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Author(s): Toni Makkai and Valerie Braithwaite

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# Professionalism, Organizations, and Compliance

Toni Makkai and Valerie Braithwaite

*Earlier studies have shown that professional orientations are related to individual compliance with laws and regulations. However, no quantitative studies have focused on compliance at the organizational level and the professional orientations of the chief executive officer. Studies on values and law breaking at the individual level have focused on professional orientations, but within an organization there are other aspects of professionalism that will be of import in determining the organization's compliance with the law. We posit that professionalism is a more complex notion for individuals located in an organizational setting. Utilizing data collected from 410 Australian nursing homes, which are characterized by a flat management structure, the data show that of three aspects of professionalism—orientation, values, and autonomy—it is professional autonomy that directly affects organizational compliance. However, the data do suggest that the relationship between professional orientations and organizational compliance are mediated by the complexity of the organization. Organizational culture is also shown to be an important factor in explaining compliance with the law.*

Organizations' compliance with the law has become an important issue with the widespread realization that corporations have harmed and have the potential to harm large numbers of innocent individuals. One response to this increased harm has been the introduction of state regula-

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**Toni Makkai** is a Research Fellow in the Sociology Program, Research School of Social Sciences, Australian National University. **Valerie Braithwaite** is a Senior Research Fellow in the Administration, Compliance and Governability Program, Research School of Social Sciences, Australian National University.

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33

tions and penalties to control the behavior of organizations. Organizations, however, are made up of individuals who make decisions about the extent to which their organization complies with the law. Thus, the values and attitudes of individuals working within the organizational culture will impact on the organization's performance against regulatory standards. The level of impact will vary with the organization's normative system, its size, and its decision-making structure. An important feature of this article is to demonstrate the way in which the level of control the chief executive officer has over the organization's performance on regulatory standards explains compliance with the law.

Managers have multiple selves, and this is nowhere more evident than for professionals operating in bureaucratic settings. Professionals are defined not only by their technical competence in specialized areas but also by their moral norms which dictate that they can be objective, motivated by a service ideal.<sup>1</sup> In an organizational setting, however, they are required to perform two roles—one the responsible professional whose loyalty is to the standards of the profession, the other the responsible employee whose loyalty is to the organization. Their training teaches would-be professionals that their first loyalty is to the profession and its standards; all else comes second in professional life. Yet bureaucracies, particularly for-profit bureaucracies, may prioritize efficiency, profit, and rationalization. This has led some to argue that professional and business roles are somehow inconsistent with each other.<sup>2</sup>

Potential conflict for professionals is further increased when regulatory demands are also made on the actor. The increasing governmental regulation of both industry and welfare agencies has forced professionals to face their multiple work roles as they attempt to comply with externally imposed regulations and internal requirements. Although regulation is

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1. M. Cohen & D. Wagner, "Social Work Professionalism: Reality and Illusion," in C. Derber, ed., *Professionals as Workers: Mental Labor in Advanced Capitalism* (Boston, Mass.: G. K. Hall & Co., 1982) ("Derber, *Professionals as Workers*"). An alternative view is put forward by Andrew Abbott, *The System of Profession* 8–9, 318 (Chicago: University of Chicago Press, 1988), who presents a persuasive argument that "a firm definition of profession is both unnecessary and dangerous." He argues that there is ambiguity about what is a profession because profession "means at once a form of organization, a level of social deference, an association with knowledge, a way of organizing personal careers . . . 'Profession' thus enjoys a vibrantly real but highly elusive existence, qualities that make it both worthwhile and impossible to discuss objectively."

2. Derber, "The Proletarianization of the Professional: A Review Essay," in Derber, *Professionals as Workers*; Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd & Mead, 1970) ("Freidson, *Profession of Medicine*"); R. Hall, "Professionalization and Bureaucratization," 33 *Am. Soc. Rev.* 92 (1968); Peter Blau, Wolf Heydebrand, & S. Stauffer, "The Structure of Small Bureaucracies," 31 *Am. Soc. Rev.* 179 (1966); W. Kornhauser, *The Mental Health of the Industrial Worker* (New York: Wiley, 1965). Others have argued, however, that professional and bureaucratic principles are compatible; see Arthur Stinchcombe, "Bureaucratic and Craft Administration of Production," 4 *Admin. Sci. Q.* 168 (1959).

more often than not an attempt by the state to ensure that professional standards are met, regulatory compliance incurs costs, forcing professionals as managers to balance the two demands.

## PROFESSIONAL ORIENTATION AND COMPLIANCE

In what has become a classic study, Richard Quinney examined the relationship between occupational role orientations and criminal violations in the workplace. Quinney argued that understanding the norms and rules of conduct within an occupation may shed some light on criminal violations that occur in organizational settings.<sup>3</sup> To test this proposition, Quinney examined the occupational values of pharmacists and their violation of prescription laws or regulations. He differentiated two occupational roles in the pharmacy profession: the professional role of reading the literature, filling prescriptions, compounding medicines, and supporting the use of official drugs, and the business role of maintaining a successful business establishment, arranging displays, retailing a range of goods, and being a good salesperson.

Quinney argued that the dilemma of choosing between these two role orientations was resolved through occupational role organization that took the following forms: adopting a predominantly professional role orientation (16%), adopting both a professional and business role orientation (45%), being indifferent to both (19%), and being predominantly business-oriented (20%). Quinney found that the pharmacists most likely to have been convicted of prescription violations were those with a relatively strong business orientation, while those with a relatively stronger professional orientation were significantly less likely to be involved in criminal violations in the workplace.<sup>4</sup> The conclusion from this research was that certain types of occupational roles, and by implication the values imbued in those roles, will constrain individuals from violating norms and standards of conduct, while other roles fail to provide any restraint to individual actions and, more important, may encourage criminal violations.

A study by Chappell and Barnes some 20 years later also examined the role orientations of pharmacists.<sup>5</sup> Whereas Quinney had emphasized the relative importance of the professional role over the business role, Chappell and Barnes focused on the professional and business role orien-

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3. R. Quinney, "Occupational Structure and Criminal Behavior: Prescription Violations by Retail Pharmacists," 11 *Soc. Probs.* 179 (1963).

4. In developing a single measure of this type Quinney was unable to examine the independent effects of professionalism and business orientations, nor could he test for any possible interaction between the two.

5. Neena L. Chappell & Gordon R. Barnes, "Professional and Business Role Orientations among Practicing Pharmacists," 18 *Soc. Sci. & Med.* 103 (1984).

tations as single independent resources. In other words, they were interested in relating the absolute value of each role orientation to behavior in the workplace rather than its relative importance. Instead of focusing on criminal violations, they developed seven measures of "practice behavior" to examine actual behavior in the workplace. These measures covered knowledge about drugs and clients, information provided to clients, and the pharmacists' relationship with medical practitioners. Scores on the professional orientation scale were significantly associated with all seven practice behaviors, while business orientation scores were weakly linked with only three of them.<sup>6</sup> Those who were more professionally oriented had more positive practice behaviors in the workplace.

From these studies two hypotheses can be advanced. The first, drawn from Quinney's work, is that the relative strength of a professional over a business orientation is an important factor in explaining criminal violations.<sup>7</sup> Those who are relatively more professional than business oriented will be less likely to violate the law. The second hypothesis, drawn from Chappell and Barnes, is that professionalism is an absolute rather than relative sense is sufficient in explaining workplace behavior.<sup>8</sup>

Professionalism in both these studies is narrowly defined as role orientations, that is, as the attitudes and behavior that motivated professional commitment (e.g., reading professional literature, subscribing to journals and professional associations) and business commitment (e.g., being a good salesperson). No consideration has been given to professional autonomy, despite the significant theoretical role it has played in defining professionals and professional work.<sup>9</sup> Nor did these studies focus on the values held by professionals (e.g., helping others) and their possible impact on compliance. In this study, the notion of professionalism is extended to include measures of both professional values and autonomy.

