Organizational ethics in healthcare assesses the obligations of healthcare organizations and addresses how organizations ought to act in particular situations. The past decade has brought increasing attention to organizational ethics from scholars, healthcare executives, the American Medical Association, and the Joint Commission on the Accreditation of Healthcare Organizations. Despite this attention, we lack a shared understanding of what robust moral obligations healthcare organizations bear. There may be a set of minimum obligations borne by healthcare organizations, such as the obligation not to commit fraud. But it may not be possible justifiably to attribute to all healthcare the same obligations to indigent persons, for example. This lack of agreement should come as no surprise given the morally pluralistic composition of our society, a circumstance documented in this volume by Kevin Wm. Wildes, S.J. (2003) and Ronald Arnett and Janie Harden Fritz (2003).

In the absence of a shared understanding of the moral obligations of healthcare organizations, it is helpful to understand them as having two different kinds of moral obligations. First are those justifiably attributed to all healthcare organizations in our society. Second are those that particular healthcare organizations assume. Organizations that are, in the words of Christopher Tollefsen (2003), ‘strong institutions’ will have a more extensive set of moral obligations than ‘weak institutions’. From his perspective, all healthcare organizations share a minimum set of moral obligations, while certain organizations have additional obligations derived from their moral identities. What is morally obligatory for one organization may not be obligatory for another and may be impermissible for yet another organization.

The notion that all healthcare organizations have a minimum set of obligations, while some have additional obligations, raises three questions, all of which are addressed in this volume. First, what are the minimum obligations borne by all healthcare organizations? As one might ascertain from Wildes’ as well as Arnett and Fritz’s observations regarding moral pluralism, there is likely to be disagreement about the content of these minimum obligations. In this volume, Patricia Werhane (2003), Gerald Logue and Stephen Wear (2003), and Stanley Reiser (2003) offer different accounts of the minimum obligations of healthcare organizations. The
differences among the authors suggests that it may be difficult to establish the minimum set of obligations. It is not clear whether any of these three accounts would produce sufficient agreement to allow us justifiably to attribute a common list to all healthcare organizations. The set of shared obligations may be thinner than any of the authors here acknowledges. For example, we may be able justifiably to assert that all healthcare organizations are obligated to respect the forbearance rights of others such that it is impermissible for an organization committed to the beautification of the American population to kidnap and forcibly sterilize those whom its beauty police deem ugly. But we may not be able justifiably to assert that all healthcare organizations must adopt a commitment to providing free healthcare to the poor. The goal of this chapter is not to examine the full range of moral responsibilities attributable to all healthcare organizations. The objective is to demonstrate that there may be minimum obligations justifiably attributable to all healthcare organizations and that particular organizations may be obligated in special ways that extend beyond that set. The precise content of that set of minimum shared obligations is open to debate, as the papers by Werhane, Logue and Wear, and Reiser demonstrate.

Regardless of precisely what obligations are justifiably attributable to all healthcare organizations, it is likely that the list will not include many obligations particular organizations understand themselves as having. For example, while some organizations understand themselves as obligated to support the spiritual well-being of their patients, others may not understand this as an obligation. Organizations who recognize this obligation may rank it differently. A second question raised by this analysis concerns the origin of the additional obligations individual healthcare organizations possess. The papers in this volume by Christopher Tollefsen (2003) and Duane Covrig (2003) are instructive. Some organizations, such as religions institutions, have distinct moral identities such that they possess additional obligations grounded in their moral identities or in what I have called their ‘deep moral characters’ (Il'tis, 2001a and 2001b). In holding itself out as having a particular moral identity, an organization commits to others to fulfill the obligations generated by the identity it affirms. Although the examples in this volume concern religious organizations, there are other moral identities organizations may have that bring them additional obligations.

In attaching this level of authority to an organization’s moral identity, it becomes increasingly important that organizations have a strong sense of who they are and that to which they are committed. Although many organizations develop and display mission statements, many of these may be characterized as generic. For example, an organization might say it is committed to “respecting patients’ interests and needs” or to “respecting human dignity”. These commitments can be interpreted in numerous ways, particularly in a post-modern society such as the one Wildes as well as Arnett and Fritz describe. The contemporary debate on the legalization and moral permissibility of physician-assisted suicide and euthanasia illustrates the radical disagreement in our society regarding the nature of human dignity and what constitutes respect for human dignity. We can expect individuals and organizations to disagree on this and on matters because they have fundamentally different