Integrity in health care organisations:

administrators' perspectives

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Summary

Incidents in health care are often attributed to a lack of integrity. Various health care institutions are drawing up policies with regard to integrity. Yet the integrity debate often gives rise to one-dimensional notions, while integrity is a complex concept. This report explores administrators' powers and limitations in terms of promoting integrity in health care organisations. It aims to advance the debate on integrity in health care organisations, while offering administrators guidelines on how to promote integrity within their organisations.

First, we analyse the way in which the concept of 'integrity' is understood in the literature, in the public debate, and by the administrators of health care organisations. There is no single, all-embracing definition of the concept of integrity. We identify two specific pitfalls with regard to the use of this term. On the one hand, integrity is so widely used that it has become a kind of catch-all concept and/or is associated with issues that have nothing to do with integrity, as such. On the other hand, the meaning of integrity has dwindled to the point at which it is now a mere antonym of fraud or of adherence to a set of rules. As a result, the sense of integrity as virtuous conduct has been lost. In this report we use integrity to refer to a layered personal characteristic comprised of the following four components: reliability, virtue, authenticity, and reflection. Integrity is both situational and dynamic in nature. What is considered to be virtuous conduct is subject to change.

We go on to describe situations in which, according to the health care administrators we interviewed, integrity in health care organisations is at jeopardy. These vary from situations in which it is clear what constitutes conduct that is lacking in integrity – but where the temptation involved is apparently still too great (misconduct) – to situations in which it is not clear what constitutes 'acting with integrity' (the so-called 'grey areas'). The following five themes were repeatedly encountered: conflicting interests and expectations, dealing with errors, remuneration of administrators, perverse incentives within the system, and peer pressure. In discussing these themes, we were struck by the fact that integrity is a morally loaded concept. Conduct that is seen as lacking in integrity is subject to strong social condemnation, often involving personal attacks. This tends to undermine constructive dialogue about causes and solutions. One drawback in

this regard is that, in the public debate, integrity is used as antonym for fraud and other forms of clear misconduct. The fear of being associated with such behaviour prevents administrators from speaking up about what they themselves associate with integrity, i.e. struggling with complex balances of interests in grey areas where no indication of what constitutes ethical conduct can be given in advance.

Finally, we enumerate those approaches and methods that administrators use to promote integrity within their organisations. The health care administrators we interviewed tended to take a balanced view of their ability to influence the integrity of their institution. There are various ways of promoting integrity. These can be divided into approaches that focus more on rules and those that give greater emphasis to values. Rules-based approaches are particularly well suited to the promotion of integrity in situations where it is clear what constitutes 'acting without integrity'. The interviewees indicated that their institutions draw up regulations and, where appropriate, impose sanctions. However, they stressed that a purely rules-based approach is not enough. There is greater enthusiasm for values-based approaches. These can help to resolve the above-mentioned 'grey areas', which involve conflicting rules or values. Moreover, values-based approaches involve ambitions that exceed the lower limit targeted by rules-based approaches. Finally, administrators generally have no direct involvement in the private settings in which health care is provided. Thus, as they are compelled to rely on the integrity of health care professionals in this regard, administrators tend to focus on facilitating reflection on values. The preference for a values-based approach expressed by the administrators we interviewed presents them with an awkward dilemma. This is because the outside world also holds them accountable for exerting control and adhering to rules.

It is important that the dialogue about integrity in health care organisations be conducted in a balanced and impartial manner. Accordingly, in response to this report, The Netherlands Centre for Ethics and Health (CEG) will be holding a series of dialogue meetings to address dilemmas associated with various integrity-related issues.

1 Introduction

Rationale

Governance with integrity and acting with integrity are the focus of considerable attention in the health care sector. This is shown by reports in the media and by various discussion meetings organised by the Netherlands Centre for Ethics and Health (CEG) in connection with this report. Various policy recommendations have previously been issued about good governance (RVZ *[Council for Public Health and Health Care]* 2013, RVZ 2009, Good Governance Committee 2013, RMO *[Council for Social Development]* 2013). Various health care organisations are in the process of shaping or refining their policy in the area of integrity. At the same time, questions about how integrity is threatened in health care organisations and how integrity can be promoted have as yet received little attention in recent policy literature.

In other sectors, such as banking, the house building sector and science, serious abuses are attributed to a lack of integrity. Incidents associated with integrity also occur regularly in health care. Examples in this respect are the charge of misconduct and poor employment practices within the Nza *[Dutch Health care Authority]* by the whistleblower Arthur Gotlieb (2014), the case against the former neurologist Dr Ernst Jansen who was found guilty of misconduct, theft, and documentary fraud (2013), various reports that more health care is declared than is actually performed and excessive payments to retiring administrators. The Minister and Secretary of State for Health, Welfare and Sport (VWS) in a Letter to the House recently pointed out the importance of integrity in administrators and supervisors in preventing irregularities such as fraud (VWS 2015). The concept of ‘integrity’ is used in incidents and issues as diverse as these.

However, it is not always clear what is meant by ‘a lack of integrity’. Has the conduct of people in health care become less virtuous, does the system produce perverse stimuli, have the balances of interests become more complex or is there simply more transparency and media pressure as a result of which questions of integrity come to light more rapidly? Only if we are clear as to what constitute the underlying questions, concerns, and problems can we decide what steps are desirable for promoting integrity within health care organisations, if that is necessary. Set against that background is the fact that the health care sector is a semipublic sector. The behaviour of administrators

and professionals is visible and the subject of political debate and media attention. It may also be that different issues of integrity arise from those in the commercial sector.

This report

Aim

This report intends to advance the debate about integrity in health care organisations by drawing distinctions and by providing guidance on how to maintain and promote integrity in health care organisations. The primary target group of this report is constituted by administrators and employees of health care organisations.

Problem statement

The main question in this report is: what options do administrators have for promoting integrity in health care organisations and what are the limits that they come up against? We discuss this question on the basis of three sub-questions. Firstly: how is the concept of 'integrity' understood in the scientific literature, in the public debate and by the administrators of health care organisations? Secondly: according to administrators, in what situations is integrity threatened by themselves and by their employees? Thirdly: what can administrators do to promote integrity in their organisation, according to themselves and according to the literature?

Definition

By 'integrity in health care organisations' we understand the integrity of the administrators and employees of the organisation. The meaning of the concept 'integrity' is discussed in section 2. We focus on the administrators' perspective because they are often seen as the people who have ultimate responsibility for integrity in their organisation. Obviously, the influence of administrators is limited and integrity in a health care organisation is determined by several factors.

The report focuses on curative and long-term health care organisations, for example hospitals, care organisations for the elderly, GGZ *[mental health care]* institutions, and organisations for the care of the disabled. These are semipublic organisations, in other words organisations with a private nature that are to a large extent publicly funded and that are jointly responsible for the achievement of public goals.

Approach

The basis of this report is an analysis of the debate on integrity in the philosophical and management literature, an analysis of media articles, and an analysis of 11 interviews conducted primarily with health care administrators in connection with this report. Section 2 is largely based on the preliminary study accompanying this report. "A catch-all term or a clear concept: an analysis of the term integrity" (Lenselink 2014).

