ETHICAL LEADERSHIP IN HEALTHCARE INSTITUTIONS FROM ROMANIA. AN APPROACH FROM A MANAGEMENT PERSPECTIVE

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Abstract
Ethical leadership and its beneficial role in health care institutions enjoy increasingly more attention and debate in the scholarly literature. However, different theories and models focus more on the person, personality and leader traits, rather deepens concrete strategies and tools to be applied in the practice of ethical leadership, to its close connection with the management of ethics.
Our article presents the results of a pilot-study conducted among 52 people in leading positions in six hospital institutions from Iasi, Romania, related to the practice of ethical leadership, from a management perspective.

Keywords: *ethics management, ethical leadership practice, hospital*

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1. Ethics management and leadership in healthcare institutions – a necessary Siamese connection

The institutions that provide healthcare services and contribute to the well-being and successful subsistence of communities have been carefully subjected to public scrutiny. First of all, the individual's right to healthcare is a fundamental right stipulated by the constitution of every modern state; consequently, a thorough and serious concern, strengthened by a relentless pursuit, is required from the organizations with a recognized social mission. Secondly, any dealing with public resources demands responsibility from every public manager, and consideration of efficiency and transparency. Thirdly, the organization's mission is carried out only with the aid of the people involved, of the human resources attached to the organization's cause – "People are everything" [38]; and this entails to interest and motivate them in taking part in the activities and the goals to reach, to treat them with respect, to honestly communicate with them, to listen, understand and empathize with their problems, to compensate their effort and behaviour under equity conditions. The way employees are mobilized by the institution's managers determines the quality of the healthcare service and renders a successful image to the public. Thereby, managers must not only be good administrators, but also leaders able to work with people.

In the healthcare field, the theory of management and leadership is built on the premise that "all professionals are leaders" – "any person whose authority is acknowledged and whose expertise engenders supporters that use it in reaching their objectives … and anyone who has the responsibility to provide assistance for others … is a leader" (healthcare staff and students are leaders for their clients, the chief-nurse is a leader for the team-work"). Managers are responsible for the general objectives of the organization and influence others' behaviour through their acquired authority; at the same time, there are leaders who had been assigned only some of these objectives and they can exert their influence either personally, or through representatives [39]. The application of the management and leadership theory encompasses both the role of manager and the function of the leader [39]. Barr and Dowding [2] underscore the fact that "management and leadership should work together in order to reach the common goal of providing the patient with an effective quality healthcare". Only a tight connection between management and leadership can ensure the success of the organization: "leadership defines the direction, empowers and authorizes, but without the manager's competence the former can't be ensured" [47]. Moreover, the management of these institutions "requires a leadership, which is to be lived at the highest ethical standards" [9]. For a profession like medicine, "whose basic obligation is morality, ethical leadership is essential … and doctors', accreditation associations and organisms […] must be seen functioning in an altruistic manner, which demands an ethical leadership" [21]. The ethical behaviour of the leader lends itself today to much critical scrutiny and close observation [6]. Locke (quoted [10]) emphasized that "ethics is at the core of the leadership because the objective of a rational leader is to integrate together the interests of all parties involved so

that all of them would benefit from it and the organization would prosper". Organizations from all fields of activity can undergo a change in their organizational culture by developing a powerful, formal system for the application and administration of organizational ethics (ethical policies and procedures applied especially in human resources management, ethics committees, ethics officers/counselors, ethics codes, ethics programs, etc.), but this is not a guarantee for the creation of an ethical spirit, but only a preliminary condition for "ethical regimentation". Among Lao Tzu's reflections, which refer to ethical management [27], there is one according to which "a manager should insist upon moral management … with the help of decision-making, leadership, stimulation and control …". Consequently, the effectiveness and efficiency of this system depend primarily on the leadership applied to managers, on their personal example, on the way in which they succeed in inspiring trust in others, and on helping and encouraging them to work for reaching the established objectives and goals [10]. This leadership "will always exert the highest influence, irrespective of how effective the formal communication of ethics might be" [44]. The involvement of the personnel in defending the organization's reputation will hinge on how effective the leaders' communication about the importance of its ethics proves to be. They are the ones who shape the ethical environment of the organization through the attention that they pay to different aspects of its activities, the way they react during crises, they behave, reward, hire or dismiss employees [44]. We could state that ethical leadership represents "the soul", the living quintessence of an authentic, organizational ethics system.

On the leaders shoulders fall the paramount task and responsibility to create an organization with high standards of integrity and whose activity is based on values [15]. Ethical leadership has been often claimed to have contributed to the long-term success and survival of organizations. The moral principles of the leader and his/her integrity "convey legitimacy and credibility to the organization and lend to it their support" [31].

Leaders from the healthcare system "play a key-role in establishing and improving ethical practices and standards", in the context in which they, themselves wield the function of leadership [22]. McNee [30] views ethics as one of the 3 secrets of the responsible leader (characterized by an active taking on values and by promoting ethical actions), along with emotional and social components (the secret of an efficient leader manifests through self-awareness, personal management, social awareness, relational management and power – the secret of the leadership which aims to influence others, a leadership closely connected with the concrete and effective use of power). Johnstone [22] underlines the profound relationship between ethical leadership and effective leadership which in many ways are synonymous. For the author already mentioned, effective leadership presupposes "ethical influence on other persons in order to carry out the vision of the organization and to trigger a positive, constructive change for the moral benefit of the stakeholders" [22]. This idea is confirmed and strengthened by Swansburg [43], according to whom "an ethical leader

is an effective leader", and also by Johnson [20] who considers that the leader must be "effective, efficient and excellent" so that the human potential is not turned to waste. Erikson [11] identifies four critical traits that a public administrator should demonstrate to possess as a leader in front of his subordinates: honesty (truth, ethics, principles, trust), foresight or prevision (sense of direction, concern for the future, long-term vision, selection of the direction approved by stakeholders), competence (implement the organization's vision, pertinent experience, capability to carry out things) and ability to inspire (enthusiasm, hearty communicator of the vision in order to instil in his/her subordinates the desire to follow him/her, presentation of the plans). This enumeration contains a single characteristic directly linked to ethics, but the others also refer to an ethical dimension because there is a need for taking responsibility for the actions performed. These traits must be perceived as such by the others in order to earn their trust and subsequent follow-up. Moreover, the author emphasizes the necessity of a partnership, of creating a team formed by the leader and his/her subordinates pursuing the common good.

1.1 Ethical leadership and decision ethics in leadership

In the scholarly literature, there are several approaches and models of ethical leadership (see [12], [23] [3]), but also of ethical decision-making in leadership (see for example Rest, quoted [37], [34], [33]). And there are approaches which combine the two sides (see for example [46], [32], [20]).

We could say that the first category represents the conceptual part (who and what), while the second one the technical, applicative part (how). Their analysis shows the differences between them – the first approach starts with the person of the leader (role, values, his/her traits/qualities/abilities, his/her character or what defines him/her), whereas the latter is based on the study of the leader's competences (knowledge implementation, use of his/her abilities, coordination of specific moral actions).

