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# Value conflicts in public organisations: a reading of the individual values of hospital nurses and health managers.

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### ABSTRACT

In recent years, hospitals have undergone a series of reforms driven by New Public Management (NPM), which have created significant tensions, particularly regarding values. The health crisis and the challenges related to resource rationalisation have further exposed the ethical tensions faced by healthcare professionals.

To explore these tensions, we draw on Schwartz's theory of individual values (1996, 2006), Public Service Motivation (PSM) (Perry and Wise, 1990), and market values (Park and Joaquim, 2012) to analyse value tensions within public hospital organisations. We argue that individual and PSM values help mitigate tensions, while market values tend to intensify them.

Based on interviews with 22 healthcare professionals (11 healthcare managers and 11 nurses) in three French public hospitals, we identify three individual values—benevolence, conformity, and universalism—that guide action and help alleviate the ethical tensions experienced by healthcare professionals. These individual values support effective action when public service motivation and open communication between stakeholders are present.

Our recommendations emphasise the importance of adopting values-based management, supported by establishing spaces for ethical discussion the need to consider values-based management, supported by spaces for ethical discussion.

**Key words:** New Public Management; tensions; public values; universal values; hospital staff.

### INTRODUCTION

The issue of values and tensions in the healthcare sector is more relevant than ever. The deterioration of working conditions over many years and the recent COVID-19 health crisis have intensified questioning around the values of healthcare professionals. Many caregivers have expressed their distress over the challenges of caring for patients during the course of the pandemic. This unease has also recently been voiced in response to the closure of certain hospital departments during summer periods, due to insufficient medical and nursing resources to provide quality care, the overcrowding of some emergency services, and the inability to provide timely care for vulnerable patients. These situations lead to tensions, particularly around caregiving values and a certain erosion of Public Service Motivation (PSM). They have prompted experienced professionals to change career paths due to deteriorating working conditions and the inability to practise their profession in alignment with their values (Routelous et al., 2023). According to figures published by the French Hospital Federation, 10,000 nurses and nursing assistants left their profession in 2020, which is an alarming statistic. Understanding this phenomenon has fueled recent research (Abord de Chatillon and Desmarais, 2017; Commeiras et al., 2022; Rivière, 2019; Rossano and Abord de Chatillon, 2021;

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Routelous et al., 2023). These studies highlight the degradation of working conditions, the intensification of tasks, role tensions, and the difficulty for nurse managers and healthcare directors in finding solutions to address this shortage, aiming to keep services running without compromising on standards. According to caregivers' testimonies, the issues surrounding values, the tensions they create, and Public Service Motivation (PSM) are particularly relevant for studying this phenomenon.

The existence of tensions around values is not new. Throughout history, individuals and organisations have strived to defend their values, understood as deep-seated beliefs and convictions (Dewey, 2011) that structure collective actions. This term, with its broad scope and ambiguous boundaries, has never been as frequently invoked as it is now (Heinich, 2017), particularly in the healthcare sector and in public services more generally. While early research attributed these tensions to transformations resulting from new public management (NPM) (Ferlie et al., 1996; Hood, 1995) (Abord de Chatillon and Desmarais, 2012), they cannot be exclusively blamed on NPM.

NPM, driven by international organisations, has resulted in reforms, new practices (quality processes, greater emphasis on budget management, user satisfaction), and the intrusion of private sector values into the public sphere (Emery and Giauque, 2005; Park and Joaquim, 2012), along with a shift in vocabulary that is far from insignificant. Efficiency, productivity, and performance have been elevated to the status of "new" public values. In discourse, this terminology has been slightly adapted to avoid alienating staff and users (Rochette, 2015). While these terms have not yet fully penetrated the lexical field traditionally used in the public domain, their spread is not neutral regarding the evolution of practices (O'Flynn, 2007), that staff in these organisations find difficult to accept (Lacroix, 2009). Studies have highlighted the difficulty for staff to adapt to these new values, often associating them with a loss of meaning, paradoxes (Bellini et al., 2018; Commeiras et al., 2022), and in some cases, the erosion of Public Service Motivation (Hondeghem and Vandenabeele, 2005), even leading to distress and suffering at work (Abord de Chatillon and Desmarais, 2012; Resenterra et al., 2013).

Some organisations attempt to promote their values so that employees become more aware of them. They see values as a source of cohesion and collective commitment, giving meaning to action (Anton et al., 2021), and as a tool for action. From a pragmatic perspective, values guide individuals' behaviours by transforming their practices (Dewey, 2011). There is thus a genuine interest in studying how traditional values combine with so-called new values in the actions of public sector staff to improve understanding of the dynamics and to identify relevant managerial tools that public managers could adopt. While management research has primarily focused on institutional and organisational values (Emery and Giauque, 2005), individual values remain largely unexplored, even though they are central to individuals' career choices and motivation. We aim to contribute to research on values by focusing on individual values. Schwartz's work (1996, 2006), which has been widely disseminated, has been little used to explore value conflicts in public organisations (POs), despite offering an interesting analytical framework.

Thus, we explore the compatibility or incompatibility between traditional public values and so-called managerial values (referred to as "new") using Schwartz's analytical framework (1996, 2006). What are the identifiable value conflicts among public sector staff? Why are some values incompatible? How do public sector staff adapt to mitigate value conflicts? These are the questions we aim to address in this study. After presenting the conceptual and theoretical framework of our research in the first section, we will then outline our research methodology and results in the second section. These will then be discussed before concluding.

### 1. PUBLIC MANAGEMENT AND STAFF VALUES

The notion of value is explored by multiple disciplines (Anton et al., 2021). In management sciences and economics, it has a dual definition: a monetary dimension, treated from a more economic and financial perspective, related to measurement; and a non-monetary dimension, which refers to both personal (individual values) and collective (cultural values) guidelines. Considered as "collective preferences," they emerge in an institutional context and contribute to its regulation (Boudon and Bourricaud, 1983). These preferences are reflected in the general characteristics of values. They can express the views of an individual (personal values), a group, or a society (social values). They may serve as means (instrumental values) or ends (terminal values), and by nature, they are both variable and diverse (Anton et al., 2021). Addressing values is always a delicate task, given the abundance of research and the variety of approaches available. We are particularly interested in the tensions between individual values and public values, due to the intrusion of private sector values in the public domain over the past 30 years. Public values are viewed here from the perspective of collectively shared beliefs and convictions (Piron, 2002).

