Morally Managing Executive Mistakes

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SUMMARY • MEDICAL ERRORS have been the subject of extensive discussion for many years. In contrast, management mistakes have not received the same scrutiny. Why is this true, and what are some of the factors contributing to management mistakes? What constitutes a mistake or error? How do mistakes in management compare with those in medicine? When and how should mistakes be disclosed? What are appropriate options for dealing with them productively and ethically? How can the incidence of mistakes be reduced? This article is intended to stimulate discussion about a critical topic—one that has received inadequate attention by both healthcare administration and the field of organizational ethics—with important implications for improving executive and organizational performance.

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THE FAILED MERGER of the hospitals owned by Stanford University and the University of California at San Francisco cost both institutions a combined financial loss of $176 million over a 29-month period (Russell 2000), but the nonfinancial costs remain immeasurable. Like all aborted mergers, it was originally well intentioned. However, unlike most mistakes, the failure was highly scrutinized and publicized.

Although the examination of medical errors was greatly accelerated by the Institute of Medicine (IOM) 1999 report, *To Err Is Human: Building a Safer Health System,* and physicians have urged colleagues to acknowledge mistakes for years (Hilfiker 1984), the healthcare literature has rarely addressed or even acknowledged *executive* mistakes.[1]

Unsuccessful consolidations, as well as the apparent inability of other mergers to achieve cost-saving targets (Costello 2000), have contributed to a continuing perception that healthcare resources should be better managed. In part, such problems have caused a deterioration of public trust in hospitals, but this erosion has been underway for some time (Hofmann 1991). Ultimately, a reduction in management mistakes should lead to greater public trust, stronger executive performance, improved financial results, enhanced quality of patient care, and higher staff morale. It is difficult to imagine a more compelling set of incentives for aggressively pursuing an analysis and reduction in management mistakes.

In an exceptional article entitled "Morally Managing Medical Mistakes," Smith and Forster (2000) noted that medical mistakes may be simple and benign, cause serious but reversible harm, or result in permanent damage or death. The authors raised a cluster of questions, including: What counts as a mistake or an error? What are the reasons for and causes of mistakes? What happens to professionals, emotionally and spiritually, when mistakes are made? Should mistakes be routinely disclosed, and to whom? All of these inquiries are clearly relevant, but they cover only part of the healthcare landscape. Healthcare administrators also make errors; some are strategic, some may be ethical, and some are inevitable when managing large and very complex service enterprises. As in medicine, the moral imperative is to learn from our mistakes so we can lessen the probability of repeating them. For institutions striving to be learning organizations (Garvin 2000), mistakes could also be viewed as opportunities for promoting individual growth and development.

AN UNDERSTANDABLE RETICENCE

For many reasons, healthcare executives have been reluctant to talk or write about their failures and what they learned from them. Depending on the consequences resulting from a mistake, executives may fear reprimand, job loss, or even legal exposure. In addition, given human nature, pride, and ego, it is understandable that executives have not felt motivated to describe their misjudgments,

tactical errors, or blunders. To preserve their sense of self-worth or the illusion of management omniscience, they may contend that uncontrollable events conspired to cause the failure, declaring, "If not for pressures created by limited resources, conflicting opinions, severe time constraints, and uncertain market conditions, I would have made a different and better decision."

However, it is *precisely* when challenging circumstances raise the stakes of a critical management decision that executives should demonstrate their administrative competence and courage. Most managers can look good when the environment is relatively stable and benign. Indeed, displaying organizational aptitude and skill in making the tough calls correctly is one of the major reasons senior executives are compensated generously.

Mistakes cannot be managed unless they are recognized. Eventually, most errors become evident; in time the following situations will become known:

- an incompetent manager that has been tolerated for an inordinate length of time;
- negative financial results that were not promptly disclosed;
- a merger that was ill-advised, poorly planned, and/or badly implemented;
- managed care contracts that were signed without adequate due diligence; or
- substandard clinical performance by a physician, nurse, or other clinician that was not quickly addressed.

Alternatively, there could be doubt or disagreement that an error occurred. An objective third party could legitimately conclude that a bad outcome was unfortunate, but not necessarily the result of a mistake given the prevailing circumstances. Examples abound: the purchase of physician practices seemed reasonable at the time, as did the decision to acquire that managed care plan, buy the new computer system, sign all those managed care contracts, and hire that candidate for vice president of professional services who interviewed so well and whose credentials and references were impressive.

DEFINING AND ACKNOWLEDGING EXECUTIVE MISTAKES

Precisely defining an executive error is not easy. What constitutes a mistake, and from whose perspective? In some cases, the situation may be ambiguous, such as authorizing an interest-free housing loan to help recruit a new chief operating officer. In other instances, the error may be clear, such as a CEO obtaining a check for a down payment on his own home from the chief financial officer without board approval. How does one differentiate between the use of poor judgment and sound decision-making processes that simply result in decisions that "don't work out"? Some mistakes are minor or questionable, and others are major and indisputable. Thus, mistakes might be

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Organizational culture and values have a powerful influence on the extent to which errors are recognized and analyzed.

viewed on a continuum with shades of gray. Because management is a less precise science than medicine, where, for example, ordering the wrong medication or failing to initiate treatment despite repeated abnormal laboratory findings is an unequivocal error, the management continuum is longer and less exact.

The words "mistake" and "error" have so many connotations that a framework is needed to clarify my use of the terms. The 1999 IOM report defined an error "as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an end." For purposes of this discussion, a mistake is viewed as

> making or not making a decision without thoroughly assessing known evidence and incorporating stakeholders' perspectives when the action or inaction (a) places patients, staff, the organization and/or the community at risk, or (b) is costly to implement, or (c) costly to change.

Often, but not always, such mistakes result in obviously bad outcomes. Thus, at least three categories can be identified using this conceptualization: negligence, decisions or nondecisions producing bad outcomes that were neither intended nor foreseeable, and mistakes that do not produce bad outcomes.