Grace [12] proposes "the model of the four V" – Values, Vision, Voice which form together a triangle whose centre is the Virtue. According to this author, ethical leadership has as its starting point the requirement to learn and know the essential values and to develop a form of discipline that will help to integrate them in daily life. Values are meant to serve others, and this implies a latent Vision, which leads to Voice (undertaking a public action based on the vision); and this operates the passage from work to polis (city; an engagement in the art of politics) which can be expressed in different ways (oral, written, action) and which entails an on-going process of value renewal. Virtue signifies the Common Good and requires from the leader to reflect on Values, Vision and Voice in order to sustain the Virtue.

Kellar [23] argues that promoting an ethical leadership involves: setting up intrinsic standards higher than those necessary, open sharing of information, lack of interference in politics, respect for the given word, unwillingness to accept or demand gifts, speaking the truth and caring for its accuracy, careful yielding of power, constant improvement of knowledge and abilities and creation of a learning environment within the organization, acting with honesty and based on

merit, respectful and polite treatment of fellow workers, encouraging employees to seek advice, sharing the passion for public service and taking fully on the responsibilities that public service entails.

According to Bellingham's [3] synthesis of the good practices, based on the scholarly literature, the ethical leadership means: to stir up processes, to encourage, to militate in favor of consistency and congruency, long-term thinking, to have an overview of things, to support the involvement of employees and their capacity to learn, to delegate (share) the power, to promote the diversity of opinions, to create proper working conditions, to develop, build interdependent relationships, the community, to assume responsibility, to prioritize people and creativity, to strive to be authentic, to engage in stimulating collaborations, to generate stories of integrity, to create a trust culture.

In large organizations, where the executive management is more distant from employees, not close enough to them or even not known to the personnel at the bottom of the hierarchy, ethical leadership is based on the Treviño& Nelson's model [46] which brings forward the issue of reputation built upon two pillars: the moral person who shows employees how a leader should behave him/herself (exhibits ethical traits, behaves ethically, takes honest decisions grounded on values), and the moral manager who, in demonstrating to employees how they should behave themselves and how to act responsibly, uses the role of example/model (that renders visible the ethical action), the tools of reward and discipline, and the communication of messages about ethics and values. Therefore, the leader's character and the instruments he/she chooses to use combine together in forging the legitimate power that he/she wields as manager. "The form in which is exerted" this power "indicates the moral principles and values" of the leader [40].

The model proposed by Kanungo&Mendonca ([32], [18]) draws attention to the dimensions of ethical leadership: the leader's motivation (the ethical leader must always foster good intentions and be altruistic, cf. Johnson [18]), the influence strategies put in use (transactional, based on legal power, reward or coercion, or transformational – the use of the power of expertise and reference which consolidates the self-determination capacity and the belief in self-effectiveness of the subordinates), and the leader's character (stamped by the individual's spiritual dimension which offers the leader the means to develop him/herself as a moral person responsible with the setting of the moral environment of the organization). The first two dimensions are the fruits borne by the leader's character.

Johnson [20] identifies four inter-relational components which contribute to the application of ethical leadership: Aim (the leader is focused, motivated and acts with the aim and objectives of the organization in mind); Knowledge (the leader possesses the necessary knowledge for judging and acting cautiously; the knowledge is acquired from the internal and external environment of the organization and is shared with others); Authority (the leader has the power to make decisions and act, but this ability is equally recognized to belong to those involved and affected); Trust (the leader inspires

trust and is trusted within the organization and in his/her larger action area). Knowledge and trust form the basis for the leader's legitimate authority.

Rest (quoted [37]) states that the four components of ethics in decision-making processes are the following: moral awareness (the correct perception of a situation which entails ethical aspects – the first task of a leader consists in increasing the awareness of ethical dilemmas, cf. Grace, [12]; moral reasoning (determining an ethical course of action); moral intention (identification of values which should have priority in ethical decision taking); moral behaviour (conduct based on ethical decisions).

Ncube and Wasburn [34] propose "a model of synergetic mentoring" for ethical leadership in the decision-making process which is called Strategic Collaboration for Ethical Decision Making. This model mixes together the strong points of the other two models - Appreciative Inquiry (the collaborative search for the best people, their organizations, their universe and the discovery of what makes them effective and capable to do their best work), and a mentoring model (the guidance, support, knowledge and opportunities that an experienced person passes over to a less experienced one or to a protégé; this is a "mechanism for ensuring the continuity of a powerful corporate culture and of a common set of values and expectations", cf. Wilson and Elman (quoted [34]); this latter model is based in its turn on several alternative mentoring models. The Strategic Collaboration for Ethical Decision Making is meant for the creation of a positive support structure, endowed with the necessary mechanism, so that organizations "can develop and maintain their structures and processes in ensuring the ethical dimension in decision-making". The model can be used in engendering an ethical organizational culture and starts with the premise that "leadership is supportive and that the organization provides enough resources for ensuring a place for ethics in decision-making processes". The model has a major component pertaining to authorizing an ethical evaluation (focused on the stakeholders' needs; it is collaborative, participative, and directed towards action, paying heed to authorizing processes and results). The latter, along with responsibility, when seriously undertaken, are important ingredients in elevating the level of trust in organizations.

The model's functioning depends on a positive group of individuals, among which at least one should have seniority, group that offers mentoring in critical analysis and in ethical problems and dilemmas solving in organizations. They answer questions, provide information, ensure the acknowledgment of a new organizational culture, and combat the isolation that the new environment might produce.

This model shows that there is a need for specific competences (to approach and solve problems), as well as for the creation of a formal framework for ethics within the organization: the environment which conveys authority to its application and functioning. In this way, the person charged with the authority and responsibility to promote ethics in organization "must be endowed with the necessary instruments for solving complex, ethical dilemmas", for

applying ethical reasoning and strategies in order to make effective, ethical decisions because good intentions are not enough in these situations [35].

Another model concerning the leader's ethical decision-making brought to light by Nikoi [33] argues that in order to exercise the judgments of an ethical leadership, a six critical stages process must be covered: 1) the understanding and identification of the mission/vision for the particular situation; 2) the analysis of the ethical sensibility specific for that particular problem/situation; 3) the analysis of different decisions from an ethical perspective; 4) the examination of the motivation inherent in the necessity of the ethical decision; 5) making the decision with the best impact upon stakeholders; 6) revision of the decision made.

1.2. The institutionalization of the ethical leadership – the strategies and instruments needed in order to render it effective

Nevertheless, ethical leadership is often an extremely volatile theory because of the numerous models advanced by various authors. There are few organizations that retain ethical leadership issues in their assessment grid pertaining to management performance. At a closer look, ethical leadership is reduced to the individual's consciousness and common sense (hence, it depends on the person's character and on his/her level of moral development, and not all leaders get to develop an "ethical mind", cf. DuBrin [10]. It is, therefore, restrained to the level of individual actions (which is not sufficient, cf. Johnson, [20] and this is not a warrant, but an immense risk to take. Although, the scholarly literature offers a large array of theories and models concerning ethical leadership and its dimensions, there is a clear lack of talk about the concrete, effective and measurable strategies and instruments needed for its implementation.

The passage from theory to action must go through the statutory determination and description of specific competences and of its instruments; in other words, there is a need for "the institutionalization of ethical leadership" in organizations, with the aid of standards and metrics. This aspect is the most significant because the ethical leadership, as it was already shown, should be effective.

