportunity to express their personal and professional values. While this research project was not conceived as a study of management and/or leadership per se, the findings on leadership led to the discovery of literature on effective leadership practices found in the nation's top academic medical institutions (see Chatfield, et al., 2017) and calls for transformational leadership at all levels of health systems (see Larkin, et al., 2016).

The common call for transformational leadership in healthcare extends from ongoing and anticipated changes to the broad health system, and during such changes, stakeholder's (e.g. HCPs; administrators; patients) values (i.e. care and market) are awakened and become active.

The findings from this study suggest that such values may come into conflict. With that, it seems we would do well to consider an important component of the theory of transformational leadership, as originally defined by Burns (1978). He posited that transformational leadership involves the benefits that are derived from exposure to conflicting demands, goals and values, and that it is the reciprocated illumination of values that enables both leader and follower to evaluate one another's perceptions and collectively move towards higher levels of motivation and moral purpose. The upholding of moral standards is integral to health care delivery, and future research and theory development that seeks to explore leadership within the context of broad system change (evolution) should seek to acknowledge the coexisting values component of transformational leadership theory. Researchers and theorists may also wish to consider other theories that acknowledge the benefits that can be derived when leaders from across organizations acknowledge a coexisting, or competing values perspective (e.g. Heifetz's [1994] theory of Adaptive Work).

The final implication for future research and theory development was informed by a consultation with literature on the *Triple Aim* of 1) improving the health of populations; 2) enhancing the patient experience of care; and 3) reducing the per capita cost of care (Institute for Healthcare Improvement, 2009). Enhancements to the patient experience of care (aim #2) will likely bolster their satisfaction with care delivery and reductions to the per capita cost of care (aim #3) will likely promote organizational viability. These two aims are therefore strategic in nature (Berwick, Nolan & Whittington, 2008), as the realization of one or both may result in competitive advantage for a healthcare organization, and each involves the pursuit of market values (Cameron & Quinn, 2011).

Around the time of the adoption of the Patient Protection and Affordable Care Act, and soon after the *Triple Aim* initiative was published, Berwick, et al. (2008) raised the question as to whether the balanced pursuit of the three goals in the *Triple Aim* is congruent with current market dynamics and current payment incentives. The theorists use hospitals as an illustration of how the pursuit of organizational self-interest conflicts with the broader societal interests. When a hospital seeks to fill beds and increase services, it may improve the health of some populations, but the hospital's efforts work at cross-purposes with the broader goal of reducing the per capita cost of care. The competitive challenges associated with simultaneously providing products and services that warrant higher prices, while squeezing costs out of a firm's value creating activities are well understood by business strategists (Grant, 2013). However, it has been found that companies realize a higher level of performance when they are able to combine these multiple forms of competitive advantage (Dess, McNamara, & Eisner, 2016).

If the market-based solution to healthcare reform remains in place, future research should be directed at how the pursuit of multiple forms of competitive advantage (i.e. patient satisfaction and cost containment) may (or may not be) contributing to the realization of improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of care. Future research should also explore how the various payment structures (self-funded vs. reimbursement) that are used in different health systems (integrated vs. reimbursement dependent) may be (or may not be) contributing to the realization of the *Triple Aim* (Berwick, et al., 2008).

The application of an interpretivist/ constructivist methodology to this phenomenological research has been useful in terms of illuminating the social experiences of a group of HCPs and the multiple levels of context that are part of their lifeworld. Additional studies using grounded

theory research would allow for a further exploration of context and a continuous interplay between analysis and data collection in order to advance our limited understanding of the interaction between the value constructs upon which this study was built (Egan, 2002; Torraco, 2002). The use of hypothetical / deductive approaches to inquiry is also warranted. The related methods could be applied to specific systems where the phenomenon is known to exist for the purpose of advancing our understanding of the causes of the feelings of demoralization and burnout that HCPs express (Lynham, 2002). A continuous application of theory in field settings through a variety of inquiry methods is an essential step in advancing the development of a values theory that is reflective of our HCPs real world experience, and our understanding of the consequence that extend from expectations that care and market values can coexist within the context of healthcare delivery (Lincoln & Guba, 1985; Lynham, 2002).