We interviewed eight members of the Board of Directors of a health care organisation. In addition, we interviewed two employees (a medical specialist and a nurse) and a member of the Supervisory Board of a health care organisation to check whether they recognised the picture outlined by the administrators. For an overview of the interviewees, see Appendix 1. To prevent identification, we refer to all interviewees as 'he'. The administrators come from various curative and long-term health care organisations, i.e. three hospitals, a care group including a youth care department, an elderly care organisation, an organisation for the care of the disabled, a home care organisation, and a GGZ institution. In our selection we endeavoured to obtain a balanced but not a representative image. In the interviews we presented three questions:

- *What do you understand by integrity?*
- *In which situations in your opinion is integrity threatened in your institution?*
- *How can integrity be promoted?*

Guide to the report

Section 2 discusses how the concept of 'integrity' is understood in the scientific literature, in the public debate, and by the administrators of health care organisations. Section 3 describes what conflicts of integrity administrators report in themselves and in the employees in their organisation. Section 4 describes what administrators can do to maintain and promote integrity in their organisation (according to themselves and according to the literature). Section 5 reflects on the main findings of previous sections with the intention of introducing balance into the public debate on integrity in health care organisations and of offering guidance for the promotion of integrity.

2 The meaning of integrity

In this chapter we analyse how the term integrity leads to linguistic confusion in the public debate and the scientific literature. We then describe what we understand by it in this report and examine the dynamic interpretation of integrity.

Linguistic confusion

Integrity is a subject that is widely discussed in the public debate. Abuses and undesirable situations in health care are regularly attributed to a lack of integrity. This is leading to an increasing number of health care organisations developing integrity policies. However, what is meant by integrity has for a long time not always been clear.

OVERLY BROAD USE

Examination of the use of the term 'integrity' in the media shows that the concept is rarely defined and sometimes the meaning of the term is stretched very far. In the positive sense, in other words in the presence of integrity, the term integrity is associated with transparency, trust, alertness, compliance, independence, responsibility, moral compass, accountability, carefulness, and the service of a general interest. In the negative sense, in other words where there is some idea of a lack of integrity, the following terms are mentioned: fraud, corruption, conflict of interest, undesirable behaviour, lack of clarity, dishonesty, intimidation, plagiarism, and tunnel vision. If all these terms are lumped together under integrity, then it becomes a catch-all term and is relatively meaningless (Lenselink 2014).

In addition, the word 'integrity' is regularly linked to subjects with which it has nothing to do. Huberts warns against 'integritism': *"the 'i word' is used too often and too readily without someone's integrity being at issue. People can make mistakes or do stupid things without there being a doubt as to their morality or integrity."* (De Koster 2014).

OVERLY NARROW USE

It also regularly happens that the term integrity is used in too narrow sense. The RMO reports that integrity is often simplified to just right or wrong, to an 'all-or-nothing' issue, whereas integrity cannot be captured in a dichotomy (RMO 2013).

Integrity is often narrowed down to adherence to rules and transparent behaviour. Various administrators interviewed also refer in the first instance to rules, protocols, and measurement instruments where the subject of integrity is concerned. Behaving with integrity is then equated to adherence to laws and regulations, also referred to as compliance. However, if someone follows the rules, that still does not mean that he is also behaving with integrity. The opposite also applies: someone who deviates from the rules can demonstrate integrity precisely by so doing.

Integrity is also often narrowed to an antonym of fraud and corruption (Karssing 2006). Thus, commercial parties offer training courses in integrity that predominantly cover fraud management and the prevention of corruption and bribery. This approach is also too narrow because there are many situations between situations of fraud and situations of completely virtuous behaviour in which integrity is subtly threatened. All of us sometimes have the feeling that we have not acted entirely 'above board', even though equally we have not been lacking in integrity. Integrity is thus related to virtuous behaviour.

Because integrity is often represented in the public debate and in the media as an antonym of fraud and gross misconduct, the discussion of integrity as virtuous behaviour threatens to be stifled. This is because administrators do not want to be associated with misconduct. At the same time, they wrestle with integrity in the more refined sense, in other words when they seek the middle way in the light of complex balances of interests. However, in public, the statement that someone is wrestling with integrity is all too rapidly at risk of being misinterpreted.

LACK OF CLEAR DEFINITION

It is not just in the public debate that there is a lack of any clear definition of integrity. Experts also differ in their opinions on a definition. Thus, in philosophy there are two entirely different visions of integrity (Cox 2013). In the first place, a procedural view, based on the etymological meaning of the Latin word *integritas,* which refers to 'entire' or 'whole' (Philippa 2003). From this perspective, integrity by definition is not concerned with good or correct behaviour. Integrity here concerns a formal relationship with the self: it involves the maintenance of a certain unity or wholeness of character without specifying the nature of that character. Thus, the philosopher Bernard Williams describes a person of integrity as someone who is faithful to the projects that are essential to who he is (Williams 1973, 1981). According to the philosopher Harry Frankfurt, a person of integrity has control over his own will, so that his various levels of desires are in harmony with one another (Frankfurt 1971, 1987). The second idea within the philosophical discussion is that integrity is associated with moral behaviour. This relates to how the person stands in relation to others and how others see them. Thus, Graham describes a person of integrity as someone who can see what is morally right (Graham 2001).

In the management literature, the definition of integrity is equally equivocal. In a systematic literature analysis, Palanski and Yammarino note that considerable importance is attached to integrity, whereas a definition is often lacking: "everyone seems to want integrity from their leaders, but there appears to be great confusion as to what it is" (Palanski and Yammarino 2007). They classify the debate on integrity in terms of five categories: wholeness, authenticity, consistency between words and actions, steadfastness, and moral/ethical behaviour. Kaptein states that the person of integrity is authentic, reliable, and constructive (Kaptein 2003, 2005).

In short, both in the public debate and among experts, there is a difference of opinion over the definition of integrity. There appears to be unanimity that integrity is a multilevel characteristic that incorporates different components. However, opinions differ as to what those components are.

A characteristic with four components

On the basis of our literature analysis and the discussions with administrators, we find it helpful to define integrity as a multilevel characteristic composed of four components:

- *Reliability and consistency:* not contradicting oneself and doing what one says, even in situations of conflict, without being inflexible or dogmatic
- *Virtue:* behaving morally
- *Authenticity:* being intrinsically motivated
- *Reflection:* being critical towards standards and rules (both of the institution and of yourself) and towards the way in which these are or are not put into practice

RELIABILITY AND CONSISTENCY

A person of integrity is to begin with reliable and consistent. He does not contradict himself and he does what he says, even in situations of conflict. He remains true to his principles, without at the same time becoming inflexible or dogmatic. Kaptein explains reliability as follows: the reliable manager says what he does and does what he says. His words match his ideals. Words and deeds are integrated (Kaptein 2003).

Steadfastness is an important aspect of reliability. This means that someone's behaviour does not change in the face of adversity, temptations or challenges (Palanski 2007). Karssing gives various examples of people of integrity who were also steadfast: *"exemplary models of people of integrity, such as Socrates, Galilei, Luther, Gandhi, King and Mandela, are almost always people who did not bend under great adversity, sometimes even with death as the ultimate price."* (Karssing 2006).

The administrators we interviewed also associate integrity with reliability and consistency. Thus, one administrator says: *"By integrity, I think of being reliable, being honest. You must show employees that your deeds are consistent with your words, you must assume responsibility and be clear. There must be no hidden agenda."* Another

administrator remarks: *"Acting with integrity is associated with constantly weighing up what I do against the aim to which I wish to contribute. So that here too there is an element of consistency. Am I consistent in what I say and how I act?"*

VIRTUE

As well as being reliable, a person of integrity is also virtuous. The administrators we interviewed associate integrity with virtuous or morally correct behaviour so strongly that the two concepts are used almost interchangeably. To describe integrity, they refer to various moral rules of thumb, such as: "*do unto others as you would have done unto you*', '*be your brother's keeper*', and '*example is better than precept*."

