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MARTIEN A.M. PIJNENBURG and BERT GORDIJN

IDENTITY AND MORAL RESPONSIBILITY OF HEALTHCARE ORGANIZATIONS

ABSTRACT. In this paper the moral responsibility of a Healthcare Organization (HCO) is conceived as an inextricable aspect of the identity of the HCO. We attempt to show that by exploring this relation a more profound insight in moral responsibility can be gained. Referring to Charles Taylor we explore the meaning of the concept of identity. It consists of three interdependent dimensions: a moral, a dialogical, and a narrative one. In section two we develop some additional arguments to apply his concept of personal identity to organizations. The final section works out the relationship of three dimensions of identity to some actual issues in contemporary HCOs: the tension between care and justice, the importance of dialogues about the diversity of goods, and the relevance of becoming familiar with the life-story of the HCO. Identity of an HCO is established and developed in commitments to and identification with certain goods that are central for a HCO. However, many of these goods are interwoven with everyday practices and policies. Therefore, moral responsibility asks for articulation of goods that often stay implicit and should not be reduced to a merely procedural approach. However difficult this articulation may be, if it is not tried at all HCOs run the risk of drifting away from their very identity as healthcare institutions: to offer care to patients and to do this in accordance with demands of social justice.

KEY WORDS: articulation of goods, Charles Taylor, healthcare organizations, identity, moral responsibility, organizational ethics, organizational identity, social justice

INTRODUCTION

This article explores the moral responsibility of a healthcare organization (HCO) by conceiving this responsibility as an inextricable aspect of the identity of a HCO.

On the one hand, moral responsibility can be approached from the perspective of the organization's way of *acting*.[1] Examples may be: the way the HCO acts toward complex bioethical issues like non-treatment decisions or the use of scarce resources; the way it deals with its employees or organizes the care to patients; or the structures it creates to handle issues such as the setting up of an ethics com-

mittee and the development of institutional guidelines. Responsibility in acting often takes shape in do's and don'ts, some of which are made explicit by hospital rules, procedures, or prescriptions, many, however, are implicit in certain kinds of behaviour or working patterns. To act responsibly in these different instances requires both that the HCO takes care to deal properly with such issues prospectively and realize that it may be called upon to account for how it handled such issues retrospectively.

On the other hand, the moral responsibility of an HCO may be understood from its way of *being*. Responsibility in this second sense is revealed by the kind of organization an HCO is or aspires to be. Instead of do's and don'ts with regard to certain issues or parties, responsibility in being appoints to positive ideals and institutional values the HCO identifies with. It denotes the institutional responsibility for sustaining and fostering highly valued social goods like restoring health, prevention of diseases, alleviation of suffering, respect for persons, protection of the vulnerable, and social justice. It also gets shape by fidelity to its tradition – such as its founders and their intentions and commitments – and by orientation to its mission in changing contemporary and future circumstances.[2]

The positive ideals, values and mission the HCO takes responsibility for may present an important motivating and inspiring power to employees and professionals to act responsibly. Consequently, the two meanings of moral responsibility are complementary. Responsibility for being an HCO in accordance with ideals, values, and mission should be manifest through actions, and, reversely, responsibility in acting should reveal the kind of organization the HCO is and aspires to be.

The objective of this paper is to discuss these complementary meanings of responsibility by interpreting them as basic aspects of the identity of an HCO. We will try to show that, by relating responsibility to identity, we may gain a deeper insight into the moral responsibility of an HCO.

Our objective will be pursued in three sections. The first section relates morality to identity by deriving a concept of identity from the philosophy of Charles Taylor. The second section suggest a possible transition from Taylor's theory to HCOs. Because Taylor's theory considers the identity of persons, this section considers whether it is plausible to apply his concept to HCOs. The third section elaborates how Taylor's theory on identity can increase our understanding of

the moral responsibility of HCOs. The article ends with a short conclusion.