Negligence must satisfy several requirements. First, the decision made or action taken *is* one that a reasonable person would consider risky. Second, a bad outcome *occurs*. Third, the risky behavior *is* the proximate cause of the bad outcome. Fourth, a reasonable person would have been able to foresee such an outcome. Unless all the conditions are present, negligence has not occurred. Negligence is evident when an executive decides not to check the references of a candidate for vice president who has falsified his employment history and, after hiring the person, determines the individual has embezzled funds for the third time.

The category of unintended and unforeseeable bad outcomes is more self-explanatory. Sometimes in retrospect, perhaps after days, months, or years, a decision or nondecision may be described as a mistake, and the more substantial the fallout, the greater the interest in holding someone accountable. If best management practices were followed prior to a failed merger or a belated decision to merge, this would be an example of a mistake that was not the result of negligence nor quickly obvious.

Some might claim that when a mistake does not result in a bad outcome, no error actually occurred. However, mistakes that do not produce bad outcomes should not be seen as irrelevant or inconsequential, but actually "near misses" or intercepted mistakes that can provide invaluable learning experiences. For example, a manager might mistakenly fail to prepare a contingency plan to address a possible shortfall in Medicare reimbursement, but might avoid a negative outcome because legislative intervention and an improvement in payer mix make significant cost reduction measures unnecessary.

Intentional wrongdoing is purposely excluded from this overview.

Whether motivated by anger, intimidation, greed, indifference, or other impulses, no confusion or ambiguity arises in such situations; the decision or behavior is unequivocally unacceptable and inappropriate. Thus, such decisions or actions are not interpreted as mistakes. Toleration of intentional wrongdoing—that is, not discouraging and promptly sanctioning such behavior—indicates a defect in an organization's culture or value system.

UNAVOIDABLE MISTAKES

The virtues of leaders may be excessively extolled and their shortcomings minimized or overlooked to promote organizational morale. Zero tolerance for mistakes may be self-imposed or promulgated by some senior executives or, in the case of a CEO, perhaps by the governing body. In such cases, executives do themselves a great disservice when they perpetuate unrealistic expectations.

Even the most capable executive will make mistakes. The effective healthcare executive will take calculated risks to develop innovative strategies and programs, recruit independent thinkers to the board and administrative staff, invest in new technology, respond to and shape the environment, and challenge the status quo. Inevitably, an executive who is constantly considering different approaches and models will occasionally select a course that yields unanticipated and unwanted results.

In these less than successful situations, how extensive is the critique or failure analysis, and how broadly are the results disseminated? In actuality, analysis and disclosure is frequently limited because many executives may be reluctant to accept or admit the extent of their own fallibility. Defensively, they may also assert that insufficient time has passed to label a specific decision as wrong. Consequently, mistakes are commonly hidden, like those of their clinical colleagues, behind what Smith and Forster (2000) describe as "a curtain of denial and nondisclosure." This curtain, however, is frequently transparent to subordinates and others. Furthermore, that most programs dedicated to risk management and continuous quality improvement have essentially ignored such sensitive yet potentially fertile terrain is both ironic and disappointing.

Executives must be cautious not to take false refuge in the belief that a comprehensive and widely disseminated values statement is sufficient to ensure consistent adherence to those values. Few studies have been conducted to confirm an alignment between espoused organizational values and enacted values (Ray, Goodstein, and Garland 1999). Organizational culture and values have a powerful influence on the extent to which errors are recognized and analyzed. If the institution's vision and values statements promote the concept of a learning organization and the rhetoric is matched by reality, the positive aspects of individual pride and ego can contribute to an environment more open to unfettered inquiry and investigation of management as well as medical mistakes. In reality, very little learning occurs without making some mistakes.

Differentiating between a clinical mistake and a management error is not always easy; often they are inextricably intertwined.

CONTEXT FOR HEALTHCARE MANAGEMENT MISTAKES

For at least the past several decades, so many publications have made repeated reference to the healthcare crisis that one may now reasonably contend that the crisis has become a chronic condition. The cumulative pressures produced by managed care, inadequate reimbursement, growing staff shortages, increasing competition, proliferating legal and regulatory requirements, rising expenses, higher patient and staff expectations, and a host of similar issues have conspired to make the difficulties seem overwhelming. Moreover, efforts to reduce overhead costs have resulted in fewer managers who have broader assignments and more subordinates. In addition, honoring the intrinsic obligation of a charitable institution to serve the community's best interest without adversely affecting the hospital's financial condition can create unusually complex management dilemmas (Vladeck 1992).

Contributing to the administrative challenge is the fact that healthcare executives have held less functional power than comparable managers in general business. Physicians, who are generally not employees and hold an anomalous position outside the direct chain of command, exercise exceptional influence over management decisions. This imbalance of power can compel executives to make decisions that they personally find objectionable but that may be necessitated by the medical culture and accepted by the governing body. For example, at least some hospital-based physician contract terms could be difficult to defend on a productivity and service basis. In other situations, executives may have capitulated as the result of failing to engage physicians in a cooperative decision-making process. If physicians do not understand the inescapable resource constraints facing the institution and the need to help design a rational allocation system that preserves the organization's fiscal health, they may be inclined to take adversarial rather than collaborative approaches to resolving conflict.

Particularly in health systems, the need to make large financial turnarounds can create extensive organizational dissonance. If strategy, structure, process, and culture are not well-aligned around a clear vision and mission, corporate administration and business units can be at odds. Not surprisingly, suspicion, resentment, and hostility will produce an unhealthy climate in which both management timidity and error can thrive. Mistrust, not administrative competency and innocence, is the dominant presumption. Consequently, some executives may be inclined to think more about avoiding potentially risky decisions and less about making courageous ones. The challenge is intensified when clinical issues are involved.

