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Effect of Organizational Ethical Climate on Physician–Patient Relationships

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Abstract: The objective is to explore the effects of law and code-oriented and caring-oriented organizational ethical climates on physician–patient trust and interactions. A questionnaire survey was adopted and physicians of a case hospital were selected as the survey participants. A total of 116 valid questionnaires were collected, which were then analyzed through multiple regression analysis. The law and code-oriented organizational ethical climate had a significant and positive effect on physician–patient trust and interactions. In an increasingly complex medical environment, physicians must be aware of their hospitals' organizational ethical climate and understand their roles and tasks pursuant to the hospitals' missions, visions, and values. Such awareness and understanding will strengthen physician–patient relationships and enhance medical service quality.

Keywords: organizational ethical climate, doctor-patient relationship, trust, interaction, patient satisfaction

INTRODUCTION

The concept of organizational ethical climate refers to employees' common understanding and subjective experience of their company's ethical standards and policies when the employees implement these policies in practice [1]. An organization's ethical climate is also a set of systems that influences employees' values, norms, beliefs, behavior, and habits, in which employees learn about the behavior that is expected of them based on their perception of the climate. This subsequently enables them to suitably adapt to the organizational environment [2].

Finally, organizational ethical climate is also a crucial factor influencing employees' ethical behavior [3] and decisions made by companies' upper management, which can resolve ethical dilemmas encountered by companies [2].

Companies can influence their employees' work attitude, job satisfaction, organizational commitment [4], and care quality [5], as well as alleviate their moral distress [6], by improving the organizational ethical climate. Managers' efforts and abilities to create a favorable organizational ethical environment can motivate employees to interact with others for learning and performance; subsequently, the employees become individuals who engage in ethical behavior. Employee attitude and values are often the most critical drivers of organizational development and employees' caring behavior. According to Herndon [7], organizational ethical climate is required to "catalyze" an individual's ethics, after which personal management becomes effective. Favorable organizational ethical climate elicits caring behavior in medical care personnel [8]. As their personal values conform to the values of their organization, a patient care-centered organizational culture is facilitated [9].

Physician–patient relationships are a two-person social system, where both the physician and the patient play respective roles and have expectations of the other party. When physicians interact with patients, the physicians hope that their patients will be upfront and thorough about their medical conditions so that appropriate diagnoses and prescriptions can be provided. Conversely, patients hope to be taken care of and treated. Both physicians and patients communicate with each other to establish a favorable relationship, exchange information, and make medical decisions [10]. Physician–patient relationships entail physician–patient interactions, which are the basis of physician–patient trust, a key concept in modern medical ethics [11]. It also encompasses medical personnel–patient relationships during medical treatment processes [12]. Lin [13] and Lu [14] have pointed out that a favorable physician–patient relationship is built on mutual trust. To solve the problems created by the unequal statuses of physician and patient in a physician–patient

relationship, the physician must demonstrate his or her care for the patient to bring the two parties closer together, thereby achieving mutual trust. Because unequal statuses in a physician–patient relationship is inevitable, it is crucial to avoid the deterioration of the physician–patient relationship and continually foster mutual trust.

Roter and Hall [15] argued that interaction is a key component of medical care and a basic tool for both developing physician–patient relationships and meeting treatment goals. Because of the rise of patient autonomy, physician–patient interactions have evolved from one in which physicians are viewed as authoritative figures to one in which physicians and patients are gradually viewed as equals [16]. Favorable physician–patient communication helps medical personnel collect comprehensive patient data, provide appropriate diagnoses, establish a sense of trust between physicians and patients, alleviate patient anxiety, and encourage patients to actively receive treatment, which ultimately enhances the physician–patient relationship [17]. Because physicians are the "leader" in physician–patient relationships, they should take the initiative to improve their communication skills and create relatively equal and positive physician–patient interactions [16], which are the basis of physician–patient trust and cooperation in the field of modern medical ethics [7].

An organization's ethical climate embodies its managers' business policies and ideals, which are subsequently used as the organization's code of conduct. Therefore, managers should establish a caring-oriented organizational climate to shape a caring culture [18]. Accordingly, understanding organizational commitment is of marked importance, because a drop in organizational commitment is associated with reduced productivity, stagnant creativity, and decreased revenue [19]. However, few studies have investigated physician–patient relationships from the perspective of organizational ethical climate. To understand the effect that organizational ethical climate has on physician–patient relationships, the present study used two concepts in organizational ethical climate, namely, law and code-oriented organizational ethical climate, and caring-oriented organizational ethical climate, to explore physician–patient trust and interactions, as well as answer to the following research questions:

(1) How familiar are physicians with organizational ethical climate?
(2) What effect does organizational ethical climate have on physician–patient relationships?

METHODS

1. Research Participants

A cross-sectional correlation method was utilized and physicians from a hospital in eastern Taiwan were selected as the research participants after obtaining consent from the hospital. In total, this hospital 121 employed clinicians. The questionnaires were distributed during September–November 2014. A total of 116 valid questionnaires were returned, posting a valid response rate of 95.86%.

