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Four Ways People Approach Ethics

A Practical Guide to Reaching Consensus on Moral Problems

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Summary
Most people use four different approaches when making ethical decisions. Some people use one approach predominantly; others vary their approaches according to circumstances. In either case, the approaches are usually chosen unconsciously. The main source of conflict in decision making is the fact that two parties have chosen different approaches. The four approaches are:

- The *principle* approach, in which decisions are made according to a principle such as the Ten Commandments or the Golden Rule
- The *consequence* approach, in which decisions are made according to their likely outcomes
- The *virtue/character* approach, in which decisions are made according to the decision maker's view of his or her responsibilities
- The *moral sentiment* approach, in which decisions are made according to the decision maker's feelings

Conflicts in decision making become easier to resolve once the decision makers, first, recognize that they are using different approaches, and, second, agree to "change gears" and use the same approach.

A patient in the critical care unit of your hospital dies of cardiac arrest. His family, uneasy about the circumstances of his death, requests a copy of his medical record and contacts an attorney. An internal investigation reveals that an error a nurse made in giving the patient heart medication may have been a factor in his death. Management team members meet to discuss the case.

Examining the patient's medical record, they observe that the pertinent nursing notes are both incomplete and almost illegible. If they were to add a couple of smudges, this section of the record could be made completely illegible. And if they added an entry to the physician's order sheet, the error might be concealed altogether.

The chief operating officer (COO) argues against doing anything to the patient's medical record. "That would be dishonest," she says. "A medical record should never be altered."

However, the chief financial officer (CFO) argues that, in this case, it would be relatively easy to conceal the nurse's error and that failing to do so could cause serious financial repercussions for the hospital. "No matter what we do, we can't bring this poor man back to life. Let's make the best of a bad situation."

The medical director agrees, adding, "What happened was unfortunate. But it would be wrong to let a vengeful family and a greedy lawyer seriously undermine our responsibility to serve the health needs of this community."

But the vice president of clinical services shakes her head. "I wouldn't feel good about lying," she says. "Covering this whole thing up just seems wrong to me."

How can this moral dilemma be resolved successfully—that is, in a way that enables everyone involved to offer his or her perspective on the issue at hand and, after the issue has been thoroughly discussed, to "buy into" the decision?

It is popular today for healthcare organizations to have some sort of model that leaders can use in making difficult ethical decisions. Most models consist of four parts: gathering the relevant information, listing the available choices, clarifying the values, and making a choice. The problem is that no model can guarantee participants that they have made the *right* choice. This is the nature of ethics; making an ethical decision always means choosing between competing values, selecting one value over another.

Which value should be chosen in the case study above, for instance? Honesty? Or preserving the hospital from potentially embarrassing and expensive liability? People of good will can disagree about which of these values should prevail, as do the managers in this case.

How should healthcare leaders rank their values? Unfortunately, the literature on the subject does not offer clear-cut answers. Often the reader is given but a summary of some ethical theory, such as deontology or teleology, and told to apply the theory to moral dilemmas. This is usually not helpful.

For most people, trying to apply ethical theories to a given problem feels artificial and awkward. They wind up saying "We need to do this to stay within budget—now what's the name of the principle we're supposed to be using to make this right?" and "Going in the direction you propose doesn't feel right to me, though I can't explain why." I have come to believe that this is because different people think differently about ethics, and it doesn't work to try to force people to use a model or theory that is foreign to their own way of making ethical decisions.

What we tend to forget is that ethical theories are not fabricated out of thin air, but rather are reflections of and elaborations on the lived experience of human beings seeking to live morally. People who have never heard of the different ethical theories nevertheless operate unconsciously out of one or more of those theories when they make ethical decisions in their personal and professional lives.

Four Moral Approaches to Decision Making

For a number of years, I have been privileged to participate in clinical ethical committees

and administrative teams as they grapple with difficult ethical decisions. From these experiences, I have learned the following:

- There are four distinctly different ways in which people make ethical decisions.
- Almost everyone uses all four of these ways. We utilize different approaches in different roles, in different situations, at different times in our life. Yet we do so unreflectively and nearly always without conscious choice, and certainly not because of any allegiance to (or often even knowledge of) corresponding ethical theories.
- Some people use one way predominantly; others vary their approach according to a variety of factors.
- Most potentially irresolvable conflicts occur when two parties argue or negotiate their positions from *different* moral approaches. Agreement or consensus may often occur only when the two parties adopt the *same* approach.

It is less important that you know the theories behind the four approaches than that you recognize the approaches themselves. If you find yourself arguing your position from an approach different from the other party's, you may have to "change gears," maintaining your position but adopting the other party's approach. Otherwise, you and the other party may end up repeating your arguments, either failing to achieve consensus or reaching a win-lose solution.

The four moral approaches are *principle*, *consequence*, *virtue/character*, and *moral sentiment*.

Principle Approach

I list this first not because it is the best moral approach, or even because it is the one most frequently used, but because it is the most familiar, since most ethics education is based on principles.