Conclusion

The aim of this research was to illuminate the experiences of a selection of HCPs with expectations that personal, professional, and market values can coexist within the context of healthcare delivery. The study is phenomenological in that it involves an exploration of human experience that appears to be commonplace within the context of healthcare (Holloway & Wheeler, 2013; Racher & Robinson, 2002). The philosophic origins of phenomenology, as put forth by the likes of Husserl and Heidegger, were useful when contemplating this study, in that their respective beliefs relate to philosophies of the nature of reality (ontology) and how knowledge is justified (epistemology) (Guba & Lincoln, 2004). A careful examination of these philosophic axioms through a heuristic lens, coupled with an introspective look into my own orientation toward the conduct of research, led to the identification of Interpretive

Phenomenology as the "best fit" methodology for the conduct of the investigation into coexisting values among HCPs in healthcare (Glesne, 2011; Guba & Lincoln, 2004).

The location of this phenomenological research in the Interpretivist Paradigm informed the methods that were used to execute this research. These methods are rooted in approaches suggested by Colaizzi (1978) and van Manen (1991), and such methods were found to be appropriate for an inquiry into the lived experience of those who have chosen to dedicate themselves to a caring profession. The methods suggested by van Manen (1991) were also used as a partial guide to ensuring quality in the conduct of the proposed inquiry. Study quality was further enhanced by an adherence to the criteria associated with trustworthiness (Lincoln & Guba, 1985), authenticity (Lincoln & Guba, 1986a; Guba & Lincoln, 1989), a concern for ethics, and an adherence to the legal obligations as prescribed by the U.S. Department of Health and Human Services (2009).

The inquiry into *what* the HCPs experience has been with the coexisting values phenomenon and *how* they experience expectations that they can simultaneously uphold personal/professional and market values informed findings in five interrelated areas. It was found that those who participated in the study experience professional opportunities to express their values preferences, while also experiencing a paradoxical tension when it comes to leaving their patients feeling satisfied with their care experience. Most of the participants experience some interaction with the pharmaceutical industry and there are varying levels of exposure to market values. The exposure to market values appears to be contingent upon a HCPs' chosen practice area (e.g. specialized vs. general practice) and the size of the system in which they practice. The administrators in the system in which the vast majority of the research participants practice appear to understand the tensions that are inherent to the simultaneous upholding of care and

market values, and the HCPs who work in this system experience a quality of leadership and organizational support that allows them to attain their personal and professional values imperatives. While those who participated in the study do appear to benefit from system support, other HCPs appear to be less fortunate, and there is an increasing level of concern for the very real consequences that extend from feelings of demoralization, subjective incompetence, overwhelm, and burnout.

The inclusion of multiple theories was useful as a point of departure for the conduct of the inquiry. Through the course of the study I found the presence of many of the theoretical constructs that informed this investigation and I found nuances in the ways in which the HCPs experience the theories that guided the study. The findings suggest that future theory development is warranted. We would do well to direct future research toward the development of theory that is specific to the values that HCPs experience, and a deeper exploration of the consequences that may emanate from the expectation that the types of values that informed this inquiry can coexist on a sustained basis. The outcomes of such research should be brought to the attention of those who craft healthcare policy, as the future of our ability to efficiently and effectively deliver care to those who need it most may depend on it.