According to the researchers from the Center for Creative Leadership [19], the leadership's competence (accumulated abilities and knowledge, including those pertaining to ethics) can be enlarged and this will render individuals more effective in a great variety of leadership-related situations.

The legitimate questions about ethical leadership are the following: How ethical leadership is effectively implemented? Which are its models and instruments? How can one measure its effects? Which are the coordinates and strategies for its constancy and effectiveness? What should a manager in a healthcare institution know and do in order to be an ethical leader? What competences he/she should consolidate? What methods, strategies and instruments he/she should use in order to secure the success of his/her actions?

Studies show that a person's competence in a specific field can contribute to his/her taking into account the ethical decisions; consequently, public managers should avail themselves of those instruments

that can help them "to make the best decisions for the greatest number of persons" (Macaulay and Lawton, quoted [45]). Ethical leadership needs ethical competence [16]. In view of the fact that leaders are called every day to solve problems pertaining to ethics and must prove their integrity in the process, they "must possess the necessary abilities, knowledge and experience"; likewise, for their professional development they need ethical education and training [19].

Therefore, the integration of the leadership's roles within the managerial functions connected with ethics should take place [28]. In the first case, the manager emphasizes "the human elements" in decision-making: he/she is aware of his/her own values and beliefs concerning the rights, obligations and goals of human beings, he /she accepts a certain degree of ambiguity or incertitude in decision-making, takes risks and exerts a modelling influence upon subordinates.

In the second case, the manager is the person that primarily decides in situations facing ethical issues: he/she tries to make the best decision at the smallest cost; acts as an expert who uses systematic approaches in problem solving (theoretical models, ethical principles) and who, based on his/her expertise, identifies the beneficial results or those that must be avoided.

Executive management can create an ethical and socially responsible organization, by applying a strategic leadership, by providing a pleasant work place and support for a lasting environment, by engaging in philanthropic acts, collaborating with suppliers in order to improve working conditions, by applying written conduct codes, by establishing formal mechanisms to deal with ethical problems, by taking seriously any alarm bells, by offering training programs on ethical issues, by pursuing the company's interests to the detriment of the personal ones [10].

Rhode [37] states that the efforts for the institutionalization of ethics will be fruitful only if "the leadership will be taken seriously at all its levels [of implementation]" (ethical leadership is a necessity for a middle manager, a team-chief and for a CEO as well, cf. Cadwell [6], and "a real commitment to moral leadership demands the integration of ethical concerns in all organizational activities, in their day to day functions, including planning, resource allocation, hiring, promoting, performance assessment, auditing, communication, public relations, and philanthropy" [6]. In this way, it is possible to clearly differentiate between what moral leadership means (the display of a large array of values and virtues) and what ethical leadership entails (effective, ethical behaviour, the modelling role of the leader who behaves as he/she would like his subalterns to do) (cf. Landy and Conte [26]).

Therefore, the leaders concerned with ethics must be preoccupied with the following: to formulate, apply and assess certain consistent standards of ethical practice; to improve the moral culture of the institution where they work, and to develop organizational ethics [22].

Harvey, Smith and Sims [15] operate a selection of 10 behavioural characteristics of the leaders with high standards of integrity, of ethical leaders: ethical awareness and value creation (communication and discussion of commonly shared values,

of ethical principles and standards); to attract responsible people in their work (raising their own awareness, as well as that of their subordinates towards ethical behaviour; zero tolerance towards values' infringement); leadership by example (having the same expectations from others as they have from themselves by doing what they say they'll do); using values in decision-making; establishing policies and practices which support the values of the organization and its ethics at all levels (the fast solving of dilemmas without instilling a fear of repercussions); ensuring the education related to values and ethics in order to encourage employees to acquire abilities that transform beliefs into behaviours; attention paid to the perceptions, feelings, opinions, and reactions of employees, consumers and stakeholders; focus upon rapid, incremental change (emphasize bestowed upon as many improvements as possible in as many areas as possible); hiring and promoting ethically-inclined persons (using the mission, vision and values in selecting persons with integrity); encouragement of taking initiatives (in order to motivate employees to adopt ethics standards).

Leadership is characterized by the way in which the individual wields power to influence subordinates [41], [32], [24], [4]. Ethical leadership entails a responsible use of power because one of the sources of power lies exactly in the ethical expertise (competence) of the leader.

Branscome [5] brings forward three truths concerning ethical leadership: that it does not express "a universal norm" because there are differences between cultures to be taken into account (it is an ideal especially in cultures of Greek-Roman origins); its fundamental ground, as well as its result, is trust; the best approach consists in a combination between vision and value-based management.

This last element mentioned by the author leads to the assertion that ethical leadership is intrinsically connected with the management process (the personal one, of the leader, but also the one applied within the organization) with all tasks included: planning, organization, coordination and control; objectives, strategies, policies, procedures, instruments. According to Mintzberg (quoted [36]), "management without leadership is barren and leadership without management is disconnected and engenders arrogance". Only used together they can lead to earning the trust of others.

The study conducted by Ghahroodi, Ghazali and Ghorban [13] among 117 middle-managers from hospitality industry show the positive connection between ethical leadership and the employees' satisfaction at the work place, of their emotional involvement; consequently, there was reported a weak tendency among employees to leave the organization.

Ethical leadership starts and ends with people and caring for them, but its implementation entails strategies and instruments specific to concrete, ethics management and measurements of their long-term effects (Figure 1). Care for people entices the leader to erect an ethical system which protects them from ethical risks, improves their working conditions, saves their jobs and their personal reputation; thus, not only the organization is risk-proofed, but all stakeholders as well.

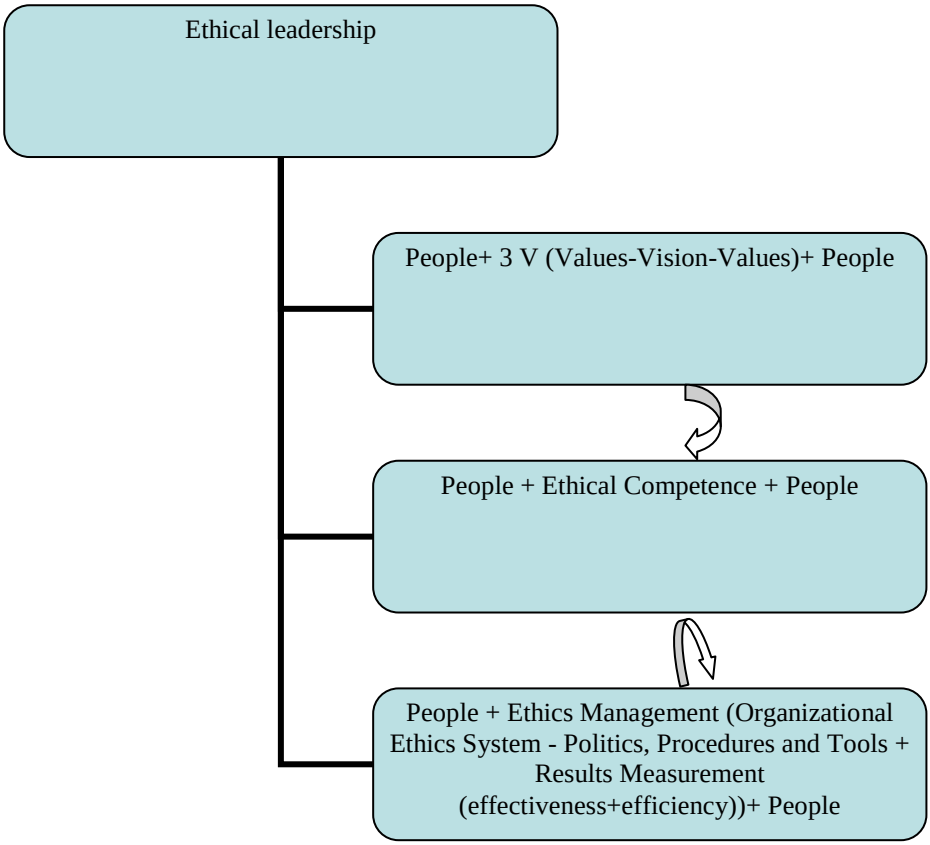

Figure 1 Coordinates and applying ethical leadership strategies
Source: author's own contribution

