PARADISE HILLS Medical Center is a 500-bed teaching hospital in a major metropolitan area of the South. It is known throughout a tri-state area for its comprehensive oncology program and serves as a regional referral center for thousands of patients suffering from various forms of malignant disease.

Paradise Hills is affiliated with a major university and has residency programs in internal medicine, surgery, pediatrics, obstetrics/gynecology, psychiatry, radiology, and pathology, all fully accredited by the Accrediting Commission for Graduate Medical Education. In addition, Paradise Hills also has an oncology fellowship program, a university-affiliated nursing program, as well as training programs for radiology technicians and medical technologists. All of these teaching programs are highly regarded and attract students from across the nation.

Paradise Hills enjoys an enviable reputation throughout the area. It is known for its high-quality care, its state-of-the-art technology, and its competent, caring staff. While Paradise Hills is located within a highly competitive healthcare community, it boasts a strong market share for its service area. Indeed, its oncology program enjoys a 75 percent market share and its patients provide significant referrals to the surgery, pediatrics, and radiology programs as well.

Paradise Hills is a financially strong institution with equally strong leadership. Its past successes, in large part, can be attributed to its
aggressive, visionary CEO and his exceptionally competent management staff.

But all is not as well as it seems to be at Paradise Hills. While the oncology program still enjoys a healthy market share, it has been slowly but steadily declining from its peak of 82 percent two years ago. In addition, the program’s medical staff are aging and some of its highest-admitting physicians are contemplating retirement. The oncology fellowship program was established a few years ago in anticipation of this, but unfortunately, thus far the graduates of this program have not elected to stay in the community. Of most concern to the CEO and his staff is the fact that the hospital’s major competitor has recently recruited a highly credentialed oncology medical group practice from the Northeast and has committed enormous resources to strengthening its own struggling oncology program.

Last week the board of trustees for Paradise Hills had its monthly meeting with a fairly routine agenda. However, during review of a standard quality assurance report, one of the trustees asked for clarification of a portion of the report indicating that 22 oncology patients had received radiation therapy dosages in excess of what had been prescribed for them. The board was informed that the errors had occurred due to a flaw in the calibration of the equipment. The board was also informed that the medical physicist responsible for the errors had been asked to resign his position. The question was then asked if the patients who were recipients of the excessive radiation had been told of the error. The CEO responded that it was the responsibility of the medical staff to address this issue and it was their decision that the patients not be informed of the errors. The board did not concur that the responsibility for informing the patients of the errors rested solely with the medical staff and requested that the administrative staff review the hospital’s ethical responsibility to these patients, as well as its liability related to this incident, and report back to the board within two weeks.

The CEO and his management staff responsible for the radiology department and the oncology program met with the medical staff department chairmen for internal medicine and radiology, the program medical directors for oncology and radiation therapy, and the attending oncologists. The CEO reported on the board discussion related to the incident and the board’s request for a review of the actions taken, specifically the decision to not inform the affected patients.

The physicians as a whole agreed that the adverse effects of the accidental radiation overdose on the patients were unknown. Therefore, they argued the patients should not be told of the incident. These are cancer patients and they don’t want or need any more bad news,
the oncologists argued. “Let’s face it, these patients are terminal.” “Informing the patients of this error will only confuse them and destroy their faith and trust in their physicians and in the hospital,” they added. Furthermore, they claimed, informing the patients of the errors may unnecessarily frighten them to the extent that they may refuse further treatment and that would be even more detrimental to them. Besides, argued the physicians, advising the patients of potential ill effects just might induce these symptoms through suggestion or excessive worry. Every procedure has its risks, insisted the chairman for radiology, and these patients signed an informed consent.

Physicians know what is best for their patients, the attending oncologists maintained, and they will monitor these patients for any ill effects. The department chairman for internal medicine volunteered that, in his opinion, this incident is clearly a patient-physician relationship responsibility and not the business of the hospital. Besides, added the chairman of radiology, informing the patients would “just be asking for malpractice litigation.”

The medical director for the oncology program then suggested that the board of trustees and the management staff “think long and hard” about the public relations effect of this incident on the oncology program. “Do you really think patients will want to come to Paradise Hills if they think we’re incompetent?”, he asked.

The CEO conceded that he supported the position of the medical staff in this matter and he, too, was especially concerned about preserving the image of the oncology program, but “his hands were tied” since the board clearly considered this an ethical issue and one that would have to be referred to the hospital’s ethics committee for its opinion.

The physicians noted that if indeed it was the subsequent recommendation of the ethics committee that these patients be informed, then realistically, that responsibility would rest with the patient’s primary care physician and not with any of them.

**ETHICS ISSUES**

**Truth Telling** Is there a difference between lying to a patient and withholding the truth? Does it matter to the patient whether the act is one of omission or commission?

**Justice and Fairness** Is it fair to these patients to withhold information about their clinical treatment and any potential risks inherent in the accidental overdose?
A Patient's Right to Know  Do these patients have a right to know about this incident? Can not informing the patients affected by this radiation overdose be reconciled with “A Patient's Bill of Rights”?

Adherence to the Hospital’s Mission Statement, Ethical Standards, and Values Statement  Are the actions considered related to this incident consistent with the hospital’s mission statement, ethical standards, and values statement?

Adherence to Professional Codes of Ethical Conduct  Are the actions considered related to this incident consistent with the codes of ethical conduct as promulgated by the professional organizations and associations representing physicians, healthcare executives, and hospitals?

Management's Role and Responsibility  What is hospital management’s role and responsibility in this matter? What is the role and responsibility specifically of the hospital CEO?

Legal Implications  What are the legal implications of the actions being considered? To the hospital? To the physicians involved? Does the withholding of this medical treatment information and its potential risks from the patients involved constitute medical malpractice? In the view of the legal system, is this action indeed fraud? Has the hospital management considered the liability exposure for fraud which is not covered under medical malpractice insurance?