2. Research Instruments

A draft version of the self-report questionnaire was prepared and underwent an expert validity review by five experts. In addition, the reliability and validity of the questionnaire were tested prior to its distribution to the participants. The questionnaires collected the participants' demographic information, including sex, age, education level, marital status, service department, job title, and typical hospital shifts. The participants were also asked to answer 46 items that had been divided into the categories of "organizational ethical climate" and "physician–patient relationships."

3. Data Collection

Prior to distributing the questionnaire, it was sent for review and approval by the institutional review boards of various hospitals. Subsequently, the participant list was compiled and coding operations ensued. Before the experiment, participants were asked to fill out a consent form. After the questionnaires were collected, a research assistant entered the questionnaire results to mitigate error, followed by statistical analyses.

4. Data Processing

All data analyses in this study were performed using SPSS 18.0, and percentage and mean values were used to present the demographic information of the study sample and statuses of current organizational ethical climate and current physician–patient relationships. Chi-square tests were also conducted to test the demographic information variables. Cells that showed an expected value of less than 5 were subject to a Fisher's exact test, and the chi-square tests were terminated when 50% or more of the cells had an expected value of less than 5. Next, a regression analysis was performed to identify the optimal regression model. The number of items and Cronbach's α of each dimension are described as follows: law and code-oriented organizational ethical climate (7 items, $\alpha = 0.901$), caring-oriented organizational ethical climate (4 items, $\alpha = 0.774$), trust (15 items, $\alpha = 0.971$), and interaction (5 items, $\alpha = 0.944$). The overall empirical data were confirmed to be reliable ($\alpha = 0.928$).

The square roots of the average variance extracted (AVE) of all the dimensions were all higher than the correlation coefficient between different dimensions, signifying that the study scale possessed favorable discriminant validity. AVE measures the variance of a latent variable in relation to the total variance of all measured variables. A variance of 0.5 or

higher indicates that the measured variable explained by latent variables is reliable and shows convergent validity. The empirical analyses confirmed that the results of this study exhibited both convergent and discriminant validity, which indicates that the measurement results are accurate (Table 1).

Table 1: Validity and average variable extracted

Construct	Mean	SD	Cronbach's α	CR	AVE
Law and code-oriented organizational ethical climate	3.895	0.567	0.901	0.9125	0.5679
Caring-oriented organizational ethical climate	3.060	0.729	0.774	0.8116	0.5205
Physician–patient trust	4.003	0.594	0.971	0.9565	0.5950
Physician–patient interaction	4.231	0.590	0.944	0.9343	0.7406

5. Research Ethics

When performing surveys, anonymity and confidentiality are two critical ethical concerns. Adequately addressing ethical concerns (e.g., engaging in data protection, avoiding harm to the participants, and respecting personal views and privacy) is indicative of the quality of a study. Thus, to protect the rights and interests of the participants and meet research ethics, this study ensured the participants' safety, confidentiality, and autonomy. Specifically, the following endeavors were made:

1. To respect research ethics and protect the rights of the participants, the questionnaire was reviewed and approved by the institutional review board of the Hualien Tzu Chi Hospital, Buddhist Tzu Chi Medical Foundation (1O3-154-B) prior to distribution.

2. To respect the rights and interests of the participants, personal information about the author of this study, research objectives and directions, privacy protection procedures for the participants, and the rights and interests of the participants were explained to the participants before recruitment. Data collection ensued only after consent was received from the participants.

3. Participants who agreed to participate in this study were required to sign a consent form. A notice was also provided on the questionnaire explaining that the participants could withdraw from the study at any time.

4. To protect participant privacy, the questionnaire was coded and deidentified. The data collected from the questionnaires were solely used for academic purposes and the rights and interests of the participants were protected throughout the study.

RESULTS

1. Sample Characteristics

A total of 116 valid questionnaires were analyzed (Table 2). The demographic information of the participants was as follows: 84.5% and 15.5% of the participants were men and women, respectively; 22.4% of the participants were supervisors; 51.7% and 25% of the participants were younger than 30-years-old and older than 50-years-old, respectively; 84.5% of the participants had an undergraduate degree; 68.1% of the participants worked in the surgery department; 55.5% of the participants worked at least four shifts a week; and 39.7% of the participants saw an average of <20 patients per shift. On the basis of the National Health Insurance special category, the participants were divided into male and female for assessment. Chi-square tests were subsequently performed, and the results showed nonsignificant differences (i.e., $p > .05$) in the categories of job title ($p = .211$), education level ($p = .428$), service department ($p = .887$), number of shifts per week ($p = .286$), and average number of patients seen per shift ($p = 0.484$) (Table 2).