Gilley's assertion [14] highlights that leadership is the center of an organizational system. The aforementioned author argues that leadership directly influences the four most important management functions (mission and strategy, organizational culture, structure and management practice) and indirectly policies, procedures and work climate. In light of the same idea, Jex [17] shows the four functions that leaders must comply with, reflecting both their importance in the organization, and clear connection with the management: providing strategic direction and vision to the group and, if applicable, to the entire organization; engaging in the motivation and coaching for employees; enhancing and interpreting organizational policies; obtaining resources for the group. Leaders have the key-role to create an ethical environment for modelling the ethical behaviour of employees. For this purpose they have to create a system based on a strong and clear mission, supported by policies, procedures and other guidelines for employees, as well as the ways that can use to denounce unethical practices (grievance procedures and structure for

deliberation) [29]. As Daft [8] says, "leaders create organizational systems and policies that support ethical behavior" ("open door policies" that encourage free and without fear communication, code of ethics, rewards for ethical conduct, zero tolerance to unethical practices).

Therefore, based on what was previously exposed, we support the idea that in the organizations' life, ethical leadership is implemented through an ethics management system; in other words, it is made visible and materially consistent through the actions undertaken for the promotion of ethical decisions and through the support structure built for their implementation. The difference between leaders and managers in applying ethics management consists in the way the coordinated people manage to internalize the goal of the ethical system and in how convinced and involved (but not constrained) they are in the actions carried out in order to render the system functional. Likewise, this difference is revealed by the way the ethics management is applied: either preventively, for diminishing ethical risk areas for the good of all, or based on the employees' fear of making mistakes and of undergoing punishments when the standards of ethical conduct, stipulated in policies and procedures, are not properly observed (due to lack of attention or knowledge).

Ethical leadership starts with people because a leader exists only if he/she has followers. The moral character of the leader shows the others that he/she is a "genuine human being". They will follow the leader if they have the perception that he/she has authentic ethical values which defend their dignity and interests (respect, empathy, openness); and this is a powerful source of self-trust for subordinates. Based on these values, the path that the leader will take together with them will be built: that is, it is formulated the vision for integrating these moral values to their benefit and for the common good of the community. A true leader will succeed in convincing people of his/her legitimacy only if he/she possesses ethical competence, a specific knowledge and the adequate know-how in applying them, makes ethical decisions in the service of people. This competence – a first condition, albeit insufficient, for an ethical leader [16] -, will be implemented through strategies specific to ethics management (policies and instruments that will produce useful results for people, will protect them, create well-being and will not dissipate their efforts and resources). Without this ethical competence, ethics management would not have been instituted; ethical competence helps the manager to become aware that there is a need for this process and it will show him/her the way to accomplish his/her vision and action-plan. In fact, values and competence are the true coordinates of the leader's power and legitimate him/her to exert authority over his/her subordinates. Moreover, the leader must prove that he/she is able and capable of producing results [36], that he/she is efficient and effective in serving people, and community, in general.

2. Material and method

Our paper presents the second part of the findings of a vast research conducted on organizational ethics and management of ethical behaviour (these aspects are marked as points in

the verification grid of an ethics audit, cf. Landman, Mouton and Nevhutalu [25], in 3 healthcare institutions from Iaşi, by exploring the opinions of 52 persons with executive powers who work there. For the purpose of this study, we selected the questions pertaining to strategies and instruments specific to value-based management and ethical leadership.

The general objective of the study is to find the opinion of the staff with managerial responsibilities on the existence of the ethical elements of the managerial system and the practice of ethical leadership in the healthcare institution. The study observes what is actually being done for the implementation of a value-based management, of an ethical leadership from the perspective of people who lead the personnel and all activities of the institution.

Among the specific objectives approached in this study, we mention the following:

O1: Identification of values and their role in the institution;

O2: The existence and application of ethics policies (regarding the personnel);

O3: Identification of ethical risk areas, of ethical dilemmas and of the potential sources of ethical conflicts (in working with employees/which affect employees' activity);

O4: Elements specific to leadership and care for employees;

O5: Identification of unethical behaviours which are related to/affect the employees' activity.

Through the application of specific tests, it was assessed the degree in which the answers differ from one another according to the type of hospital, the managerial function of respondents and their ethical education.

Research method. The study is built on a quantitative, exploratory research conducted through a questionnaire-based inquiry.

Questionnaire design. The questionnaire applied during the entire research was structured in several sections (formulated primarily with the help of the questionnaire for the ethics audit conducted in the hospital, applied by Landman, Mouton and Newhutalu [25], transposed in a total of 105 items of analysis, including the respondents' identification data [7], [1]. In order to reach directly the objectives of the study, there were selected the questions that illustrate how the management of the healthcare institution approaches both ethical aspects in personnel's management and coordinates of ethical leadership: Values in institution, Existence and application of policies, Ethical dilemmas and potential sources of ethical conflict in institution and in the medical activity, Leadership and care towards employees, Unethical behaviours in institution, Elements connected with the promotion of Respect, Equity and Responsibility in the institution.

Nominal and ordinal, qualitative variables were used in the study. Likewise, there were employed two un-parametric answer scales, in 6 grades – one for importance level assessment (1 – to a very low extent, 6 – to a very large extent) and a scale for expressing agreement, Likert-type (1-complete disagreement, 6 complete agreement).

The questionnaire was pre-tested on 3 managers of healthcare institutions from Iaşi, Romania. In its wake, certain questions were more clearly formulated.

Sampling and the Subjects of research. The sampling was non-probabilistic, based on rational selection. The questionnaire was applied within six important healthcare institutions from Iaşi, Romania (The Regional Institute of Oncology, Recovery Hospital, Saint Spiridon Hospital, "Dr. Vasile Micu" Psychiatric Residential Center, Socola Psychiatric Hospital) and was initially addressed to 58 persons with role/responsibilities in managing the institution. The final sampling comprised 52 respondents. From 58 questionnaires distributed, only 52 were retained because in 6 questionnaires the answers were incomplete.

According to their managerial position, among the 52 respondents are 25 chief-assistants (48,1%, the difference to the reference repartition is very significant, $\chi2 = 33,38$, df = 4, 1-p = 99,99%), 14 chiefs of departments/clinic (26,9%), 3 hospital managers (5,8%), 3 medical directors (5,8%), 7 directors from the administrative/financial-accounting department (13,5%). 36 of respondents (69,2%) are female (the difference to the reference repartition is very significant, $\chi2 = 7,69$, df = 1, 1-p = 99,45%), and 16 (30,8%) are male.