Other legal aspects to be considered relate to specific liability and issues of employment. Who employs and supervises the medical physicist? Who pays the medical physicist and who asked him to resign? Is the medical director for radiation oncology, who typically prescribes radiation therapy dosages, an employee of the hospital or an independent contractor? If the doctor is a contract physician does the contract stipulate that the medical physicist is hired and paid by the medical director? Should it? Is the medical director responsible for the actions of the medical physicist whether the medical physicist is employed by the medical director or not? Finally, who owns the Linear Accelerator used in this case?

Organizational Implications  How will the actions being considered related to this incident impact the oncology program? The hospital as a whole? The hospital staff?
Ethical Decision-Making Frameworks Can the actions being considered related to this incident be justified within an acceptable ethical decision-making framework?

DISCUSSION

Truth Telling/Justice and Fairness

The fundamental issue in this case seems to be one of truth telling. Is it not a basic tenet of all ethical relationships that individuals and organizations tell the truth? Is it not the “right” thing to do?

The physicians in this case have argued that telling the truth would cause more harm than good; that not sharing this incident with their patients is, in fact, in their patients’ best interest.

This, of course, assumes that the patients will never find out about the incident or that the patients will die without the incident ever coming to light. From a practical standpoint, this may indeed be the case. But upon closer examination, is this scenario likely or even probable? Sociologist John Denton reminds us that some 21 different hospital staff may interact with the patient in a single day. In a teaching hospital, that number is likely to be compounded. The prescribed radiation therapy and the received radiation therapy are a matter of medical record. Incident reports and quality assurance reports are also a matter of record. Is it realistic to believe that staff will not have questions about the incident and, worst case scenario, inadvertently discuss it with an affected patient? Is it even possible with the great number of staff, physicians, and trustees who are privy to this information to maintain a “conspiracy of silence”? Is it right for the hospital to attempt to do this?

In the event that the patients or their families find out about the incident, after the fact, what then? What impact will this knowledge have on their opinions of the physicians and the hospital?

Clearly, human relationships depend on the communication of information. Without an honest sharing of information there can be no trust. Unfortunately, not telling the entire truth in a situation usually means additional shading of the truth or outright lying when questions arise. Typically, one lie begets another and yet another. Lying is, quite simply, self-destructive behavior, for once found out, liars are no longer trusted.

In this case, lying or a withholding of the truth has enormous potential for undermining the image of the physicians and the hospital. If the knowledge of the incident is “discovered” by the patients or their families, the physicians and the hospital could be then accused
of attempting to “cover-up” the incident. This could prove disastrous in the judgment of the community and in a court of law. Recent political scandals are a tragic reminder that the public will not stand for deceitfulness.

However, it could be argued that the intent here in withholding information is to protect the patients from unnecessary stress and anxiety, not unlike the “white lies” that one may use to spare someone’s feelings in everyday life. Is this a fair comparison? Using the Golden Rule as a guide, if you or a loved one were the patient, would you want to know the truth about the incident? Or would you wish to be spared the anxiety?

In the assessment of Elizabeth Kubler-Ross, “the important question is not should I tell the truth, but how I should tell the truth, or how should I share information, important or not, with those who are asking me questions or who need to know what the truth is.” Does her assessment apply here?

**Patient’s Right To Know**

Do the patients in this case have a right to know about the incident and how it may potentially effect them? A Patient’s Bill of Rights as published by the American Hospital Association is publicly posted in Paradise Hills Medical Center. It states:

Open and honest communication, respect for personal and professional values, and sensitivity to differences are integral to optimal patient care.

Hospitals must ensure a healthcare ethic that respects the role of patients in decision making about treatment choices and other aspects of their care.

The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment and prognosis.

Except in emergencies when the patient lacks decision making capacity and the need for treatment is urgent, the patient is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits.

How do these standards of conduct apply to the radiation therapy incident at Paradise Hills? The management team and the physicians involved must review their applicability. In light of the fact that these standards are publicly posted, their review must take into consideration the patients’ and their family members’ interpretation of the standards, as well.
Do patients and their families have a right to know when a medical error has occurred during the course of their treatment? It seems the federal government is saying “yes.”

**Adherence to Hospital’s Mission Statement, Ethical Standards, and Values Statement**

In late 1999, the Institute of Medicine published a report entitled *To Err is Human: Building a Safer Health System* which claims that medical errors occurring in the nation’s hospitals, clinics, and physician offices account for the deaths of nearly 100,000 Americans each year. As expected, this report was covered extensively by the media and this in turn prompted a rapid political response. Congressional hearings, a report from the Quality Interagency Coordination Task Force entitled *Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact*, and a major policy speech on reducing medical errors by the president soon followed.

In his speech, President Clinton introduced a National Action Plan to reduce preventable medical errors by 50 percent within five years. This action plan called for:

- $20 million for the creation of a center for Quality Improvement in Patient Safety to sponsor research and education in reducing errors.
- New regulations requiring all 6000 hospital participants in the Medicare program to implement patient safety programs to reduce medical errors.
- Development of a national, state-based system for reporting medical errors that include mandatory reporting of preventable errors causing death or serious injury and voluntary reporting of other medical errors including “near misses.”
- Support of legislation that protects provider and patient confidentiality without undermining existing tort remedies.
- New steps to specifically reduce medication errors.