## PROFESSIONAL VALUES AND AUTONOMY AND COMPLIANCE

Values refer to generalized modes of conduct or goals in life that may cluster together as value orientations.<sup>10</sup> Value orientations research suggests that values are learned through experience, that values change as one moves to a different culture or subculture, and that values are linked with beliefs about the self. Values are fundamental to attitudes and behavior.<sup>11</sup>

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6. Chappell and Barnes did not attempt to examine the main effects net of each other or for a possible interaction between the two.

7. Quinney, 11 *Soc. Probs.* at 181–82.

8. Chappell & Barnes, 18 *Soc. Sci. & Med.* at 108–9.

9. Derber, *Professionals as Workers*.

10. M. Rokeach, *The Nature of Human Values* (New York: Free Press, 1973).

11. Valerie Braithwaite & William Scott, "Values," in John Robinson *et al.*, *Measures of*

Thus role orientations, as attitudes and behavior, are determined both externally by the values of the institutional setting in which individuals are located and internally by the inclusion of such values into the individual's belief system.

Consonant with this perspective are studies of the professions in which the immediate work environment is seen as the major factor in conditioning professional attitudes and actions.<sup>12</sup> Chappell and Barnes, for example, found that work setting was a significant predictor of both business and professional role orientations among pharmacists.<sup>13</sup> In particular, pharmacists who were located in a hospital setting had a stronger professional role orientation and a weaker business role orientation. Even after the demographic factors were taken into account, work setting remained a strong predictor of role orientations; its effect on compliance was not examined. Work setting has also been associated with differences in value orientation in studies of a variety of professional groups, although links between role orientations and values were not clearly established.<sup>14</sup>

Braithwaite and Geis have suggested that corporate values as distinct from individual occupational values will be important in the level of organizational compliance.<sup>15</sup> It could be argued that organizations which promote an atmosphere of social responsibility will be more likely to engender compliance with government regulations by their workers. Similarly, those organizations which appear to disregard the general community in the pursuit of profit may promote a culture wherein noncompliance with government regulations is tolerated or condoned. Victor and Cullen have also argued that a firm's ethical climate affects both the types of issues considered within the organization and the responses the organization makes to these issues.<sup>16</sup>

The extent to which corporate value override professional values will be influenced by professional autonomy. Autonomy is seen as one of the most important aspects of professional labor. Goode, for example, argues that whether or not professionals work in bureaucratic settings is immaterial to their professional status—the important aspect of their work is their

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*Personality and Social Psychological Attitudes* (New York: Academic Press, 1990) ("Braithwaite & Scott, 'Values'").

12. Freidson, *Profession of Medicine* (cited in note 2).

13. Chappell & Barnes, 18 *Soc. Sci. & Med.* 107.

14. Carol L. Kronus, "Occupational versus Organizational Influences on Reference Group Identification," 3 *Sociology of Work & Occupations* 303 (1976); Freidson, *Profession of Medicine*; Jerome E. Carlin, *Lawyers on Their Own* (New Brunswick, N.J.: Rutgers University Press, 1962).

15. John Braithwaite & G. Geis, "One Theory and Action for Corporate Crime Control," 28 *Crime & Delinq.* 292 (1982).

16. Bart Victor & John B. Cullen, "The Organizational Bases of Ethical Work Climates," 33 *Admin. Sci. Q.* 101 (1988).

autonomy.<sup>17</sup> Both Freidson<sup>18</sup> and Johnson<sup>19</sup> also emphasize control and self-regulation as the important features delineating professional workers from others. We might expect managers who are also trained as professionals, and who have greater autonomy in the workplace, to be more likely to comply with government regulations when those regulations also fulfill their professional obligations. Where corporate goals and procedures are to be strictly adhered to and professional autonomy weakened, individuals will have little leeway in performing their duty. Thus, the way in which power is structurally divested throughout the company will affect the way in which individuals are able to implement their own personal values. In those organizations where workers are able to exercise discretion in their work, are responsible for their actions, and use their own judgment in making decisions within the structure to implement policy, values will impact on organizational compliance.

## RESEARCH GOALS

This study aims to examine the effects of three aspects of professionalism on organizational compliance: role orientations, values, and professional autonomy. The context is the nursing home industry and the key actors are the directors of nursing. Professional autonomy is an important feature of the organization of Australian nursing homes. This characteristic was expected to be not only important in its own right but to act as a buffer between values and role orientation and compliance.

In the context of Australian nursing homes, directors of nursing are responsible for their staff and the daily running of the home. However, these activities will be helped or hindered by the degree to which they also have control over the financial management of the homes. Thus professional autonomy is conceptualized in terms of their control over both staff and finances. The latter form of professional autonomy is more likely to be enhanced if the director of nursing is an owner or part owner of the organization.

The values considered most relevant to the study were those reflecting ideal modes of conduct. In a study of the major dimensions underlying this domain,<sup>20</sup> Braithwaite and Law identified two major dimensions—concern for the welfare of others and competence and effectiveness. While both types are regarded as highly desirable in society, one epitomizes nurs-

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17. W. Goode, "The Theoretical Limits of Professionalization," in Amitai Etzioni, ed., *The Semi-Professions and Their Organization* (New York: Free Press, 1969).

18. Eliot Freidson, *Professional Powers* (Chicago: University of Chicago Press, 1986).

19. T. Johnson, *Professions and Power* (London: Macmillan, 1973).

20. Valerie Braithwaite & Henry Law, "Testing the Adequacy of the Rokeach Value Survey," 49 *J. Personality & Soc. Psychology* 250 (1985); Braithwaite & Scott, "Values."

ing values, the other business values. The former were comprised of caring values and, as such, epitomized professional nursing values. The latter represented efficiency and, as such, could be readily linked with being business oriented.

Two measures of role orientations were included in this study. On the basis of the findings of Chappell and Barnes, nursing professionalism was expected to be the role orientation most likely to affect compliance in the nursing home industry. Nursing professionalism was operationalized in terms of commitment to nursing, in particular, gerontological nursing. In response to Quinney's work, a relative professionalism scale was also included that assessed the extent to which director of nursing allowed their nursing orientation to dominate their business orientation. Including both these indices enables us to examine the main effects of nursing professionalism and the relative importance of nursing professionalism net of each other.

## THE DATA

To examine these research questions we have taken data from a study of regulation in the Australian nursing home industry. Australian nursing homes are an excellent context for testing the effect of professionalism on organizational compliance. Nursing homes in Australia are relatively small organizations (they average around 40 employees) in which the chief executive, the director of nursing, is very much in control. Unlike the American situation in which directors of nursing answer to an administrator above them and have a middle management below them, Australian nursing homes have flat management structures. When asked if they had the final say on most decisions that mattered, more than three-quarters agreed (76%) and less than 12% disagreed; 12% did not view themselves or others as having the most say.