### **1.1. Evolution of values in public management: from NPM to Post-NPM.**

Since the 1980s, the spread of New Public Management (NPM) has collided with the traditional values that once prevailed in the public sector and the strong "public ethos" that characterises public service (Fortier, 2010). NPM introduced three major new types of values: 1) values focused on performance and results (managerialism, de-bureaucratisation), 2) values focused on the market and customers (downsizing, privatisation, decentralisation), and 3) values focused on objectives and strategy (strategic management, workforce planning) (Park and Joaquim, 2012). It brought an economic dimension that was previously foreign to public administrations, along with values centred on individualism, production (performance, productivity), and economic rationality, which struggle to co-exist with classical values. The criticisms of NPM—including its failure to consider the relationship between individual issues and broader community concerns, democratic values, and public service (Perry, 1997)—fuelled the emergence of post-NPM movements. Thus, the rationalist approach to public decision-making under NPM was succeeded by a more humanistic and participative approach under post-NPM (Bozeman, 2007; Moore, 1995). It also affirmed principles such as social equity, the humanisation of the workplace, and participation at work (Wise, 2002), which have led to increased expectations for quality of life at work. The challenge then lies in reconciling individual values with collective values, and reforming values from NPM (performance, results, etc.) with post-NPM values (humanisation, work-life balance). In healthcare settings, this manifests in the delicate balance between normative values (promoted by regional health agencies) and more humanistic values, which can be expressed in hospital projects (e.g., employer branding, value charters) or initiatives led by healthcare management (work teams, dialogue spaces).

In their research on U.S. federal agencies, Park and Joaquim (2012) showed a gradual decline in NPM values over time, in favour of post-NPM values. According to them, public organisations have been able to establish a satisfactory work-life balance for their employees and to link performance measures to intrinsic values, thus easing tensions around values. Moreover, Public Service Motivation (PSM), generally associated with defending the public good or the general interest (Perry and Wise, 1990), seems to "influence certain values (e.g., rational/extrinsic and normative/intrinsic values), certain behaviours (such as sociable behaviours and institution-based behaviours), and certain cultures (such as group or development cultures) in public organisations" (Park and Joaquim, 2012). Research on this topic tends to focus on the compatibility or incompatibility between NPM values and traditional values, highlighting the conciliatory role of post-NPM. However, it gives relatively little attention to individual values and their compatibility with the evolution of institutional and/or organisational values.

Overall, research shows that the introduction of NPM values leads to value conflicts for public sector employees, whose motivation was rooted in traditional public values (akin to PSM). In a post-bureaucratic context, studies highlight the difficult reconciliation of traditionally opposed values—traditional versus new—especially in the healthcare sector (Routelous et al., 2021).

### **1.2. Reforms and tensions in the French public hospital system: from T2A to ethical, organisational, and axiological challenges.**

The French public hospital system has undergone numerous reforms over the past decades, aimed at improving organisational efficiency and service quality while meeting the expectations of stakeholders (Abord de Chatillon and Desmarais, 2012). In 2004, the "Hôpital 2007" plan introduced Activity-Based Pricing (Tarification à l'Activité, T2A), bringing a strong managerial and strategic approach to healthcare institutions. It was presented as a profound reform designed to *"modernise management, encourage investment, and motivate each actor on a daily basis."*<sup>1</sup> Its goal was to transform hospital organisations by decentralising management (with expanded powers granted to regional hospital agencies—later renamed regional health agencies—and hospital boards), and introducing new management tools that fostered more performance-oriented management styles (Commeiras et al., 2022; Rivière et al., 2019), driven by a logic of numbers stemming from T2A. On the operational side, this new logic requires healthcare staff to see an increasing number of patients in less and less time. Studies have reported that staff increasingly feel they have less time to devote to patients (Commeiras et al., 2022). Several criticisms have been levelled at T2A: selective patient admission in certain hospitals, manipulation of patient coding, and the premature discharge of patients (Commeiras et al., 2022), leading to its evolution. The deep changes in care practices, partly stemming from NPM (and also from medical innovations), and the introduction of market values, have led to a perceived deterioration in the nursing profession or caregiving value, a loss of meaning, and a disruption of reference points, calling into question the very essence of the profession and how it is practised (Moisson and Gardody, 2021). Many caregivers no longer perceive the purpose and social utility of their role.

These transformations, driven by rationalisation efforts (Bezes, 2020), have generated role tensions (Routelous et al., 2023), significant ethical tensions (Méziade et al., 2019), and ethical dilemmas (Langlois, 2008) for both nurses and nurse managers. They have contributed to deteriorating working conditions and demotivation (Abord de Chatillon & Desmarais, 2017; Rivière, 2019). These tensions or dilemmas<sup>2</sup> involve axiological confrontations (conflicts of personal, professional, or organisational values), leading individuals to engage in reflective processes to temporarily or permanently legitimise their decisions and/or actions (Langlois, 2008). Thus, when individuals face ethical dilemmas, they develop strategies, drawing on their knowledge and experience, to reduce the tension they experience (Langlois et al., 2009). These strategies may take the form of verbal exchanges or ethical discourse aimed at legitimising one value over another. They form the foundation of values-based management (Anton et al., 2021). In such situations, individuals may develop, formally or informally, a competency in ethical discussion that helps mitigate tension, as demonstrated by the example of healthcare workers in a paediatric oncology department (Gagnou–Savatier and Mercier, 2015). These formal or informal discussions take place in dialogue spaces (Espaces de Discussion, EDD<sup>3</sup>), which are

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<sup>1</sup> Newsletter from the Directorate of Hospitalisation and Healthcare Organisation No. 1, June 2003, [https://sante.gouv.fr/IMG/pdf/lettre\\_h2007\\_1.pdf](https://sante.gouv.fr/IMG/pdf/lettre_h2007_1.pdf)

<sup>2</sup> These tensions can be identified at three levels: personal, professional, and organisational (Langlois et al. 2009).

<sup>3</sup> translated by Discussion Spaces

known for their beneficial effects in reducing organisational tensions (Abord de Chatillon and Desmarais, 2017; Detchessahar et al., 2015) and enable the confrontation between personal and institutional values. The EDD serves as a space for the sharing of words and actions, where each individual reveals their subjectivity to address collective issues (Detchessahar et al., 2015). One of the three levels of discussion takes place between operational staff and managers. These spaces allow the confrontation of representations belonging to different systems (Lochard, 2012). Focused on daily work, they address the inconsistencies and shortcomings in guidelines, engaging the practical intelligence of actors to find solutions to the problems they face. They differ from consultation spaces, which operate at a more strategic level. These spaces aim to reclaim prescribed rules and test their frameworks to make them more understandable. They allow individuals to reposition themselves around an ethical framework to give meaning (Anton et al., 2021). These two types of spaces can provide privileged settings for addressing tensions around personal values, questioning motivation, and fostering reflexivity.