This National Action Plan signals governmental intervention in a domain that previously has been notorious for “policing its own” and where medical errors have been held in secret for fear of malpractice litigation and where those committing medical errors were blamed and punished and the prevailing standard for prevention of medical errors was to educate those involved in the hope that such errors would not happen again.
In an attempt to change what some have called a “conspiracy of silence,” the Institute of Medicine and the Quality Interagency Coordinating Task Force recommended further actions including:

- Employers should incorporate patient safety performance into their healthcare purchasing decisions.
- Periodic relicensing and reexamination of physicians and nurses by state boards should include knowledge and competence in patient safety practices.
- Healthcare organizations should have a goal of continually improved patient safety.
- Proven medication safety practices should be implemented by healthcare organizations.
- Accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations and others should review organizational efforts to minimize errors and promote patient safety.
- Computerized medical records should be implemented that are integrated with drug ordering and administrative systems.6

For healthcare providers, perhaps the most disconcerting of these recommendations is the mandatory reporting of medical errors to patients and their families. No responsible healthcare professional will argue with the need for strategies to reduce medical errors and provide assurances for patient safety. But the notion of placing the organization and its staff at risk for malpractice litigation gives one pause.

Yet, in the president’s policy address he stated, “People should have access to information about a preventable medical error that causes serious injury or death of a family member, and providers should have protections to encourage reporting and prevent mistakes from happening again.”7 Is it reasonable to believe that this is possible, and more to the point, is the fear of litigation sufficient justification for withholding the truth from those affected by medical error?8

In fact, Kraman and Hamm argue that honesty may be the best policy in risk management. In their recent article in the Annals of Internal Medicine, they cite a study by Heckson and colleagues who found that of 127 families who sued their healthcare providers after perinatal injuries, 42 percent were motivated by suspicion of a cover-up or revenge.9
Kraman and Hamm reported on the experiences of one Veterans Affairs Medical Center that implemented a policy of full disclosure of medical errors to patients and families in the presence of a family attorney, if the family so desired. The medical center initiated this practice because staff believed it was the “right thing to do.” They also found that this honest approach resulted in unanticipated financial benefits to the medical center when lower-cost settlements began replacing higher-cost litigation.\textsuperscript{10}

**Professional Codes of Ethical Conduct**

Do the existing professional codes of ethical conduct promulgated by the professional organizations and associations representing physicians, healthcare executives, and hospitals require that the incident be fully disclosed to the patients? 

Excerpts from the Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs published by the American Medical Association state:

> A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.\textsuperscript{11}

> The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interests that their physicians might have, and to receive independent professional opinions.\textsuperscript{12}

Excerpts from the American College of Healthcare Executives *Code of Ethics* state:

> The healthcare executive shall conduct all personal and professional activities with honesty, integrity, respect, fairness, and good faith in a manner that will reflect well on the profession.\textsuperscript{13}

> The healthcare executive shall assure the existence of a process that will advise patients or others served of the rights, opportunities, responsibilities, and risks regarding available healthcare services.\textsuperscript{14}

Excerpts from the American Hospital Association’s Management Advisory on Ethics: Ethical Conduct for Health Care Institutions state:
Healthcare institutions by virtue of their role as healthcare providers, employees, and community health resources have special responsibilities for ethical conduct and ethical practices that go beyond meeting minimum legal and regulatory standards. Their broad range of patient care, education, public health, social services, and business functions is essential to the health and well-being of their communities. These roles and functions demand that healthcare organizations conduct themselves in an ethical manner that emphasizes a basic community service orientation and justifies the public trust.\textsuperscript{15}

The governing board of the institution is responsible for establishing and periodically evaluating the ethical standards that guide institutional policies and practices. The governing board must also assure that its own policies, practices, and members comply with both legal and ethical standards of behavior. The chief executive officer is responsible for assuring that hospital medical staff, employees, and volunteers and auxiliaries understand and adhere to these standards and for promoting a hospital environment sensitive to differing values and conducive to ethical behavior.\textsuperscript{16}

While the language in these ethical standards is somewhat general, the standards do provide guidance to those wrestling with this ethical dilemma. As professionals, each physician and executive must determine if his or her actions are consistent with their respective ethical standards.

The American Hospital Association’s Advisory on Ethical Conduct for Health Care Institutions clearly delineates the ethical responsibilities of the governing board and the CEO lending credence to the argument that ethical matters involving patient-physician relationships are indeed the “business of the hospital.”

**Understanding the Medical Staff Perspective**

It is not surprising, however, that the physicians involved in this case would feel otherwise. A basic understanding of the factors that contribute to the medical staff orientation helps to explain why physicians adamantly protect what they consider to be their professional province.

Typically, the physician enjoys the supreme position in the hospital organizational hierarchy. The physician generally establishes and maintains the rules that regulate most patient care in the hospital and it is only through the physician that the patient can access the healthcare system. Herbert Blumer suggests that all organizations “represent the application of somebody’s definition of what the organization should be.” It is the physician who sets the standards for patient care and who defines illness.\textsuperscript{17}

The physician is granted the authority to define illness because the physician possesses “a body of knowledge that defines and constructs the roles to be played in the context of the institution.”\textsuperscript{18} Roles make
it possible for institutions to exist. By virtue of the role the physician plays, he/she is inducted into specific areas of knowledge, not only in the narrower cognitive sense but also in the sense of norms, values, and even emotions. This knowledge may become so internalized that the physician considers the role “an inevitable fate for which (he/she) may disclaim responsibility.” “I have no choice in the matter, I have to act this way because of my position.”

Physicians learn their roles through a complex socialization process that begins when they enter medical school. The rigors and expense of medical school, the admission requirements, the protégé system, and the collegial bonds of the medical profession all reflect occupational socialization. Upon completion of medical school, the symbolic universe of the physician includes elaborate rights, obligations, standard practices, and a role-specific vocabulary. The physician is now socialized to play the role as definer of reality for the patient.