The regulation of the nursing home industry is controlled and monitored by the Australian Commonwealth government. The Australian system requires that nursing homes be evaluated on 31 outcome standards using a three-point rating scale (met, met in part, and not met). The 31 standards were designed to cover seven broad objectives specific to resident's outcomes; health care, social independence, freedom of choice, homelike environment, privacy and dignity, variety of experience, and safety (table 1). Previous work suggests that the standards provide a reliable, valid, and comprehensive coverage of the medical, personal, and social needs of the nursing home's residents.<sup>21</sup>

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21. Commonwealth/State Working Party on Nursing Home Standards, *Living in a Nursing Home: Outcome Standards for Australian Nursing Homes* (Canberra: Australian De-

**TABLE 1**  
**Outcome Standards for Australian Nursing Homes**

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**Objective 1: Health care**

- 1.1 Residents are enabled to receive appropriate medical care by a medical practitioner of their choice when needed
- 1.2 Residents are enabled and encouraged to make informed choices about their individual care plans
- 1.3 All residents are as free from pain as possible
- 1.4 All residents are adequately nourished and adequately hydrated
- 1.5 Residents are enabled to maintain continence
- 1.6 Residents are enabled to maintain and, if possible improve, their mobility and dexterity
- 1.7 Residents have clean healthy skin consistent with their age and general health
- 1.8 Residents are enabled to maintain oral and dental health
- 1.9 Sensory losses are identified and corrected so that residents are able to communicate effectively

**Objective 2: Social independence**

- 2.1 Residents are enabled and encouraged to have visitors of their choice and to maintain personal contacts
- 2.2 Residents are enabled and encouraged to maintain control of their financial affairs
- 2.3 Residents have maximum freedom of movement within and from the nursing home, restricted only for safety reasons
- 2.4 Provision is made for residents with different religious, personal, and cultural customs
- 2.5 Residents are enabled and encouraged to maintain their responsibilities and obligations as citizens

**Objective 3: Freedom of choice**

- 3.1 The nursing home has policies which have been developed in consultation with residents and which:
  - enable residents to make decisions and exercise choices regarding their daily activities
  - provide an appropriate balance between residents' rights and effective management of the nursing home
  - and are interpreted flexibly taking into account individual resident needs
- 3.2 Residents and their representatives are enabled to comment or complain about conditions in the nursing home

**Objective 4: Homelike environment**

- 4.1 Management of the nursing home is attempting to create and maintain a homelike environment
- 4.2 The nursing home has policies which enable residents to feel secure in their accommodation

**Objective 5: Privacy and dignity**

- 5.1 The dignity of residents is respected by nursing home staff
- 5.2 Private property is not taken, lent, or given to other people without the owner's permission
- 5.3 Residents are enabled to undertake personal activities, including bathing, toileting, and dressing in private
- 5.4 The nursing home is free from undue noise
- 5.5 Information about residents is treated confidentially
- 5.6 Nursing home practices support the resident's right to die with dignity

**Objective 6: Variety of experience**

- 6.1 Residents are enabled to participate in a wide range of activities appropriate to their interests and capacities

**Objective 7: Safety**

- 7.1 The resident's right to participate in activities which may involve a degree of risk is respected
  - 7.2 Nursing home design, equipment, and practices contribute to a safe environment for residents, staff, and visitors
  - 7.3 Residents, visitors, and staff are protected from infection and infestation
  - 7.4 Residents and staff are protected from the hazards of fire and natural disasters
  - 7.5 The security of buildings, contents, and people within the nursing home is safeguarded
  - 7.6 Physical and other forms of restraint are used correctly and appropriately
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These standards were given a legal basis under section 45D of the National Health Act in November 1987. There are three sanctions that the Commonwealth government can impose on homes for noncompliance:<sup>22</sup>

1. Withdrawal of Commonwealth funding for new admissions to the nursing home
2. Withholding an annual Commonwealth funding increase to compensate for inflation
3. Cutting off all Commonwealth funding

The Commonwealth government also works with the state government to use state powers when that seems the most effective way to go.<sup>23</sup>

The evaluation of each nursing home is undertaken by teams of Commonwealth inspectors located in each state of Australia. Teams spend an average of 6.5 hours in their initial visit to assess compliance with the standards. These initial assessments are then discussed with the nursing home at a second negotiation visit. The inspection teams cannot be smaller than two, and one of the members must be a trained nurse.

The data are drawn from interviews conducted with directors of nursing in 410 nursing homes over a 20-month period from May 1988 to March 1990. Of the 410 nursing homes, 242 were selected as a random sample stratified by number of beds, type of ownership, and level of disability, within four sampling regions. The sampling regions surrounded the four large metropolitan centers of the states of New South Wales, Queensland, South Australia, and Victoria, in which more than two-thirds of all nursing homes in the country are located. The Australian government ensured that these homes were inspected during the time frame, and 96% of the homes cooperated in the study.<sup>24</sup>

Within these four sampling regions, all other nursing homes inspected during the 20-month period as part of the government's normal inspection schedule were included in the study. As analyses conducted elsewhere showed no substantial differences between the randomly and

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partment of Community Services & Health, 1987); John Braithwaite, Toni Makkai, Valerie Braithwaite, Diane Gibson, & David Ermann, *The Contribution of the Standards Monitoring Process to the Quality of Nursing Home Life: A Preliminary Report* (Canberra: Australian Department of Community Services & Health, 1990) ("Braithwaite *et al.*, *Preliminary Report*"); John Braithwaite, Valerie Braithwaite, Miriam Landau, Diane Gibson, & Toni Makkai, *The Reliability and Validity of Nursing Home Standards* (Canberra: Australian Government Publishing Service, 1992); John Braithwaite, Toni Makkai, Valerie Braithwaite, & Diane Gibson, *Raising the Standard: Resident Centred Nursing Home Regulation in Australia* (Canberra: Australian Department of Community Services & Health, 1992) ("Braithwaite *et al.*, *Raising the Standard*"); Valerie Braithwaite, John Braithwaite, Diane Gibson, & Toni Makkai, "Assessing the Quality of Australian Nursing Home Care," 16 *Australian J. Pub. Health* 89 (1992).

22. See John Braithwaite & Toni Makkai, "Testing an Expected Utility Model of Corporate Deterrence," 25 *Law & Soc'y Rev.* 7 (1991).

23. *Id.*

24. For more details, see Braithwaite *et al.*, *Preliminary Report* (cited in note 21).

nonrandomly selected homes, they have been combined to increase the sample size from 242 to 410 nursing homes in which the chief executive officer was interviewed.<sup>25</sup>

The interviews with the directors of nursing were conducted on the completion of a standards monitoring process which covered not only the initial inspection but also negotiations concerning the accuracy of the inspection report and procedures for implementing actions to remedy non-compliance. Thus, the inspection process extended over months, with the median duration being five months.

In addition to data collected from the 410 directors of nursing, the inspection teams' assessment of the home's compliance with the 31 standards for quality nursing home care was obtained and matched to each nursing home interview. As the inspection protocol requires the homes to be evaluated to all 31 standards, this provides us with what Quinney calls "a homogeneous unit of behavior." On completing each nursing home inspection, the team was asked to complete a short self-administered questionnaire for the researchers which was also matched to the director of nursing interview data. Finally, a subset of aggregate demographic data collected by the Australian Commonwealth government on each resident entering a nursing home in the country was extracted and matched to the 410 nursing homes in this study.

### The Dependent Variable—Organizational Compliance

A detailed study of the 31 standards has shown that individual ratings can be summed to give an overall compliance score, where 31 indicates that all standards were met and zero indicates that none were met.<sup>26</sup> As noncompliance is the exception rather than the norm, the distribution of government-assessed compliance is skewed with most homes having an overall compliance rating closer to 31 than to zero. The compliance scale has a mean of 26 and a standard deviation of 4.78.<sup>27</sup>

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25. See *id.* for further information regarding the two samples.

26. *Id.* at 40–50. Braithwaite *et al.*, 16 *Australian J. Pub. Health*.