### 1.3. The theory of values and PSM: instruments of public employees' motivation.

In psychology, values are considered a motivational factor. They guide action and justify the decisions of individuals. Values represent what individuals hold dear in a given situation (Dewey, 2011). The foundational work of Perry (1997) provides the conceptual basis for values in the public sector. It is centred around Public Service Motivation (PSM), a characteristic of public servants' behaviour. PSM is defined as "an individual's predisposition to respond to motives grounded primarily or uniquely in public institutions" (Perry, 1997). This public motivation is, among other things, the theoretical foundation of Post-NPM principles (Park and Joaquim, 2012). Motivation, which arises from the interaction between individual values and a real-life situation, allows the individual to put their values into practice. Individual values are highlighted in Schwartz's theory of values (2006) and in Schwartz and Bilsky (1987). These authors focus on the values that individuals across all cultures consider to be core values.

Schwartz (2006) defines values as "socially desirable concepts used to represent these goals on a mental level, and at the same time, the lexicon used to talk about these goals in social interactions" (p. 932). According to him, values are universal because they are deeply rooted. They clearly constitute the elements that motivate the nature of human action (Schwartz, 2006). His work, conducted over more than twenty years and beginning in the late 1980s (Schwartz & Bilsky, 1987), identified ten universal values (Schwartz, 1996) (Table 1).

**Table 1: The ten universal values common to the vast majority of individuals according to Schwartz (2006)**

Rank	Values	Rank	Values
1	Benevolence	6	Hedonism
2	Universalism	7	Achievement
3	Autonomy	8	Tradition
4	Security	9	Stimulation
5	Conformity	10	Power

*Source: Schwartz (1996, 2006)*

The value of Schwartz's work lies in highlighting the incompatibility between certain values by proposing a theoretical model, which is easily applicable, for articulating the relationships between ten values grouped into four categories (Figure 1). This diagram clearly describes the relationships between values (compatibility or incompatibility).



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An action induced by one value may be incompatible with an action guided by another value or values if they belong to opposing categories (for instance, an action cannot be determined by both continuity and change at the same time), as per Schwartz and Boehnke (2004). Each value does not hold the same level of importance for every individual. For this reason, Schwartz suggests ranking them in order to explore their intensity when expressed by individuals (Appendix 1). This model is particularly useful for understanding value conflicts experienced by employees in public organisations (POs). These ethical tensions emerge as the result of an appreciation or depreciation of the immediate qualities of a situation, event, or object (Dewey, 2011), such as the transformations experienced by POs, particularly in the healthcare sector (Routelous et al., 2021).

The main limitation of this model is that it has rarely been used in management studies, as the individual values presented were not originally designed to be identified within a professional context (Moriez and Grima, 2019). Research that has applied this model empirically has adapted it. According to Moriez and Grima (2019), it is important to distinguish between two types of values: active values and accepted values. The former defines "how to think," while the latter determines "how to act." This classification helps clarify how individual values are expressed within organisations (Mériade and Sales, 2022). Mériade and Sales (2022) use this classification of active/accepted values and Schwartz's individual values to identify the values expressed by volunteer firefighters in their daily activities.

In our research, we focus on the ethical tensions resulting from organisational transformations following the introduction of NPM. These tensions stem from the three main orientations of NPM<sup>4</sup>: the pursuit of performance, market and customer orientation, and the strategic approach. Park and Joaquim (2012) identify three strategic principles induced by NPM:

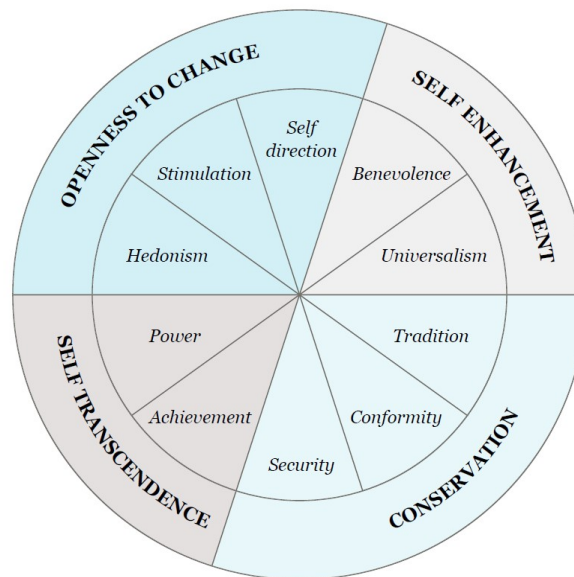
- Performance and results (or managerialism and de-bureaucratisation),
- Market and customer (downsizing, privatisation, and decentralisation),
- Objectives and strategy-oriented values (strategic management and workforce planning).

Most research has focused on the new values introduced and disseminated by NPM. Few have looked into other forms of values that may arise or manifest in this context. Our aim is to shed light on the value conflicts that may exist between the so-called market-driven values introduced through NPM's key principles (performance-results, market-client, etc.) and individual values, as defined by Schwartz (1996), which may be more closely aligned with post-NPM values. Therefore, we focus on the ethical tensions between NPM values and individual values.

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<sup>4</sup> They are associated with managerialism, accountability, and also contractualisation (Abord de Chatillon and Desmarais, 2012).