To further exacerbate the problem, differentiating between a clinical mistake and a management error is not always easy; often they are inextricably intertwined. Also, some decisions are clearly errors, whereas others are simply immoral. The most obvious examples involve the familiar tension between financial and patient care priorities, for instance:

- permitting early discharge of seriously ill patients because of economic pressures;
- closing a trauma center because too many patients lack insurance;
- reducing social work and home health personnel, with the result that patients are discharged without adequate regard for their ability to care for themselves;
- allowing an organ transplant program to continue for nonclinical reasons, although its volume is low and its patient outcomes are poor;
- using insufficiently trained lower skilled personnel to perform duties previously assigned to higher skilled and more expensive staff;
- deferring funding of essential but mundane capital equipment (replacement beds, sterilizers) to accommodate less urgent requests of influential physicians.

The reconciliation of tensions around resource allocation decisions, and the tradeoffs among them, cannot be avoided, nor can the inextricable link between cost and quality be ignored. However, improving quality does not always require more resources. In a hospital truly committed to a "patients first" philosophy, the above examples should not exist. Too frequently, management mistakes are repeated because previous assumptions about the tradeoffs between resource allocation decisions and quality are not subject to proper review, evaluation, and audit in the context of the institution's mission.

Many conflicts of interest that influence these decisions are apparent, but not all. Edward Spencer and his colleagues (2000) suggest that conflicts of interest occur in "situations where one's profession, professional judgment, or professional code is in conflict with other demands or influences that, if acted upon, would compromise professional judgment." The authors offer four guidelines when one is confronted with these circumstances:

1. The existence of the conflict should be recognized and acknowledged.
2. Whenever possible, the conflict's existence should be disclosed to all parties.
3. A series of questions should be asked: (a) How would an impartial professional evaluate and act in this kind of situation? (b) Would acting on the conflict of interest compromise one's professional judgment? (c) What kinds of precedents would acting on this conflict set? Would you expect other professionals to act similarly? Can this be defended in a public forum? (d) Who is harmed or benefited from acting on the conflict of interest? (e) Can such actions prevent gratuitous harm or unfair practices, processes, or outcomes; lying; breaking promises and contracts; and not respecting individuals and their rights? (f) What kind of institutional structure, accountability procedure, or other constraint might have contributed to the existence of this conflict? Can these factors be mitigated in the future?
4. When encountering an unavoidable and intractable conflict of interest, one may have to withdraw

from the situation and, in some circumstances, report the matter to an external entity.

Whether or not conflict of interest is a contributing factor, a decision may be made that could constitute a serious mistake and a sentinel event. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO 1999) defines a sentinel event as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." When such an event occurs, JCAHO expects that "the organization will quickly, thoroughly, and credibly engage in a critical, self-reflective process known as root-cause analysis" (Johnson and Roebuck-Colgan 1999). Given that JCAHO's definition of a sentinel event is clinically focused, how might the concept be modified to accommodate an unexpected outcome due to an administrative decision? Is a root-cause analysis any less relevant in such a situation?

For purposes of this discussion, I suggest the following definition of a sentinel event for use in stimulating a healthcare management internal investigation:

> a sentinel administrative event is an unexpected occurrence involving major economic or noneconomic losses adversely affecting patients or others or having the potential of leading to serious negative consequences.

Such an event is intended to include any significant development adversely affecting patients, the community, or financial or human resources. In these cases, conducting a root-cause analysis should be just as appropriate and potentially productive as when dealing with serious clinical problems.

At a minimum, such an analysis should attempt to identify the source of the error and its cause. First, to identify the source, a distinction should be made between a *manager's* mistake and a *management* mistake. This is not simply a semantic consideration; there is a substantive difference. A manager's decisions and actions, whether they are right or wrong, reflect how a particular individual manages his or her priorities, goals, values, and relationships. Most mistakes by managers are the result of mismanaging people and other resources, as well as inattention to critical details. In contrast to a manager's individual decisions and actions, management mistakes and successes usually result from collective decision making. Poor systems will undermine the quality of decisions by both managers and management. Second, regardless of the source of the error, any informed analysis should include an examination of its cause(s). Figure 1 includes a brief list of possible sources and causes of healthcare management mistakes.

Management is subject to errors of omission as well as commission. Although errors of omission may be less apparent, their consequences can be just as damaging. Inaction or wrong decisions can occur because of (1) a personal preference for maintaining the status quo, (2) political pressure from internal or external stakeholders, (3) a failure to monitor

Figure 1 Sources and Causes of Healthcare Management Mistakes

Sources of Mistakes
Directed board decision
Shared CEO/board decision
CEO decision
Shared CEO/management decision
Shared CEO/medical staff or physician group decision
Manager decision
Shared manager/management decision

Causes of Mistakes
Inadequate preparation of/by decision maker(s)
Insufficient or inaccurate information
Lack of expert input
Ignorance of all legitimate alternatives
Flawed decision-making process
Carelessness
Political pressure, fear, timidity
Conflict of interest
Undue haste
Failure to follow established policies and/or external requirements

the activities of subordinates, (4) a need to support physicians' pecuniary interests, (5) excessive competitive drive or competitor emulation, (6) fear of making or admitting a mistake, (7) denial of the need to act, or (8) being personally overextended physically, emotionally, or intellectually. A mistake can also be compounded by "escalating commitment," when efforts are redoubled in the belief that trying harder will lead to success, rather than recognizing that the original idea or strategy was flawed. Figure 2 lists acts of omission and commission.

I must quickly note that not all acts of omission and commission necessarily constitute mistakes. The decision maker may be limited to a small number of options, each of which has negative consequences. Likewise, the goals can be in conflict. For example, perhaps the only means of protecting the corporation's assets is to reduce or eliminate a vital community health program, as illustrated by the difficult choices faced by New York City's public hospital system (Steinhauer 2001). Thus, an economic choice could be made that reduces access to services, but every reasonable alternative may have been evaluated and dismissed as untenable. In other words, a "right" decision can still have bad results.