The effects of this socialization on the moral reasoning of medical students is reflected in a study conducted by Herbert, Meslin, and Dunn at the University of Toronto and published in the *Journal of Medical Ethics* in 1992. Their research instrument presented four clinical vignettes and respondents were asked to list the ethical issues in each. The study assumes that physicians must recognize issues before they can behave appropriately. Students in all four medical school years participated in the research project. The first-year students completed the survey during their medical school orientation. The fourth-year students identified far fewer ethical issues than the first-year students. The researchers concluded that “these studies show(ed) a disturbing pattern; the ethical sensitivity of medical students seems to decrease with more time in medical school. Is this the consequences of medical socialization and is it harmful?” they asked.

In any discussion of the role of the physician, some attention must be given to professionalism. Critical components of professionalism include autonomy and self-regulation. The source, structure, and characteristics of professionalism place professionals in a position of dominance. Professionalism is considered by many as the ultimate in occupational status and the physician is the prototype of professionalism. There are some who will argue that the physician’s position of dominance is justified. After all, they say, physicians must make life and death decisions. Advocates of patient self-determination claim that physician dominance is detrimental. But the greatest challenge to the physician’s dominant role in healthcare has been managed care. At Paradise Hills, the physicians have not yet experienced the prevalence of managed care that exists in other parts of the country.
Given the occupational socialization and the professional dominance that the Paradise Hills physicians enjoy, it is not surprising that they tend to believe that matters of patient care fall strictly within their domain.

**Hospital Management’s Role and Responsibility**

What is hospital management’s role and responsibility in this case? What is the role and responsibility specifically of the hospital CEO? Strict adherence to a literal interpretation of the standards of ethical conduct promulgated by the American College of Healthcare Executives and the American Hospital Association as discussed earlier would indicate that the role of the CEO in this case is indeed burdensome and one in which the CEO must balance complex needs and conflicting interests. In the fulfillment of all the CEO’s duties, the executive has responsibilities to the governing board, to the institution, to the medical staff, to the employees, to the community, to the patients, to the profession, and to self.

The CEO is mandated to carry out the policies of the governing board which includes ensuring compliance with the ethical standards approved by the board for the practices of the institution. The CEO, likewise, is charged with the responsibility for ensuring that the institution operates in ways that are consistent with its mission statement and its statement of values, assuming one exists. Indeed, Austin Ross in his book, *Cornerstones of Leadership for Health Services Executives* says that “The CEO’s greatest source of support in preserving ethical conduct within the organization is the organizational mission.”

**Partnering with the Medical Staff**

Paradise Hills and its management staff have a strong working relationship with its medical staff. Its oncology physicians have been especially loyal and committed to Paradise Hills and in return, hospital management has provided the resources and technology needed for the physicians to practice state-of-the-art medicine. It has been a “win/win” situation for Paradise Hills. The CEO is now determined to arrive at a solution to this problem that will preserve the existing medical staff–management relationship. Not incidentally, he knows he must avoid alienating these community-based physicians whose patients are vital to the financial viability of the hospital.

It is generally accepted that leadership hospitals embrace the core belief that medical staff participation is essential to the successful operations and strategic planning of the institution. Management in such an institution enthusiastically integrates medical staff participation into
its way of doing business, fosters ongoing dialog with physicians, and recognizes the medical staff as a needed resource. The CEO at Paradise Hills has worked to develop such an environment and is staunch in his resolve that the medical staff must be full and active participants in this ethical decision making. The CEO believes that a satisfactory solution to this incident must not violate confidentiality of patient information, must not infringe upon or threaten the patient-physician relationships, and must not precipitate a lawsuit. He knows that to secure these objectives he must work closely with the medical staff on this issue and avoid an adversarial confrontation. The physicians must be full partners in the analysis and resolution of the problem. Their voice in the proceedings must be heard and attended to. The outcome must be one in which they have been allowed to exercise some element of control.

Fortunately, the CEO at Paradise Hills is armed with the primary prerequisite to successful partnering with the medical staff: they trust him. Now, he knows that to successfully solve this ethical problem, he must be well prepared with solid facts, a well-thought-out rationale for actions, and a commitment and a plan to deal with all consequences of the actions taken.

The CEO and the management staff must also recognize that medical errors take their toll on the physicians and other staff that may be involved. In an organizational culture that emphasizes perfection, self-reproach, and accountability, guilt can affect a clinician’s effectiveness in future patient care. Management must, therefore, take measures to assist staff in appropriately coping with medical errors.24

Leadership

In this case, as in all ethical matters, the CEO has enormous leadership responsibility. It is the CEO who is responsible for the ethical culture within the organization, implementing the standards of ethical conduct, and serving as an ethical role model for staff. While clinical professionals may bring their own codes of conduct to the workplace, it is management that must set the tone for how business is conducted, how professionals interact, and how patients are served.

Bennis and Namus are clear on this point. “The leader is responsible for the set of ethics or norms that govern the behavior of people in the organization. Leaders set the moral tone.”25

William D. Hitt in his book, Ethics and Leadership: Putting Theory Into Practice, cites results of research studies that demonstrate that the ethical conduct of individuals in an organization is influenced greatly by their leaders. Hitt says that leaders have three basic obligations:
1. Achieve an understanding of ethics.
2. Serve as a role model in making ethical decisions.
3. Develop and implement a plan of action for promoting ethical conduct on the part of his or her staff.26

The significance of the leader as role model should not be underestimated. Schmidt and Posner conducted studies to identify the five primary factors that influence ethical conduct in organizations by rank. They were:

1. Behavior of superiors
2. Behavior of one’s peers in the organization
3. Ethical practices of one’s industry or profession
4. Society’s moral climate
5. Existence of organizational policy27

Austin Ross in his book, *Cornerstones of Leadership for Health Services Executives*, states that “effective leadership is still the healthcare system’s best hope for anchoring ethics, values, and social responsibility within organizations.” He continues that “The CEO nurtures the organizational social conscience by being personally dedicated and committed to accomplishing an organizational mission based on good ethical conduct.”28 Ethical problems are a true managerial dilemma because they represent conflict between an organization’s economic performance and its social obligations to parties both within and outside the organization.29 This case, like all ethical problems, requires that the CEO, his management team, and the medical staff think through the consequences of their actions on multiple dimensions using ethical analysis as well as economic and legal analysis.30 While the task is complex and the conflicts may appear insurmountable, Bennis and Namus remind us that “Leaders are persons who are able to influence others; this influence helps to establish the organizational climate for ethical conduct; ethical conduct generates trust; and trust contributes substantially to the long-term success of the organization.”31

Notes


8. Ibid.


10. Ibid.


16. Ibid.


31. Bennis and Namus, 186.
DECIDING VALUES

Joan McIver Gibson, Ph.D.