Table 2: Characteristics of the participating doctors (n=116)

Measure	Female	%	Male	%	All	%	*p-value*
Position							.211
Not supervisor	16	13.8	74	63.8	90	77.6	
Supervisor	2	1.7	24	20.7	26	22.4	
Age							.013**
≤30 years	15	12.9	45	38.8	60	51.7	
31–50 years	2	1.7	25	21.6	27	23.3	
≥51 years	1	0.9	28	24.1	29	25.0	
Education level							.428
Bachelor	17	14.7	81	69.8	98	84.5	
Master's	1	0.9	14	12.1	15	12.9	
Doctoral	0	0.0	3	2.6	3	2.6	

Department							.887
Internal medicine department	6	5.2	31	26.7	37	31.9	
Surgery department	12	10.3	67	57.8	79	68.1	
Number of shifts per week							.286
≤3	6	5.2	46	39.7	52	44.8	
≥4	12	10.3	52	44.8	64	55.5	
Average number of patients seen per shift							.484
≤20	5	4.3	41	35.3	46	39.7	
21–40	9	7.8	36	31.0	45	38.8	
≥41	4	3.4	21	18.1	25	21.6	

Table 3: Regression model

Control variable	Trust	Interaction
Sex (Reference group: Female)	.446	.354
Position (Reference group: Supervisor)	.727	.764
Age (Reference group: ≤30 years)		
31–50 years	.544	-.049
≥51 years	-.313	-.672
Education level (Reference group: Doctoral)		
Bachelor	-.846	-1.282
Master's	-.064	-.150
Department (Reference group: Surgery department)	.196	1.278
Number of shifts per week (Reference group: 4 or more per week)	2.013*	.304
Average number of patients seen per shift (Reference group: ≤20)		
21–40	.914	-.386
≥41	-.077	-.917
Independent variable		
Law and code-oriented organizational ethical climate	3.091**	5.297***
Caring-oriented organizational ethical climate	.898	.337
R^2	.171	.273
Adj. R^2	.075	.188
F values	1.776	3.226
P values	.062*	0.001

Note: *** p<0.01, ** p<0.05, *p<0.1

2. Organizational Ethical Climate and Physician–Patient Relationships

The effects of law and code-oriented and of caring-oriented organizational ethical climates on physician–patient relationships were also analyzed and compared. To eliminate the problem of collinearity between the control and study variables during the regression analyses, variance inflation factor (VIF < 10) and condition index (CI < 10) tests for related variables were conducted.

The regression model results are presented in Table 3, which shows that organizational ethical climate significantly explained 7.5% and 18.8% of the variance in physician–patient trust and physician–patient interactions, respectively. The factors that most affected physician–patient trust included number of shifts per week and law and code-oriented organizational ethical climate, both of which achieved significance (p <.05). Conversely, of all the factors that influenced physician–patient interactions, only law and code-oriented organizational ethical climate attained significance (p < .05).

CONCLUSION AND SUGGESTIONS

In this study, the effect of organizational ethical climate on physician–patient relationships was explored. The study results showed that the higher the level of law and code-oriented organizational ethical climate was, the greater the effect of the professional medical system on physician role became. This facilitates stronger physician–patient trust, which leads to physicians displaying higher physician–patient trust and more interactions. By contrast, caring-oriented organizational ethical climate had a nonsignificant effect on physician–patient relationships. Given the increasing complexity of medical environments, physicians must be aware of their hospitals' organizational ethical climate and understand their roles and tasks pursuant to the hospitals' missions, visions, and values. Such awareness and understanding

strengthens physician–patient relationships and enhances medical service quality.

Caring-oriented organizational ethical climate did not show a significant effect on physician–patient relationships, which may be because medical care is already a field work that requires substantial work ethics; hence, the importance of medical ethics is already regularly emphasized during medical treatment and physicians are constantly asked to abide by medical ethics when treating patients. However, ethical dilemmas may create psychological stress in physicians and lower their retention desire, which can negatively affect their organizational commitment and hinder organization development. Therefore, hospital managers should seek to establish a favorable organizational ethical climate and accompanying strategies to ensure that physicians abide by medical ethics in clinical care.

Some recommendations for related follow-up academic research are offered. First, research samples for similar studies are not limited to a specific industry because organizational ethical climate generally exists in all industries. However, because there are differences in the organizational ethical climate of different industries, future researchers are suggested to focus on a specific industry to elucidate the unique ethical climates of different types of organizations. Second, the job title category could be further divided before conducting similar studies to analyze whether differences existed between people with varying types of jobs. Finally, this study only explored the relationship between organizational ethical climate and physician–patient relationships. Other mediating variables should be added in future studies to generate more detailed results.

The limitations of this study are as follows: First, the participants of the study consisted of only physicians, resulting in the use of a single-source statistical method, which may have produced biased results. Future researchers are recommended to use a multiple-source collection method and pair and analyze the obtained data. Second, because this study adopted a cross-sectional research design, any potential causal relationships between the variables cannot be confirmed. Future researchers are encouraged to conduct longitudinal field studies or controlled experimental studies to identify any causal relationships between the variables.

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