In some respects, management errors can be less obvious and perhaps more pernicious than those that occur in medicine.

Figure 2 Examples of Acts of Omission and Commission

Omission:

- Failure to anticipate significant factors affecting decisions
- Failure to act promptly on changed conditions
- Failure to consider all options
- Failure to delegate and hold subordinates accountable
- Failure to balance power interests
- Failure to keep patient and corporate needs paramount
- Failure to follow the law, economic principles, or prudent person rule
- Failure to anticipate likely consequences
- Failure to fulfill contractual commitments and obligations to employees
- Failure to protect the assets of the corporation
- Failure to lead where there are opportunities to improve the health of patients or the community

Commission:

- Permitting decisions to be made without adequate analysis
- Choosing political, not business solutions
- Making economic decisions that harm clinical care and outcomes
- Allocating limited resources without applying objective criteria
- Withholding negative information from individuals with the right to know
- Making selective use of facts with different audiences
- Showing favoritism among the board, management, medical staff, and employees
- Signing contracts that are not achievable
- Condoning discrimination among patient types on the basis of source of payment, ethnicity, gender, or other inappropriate or illegal factors
- Allowing a climate of male dominance to harm relationships between doctors and nurses, thus accelerating nurse turnover and poor patient care
- Making high technology investments without addressing access problems

MANAGEMENT VERSUS MEDICAL ERRORS

In his book, *Forgive and Remember: Managing Medical Failure,* Bosk (1979) notes that our healthcare institutions, like most organizations, rarely welcome questioning or admission of errors. The conspiracy of silence that once shielded many physicians has partially but not completely dissipated. Such a conspiracy also shields managers. In some respects, management errors can be less obvious and perhaps more pernicious than those that occur in medicine.

Compared to medicine, defining error in management is even more difficult because perfection is especially elusive and standards of performance are poorly delineated. As

suggested previously, management practices have far less precision, consensus, and objectivity than medical procedures. Formal processes and decision trees are not as prevalent in management as they are in medicine, resulting in fewer algorithms for enhancement. Consequently, the reasons, or perhaps excuses, for not pursuing a systematic analysis of management mistakes are many.

Although designed for medical errors, a proposed system by Smith and Forster (2000) also has relevance for examining management errors. They suggest a structure that (1) focuses on unintended acts only, leaving willful and malicious activity for other classifications and assessments; (2) includes "intercepted" mistakes without limiting identification of mistakes to a clear determination that a patient has been harmed by the mistake; (3) is not limited to a negligence standard (which focuses on legally culpable errors and is only a subset of all errors committed); (4) uses a skill-, rule-, and knowledge-based model as a mechanism to classify error types; and (5) provides a practical and reasonable standard for determining whether a mistake has occurred (e.g., an action that would have been judged wrong by skilled and knowledgeable peers at the time it occurred).

When a patient has been hurt or would have been severely harmed by an intercepted mistake, the consequences are clear. Because management errors may be more difficult to isolate, we should work diligently to find and apply any structure that promotes their timely disclosure.

Management science shares some other common characteristics with medical science. These include "inherent uncertainty, imperfect predictability, and unavoidable temporality" (Rubin and Zoloth 2000). But unlike medicine, in management little recognition of the need for programs encouraging prevention of mistakes, early detection, source determination, and timely correction occurs. Although fewer management standards are available against which to measure performance, financial measures are plentiful (net income, credit rating, cash reserves, accounts receivable, debt ratio), as are those related to other outcomes influenced by healthcare management, for example, patient and staff satisfaction, staff turnover and vacancies, market share, institutional reputation, and, increasingly, quality and patient outcome measures.

Additional comparisons between medicine and management may provide further insights. Just as complexity, uncertainty, and imperfect information surround most medical encounters, making it difficult to define and categorize errors, the same is true of management mistakes. Decision-making errors in both medicine and management can be questionable or unverifiable. Also, as in medicine, mistakes in management may be the result of ignorance, negligence, or the inherently errant nature of the act. Regardless of the cause, the players should not "rush to judgment"; conclusions should not be drawn until the facts have been dispassionately evaluated.

Unlimited candor is neither obligatory nor appropriate.

Regrettably, medicine and management share another attribute that is not only destructive, but underestimated in its influence on organizational and individual behavior. Abuse of power takes many forms and compromises anyone vulnerable to the improper exercise of authority or influence by another (Hofmann 1998). Whether the victims are patients, families, or staff, the degree and extent of intimidation can repress legitimate questioning of actions and decisions for an extended period. When such actions and decisions are wrong, the mistakes may not be revealed and, as a result, are often repeated.

DISCLOSURE OF MANAGEMENT MISTAKES

Many management mistakes can be attributed to faulty information or data and can be reversed without causing substantial damage. Even those decisions that produce poor outcomes and that should not have occurred will benefit from disclosure and analysis. More serious are "reportable" mistakes involving an action with untoward results, the hiding or denial of which constitutes a breach of intellectual honesty or ethical behavior. These decisions should cause a conscientious person to have difficulty sleeping at night unless they are disclosed.

At a minimum, two levels of exposure should be considered in disclosing and preventing management mistakes. The first is the *macro* or policy level, at which the CEO, guided by the board, manages the organization's priorities, its relations with the outside world, and strategic opportunities. At this level, at least initially, the CEO's ego and lack of objectivity may interfere with an ability to recognize and evaluate a major error, such as overextending financial and corporate resources in acquiring additional facilities. The second is the *micro* or operating level, at which the CEO establishes the institutional climate, makes decisions, and influences and monitors decisions made by others. However, at the micro level, less excuse exists for failing to acknowledge and disclose mistakes. Of course, the organization's culture and values invariably influence both levels.