INTRODUCTION

Decisions whether to tell patients the “whole” story (including uncertainty, ambiguity, and “bad news”), honor professional responsibility, minimize legal liability, provide safe, quality care, and enhance programmatic and institutional financial health (not to mention survival) are values-based decisions. That is, they reflect what matters, in a given situation, to the decision maker(s).

Indeed, we would be hard pressed to come up with any decision or issue (public, private, or professional) that is not at bottom defined by values—that is, by our beliefs of what is useful, important, worthwhile, or desirable. Certainly this is the case with the issues at Paradise Hills Medical Center. So what should healthcare administrators, board members, and other managers, whose main “products” are decisions, do with this observation?

In a culture that still feels the effects of the nineteenth century positivist separation of “fact” from “value” we find ourselves without a robust language or strategy for seeing, naming, and working with...
values. We are confident that as long as we are dealing with “facts” we can make progress. And so we search for “hard” data to lead the way. Would a right decision become clear if there were more conclusive data on the adverse effects of the accidental radiation, or if hospital policy were “black and white” regarding the ultimate decision makers on this issue, or if there were an in-depth analysis of projected market share over the next five years? Probably not. The decision maker(s) still must navigate a sea of conflicting interests and values.

As soon as someone raises the specter of a values discussion, however, many people fear a slide into the black hole of private, subjective, and interminable discussion. This is not helpful when things need to get done. This chapter introduces a process of values-based decision making for administrators and managers in healthcare institutions. It is, however, transferable to virtually every decision-making facet of our lives: professional, public, and private.

**THEORY AND HISTORY**

Are values really that separable from facts? Do values enter decision making only when we specifically invite them in? Scientists and philosophers over the past half century have dropped the fact/value dichotomy as at best outmoded and unhelpful, at worst—wrong. They observe that all reasoning, from the beginnings of language development through complex theory building, is the attempt to create, reflect on, and communicate meaning. Reasoning is the process of making meaning, or valuing. To label something as “factual” is already to make a very strong claim about its importance, status, utility, and reliability—that is, about its value.1

How do we go about discerning the values dimension of an issue or decision? What vocabulary do we need for capturing values and crafting decisions that appropriately reflect those values? Expanding our understanding of sources and types of values and their historical evolution in western philosophy may help.

**VALUES: SOURCES AND TYPES**

Professions, organizational culture, law, religion, social customs, family, and personal experience communicate important values (see Table 1a.1). What matters to us comes from the areas of strong influence in our lives. Consider the relative weight we place on these sources of interests and values. Sometimes, when faced with otherwise intractable conflicts among values, we make choices based on what we consider
Table 1a.1: Sources of Values

<table>
<thead>
<tr>
<th>Sources of Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Organization</td>
</tr>
<tr>
<td>Society/Culture</td>
</tr>
<tr>
<td>Law</td>
</tr>
<tr>
<td>Profession</td>
</tr>
<tr>
<td>Experience</td>
</tr>
</tbody>
</table>

An influential source for values. For example, how should the Paradise Hills CEO weigh the relative influences of professional, personal, and community values? Should values issuing from one of these sources trump the others?

Another related strategy is to recognize that decision makers project various roles and approach decisions based on these roles. Cases present themselves differently, depending on the “disciplinary lens” through which we view them. Our roles grow out of our professional, social, and personal identities and entail specific perspectives or “lenses” that refract according to the types of values important to a given discipline or role. Consider the following perspectives:

- **Legal:** What does the law require?
- **Scientific:** Is the explanation comprehensive, coherent, and simple?
- **Economic:** Is this the best distribution of the resources available?
- **Social:** Does this policy respect the values and traditions of our diverse community?
- **Aesthetic:** Do things fit together and run efficiently and smoothly?
- **Moral:** Is it really the right thing to do?

This list is suggestive, not exhaustive, of ways to unpack, label, and reorganize the variety of interests and values embedded in a single issue or decision.
Table 1a.2:  Examples of Values by Type