27. Quinney's measure of criminal violations was based on official state and federal records (11 *Soc. Probs.*; cited in note 3); Chappell and Barnes's measure of practice behavior comprised seven activities on which pharmacists assessed themselves (18 *Soc. Sci. & Med.*; cited in note 5). In this study one measure of compliance is presented—government-assessed compliance. We also had a second measure of compliance involving self-assessment. Self-assessed compliance was measured at the time of the interview with the director of nursing. The director was shown the ratings assigned to each of the standards by the inspection team and asked whether or not they agreed with the ratings. If they did not, they were then asked what they thought the correct ratings were for the home. Mostly the director of nursing agreed with the inspection teams' assessment of the home. It is of note that there were occasions when the director of nursing assigned the home a lower rating than did the team. Clearly, these two measures of compliance are not independent, and this is shown by the high correlation between the official recording of compliance with the self-reported com-

The general policy of the Australian government is to list a home as a “home of concern” when the compliance rating drops below 21. The home remains in this category until more than half of the unmet or met in part ratings are rectified, resulting in an improved compliance score that exceeds 26. From July 1990 to December 1991, 39 homes had been sent a formal notification of intent to declare that the home did not meet the standards. Of these, 11 resulted in eventual closure of the nursing home, either through government action to stop funding for residents or negotiated closure. The remaining 39 responded by coming into compliance with the law.

### Control Variables

Neither Quinney nor Chappell and Barnes controlled for the work environment when they examined the relationship between professional orientations and prescription violation/practice behaviors. Yet aspects of the work environment, such as the size of the business, geographic location of the business, number of staff in the business, and profile of the clientele may condition the nature of the relationship between professionalism and compliance.

The work environment of Australian nursing homes varies on a number of dimensions. Two structural environmental features of nursing homes that may influence compliance are the size of the home and its age. In the case of size, a larger home will have more chance of running afoul of the standards than a smaller home, while older homes are likely to have lower compliance scores because it is often harder to implement physical structural changes to meet fire and physical safety standards. Unlike the studies of Quinney and Chappell and Barnes, these analyses control for the structural features of the work environment in assessing the relationship between professional role orientations and organizational compliance.

Given the increasing empowerment of residents in Australian nursing homes, this constituency in the industry may have an important role to play in effecting organizational compliance. Three indicators of the composition of the residents in the home are controlled in the following analyses—the percentage of female residents, the percentage of married residents, and the average level of disability of those residing in the home.<sup>28</sup>

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pliance—.88. For this reason we choose to only present results for government-assessed compliance. However, analysis of self-assessed compliance produced substantially the same results.

28. The average level of disability for each home was estimated by taking each resident's service need and multiplying it by the number of average hours of nursing and personal care (NPC) required per week by a resident with that classification. The residents service need (based on information supplied by the nursing home), also referred to as the

As indicated previously, inspection teams vary in size. Larger teams should be more likely to detect violations with the standards simply by virtue of having more inspectors in the home. As with the physical structure of the home and its resident profile, the possible effect of the size of the inspection team needs to be controlled in the analyses. Although the standards are uniform across the country, inspection teams are located in each state. Inspectors do not work on teams operating in other states, and previous work has shown that one of the states differs from others in compliance ratings.<sup>29</sup> To control for geographical location, three dummy variables representing Queensland, New South Wales, and Victoria are entered into the regression equations.

### Professional Orientations, Values, and Autonomy

The most fundamental differences between nursing homes occur at the level of ownership.<sup>30</sup> Homes can be run either as profit or nonprofit enterprises, a distinction at the corporate level that has parallels at an individual level when we refer to business and professional (nonprofit) values. Not-for-profit homes include government, charitable, and church-owned homes. For-profit homes include homes where the director of nursing is an employee of the proprietor(s), or a joint owner or a sole proprietor. Homes located in the private sector are ultimately concerned with making a profit for the owners; homes that are owned by government, charities, and churches have as their formal goal the provision of social welfare.

In considering professional autonomy, it is therefore critical to distinguish sector location (profit or nonprofit) and director of nursing as owner or employee and take account of both. Quality of care tends to be higher, on average, in the not-for-profit sector than in the for-profit sector. Roberta Riportella-Muller and Doris P. Slesinger's North American research has shown repeatedly a significant correlation between compliance ratings and type of home ownership, with for-profit homes having lower

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resident's classification index (RCI), can range from 1 to 5. The standard hourly rates, as of 1 July 1988, are: 27 for an RCI of 1, 23.5 for an RCI of 2, 20 for an RCI of 3, 13 for an RCI of 4, and 10 for an RCI of 5 (Australian Department of Community Services & Health, *New Nursing and Personal Care and Staffing and Funding Arrangements*, 24 June 1988 (CNH 88003 (NG))).

29. Braithwaite *et al.*, *Preliminary Report* 115–29 (cited in note 21).

30. Roberta Riportella-Muller & Doris P. Slesinger, "The Relationship of Ownership and Size of Quality of Care in Wisconsin Nursing Homes," 22 *Gerontologist* 429 (1982).

compliance.<sup>31</sup> Others, however, have failed to confirm these results, claiming no difference in quality of care and sector location.<sup>32</sup>

Of the 410 nursing homes in our study, one third ( $n = 136$ ) were not-for-profit homes, mostly church homes ( $n = 106$ ). The remaining two-thirds of the sample were for-profit homes. Of the for-profit homes, 64 (24%) were run by a chief executive who was either the sole owner or part owner of the home. In the remainder, the chief executive was an employee. The distinction between directors of nursing who are owners and those who are employees is important because it could reasonably be argued that ownership is a measure of autonomy. Where chief executives are owners or part owners of the nursing home, they are more likely to be in control of both finances and staff. While this is generally the case, it is important to acknowledge that a minority of cases violate this assumption.

In some nursing homes, financial management may be regulated by an outside firm of financial consultants, whose job it is to ensure that the home remains an efficient and viable concern. In some other cases, where there is joint ownership, the other partner(s) may be concerned with the financial running of the home while the owner/director has control of the nursing care. Data collected from the teams that visited the homes indicated that in 16 cases the team had important dealings with a co-proprietor. Generally, this partner had responsibility for financial management and budgeting.<sup>33</sup>

Other measures of autonomy were included in the study. Autonomy can also be reflected in the extent to which directors have control over the work process. As chief executive, the director of nursing has to ensure compliance with the standards in order to obtain large government subsidies. These efforts will be frustrated or eased according to how much autonomy they have from the proprietor. Proprietors who control the purse strings can frustrate management's attempts to improve the quality of care in the nursing homes and may cause low compliance. Equally, proprietors who constantly interfere with the daily running of the home may adversely affect compliance levels. Those homes where the proprietors provide directors of nursing with the access to necessary funds and resources should

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31. *Id.*; see also George E. Molloy, "Quality Assurance and the Survey Process," 5 *J. Long-Term Care Admin.* 1 (1977); Michael Koetting, *Nursing Home Organization and Efficiency—Profit versus Non-Profit* (Lexington, Mass.: Lexington Books, 1980) ("Koetting, *Nursing Home Organization*"); Bradford H. Grey, ed., *For-Profit Enterprise in Health Care* (Washington, D.C.: National Academy Press, 1986) ("Grey, *For-Profit Enterprise*").