Clinical ethics is predominantly principle based, teaching caregivers to apply such principles as autonomy, beneficence, and justice. Business ethics is also usually expressed in terms of principles, including those prohibiting fraud, misrepresentation, and false billing, for instance.

Put most succinctly, a principle is a general normative standard of conduct, holding that a particular decision or action is true or right or good for all people in all times and in all places. The Ten Commandments and the Golden Rule are principles. For a principle-oriented person, an action or decision is right or wrong regardless of the consequences. People who find it natural to use the principle approach to ethical decision making tend to use words like "must," "ought," "duty," "obligation," and "never."

Certain professional healthcare roles seem to attract people who use the principle approach. For example, many senior healthcare executives articulate principles in their decision making ("We must do what is best for the community"; "No mission, no

margin"), as do many human resource leaders ("No exceptions to the policy—if you make an exception, you have a new policy").

Everyone should *sometimes* use the principle approach to ethical decision making; without principles, decision makers have no parameters limiting what they will or will not do. On the other hand, one who *always* uses the principle approach will likely be considered dogmatic and hard to get along with.

In the case cited at the beginning of this article, the COO said that altering the medical record would be "dishonest," and should "never" be done, whatever the consequences. She is using the principle approach.

Consequence Approach

But what the COO said failed to persuade the CFO, who was essentially saying, "Look at all the bad things that will happen if we follow your principle of never altering medical records." The CFO was using the consequence approach to ethical decision making.

People using this approach often ask such questions as, What's the bottom line? What effect will this have? What good will that bring about? and Will this help in the long run? In the consequence approach, the decision maker weighs several possible results and arrives at the decision likely to produce the best result. The problem is that not everyone weighs and evaluates possible results in the same way.

This is why the CFO and the COO in our case failed to agree. The latter, using the principle approach, kept repeating that it is wrong to lie and alter medical records. The former, using the consequence approach, kept saying that it would be more wrong to allow the hospital to incur an avoidable costly lawsuit. They were not only arguing about different values; they were also using different approaches to moral decision making.

Because there are different moral approaches, it is often difficult to achieve consensus in both professional and personal situations. For example, when my daughter was learning to walk, my wife would tell me, "Don't let her get near those two steps; it would be wrong to let her fall." I, on the other hand, would say, "The steps are not that high. I don't think she'll get hurt—let her fall once or twice and she'll learn how to use them." This did not persuade my wife. She was using the principle approach to decision making, and I was using the consequence approach. I have come to believe that one reason some parents argue about child raising is that they have adopted these two different approaches to decision making.

The consequence approach, like the principle approach, seems to attract certain kinds of people to certain healthcare roles. For example, I have rarely met a risk manager or utilization review specialist who was not result oriented in his or her moral approach. And because many middle managers clearly see what happens when senior managers' directives are carried out, middle managers tend to be consequence oriented too.

Everyone should probably use a consequence approach to ethical decision making some of the time, because a person who is apparently unconcerned about results may be

accused of being naive, of having his or her head in the clouds. If, on the other hand, you always use the consequence approach, you may be seen as cold and calculating.

Virtue/Character Approach

This approach resembles the principle approach except that the "moral oughts" here are applied to a particular person, role, or group, not to everyone. The approach examines the person's (or role's, or group's) intentions, dispositions, and motives and then makes a moral assessment or judgment of the person's (role's, group's) character.

People using the virtue/character approach often use the words "good" or "bad." They say, "She's a good CEO," or "He's a good physician," or, on the other hand, "She's not a very good mother," or "He's a bad leader." The judgment involved addresses neither the morality nor the consequences of an act but, rather, the character of the person performing the act.

"Integrity" and "walking the talk" are very important to people who use the virtue/character approach. The statement attributed to Martin Luther when he nailed his 95 theses to the church door—"Here I stand, I can do no other"—strikes me as a classic virtue/character statement because it describes what Luther believed he *had* to do, regardless of the consequences.

In our case, the medical director seemed to be expressing a virtue/character argument. He was not swayed by the COO's principle argument that it is always wrong to alter a medical record. And although the medical director was receptive to the CFO's consequence approach, he made character judgments of the patient's family ("vengeful") and lawyer ("greedy") and expressed his moral position in terms of what he saw as the hospital's obligation to the community.

Many clergy and mission services leaders seem to me virtue/character oriented in their decision making ("We must be faithful to our Catholic identity"), as do many physicians ("I have to do what's best for my patient"). Everyone should probably use a virtue/character approach in making some moral decisions because, as my father used to say, "It's good to have some character." But if you use only this approach, people may try to manipulate you by playing on your fear of being thought irresponsible. But if you never use it, people may find it hard to understand who you are and what you stand for.

Moral Sentiment Approach

Nearly everyone experiences strong feelings when facing a difficult moral decision, but most people do not base their decisions on their feelings. People who do, however, have powerful feelings of approval or disapproval; what is vital to understand is that their moral judgment is the feeling itself.