<table>
<thead>
<tr>
<th>Economic</th>
<th>Context</th>
<th>Scientific</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Profitability</td>
<td>We hold values that we use in making decisions. These values come from</td>
<td>• Accuracy</td>
</tr>
<tr>
<td>• Efficiency</td>
<td>different sources. We have listed common values by type to assist you in</td>
<td>• Objectivity</td>
</tr>
<tr>
<td>• Frugality</td>
<td>identifying the values that you use in your work to make decisions.</td>
<td>• Honesty</td>
</tr>
<tr>
<td>• Financial</td>
<td>These types of values are not exclusive. For example, honesty is a</td>
<td>• Knowledge</td>
</tr>
<tr>
<td>Security</td>
<td>religious value, a moral value, and a scientific value. We incorporate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>differing types of values to form our own unique set of personal values.</td>
<td></td>
</tr>
<tr>
<td>Aesthetic</td>
<td>Your Personal Values Related to Work</td>
<td>Legal</td>
</tr>
<tr>
<td>• Beauty</td>
<td></td>
<td>• Justice</td>
</tr>
<tr>
<td>• Creativity</td>
<td></td>
<td>• Equality</td>
</tr>
<tr>
<td>• Simplicity</td>
<td></td>
<td>• Freedom</td>
</tr>
<tr>
<td>• Elegance</td>
<td></td>
<td>• Order</td>
</tr>
<tr>
<td>Personal</td>
<td></td>
<td>Social</td>
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<tr>
<td>• Inner Harmony</td>
<td></td>
<td>• National Security</td>
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<tr>
<td>• Competence</td>
<td></td>
<td>• Cooperation</td>
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<tr>
<td>• Reliability</td>
<td></td>
<td>• Responsibility</td>
</tr>
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<td>• Happiness</td>
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<td>• Loyalty</td>
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<tr>
<td>Religious</td>
<td></td>
<td>Religious</td>
</tr>
<tr>
<td>• Charity</td>
<td></td>
<td>• Autonomy</td>
</tr>
<tr>
<td>• Sanctity of Life</td>
<td></td>
<td>• Respect</td>
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<tr>
<td>• Fidelity</td>
<td></td>
<td>• Responsibility</td>
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<tr>
<td>• Compassion</td>
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<td>• Truth Telling</td>
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<td></td>
<td></td>
<td>• Nonmaleficence</td>
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<tr>
<td>Institutional</td>
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<td>Moral</td>
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<tr>
<td>• Quality</td>
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<td>• Autonomy</td>
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<td>• Leadership</td>
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<td>• Teamwork</td>
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<td>• Beneﬁcence</td>
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<tr>
<td></td>
<td></td>
<td>• Integrity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Justice/Fairness</td>
</tr>
</tbody>
</table>

**History of Values**

Finally, *history* helps. In the United States, our contemporary set of values is a microcosm of 2000+ years of history. For example, reviewing our cumulative western (primarily Anglo-Saxon and European) heritage, we see certain markers along the way that signal different approaches to values. Understand that this tradition is but one of many cultural and historical strands that contribute to our American tapestry of values (see Table 1a.2).

In ancient Greece, at least for Plato and Aristotle, *virtue* mattered most (cf. today’s “character counts” initiative). The question was: How do I personally cultivate virtuous character traits, that is, who should I *be*? rather than, what should I *do*? Plato and Aristotle believed that a morally good person with right desires, motivations, or intentions, is more likely to understand what should be done, more motivated to perform required acts, and more likely to form and act on moral ideals than someone without such virtuous traits.
At the beginning of the Christian era, two fundamental values were added: the sanctity of life and the importance of the individual person. Regardless of faith, the obligation to avoid harm and protect life, as well as the intrinsic worth of persons as autonomous agents are values and imperatives that continue to drive American law and social policy.

During the Renaissance and Enlightenment, science, reason, and moral philosophy joined forces. The scientific values of simplicity, coherence, and comprehensiveness in explanation were extended to other disciplines (e.g., social theory, religion, art). There was a deep faith in the power of reason and the promise of progress, and morality was an important—perhaps the primary—object of rational inquiry. Faith in reason as the guide to right action continues, even (perhaps especially) as we lament its absence.

In the twentieth century, the application of reason to moral values became more and more systematized, even as it was separated from scientific and “factual” inquiry. Just as science, in one of its dimensions, is systematized explaining, so moral philosophy (ethics) is systematized valuing. One way of doing this is by extracting and abstracting from individual cases, those evermore general and encompassing reasons, standards, and justifications for what constitutes right actions. These most general and broadly applicable standards we call principles. In medical ethics especially this system of analysis and decision making took hold.

A principlist approach to valuing and ethics:

- identifies the fundamental standards of right conduct, such as autonomy, respect for persons, beneficence, justice, truth telling, professional responsibility/integrity;
- argues the moral importance of such standards; and
- applies each (where necessary) to a given situation.

How we justify these principles and the actions they support is important. Do we look to these standards themselves for self-evident value, rather than to their consequences? Is there something about respect for persons and telling the truth that is intrinsically valuable, regardless of the circumstances or outcomes?

Should we calculate the consequences and seek the greatest good for the greatest number of people? The former approach is a formalist approach, the latter utilitarian. They are not mutually exclusive and both are helpful.

The task, however, is not simply and mechanistically to follow or apply certain principles (e.g., a Code of Ethics) to a given case, as one
might follow a recipe, but rather to see how these standards help us understand and develop the moral dimension of a decision.

Toward the end of the twentieth century, as principlist ethics was focused on formulating and impartially applying universally binding moral principles, contemporary philosophers began to observe that universal principles are inadequate for practical guidance; that abstract formulations and hypothetical cases that separate moral agents from the particularities and uniqueness of their individual lives and circumstances, and moral problems from social, historical, contextual realities, are often less than helpful (see Table 1a.3).

For example, it is important to tell the truth. Yet, sometimes it is not clear what the truth is, or what meanings different “messengers” might communicate, or the degree to which quality patient care and safety might be compromised if a program is shut down. Unique circumstances, players, and environment are moving targets to be reckoned with. Context matters.

VALUES-BASED DECISION MAKING: A CONTEXTUAL APPROACH

A contextual (not to be confused with relativistic) approach to values-based decision making accommodates general principles, uniqueness, and particular details by focusing on roles, relationships, and process. The following elliptical diagram (Table 1a.4) illustrates the approach.

Features of the decision-making ellipse include: the importance of context, the frames we and others bring to a situation, working with values by naming, clarifying, and weighing them, deciding based on these values, and communicating accurately and thoroughly the decision and the reasons behind it as well.