Figure 1: Circular model of the relationships between the 10 fundamental values



Source: Schwartz (1996, 2006)

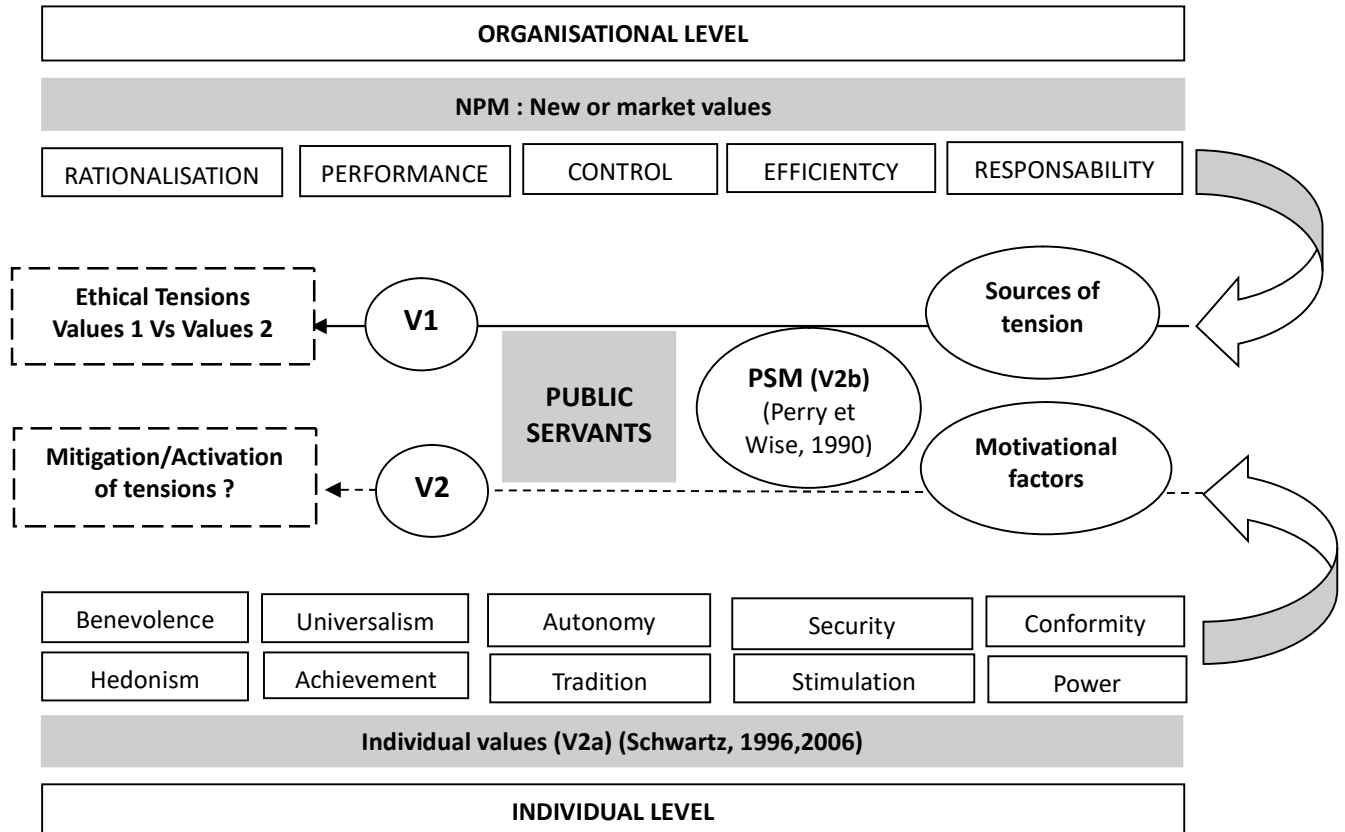
In summary, within public organisations (POs), the so-called market values (value set 1) introduced as a result of NPM encompass values such as performance, control, rationalisation, efficiency, and accountability. These organisational-level values clash with both the individual values of employees (value set 2), derived from Schwartz's (1996) framework (value set 2a), and the traditional values embedded in public service motivation (value set 2b), as defined by Perry and Wise (1990). Values in set 2a (e.g. the individual value of benevolence) and set 2b (e.g. altruism as part of PSM) may encompass similar notions. It is the confrontation between value set 1 and value set 2 that generates ethical tensions among employees.

Public service motivations can relate to both the organisational and individual levels, as some values introduced by NPM can be legitimised by employees in the interest of the common good (such as accountability). We posit that value set 1 acts as a source of tension, while value set 2 can be a motivating factor, capable of either mitigating or amplifying the ethical tensions experienced. Conceptual model 1 summarises our framework. We propose the following:

- ✓ P1: The values derived from NPM clash with individual values and generate ethical tensions;
- ✓ P2: Public service motivations incorporate NPM values;
- ✓ P3: Individual values are a lever to mitigate ethical tensions.



Diagram 1: Conceptual model of conflicting values.



Source: Authors

## 2. METHODOLOGY AND MAIN RESULTS

To test our conceptual model in the field, we approached three French public hospitals (a University Hospital Centre - CHU, a General Hospital - CH, and a Local Hospital Centre - CHP). These hospitals are facing financial difficulties, sometimes due to cash-flow problems that have led to budget restriction plans or restructuring, resulting in recruitment freezes in some cases.

### 2.1. Data collection, processing, and analysis.

Our work is grounded in critical realism and follows a qualitative approach. We conducted 22 semi-structured interviews with 11 nurse managers and 11 nurses at their workplaces (Table 2). These interviews aimed to identify the transformations within hospitals and their impacts on the practices of the staff. When the interviewees reported negative impacts, we probed further to identify any potential presence of value tensions. Special attention was given to identifying the values in conflict and the actions taken by these professionals to either mitigate or activate them.

The interview guide consisted of three parts. The first part focused on transformations (both internal and external) and the interviewees' descriptions of their roles (missions and daily tasks). The second part addressed ethical tensions, their presence, and how the interviewees described them. The final part aimed to identify the means or actions available to nurses and nurse managers to mitigate or activate these tensions. The interviews were designed to last no more than 1 hour for nurse managers and 30 minutes for nurses, considering their professional commitments. In total, we

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recorded 15 hours and 33 minutes of interviews, which were transcribed and analysed. The majority of the interviewees were women. The average length of service in their current position was 5 years for nurse managers (including acting periods<sup>5</sup>) and 12.5 years for nurses. Various types of departments were represented, including paediatrics, geriatrics, and adult and paediatric emergency services.

Content analysis was conducted using Nvivo 12 software. This process is based on the same principles as manual analysis but offers greater ease in coding the data and also facilitates navigation through the information. The main thematic coding nodes for the verbatim responses were: the transformation of practices following changes in the institutions (public organisations), the expression of ethical tensions at work among nurse managers and nurses, and the actions identified to mitigate them.