CHARLES TAYLOR ON IDENTITY

Why Taylor?

There are several reasons. First, Taylor links the two questions, What do I value? and, Who am I? He deduces the identity of persons from their concrete moral judgments.[3] In a similar way, we believe that the moral choices HCOs make, as these are reflected, for instance, in ethical guidelines or in the distribution of scarce resources, reflect important aspects of their institutional identity.

Second, Taylor emphasizes that morality is not just about what is right or right acting, but also about what moves us to behave morally.[4] What really moves us cannot be sufficiently explained by external incentives, such as financial rewards or legal sanctions. In his view, commitments to what is perceived as morally good and valuable are the central issue. They are central because human beings derive their very identity from these commitments. Analogously, an HCO's moral responsibility should be approached from the perspective of its basic commitments.

Third, Taylor relates identity and morality to the cultural, social, and historical surroundings. He explicitly focuses on "the making of identity" in modern western culture.[5] His main question is how modern individuals interpret themselves and shape their moral responsibility in the context of contemporary North-Atlantic societies. Our assumption is that reflection on the moral responsibility of contemporary HCOs makes no sense unless it is related to the identity of an HCO as an institution that is bound to the context of western societies in every respect: historical, social, cultural, economic, scientific, and so on.

In sum, Taylor links morality to identity by conceiving our moral judgments and commitments as intertwined with our identity as beings, living in concrete social and historical surroundings.

Dimensions of the Identity of Persons

Taylor distinguishes three dimensions of the identity of persons: a moral, a dialogical, and a narrative dimension.[6]

The Moral Dimension

The first dimension relates identity to moral concerns. These come to the fore in the human ability to strongly evaluate certain desires. Although desires are common to all living beings, animals included, only humans are able to reflect on them and to evaluate them in terms of their desirability, that is to say, in terms of what ought to be desired. This evaluation can be ''weak'' or ''strong.'' It is weak if a choice between different desires can be made on pragmatic grounds, such as outcomes, costs, or convenience. For example, a weak evaluation will do if we have to make a choice of a holiday either in a warm or in a cold climate. Strong evaluations, however, are needed if our choice depends on qualitative distinctions about what we consider to be worthy or unworthy, or a higher or lower mode of life. Strong evaluations, in contrast to weak ones, refer to judgments about a certain way of life that we strive for, and to the kind of person that we aspire to be.[7] To use the same example: the choice of the warm and sunny country may be attractive for weak reasons, but nevertheless undesirable if we know that its government violates human rights.

Strong evaluations embody the goods with which we identify ourselves.[8] In Taylor's view these goods entail both moral and spiritual dimensions: they comprise the moral rightness of our behaviour towards others; our ideas and ideals about a good and meaningful life; and our convictions about attributing dignity to human beings.[9]

It is important to denote that the goods we appeal to in our evaluations cannot be conceived as merely personal inventions. To explain why we evaluate certain desires as good or others as bad, we are bound to the framework of the concrete community, culture, and tradition within which we are born and live our lives. Frameworks provide us with sets of qualitative and contrasting moral distinctions. They enable us to acknowledge that there are certain goods and ends that transcend the individual level, and that are intrinsically valuable and meaningful. Because these goods exist beyond us they can command our awe or admiration, and function as standards for us.[10] However, although we receive, build up, and develop our identity within such frameworks, they do not fully determine our understandings of our self. On the one hand, living is itself a process of ongoing self-interpretation and evaluation. On the other hand, cultures and societies are by themselves subject to changes. In consequence, we are continuously redefining and re-evaluating our stance towards the goods.