Respondents' distribution according to age looks like this: 26 persons aged between 36-45 years (50%, the difference is very significant, $\chi2 = 38,58$, df = 4, 1-p = 99,99%.), 13 (25%) between 46-55 years, 4 between 26-35 years (7,7%), and 9 (17,3%) over 55 years. Regarding seniority in organization, 16 persons (30,8%) worked over 20 years, 7 (13,5%) between 15-20 years, 7 (13,5%) between 10-14 years, 9 (17,3%) between 3-5 years, and 8 (15,4%) under 3 years.

According to seniority in managerial position: 13 (25%) of those questioned have between 3-5 years, 12 (23,1%) over 10 years of seniority in the healthcare institution, and 11 (21,2%) under 1 year.

According to the nature of their education, 43 (82,7%), from the managers questioned possess medical studies (the difference is very significant, $\chi2 = 93.38$, df = 3, 1-p = >99,99%); 5 (9,6%) socio-humanistic studies, 4 (7,7%) technical studies. 28 (53,8%) of respondents have management education, 18 (34,6%, the difference is significant $\chi2 = 4,92$, df = 3, 1-p = >97,35%), and professional training in the field of ethics. Regarding the educational background, 24 (46,2%, the difference is very significant $\chi2 = 22,81$, df = 4, 1-p = >99,99%) have undergraduate studies, 7 (13,5%) PhD studies, 8 (15,4%) post-doctoral studies, 8 (15,4%) high-school studies, 5 (9,6%) master studies.

Data collection. The data were collected in two periods: 27 questionnaires were applied during October 2012 to February 2013 at the first three mentioned hospitals and other 31 questionnaires (from which only 25 questionnaires were valid and have been processed) in December 2013-January 2014 to other three hospitals, by directly approaching the respondents within the healthcare institution.

Method of data processing. For data processing it was used the statistic software Sphinx Plus², with a 2007 licence use belonging to Alexandru Ioan Cuza University, Iaşi.

According to the nature of variables, the data analysis and the presentation of results took into account the frequency of responses, the

application of hi-square independence test, the cross-tabulation and Cramer's correlation coefficient (V Cramer).

The Alpha Cronbach coefficient for the entire questionnaire is 0,88, which indicates a high internal consistency.

2.1. Findings. Important values in institution

The answers to the questions pertaining to the three major values considered the most important in the healthcare institutions ranked the quality of the medical service (92,3%, N=48) and respect for the rights of the patients (78,8%, N=41) on the first two positions, the difference to the reference distribution being very significant - $\chi 2 = 192,77$, df = 11, 1-p = >99,99%. The values (concerning employees) triggered the following confirmations: respect for the rights of employees 38,5% (N=20) by managers; justice, fair treatment 13,5% of respondents (N=7), and loyalty towards the organization by 9,6% (N=5). The participative leadership was mentioned only by 5,8% (N=3) respondents.

Concerning the values promoted in institutions in the relationship of the personnel with the patients, the first place is taken by the quality/excellence of the medical act (78,8%, N=41, very significant difference with the reference distribution, $\chi 2 = 72,41$, df = 9, 1-p = 99,99%). A high percent of respondents mention the confidentiality (55,8%, N=29), respect for deontological principles (42,3%, N=22), involvement (30,8%, N=16), and impartiality, equal chances (15,4%, N=8).

The following Ethical values within institutions were identified: respect for deontological principles (82,7%, N=43, very significant difference with the reference distribution, $\chi 2 = 28,47$, df = 6, 1-p = 99,99%). Other issues remarked upon were: a strong work ethics (59,6%, N=31), treatment of maximum number of patients (55,8%, N=29), protection of the institution's image (30,8%, N=16). The adequate work environment is mentioned by 14 respondents (26,9%, N=14), and the same number of respondents mentioned the avoidance of interest conflicts. Cross-tabulation with "type of hospital" does not show a significant difference. Also, there is no significant dependence regarding the cross-tabulation with the variable "the ethical training" of respondents because the ethical values were not taken into account by the respondents according to this criterion.

Other intrinsic elements connected with the institution's values pertain to **the promotion of Respect** in its activity – confidentiality (86,5%, N=45, $\chi 2 = 44,59$, df = 10, 1-p = 99,99%), lack of discrimination (69,2%, N=36), doing good, honesty (each with 61,5%, N=32), lack of abuse (55,8%, N=29), politeness (51,9%, N=27); **the promotion of Equity**: fair treatment (92,3%, N=48, very significant difference $\chi 2 = 50,34$, df = 6, 1-p = 99,99%), transparency (69,2%, N=36), tolerance (67,3%, N=35), recognition (42,3%, N=22), diversity (36,5%, N=19); **the promotion of Responsibility**: to assume responsibility (86,5%, N=45); effectiveness (80,8%, N=42); efficiency (78,8%, N=41); trust (57,7%, N=30).

Only 50% (N=26) of the respondents believe that the performance indicators are established according to the personnel's capacities/competences. 76,9% (N=40) of the respondents consider that they

are determined on the needs of the patients (very significant difference with the reference distribution $\chi 2$ = 43,50, df = 6, 1-p = 99,99%); 73,1% (N=38) appreciate that they are determined based on the compliance with specific organizational policies and regulations; 38,5% (N=20) according to the vision of the institution, while 34,6% (N=18) consider the meeting of budgetary restrictions. Cross-tabulation with "the managerial function" of respondents and with "the type of hospital" does not show a significant dependence. The values are transposed primarily in internal regulations policies (88,5%, N=46, very significant difference with the reference distribution, $\chi 2$ = 95,00, df = 9, 1-p = >99,99%). Cross-tabulation with "the type of hospital" and "the managerial function" does not suggest significant dependence.

Among ethical risk areas, there were identified (potentially related to personnel and leadership practice): providing the medical service at optimal standards (38,5%, N=20), ethics of the decisional process (30,8%, N=16), human resource development (25%, N=13). In equal percentage (23,1%, N=12), there were selected the provision of professional ethics and the employees' rights. Cross-tabulation with "type of hospital", "managerial function" and "ethical training" does not indicate a significant dependence.

28,8% (N=15, very significant difference with the reference distribution $\chi 2$ = 26,92, df = 5, 1-p = >99,99%) of respondents consider to a very great extent that the values of the institution are established and communicated within and without the organization. These answers concur with those offered to the question of whether the institution's vision is presented and communicated to employees and other stakeholders, whereas 28,8% (N=5, very significant difference, $\chi 2$ = 20,46, df = 5, 1-p = 99,90%) consider it to a great extent. Likewise for those pertaining to the question about the employees' awareness of the institution's vision (34,6%, N=18, to a very great extent, very significant difference with the reference distribution, $\chi 2$ = 20,23, df = 5, 1-p = 99,89%).

Values constitute the basis for the formulation of the institution's vision to a very great extent for 36,5% (N=19) from the persons with executive roles in the healthcare institution scrutinized, and 34,6%, (N=18) to a fairly great extent (the difference with the reference distribution is very significant - $\chi 2$ = 44,23, df = 5, 1-p = 99,99%). Cross-tabulation with "type of hospital" indicates a significant dependence ($\chi 2$ = 22,50, df = 12, 1-p = 96,77%), the Cramer's V correlation coefficient shows a positive association, but with a low, under mean intensity (V Cramer – 14,42%).