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APPENDIX A: OVERVIEW OF THE STUDY THAT WAS PRE-APPROVED FOR DISTRIBUTION BY CSU'S OFFICE OF RESEARCH INTEGRITY AND COMPLIANCE REVIEW

A Phenomenological Investigation Of Coexisting Values In Healthcare

A Brief Overview

Christopher W. Stewart
January 7, 2017

Healthcare delivery in the United States has a long and storied history. In turn, the American public has come to expect that their Healthcare Practitioners (HCPs) will personally and professionally enact patient-oriented values such as altruism, equality and capability. Recent changes to the healthcare system have compelled those concerned with the viability of healthcare organizations to reconsider notions of consumerism, markets, and competition and place an increased level of emphasis on market-oriented values. The organizational pursuit of productivity and competition values now appears as commonplace in an environment where not-for profit entities closely resemble their for-profit counterparts. Within this environment, HCPs are expected to uphold market values that are important to competitive advantage and organizational viability, while also working to fulfill personal and professional value imperatives. There exists a need to understand better how those who operate at the nexus of care delivery experience the coexistence of values that are at times compatible, and at other times incompatible.

This overview features a summary description of research that is intended to explore and describe what HCPs experience has been with the coexistence of personal, professional and market values and how HCPs experience the coexistence of these values within the context of healthcare. This document also includes an brief overview of the consequences that can come about when personal, professional and market values are expected to contextually coexist and a description of the methods that will be used to arrive at a better understanding of HCPs' experience with these values.

The Purpose of the Study

Human values serve as interpretive criteria and motivate both individual and collective action. Such values are therefore presumed to be one of the main determinants of social behavior and are considered to be central to organizational phenomena. The purpose of the study is to illuminate HCPs' experience with a common phenomenon. Study outcomes will include a description of experiences, actions and interpretations in light of the presence of personal, professional and market values. The intent is to provide findings that are of use to those who wish to understand better the organizational dynamics and strategic implications stemming from the simultaneous pursuit of certain values within the context of healthcare.

The Consequences of Coexisting Values

There are believed to be both beneficial and problematic consequences that emanate from this current phenomenon. In terms of beneficial consequences, coexisting personal, professional and market values can serve as an effective counterbalance to one another and do enable the delivery of quality care at lower costs. The simultaneous pursuit of diverse value types can, at times, enhance organizational performance. The problematic consequences of coexisting values appear to be directly experienced by HCPs. Some HCPs may experience demoralization, feelings of subjective incompetence and ultimately burnout when their personal and professional value preferences are thwarted by the presence of conflicting market-oriented values. There is also a common belief that important values (e.g. altruism; fairness) are becoming de-emphasized as healthcare becomes increasingly commercialized. This tension may prove to be problematic for Healthcare Administrators who seek to infuse care-centric organizations with market-oriented values.

The Proposed Methods and the Intended Outcomes

The aim of the study is to gain practical insight and knowledge with the phenomenon of co-existing values in healthcare settings by accessing the experiences of HCPs. HCPs are defined as those recognized by federal regulation as healthcare *providers*, specifically Medical Doctors (MDs), Doctors of Osteopathy (DOs), Dentists (DDS), Nurse Practitioners (NPs), Physicians Assistants (PAs), Clinical Psychologists and Clinical Social Workers. I also wish to include research participants who hold *nursing care credentials*, specifically Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Advanced Practice Nurses (APNs). Depending on the interests of the organization(s) I work with, the study may possibly include Medical Assistants (MAs) and/ or Healthcare Administrators.

Participants will have to have had some experience with coexisting values within the context of healthcare so that they can provide narrative accounts of relevant experience. A confirmation of such experience is a requisite for participation and is tied to the consent to participate. The projected number of participants is 8 - 10 and the targeted duration of an interview is anticipated to be 1 - 1.5 hours per individual. Participants will also be asked to verify the accuracy of my write-up of their narrative account of experience, bringing the total time commitment to an estimated 2 - 2.5 hours per participant. My goal is to begin conducting interviews in the early part of 2017 and I expect the interview period to span 3 - 4 months.