Morally correct conduct is associated by most of those interviewed with good patient care: *"What I get out of bed for and what is very important in my behaviour is to ask myself constantly: is what I am doing right for the patient?"* From the perspective that integrity and morally correct conduct are closely associated with good patient care, policy for promoting quality in a health care organisation can also contribute to certain aspects of integrity. The boundary between integrity, quality, and safety thus becomes blurred.

Integrity is also closely associated with virtue in the public debate. Integrity is regularly mentioned in the same breath as the term 'moral compass', which refers to an inner sense of what is the morally correct way of behaving. However, equating integrity to virtue is too simplistic according to various experts: they see integrity as a character property that includes other components, such as authenticity and reliability, as well as morally correct behaviour.

AUTHENTICITY

As well as being reliable and virtuous, a person of integrity is also authentic. This means that he is intrinsically motivated. Not all experts mention authenticity as a component of integrity, but we consider it an important addition because it shows that people must not only abide by values (their own or those of the organisation) but must also experience them from within. They must be your own moral values because the extent to which you put them into practice is then greatest. Character and authenticity are important for acting with integrity because authentic leaders have a highly developed moral perspective. The extent to which someone identifies themselves with a moral value determines how strongly the motivation is to act consistently with that value. The more developed the character of the manager is, the stronger is the urge to act in accordance with his or her character. And this is where integrity must be sought: in a character in which thoughts, motivations, and actions are integrated. This therefore relates to the person's intrinsic motivation: if he finds the value itself important (and therefore it is not imposed from outside), he is motivated to act consistently with that value (Hannah 2013).

Various interviewees emphasise the importance of intrinsic motivation. One administrator notes that it is important that you as an administrator are always aware of your deepest motivation: *"I think that first of all you must simply define your benchmark very clearly. Why are you doing it now?"* One of the administrators who attaches great importance to authenticity notes that too much emphasis on rules can inhibit intrinsic motivation: *"I believe that too many rules can cause you to lose sight of your own compass, of your own standards and value pattern, because then you constantly have to check whether you are following the rules. At that point, there is a risk that you are no longer acting with integrity."*

A term that came up regularly in the interviews as a component of integrity is 'purity'. We rarely find this term in the literature on integrity. Interviewees meant by this that administrators with integrity are intrinsically motivated. In their opinion, In order to be able to manage with integrity, it is crucial that you act from the right motives, that you keep the essence of your work before your eyes and subordinate other interests (such as personal interest) to this. One administrator articulated that as follows: *"You must act purely where aims and interests are concerned. For example by giving preference in principle to the interest of the client and the interest of the careful use of public resources over the interest of employees."* If someone's behaviour is consistent with the principles to which he attaches, he can justify his choices to himself and to the outside world. All sorts of metaphors apply here: one administrator wants to be able to continue to look himself straight in the face in the mirror; another administrator imagines an extra chair in the office with a patient on it during each discussion to check whether he can justify himself.

REFLECTION

Lastly, the fourth component of integrity is reflection. The person of integrity reflects on his actions and the values with which he identifies himself.

Various interviewees remarked that critical reflection is necessary to operate with integrity in what are referred to as 'grey areas' where regulations give no clue: *"There are a whole number of things that you simply must not do. However, the much larger, somewhat vaguer area that cannot be directly circumscribed by rules, that is where the essence of it all lies. To my mind the critical debate about this constitutes the core of integrity."* Another administrator notes that critical reflection is also necessary to adapt behaviour and to learn from errors. Yet another emphasises the importance of reflection in bearing responsibility: "*Integrity has a whole lot to do with responsibility. Because if you are responsible for your actions, then you also reflect independently about them."* Lastly, the interviewees note that critical reflection helps to prevent consistency from degenerating into dogmatism and inflexibility: "*I think that you must dare to put something forward and to pursue it, but you must allow yourself to adapt along the path that you have to take."* It was also noted in this respect that counterbalance and review

are extremely important, for example in the form of a works council, a family council, a client council, a supervisory council and the inspectorate: *"It helps the integrity of an organisation or an individual if you have an environment that forces you to look at whether you are doing what may be expected of you."*

Dynamic nature of acting with integrity

Even if there were to be agreement about the definition of 'integrity' as a combination of reliability, virtue, authenticity, and reflection, a difference of opinion can still remain as to what acting with integrity involves in a given situation. This has to do with the situational nature of acting with integrity: what is understood by it differs between persons, cultures, and periods of time

It is remarked in various interviews that things that were previously found acceptable are now regarded as lacking in integrity. Examples of this are the declaration of attendance at conferences abroad. In addition, the way in which the integrity of an administrator is operationalised is subject to change. At present, reliability is more strongly linked to transparency than before. The expectations that are placed on good governance shift as a result of new policy discourses, such as the introduction of market forces and the process of decentralisation. Internal developments in health care also have consequences for what is understood by acting with integrity. Previously the view prevailed that a doctor of integrity made every effort to save his patient's life, whereas now in certain situations he can be considered to exhibit equal integrity by not intervening. In short, administrators of health care organisations are required to adhere to shifting views of integrity.

Conclusion

The term integrity has a variety of meanings. We point out two pitfalls in the use of the term. When interpreting integrity, there are two extremes that must be avoided. One pitfall is that the concept is interpreted so broadly that it loses its meaning or even that integrity becomes associated with issues that have nothing to do with it. The other pitfall is that integrity is narrowed down to adhering to rules and acting transparently. By integrity we understand a multilevel personal characteristic with four components: reliability, virtue, authenticity, and reflection. Integrity is both situational and dynamic in nature. This means that what constitutes acting with integrity is not fixed but is subject to change.

3 Where integrity is tested

In this chapter we examine five situations in which integrity in health care organisations is tested, according to interviewees. We then examine the moral implications of the debate on integrity.

Integrity threatened in five situations

Five situations in which integrity in health care organisations is tested came up regularly in the interviews:

- *conflicting interests and expectations*
- *dealing with errors*
- *remuneration of administrators*
- *perverse incentives within the system*
- *peer pressure*

The first three situations involve wrestling with integrity in what are known as 'grey areas': integrity is threatened because it is not clear how to act with integrity in that situation and those involved must themselves therefore weigh up the pros and cons. In the last two situations, there are as such clearer standards or rules of how to act with integrity, but there is a temptation to deviate from them.

The interviewees responded to the question of when integrity is threatened from two perspectives. In the first place they report threats to integrity themselves: they express concern about a clear lack of integrity in behaviour (usually in others) and mention conflicts in which it is difficult to find the right balance (usually in themselves). Secondly, they reflect on threats to integrity reported by the outside world (media, politicians, society), to which they add critical comments.

CONFLICTING INTERESTS AND EXPECTATIONS

According to the interviewees, integrity is regularly tested when administrators have to choose between different values or interests. The outside world sometimes has different expectations from yourself as to how this choice should be made. In addition, it sometimes happens that expectations change.