Context

Cases arise and decisions are made in specific contexts. Decision makers must “see” the full context, history, tradition, current conditions, institutional values, as well as specific people, roles, and relationships that are at work. They must promote values and argue for their relative weight. Any decision involving Paradise Hills Medical Center must consider its history and role in the community, the current business climate, the institution’s role as a teaching hospital, as well as the various roles and relationships of the respective players (physicians, CEO, board members, community at large). Effective decision makers understand the influence of context and use it to their advantage.
Table 1a.3: Major Historical Developments in Ethics

<table>
<thead>
<tr>
<th>Historical Period</th>
<th>Major Ethical Tenet</th>
<th>Relevance to Us</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancient Greece</td>
<td>Virtue</td>
<td>The “Character Counts!” movement</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>The Book of Virtues</em> by William Bennett</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individual freedom as a political and moral principle, autonomy in decision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>making, civil rights.</td>
</tr>
<tr>
<td>Christian Era</td>
<td>Sanctity of Life</td>
<td>Abiding faith in the power of reason to discern right action and promote</td>
</tr>
<tr>
<td></td>
<td></td>
<td>progress.</td>
</tr>
<tr>
<td>Renaissance/Enlightenment</td>
<td>Scientific Morality</td>
<td>Our rights and duties to each other and to society are the focus of ethics.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ethical principles are the standards for determining right action. Appeals to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>these principles are often used in public and political debate.</td>
</tr>
<tr>
<td>Mid-20th Century</td>
<td>Principled Decision Making</td>
<td>Increasing emphasis on the impact of roles, relationships, and process in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>shaping the values that are present and operative when making good decisions.</td>
</tr>
<tr>
<td>Late 20th Century</td>
<td>Context and Interdependence</td>
<td></td>
</tr>
</tbody>
</table>

**Framing: What Kind of Issue Do I Think This Is?**

Each of us comes to any decision with a first “take” on what kind of issue it is. We might initially consider the Paradise Hills case to be an issue of public relations, or perhaps liability exposure, or program/institution survival, or professional fiduciary responsibility, or simply a matter of telling the truth. It is a virtual certainty that different parties will bring different initial frames to the decision. Frames are neither right or wrong,
### Table 1a.4: “Decision-Making Ellipse”

<table>
<thead>
<tr>
<th>Context</th>
<th>Important elements surrounding decisions, History, Experience, People, Roles, Relationships, Institutional culture.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naming</td>
<td>What is important to me and to others in this issue? Prepare to communicate values that are important to you. Elicit from others and capture.</td>
</tr>
<tr>
<td>Clarifying</td>
<td>Do I understand what is important to others in this issue? Hear from others about what matters. Engage in genuine dialog. Reflect back your understanding of others’ values.</td>
</tr>
<tr>
<td>Reporting</td>
<td>How do I justify the decision to others? Explain the decision, the process, the “top” values and the unincorporated values. Address foreseeable negative impacts.</td>
</tr>
<tr>
<td>Framing</td>
<td>What kind of issue do I and others think this is? Consider alternate ways to look at the decision “frames” at the beginning, during, and at the end of the process.</td>
</tr>
<tr>
<td>Weighing</td>
<td>What do I and others think is the relative importance of the values involved? (Re)align with decision frame. Organize, compare, or rank to determine “driving” values.</td>
</tr>
<tr>
<td>Deciding</td>
<td>What kind of action(s) do I believe follow from the driving values? Use the “top” driving values as criteria for choosing options. Acknowledge values not incorporated in the decision.</td>
</tr>
</tbody>
</table>

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they simply “are.” The Talmud reminds us that, “We see the world, not the way it is, but the way we are.”

We need ways to simplify and structure all the information “noise” that surrounds us. Our brains are “hard-wired” to use categorical frames to bound what is “in” (relevant, important) and “out” (irrelevant, less important). Frames usually exist below our awareness and often remain untested and unexamined. They are not accessible for problem solving and decision making. Worse yet, they may impede our ability to see root causes of conflict. When frames are understood, appropriate, and flexible, they serve us well in dealing with difficult decisions and challenging situations. When they are hidden, unduly rigid, or based on flawed assumptions, they limit our ability to make wise decisions and may cause us to react to complex situations in an overly simplistic manner.

In decision making, frames determine who should participate, how the decision/question is formulated, what principles/values/standards are applicable, what information is relevant, what is at stake, what is the range of acceptable outcomes, and how we should treat each other.

The major task of the framing step is to consider alternative ways to define the problem or structure the question, both at the beginning and throughout the decision-making process. Key framing questions include: What kind of decision is this? What assumptions are we making? What boundaries do I/we/they put on this question? Who are the people involved?

Specific framing activities might include: Periodically stepping back during the decision process and asking if we have the question/issue/problem framed well; consulting with possible stakeholders about ways to frame the issue; listing three to five different ways to ask the question and getting feedback from key people about the best way to approach the problem.

**Naming and Clarifying: Do I Understand What Is Important to Me and to Others in This Issue?**

The real “brainstorming” part of this process involves identifying the interests and values held by stakeholders. The goal of this step is to generate a comprehensive list of values described in everyday language—always avoiding jargon. Questions that prompt useful “values answers” include: What really matters in this issue? What is important here that we really need to look at? What do you think our duties and obligations are in this situation? What worries you about this issue? When we look back on this decision one year from now, how will we know we did the
right/best thing? If your teenager were watching us make this decision and asked why we did it, what would you say to her/him?

Answers to the question, “What is important?” might include: (1) that Paradise Hills Medical Center protect its good reputation; (2) that quality care and patient safety remain paramount; (3) that past, current, and future patients and families be able to trust the healthcare professionals at Paradise Hills; (4) that the hospital enjoy a strong economic position in the local healthcare community; and (5) that physicians honor their fiduciary duties to patients.

As values are named it is important for others to understand what they mean to the holder. Frequently our stated values are merely the visible tip of their larger meaning. Listening well, not merely waiting to speak, is essential. Skills for avoiding “serial monologues” and creating dialog include: making “reflecting back” your understanding of someone’s stated values a behavioral norm in decision-making discussions; avoiding jargon by finding fresh ways to express values; using the services of a facilitator to ensure that you have a full, fair, and productive discussion.