The research design calls for the use of semi-structured interviews to obtain recorded experiential descriptions of how participants perceive, interpret and act upon the phenomenon of coexisting values. Data analysis will involve a reflective process that includes an extraction of significant statements from transcribed interview data and an assessment of the meaning of these identified statements. The intended outcomes involve an arrival at a set of themes that, taken together, illuminate the nature and significance of the phenomenon of coexisting values among HCPs. The proposed study will feature a strong commitment to the quality criteria associated with the conduct and reporting of qualitative research (e.g. trustworthiness; authenticity). Specific protocols are in place to ensure the confidences and protect the well being of those who

participate in the study. Based on these protocols, the study has been given approval to proceed by the Institutional Review Board (IRB) at Colorado State University (CSU).

There is much that can be learned by accessing, analyzing and reporting on the experiences of HCPs with coexisting personal, professional and market values. Such knowledge will be of use to those concerned with the dynamics that emanate from the concurrent pursuit of important values within the context of healthcare. If you (or anyone you are associated with) are interested in participating in this research, or wish to learn more about the study, please contact Christopher Stewart by e-mail at cws@colostate.edu or phone at (303) 913-1797.

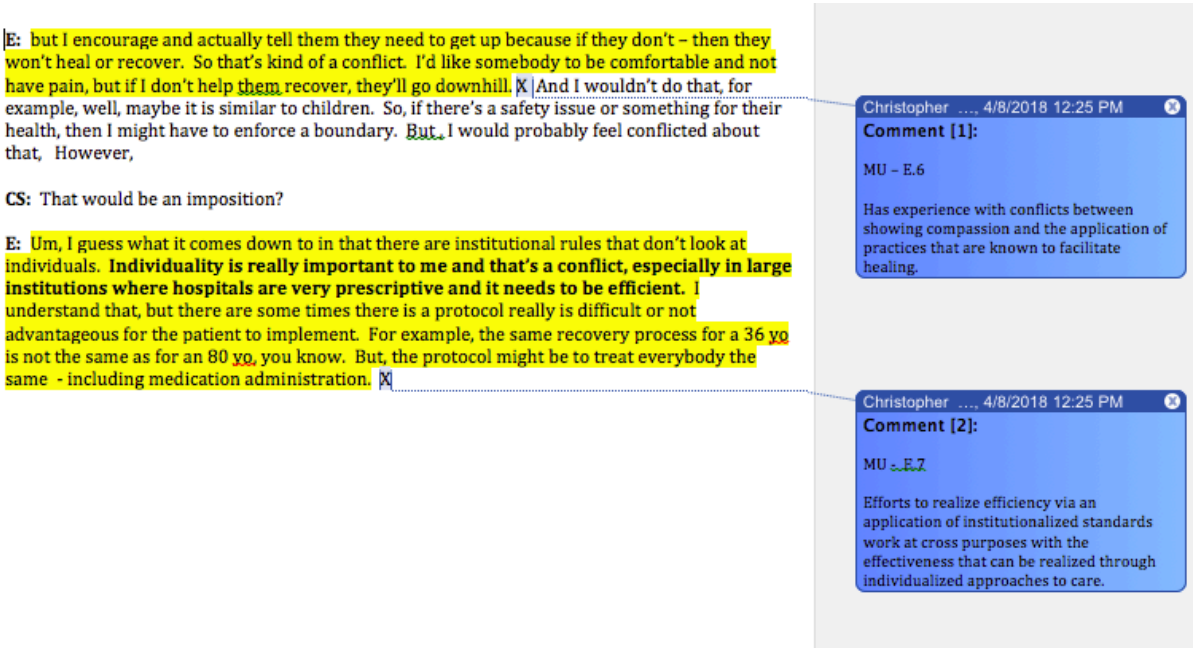
APPENDIX B: THE QUESTIONS THAT WERE DERIVED FROM THE THREE OVERARCHING (WHAT AND HOW*)* RESEARCH QUESTIONS AND USED TO GUIDE PARTICIPANT INTERVIEWS

1. What has been your experience of HCPs with the co-existence of personal, professional and market values (textural and descriptive)?
   a. Can you describe, in detail, an instance(s) where (your) personal and professional values came into contact with market values? Please include a description of the context surround this event(s)
   b. Please describe (in detail) what it was like for you, when your personal and professional values came were expected to coexist with market values?