**Table 2: Description of the sample**

	Type of hospital	Years of service	Department	Interview duration	Nurse (Nu)	Type d'hôpital	Years of Service	Service	Interview duration
<b>NM1</b>	CHU	5 years	Paediatric Oncology	1h 26min	<b>Nu1</b>	CHU	10 years	Paediatric Emergency	48min
<b>NM2</b>	CHU	5 years	Neonatology	1h 01min	<b>Nu2</b>	CHU	11 years	Paediatric Emergency	30min
<b>NM3</b>	CHU	3 years	Haematology	52min	<b>Nu3</b>	CHU	10 years	Digestive Surgery	33min
<b>NM4</b>	CHU	4 years	Haemovigilance	1h 09min	<b>Nu4</b>	CHU	4 years	Paediatric Emergency	22min
<b>NM5</b>	CHU	7 years	SSR	37min	<b>Nu5</b>	CHU	10 years	Surgery	28min
<b>NM6</b>	CHU	7 years	EHPAD	49min	<b>Nu6</b>	CHU	11 years	EHPAD	32min
<b>NM7</b>	CH	7 years	CSG	1h 08min	<b>Nu7</b>	CH	36 years	GSSU	35min
<b>NM8</b>	CH	2 years	Adult Emergency	43min	<b>Nu8</b>	CH	9 years	Surgery	27min
<b>NM9</b>	CH	9 years	Psychiatry	1h 08min	<b>Nu9</b>	CH	6 years	Surgery	35min
<b>NM10</b>	CHP	2 years	Geriatrics	35min	<b>Nu10</b>	CHP	30 years	Psychiatry	22min
<b>NM11</b>	CHP	9 years	Adult Emergency	41min	<b>Nu11</b>	CHP	1 year	Adult Emergency	21min
<b>TOTAL/Average</b>		<b>5 years</b>		<b>10 hours</b>	<b>TOTAL/Average</b>		<b>12.5 years</b>		<b>5h33min</b>

**NM** : Nurse Manager; **Nur**: Nurses; **CHU**: University Hospital Centre; **CH**: General Hospital; **CHP**: Local Hospital Centre. **EHPAD** : Residential care facility for dependent elderly people - retirement home ; « Soins de suite et de réadaptation » **SSR** : Care and rehabilitation unit ; **GSSU** : Geriatric Short Stay Unit

*Source: Authors*

<sup>5</sup> The acting nurse manager position is offered to nurses who wish to become nurse managers. This is a period, typically lasting one to two years depending on financial availability for taking the competitive exam, during which nurses gradually take on managerial tasks (scheduling, logistics, etc.) in addition to patient care. The acting nurse manager role usually occurs before the nurse takes the competitive exam.

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Nvivo coding was carried out in three steps: 1° extracting commonly used expressions from the interviews, 2° creating meta-codes to group them by similarity, and 3° linking the thematic codes to theoretical concepts. We then analysed the data using a comparative method (gathering the differences and similarities found in the statements of nurses and nurse managers).

### 2.2. Main Results.

Our analysis reveals two main results:

- ✓ A degradation of professional values and the presence of ethical tensions;
- ✓ Individual values as a means to reduce these tensions.

The main results of our research highlight the **significant introduction of market values** in the three hospitals studied. These values manifest through the imposition of activity monitoring indicators such as Average Length of Stay (ALS). The introduction of such indicators is associated by most respondents with a deterioration in working conditions and practices for both nurses and nurse managers. It generates professional unease, likely linked to a lack of understanding, as they do not see the purpose of these indicators. Ethical tensions arise from the difficult balance between values centred on performance goals, reduced resources (rationalisation of spending, staff reductions), and Schwartz's individual values. The individual values expressed (benevolence, universalism, conformity) often serve as motivations for action. They guide the actions of these professionals and act as tools to alleviate the tensions experienced.

#### 2.2.1. Ethical tensions between professional and normative values.

Nurses have the primary mission of ensuring the physical and psychological well-being of their patients through various categories of care: technical, relational, and nursing care. Their approach to care, shared with nurse managers<sup>6</sup>, is strongly focused on the patient and their treatment. Nurse managers are responsible for ensuring quality of care through various operational and management tasks. For example, they ensure that there is sufficient staff to provide adequate and safe care. However, the introduction of values focused on performance and results has had a negative impact on the habits and practices of both nurses and nurse managers. Beyond the technical aspects of care, the interviewees emphasise the importance of human relationships in caregiving. They note that more and more time is spent on technical and administrative aspects, such as coding procedures, at the expense of human interactions. Nurses express difficulties in fully delivering relational care, which is based on listening and empathy, as well as nursing care, which they consider essential to ensuring the dignity of patients.

*"I'm very focused on verbal communication, on interaction, and I believe that's how it works— if someone needs to be calmed, it's through words, but now I no longer have time to do that and do my job properly." (Nu1)*

Nurse managers face the challenge of reconciling management's expectations, which are centred on rationalisation and performance, with the specific missions of nursing care, particularly regarding patient well-being, which is often viewed through a relational lens. For them, the "in-between" position is difficult to maintain, especially as their previous caregiving culture often remains deeply ingrained. They find themselves assuming various roles they were unaware of during their

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<sup>6</sup> Nurse managers predominantly come from the nursing sector. We use the term "managers" to refer to nurse managers.

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professional training and before the organisational changes. The relative autonomy associated with the position of nurse manager can be destabilising and uncomfortable for them.

*“We are asking the institution to address the roles because nothing is clear or established.”*  
(NM2)

This working context reveals identifiable value conflicts in the statements of both nurse managers and nurses. The demands for performance and results, imposed by management (normative values), conflict with the values held by nurses and nurse managers (professional caregiving values). This likely reflects a tension between two visions: one focused on addressing the pathology (clinical approach) (normative value) and one focused on treating the person (human value). These two visions are not neutral in how they define quality work: technical quality (mastery, precision) within the clinical approach and quality of the relational exchange (attention, listening) in the second approach.

Both nurses and nurse managers are sometimes asked to code all care activities, but this request does not always make sense to them, as not all activities (such as time spent listening to a patient) can be coded or quantified in a care unit. This illustrates the challenge, beyond the economic dimension of coding, of perceiving the traceability that coding allows, which is also a means of collecting valuable data to analyse and potentially improve care pathways. Interviewees associate coding with a commercial act, which explains their resistance and the perceived ethical tension.

*“What’s difficult for me is the T2A. It’s because of my department—we work with children who have cancer.”* (NM1)

*“Sometimes we keep patients for short stays just to say we’ve admitted them, rather than keeping them in the observation area for six hours. But if we move them to the UHCD, it’s coded differently and brings in different revenue, so we move them to the UHCD.”* (Nu4)

Additionally, management asks teams to ensure continuity of care and to maintain a certain quality level, even though the teams report insufficient staffing.