Although executives should allow and encourage sincere disclosure of mistakes with impunity, they must not be hypocritical. For example, I recall an administrator who frequently urged his subordinates to give him constructive criticism and invariably responded defensively and somewhat belligerently when it was offered. Predictably, despite his continuing reminders that he welcomed negative feedback, he rarely received it again. Executives who espouse the concept and then repudiate it by their reactions reflect a remarkable degree of arrogance at worst or naiveté at best. Ultimately, the question becomes, Is the organizational support real or is it an ethical mirage?

Just as important as the timely disclosure of errors and a receptive climate is deciding to whom mistakes should be reported. Obviously, several factors must be evaluated, such as the magnitude of the error, the number of people compromised, if and when the mistake can be corrected, any mandated reporting requirements, implicit

Figure 3 Mistake Disclosure Considerations

What stimulus requires disclosure?
Legally Advised
JCAHO Required
Board Mandated
Ethically Determined

To whom should the error be disclosed?
Board
Medical Staff
Employees
Media
Community Groups

Who should be the designated spokesperson?
Board Chair
CEO
Legal Counsel
Public Relations

What other issues need to be taken into account?
Confidentiality and Liability Factors
Discussion of Prevention Measures

ethical obligations to disclose, and compliance with existing institutional policies. Generally, mistakes should be disclosed to those most affected by them and to those in authority, for example, the governing board. And yet, pragmatically, the number of audiences to which disclosure is necessary is limited. Unlimited candor is neither obligatory nor appropriate. If a hospital, for example, were to publicize every error, regardless of its size or consequences, the institution's reputation could be irreparably and unreasonably harmed. Because the least convenient time to develop any policy is in a time of crisis, organizations should establish disclosure criteria in advance of the need to apply them. Figure 3 lists principal considerations for disclosure.

Recently, some positive signs about handling negative news have appeared. Noting the burden created by credit-rating agencies pursuing financial information, Carpenter (2001) described the growing consensus among nonprofit organizations that increased disclosure demonstrates a pattern of greater accountability and may actually result in a better reception for an issuer's bonds.

As clinicians and others promote a safer institutional environment for patients, families, and staff, what should executives do to promote more prudent management decisions in the future? Does the organizational culture encourage or discourage candor and open discussion of management misjudgments? Does the organization recognize that truth telling and promise keeping are as relevant to business decisions as they are to clinical activity? Acknowledging the wisdom of the old adage to tell the truth early, when does not disclosing an error become indefensible?

The issues here are just as relevant to staff at all organizational levels as

Patients and families understand that mistakes will occur, but they cannot understand deceit.

they are to the executive team. The economic and noneconomic consequences of real or perceived cover-ups when mistakes do occur are undeniable. By encouraging timely and complete disclosure, organizations not only can act to minimize loss and exercise appropriate damage control, they also can move more quickly to learn from the mistake and strengthen or implement preventive measures.

Alternatively, discouraging disclosure by penalizing staff who report errors will promote a much less constructive activity—whistleblowing. Although frequently defined as an action taken when information is reported to an external organization about an allegedly illegal act or set of activities, whistleblowing can also include internal reporting of mistakes that may have been consciously suppressed by the person responsible for the error. Regardless of the circumstances, efforts to stifle timely disclosure are unethical. Darr (1997) notes that patients and families understand that mistakes will occur, but they cannot understand deceit. The same is no less true of staff members who may know a management error has been made and resent attempts to conceal it.

Executives must realize that organizational reaction will vary according to the type and magnitude of a mistake, as well as the stakeholders involved. The senior executive must take into account the following five core constituencies.

1. The Board—If the responsibility for a mistake is shared, the CEO will likely be held accountable for the consequences (and probably should be). Regardless of who was responsible for the error, the CEO must decide if complete candor will be accepted by the board as part of properly addressing the problem or if unexpurgated disclosure will irreversibly compromise the executive's future influence. Nondisclosures or partial disclosures obviously carry their own risks.

2. Medical staff—If a mistake is so serious that disclosure produces a vote of no confidence by the medical staff, the CEO will usually be forced to leave the organization. Depending on the CEO's tenure and reputation, timely disclosure of lesser mistakes may, in some situations, actually enhance the executive's credibility.

3. Management team—Some mistakes will be the result of unilateral decisions and others will be the product of shared decision making. In either case, disclosure and analysis usually contribute to team building and effectiveness. By discussing and dissecting the error, team members develop a better understanding of why the mistake occurred, how it might have been prevented, and how its harmful effects can be mitigated. Such an analysis also helps promote a constructive and nonpunitive climate for revealing mistakes.

4. Employees—Particularly if the mistake is "public knowledge," management should explain what happened, why it happened, and how the consequences will be addressed. Interpretations of the decision could be widely disparate, and one of the disclosure objectives is to sustain confidence in management.

Figure 4 Typology of Healthcare Management Errors*

Levels:
Macro (Policy)
Micro (Operational)

Classification:
Economic
Organizational
Strategic
Clinical

Consequences:
(Measured by number of people and/or dollars adversely affected)
None
Moderate
Major

Constituency Influenced:
The Board
Medical Staff
Senior Management
Employees
Patients
Community
Regulators, Payers, Buyers, and Vendors

*None of these is mutually exclusive.

5. Patients—Medical errors, not management mistakes, are more likely to adversely affect patients and their families, but executives do make errors of commission and omission that affect individual patients and groups of patients, as illustrated previously.

The first of two other major constituencies, of course, is the community. Again, depending on the mistake and its relevance for the community, disclosure should be carefully evaluated. Factors to assess include confidentiality, legal obligations, current or potential harm to the community, liability exposure for the institution, and political repercussions. These same elements are pertinent to a second external group of constituents, namely regulators, payers, buyers, and vendors. Figure 4 contains a broad taxonomy of management errors.

