RESEARCH ARTICLE

COMMON ETHICAL DECISION-MAKING PITFALLS AND HOW TO AVOID THEM

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Common ethical decision-making pitfalls and how to avoid them

Being a leader is difficult and complicated. It involves making decisions that impact the lives of employees, peers, suppliers and customers. Due to the complexity of decisions faced by leaders, making sound ethical decisions is far from easy. However, every now and then we hear about leaders who have made unethical decisions. I divide these leaders into two groups. The first group are leaders who lack certain personal qualities, such as moral character, and who consciously break the rules and make unfair decisions. These are in the minority. The second group, by far the majority, are those who see themselves, and are seen by others, as good people but who, despite good intentions, make decisions that prove to have harmful consequences. This article is aimed at this second group. In this article, I identify several common ethical pitfalls that leaders might inadvertently fall into when making decisions in the workplace. I also expand each of the pitfalls with relevant examples and guidelines on how to avoid them. Whilst this is not an exhaustive list of ethical pitfalls, the purpose of this brief article is to identify some of the common pitfalls¹ that may lead a manager to make an unethical decision.

¹ The ethical pitfalls are from Bazerman and Tenbrunsel (2011), Messick and Bazerman (1996) and Kerns (2003).
Pitfall 1: Disregarding low probability events

The first ethical pitfall is discounting outcomes which are considered to have a low probability of occurring, or which if they do occur, are considered unlikely to affect many people. One could argue that the recent Jimmy Savile scandal is an example of such an event. Derek Chinnery, controller of Radio 1 between 1978 and 1985, recalls that he confronted Savile and asked him “what’s all this, these rumours we hear about you Jimmy?” and Savile responded “that’s all nonsense”. Derek says that there was no reason to disbelieve what he said (Singh, 2012), and most likely felt that the rumours were in some sense unlikely to be true.

To avoid falling into this trap, managers should think not just about the likelihood of an event but also its potential impact. They should also take time to collect evidence about the range of possible consequences of any decision and be prepared to review and reconsider decisions in the light of emerging evidence.
Pitfall 2: Oversimplifying the issue

It is human nature when faced with a complex decision to seek to simplify it, to somehow reframe the problem into one that we recognise and feel we can comfortably solve. Oversimplifying the problem may lead to decision-makers missing important information or failing to consider all the potential consequences of a decision.

One way to avoid this pitfall is to encourage all those with an interest in the problem at hand to discuss and debate it. Encouraging a healthy culture of challenge and a climate in which difficult questions can be asked is essential to avoiding simplifying the problem and making a decision which turns out to have unforeseen and harmful consequences.
Pitfall 3: A focus on the ‘what’ rather than the ‘how’

Goal setting is a common feature of organisational life, with the term SMART (Specific, Measurable, Achievable, Realistic, Time-related) ingrained in the lexicon of working life. However, goal setting can have unintended consequences. Whilst specific and challenging goals have been shown to improve performance in some circumstances (Locke & Latham, 2006) they can also narrow the focus and attention of employees, blinding them to important issues, in particular how the goal is attained. Short-term goals can encourage improvements in performance but at the expense of long-term sustainability. In late 1960, Ford was behind the competition in the small economy car market. The CEO of the company at the time announced a specific challenging goal of producing a small economic car under £2000 by early 1970. This challenging goal coupled with a tight deadline meant that managers inappropriately signed off many of the safety checks to get the car to the market as soon as possible. However, later it was revealed that due to one of the unperformed safety checks the car could ignite upon impact. In this example, it is clear that setting a specific challenging task resulted in managers neglecting other important features that were not specified (safety, ethical behaviour and company reputation) (Ordóñez, Schweitzer, Galinsky, & Bazerman, 2009). A more recent example of the potentially detrimental impact of targets is that of the scandal at the mid-Staffordshire NHS foundation trust. It could be argued that the management team of the trust were so focussed on gaining foundation status that they forgot about quality of care, arguably what should have been their central purpose.