32. See R. H. Holmberg & N. N. Anderson, "Implications for Ownership for Nursing Home Care," 6 *Medical Care* 300 (1968); S. Lee Yong, "Nursing Homes and Quality of Health Care: The First Year Result of an Outcome-oriented Survey," 7 *J. Health & Hum. Resources Admin.* 32 (1984). Catherine Hawes & Charles D. Phillips, "The Changing Structure of the Nursing Home Industry and the Impact of Ownership on Quality, Costs, and Access," in Grey, *For-Profit Enterprise*; Riportella-Muller & Slesinger, 22 *Gerontologist*.

33. Unfortunately the data do not enable us to distinguish between sole owners and partners, and the two groups will be referred to as owners from this point on in the article.

be more likely to comply with regulatory standards. Thus, the extent to which directors of nursing have access to funds and resources to provide quality care to residents is an important measure of professional autonomy.

The extent to which directors of nursing had control over financial decisions was measured using four items. Directors of nursing were asked, first, how involved the proprietor had been in deciding what to do about the standards monitoring report and, second, who had the most say over the setting of the budget. A score of 3 was given for each answer if only the director of nursing was involved, a score of 2 meant that someone else had been involved but not to the exclusion of the director of nursing, and a score of 1 was used if the director of nursing did not have a say. A third question asked respondent to agree (1) or disagree (2) with the item "Director of Nursing has only minor responsibility for financial management." The fourth item in the scale was not a question directed to the director of nursing but rather to the standards monitoring team: "During the recent standards monitoring process, did you have any important dealings with anyone above the Director of Nursing?" A score of 2 was given if no such person was interviewed, and a score of 1 was given if another was interviewed. The correlation among these items ranged from .05 to .41, producing an alpha reliability coefficient of .54.<sup>34</sup> To ensure equal weighing for the items, scores were divided by their standard deviation before being added.<sup>35</sup> As the scale had no natural metric, it was rescored from zero to 10 where a high score indicated high financial control and a low score indicated low financial control. The scale had a mean of 3.87 and a standard deviation of 2.99.

The primary objective of the 31 standards used to assess Australian nursing homes is to ensure good "quality of life" for the residents. In attempting to produce such an outcome, the director of nursing must be able to effectively direct staff in the home. If the director of nursing does not feel that she has the autonomy to control staff, her ability to ensure that standards are complied with is limited, and compliance in such homes can be expected to be lower. Thus professional autonomy not only applies upward, but it must operate downward as well.

The measure of control over staff comprised three attitude items: "I have the authority to run this home in the way I think best," "I have the

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34. The alpha coefficients for all the scales are based on the standardized items.

35. In those cases where there were missing data, the mean was substituted for all items used to construct the scales. While wanting the items to have equal weight in the scale, we did not want to standardize scores around a mean of zero. The traditional practice of converting to *z*-scores reduces interpretability in some instances; information about whether the sample lies above or below the midpoint can be important for interpretation and is lost when items are converted to *z*-scores with a mean of zero. To simplify scale construction and description, all scales in this article were constructed in the same way.

freedom to run this home pretty much as I like,” and “As the director of nursing I have the final say on most of the decisions that matter.” Directors of nursing indicated the extent to which they strongly agreed (5), agreed (4), neither agreed nor disagreed (3), disagreed (2) or strongly disagreed (1). Correlations among items ranged from .38 to .55 with an alpha reliability coefficient of .73. After dividing by the standard deviation, scores on the three items were summed together and then rescored from zero to 10. A high score indicated high control and a low score indicated low control; the scale had a mean of 6.96 with a standard deviation of 2.01.

Being in charge of a nursing homes requires directors of nursing to bring to bear their professional training as nurses and their skills as managers of small organizations. In this situation, as with Quinney's and Chappell and Barnes's pharmacists, directors of nursing are located in an organizational position that may require them to trade off their different roles. The trade off hypothesis was tested using a professional versus business orientation scale. Respondents used the strongly disagreed (1) to strongly agree (5) scale to respond to four items that reflected the degree to which nursing professionalism dominated a business orientation—“Running a nursing home is like running a business” (reverse scored), “I always bring a nursing orientation to my job rather than a business orientation,” “As a director of nursing I am a nurse first, a manager second,” and “We need a nursing home industry with caring values rather than business values.” The correlations among the items ranged from .11 to .49. The alpha reliability coefficient was .61.

Nursing professionalism was assessed through commitment to the profession of nursing. Such commitment is demanded of directors of nursing to instill confidence in the provision of care to residents and to act as a positive role model to staff. A strong sense of occupational solidarity is considered essential for professional development, and this requires that colleagues, rather than patients, employers, or other professional groups, become the major reference group. Commitment to nursing was assessed through three items—“Working in a nursing home is not my idea of a top nursing job” (reverse scored), “If I could choose my career over, I would choose something other than nursing” (reverse scored), and “If I could choose my nursing specialization over, I would choose gerontics.” The correlations among the scales ranged from .21 to .34. The alpha reliability coefficient was .54. As neither the professional versus business scale nor the professionalism scale had natural metrics, they have been rescored from zero to 10. Nursing professionalism had a mean of 7.14 and a standard deviation of 2.23; prioritizing nursing professionalism over a business orientation had a mean of 5.92 and a standard deviation of 1.90.

The value measures provided the opportunity to assess the commitment to the profession. A third aspect of professionalism is the level of commitment to the primary goal of nursing—the care of the sick and disabled. A problem with measuring such a commitment is that the items tend to be “motherhood” statements that everybody, not just nurses, supports. It is also the case that value measurement yields highly skewed rating data in many instances, with the majority of respondents overwhelmingly agreeing with values, such as being considerate or being capable. In an attempt to overcome this problem, directors of nursing were asked the priority they gave to particular ways of behaving when hiring staff. This form of the question attempts to move from the world of abstraction to the world of action. As directors of nursing have essentially become managers, with little time for the day-to-day care of patients, their values will most obviously transmit themselves into action, by the value they place on ways of behaving when they are hiring new nursing staff.

Directors of nursing were presented with ten ways of behaving and were asked to indicate the priority they would give to each one when hiring nursing staff to work in their nursing home. The values were helpful, competent, understanding, adaptable, knowledgeable, considerate, resourceful, loving, forgiving, and efficient. Responses were made on a 7-

**TABLE 2**  
**Factor Analysis of Desirability of Staff Behavior Variables<sup>a</sup>**

|  | Top Priority <sup>b</sup> | Factor |      | Item to Total Correlation <sup>c</sup> |
|--|---------------------------|--------|------|--|
|  |                           | 1      | 2    |  |
| <b>Caring ways</b>   |                           |        |      |  |
| 1. Forgiving (willing to pardon others)                      | 27                        | .76    | .21  | .57                                    |
| 2. Loving (showing genuine affection)                        | 45                        | .76    | .09  | .55                                    |
| 3. Understanding (able to share another's feelings)          | 52                        | .67    | -.11 | .42                                    |
| 4. Helpful (always ready to assist others)                   | 36                        | .60    | .03  | .39                                    |
| 5. Considerate (thoughtful of other people's feelings)       | 63                        | .53    | .13  | .35                                    |
|  |                           |        |      | (.70)                                  |
| <b>Efficient ways</b>  |                           |        |      |  |
| 6. Efficient (using the best method to get the best results) | 45                        | .04    | .78  | .52                                    |
| 7. Knowledgeable (well informed)                             | 24                        | .06    | .75  | .50                                    |
| 8. Competent (capable)                                       | 48                        | .00    | .67  | .41                                    |
| 9. Resourceful (clever at finding ways to achieve a goal)    | 26                        | .17    | .61  | .38                                    |
| (% of variance accounted for)                                |                           | 29     | 19   | (.67)                                  |

<sup>a</sup> Exact wording of the question was as follows: “Here is a list of ways of behaving which are generally valued in the community. What priority would you give to the following ways of behaving when you are recruiting staff for your nursing home?” Response categories were a seven-point scale (1) lesser priority to (7) top priority.