COPING WITH MISTAKES

Not all mistakes will or should produce feelings of embarrassment or guilt. But when an executive does have these feelings, how can they be assuaged? Should he or she seek and receive forgiveness, and from whom? What should be the limits of personal and organizational loyalty? How can he or she deal with concerns about real or imagined liability?

Like their clinical colleagues, some executives believe they must be perfectionists. Most managers and physicians do not allow themselves the luxury of failure, and as a result, they create a false sense of infallibility. Alternatively, rather than wanting to

Admitting, analyzing, and disclosing administrative errors should be considered legitimate dimensions of management maturity.

avert a mistake, their overriding concern may be taking the popular action and, as a result, not antagonizing or alienating an individual or a group. For example, they find it easier to avoid renegotiating untenable physician contracts than dealing with the ire of clinicians.

Given human nature, the level of embarrassment or guilt will vary depending on not whether but how much the executive rationalizes some degree of the error. Daigneault (1997), president of the Washington, DC–based Ethics Resource Center, has asked the question, "Why do good people do bad things?" Among the reasons, he cites:

- a lack of organizational loyalty,
- the way "success" is measured,
- a belief that the act is not illegal, and
- the result of peer pressure.

In fact, as noted by Johnson and Roebuck-Colgan (1999), "A recurring theme in the literature about the process of root-cause analysis is that good people can be trapped in flawed systems." Blaming or being blamed is not constructive behavior, but dealing with guilt and even, in some situations, grief may still be necessary. Actually, the five stages encountered by many terminally ill patients—denial and shock, anger, bargaining, depression, and acceptance—may also be relevant in working through the analytical process (Kubler-Ross 1969). Recognize in which stage the decision maker is and how loyalty may have affected this person's attitude and actions.

Webster and Baylis (2000) say moral distress can lead to compromised integrity and what they define as "moral residue." According to these authors, moral distress occurs "when there is incoherence between one's beliefs and one's actions, and possibly also outcomes (that is, between what one sincerely believes to be right, what one actually does, and what eventually transpires)." Moral distress does not occur just when institutional constraints make pursuing the right action difficult, but also when "one fails to pursue what one believes to be the right course of action (or fails to do so to one's satisfaction) for one or more of the following reasons: an error of judgment, some personal failing (for example, a weakness or crimp in one's character such as a pattern of 'systemic avoidance'), or other circumstances truly beyond one's control." Moral residue, they explain, "is that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised." Among the reasons for doing so, they add, are expediency, laziness, and cowardice.

When a major management mistake is made, personal and organizational angst cannot always be avoided or eliminated. The imperative is to support those affected and to maintain a caring environment. According to Potter (1999), "When the captains of the industry understand the linkage among integrated bioethics, corporate integrity, and commercial success, there will be a rush to the moral bank for more social capital." This moral

bank is in no current danger of being overdrawn.

If being a successful "transformational" business leader requires an individual who "blends extreme personal humility with intense professional will" (Collins 2001), acknowledging one's mistakes not only demonstrates fallibility, it also allows others the freedom to fail without fear of retribution. Andre (2000) describes why the virtue of humility is so central to an examination of errors:

> On the one hand, mistakes are inevitable. On the other hand, they are to be avoided; nothing counts as a mistake unless in some sense we could have done otherwise. This fundamental paradox creates the moral challenge of accepting our fallibility and at the same time struggling against it. Humility is crucial to both aspects of this task—humility not of shame but of compassion toward oneself. At the heart of compassion is simple kindness, an attitude that is essential to clarity about oneself and to living with imperfection while striving mightily for something better.

Admitting, analyzing, and disclosing administrative errors should be considered legitimate dimensions of management maturity, but little evidence exists that such is the case.

What process should be followed by a CEO who has made a bad decision—one that, in retrospect, really was a serious error? Depending on the circumstances, coping with this mistake could involve some of the following steps.

1. Accept the truth by documenting the problem, its roots, and its consequences, and include options for addressing the mistake. If appropriate, solicit advice from peers or a consultant.
2. Speak with selected officers of the board, medical staff, management, and/or legal counsel.
3. Present a summary to the management team and facilitate a discussion and analysis.
4. Determine if a new policy or refinement of an existing policy would minimize the repetition of a similar error.
5. Decide if the organization's supervisory development program or any other training activities should incorporate insights acquired as the result of this process.

Clarifying the limits of personal and organizational loyalty can be helpful both to the individual and the institution. Occasionally out of personal loyalty, but more often due to a concern about retribution and a fear of the consequences, subordinates may be reluctant to report a manager's mistake either to that individual or the person at the next management level. The disclosure is even more problematic if the CEO has made the error and there is evidence that it has not been disclosed immediately to the board.

Assuming the mistake does not justify termination, a supportive organization will provide for a thorough examination of the error, not with the goal of placing blame, but for the purpose of identifying problems and learning from the

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experience. Circumstances will determine whether an apology should be offered and to whom. As in personal relationships, too seldom expressions of regret can defuse emotions and permit mutual healing to occur. Similarly, in some situations, simply seeking forgiveness will not be enough; arrangements for making amends should also be made.

Undeniably, occasions will arise when the gravity of the mistake or combination of mistakes justifies discharging or disciplining a manager. Most organizations want to avoid taking this action and, even when warranted, may delay moving expediently. In some situations, the individual could be impaired by psychological problems or substance abuse; in other cases, the person may have been promoted beyond his or her level of competency. Procrastination usually serves neither the organization nor the manager well. Regardless of the circumstances, the proper board or management response will reflect sensitivity for the individual and the organization.