Taylor distinguishes among the "life goods" that denote aspects of a good life, such as respect, justice, or health, and "hypergoods" that enable us to rank different life goods. The most important however are "constitutive goods." These goods constitute the being good of life goods; for instance, they determine *why* universal justice is a good. To some of us, justice can be "made" good because all humans are considered as persons with equal rights; to others, justice can be good because they consider all humans as a family, as children of the one and only God. The essential feature of a constitutive good, however, is that it functions as a moral source: "something the love of which empowers us to do and be good."[11] Reflecting or contemplating on a constitutive good can empower us to realize this good more completely in our lives and to recognize it as a source of who we are and the kind of person we want to be. Moral sources evoke commitment and identification, and strengthen motivation. A truly felt respect for human rationality and autonomy as promoted strongly by the Enlightenment can be a moral source for people to aspire to these goods more fully. For others, this aspiration can be empowered by their belief in a God who created us as responsible human beings.[12]

The Dialogical Dimension

Identity also demands an answer to the question of who we are in relation to others. Identity involves "webs of interlocutors."[13] These webs are inherent to the concept of frameworks, while frameworks are embedded in communities of language and shared convictions. It is by participation in communities that we discover the qualitative distinctions between good and bad, higher and lower, and so on. In this sense we receive our identity from our being amidst of others. We are beings who can be addressed, and who can reply. We are "respondents."[14]

Taylor can be considered as a communitarian because he resists the idea of procedural liberalism that holds that persons are independent, atomistic beings that build up their identity by force of their own rationality (Kant) or by calculating their own – enlightened – self-interest (utilitarians). Liberalism denies the importance of human relations by attaching to them only an instrumental value for pursuing personal goals. According to communitarians, however, our relations with other people and society at large may not be equated to mere means in realizing someone's personal good, but they are "the very possibility of being an agent seeking that good."[15]

As a consequence of these essential relational and social dimensions of human life, the making of identity proves to be an ongoing dialogical process. People stay in need of dialogues with other people to learn who they are, what is significant for them and to which direction they want to move their lives. They need others to become aware of what matters to them. These dialogues do not have to be limited to people we can actually meet. We also can engage ourselves in imaginary dialogues, for instance, with deceased parents, future generations, people living in the third world, and so on.

Dialogues are not just a means to check our conceptions and visions, nor a way merely to conform our opinions to the opinions of others. Taylor considers them as essential: the denial of this dimension would be a denial of what makes life a human life. Human beings exist as dialogical beings.

The Narrative Dimension

Finally, our identity relates "to our sense of our life as a whole and the direction it is taking as we lead it."[16] It implies an answer to the question of where we are at a certain moment of our life. To understand who we are also presupposes an awareness of where we came from and to where we are moving: "My sense of myself is of a being who is growing and becoming."[17] The narrative of our life shapes our identity. Telling about our past, present, and future is a way of explaining who we are and what matters to us. Hence, our identity is necessarily narrative.

The moral, dialogical and narrative dimensions are interdependent. Each of them requires the other two for its growth. To know who we are is to know what we stand for, who we are in relationship to others, and what we are at a certain moment in our life. Consequently, our identity is not a fixed state once and for all. It exists as an ongoing process of continuity and change with respect to creating meaning in our life and to evaluate ourselves. Nor is our identity always clearly and well articulated. First, we do not always feel the need to articulate to which goods we are oriented. The need to reflect on what kind of person we want to be will be present only in cases of hard choices that will have an influence on the course of our life. Second, any articulation itself will often be tentative and imprecise. Giving words to what moves us is usually characterized by uncertainty.

Nevertheless, to understand and to make sense of human life we have to recognize the existence of these dimensions. They belong to the essence of being human. The recognition of their existence corresponds to what Taylor calls the "Best Account" principle: we cannot deny their existence because they yield the best account of human life.[18]

Taylor's Criticism of Modern Culture

As we mentioned above, the way persons understand themselves is necessarily related to their cultural, social and historical context. Given this connection, Taylor is interested in the main characteristics of modern culture.