Thus, administrators are responsible for the efficiency of their institution, but at the same time the government and society expect them to preserve jobs in the region. If they then opt for the former by implementing a large round of redundancies, they are at risk of being accused of a lack of integrity. An administrator describes the tension as follows: *"I am expected to link production and the means of production together. And then I have to go and reorganise. Then the press stand on my doorstep and everyone thinks I am terrible."* This administrator himself feels that in that particular situation he made a virtuous decision between two conflicting interests, i.e. the efficient management of public resources versus the preservation of jobs. In addition to conflicting interests, contradictory expectations as to how an administrator should balance these interests also play a role here. The administrator concerned considers that he is primarily responsible for the efficient management of public resources. However, he reports that the government and society have recently begun to attach increasingly more value to the responsibility of administrators for preserving jobs in the region: *"I am therefore slowly coming to believe that the health care sector has a greater importance in employment than in booking health gains."*

The more intensive co-operation between health care institutions and local authorities also results in administrators having to deal with conflicting interests and shifting expectations. For example, an administrator was asked to provide information from the electronic patient record because the local authority wanted to include this in the municipal basic administration. The administrator found this incompatible with his task of protecting the privacy of his clients. The only way of acting with integrity for him was therefore to resist this request: *"What I consider to be acting with integrity, for me as an administrator and for me as a person, is to stand firm. Medical secrecy must not be abandoned."* Although the administrator took a decision consistent with his own beliefs, he was accused of arrogant behaviour and the discussion was framed directly in terms of transparency and fraud. On this issue also, the local authority and the administrator clearly have different expectations of the task of an administrator: one gives precedence to data transparency, whereas for the other professional secrecy is more important. The administrator notes that there is a question of conflicting paradigms: for one party transparency is sacrosanct, whereas according to the other party transparency can clash with integrity. Here again the administrator is faced with new expectations that conflict with his own beliefs.

Yet another administrator states that he was placed in a predicament between the expectation of implementing economies and his own views of what is good for the sector. He opted to stand up for his views. This led to the preservation of jobs in his organisation and therefore to the maintenance of support for the clients concerned. The administrator notes that it is sometimes important to stand up for what one believes in, as long as it is well substantiated: "*We therefore really made a point there. I think that is important, but you must be able to substantiate it really well."*

These examples show different sorts of considerations. When an administrator makes a decision that goes against certain interests, this leads directly to accusations of a lack of integrity. However, choosing between differing values and interests is simply part of the business of administration. This often happens in grey areas in which there are no rules or standards as to what constitutes acting with integrity. Administrators then act according to their own intuition and convictions. Rather than framing the situations in terms of the personal integrity of the administrator concerned, the debate would benefit more from a discussion of the conflicting expectations themselves. How important is the responsibility of an administrator for preserving jobs in his region relative to his responsibility for spending public resources efficiently? How can responsibility be exercised over the treatment of patients without their privacy being at issue? And to what extent and under what conditions must administrators resist expectations from government where they themselves have other views?

DEALING WITH ERRORS

The second situation in which integrity in health care organisations is tested concerns dealing with errors. Dealing with errors with integrity requires making a choice between two strategies. One strategy involves offering the possibility of reporting certain errors without incurring any sanctions because one can learn from one another's errors. The other strategy involves punishing and publicising certain errors to make clear what behaviour is not tolerated. Administrators have the feeling that their integrity is tested in making a decision because this often also involves grey areas. In addition, the decision to be taken can be painful: sometimes an administrator still has to punish an employee who reported an error honestly.

In addition, the inspectorate places greater emphasis on sanctioning than administrators. This can undermine the willingness of doctors to report incidents, according to various interviewees. Above all, the threat of disciplinary action makes doctors wary of reporting an error. One of those interviewed drew the line when the inspectorate asked him to begin disciplinary proceedings against his own employees: *"To which I said: that is a question that you cannot ask me. These are my people and I am responsible for them. If they are doing it wrong, then we must have it out. I'm not going to string them up."*

When mistakes are made public, accusations of lack of integrity lie in wait. Several administrators say that they are experiencing a culture of mistrust. According to them, the focus in both the media and government is on finding the guilty party and holding them to account. There is too little allowance for the idea that errors with serious consequences are sometimes just unavoidable and that choices sometimes turn out badly without anyone having made a mistake.

The interviewees also warn that framing mistakes in terms of personal integrity is not particularly constructive: it restricts an open discussion about the causes of problems. By pillorying those people who have made wrong choices, a discussion of the context in which the choices were made is omitted. The context in which administrators operate is continuously subject to change. Decisions that are accepted at one particular time can be dismissed ten years later as choices that lack integrity.

Various interviewees remark that there is a lack of understanding among politicians and in society that new policies set in motion a new dynamic. In the new dynamic, grey areas arise in which it is unclear what is desirable behaviour and what is not. Someone mentions the example of various scandals that occurred following the introduction of market forces. Administrators who proceeded a long way down the path of market forces were pilloried, whereas innovation, making bold choices, and standing out in fact epitomise the policy for which the politicians had opted. The interviewee points out: *"people made mistakes but they weren't scoundrels. We therefore need to know about the context in which the wrong choices were made."* He adds that a discussion of this kind is not entirely possible at the present time.

The fear of reputational damage, according to several of those interviewed, is sometimes also a guiding factor in their decision whether or not to admit to simple errors that are just part of their work. An administrator once wanted to instigate a discussion in the organisation about social skills. The threshold for doing this was very high: "*If you frame it slightly wrongly, then it appears in the press as if abuses are going on here. And obviously that is what we don't want."* Another administrator on the other hand deliberately opted to contact the press about a mistake which the organisation could also in all propriety simply have reported to the patients: "*as a result of the reputational damage following another incident, we deemed it necessary to seek publicity ourselves. This raises the question as to whether this policy is not unsafe for doctors."*

Finally, the interviewees stated that the pressure for transparency from government has negative effects on the debate. It results in a culture of condemnation and not of insight. One administrator remarks that health care employees sometimes need some degree of protection in order to be able to do their work properly: *"There must be room for improvement. The focus on condemning the guilty party doesn't work. This is what the government does towards administrators. And do I therefore also have to do that it in my institution?"* Another drawback of transparency is that it can sometimes instil a false sense of control. Someone noted that drawing up lists of who has received what gift or Christmas hamper still does not lead to a critical discussion about it and thus to any improvement: *"People then report it strictly. Three bottles of wine. And then you read in the annual report that someone has kept strictly to the code. But they don't talk to one another about it."*

REMUNERATION OF ADMINISTRATORS

A third situation that is mentioned as an example of the threat to integrity is the lack of clear discussions about administrators' salary. This too can be seen as a grey area. Under the law, administrators with an excessively high salary must reduce it within a certain number of years. Politicians have now issued a moral appeal to do this earlier. And opinions differ about that moral appeal. Administrators must therefore decide themselves what they consider to constitute acting with integrity.

Some interviewees point to the imbalances in salary and attribute this to a lack of integrity. The number of golden handshakes causes them concern, particularly against the background of cutbacks and redundancy rounds among ordinary employees. If therefore golden handshakes are still being handed out after incidents in the institutions concerned, in their opinion that can genuinely no longer be described as acting with integrity. Someone also finds it unjust that the difference in difficulty between, for example, an administrative post in a hospital and an administrative post in a care home or a health care insurer is not reflected in the remuneration.