<sup>b</sup> Percentage of respondents who indicate “top priority” for this value.

<sup>c</sup> Figures in brackets show reliabilities (Cronbach Alpha).

point scale ranging from 1 (less priority) to 7 (top priority). The distribution of responses were skewed. In many instances, the majority of directors would give the value top priority as is shown by the data in table 2. Nor unexpectedly, 63% of directors valued consideration of other people's feelings as a top priority in hiring staff. Similarly, 52% gave top priority to being understanding. Knowledgeable and resourceful were valued less, with one in four directors placing these two values as top priority.

A principal-axes factor analysis followed by a varimax rotation resulted in a two-factor solution with the first referring to values generally associated with efficiency, and the second referring to values generally associated with caring. The value "adaptable" was dropped from the final analysis because it cross-loaded on the two dimensions. The two sets of items were used to develop scales in the manner outlined previously. The efficiency scale has a mean of 8.9 and the caring scale a mean of 8.8 out of a theoretical maximum of 10. The standard deviations were 1.4 for efficiency and 1.7 for caring.

### The Links between Different Aspects of Professionalism

The development of these scales has provided measures of three aspects of professionalism—orientations, autonomy, and values. In table 3 the correlations between the various dimensions of are professionalism are presented. With regard to orientations, those who indicate a high level of commitment to the profession are significantly more likely to place a higher value on professional rather than on business values. Similarly, the two forms of professional autonomy are linked, with those having autonomy in financial matters also having autonomy over staff in the organiza-

**TABLE 3**  
**Intercorrelations between Professionalism Scales (n = 410)**

|                                    | 1      | 2     | 3     | 4     | 5   |
|------------------------------------|--------|-------|-------|-------|-----|
| <b>Professional orientations</b>   |        |       |       |       |     |
| 1. Professionalism versus business |        |       |       |       |     |
| 2. Commitment to the profession    | .09**  |       |       |       |     |
| <b>Professional autonomy</b>       |        |       |       |       |     |
| 3. Control of finances             | -.11** | -.03  |       |       |     |
| 4. Control of staff                | -.09** | .11** | .23** |       |     |
| <b>Professional values</b>         |        |       |       |       |     |
| 5. Caring values                   | .19**  | .03   | -.03  | .03   |     |
| 6. Efficiency values               | -.08*  | .07*  | .04   | .09** | .06 |

\*  $p < .05$ , \*\* $p < .01$ ; one-tailed tests of significance.

tion. With regard to values, caring and efficiency values were not significantly correlated. Thus, caring is not incompatible with efficiency: the two are not in conflict.

The different aspects of professionalism are also interrelated. The most interesting finding is that those who prioritize professional over business interests are significantly less likely to have autonomy in the workplace. Possibly directors of nursing who exhibit a strong commitment to a professional rather than business orientation are subject to constant challenges to their autonomy. Alternatively, directors of nursing with such orientations may choose not to enter organizational structures in which they need to exercise control over money and persons. The notion of self-selection is an important theoretical issue. It may be that individuals are quite discerning in where they choose to be employed, particularly in an industry where good directors of nursing will always get jobs.

Interestingly, commitment to the professional does not correlate with control of finances, but it does correlate with control of staff. Those with a strong commitment to the professional also feel that they have autonomy in running the home. Possibly their obvious professional commitment brings with it respect from others for ability to manage staff. Strong professional commitment, however, does not necessarily mean that one can or wants to manage finances.

Directors who are more professionally oriented are more likely to give priority to both efficiency and caring values when hiring staff. This elaborates our point above that efficiency and caring values are not necessarily incompatible; a highly professional director of nursing will value both when hiring staff. The relationship between autonomy and values is complex. Financial control is not correlated with either caring or efficiency values in employing others, but control of staff is associated with efficiency. A director of nursing who runs her own ship will place a high priority on efficiency values when hiring.

### **Work Setting and Professionalism**

As mentioned above, there are essentially two major sectors involved in the provision of aged care services: the for-profit sector and the not-for-profit sector. We have posited a third important sector that divides the for-profit sector into those directors of nursing who own the means of production and those who do not. To examine the extent to which measures of professionalism vary among different work settings, analyses of variance were undertaken. The results are presented in table 4.

Professional values do not vary significantly across the three types of working settings. Caring and efficiency are equally valued regardless of whether the director of nursing is an owner or an employee in either the

**TABLE 4**  
**The Relationship between Work Setting and Professionalism**  
**(n = 410)**

|                                  | Owner/Director<br>of Nursing<br>(n = 64) | For-Profit<br>Employee<br>(n = 208) | Not-for-Profit<br>Employee<br>(n = 138) |
|----------------------------------|--|-------------------------------------|---|
| <b>Professional orientations</b> |  |                                     |   |
| Professionalism versus business  | 6.00                                     | 5.86                                | 5.96                                    |
| Commitment to profession         | 6.61                                     | 7.07                                | 7.50*                                   |
| <b>Professional autonomy</b>     |  |                                     |   |
| Control of finances              | 7.64                                     | 2.88                                | 3.61**                                  |
| Control of staff                 | 7.48                                     | 6.90                                | 6.80                                    |
| <b>Professional values</b>       |  |                                     |   |
| Caring values                    | 8.87                                     | 8.69                                | 8.87                                    |
| Efficiency values                | 9.13                                     | 8.81                                | 8.96                                    |

*F*-tests significant at \*  $p < .05$ , \*\*  $p < .01$ .

for-profit or not-for-profit sector. Similarly, the priority of professional over business orientations does not vary across work settings. Commitment to the professional is, however, stronger in the not-for-profit sector than in either of the other two sectors. The mean levels of professional commitment are lowest for chief executives who are owners and highest for chief executives who are employees in not-for-profit homes.

The average level of control of finances, but not control over staff, varies across the work settings. Owners, not unexpectedly, have much higher levels of control over budgeting and finance than employees. Scheffe tests between the three means indicated no significant difference between for-profit and nonprofit employees. The mean level of financial control is at a similarly low level in both groups, indicating that such is autonomy is largely restricted, remaining in the hands of owners.

## PREDICTING ORGANIZATIONAL COMPLIANCE

To estimate the relationship between our three aspects of professionalism—orientations, autonomy, and values—and organizational compliance, an ordinary least squares regression model was fitted to the data, after controlling for all the variables discussed above as having possible influences on compliance scores.<sup>36</sup> The scoring, means, and standard devi-

36. An ordinary least squares regression assumes that the model is linear and additive (Michael S. Lewis-Beck, *Applied Regression: An Introduction* (Beverly Hills, Cal.: Sage Publications, 1980). In estimating the model listwise deletion of missing data was used. Preliminary hierarchical regressions resulted in the same substantive conclusions drawn from the final

ations for the control variables in the model are provided in appendix table A. As the purpose of this article is not only to determine if our measures are significantly associated with compliance levels but also to examine the relative weights of each of the measures in predicting compliance, the standardized coefficients are presented in table 5 along with the unstandardized coefficients.

Having controlled for a range of influences, neither the relative priority of professionalism over business concerns nor nursing professionalism itself directly predicted organizational compliance. Those who are relatively more professionally oriented are neither more nor less likely to be responsible for a highly compliant home than those who are relatively more business oriented.<sup>37</sup> Similarly, those who have a higher absolute commitment to nursing professionalism are neither more nor less likely to be managing a home with high compliance on the standards than those with a lower level of commitment.