In the historical parts of *Sources of the Self* Taylor elaborates the development of the moral sources of modern identity.[19] These sources are defined by the turn into inwardness, leading to a strong appraisal of a disengaged and self-acquired rationality; the recognition of dignity in the ordinary life of family and work; and finally, the high value that modern culture attaches to expressivism – identity as an authentic expression of what a person is. These sources are in danger, however, because modern Western culture considers them as merely optional and personal and not as objects of public debate and assessment. The mainstream of modern moral philosophy offers rational arguments that support this degrading of moral sources to personal emotions or preferences. At the same time, it encourages a reduction of morality to common accepted norms and a proceduralist approach to ethical questions. As a result, modern culture can be characterized both by a widespread consensus on moral norms and criteria to support high moral standards of universal respect, justice, and benevolence, and also by a poverty of sources that commit us to these standards.[20]

Taylor considers this non-articulation as a fundamental misconception, and with devastating consequences. The hiding of the moral sources of modern culture may result in their deterioration, may deprive them of their potentially empowering and motivating force, and may in the end jeopardize the achievements of modernization itself.[21]

For instance, instrumental rationality can degenerate in a dominance of technology or economics, if it is drifting away from its original moral impetus: to emancipate people, to improve the circumstances of ordinary life effectively, and to realize universal benevolence and justice. Another example in the development of

modern culture is the process of disengagement from encompassing, collectively shared frameworks and traditions. This is a gain, because it liberated people and enabled them to take up their own responsibility. But, at the same time, this process brought with it the loss of collective narratives that are needed to support modern subjects in acquiring and in articulating new meanings. As a result, the fear of meaninglessness becomes paramount.[22]

APPLYING TAYLOR'S CONCEPT OF IDENTITY TO HCOS

It is striking that Taylor hardly pays any attention to the contribution of institutions to the development of identity. Going beyond Taylor, Ricoeur attaches to institutions a pivotal role in his studies about the self. Like Taylor, Ricoeur also connects a theory of identity with a theory of ethics. Both stress the importance of the good life and of relations with others, but Ricoeur emphasizes institutions as a third dimension. The ethical dimension of the self-consists in "aiming at the good life with and for others in just institutions."[23]

There are good reasons to agree with this approach. First, most of our lives are spent in institutionalized roles, services, activities, and responsibilities: persons live as doctors, nurses, and managers in a HCO. Second, institutions can be considered as middle terms between persons and society. They present "a structure irreducible to interpersonal relations and yet bound up with these (...)."[24] They are setup by concrete and historical communities, they offer frameworks of qualitative distinctions, and they are influential because of their ability to exercise power on their members and consumers. Third, institutions already include certain conceptions of the good and, therefore, frameworks in the sense Taylor refers to: "What fundamentally characterizes the idea of institution is the bond of common mores (...)."[25] Consequently, working in an institution includes taking a stance towards these conceptions: someone works in accordance with these conceptions or in resistance to them. Institutions are constitutive of one's identity, either by the possibility that a person can identify himself with the goods of the institution or by the possibility that he rejects them. In other words, a person's identity is determined not only by the positive disposition he has towards the goods of a given institution but also by the negative disposition he may assume towards those goods.

Within the context of this article we will not elaborate on Ricoeur. The essential point that we will derive from his approach is that institutions are constitutive for the identity of persons. The question we will deal with is whether the identity of these institutions, *in casu* HCOs, can be clarified with the concepts of Taylor about personal identity.

Although organizations and persons differ in many respects, they also have many similarities. HCOs, for example, have a name, age, past, and future. Like persons they fulfill different roles, such as caregiver, employer, trustee of collective funds, educator, and partner in a healthcare market. Organizations also have characters and temperaments: they are innovative or conservative, open or closed, friendly or blunt, religious or secular. In addition, they can be idealistic and ambitious, or uninspired, burned out, and just floating from day-to-day. Moreover, an organization is founded by persons and staffed by persons. In spite of this, it is more than just an aggregate of individuals. It exists as a collective with a responsibility that binds all these individuals together and that can be praised or blamed for the way it performs its collectively shared tasks.[26] They perform "actions in concert."[27] It is in this sense that an HCO as a whole can be falling short if it delivers bad healthcare to patients, while not denying, at the same time, the responsibility of individual employees. When an HCO is blamed for delivering impersonal care, for example, it is not just that one person has failed but "we" as a collective have failed and "we" can feel guilty because of falling short in "our" moral responsibility. To blame an HCO has a pendant in law: HCOs are legal persons or conglomerations of persons, i.e. corporations. Like natural persons, legal persons can own properties, enter into contracts, take decisions, and so on. In addition, legal personality of corporations means that the torts of their employees or agents are attributed to them.