2. How have you experienced the expected coexistence of personal and professional and market values (structural and interpretive)?
   a. In what ways? To what degree or extent?
   b. Can you recall and describe how you interpreted an event(s) where the types of values that are the focus of this study were simultaneously active (in use)? Or were expected to coexist?
   c. Can you describe an instance where you experienced the types of values (personal, professional and market) that are the focus of this study as ***conflicting***?
   d. Can you provide an example of where you have experienced the types of values that are the focus of this study as being ***compatible***?
   e. Can you recall and describe how you interpreted event(s) where certain personal, professional and market values were ***espoused***, but other values were in **use**?

3. What is the significance of the co-existence of personal, professional and market values in healthcare for HCPs?
   a. Do you perceive the expected coexistence of these values as being significant within the context of your practice? If so (not), why so (not)? Are there specific experience(s) that have led you to this conclusion? Please describe.
   b. Can you provide an account/ story describing an experience where you have experienced ***negative consequences*** emanating from the coexistence of personal, professional and market values?
   c. Can you provide an example of when you have experienced ***positive consequence****s* emanating from the coexistence of personal, professional and market values in your practice? Describe this experience(s)
   d. Do you perceive the expected coexistence of these values as being an effective counterbalance to one another? Are there specific experience(s) that have led you to this conclusion? Please describe.

APPENDIX C: A SAMPLE SECTION OF AN ANNOTATED TRANSCRIPT FEATURING AN IDENTIFICATION OF SIGNIFICANT STATEMENTS (YELLOW HIGHLIGHTS) AND THE ACCOMPANYING FORMULATED MEANING UNITS (COMMENT BUBBLES)



E: but I encourage and actually tell them they need to get up because if they don't – then they won't heal or recover. So that's kind of a conflict. I'd like somebody to be comfortable and not have pain, but if I don't help them recover, they'll go downhill. X And I wouldn't do that, for example, well, maybe it is similar to children. So, if there's a safety issue or something for their health, then I might have to enforce a boundary. But, I would probably feel conflicted about that, However,

CS: That would be an imposition?

E: Um, I guess what it comes down to in that there are institutional rules that don't look at individuals. **Individuality is really important to me and that's a conflict, especially in large institutions where hospitals are very prescriptive and it needs to be efficient.** I understand that, but there are some times there is a protocol really is difficult or not advantageous for the patient to implement. For example, the same recovery process for a 36 yo is not the same as for an 80 yo, you know. But, the protocol might be to treat everybody the same - including medication administration. X

Christopher ...., 4/8/2018 12:25 PM
Comment [1]:
MU – E.6
Has experience with conflicts between showing compassion and the application of practices that are known to facilitate healing.

Christopher ...., 4/8/2018 12:25 PM
Comment [2]:
MU – E.7
Efforts to realize efficiency via an application of institutionalized standards work at cross purposes with the effectiveness that can be realized through individualized approaches to care.

APPENDIX D: APPROVAL TO CONDUCT RESEARCH IN COMPLIANCE WITH HEALTH AND HUMAN SERVICES EXEMPT # 2 CRITERIA GRANTED BY THE CSU/ OFFICE OF RESEARCH INTEGRITY AND COMPLIANCE REVIEW

Colorado State University

Research Integrity & Compliance Review Office
Office of Vice President for Research
Fort Collins, CO 80523-2011
(970) 491-1553
FAX (970) 491-2293

Date: January 10, 2017

To: Susan A. Lynham, Ph.D., Associate Professor, School of Education
Christopher W. Stewart, Graduate Student, School of Education

From: IRB Coordinator, Research Integrity & Compliance Review Office
(RICRO_IRB@mail.colostate.edu)

Re: *A Phenomenlogical Investigation of Coexisitng Values in Healthcare*

Funding: None

IRB ID: 292 -17H **Review Date:** January 10, 2017
This project is valid from three years from the review date.