When an individual’s position is honored and allowed to take root in open dialog, the “health” of the decision-making process is enhanced. Meanings are clarified and participants feel they have been heard and even may be willing to “let go” of certain strong positions that might otherwise impede agreement. Even when full consensus is not possible or is not the goal, comprehensive naming and thorough clarification are necessary for decisions to last.

**Weighing: What Do I Think Is the Relative Importance of the Values Involved?**

A comprehensive list of interests and values is usually too large to be fully and equally honored. For example, profit, fiduciary responsibility, quality and safety, public reputation, professional autonomy, organizational mission, and increased market share are not entirely compatible. The question thus becomes: If we cannot fully honor all these important interests, which is/are most important? Put another way: If we do nothing else, we must make certain that... (fill in the value).

There are several ways to weigh and prioritize values. Sometimes an “advocacy round” helps. Participants each speak, briefly but strongly, to the value they think is most important. Other techniques include multiple voting, weighted multiple voting, and rank ordering. The rule of thumb is always to use a method that fits the situation. Patterns and
agreement begin to emerge, at which point—and only at this point—
decision options should be considered.

**Deciding: What Action(s) Do I Believe the Most Important
Values Warrant?**

This entire process is not meant to replace full blown decision-making
processes already in use. Rather, it highlights a dimension of decision
making that is routinely overlooked in much of decision-making theory
and practice—the values base. At the point in any decision-making
process where alternative options are generated and considered, each
option should immediately be tested against the prioritized list of values.
The goal is to develop a decision that is genuinely driven (not just “spun”
or superficially rationalized) by the identified top values. The coherence
between a decision and its stated reasons must be genuine.

**Communicating: How Do I Justify the Decision to Others?**

Decision makers may feel, as a matter of course, that they usually work
through many of the steps described so far, and they may tout their
decisions as strong and sound on that basis. Chances are, however,
their communication of decisions and their real reasons frequently leaves
something to be desired. People who have a reason to know should be
informed about the grounds for the decision. First, who actually made
the decision (which is not addressed by leading with, “It was decided
that . . .”)? How was the decision approached and who was involved?
What did the decision makers struggle with? What was most important
in making the final decision? What is the decision?

Some decision makers prefer the “bottom-line” approach, starting
with the decision and working backwards through the justifying reasons.
Others prefer a more contextual or narrative approach that concludes
with the decision. The components of a complete report are the same,
and the common goal is to explain and justify the decision to stakeholders.
Consider the two following “Decision Summary Forms.”

**Form No. 1:** State the decision in direct, simple language. Be clear who “owns”
the decision. (*I/the executive committee . . . have decided to . . .*)

Describe the most important values that “drove” the decision.
(*Ultimately, we believe that . . . , . . ., and . . . had to drive our final
choice.*)

Directly address the “downside” of the decision, that is, what you
do not like about the decision. (*There are some parts of this decision
I/we do not like . . .*)
Describe applicable values that could not be honored and indicate the reasoning for your judgment that other values were more important in this situation.

Address any negative impacts of the decision on stakeholders. Pay particular attention to those who were not fully consulted in the decision process.

Form No. 2: How did you approach this decision? (Provide some brief highlights of the decision process, e.g., the steps you took, who was at the table, whom you consulted, the level of time and effort involved.)

( Let me give you a sense of the road we took to get to this decision . . . )

Be candid about the “downside” of the decision.
Describe applicable values that could not be honored.
Address negative impacts of the decision on stakeholder.
Describe (using everyday language) the values that “drove” the decision.
State the decision in direct, simple language. Be clear who “owns” the decision.

CONCLUSION

Decisions made with integrity are comprehensive, coherent, and transparent (see Table 1a.5). First, the decision maker(s) has made a good faith effort to consider the full range of interests and values (comprehensive). Second, the decision is logically grounded in the values held out to be the driving values. That is, the stated basis for the decision genuinely supports the decision (coherent). Third, the decision maker communicates the decision to those who deserve to hear about it in a sincere, forthright manner. The decision maker is willing to stand up, be open and accountable to stakeholders by exposing the reasoning for the decision. This requires a willingness to be tested, questioned, and judged by others (transparent).

This values-based decision-making process rests on certain important assumptions, observations, and hypotheses. All choices and decisions are driven by values, by what matters. Contemporary business approaches to “ethics” and “integrity” often focus on avoiding wrongdoing or breaking the law. Many decisions, however, are not about right versus wrong, but rather right versus right (competing “goods”). Decisions are effective and enduring when they are based on clearly identified values, are made efficiently, have the resources and support to be fully implemented, and produce positive results that significantly outweigh the negatives. Durable decisions usually follow thorough dialog, consultation, and collaboration.
Table 1a.5:  Triangle

Decisions have INTEGRITY when they are:

Isolation is the worst possible counselor.

Miguel de Unamuno, Philosopher, Spain

POSTSCRIPT

The following is a “tool” for a “values analysis on the fly,” when time is short but values still must be considered.

1. Come prepared to speak directly to the values dimension of the decision.
   • If you know the issue ahead of time, ascertain what frame you bring, what values you think are most important, and be prepared to communicate these.
   • Encourage others to think ahead of time about their frames and values.
   • Create the expectation that this kind of “homework” will be done.

2. Commit to a “values round.”
   • Ask everyone in the room to explain their frame and values list.
• Avoid jargon and encourage ordinary language that captures the “values in context.”
• Listen well and check in with people as they explain their values.
• Record the frames and values where everyone can see and refer to them.
• Weigh these values for relative importance.

3. Return to the values list as appropriate.
• As issues and options are explored, ask: Which value(s) does this choice honor?
• Craft decisions that are genuinely driven by the values that are most important in this situation.

4. Report your values-based decision.
• State the decision and name the values that drove it.
• Acknowledge the values that could not be honored.
• Explain values priorities.

Note