Leaders need to make sure that the cost of cheating to achieve a goal is far greater than its benefit. They need to consider all the unintended consequences that may be encouraged by setting a target. If there is any, there should be multiple safeguards in place to ensure ethical behaviour while attaining a goal (Ordóñez, Schweitzer, Galinsky, & Bazerman, 2009).
Pitfall 4: The thin end of the wedge

People are less likely to notice unethical behaviour if it develops gradually over time. Again, using mid-Staffordshire as an example, it is clear that the culture of neglect in the hospital did not develop overnight. Managers did not take action in response to misconduct perhaps because there were felt to be other, more important things (e.g. gaining the foundation status) to focus on. In his report, Francis (2013, p. 24) indicated that “...whatever they believed at the time, they were not being sufficiently sensitive to signs of which they were aware with regard to their implications for patient safety and the delivery of fundamental standards of care”. This continued to the point that a large number of patients were left unprotected and subjected to unacceptable risks of harm over a period of years (Francis, 2013).

Leaders need to be alert and address even minor ethical transgressions in their organisations. They also need to communicate this to their followers and embed this in the culture of their organisation.
Pitfall 5: Overvaluing outcome

People are more likely to ignore an unethical decision if it results in a good outcome. The News International phone hacking scandal is perhaps an example of this. An experiment by Bazerman and Tenbrunsel (2011) shows that people are inclined to judge an action based on its outcome rather than the ethics of it. The experiment presented two groups of participants with the same story but with two different outcomes. The story concerned a pharmaceutical researcher who was trying to get a drug to market under a tight schedule. Group A was presented with a scenario in which the researcher, when discovering that including the results from study participants who should have been excluded due to a technicality led to a positive result, included them. Group B was presented with a scenario in which the researcher manipulated the test result to fit their belief that the drug was safe and effective. Group A are told that following the drug going to market, six patients died as a result of taking it and the product was withdrawn from sale. Group B are told that the drug proved to be effective and saved thousands of lives. Each group were asked about how ethical they believe the researcher to be. Group A were more critical than group B and thought that the researcher should be punished. Yet what the researcher did in story B was as unethical as what he did in story A.

This experiment shows that individuals should not be rewarded based solely on the outcome of their activities, but also the means used to achieve the outcome and how consistent this is with organisational values.

Pitfall 6: The power of language

This ethical pitfall is about using euphemisms or softened characterisation. An example of using euphemisms that turned a crime to an organisational scandal is the Penn State’s sexual abuse scandal (Lucas & Fyke, 2013). For a number of years former assistant football club coach Jerry Sandusky used his position to molest and rape his victims. Although an eye witness alerted senior leaders to Sandusky’s behaviour, no proper action had been taken until late 2011. Lucas and Fyke (2013) report that although Penn State personnel did not report the crime to authorities, they did talk about it. They explained that how language choices made by the personnel resulted in the crime staying uncovered for such a long period of time. Staff used coded language (e.g. “horsing around”, “kind of wrestling”) to report the assault to their managers, whilst senior leaders relied on a harmless interpretation of the earlier euphemisms as the basis for their decision making about the crime.

When it comes to ethical leadership, leaders are responsible for seeking clarity. Lucas and Fyke (2013) recommend that leaders must hold themselves accountable for asking difficult questions. They also need to learn how to handle tough conversations by letting employees speak in clear language or even use impolite and disagreeable terms.


**Author’s biography**

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Meysam has a wealth of experience in the design, delivery and analysis of employee attitude and engagement surveys. He is also experienced in the design of 360 and psychometric instruments. He has recently helped develop a self-assessment psychometric instrument to measure personal resilience and is in the process of developing another on compassionate leadership. He has strong data analysis and modelling skills and has particular expertise in Social Network Analysis (SNA), Structural Equation Modelling (SEM) and Fuzzy-set Qualitative Comparative Analysis (fsQCA).

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