Establishing objectives takes into account the capacities and competences of the human resources from the institution - 30,8% (N=16, the difference with the reference distribution is very significant - $\chi 2$ = 30,85, df = 5, 1-p = 99,99%) of respondents appreciate this aspect to a fairly great extent and in equal percent to a very great extent; the Audience program is adjusted to the employees'/patients' requests – to a very great extent in the opinion of 36,5% (N=19) and to a fairly great extent ($\chi 2$ = 38,46, df = 5, 1-p = 99,99%) by 32,7% (=17) of respondents. **The employees of the**

institution are consulted with/involved in the process of establishing the objectives and decisions involving them - 32,7% (N=17, $\chi 2$ = 25,31, df = 5, 1-p = 99,99%) of the respondents considers this to a great extent (but 26,9% to a fairly low extent).

Existence and application of ethics policies (related to employees). There are policies/ethics codes/ethical standards which guide the institution's behaviour towards its internal stakeholders (employees)– to a fairly great extent – 38,5% (N=20, $\chi 2$ = 41,92, df = 5, 1-p = 99,99%) and to a fairly extent - 32,7% (N=17), to a great extent; the Audience program is adjusted to the employees'/patients' requests – to a very great extent according to 36,5% (N=19) of respondents. Dependence with "type of hospital" is not significant.

Clear **ethics programs and policies are applied** in the institution regarding: avoiding conflicts of interest – to a very great extent - 30,8% (N=16); anti-discrimination – to a very great extent - 42,3% (N=22), the difference to the reference repartition is very significant, $\chi 2$ = 39,62, df = 5, 1-p = 99,99%); diversity management - 34,6% (N=18) to a great extent (very significant difference $\chi 2$ = 29.46, df = 5, 1-p = 99,99%). The **channels of internal communication** correspond to the employees'/patients' requests (numerous, easily accessible, complementary) – to a great extent - 44,2% (N=23), the difference to the reference distribution is significant ($\chi 2$ = 44,46, df = 5, 1-p = 99,99%). Cross-tabulation with the variable "type of hospital" indicates a significant little dependence; the existent channels of communication allow the complete circulation, without discrimination, of the information towards all institutional levels, within and without as well – to a fairly great extent - 30,8% (N=16, $\chi 2$ = 28,54, df = 5, 1-p = 99,99%). Cross-tabulation with the "type of hospital" variable is little significant ($\chi 2$ = 17,04, df = 12, 1-p = 85,21%, the Cramer's correlation coefficient shows a positive association, but with a low intensity (V Cramer =10,93%)

Concerning the Deficient communication with employees – a percentage of 26,9% (N=14) of managers express a partial agreement. Only 5,8% (N=3) of them strongly agree with this assertion (the difference to the reference repartition is low significant, $\chi 2$ = 9,15, df = 5, 1-p = 89,69%).

Regarding **Ethical dilemmas and potential sources of ethical conflicts in institution and in the medical activity (ethical dilemmas and stress sources pertaining within the institution pertaining to the available personnel)**, several aspects have been appreciated as follows: Inadequate remuneration - 11,5% (N=6) very strong agreement (13,5% (N=7) partial agreement, 23,1% (N=12) strong disagreement, 21,2% (N=11) very strong disagreement; Overtime working program – 26,9% (N=14) partial agreement, and in equal percentage partial disagreement (the difference to the reference repartition is significant, $\chi 2$ = 12,15, df = 5, 1-p = 96,73%); Night working program – 32,7% partial agreement (N=17, the difference to the reference repartition is very significant, $\chi 2$ = 16,08, df = 5, 1-p = 99,34%); Recruitment and selection completed in an inadequate manner - 25% (N=13) very strong disagreement and in the same percentage, partial agreement;

Lack of qualified personnel- 28,8% (N=15) very strong disagreement; 7,7% (N=4) strong agreement and in equal percent partial strong agreement, the difference to the reference repartition is low significant - $\chi 2 = 11$, df = 5, 1-p = 94,86%; Personnel insufficiency – 28,8% (N=15) strong agreement (the difference to the reference repartition is very significant, $\chi 2 = 11,92$, df = 5, 1-p = 96,41%); Employees' Deficient communication –26,9% (N=14) partial agreement.

A percentage of 25% (N=13) indicates a very strong disagreement (and the same percentage of 25% (N=13) strong disagreement) with the assertion that there are Problems in showing respect to authority by employees. Only a percentage of 5,8% (N=3) strongly agree with this statement. The difference to the reference repartition is low significant, $\chi 2 = 10,77$, df = 5, 1-p = 94,38%.

Likewise, 21,2% (N=11) report a very strong disagreement, and the same percentage of 21,2% (N=11) a partial disagreement that there are Problems in assuming responsibility. Only a percentage of 7,7% (N=4) each declare a very strong and a strong agreement in this regard.

Ethical dilemmas and stress sources within the institution pertaining to the working environment - 48,1% (N=25) express a very strong disagreement with the idea that equipment is insufficient or unable to perform its tasks properly (very significant difference, $\chi 2 = 42.64$, df = 5, 1-p = 99.99%); 40,4% (N=21), very strong disagreement that there is a lack of necessary medication (significant difference, $\chi 2 = 29,69$, df = 5, 1-p = 99,99%); 36,5% (N=19) express a very strong disagreement concerning the lack of the necessary facilities (very significant difference, $\chi 2 = 15,85$, df = 5, 1-p = 99,27%). Moreover, 48,1% of respondents (N=25, very significant difference, $\chi 2 = 39.38$, df = 5, 1-p = >99.99%.) expressed a very strong disagreement concerning the topic of Inadequate working conditions.

Leadership and care for employees operate in the institution through several levers: There are policies/ethics codes/ethical standards which guide the personnel's behaviour - 32,7% (N=17) to a great extent (very significant difference, $\chi 2 = 26,46$, df = 5, 1-p = 99.99%); Employees express openly their opinion in front of the managers, they vent without holding back their own complaints, and provide by themselves suggestions to the management - 42,3% (N=22) of managers believe this to be the case to a great extent (very significant difference, $\chi 2 = 38,00$, df = 5, 1-p = 99,99%). Cross-tabulation with "the type of hospital" shows that dependence is not significant; The feedback ensued from the data of the internal inquiry related to the personnel's satisfaction is taken into account in grounding decisions/taking corrective measures - 40,4% (N=21) contend that this is the case to a great extent (very significant difference, $\chi 2 = 29,69$, df = 5, 1-p = 99,99%).

There are ceaseless efforts in motivating employees to improve/consolidate their performance - 32,7% (N=17) to great extent (very significant difference, $\chi 2 = 29,31$, df = 5, 1-p = 99,95%).

Promotion of a tight cooperation between employees, searching together for solutions to the new problems in the institution - 44,2% (N=23) to a great extent (very significant difference, $\chi 2 = 42,38$, df = 5, 1-p =

99,99%). Concerning the fact that the access to training and professional improvement plans by employees is transparent and equitable, offers equal opportunities to the employees willing to access them: 40,4% (N=21) of managers consider this to be the case to a great extent (very significant difference, $\chi 2 = 34,54$, df = 5, 1-p = >99,99%).