Without making the much stronger claim that the identity of organizations is identical to the identity of persons – which is a claim that could be rightly disputed – the similarities between persons and organizations, the latter conceived as collectives of persons, offer plausible arguments for applying Taylor's concept of identity of persons to organizations.

MORAL RESPONSIBILITY AS A MATTER OF IDENTITY

In this final section we will argue that applying Taylor's theory of identity to an HCO will lead to a more profound insight into its moral responsibility as a social institution.

Moral Dimension

In the introduction of this paper we argued that the moral responsibility of an HCO can be conceived as related to the way of acting responsibly and to the way of being responsible. From the perspective of Taylor's theory on identity, we can see now that the goods held by the HCO shape its organizational identity. Like persons, however, an HCO does not always articulate these goods. What is articulated, for instance, by clearly stated values, mission, goals or guidelines on certain moral questions, reflects the formal identity of the HCO. They expose the kind of organization it officially declares itself to be. Nevertheless, there are also goods implied in its practices and policies which are not articulated explicitly. These practices and policies show what an HCO actually is; they show its informal identity. In the ideal case, formal and informal identity are in harmony with each other. An HCO that declares the patient to be its primary focus should give proof of this claim in its actual performances. Many practices, however, seem to give priority to other interests, such as the organizational interest of efficiency or the personal interests of employees. From the perspective of moral responsibility conceived as a matter of identity, the question then must be raised whether an HCO really is in its daily practice and policy what it claims to be officially.

In addition to the potential gap between formal and informal identity, there can also be a specific reason to re-examine the HCO's identity in relation to its moral responsibility. Changes in culture and healthcare can force the HCO to reflect on the goods it is committed to and to question if and how these goods can be harmonized with contemporary challenges. To illustrate this point, we will take as an example the growing dominance of economic frameworks in healthcare.

This dominance is mainly due to a shortage in resources and causes a lot of concern and criticism from employees, consumers, and society at large. The opposite and positive side of the coin, however is, that it also offers compelling reasons to re-articulate the original goods that motivate care, and to balance these goods against other

goods.[28] Paris and Post (2000) for example, point out that the traditional good for doctors to be the patient's advocate now must be counterbalanced against goods resulting from emphasis on economic costs.[29]

Essentially, there is a dilemma between two claims: cost-effectiveness for the HCO as a whole, and the offering of optimal healthcare services to patients. A choice between these claims requires what Taylor calls "strong evaluations." Both claims evoke the question of what kind of organization the HCO wants to be. Some ends may be understood to be a more integral part of its identity as a social institution than others. The improvement of health and the alleviation of suffering are goods that cannot be given up by an HCO without severe damage to its identity. It is also a good that caregivers are committed to as part of their professional identity. However, the more that economic goods determine decisions the HCO makes, the more caregivers feel the pressure of being forced to work and of being measured according to values and criteria external to their own professional and dearly held values. The latter represent the "touchstones by which we live and work."[30]

In light of the good of healthcare, one approach is to eliminate the dilemma by considering cost-effectiveness as only a means to an end. This solution, however, would be too simple; in fact, it redefines the dilemma into a non-dilemma by eliminating a quite justifies opposing claim. The dilemma still obtrudes itself, because behind cost-effectiveness a more fundamental and very cogent good is at stake. The desire to be cost-effective is motivated by the good of justice to other patients, now and in the future. One of the arguments of Ricoeur to stress the importance of just institutions is, that they bear moral responsibility to distribute goods among all members of a community, including the unknown "third" parties. For the sake of justice between strangers also Rawls declares justice to be "the first virtue of social institutions."[31]