Professional autonomy can be examined by focusing on the nature of the relationship between the director of nursing and those above and below her in the organization. Clearly, directors who have control over staff behavior are in a stronger position to ensure that practices which will improve the quality of care are implemented, and this is indeed confirmed by these data. Control of staff below is significantly associated with officially recorded compliance. Also of importance in explaining compliance with the regulations is the extent to which directors of nursing have control of financial resources, with financial control significantly improving compliance. The coefficients also show that financial control is more than twice as potent in explaining government-assessed compliance as control of staff.

Professional autonomy is at its maximum in homes where the director of nursing is either the owner or part owner of the establishment. This was most clearly evident when we examined mean level of professional autonomy for the different work settings. Owners had a significantly higher mean level of financial control. Yet, as was discussed earlier, the nonprofit sector has been found to provide higher quality service. In the previous section, the data show that mean levels of commitment to the profession differ significantly between owners, those who worked in the for-profit sector, and those who worked in the nonprofit sector. Owners had the lowest mean level of commitment to the profession, while nonprofit directors of nursing had the highest mean level of commitment.

The multivariate analysis shows that both nonprofit directors of nursing and for-profit directors of nursing who are employees have significantly

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model presented here. The exception was that when the organizational items were entered into the model as the first block, mean disability of residents was significant at .05 (one-tailed, same sign). These results are available from the authors on request.

37. This is true whether we use an official measure of organizational compliance or a self-reported measure of compliance.

**TABLE 5**  
**Professionalism and Organizational Compliance (n=410)**

|  | <i>b</i> | Beta    |
|--|----------|---------|
| <b>Control variables<sup>a</sup></b>         |          |         |
| Number of beds in the home                   | -.01     | -.10**  |
| Age of the home                              | -.02     | -.15*** |
| % of residents female <sup>b</sup>           | .03      | .11*    |
| % of residents married <sup>b</sup>          | .05      | .11*    |
| Mean disability of residents                 | .16      | .07     |
| No. of inspectors                            | -1.08    | -.14*** |
| Queensland home <sup>b</sup>                 | 5.30     | .43**   |
| Victorian home <sup>b</sup>                  | 4.11     | .36**   |
| New South Wales home <sup>b</sup>            | 3.97     | .41**   |
| Sample home                                  | -.62     | -.06    |
| <b>Work setting</b>                          |          |         |
| For-profit employee                          | 1.52     | .16*    |
| Nonprofit employee                           | 2.65     | .26**   |
| <b>Professional orientations<sup>c</sup></b> |          |         |
| Professionalism versus business              | .01      | .00     |
| Commitment to the profession                 | .00      | .00     |
| <b>Professional autonomy<sup>c</sup></b>     |          |         |
| Control of finances                          | .29      | .18***  |
| Control of staff                             | .19      | .08*    |
| <b>Professional values<sup>c</sup></b>       |          |         |
| Caring values                                | -.07     | -.02    |
| Efficiency values                            | -.19     | -.05    |
| Constant                                     | 18.23    |         |
| Adjusted R <sup>2</sup>                      | .31      |         |

<sup>a</sup> See appendix table A for a description of the control variables.  
<sup>b</sup> Two-tailed tests of significance.  
<sup>c</sup> For a description of the variables see text.  
\*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$ ; one-tailed tests of significance.

higher compliance levels than directors of nursing who are owners. As the model controls for the level of professional autonomy the directors have in the nursing home, as well as their professional values and orientations, these findings suggest that work setting has a distinctive contribution to make to compliance. One explanation could be that self-managed homes face the greatest financial stress due to either limited resources, funding, the profile of the residents, or the size of the organization. However, the regression model controls for both the resident profile and organization size. Furthermore, all nursing homes in Australia are funded by the federal government under the same complex formulas that take account of

the number of residents in the nursing home and the level of nursing and personal care required by each resident.<sup>38</sup>

Another explanation could be that work setting, as measured here, sets the priority for profit maximization. The director of nursing's decisions at a particular time are not based on what she would like to do, that is, on professional orientation, but rather responds to the financial imperatives of the moment (e.g., raising enough money for the new dementia wing). Situational factors arising from the work setting may override more deeply thought out ideals and personal standards. If this is the case, this finding provides support at a structural level for Quinney's general proposition that criminal violations are more likely to occur in an environment where the goals are at odds with the intent of the regulatory regime or where the implementation of the regulatory regime will lead to adverse consequences for the organization's goals.

As many of the standards embody notions of good nursing practice and are primarily directed at securing high quality for residents in nursing homes, we expected that professional values would directly affect the performance of the home on the regulatory standards. The data show that once other aspects of professionalism and a variety of factors are controlled, there is no such effect. Regardless of the priority that directors of nursing place on caring or efficiency values for her staff, there is no tangible effect on the outcomes standards.

Previously, we had suggested that the relationship between values and role orientations and compliance with the law would be moderated by the extent of the director of nursing's professional autonomy in running the home. A series of interaction terms between each of the professional values and orientations scales and the two measures of control were added to the model. None of the eight interactions had a significant effect on compliance with the law. Furthermore, interactions between values and role orientations and ownership were not significant. It would appear that although professional autonomy has a direct impact on compliance, it does not act as a moderator between the independent predictors, values and role orientations, and the outcome, compliance.

## DISCUSSION

On the basis of our examination of the relationship between professional orientations, values, autonomy, and organizational compliance, the data from the nursing home study would seem to indicate that professional orientations do not have a significantly direct effect on nursing home com-

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38. As part of the funding arrangements all nursing homes are guaranteed a minimum occupancy rate of 98% by the federal government.

pliance, net of the structural and residential characteristics of the home, the inspection team size and location of the home, the professional values held by the director of nursing, and finally, the level of professional autonomy that the director has in running the nursing home.<sup>39</sup>

Given the findings of Quinney and of Chappell and Barnes, why have we not found effects for professional orientations? There are a number of possible explanations. First, it may simply be that once the organizational environments taken into account, the professional orientations managers bring to their work environment are of little direct importance in determining the organization's compliance with regulatory standards. As was suggested earlier, even though a manager may be highly committed to professional values, such commitment may be overridden by the particular features of the organizational environment in which that manager finds herself. While the structural complexity of the nursing home environment is not as overwhelming as in larger organizations, it is more so than in the retail pharmacy context.

Second, a measure of relative commitment to professional/business orientations forces individuals to choose between the two orientations. The variable being measured is the size of the discrepancy. However, the more important variable for organizational compliance may be commitment to both orientations. Directors of nursing, by virtue of their positions, are required to perform two tasks—nursing administration and financial management—and nurses who end up in such positions may have demonstrated their commitment and ability to do both. As compliance requires nursing home managers to allocate resources and personnel in particular ways, a sense of business/managerial skills will enhance rather than detract from the home's level of compliance. Rather, what follows from this is that strong commitments to *both* professionalism and business efficiency will predict compliance.

The measure used in this analysis for commitment to the profession was not unlike measures used to assess overall level of satisfaction with nursing and gerontology. Thus, one might argue that one would not expect to find a relationship between commitment and compliance, since a truly professional director of nursing would not allow her personal satisfaction with the job to adversely affect the home's overall performance. Such an argument, however, is implausible and is not consistent with the data. Further analyses suggest that those who are unhappy in their jobs are likely to abrogate professional responsibilities as well. Again, the most likely explanation for the absence of a relationship between commitment to the professional and compliance is that personal values are being overridden by the structural complexity of the organization.

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39. This was also found to be the case when we substituted the self-reported measure of organizational compliance for the government-assessed compliance measure.