At the same time, interviewees comment critically on the way in which the debate on the remuneration of administrators is currently being conducted. One of the comments was again that social views of integrity change, so that administrators also have to meet a different criterion. What was previously considered an appropriate remuneration is now dismissed as lacking in integrity. If an administrator does not listen to the moral appeal to take a cut in salary earlier (for example because he has objections on principle to lower salaries in health care), then he is immediately at risk of being accused of a lack of integrity. One administrator illustrates the dichotomy in the debate as follows: "*It is right or it is wrong in the current discussion on integrity. The dominant social view is equated to right. And if you do not conform to that, then immediately you are no longer someone of integrity."* And yet it is too simplistic to think that administrators who do not take a cut in salary do not have any moral considerations. This administrator himself has objections on principle to the cut in salary and for that reason finds it actually *lacking* in integrity to take a salary cut. In the short term he would be commended for doing so, but in the long term he would as a result contribute to a line of policy that went against his convictions: *"It is therefore about my social conscience."*

According to various interviewees, moral condemnation in the debate is then so strong that people whose opinion differs from the politically correct standpoint no longer dare to open their mouths for fear that they will *'appear on the front page of the press'.* When a more sensitive topic comes up in one of the interviews, one administrator notes: "*In the public debate, I can naturally never say that out loud, can I, because then I belong to the wrong camp. I think that as a result we do not understand what acting with integrity does and does not involve."*

Unrestrained regulation is also highlighted as a factor that causes the debate to fail. Instead of trying to understand problems by talking about them, it seems that each problem has to be framed within a new rule, says one interviewee. When, for example, in the healthcare sector there was a lack of corporate vision, a policy was conceived to attracted administrators from outside. A logical consequence of that was that wages started to increase. In order to tackle the excesses that have occurred, new rules are now again being framed. However, according to this administrator, sustained solutions come from a different angle: *"We should tackle the debate as to what is now a good remuneration for someone who does this sort of work. So that you also reassure them that remuneration is permitted."*

INCENTIVES WITHIN THE SYSTEM

In addition to the three previously mentioned situations in which acting with integrity is not clearly defined in rules or agreements, situations are also mentioned in which integrity is threatened even when the rules of the game are clear. One of these concerns perverse stimuli in the current funding system, or characteristics that invite behaviour that is lacking in integrity.

Thus, the fact that institutions and specialists are paid for procedures (for example on the basis of a complex and extensive number of Diagnosis Treatment Combinations) encourage them to treat more or, on the contrary, less than is desirable for the patient, or even to declare more care to the health care insurer then actually occurred in practice. Administrators recognise that this behaviour could occur, but at the same time note that the scale of the problem suggested in the public debate is exaggerated. Someone notes: *"I find the emphasis on combating fraud and the idea that there is so much fraud in fact completely exaggerated on the basis of the figures."*

In addition, interviewees stress that it does not help to interpret the effects of paying for procedures in terms of integrity or a lack of integrity. This is because there are many shades of grey between behaving with integrity and behaving without integrity. At the beginning of this spectrum, for example, there is an incorrect declaration because the system is so complex and requires such detailed information that it is difficult to record information in exactly the right way. Reference is also made to a lack of knowledge and of knowing better: *"The overwhelming majority is related to a culture of 'we have always done it this way and people are still satisfied?''.* Somewhat further along the spectrum, for example, is giving in to social pressure. This already goes further in the direction of acting without integrity, but is still not the same as outright personal financial gain: "*If you are a doctor who performs few procedures from which money can be earned, for example because you are more of a talker, then the patient is satisfied, but not your mates. So how do you keep your position in the group? You also have your own urge to survive."*

A second stimulus that can induce behaviour that is lacking in integrity is the agreement that institutions may only offer treatments for which they must meet annual volume standards in order to guarantee quality. Imagine that a hospital may only continue a certain treatment if fifty procedures are performed annually. If then in November the counter stands at forty-nine, that can encourage the institution and the specialists to proceed to treat a certain patient, although from the patient's perspective that is not necessarily the best option. Motives that are lacking in integrity can then start to play a part, such as the sense of pride in continuing to be able to undertake a certain treatment with a centre.

In relation also to the pursuit of volume standards, interviewees stress that it is too black and white to say that this is always driven by personal interests or other motives that are lacking in integrity. Thus, one administrator explains that volume standards ensure that it is not clear how to act: *"Before you know it, the wrong picture emerges: because the IGZ obliges me to focus on volume standards, my employees can implicitly assume that I'm satisfied if they ensure that the volume standard is obtained."* Other motives can also play a role. Thus, doctors are trained to intervene, so that they are not accustomed to examining when it is better for the patient to refrain from treatment. Or a team spirit to reach the volume standards arises from the idea that patient care in the region will suffer if a certain treatment is no longer provided. This does not make the behaviour any less undesirable, but it clearly illustrates the fact that it is wrong to think here in terms of the extremes of virtuous doctor versus fraudster.

At the same time, administrators report that there are too many rules and too few substantive discussions about what is good care. Thus, one interviewee remarks: *"We think that we can resolve these sorts of questions of integrity by devising ever more rules, but that is just an illusion. You will only solve it by engaging with one another in the real discussion."* What is the most sensible treatment for a patient? And how is it that this patient developed this disease in the first place? Such questions are posed too infrequently. Another administrator remarks that professionals experience recurrent tension between what they receive money for and what they themselves find important: *"Many professionals have the feeling that they have no time for doing the things they would like to do. But if we all think that certain things are important, then obviously it is a matter of defining priorities."*

PEER PRESSURE

Lastly, peer pressure is highlighted as a factor that can be a threat to integrity. Independent partnerships of medical specialists would appear to be particularly vulnerable in this respect. On this issue, the opinion of the outside world was given less of a hearing and it was discussed predominantly from the internal perspective of the organisation.

When a group of the same people work together with one another for a long time, a group culture develops in which one no longer talks honestly and critically to one another about behaviour that is lacking in integrity, but covers for one another. One administrator states that a lack of hierarchy can exacerbate this still further: *"Matters fester for much too long in such a partnership. But if there was someone who was the boss, then they could say: 'Wait a minute, we're going to do something about that for once. But because they are constantly thinking: 'today him, tomorrow me', they keep a lot of things quiet."*

Ethical behaviour comes under particular threat when a strong group culture is combined with a negative atmosphere. One interviewee finds it worrying that insufficient attention is paid to personal development in certain partnerships. Everyday routine takes precedence. This ensures frustrations and a lack of meta-perspective, according to the interviewee: *"In the end it is about a patient sitting opposite a healthy doctor. And they are experiencing all sorts of things in their life. Including frustrations and these must find an outlet*." When the common aim is lost from sight, money, and status threaten to start playing an important role, this person goes on to add.

A negative group culture has various negative consequences for integrity in an organisation. In the first place, it has been shown that particularly in a work atmosphere in which there is strong group pressure and close relationships, it is more difficult to denounce unethical conduct. Someone mentions as an example that if the person of confidence takes to the hockey field with his colleagues at the weekend, there is a very high threshold for approaching that person of confidence with a complaint about a colleague. Within a culture in which everyone covers everyone's back, it is also risky to act as a whistleblower because there is a strong tendency to blame the messenger.

Secondly, a negative group culture threatens to undermine the interest of the patient. When, for example, a doctor reports that a certain high-risk treatment is being continued for too long, it may be difficult to talk openly and critically about it because he can as a result lose social credit with his colleagues. In addition, mutual frustrations will ultimately be to the detriment of the focus on the patient.

Thirdly, a closed and homogeneous social system can lead to unequal work relations in which specialists who deviate are disadvantaged, for example because they are the only woman in a male society or because they are younger than their colleagues.