Only 26,9% (N=14, very significant difference, $\chi 2 = 19,77$, df = 5, 1-p = 99,86%) of the persons with executive roles consider that employees are prepared and encouraged - to a great extent and to a fairly great extent- to signal incorrect practices in order to improve the ethical climate/environment in institution. Employees can use effective and efficient mechanisms for signalling incorrect practices, without being victimized - 30,8% (N=16) to a fairly great extent (very significant difference, $\chi 2 = 24,85$, df = 5, 1-p = 99,99%).

The variety of the answers defining the image of the ethical leadership in the six Romanian hospitals under study is completed by the managers' opinion about the **Presence of unethical behaviours in organization**: overestimation of the necessary stock of medication (to a very low extent, 38,5%, N=20, very significant difference, $\chi 2 = 29,92$, df = 5, 1-p = 99,99%); staff bribing by patients (61,5%, N=32 to a very low extent, very significant difference, $\chi 2 = 82,54$, df = 5, 1-p = 99,99%); verbal abuses from personnel towards patients (to a very low extent, 50%, N=26, very significant difference, $\chi 2 = 57,38$, df = 5, 1-p = 99,90%); physical abuses from personnel towards patients (to a very low extent, 65,4%, N=34, $\chi 2 = 97,54$, df = 5, 1-p = >99,99%); lack of compassion towards patients (to a very low extent 51,9%, N=27, very significant difference, $\chi 2 = 53,92$, df = 5, 1-p = 99,99%); discriminatory treatment (to a very low extent, 75%, N=39, very significant difference, $\chi 2 = 132,15$, df = 5, 1-p = >99,99%); transgression of the working program (67,3%, N=35, very significant difference, $\chi 2 = 99,85$, df = 5, 1-p = >99.99%); malpractice and negligence (to a very low extent, 71,2%, N=37, $\chi 2 = 119$, df = 5, 1-p = >99,99%).

Furthermore, managers expressed their agreement/disagreement with the following aspects pertaining to ethics and the way of working with employees: the employees involved in unethical behaviours are immediately charged with disciplinary sanctions - 38,5% (N=20) very strong agreement (very significant difference, $\chi 2 = 27,38$, df = 5, 1-p = 99,99%); unethical behaviour is primarily connected with lack of discipline - 30,8% (N=16) partial agreement very significant difference, $\chi 2 = 16,77$, df = 5, 1-p = 99,50%; the disciplinary measures applied in institution are not "visible" - 32,7% (N=17) very strong disagreement, very significant dependence, $\chi 2 = 26$, df = 5, 1-p = 99,99%; because of task overload and low wages, the medical personnel is entitled to receive gifts of little value - 44,2% (N=23) very strong disagreement, significant difference, $\chi 2 = 41,46$, df = 5, 1-p = 99,99%, but paradoxically a percentage of 3,8% (N=2) expressed a very strong agreement.

2.2. Discussions and conclusions

The study's findings bring forth the strong mark of the field of activity. Thus, our analysis indicated that among the values mentioned by managers the top spot is occupied by

both the quality of the medical service and respect of patients' rights, whereas confidentiality is one of the values for promoting Respect. These values are concretely implemented by employees. Nevertheless, their answers do not show a unanimous agreement with the idea that values are communicated within and outside the institution. The results ensued in the exploratory research conducted on 52 persons with executive positions from six hospital institutions from Iaşi, Romania show that, according to their own estimation, there are strategies and instruments specific to ethics management and ethical leadership: it is encouraged a value-based management, human resources' capacities and competences are taken into account in establishing indicators, employees are consulted in decision-making, the feedback ensued from inquiries pertaining to the employees' satisfaction are used in justifying the decisions, the internal, communication channels meet the employees'/patients' requirements (they are numerous, easily accessible, and complementary), the communication channels in place allow the complete, discrimination-proofed circulation of information at all levels of the institution, the communication with employees is not deficient, ongoing efforts are undertaken to motivate employees to improve/consolidate their performance, promotion of a tight cooperation between employees, aggregated search for solutions to the new problems in the organization, employees are encouraged to signal unethical practices within the institution and for this purpose they can use the appropriate mechanisms, etc. The results did not show differences in how managers perceive the ethics management issues and ethical leadership in other hospitals.

Nevertheless, the analysis of the responses indicates that there are important gaps between the theoretical, normative level "to a great extent" or "complete agreement" (what should be the case) and what the managers deem to be really the case (what is concretely being done) in the institution where they work. Therefore, we could claim that there is a "normal", "common sense" ethical leadership which normally prevails in institutions in order that their activity rises to standard parameters and not a "conscious", "willed", "formed" or authentic one. The main conclusion is that managers should be aware of the importance of ethical leadership, of its advantages, and they should be educated in order to identify and apply the necessary strategies and instruments for its promotion and effectiveness.

The present study can be considered as a diagnosis of ethics management and leadership in healthcare institutions. The low number of respondents (due to the difficulty of contacting them) renders this exploratory study into a pilot one, whose philosophy and stock of instruments might be extended to all healthcare institutions in Romania in order to conduct a real diagnostic/audit which could help in drawing the concrete picture of the ethical leadership and management. These criteria might be included in the accreditation grid of hospitals.

The study must be counterbalanced with other types of research on employees in order to better grasp their opinions about ethical leadership; likewise, the study of public interest, official documents should be taken into

account in order to confirm or refute the assertions of the persons under scrutiny.

Acknowledgement

This paper has been supported within the Project entitled: "Excellence Programme in Multidisciplinary Doctoral and Postdoctoral Research in Chronic Diseases" ID POSDRU/159/1.5/S/133377, beneficiary "Gr. T. Popa" University of Medicine and Pharmacy, co-funded by the European Social Fund through the Sectoral Operational Programme – Human Resources Development 2007-2013." This paper does not represent the official view of the Romanian Government or European Union.