*“We’re really working at full capacity, there’s little room to manoeuvre.”* (NM3)

Finally, according to nurses and nurse managers, this focus on performance leads to unjustified and sometimes abusive hospitalisations. Once again, the comments likely reflect a narrow definition of performance. According to the interviewees, performance is understood in financial terms rather than in the ability to manage patient flow and pathologies effectively. Staff are subject to contradictory demands, which are a source of ethical tension. These clearly reveal a clash between different perspectives, which we refined using Schwartz’s value framework.

### 2.2.2. Exploration of universal individual values.

Indeed, out of the ten individual values identified, only five were found in the statements of nurse managers and nurses: **benevolence, autonomy, power, universalism, and conformity**. Benevolence and universalism both belong to the self-transcendence category and are compatible. Conformity (continuity category) and autonomy (change category) may initially seem opposed. Conformity can be understood in two ways. Firstly, it can be seen as the need to conform to a new norm (such as respecting criteria like ALS - Average Length of Stay). It may be perceived as misaligned with PSM (for example, altruism), thus generating ethical tensions, as individuals are required to conform to the norm. Secondly, conformity can refer to the desire to align with one's PSM, which may result in

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resistance to change, and this can be compatible with a degree of autonomy. Both perspectives appear in the responses, although the first is more dominant. Finally, power is situated in the self-enhancement category and refers to control over people and resources.

### - **Benevolence.**

**Benevolence** is highly present in the nurses' narratives. It is expressed through the desire to provide high-quality care (with a strong relational dimension) aimed at improving patients' well-being. It is challenged by the pressure to fill beds, showing that healthcare professionals do not always view it from a holistic perspective. Yet, freeing up beds also allows other patients to receive care.

*"We're discharging children at 5 a.m. to admit more critically ill children." (Nu2)*

This is, in fact, the principle behind the functioning of hospital emergency departments, which allocate beds based on the severity of patients' conditions. This widely accepted principle illustrates the complementarity between benevolence and tradition.

### - **Universalism.**

**Nurse managers and nurses share the value of universalism**, expressed through their commitment to preserving public service and its principles in the general interest. They believe it is essential to reject any action that would contradict the fundamental values of public service to ensure equal access to care and continuity of services for all. From this perspective, motivated by a concern for social justice, they challenge performance-focused values, which they see as sources of inequality. Their comments reflect difficulty in distinguishing between what is part of the public service mission (providing care) and what is more of a comfort service, such as the option for wealthier patients to have a private room.

Moreover, for example, two patients receiving treatment for the same clinical condition may have very different personal situations. One might have a supportive family environment for their return home, while the other might be isolated, or socially and economically vulnerable. For healthcare professionals, these social inequalities cannot result in identical responses, as they generate ethical tensions. An explanation for this is that, in healthcare, the medical and social dimensions are difficult to separate, which is the basis of the core principles of public health. This is a significant limitation of the ALS, as noted by many professionals.

However, by referring solely to public service principles, universalism, combined with benevolence, could be compatible with the value of public service efficiency (NPM), which is crucial to ensuring care for all patients and maintaining social justice. Therefore, it is essential to return to the fundamental values of public service to guide actions.

*"We have to be demanding, we must not forget these values for which we chose to work in public service." (NM8)*

### - **Autonomy.**

Nurse managers naturally mention the need for autonomy more frequently than nurses. They express a sense of not having enough latitude in decision-making. They would have liked to be able to decide on the necessary resources to ensure the proper functioning of their departments or at least be consulted on the matter. Despite having reached positions of responsibility and promising managerial roles in terms of autonomy, they feel they do not have sufficient autonomy, or sometimes none at all. Resource allocation decisions are made and controlled by supervisory bodies and ultimately imposed on hospital directors, who themselves have little room for manoeuvre.

*"Sometimes they ask our opinion. But we feel the decision has already been made." (NM6)*

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Furthermore, the value of autonomy can be compatible with universalism and interpreted in a different context. Nurse managers feel frustrated by their inability to truly contribute to strategic decisions. They recognise the importance of streamlining processes to ensure all patients can benefit from public services. Thus, this value of autonomy is perfectly compatible with NPM through the value of accountability, making each staff member responsible for the judicious use of public resources.

*"The values of public service are equal treatment for everyone, respect for neutrality, professional secrecy, equal treatment... whether we face financial challenges or not, we have to uphold these, and that's what we can work on with the teams." (NM3)*

### - **Power.**

The feeling of power is reflected in the comments of nurse managers, linked to their desire for autonomy and their willingness to implement meaningful actions despite the limits of their responsibilities. Nurse managers spend much of their time managing day-to-day operations (such as scheduling and handling absences), leaving them little time to lead new projects, even though these are important for the development of their departments. The priority is, of course, to ensure the best possible care for patients. While managing the patient flow requires primarily logistical responses (aligning resources with needs, including the availability of professionals, beds, and equipment), it cannot be separated from the types of pathologies and medical situations to be treated, which are linked to medical practices and the complexity of care pathways (which can vary between practitioners and hospitals for the same condition). While hierarchy cannot do everything, it can support projects or requests with the authorities and back the initiatives of their teams. The frustration stemming from the inability to develop projects and showcase their teams also manifests in their difficulty in increasing activity in certain departments due to the complex medical situations of the patients they care for, such as in paediatrics or geriatrics. Their desire to succeed in their managerial roles is clear, as is their aspiration to be recognised and legitimised by the nursing staff. This highlights the compatibility between the value of power and that of achievement in their professional context.

*"Sometimes you can tell she's frustrated too, she'd like us to do things, but we can't because the request won't be approved higher up." (Nu3)*

### - **Conformity.**

Finally, a trend towards conformity can be observed in the majority of the nurse managers interviewed. Faced with ongoing changes and the adoption of a results-oriented culture, they comply with new directives, having little or no room to oppose them. This feeling generates tensions. These professionals are thus forced to meet expectations that may sometimes conflict with their habits, ideas, or values.

*"We're coding, we're doing PMSI, I make my nurses do it because sooner or later it's going to come down on us, and at least we'll be up to speed and get it done." (NM5)*

This conformity can also take the form of obedience or loyalty to the public hospital organisation, despite the introduction of new management practices. It is a sign of respect for the institution. In this sense, conformity is compatible with benevolence and, to some extent, with the public service mission (as illustrated by universalism in the following quote).