Moral loading inhibits constructive debate

In discussing these five situations in which integrity comes under threat, we were struck by the fact that integrity is a highly morally loaded concept. Conduct that is seen as lacking in integrity is subject to such strong social condemnation that a constructive discussion about causes and solutions is no longer possible. In various discussions,

such as those about remuneration of administrators, only the politically correct perspective can still be mentioned and an atmosphere of taboo develops. The fact that the question of when integrity is threatened is consistently discussed by the interviewees from their own perspective and from that of the outside world shows that administrators are continuously aware of society, politicians, and the media looking over their shoulders. Politicians place emphasis on transparency. The media discuss questions of integrity exclusively from the personal perspective. In addition, infringements that occur relatively infrequently threaten to assume a generic connotation, as a result of which a picture is wrongly portrayed that fraud and grasping behaviour are occurring on a large scale. One administrator states that he himself tries to give his employees as much trust as possible, but that he does not have that trust himself and that it therefore can be a tough job to protect employees from negative judgements from the outside.

We described earlier how integrity can be used both for situations in which it is absolutely clear what is misconduct and for situations in which it is unclear what constitutes acting with integrity. The interviewees state that they struggle in particular with the grey areas and express a strong need for the possibility of being able to speak constructively and without prejudgement about it. However, it is precisely over the struggle with grey areas that the discussion appears to be stifled. In the media and in the public debate, integrity is defined as adhering to rules and thus as an antonym of fraud. Administrators do not want to be associated with this behaviour, therefore they dare not speak up about what they themselves associate with integrity, i.e. struggling with complex balances of interests in grey areas where it is not possible to define in advance what constitutes acting with integrity. There is naturally a world of difference between making yourself guilty of intimidation and self-enrichment, and weighing up how to deal virtuously with conflicting interests in a round of redundancies, but because both of these are lumped together under integrity, people are afraid that talking about struggling with integrity will be directly associated with misconduct.

Conclusion

The administrators interviewed described various situations in which integrity in health care organisations regularly comes under threat. These vary from situations in which it is clear what constitutes conduct that is lacking in integrity, but where the temptation is apparently still too great (gross misconduct), to situations in which it is not clear what constitutes acting with integrity (grey areas). Five situations regularly come up: conflicting interests and expectations, dealing with errors, remuneration of administrators, perverse incentives within the system and peer pressure. In the discussion of these situations, it is striking that integrity is a morally loaded concept. Conduct that is seen as lacking in integrity is subject to strong social condemnation, often involving personal attacks, so that a constructive discussion about causes and solutions is no longer possible. What does not help here is that integrity is used in the

public debate as an antonym for fraud and other forms of gross misconduct. The fear of being associated with such behaviour prevents administrators from speaking up about what they themselves associate with integrity, i.e. struggling with complex balances of interests in grey areas where it is not possible to define in advance what constitutes acting with integrity.

4 Promoting integrity

In this section, we describe the procedures mentioned by administrators for promoting integrity. In the process, we distinguish between a rules-based and a values-based approach. We then reflect on the limits of the influence that administrators can exert on the integrity of employees and we examine how professionals themselves promote integrity.

Before discussing the procedures, we must first make two comments. Firstly, we saw in section 2 that people interpret the concept of integrity differently, as a result of which administrators probably differ in their views of what constitutes suitable procedures for promoting integrity. Secondly, the administrators we interviewed are generally reticent about the extent to which they exert an influence on integrity within their health care institution. However, none of the administrators states that they have absolutely no influence.

Integrity policy

From the discussions with administrators, we conclude that some form of integrity policy is applied in almost all institutions. One of the interviewed administrators states that within his institution there is an integrity and fraud committee that draws up policy: *"What we understand by integrity, what rules should apply, how we deal with it and how we make it open for discussion. And how we keep our finger on the pulse and reports can be made. The committee also discusses complaints about integrity and fraud".* On the basis of the interviews, however, we have the impression that most health care institutions tend more to apply loose procedures and methods rather than having formulated a coherent integrity policy.

In section 2 we distinguished between, on the one hand, situations in which it is clear what constitutes acting without integrity and, on the other hand, so-called grey areas in which it is not possible to define in advance what constitutes acting with integrity and to what extent the person involved must themselves make a decision. Further to this, we distinguish two approaches to promoting integrity. In situations where it can be clearly established what constitutes acting without integrity, or in order to prevent this, a rules-based approach can be employed. Examples of this include fraud, invasion of privacy,

abuse, engaging in relations with clients, and bribery. In a rules-based approach, use is made of formal and detailed regulations to combat infringements of integrity and to prevent corruption (OESO 2009). These rules, laws, standards, codes, protocols (and their associated sanctions) operate as guidelines. This approach also has its limitations. A first limitation of a rules-based approach is that it merely provides a lower limit and does not encourage administrators and staff to aspire beyond this lower limit. Another limitation is that a rules-based approach is insufficient for the previously mentioned grey areas, because these often involve conflicting values or rules. A values-based approach, however, could provide some consolation. This focuses on stimulating insight into values and their daily application and on promoting moral competences of employees (OESO 2009).

In this section, we divide the proposed procedures according to the difference between rules-based and values-based approaches. Obviously, the difference is not so dichotomous in practice and approaches overlap one another.

Rules-based approaches

Examples of rules-based procedures that we encountered in the interviews are codes of conduct, the use of objective indicators for monitoring integrity, a whistleblowers' charter and the adoption of sanctions.

CODES OF CONDUCT AND PROTOCOLS

Almost all the administrators interviewed state that their organisation has a code of conduct. There are also sometimes specific protocols, for example on privacy and abuse. These documents contain rules about the desired conduct of employees and managers. Familiarity with the codes and protocols within the organisations is shown to differ somewhat. One administrator states that there is a code but that his employees probably do not know it. According to the administrator concerned, this is not a serious problem because it contains aspects that everyone knows about. In another organisation, on the other hand, efforts are made to communicate the rules of conduct to employees. Several administrators state that employees entering service are given the code of conduct or rules. The codes of conduct of the institutions whose administrators we interviewed in most cases also include values-based elements as well as rules-based elements. For example, these codes encourage discussing difficult situations, talking to one another about behaviour and setting a good example. One example is the Philadelphia code of conduct, which concludes with: *"It is important that we keep discussing this code of conduct and the standards that lie at its basis with one another. Therefore, put the code of conduct on the agenda for your annual team meeting."* (Philadelphia 2014).

MONITORING

Monitoring is an example of an approach that can be applied within both rules-based and values-based approaches. Using objective indicators, monitoring attempts to gain insight into how integrity is viewed within an organisation. The interviews show that this happens in each case in two organisations. Indicators used in these institutions are the number of complaints, the prevalence of complications and patient experience. If there is a correlation between these objective indicators and the components that are grouped under integrity, then indicators can have a, possibly limited, warning function. One administrator states that these signals, together with qualitative information, have led to discussions within his organisation with an expert group and to the instigation of coaching programmes. Another administrator reports that two investigators monitored discussions in the lift and in this way charted how often staff talk about patients. The outcomes of this study are then placed in the staff journal to draw the organisation's attention to the responsibilities that employees have and to the fact that you are obliged to abide by certain agreements in public spaces. We see here that a rules-based approach of monitoring is linked to a values-based approach of communicating desirable behaviour.

WHISTLEBLOWERS' CHARTER

Relatively little was said during the interviews about whistleblowers' charters. Several administrators did say that there is a whistleblowers' charter within the institution. It came out in one of the discussions that it is important for example for a junior doctor to be able to report abuse and that he or she must then be protected. One interviewee also emphasised how difficult it is to whistleblow and to report abuse in a company.