Caregivers are strongly committed to admitted and individual patients: this commitment is an integral part of their identity and strongly supported by the Hippocratic heritage. But it is only by articulating the institutional good of justice that is behind the emphasis on cost-effectiveness that this good can be interpreted and discussed. Articulation will create the opportunity to discuss whether the way cost-effectiveness is implemented in a particular HCO or a particular community is a means to the end of social justice or has become an aim in itself.

To be able to reframe the economics versus care dilemma into a dilemma between two institutional goals – care and justice – frameworks are needed in which these diverse goods are embodied and articulated and that inspire and motivate us. Taylor, however, criticizes modern culture because it neglects such frameworks and their underpinning moral sources. Within modern culture's prevailing pluralism frameworks are often reduced to sets of rules and procedures; their moral sources are banished to the spheres of the private and the personal and left out of the public debate. But by excluding these sources from public debate, there is the risk, first, that they get diminished and distorted with regard to their content, and a real and profound discussion on how to proportion the diversity of goods is hindered. Second, there is the risk that the motivation, being an essential feature of moral sources, to strive for justice, carefulness, or respect for human dignity gets weakened. To recall, a source both constitutes a good and empowers us to do and to be good; they are named "sources" because they evoke motivation and identification. Underlying our will to provide good care to patients stand strongly valued moral sources we identify ourselves with; for example, practical benevolence in ordinary life as our cause of human dignity, or good care as the essence of our Hippocratic tradition, or charity as the soul of our religious traditions. Underlying our efforts for economic constraints stand other strongly valued moral sources that call for justice: our commitment to human rights as expressions of our will to give due to the dignity of human beings, or religiously and humanistically inspired ideals to pursue a world of peace and social justice. In all these sentences the term "our" not does simply denote sources of "us" as individuals, but in the context of this article more importantly, sources of our social institutions and of our modern culture. It is on these institutional and cultural levels that such sources are in need of articulation. Only by articulating sources and their accompanying frameworks, in the case of the sources behind offering care and pursuing justice, can we empower engagement and commitment.

To reframe a dilemma into competing moral sources is not to solve it. But it is brought up to a level where the moral responsibility of an institution is related to a diversity of goods that are decisive and empowering with respect to the identity of a contemporary HCO. Conversely, reflection on the identity of a contemporary institution can open our eyes to the dilemma: its identity as a societal institution urges it to be both a caring *and* a just institution.

Dialogical Dimension

HCOs include internal webs of interlocutors. Moreover, they operate in dialogue with external interlocutors, like insurance companies, consumer organizations and government.[32] In these internal and external dialogues, the identity of the organization is defined and developed. Dialogue is a forum that contributes to the awareness of similarities and differences with other organizations, and of what is decisive, distinctive, and exclusive for this particular organization.[33] It is a means of trying to give the best account of the diversity of goods embodied in the HCO and of seeking its most adequate articulations. We will concentrate on the internal webs of interlocutors.

There are several reasons for emphasizing internal dialogues. The first stems from the objective to articulate and evaluate the goods that are implicit in HCOs practices and among its employees. The economy versus care dilemma described above illustrates this. By articulations organizations can try to express the different senses of the good and the plurality of goods. But both the words "try" and "senses" indicate that articulations can turn out to be more or less adequate. The "best account" principle of Taylor calls for accepting the responsibility to give the best possible account of a certain good, while being fully aware also that the best possible account is only partial and imprecise, bound to time, situation, and circumstances, and should always be open for revision and re-articulation.