People who use the moral sentiment approach say, for example, "I don't feel good about this," "This feels OK to me," "This just doesn't seem right," "Is everyone comfortable with this?" and "Can everybody live with this?" A person who is cheered by the birth of septuplets—although aware of the process's cost to society, its irresponsible use of fertility treatments, and other negative factors—is probably operating out of moral

sentiment. No appeal to principles, weighing of consequences, or reliance on personal integrity is involved. For the person guided by moral sentiment, something either feels right or it does not feel right.

But those who rely on their feelings in making moral judgments often feel at a disadvantage when—at a management meeting, for example—difficult decisions must be made. Colleagues who use the principle or consequence approaches will likely insist that the moral sentiment person give objective reasons for his or her position. If the moral sentiment person then tries to couch the argument in the language of principle, consequence, or virtue/character, it will—because it was based on feeling, not on those approaches—probably be weak.

In our case, the vice president of clinical services relied on her feelings. She said she did not "feel right" lying about the medical record; covering up the incident "seemed wrong" to her.

Nurses, social workers, and chaplains often seem to take the moral sentiment approach to moral decision making, acting out of feelings arising from their interaction with patients. Because they do so, such people are sometimes accused of making their moral decisions subjectively, without the benefit of clear thinking. On the other hand, people who never seem to act out of moral sentiment often strike their colleagues as unfeeling.

Resolving Different Approaches

If the members of a group unknowingly adopt four different approaches to moral decision making, how can they arrive at a consensual decision? This is obviously an important question for any healthcare leadership team.

The team can do two things.

Recognize the Moral Approach Being Used A principle argument will not be persuasive to a person who is most concerned about the consequences of following that principle. A virtue/character argument will not be persuasive to a person who just does not feel right about the proposed course of action.

Discuss the Issue within That Moral Approach Faced with a principle-oriented member, the team might introduce *other* applicable principles. And the team might suggest that a consequence-oriented member weigh *different* consequences; that a virtue/consequence oriented member consider *alternative* definitions of "professional responsibility"; and that a moral sentiment oriented member *experiment* with different options to determine whether he or she has a better feeling about any one of them.

In our case, the principle-oriented COO could (instead of simply repeating that changing the medical record would be wrong) outline the possible repercussions of changing it and getting caught. In doing this, she might persuade the consequence-oriented CFO to weigh the consequences differently. And then—if it were argued that the hospital's obligation to be truthful with the community was at least as great as its obligation to meet the community's healthcare needs—the virtue/character-oriented medical director might begin to agree with the COO and the CFO.

I believe that once a leadership team has reached consensus on a difficult ethical issue, it should explain its decision (to its employees, board, community, or other relevant audience) with three supporting reasons: a principle reason, a consequence reason, and a virtue/character reason. (Because it is based on feelings, a moral sentiment reason will be difficult to articulate.) The team can thus be sure that it has addressed most of its audience's moral concerns.

IDENTIFYING DIFFERENT MORAL APPROACHES

In the following three hypothetical cases, each of the responses represents a different approach to moral decision making. Identify the response that best reflects a *principle*, *consequence*, *virtue/character*, or *moral sentiment* approach.

1. The four members of a hospital's administrative team, agreeing that their management style has been too hierarchical, want to improve team dialogue and decision making. But each member argues this differently.

   A. These are essential ways to promote our dignity and self-respect.

   B. We feel frustrated by our inability to have an impact on key decisions; low morale is indicative of a problem here.

   C. Pooling of ideas can lead to better results and better decision making.

   D. Part of being a good leader is having the ability to encourage dialogue and decision making by consensus.

2. The members of the administrative team plan to fund a program to meet the special needs of dying patients and their families. The hospital will not be reimbursed for this service. Although agreeing on the project, the members vary in the language they use to promote it.

   A. This is the best way to make sure our caregivers neither overtreat nor undertreat the terminally ill.

   B. The dying and their families have special needs that ought to be addressed.

   C. As caregivers, part of our professional responsibility is to address the special needs of the terminally ill.

   D. We often feel helpless when dealing with the dying and their loved ones; this program will provide us with an excellent way to express our empathy and caring.

3. A downsizing is planned at the hospital. The administrative team agrees that everyone affected should be offered either benefits and training or outplacement help. However, the hospital's board thinks this might be too costly. The team members defend their proposal, each in his or her way.

   A. We should consider the Golden Rule; if we were to be laid off, we would want to be treated humanely.

   B. This approach is consistent with our mission and values.

   C. This approach would minimize the negative effect not only on those being laid off but also on the survivors, and thus on the organization.

   D. A layoff is devastating; we owe it to our employees as human beings to minimize the suffering it will cause them.

Answers:

1. A *principle*;
   C *consequence*;
   D *virtue/character*;
   B *moral sentiment*
2. B *principle*;
   A *consequence*;
   C *virtue/character*;
   D *moral sentiment*
3. A *principle*;
   C *consequence*;
   B *virtue/character*;
   D *moral sentiment*