The revised Health Care Sector Governance Code (ZGC) has been effective since January 2010. This code includes the fact that employees can safely report serious abuses in the company without the reporter having to fear being disadvantaged in his or her legal position. This whistleblowers' charter must be made generally known (ZGC 2010). On the basis of this code, the joint Health Care Sector Organisations (BOZ) have also produced a model whistleblowers' charter. Figures from the Advice Centre for Whistleblowers (a free advisory body for people who suspect wrong-doing in or around their work) show that a relatively large number of the cases it handles come from health care. Possible reasons for this are that there is a lack of formally defined procedures in health care and that not all organisations have a whistleblowers' charter (Skipr 2015). The fact that not all health care organisations yet have a whistleblowers' charter raises the question of whether the Health Care Sector Governance Code is being adhered to. The code has recently been introduced and the number of organisations with a whistleblowers' charter has possibly increased since then.

SANCTIONS

Several administrators state that situations occur in which conduct is so lacking in integrity that an intervention must be made and a sanction must follow. This does not just involve calling to order the employee who has not acted with integrity, but also giving a clear signal to the whole organisation as to where the limits lie. The aim is therefore also to prevent unethical behaviour in the future. Thus, one administrator states that in the case of fraud, he intervenes explicitly, for example by involving an outside agency, or suspending people on suspicion of fraud. Sanctions vary from a reprimand in the personal staff record to immediate dismissal in extreme cases. One administrator points out that a number of behaviours are unacceptable: "*there are therefore a number of things where it is clear that no discussion is possible. And if you do that, then you are out".* Another administrator mentions the example of immediate dismissal if someone logs in to the Electronic Patient Record (EPR) to look at the record of the neighbour's child. Obviously it is important that it is clear what behaviour leads to sanctions

RULES-BASED APPROACH APPEARS LESS POPULAR

It struck us that all the administrators to whom we talked remarked on the shortcomings of a purely rules-based approach. However, rules are formulated within the institutions of all those interviewed and several administrators also find it important that a code of conduct is drawn up in a health care organisation. Thus, it is clearly stated within the organisation what is understood by acting without integrity and a lower limit is set. In order to be effective, these rules of conduct must be communicated in a way that is accessible to the target group and it must be predictable as to what sanctions will follow in the event of infringements. The moral dilemma that exists between punishing errors and creating a safe culture in which to discuss errors and learn from them, as mentioned in section 3, comes into play here (p. 25).

A values-based approach

Examples of values-based procedures and methods that we encountered in the interviews are the focus on core values, the focus on openness and a willingness to discuss, and setting a good example oneself.

FOCUS ON CORE VALUES

Most institutions have formulated a mission, a vision and sometimes also explicit core values for which the organisation stands. What is striking is that the core values of different institutions are reasonably consistent. Core values such as reliability, professionalism, and politeness or friendliness, including customer-friendliness, recur several times. The extent to which this mission, vision, and core values are known to employees and are used as an instrument differs between institutions. Several administrators state that they are probably little known if at all to employees. Conversely, one administrator expects that all employees should know the

organisation's core values: *"you should be able wake up a random employee at night and he can then name all the core values."* The health care organisation concerned offers various forms of health care. The administrator states that it is precisely the core values that bind employees together. Another administrator states that the core values play a role in employing new staff. Each employee must possess a number of basic skills in order to implement these core values. Yet another administrator says that they consider it important that employees relate primarily to their own standards and values. According to the administrator this works much better than documents such as codes of conduct. Authenticity as a component of integrity is again apparent here.

EMPHASIS ON OPENNESS AND WILLINGNESS TO DISCUSS

Administrators mention various procedures for focusing on openness and a willingness to discuss. This involves communicating desired behaviour, entering into discussion about this with one another and offering room for reflection. These procedures appear to focus specifically on components of integrity such as virtue and reflection.

A number of administrators state that within their organisation attention is paid to the communication of desired behaviour and to making it open for discussion. In one institution, a theatre performance involving sketches is used and these are then discussed in teams. In another institution there is a plan to introduce a comic strip so as to be able to portray the grey areas in this way. One administrator remarks that it is important that the method of communication is adapted to the target group.

Several interviewed administrators emphasise the fact that discussing and reflecting on questions of integrity is very important for promoting virtue and reflection, two components of integrity. This occurs in various institutions via systematic discussion techniques such as moral counselling or a Socratic discussion. One administrator states that moral counselling helps to discuss complicated issues at both low and high levels of the organisation. The Supervisory Council can also use this for questions about Board remuneration. One hospital administrator states that these methods of discussion are use relatively often in intensive care but hardly at all in other departments. Yet another administrator states that each care provider in the institution can convene a consultation: "*in the consultation, you are invited and challenged to actually say to one another what you are worried about, under the leadership of the site manager. But also, for example, to speak out: 'I see that you do this with the client, but wonder whether that helps the client'.''* One administrator states that it is possible to organise a Socratic discussion in difficult situations, in particular around patients with complex problems. In this discussion, people with different backgrounds examine a situation, as a result of which an unbalanced judgement is prevented.

Administrators use discussions to obtain a better view of what the attitude is towards the integrity of employees within the health care institutions. Thus, one administrator

states that management talk personally to all specialists working in the hospital: *"Three years ago as a management we introduced the idea of holding separate discussions with all medical specialists. Once every three years and sometimes slightly more often."* Another administrator states that he considers it important to talk to various employees. "*I have started to organise lunches for nurses. We then lay the table quite nicely and then they are able to chat to me about everything. But I also say: 'you can't do anything through me, you must do things with your team leader'."* Yet another administrator states that a member of the board of directors has lunch with new employees who have been in service for three months to discover their initial experiences.

In some discussions it is apparent that openness and a culture of open dialogue are of great importance for integrity. According to one administrator, this is still a problem in health care. In everyday business life, people can talk directly and vigorously to one another and then afterwards still be able to get on very well. In health care, however, nothing is said for a long time, which gives rise to the risk that an explosion may occur at a given moment and you paint yourself into a corner, not just as a manager but as a person. As was discussed in the previous section, openness and a culture of open dialogue in partnerships in hospitals can come under threat. The interviews show that it is difficult for administrators to focus on this. Some options are mentioned in the discussions for stimulating a culture of open dialogue. One administrator states that it is important to focus on professionalising nurses and giving them more responsibility. This can improve co-operation between specialists and nurses and better co-operation makes it easier to talk to one another. Furthermore, according to one of the interviewees, it is important to invest in the career development and mobility of medical specialists. At the same time, one administrator pointed to the importance of job discussions for medical specialists via the IFMS system (Individual Functioning of Medical Specialists). This administrator also finds it desirable for new specialists to be welcomed collectively by the board of directors and the partnership.

SETTING A GOOD EXAMPLE ONESELF

A third way of focusing on values is that administrators give a message as to what is acceptable and what is not through their own behaviour. Several administrators point to the importance of setting a good example. Thus, one administrator says: "*I think that as a board of directors you can really play an enormous role by not sitting in your office behind closed doors but simply by being active in house."* Another administrator states that employees find reliability hugely important: *"They look in particular at: does he do what he says that he does? Or does he have a hidden agenda?"* Yet another administrator emphasises the importance of being a good role model: if something goes wrong, the administrator must in principle protect his people and not immediately single out a scapegoat. This administrator also finds it important to encourage employees to constantly improve and be curious, and to follow through with clients.