Adequacy is not a matter of a better or worse description alone. It asks by itself for a deliberate responsibility, while any articulation models the sense of the good. There is a difference, for instance, between articulating respect for a patient because he is a person or a client. Both are a part of the truth. Responsibility of HCOs begins when they start to reflect on which articulation offers the best account of the sense that patients must be respected, and which corresponds most with its strong evaluations. Because, in principle, any articulation is insufficient, organizations need dialogues among employees and with patients and consumers to be open to different perspectives and to have a clearer understanding of the goods which identify them as a collective and which enforces the commitment of those involved.

The second reason arises from the fact that much of an HCOs identity is informal and stems from practices that are performed

daily. To assume moral responsibility for these practices by strong evaluation is a way of self-interpretation and critical self-evaluation.[34] Strong evaluation means, in this context, that employees enter into a critical dialogue about whether their practices really correspond with and realize the strongly valued goods of the HCO, and whether their practices really reflect their identity and the identity of the HCO. To use the same example as mentioned above: a practice in which patients are approached as consumers can cause moral distress, because there is a strongly valued good of protecting patients or a sense that patients are much more than simply consumers: they are – also – persons in need of help, with families, questions of meaning, hope, and distress.

The third reason for paying attention to internal dialogues is that moral responsibility should be rooted in commitments more than in obligations. An obligation to fulfil a certain duty, like asking patients for an informed consent, is much more appealing if the agent involved is committed to the underlying good of respecting people. If this commitment is absent, and informed consent is asked only because the law prescribes it, the agent shows an act of compliance not of moral responsibility. Dialogues about our strong evaluations do enhance such commitments. Like moral sources: they empower us to act and to be good.

Narrative Dimension

Institutions exist in time. They chronologically precede the actual staff and patients and they have the ambition to remain when present staff and patients have left. Moreover, any particular HCO is embedded in the extended temporal dimension of health care as a social institution at large: the goods that shape the identity of a particular and contemporary HCO are related to the past and the future of mankind, of medicine, and of care for the sick. To reflect and to articulate the narrative dimension of the institution identity means: examining its history to know what kind of HCO this is, looking at the different stories that are told about the HCO, to what goods it was and is committed in these stories, to how it understood its moral responsibility in the past and shapes its responsibility for the future, and to how it understands itself as a unity in the dialectical relation to continuity and change.

To become familiar with the narrative dimension is relevant for what is central, enduring, and distinctive. Illustrative is the somewhat sad observation of Blake, that many healthcare ethics committees in the USA are quite familiar with Beauchamp and Childress and with the leading court opinions of patient's rights, but that they have no familiarity with the values, traditions, or heritage of their own organizations.[35]

CONCLUSION

In this article we attempt to understand the moral responsibility of a contemporary HCO as a part of its identity.

We distinguish two meanings of moral responsibility: responsibility as a way of acting and responsibility as a way of being. Referring to the philosophy of Charles Taylor, we hold that a more profound insight into moral responsibility is gained by relating this responsibility to the identity of the HCO and to the multitude of identities that are represented by its employees. This relation is reciprocal: the way an HCO understands its identity influences its moral behaviour, and, conversely, in its moral behaviour the identity of an HCO is defined and developed.

Central to identity is a commitment to and identification with certain goods. For an HCO, some of these goods will be found in mission statements, core values, or certain policies. Like an iceberg, however, most of its goods are hidden under the surface. They are implicit in certain practices. They can also be implicit in certain policies, because many of these policies are one-sidedly focused on procedures or rules. Procedures or rules may be necessary for an adequate functioning of the HCO, but their binding force will be greater to the extent that they are related to moral sources that anchor commitment and engagement.

To act and to be responsible require the articulation of the different senses of the good, as well as the different sources and diversity of goods present among employees, in the practices and in the narratives of the HCO. Dialogues and practical reasoning about dilemmas and about the goods underlying practices are needed as means for critical self-interpretation and self-evaluation. They connect responsibility to what is decisive for the identity of an HCO and its employees: this cannot be given up without severe damage to the identity of both.