The Institutional Review Board (IRB) Coordinator has reviewed this project and has declared the study exempt from the requirements of the human subject protections regulations with conditions as described above and as described in 45 CFR 46.101(b):

Category 2 - Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

The IRB determination of exemption means that:

- **This project is valid for three years from the initial review.** After the three years, the file will be closed and no further research should be conducted. If the research needs to continue, please let the IRB Coordinator know before the end of the three years. You do not need to submit an application for annual continuing review.
- You must carry out the research as proposed in the Exempt application, including obtaining and documenting (signed) informed consent if stated in your application or if required by the IRB.
- Any modification of this research should be submitted to the IRB through an email to the IRB Coordinator, prior to implementing any changes, to determine if the project still meets the Federal criteria for exemption.
- Please notify the IRB Coordinator (RICRO_IRB@mail.colostate.edu) if any problems or complaints of the research occur.

Please note that you must submit all research involving human participants for review by the IRB. **Only the IRB or designee may make the determination of exemption**, even if you conduct a similar study in the future.

APPENDIX E: FORM USED TO OBTAIN THE INFORMED CONSENT OF STUDY PARTICIPANTS

Consent to Participate in a Research Study
Colorado State University

TITLE OF STUDY: A Phenomenological Investigation of Coexisting Values in Healthcare

PRINCIPAL INVESTIGATOR: Susan A. Lynham, Ph.D., Associate Professor, School of Education, Colorado State University. (970) 491-7624 (work), susan.lynham@colostate.edu

CO-PRINCIPAL INVESTIGATOR: Christopher W. Stewart, Ph.D. Candidate, School of Education, Colorado State University. (303) 913-1797, cws@rams.colostate.edu

WHY AM I BEING INVITED TO TAKE PART IN THIS RESEARCH?
As changes to the healthcare system bring increasing levels of emphasis to market values (e.g. competition; productivity), it has become important to understand how such values interface with those values that Health Care Practitioners (HCPs) appear to personally and professionally prefer (e.g. benevolence; fairness; patient advocacy). You are being invited to participate in this research because you appear to have had lived experience with the coexistence of values comparable to the aforementioned while working as a HCP. You are therefore in a position to provide a narrative account of your experience with the coexistence of personal, professional and market values within the context of healthcare.

WHO IS DOING THE STUDY? This study is being conducted by Christopher W. Stewart, doctoral candidate at Colorado State University, under the supervision of his Advisor, Associate Professor Susan A. Lynham, Ph.D., from the School of Education at Colorado State University.

WHAT IS THE PURPOSE OF THIS STUDY? The purpose of the proposed study is to develop a deeper understanding of the nature and significance of the coexistence of personal, professional and market values as experienced by HCPs. It is believed that the proposed study will yield valuable local insight into the opportunities and challenges associated with the pursuit of personal, professional and market values within the context of health care. The goal is to be useful and informative to healthcare's primary stakeholders and those who operate in a comparable context.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST? As a participant in the study, you will be interviewed in your office (or another place of your choosing/ convenience) for 60-90 minutes. Interview data from you and other participants will be collected and analyzed over the 4-6 month period beginning in the early part of 2017. Results will be written up in the Spring of 2017. The results will be used for a doctoral dissertation aimed for completion by the end of 2017.

WHAT WILL I BE ASKED TO DO? You will be interviewed, for a 60-90 minute (1 to 1.5 hour) period. The interview questions will focus on your experiences as a health care practitioner. It is also possible that the investigators may need additional time for follow up questions. You will be given the opportunity to review your interview transcript and the researcher's interpretations of the information you provide in order to ensure that findings are a true representation of both your intended meaning and your lived experience. Your total time commitment for participation in the study will be a maximum of 3 hours.