Is it the case that organizational complexity rather than professional autonomy moderates the relationship between professional orientations and values and organizational compliance? Perhaps, organizational complexity also moderates the relationship between professional autonomy and compliance. We can only provide a partial test of this hypothesis, as the data provide only one measure of organizational complexity—size of the organization. A series of regression models were tested which included bilinear interaction terms between organizational size and the six measures of professionalism. Of the six interaction terms included in the models, only the interaction between organizational size and relative commitment to professional/business values was significant. This interaction accounted for 9.7% of the variance in organizational compliance. These data suggest that in a “small” home, a unit increase in relative commitment to professional values results in an increase in compliance, whereas in a “large” home, a similar increase in relative commitment to professional values results in a decrease in compliance. It would appear that organizational complexity, as measured by size, may moderate the professional orientations of managers in determining the organization’s lawbreaking behavior, but it does not moderate the relationship between professional values and autonomy and compliance.

As with professional orientations, individual professional values have no significant direct effect on the organization’s compliance levels. Thus, caring values do not improve compliance, nor do efficiency values reduce compliance. As the director of nursing is not involved in the day-to-day aspects of nursing and caring for residents, it may be that her professional values are of little importance in determining outcomes for residents. Although, in theory, directors of nursing hire and fire staff, staffing problems complicate the situation in practice. First, it is difficult to employ nursing staff; salaries are low, conditions are poor, and nurses who are prepared to work in the aged care industry are in short supply in the Australian labor market. Second, turnover is high at both staff and management levels. Under these conditions, directors of nursing may be constrained in their ability to pick and choose staff who fulfill their personal values. Another possible alternative is that they will inherit staff chosen by others who have different values from themselves.

What these data do demonstrate is that professional autonomy and work setting are significant direct predictors of organizational compliance. However, the influence of the work setting is not quite as some would have expected. Ownership does not result in higher compliance; the data show that when directors of nursing are owners, they are more likely to compromise on standards.<sup>40</sup> Although ownership enables significantly higher

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40. A number of North American studies on type of nursing home and quality care have a significant correlation between compliance ratings and type of home ownership with

levels of financial autonomy, it does not translate into higher compliance. The regression analysis has controlled for size of the home, age of the home, and the level of disability of residents in the home, thereby ruling these factors out as possible confounding variables in explaining the link between type of ownership and compliance. Type of ownership may be a surrogate for a broader organizational culture that pervades the nursing home, particularly when we take into account the finding that mean levels of commitment to the profession vary across type of ownership, being lowest for directors of nursing who are owners. Earlier in the article we suggested that more professionally oriented managers may be less likely to enter organizations where the organizational culture emphasizes profit rather than care. It may also be the case that more business-oriented nurses choose to become owners. Our qualitative fieldwork does suggest that highly professionally committed nurses sometimes choose not to work for cost-cutting firms.

In addition to the profit orientation of the home, the level of professional autonomy that the director of nursing has in the nursing home is a significant factor in explaining regulatory compliance. Those homes in which the chief executive has control of both finances and staff have significantly higher compliance. This should not be a surprise. Without the power to control the budget within the nursing home, a director of nursing cannot make the necessary changes to bring the home into compliance and, perhaps more important, ensure that it remains in compliance with the regulatory standards. Furthermore, without power to change staff practices and procedures within the home, a director of nursing will be unable to improve the quality of care provided to residents. It should be remembered that these effects are net of type of ownership.

This interpretation locates lack of power as a precursor to poor standards. An alternative interpretation is that poor compliance scores are used by chief executives with restricted access to resources to gain more resources. In such circumstances the chief executive is professionally motivated. These directors of nursing take advantage of the fact that the home fails to comply with the law to pressure the proprietor to change the way in which power is divested through the organization. In this manner, directors of nursing may be using the standards monitoring process to bring about change in their level of professional autonomy in the nursing home. We have certainly observed this in our fieldwork. There were many in-

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for-profit homes having lower compliance. See Molloy, 5 *J. Long-Term Care Admin.*, and Koetting, *Nursing Home Organization* (both cited in note 31); Yong, 7 *J. Health & Hum. Resources Admin.* (cited in note 32). An earlier study had shown no relationship between ownership and quality of care; see Holmberg & Anderson, 6 *Medical Care* (cited in note 32). A later study found an interaction between size and type of ownership in its impact on quality care. Large nonprofit homes had lower compliance than large for-profit homes. See Riportella-Muller & Slesinger, 22 *Gerontologist* (cited in note 30).

stances where teams told us that directors of nursing would bring to their attention a violation of the standard in order to put pressure on the proprietor to provide the funds to bring about change. In other cases, directors of nursing used the monitoring process to bring about changes in staff practices in the home.

## CONCLUSION

Our initial hypothesis that professionalism would directly impact on organizational compliance is only partially supported. Whereas Quinney's study supported the crucial role played by professional values in reducing law violation, our study emphasizes the importance of professional autonomy and the organizational culture as factors that impede or facilitate law-breaking within an organizational setting. Neither values nor role orientations were found to play a salient role in predicting compliance. Yet when organizational complexity was controlled, some evidence of Quinney's proposition emerged. These findings demonstrate the importance of developing models of organizational compliance that are both social and individualistic in that they contextualize individuals' values and role orientations within social structures. The circumstances in which structure overrides individual characteristics and vice versa requires much more research. Furthermore, disentangling the two presents methodological difficulties we have not addressed here. Individuals are not randomly allocated to organizations. Long-term prospective studies are required for understanding of the process by which individuals in organizational settings are molded by their social milieu to engage in activities that enhance or jeopardize compliance.

**APPENDIX TABLE A**  
**Definitions, Means, and Standard Deviations for Control Variables**

| Variables                                   | Definitions                    | Mean  | (S.D.)  |
|---|--------------------------------|-------|---------|
| Number of beds in the home <sup>a</sup>     | Number                         | 49    | (36)    |
| Age of the home <sup>a</sup>                | Years                          | 36.4  | (30.6)  |
| % of residents female <sup>b,d</sup>        | Percentage                     | 77.19 | (14.93) |
| % of residents married <sup>b,d</sup>       | Percentage                     | 23.51 | (11.02) |
| Mean disability of residents <sup>b,c</sup> | Mean hours of funded care      | 19    | (2.11)  |
| No. of inspectors <sup>a</sup>              | From a low of 2 to a high of 4 | 2.49  | (.60)   |
| Queensland home <sup>a</sup>                | 1=yes, 0=other                 | .18   | (.39)   |
| Victorian home <sup>a</sup>                 | 1=yes, 0=other                 | .23   | (.42)   |
| New South Wales home <sup>a</sup>           | 1=yes 0=other                  | .41   | (.49)   |
| Sample home                                 | 1=yes, 0=no                    | .59   | (.49)   |

<sup>a</sup> These variables are taken from the interviews conducted with directors of nursing.

<sup>b</sup> These variables are taken from the Commonwealth Department of Community Services and Health data base, which contains basic demographic information about all residents within a nursing home.

<sup>c</sup> Each resident entering the nursing home is allocated to one of five service need categories (RCI). The Commonwealth has determined that residents allocated to level 1 require 27 hours of nursing and personal care (NPC); those at level 2 require 23.5 NPC hours; level 3 requires 20 NPC hours; level 4 requires 13 NPC hours; and level 5 requires 10 NPC hours. To calculate the mean hours of nursing home care provided by each home, each resident's RCI is multiplied by the NPC and the mean number of hours for all residents within the home is deduced.

<sup>d</sup> The percentage within each group for each home.