References

[1]. Agheorghiesei DT, Poroch, V. Pilot-study concerning the management of ethical behavior in healthcare institutions from Iași. Values, Visions, Objectives and Ethics Policies. Revista Română de Bioetică, 2013, 11 (2), 133-147.
[2]. Barr, J, Dowding, L. Leadership in Health Care. 2nd edition. London: Sage Publications, 2012, p. 10.
[3]. Bellingham, R. Ethical leadership: rebuilding trust in corporations. 2nd ed. Amherst, Mass.: HRD Press. 2003, p. 6.
[4]. Bolden, R, Hawkins, B and Gosling, J. Exploring Leadership: Individual, Organizational, and Societal Perspectives. Oxford: OUP Oxford. 2011, p. 73.
[5]. Branscome, GC. Ethics: Ethical leadership. PM. Public Management, 2008, 90 (5), 2.
[6]. Cadwell, CM. Leadership skills for managers. [New York]: American Management Association, 2004, pp. 11; 37.
[7]. Corodeanu Agheorghiesei, DT. Etica în administrația publică. București: Tritonic, (Annex), 2013, p. 209.
[8]. Daft, RL. The Leadership Experience. Thomson Learning, 2008, p. 168.
[9]. Dolan, TC. A Time for Ethical Leadership. Healthcare Executive, 2004, 19 (1), 6-8.
[10]. DuBrin, AJ. Leadership: research findings, practice, and skills. Mason, OH: South-Western Cengage Learning, 2011, pp. 28; 174; 179-181; 195.
[11]. Erikson, AL. Ethical Leadership and the Public Trust. Public Manager, 2006, 35 (1), 62.
[12]. Grace, WJ. Center for Ethical Leadership. Ethical leadership: in pursuit of the common good. Seattle, W.A. Center for Ethical Leadership, 2006, pp. 9, 10.
[13]. Ghahroodi, HK, bin Tan Sri Mohd Ghazali, MZ and Ghorban, S. Examining Ethical Leadership and Its Impacts on the Followers' Behavioral Outcomes. Asian Social Science, 2013, 9 (3), 91-96.
[14]. Gilley, JW. The manager as politician. Westport, Conn.: Praeger Publishers, 2006, p. 60.
[15]. Harvey, E, Smith, A. and Sims, P. Leading to ethics: 10 leadership strategies for building a high-integrity organization. Dallas, Tex.: Walk the Talk Co, 2003, pp. 5; 6; 7.
[16]. Heres, L, Lasthuizen, K."From Ethical Competence to Ethical Leadership", in Cooper and Menzel (eds), Achieving Ethical Competence for Public Service Leadership. Armonk, N.Y.: M.E. Sharpe, 2013, pp. 51-70.
[17]. Jex, SM. Organizational Psychology: A Scientist-Practitioner Approach. John Wiley&Sons: 2002, pp. 269-270.
[18]. Johnson, BE. "The Leadership Development Triad: A Balanced Approach to Cultivating Effective Leadership", in Coe, Sukhodoyeva and Johnson, (eds), Strategies for effective leadership: U.S. and Russian perspective, Bloomington, IN : Authorhouse, 2005, pp. 9-32.
[19]. Johnson, CE. Meeting the ethical challenges of leadership: casting light or shadow. Thousand Oaks, Calif.: SAGE, 2012, pp. 62, 330.
[20]. Johnson, K., Ethics Resource Center. The role of leadership in organizational integrity and five modes of ethical leadership, 2003. [Online] Available:

http://www.ethics.org/resource/role-leadership-organizational-integrity-and-five-modes-ethical-leadership. [accesed July 1st, 2013].
[21]. Johnston, SE, Cruess, SR and Cruess, RL. Ethical leadership in modern medicine. Canadian Journal of Administrative Sciences, 2001, 18 (4), 291-297.
[22]. Johnstone, M-J. "Leadership ethics in nursing and health care domains", in Daly, Speedy and Jackson (eds). Nursing Leadership. Marrickville, N.S.W.: Elsevier Australia, 2003, pp. 91-97.
[23]. Kellar, EK. 12 Steps for Ethical Leadership. PM. Public Management, 2005, 87(10), 2. [Online]: http://icma.org/en/icma/knowledge_network/documents/kn/Document/2198/12_Steps_for_Ethical_Leadership. [accesed December 2, 2012].
[24]. Neuschel, RP, Kellogg School of Management. The servant leader: unleashing the power of your people. Evanston, Ill: Northwestern University Press, 2005, p. 124.
[25]. Landman, WA, Mouton, J and Nevhutalu, KH. Chris Hani Baragwanath Hospital Ethics Audit. Research Report No. 2., 2001. [Online]: http://www.ethicsa.co.za/UserFiles/ethicssa.intoweb.co.za/CHBHFinalReport.pdf. [accessed December, 15, 2011].
[26]. Landy, FJ, Conte, JM. Work in the 21st century: an introduction to industrial and organizational psychology. Malden, Mass.: Wiley-Blackwell, 2010, p. 561.
[27]. Ma, F. Primary Investigation into Management Ethical Thoughts by Lao Tzu. Asian Social Science, 2009, 5 (11), 67-71.
[28]. Marquis, BL, Huston, CJ. Leadership roles and management functions in nursing: theory and application. 6th edition. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2009, pp. 71; 88.
[29]. McDaniel, C. Organizational Ethics: Research and Ethical Environments. Aldershot : Ashgate Pub. Group, 2004, p. 9.
[30]. McNee, A. Management. A Focus on Leaders. Second edition. New Jersey: Pearson Education, 2012, p. 25.
[31]. Mendonca, M. Preparing for ethical leadership in organizations. Canadian Journal of Administrative Sciences, 2001, 18(4), pp. 266-276.
[32]. Mendonca, M, Kanungo, RN. Ethical leadership. Maidenhead [u.a.]: Open Univ. Press, 2006, pp. 43, 51, 74.
[33]. Nikoi, AAA. Ethical Leadership and Business Decision Making in Contemporary Times. International Journal of Business and Management, 2008, 3(10), pp. 183-193.
[34]. Ncube, LB, Wasburn, MH. Strategic Collaboration for Ethical Leadership: A Mentoring Framework for Business and Organizational Decision Making. Journal of Leadership and Organizational Studies, 2006, 13(1), 77-92.
[35]. Odom, L. Leadership ethics: is doing the right thing enough?. [Bloomington, Ind.?] Xlibris, 2010, p. 101.
[36]. Prosser, S. Effective people: leadership and organization development in healthcare, Oxford: Radcliffe Pub, 2010, pp. 10, 11, 12.
[37]. Rhode, DL."Introduction: Where is the Leadership in moral leadership", in Deborah L. Rhode, Moral Leadership: the Theory and Practice of Power, Judgment and Policy. Hoboken: John Wiley & Sons, 2006, pp. 1-53.
[38]. Ridderstråle, J, Nordström, K. Funky Business. Bucureşti: Ed. Publica, 2007, p. 226.
[39]. La Monica Rigolosi, E. Management and Leadership in Nursing and Health Care: An Experiential Approach. New York: Springer, 2013, p. 4.
[40]. Dos Santos RA, Guevara AJ, Amorim MC and Ferraz-Neto BH. "Compliance and leadership: the susceptibility of leaders to the risk of corruption in organizations". Einstein, 2012, 10 (1), 1-10, 6, [Online]: http://www.scielo.br/pdf/eins/v10n1/v10n1a03.pdf [accessed February 4, 2013].
[41]. Sims, RR. Managing organizational behavior. Westport CT : Greenwood, 2002, p. 221.

[42]. Storch, J, Schick Makaroff K, Pauly, B. and Newton, L. Take me to my leader: The importance of ethical leadership among formal nurse leader. Nursing Ethics, 2013, 20; 150-157.
[43]. Swansburg, RC. Management and Leadership for Nurse Managers. Management and leadership for nurse managers. Sudbury, Mass.: Jones and Bartlett Publishers, 1996, p. 255.
[44]. Thoms, JC. Ethical Integrity in Leadership and Organizational Moral Culture. Leadership, 2008, 4; 419, 421. [Online] http://lea.sagepub.com/content/4/4/419. [accessed November 29, 2012].
[45]. Vance, NR, Trani, BV. The ethical grounding to 21st century public leadership. International Journal of Organization Theory and Behavior, 2008, 11 (3), 373-381.
[46]. Treviño, KL, Nelson, KA. Managing business ethics: straight talk about how to do it right. New York : John Wiley, 2011, p. 159.
[47]. Wattis, J, Curran, S. Practical management and leadership for doctors. London: Radcliffe Pub., 2011, p. 10.