In a highly litigious society, the possibility of legal liability should obviously not be ignored. Again, depending on the nature of the mistake, the potential exposure may be real or imagined. Damages quickly escalate when the action was an avoidable flaw, for example, "up-coding" or other evidence of overbilling. Healthcare institutions, like other businesses, must be vigilant in their dissemination and enforcement of policies mandating compliance with local, state, and federal laws and regulations. The combination of the 1991 Federal Sentencing Commission guidelines and the Health Insurance Portability and Accountability Act of 1996 has made compliance an unprecedented priority, but as Paine (1994) has observed, "managers who define ethics as legal compliance are implicitly endorsing a code of moral mediocrity for their organizations." Orientation and continuing education programs represent convenient opportunities to convey an unambiguous message to both supervisory and nonsupervisory staff that the spirit as well as the letter of these requirements must be met.

IMPROVING MANAGEMENT PERFORMANCE

To risk stating the obvious, competent management involves much more than preventing or morally managing mistakes. Challenging times demand aggressive and innovative leadership, not risk-averse executives who are hesitant to make difficult choices. We should be examining our informal decision systems and assessing how their ambiguity may contribute to uneven management outcomes. The unacceptable alternative is to rationalize our inability to emulate our clinical colleagues who continue to refine their decision-making processes and achieve more consistent and predictable results.

Ethically, making a mistake haphazardly or cavalierly is vastly different from making one using formally designed decision-making processes that are rigorous, open, and rational. If an error occurs as the result of a logical disciplined process, it is still unfortunate, but one's ethical "liability" is limited. Worthley (1999)

contends that a mature ethical reasoning process is characterized by collaboration and a systematic methodology. In contrast, he says a single-minded ethical reasoning process "inevitably degenerates and debilitates judgment."

To enhance ethical reasoning when making a decision, Nash (1981) suggests 12 questions be raised to maximize an understanding of the responsibilities involved and to promote the decision maker's objectivity.

1. Have you defined the problem accurately?
2. How would you define the problem if you stood on the other side of the fence?
3. How did this situation occur in the first place?
4. To whom and to what do you give your loyalty as a person and as a member of the corporation?
5. What is your intention in making this decision?
6. How does this intention compare with the probable results?
7. Whom could your decision or action injure?
8. Can you discuss the problem with the affected parties before you make your decision?
9. Are you confident that your position will be as valid over a long period of time as it seems now?
10. Could you disclose without qualm your decision or action to your boss, your CEO, the board of directors, your family, or society as whole?
11. What is the symbolic potential of your action if understood? If misunderstood?
12. Under what conditions would you allow exceptions to your stand?

A specific process or methodology does not guarantee an ethically defensible outcome, but Worthley (1997) indicates it "can help healthcare professionals identify and utilize the resources needed to advance ethical maturity." At a minimum, executives have a responsibility to ensure that simple systems are implemented to prevent, discourage, detect, and address mistakes.

A modest beginning might involve a decision system that promotes the prevention of management errors, minimizes bad decisions at the outset, discloses and addresses mistakes afterward, and conveys a clear message that examining and understanding the reasons for mistakes represents a learning opportunity. Such a system would:

- be designed with clear objectives, formal criteria, and explicit performance measures; reflect relevant organizational values and policies; and incorporate a process that sensitizes the decision maker to the implications for affected stakeholders
- provide for decision tracking and evaluation, including (a) programs to encourage the "safe" disclosure of problems and (b) error detection through an audit procedure that defines accountability, outcome measures, and timelines
- require a post-implementation analysis to explore factors that may have contributed to flaws in the original decision-making process

Organizational and professional codes of ethics should be followed and monitored, but they are not a panacea and their limitations should be recognized.

Time is always in short supply, but somehow adequate time is found when litigation occurs in response to a major error.

- specify a range of options to minimize the immediate effect of future errors, including both economic and noneconomic costs, as well as possible longer-term organizational impact
- designate what actions will be considered to prevent similar mistakes in the future, including revisions in policies, procedures, and business practices

Any such system will not function effectively unless the organization's CEO and governing body are unequivocally committed to establishing and sustaining a climate conducive to reducing management errors. According to Cashman (1999), CEO leadership requires three elements. The first is authenticity—is the person believable, real, humble? The second is self-expression—can the CEO communicate the institution's vision in language relevant to the staff? And the third is value—does the leader bring real benefit in terms of the bottom line, quality, and improved performance? Each of these elements is vital to promoting a culture that not only permits but also encourages the timely identification, disclosure, and resolution of management errors.

RECOMMENDATIONS

Although management mistakes will certainly continue to occur, ten steps can be taken to increase the probability that they will be managed ethically.

1. Health administration programs should make use of case studies and presentations by executives to promote discussion of the problems and opportunities created by errors.

2. National bodies, such as the American College of Healthcare Executives, American Hospital Association, Catholic Health Association, Premier, Veterans Administration, and VHA should explore their possible roles in helping healthcare leaders implement procedures to reduce management mistakes.

3. Organizational and professional codes of ethics should be followed and monitored, but they are not a panacea and their limitations should be recognized (Brien 1996; Higgins 2000).

4. The rhetoric of a learning organization should be aligned with reality by:

a. Emphasizing the institution's philosophy and values regarding both management and clinical mistakes in orientation and continuing education programs.
b. Using a management retreat to summarize a current management dilemma, highlight competing interests, and raise critical questions. The participants should be stimulated to develop new insights and be better prepared for existing and subsequent challenges. As described by Reiser (1994), "Cases illuminating the relationships and actions of organizations can be used to: test how effectively the values in institutional statements of purpose are applied in practice; formulate and critique policies and goals; analyze troublesome problems; and create an institutional memory to guide future policies."

c. Including several questions or statements to assess employee perceptions in regularly scheduled opinion and attitude surveys. For example:

- Does the organization allow, within reasonable limits, the administrative freedom to fail or is the fear of potential criticism so great that managers rarely exercise initiative?
- Do individuals feel comfortable disclosing management mistakes? What will these individuals do if certain errors are made? What have they done in the past?
- Are identifiable resources available to provide constructive advice when mistakes are made? Who can staff members consult if they are uncertain what to do?
- Is there an external entity to whom they can go if internal lines are blocked?
- Have respondents encountered retributions when mistakes have been reported or disclosed?

d. Conducting an organizational ethics audit to determine gaps between formal policies and actual behavior. Such an audit would not only incorporate an inventory of existing documents, but also training programs, committees, challenges facing the institution, and staff perceptions of the organization's ethics standards and practices (AHA 1997). Most management mistakes are *not* ethical ones; however, policies on advertising, receipt of gifts, confidentiality, sexual harassment, and uncompensated care do have ethical implications, as do the organization's vision, mission, and values statements.