VALUES-BASED APPROACH APPEARS MORE POPULAR

Administrators see engaging in dialogue, whether or not systematically, and focussing on a culture of open dialogue as important ways of promoting integrity. Focusing on core values is less used by administrators. The question is whether this procedure is actually not complementary to the focus on openness and a willingness to engage in discussion. Must employees not have sight of the core values of the organisation in order to be able to engage in the discussion about integrity? It may be that, by specifically establishing a link with the core values also for certain situations in the grey area, standards can come about and can be focused upon. The interviews also showed that it is important for integrity within the health care institution to set a good example as an administrator. If administrators act with integrity, this can filter through into an organisation, but similarly if they act without integrity. Although there was no discussion about the consequences for the integrity of employees if administrators act without integrity, conversely it is equally to be expected that setting a poor example has a negative influence on the behaviour of employees. The greater attention to a values-based approach contrasts with the image of corporate life. Studies of the integrity policy in the thousand largest American companies have shown that they also use a combination of rules-based and values-based approaches, but that they place the emphasis more often on a rules-based approach (Karssing 2006).

Limits to the promotion of integrity by health care administrators

The interviewees emphasise that the extent to which administrators can promote the integrity of employees has its limits. Employees are in principle largely responsible themselves for acting with integrity. This probably applies probably even more in health care than in other sectors because of the nature of the relationship between the patient or client and the professional and because of the highly organised professional groups. In addition, there is self-regulation from government and branch organisations by which administrators must abide *de jure* or *de facto*.

SPACE AND TRUST

The relationship between the patient or the client and the professional is characterised to a greater or lesser extent by inequality of information (between patient and care provider, but also between administrator or manager and health care provider), by uncertainty about the treatment and its outcome, and by the dependent position of the client or patient. Administrators often have a limited view of the health care process and have difficulty measuring whether it is going well. As a result, they are required to accord professionals space and trust. Administrators generally consider it a good thing to accord trust and space. One administrator states that health care often takes place in a private setting, as a result of which the administrator must in fact rely on the integrity of professionals. According to this administrator, it is important for this reason to tackle the discussion of integrity with employees. Several administrators say that in this case

the principle of ‘high trust, low tolerance’ applies: considerable trust is accorded, but if things go wrong then they will intervene.

POLICY FROM THE PROFESSIONAL GROUP

Compared with other sectors, professional groups are relatively well organised within health care. They are often supported by legal recognition, registration, and disciplinary codes. In the specific case of medical specialists, a further factor is that they have organised themselves into partnerships, some of which are independent. In that case, the hospital management has no direct say over the specialists.

Various procedures and methods are also deployed by the professional groups to promote professional integrity, such as a code of ethics and an oath. One interviewee sees particular opportunities for promoting integrity through the professional sphere and in particular through reregistration. By specifically making personal development compulsory for reregistration, more room is created for openness and for talking to one another.

There is also the question of whether policy from the institution and the professional group is mutually reinforcing or whether it specifically clashes. Thus, one of the administrators points out that the codes of the institution and the professional group do not always coincide. The professional group in particular has the tendency to introduce more rules and standardised methods. One of the interviewed administrators points to the interest that professionals with specialist expertise (also known as ‘classic professionals’) attach to their own responsibility. According to the administrator, classic professionals want to set up their own framework of integrity, while employees with a nursing role, for example, find it important to have a clear set of rules. *“When professionalism becomes important, people also tend to want to draw up their own rules more. They want to define their framework of integrity themselves and it is therefore more difficult to produce good regulations here. Whereas carers in home care want to have a set of rules. That is easier in itself and the penalty if things go wrong there is also much lighter.”*

POLICY FROM GOVERNMENT

Government and the health care sector organisations impose regulations and self-regulation in the field of quality and safety. This touches on the different components of integrity, such as virtue and critical reflection. Examples that were mentioned several times in the interviews are the safety management system and the ability to report incidents safely (VIM system).

The nature of the relationship between the professional and the patient/client, and the strong professional atmosphere are a possible explanation as to why relatively more stress is placed on a values-based approach than on a rules-based approach in health

care. The question is how this relates to the development in health care in which increasing emphasis is specifically coming to be placed on control systems and regulations.

Conclusion

The administrators interviewed take a balanced view of the influence that they can exert on integrity in their institution. Ways of promoting integrity can be subdivided into approaches that focus more on rules and approaches that focus more on values. Rules-based approaches are particularly well suited to the promotion of integrity in situations where it is clear what constitutes ‘acting without integrity’. All those interviewed indicate that their institution formulates rules and where necessary imposes sanctions, but they stressed that a purely rules-based approach is not enough. Values-based approaches can count on greater enthusiasm. These can help to resolve what are referred to as ‘grey areas’, which involve conflicting rules or values. Moreover, administrators can achieve higher ambitions by focussing on values than focussing on the lower limit targeted by a rules-based approach. Finally, administrators generally have no direct involvement in the private settings in which health care is provided. As a result, the administrator is required to rely on the integrity of the professionals and focus on facilitating reflection on values.

5 Conclusion

When undesirable situations occur in health care, this is regularly attributed to a lack of integrity. As a result, health care organisations are increasingly focusing on integrity policy. In this report, we studied the options and limits for administrators to promote integrity in health care organisations. There is no clear definition of the term, integrity. We point out two pitfalls in the use of the term. The first pitfall is that the term is interpreted so broadly that it loses its meaning. The second pitfall is that it is reduced to the antonym of fraud or to adherence to rules, as a result of which the significance of integrity as virtuous conduct is lost. Integrity is often presented as a dichotomy, but there are many shades of grey between complete integrity and complete lack of integrity. We define integrity as a multilevel property with four components: reliability, virtue, authenticity, and reflection. Integrity is both situational and dynamic in nature. This implies that administrators of health care organisations are required to relate to changing conceptions of integrity.

The administrators we interviewed point to a number of situations in which integrity in health care organisations is regularly under threat. Thus, conflicting interests and expectations, dealing with errors, remuneration of administrators, perverse incentives and, peer pressure are mentioned. The first three situations involve wrestling with integrity in what are known as ‘grey areas’: integrity is under threat because it is not clear what acting with integrity is. Those involved must themselves draw their own conclusions. In the last two situations, there are clear standards and rules as such as to what acting with integrity involves, but there is a temptation to deviate from them. What was striking in the discussion of these situations was that integrity is a morally loaded term. There is strong social condemnation of behaviour that is considered to be lacking in integrity and often involves personal attacks so that an open debate about causes and solutions is no longer possible. Added to that is the fact that integrity in the public debate is used as an antonym for fraud and other forms of misconduct. The fear of being associated with such behaviour prevents administrators from speaking up about what they themselves associate with integrity, i.e. wrestling with complex balances of interests in grey areas in which no indication of what constitutes ethical conduct can be given in advance.

Administrators take a balanced view of their ability to influence the integrity of their institution. They ways in which health care organisations try to promote integrity can be divided into rules-based approaches and values-based approaches. The administrators of health care organisations to whom we talked prefer a values-based approach. This approach can provide a lead in grey areas which involve conflicting rules or values. In addition, a values-based approach is focussed on ambitions that exceed the lower limit targeted by a rules-based approach. Finally, administrators generally have no direct involvement in the private settings in which health care is provided. Thus, the administrator is compelled to rely on the integrity of health care professionals and focus on facilitating reflection on values.

The preference for a values-based approach expressed by the administrators present them with an awkward dilemma. This is because at the same time administrators are accountable to supervisors, health care insurers and in the public debate for exerting control and adhering to rules. The discussion about virtuous behaviour in the light of complex considerations and the values-based approach to promoting integrity is closely reflected in the public debate. That is unfortunate because rules only offer a lower limit. Should we not be more ambitious and tackle the debate about grey areas in which integrity is coming under threat?

It is important that the dialogue about integrity in health care organisations be conducted in a balanced and impartial manner. Accordingly, in response to this report, the CEG will be organising a series of dialogue meetings to address dilemmas associated with various integrity-related issues.