*"We want to take care of everyone, and we're going to cut our time... we'll spread the care, our time, and take care of everyone, all 120 of them, and they'll leave, and everyone will have*

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*been treated. That's quality work, and we won't do things the way we would have wanted, but we'll do what we can with the resources we have."* (NM1)

Following protocols provides safety. If these protocols exist, it's because they have proven to be effective and capable of reducing the risks involved in care (safety). In this way, they also align with principles of conformity, as the application of these protocols must be documented to meet regulatory requirements. Thus, safety and conformity cannot be separated. In certain situations where services are under great pressure (lack of time), completing records of procedures and interventions for traceability represents time that caregivers feel is taken away from patients waiting for care. This can be perceived as an ethical dilemma. Caregivers do not necessarily recognise that this traceability is also "proof" of appropriate care (that the necessary actions were taken to provide the best possible care for the patient), which also ties back to universalism.

### 2.2.3. Individual values as tools for managing ethical tensions.

Among the individual values identified (autonomy, power, benevolence, conformity, and universalism), some can help reduce and some can intensify tensions. This is the case with **benevolence, conformity, and universalism**. By guiding the actions of nurse managers and nurses, these values can sometimes give normative meaning to actions (values produced by supervisory bodies) and, at other times, anchor them in the individual values and Public Service Motivation (PSM) of the staff. For example, complying with the expectations of the Regional Health Agency (ARS) regarding the resources (human and material) provided allows nurse managers to maintain their standing with both the ARS and their staff. Benevolence, combined with professional practice and societal expectations, motivates nurses to prioritise the delivery of high-quality technical care, and if time permits, to also provide relational care. Recognising this benevolence and its universal nature allows nurses, and sometimes nurse managers in exceptional circumstances, to ask the prescribing physician to reconsider their decision, thereby managing significant ethical tensions related to the unique situation of a patient who may need to stay under observation longer than the norm dictated by the Average Length of Stay (ALS).

*«What matters for the patient is the care, not the numbers. No matter what we're told, or if there's a regulation saying that for a femur fracture, it's 4 days maximum, if the patient needs more time, then that's what will prevail, not the deadline set at the beginning. She'll stay longer."* (Nu 8)

Universalism is based on the notions of trust and commitment, which we found among the nurse managers and nurses interviewed. Overall, the values they embody are closely tied to their status as public hospital employees. These traditional values, characteristic of public institutions, form a common good on which they can rely to guide their practices. The beliefs underpinning their thought processes help to legitimise certain actions while dismissing others. In this sense, universalism can be compatible with the efficiency and performance of public services.

*"Whether it's the public hospital or any public service, just because it's public doesn't mean it's your money or mine that should be wasted. We need to learn to manage it better so that the money is used for things we really need, not wasted on things that don't matter. Learning to manage well is also part of the duty of all public services, and I think that's normal."* (Nu 7)

*"Now they've understood in the SMT (medico-technical care), that the cost of a stay is about €2,200, for families, it's a significant expense. They've understood that if we want this service to continue, if I have places available, we need to fill those places, otherwise, this service won't exist anymore."* (NM 10)



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Invoking conformity, benevolence, and universalism can help reduce the ethical tensions expressed by staff. Indeed, the values of conformity and benevolence are nurtured through transparent, honest, and even ethical communication with various stakeholders. Universalism, on the other hand, is based on notions of commitment and trust in public service. These three values can serve as tools to reduce ethical tensions, as when expressed with intensity, they take precedence over the rationalisation efforts driven by political orientations.

At the conclusion of this study, we can confirm **Proposition 1**: The values derived from NPM clash with individual values and generate ethical tensions, particularly around the perceived dominance of economic considerations, the lack of time, and limited resources, which are attributed to the spread of a public service culture inspired by the private sector. Similarly, it appears that Public Service Motivation (PSM) integrates some values derived from NPM. For example, ensuring access to healthcare services for all may involve managing care through the average length of stay in order to free up beds for new patients and provide care. Thus, **Proposition 2** is confirmed. Finally, individual values can, in some cases, serve as a lever to temporarily mitigate ethical tensions by justifying procedures that may seem unnatural (and contrary to traditional public principles). Therefore, **Proposition 3** is partially confirmed.

These findings raise an important question in the current context of French public hospital organisations: the role given to values or ethics within these organisations and by their employees.

### 3. DISCUSSION POINTS

NPM introduced performance, service efficiency, and resource control into public organisations (POs). These values have clashed with the traditional values that formed the foundation of public service missions and Public Service Motivation (PSM). Staff members are unfamiliar with and unprepared for the emerging practices (Commeiras et al., 2019) derived from new public values, as evidenced by the tensions around values identified in our study. Beyond confirming the presence of tensions, specifically ethical ones, as highlighted by sociological studies (Langlois et al., 2009) or public management research (Routelous et al., 2023; Mériade et al., 2019), our study proposes a different approach to understanding the origins of ethical tension and how to mitigate it. Our approach combined Schwartz's universal values with those stemming from NPM and individual values at the core of PSM. Our work goes beyond identifying the types of tensions to understand their origins. By highlighting the conflicting values, we sought to understand which values drive action among nurses and nurse managers, distinguishing between those appreciated and those disliked or rejected (Dewey, 2011) (benevolence vs performance) through Schwartz's framework (1996, 2006). The behaviours observed reflect how individuals adapt to changes in their working environment.

Some values (benevolence, universalism, and conformity) are sometimes presented as tools for reducing the tensions experienced. They lead to "active" behaviours or attitudes (Dewey, 2011) to overcome tensions. In this way, we contribute to the body of knowledge on managing tensions. Indeed, staff members often adopt adaptive behaviours, expressing ethical concerns about resource preservation or maintaining work, particularly encouraged by nurse managers to continue meeting patient needs despite resource constraints. These interactions could be interpreted as tacit agreement among staff members, enabling them to shape the work (Routelous et al., 2023), facilitated by the individual and professional values embraced by each person. In situations of value conflict, individuals express the values they consider legitimate to overcome the tension, using other tools such as communication with various stakeholders. This communication is particularly important regarding the values of autonomy and power, which were raised in the discussions and which intensify perceived tensions. Moreover, some values give meaning to daily practices, as the analysed

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discussions show. This is the case with the values of benevolence, universalism, and conformity. Clear and relevant communication about the roles and responsibilities of nurse managers, prior to taking the role (during training school) and ongoing monitoring of the changes surrounding the profession (hospital and healthcare services), could help establish a calm and peaceful working environment (Commeiras et al., 2022) by enabling managers to clearly identify their functions.