5. CEOs should establish a predetermined date and allocate time, as part of a strategic investment decision-making process, to assess whether the results have met forecasted outcomes. Time is always in short supply, but somehow adequate time is found when litigation occurs in response to a major error.

6. Annual CEO performance reviews should be modified to incorporate questions or statements promoting discussion of mistakes and how they were addressed. At the senior management level, pivotal issues would include the outcomes of strategic initiatives involving the medical staff as well as the board; responses and nonresponses to competitive market forces, health plans, and reimbursement changes; significant budget variances; staffing shortages; and indigent care. The self-assessment component should provide reflections about decisions that, in retrospect, were incorrect or inappropriate. In addition, the governing body's own annual self-assessment process should include a review of its role in learning about mistakes and evaluating them.

7. Supervisory performance reviews should also include how the individual has dealt with his or her mistakes and the individual's response to the mistakes of others. Has there been a tendency to shift blame or to accept and promote accountability (Friedman 2001)?

8. CEOs should develop a policy governing management mistakes and submit it to their boards for consideration. The development and discussion of policies and guidelines can help employees at all levels understand the limits of personal and organizational loyalty and decide how to proceed when confronted with a substantive management mistake. When a direct approach is not viewed as safe or productive, the individual might seek advice from a colleague, use a telephone hot line, consult with someone in human resources, or take another step described in the guidelines. Figure 5 lists the components that should be covered in a policy on management mistakes. This document should be written in simple language appropriate for employees and distributed to all staff members. (An alternative would be the development of a policy on management decision making that incorporates elements of both the decision system described previously and components of the policy on management mistakes.)

9. Executives should serve as role models and mentors to demonstrate how to behave ethically. They can encourage others to do so by following Dye's (2000) admonitions to: (1) tell the truth and not exaggerate, (2) ensure that actions match words, (3) use power appropriately, and (4) admit mistakes.

10. Ethics committees should expand their role beyond the traditional focus on clinical matters (Seeley and Goldberger 1999). Whether described as management, organizational, institutional, or business ethics, the related issues have much in common with clinical ethics.

CONCLUSION

Devoting appropriate attention to management mistakes requires a board that is truly deliberative and well-informed—one that has created a relationship with its CEO based on mutual trust and confidence as well as respect. Also required are management staff members who are challenged by the CEO to be loyal skeptics, not simply unquestioning followers. Such an attitude is encouraged and supported when supervisors are motivated to express their views about dubious projects and to acknowledge their own mistakes. Finally, this climate must be sustained by (1) internal systems producing accurate and timely information that is widely available, (2) formal training programs across the organization on how to use information effectively, and (3) a culture that listens and responds.

Executives cannot avoid making mistakes. The repercussions from unintentional errors will range from negligible to enormous. To manage them properly, it is imperative that they be defined, disclosed, and analyzed; their economic and noneconomic consequences be understood; and their recurrence be minimized. Many mistakes by managers might be prevented or mitigated by a little less hubris and a little more willingness to seek advice and obtain further input. In the absence of incentives to acknowledge and examine management mistakes, individual and

Figure 5 Essential Components for a Policy on Management Mistakes

Preface:
Include the policy's purpose and describe the importance of identifying, confirming, investigating, reporting, and addressing management mistakes.

Definition of Management Mistake:
Provide a definition created by the organization reflecting its specific culture, values, and expectations; include hypothetical examples or even actual mistakes from the organization's history.

Criteria for Reporting Mistakes:
Establish criteria for bringing alleged mistakes to the attention of appropriate individuals.

Assurance of Nonrecrimination:
Assure staff members that recriminations against reporting staff members will not be permitted or tolerated.

Disclosure of Mistakes:
Review the organization's process for determining to whom mistakes will be disclosed.

Description of Available Resources:
Describe the roles of administration, human resources, legal counsel, risk management, compliance office, ethics committee, and other resources in addressing management mistakes.

Summary of Procedures:
Explain what steps should be taken when a reportable mistake has occurred.

organizational integrity will be damaged. More importantly, patients, family members, staff, and the community served by the institution will be compromised.

Denial and rationalization are convenient forms of ethical amnesia. Morally managing mistakes requires that executives admit their fallibility and promote an organizational environment that makes it safe to report and evaluate our imperfections.

The journey is not an easy or simple one. Not all executives will be able to transform their management style to accommodate the personal growth required. The most effective leader will be one who thinks in terms of

The trip should not be undertaken without a full appreciation of the challenges that will be encountered but knowing that the potential benefits are incalculable.

change and renewal, not merely survival; is a coach and facilitator, not an autocrat; focuses on quality and service, not just the bottom line; builds commitment rather than demanding compliance; and empowers people instead of controlling them. Therefore, the trip should not be undertaken without a full appreciation of the challenges that will be encountered but knowing that the potential benefits are incalculable.

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NOTE

1. A recent and notable exception to this impression is found in *Trials to Triumphs: Perspectives from Successful Healthcare Leaders,* 2001, edited by D. Lloyd, D. Wegmiller, and W. Wright. Chicago: Health Administration Press.

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