WILL MY INTERVIEW BE RECORDED? The researchers would like to audiotape your interview to be sure that your comments are accurately recorded. Only the research team (principal investigator and co-investigator) will have access to the audiotapes, and they will be destroyed

upon transcription by the co-investigator. Do you give the researchers permission to audiotape your interview? Please initial next to your choice below.

- ☐ Yes, I agree to be digitally recorded _____ (initials)
- ☐ No, do not audiotape my interview _____ (initials)

ARE THERE REASONS WHY I SHOULD NOT TAKE PART IN THIS STUDY? Other than having an absence of lived experience with the coexisting values phenomenon under study, there are no known reasons why you should not take part in this study.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

- There are no known risks to you in this study. However, recalling some of your experiences in an interview may cause you discomfort, depending on their severity.
- It is not possible to identify all potential risks in research procedures, but the researcher(s) have taken reasonable safeguards to minimize any known and potential, but unknown, risks.

ARE THERE ANY BENEFITS FROM TAKING PART IN THIS STUDY? There are no known direct benefits other than providing the opportunity to share your experiences. Participants are being asked to share their experiences so that the researchers can illuminate the meaning and significance of coexisting personal, professional and market values within the context of healthcare. The results from this study will be published as the Co-Principal Investigator's dissertation.

DO I HAVE TO TAKE PART IN THE STUDY? Your participation in this research is voluntary. If you decide to participate in the study, you may withdraw your consent and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.

WHO WILL SEE THE INFORMATION THAT I GIVE? We will keep private all research records that identify you, to the extent allowed by law. You will be assigned a pseudo name as an identifier and this pseudo name will be used in all written records of the research. Any key code that might connect your actual identity to your pseudo identity will be available only to the investigators. This key code will be kept completely separate from your research records and these two items will be stored in encrypted files on separate devices, each under lock and key.

We will make every effort to prevent anyone other than the investigators from knowing that you gave us information, or what that specific information is. The information that becomes the data for analysis will be protected behind a password protected used interface and stored in encrypted files.

Your information will be combined with information gathered from other people taking part in the study. When we write about the study and share it with other researchers, we will write about the combined (thematic) information we have gathered. You will not be identified by name in any of these written materials.

WILL I RECEIVE ANY COMPENSATION FOR TAKING PART IN THIS STUDY? No. Participation in this study is completely voluntary and no compensation will be provided.

WHAT HAPPENS IF I AM INJURED BECAUSE OF THE RESEARCH? There is minimal risk of injury for participating in this study. The Colorado Governmental Immunity Act determines and may limit Colorado State University's legal responsibility if an injury happens because of this study. Claims against the University must be filed within 180 days of the injury.

WHAT IF I HAVE QUESTIONS?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind. Later, if you have any questions about the study, please contact the Co-Principal Investigator, Christopher W. Stewart at (303) 913-1797 or via e-mail at: cws@rams.colostate.edu. You may also contact the Principal Investigator, Dr. Susan A. Lynham at susan.lynham@colostate.edu. If you have any questions about your rights as a voluntary participant in this research, contact Colorado State University Institutional Review Board Coordinator at (970) 491-1553 or via e-mail at RICRO_IRB@mail.colostate.edu.

Your signature acknowledges that you have read the information stated and willingly sign this consent form. Your signature also acknowledges that you have received, on the date signed, a copy of this document containing three pages.

_____ _____

Signature of person agreeing to take part in the study Date

_____

Printed name of person agreeing to take part in the study

_____ _____

Christopher W. Stewart, Co-Principal Investigator Date

_____

Signature of Research Staff

CSU#: 292-17H
APPROVED: 2/24/2017 * EXPIRES: 1/9/2020