Our findings also confirm those of public management studies that highlight the plurality of values within POs, stemming from various reforms (Bozeman, 2007; Park and Joaquim, 2012). Many categories of values are present in these organisations, raising concerns that PSM (Perry and Wise, 1990) may struggle to persist as discourses of performance, rationalisation, and efficiency increasingly permeate these institutions. PSM, intertwined with individual and professional values, is clearly present in the statements of nurse managers and can serve as a tool to mitigate tensions. Our findings emphasise the need to clearly articulate shared values among all staff, as well as the importance of these values being supported by the agencies responsible for implementing reforms at regional levels.

These reforms are not only intended to introduce market mechanisms, but also aim to provide solutions for users and to meet patients' needs, while taking into account the normative role of post-NPM (Park and Joaquim, 2012). It is therefore urgent for institutional stakeholders (Abord de Chatillon and Desmarais, 2012) to co-construct, alongside healthcare staff, the values that, today, underpin not only their organisation but also their professional practices. In our findings, the early signs of the dissemination and integration of a new approach to public management, based on new public values (Moore, 1995), are apparent, particularly in the collaboration between healthcare professionals and managers. This collaboration could be extended to include administrators and users, to foster the co-creation of public value by mobilising efforts around design, control, and/or evaluation. In this effort, discussion spaces have a key role to play in supporting co-construction processes, as demonstrated by the work of Anton et al. (2021). These forms of reconciliation illustrate a value-driven management approach that should be further explored. However, they require that managers are trained to adopt them, moving beyond the informal nature mentioned in the interviews. Thus, we are still far from developing the ethical discourse competency needed to reduce ethical tensions, which could also help precisely define or redefine the notions of performance, results, and efficiency applied to POs. Discussion spaces (EDDs) (Detchessahar et al., 2015) remain an underutilised tool, as they encompass diverse forms and realities (Abord de Chatillon and Desmarais, 2017), being formal in some organisations and informal in others. Within these spaces, consensus can be reached regarding ethical tensions (Gagnou-Savatier and Mercier, 2015), and values can be transmitted and institutionalised. These spaces, already recognised for their capacity to mitigate organisational tensions (Abord de Chatillon and Desmarais, 2017), deserve to be formalised through institutionalised management practices.

Our findings contribute to the limited body of research that has identified individual values using Schwartz's model in public professional contexts. We show that the values of benevolence, conformity, and universalism are prevalent among nurse managers and nurses, and are in opposition to performance, efficiency, and results. Schwartz's (2006) work demonstrates a positive correlation between "social" professions and the values of benevolence and universalism, and a negative correlation with power and self-enhancement. In this way, our results confirm Schwartz's findings. However, our study identified only five of the ten individual values proposed by Schwartz among nurse managers and nurses. One hypothesis is that the other values may be dormant. They may not have been mentioned in our interviews because they are either too obvious or too scarce, or they may not be explicitly declared, as suggested by Moriez and Grima (2019).

### CONCLUSION

The recent developments observed in public organisations (POs), marked by the adoption of principles focused on performance, efficiency, and results, are leading to changes in the practices of public sector employees. These employees often find themselves at odds with the new work demands, creating a climate conducive to tensions, particularly in terms of values. Value tensions have been widely studied in sociology and management, but few research studies specifically highlight value conflicts. As we have noted, identifying conflicting values could help reveal the strategies adopted by actors to mitigate these tensions, as well as promote greater investment in discussion spaces. In this work, we combined Schwartz's framework of individual values (1996, 2006) and the public service motivations of Perry and Wise (1990) with the values stemming from NPM. Based on 22 interviews with healthcare professionals (nurse managers and nurses) from three French public hospitals, we highlight the presence of ethical tensions, particularly surrounding principles of rationalisation, control, and performance, which conflict with Schwartz's values of autonomy, benevolence, power, conformity, and universalism (1996, 2006). Some of these values also appear to have the potential to alleviate these tensions. Additionally, the personal values of universalism and autonomy were found to be compatible with the organisational values of performance and responsibility derived from NPM. Based on these findings, our main recommendation, beyond the systematic establishment of ethical discussion spaces, is the adoption of genuine values-based management. Our study did not allow for an in-depth exploration of the intensity of the Schwartz universal values present, which is a first limitation. A second limitation concerns the absence of data on the mediating role of staff representatives, as they were not mentioned by the interviewees. Furthermore, we did not interview those responsible for shaping healthcare policy (politicians, agencies) regarding the axiological dimensions of political orientations. This point represents a potential avenue for future research, as does the replication of this type of study in for-profit healthcare institutions. Finally, the diffusion of artificial intelligence in hospitals also presents opportunities in terms of transforming administrative processes. By automating certain tasks, AI could reduce the administrative burden on managers, freeing up healthcare time and thus mitigating ethical tensions. This is an area for future research. Reducing administrative burdens, which for many public sector employees and managers in healthcare, as well as in education, justice, etc., constitutes a barrier to user care, could be a lever to refocus work on core professional duties.

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### Appendix 1: Universal values.

Rank	Values	Characteristics
1	<b>Benevolence</b>	Preserving and enhancing the well-being of people with whom one has frequent personal contact: helpfulness, honesty, forgiveness, true friendship.
2	<b>Universalism</b>	Understanding, appreciation, tolerance, and protection of the well-being of all people and nature; open-mindedness, social justice, equality, a peaceful world.
3	<b>Autonomy</b>	Creativity, freedom, choosing one's own goals, curiosity, independence.
4	<b>Security</b>	Safety, harmony, the stability of society, relationships and oneself, sense of belonging.
5	<b>Conformity</b>	Obedience, self-discipline, politeness, respect for parents and elders, loyalty and responsibility.
6	<b>Hedonism</b>	Pleasure and/or personal satisfaction.
7	<b>Achievement</b>	Ambition, performance, capability, influence, intelligence.
8	<b>Tradition</b>	Respect, commitment, acceptance of the customs and ideas of one's culture or religion; humility, devotion, acceptance.
9	<b>Stimulation</b>	Excitement, novelty, and challenge in life.
10	<b>Power</b>	Social status and prestige, control or dominance over people and resources.

Source: Author