We elaborate this identity–responsibility connection through some concrete moral challenges for contemporary HCOs offered by the tension between the good of care and the good of social justice, the way respect for patients is motivated, and the difference between fulfilling obligations and being committed to goods and sources that generate these obligations.

The plurality of goods and of senses of these goods offer to mainstream, modern moral philosophy an argument for simply accepting the competing moral goods, and for solving moral problems by rational procedures and by calculating the advantages and disadvantages of different options. In our opinion, however, Taylor rightly makes the claim that the opposite should be the case. Certainly, HCOs with their different internal "webs of interlocutors" should try to articulate the plurality of goods and sources that are present within the organization and the community, and bring them into debate. Complex bioethical issues like cloning, decisions about the end of human life, the allocation of scarce resources, and the demands for social justice ask for a substantive ethics, and not, or not alone, for a procedural one.[36]

It may be difficult to articulate moral goods. But this difficulty is not an argument for not trying. If this articulation is not tried at all, the HCO is at risk of gradually drifting away from the ultimate cornerstone of its identity: to be a caring and just institution for both present and future patients.

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NOTES

[1] See for these distinct meanings: W.K. Frankena, *Ethics* 2nd ed. (Englewood Cliffs, New Jersey: Prentice-Hall Inc, 1973), pp. 62–78.

[2.] B. Jennings, B.C. Gray, V.A. Sharpe, A.R. Fleischman, "Introduction: A Framework for the Ethics of Trusteeship," in *The Ethics of Hospital Trustees*, eds. B. Jennings et al. (Washington: Georgetown University Press, 2004), pp. 1–10.

[3.] I. Singer, "Morality and Identity," in *Routledge Encyclopedia of Philosophy* ed. E. Craig (London: Routledge, 1998), retrieved November 17-2003, from http://

www.rep.routledge.com/article/L066; L066Sect 1–4).

4. In line with Bernard Williams, Taylor criticizes modern moral philosophy as being too much concentrated on obligations instead of on motivations. C. Taylor, *Sources of the Self: The Making of The Modern Identity* (Cambridge UK: Cambridge University Press, 1989), pp. 89–90; see also: B. Williams, *Ethics and the Limits of Philosophy* (London: Fontana, 1985).

5. The work we will particularly refer to is *Sources of the Self*, cited in n. 4, above.

6. *Sources*, cited in n. 4, above, Part I. A specific argument for paying attention to the relation between identity and morality is: ''that the moral philosophies today tend to obscure these connections'' (p. x).

7. C. Taylor, ''Human Agency and the Self,'' in C. Taylor, *Human Agency and Language: Philosophical Papers 1* (Cambridge: Cambridge University Press, 1985), pp. 15–44. See also: H. Frankfurt, ''Freedom of the Will and the Concept of a Person,'' *Journal of Philosophy* 67 (1971): 5–20.

8. *Sources*, cited in n. 4, above, pp. 5, 11–15.

9. Several commentators on Taylor use the term ''value'' instead of ''good'' or use these terms interchangeably. See for instance N.S. Smith, *Charles Taylor: Meaning, Morals and Modernity* (Cambridge UK: Polity Press in association with Blackwell Publishers Ltd, 2000), p. 113–114; I. Breuer, *Taylor* (Rotterdam: Lemniscaat b.v., 2002); H. Joas, *Die Entstehung der Werte* (Frankfurt am Main: Suhrkamp, 1999), pp. 195–226. Taylor perceives the use of the value-concept as an illustration of the reduction of morality by main streams of contemporary thinking to personal projections or emotions. He associates ''values'' with ''relatively colorless subjectivist talk'' (*Sources*, cited in n. 4, above, p. 507) and with emotions and feelings. As opposed to this subjectivism he understands ''goods'' as objective parts of reality, and due to this status, significant and demanding for us and able to move us. In this article we will follow Taylor's preference for the term ''good'' and ''goods.''

10. *Sources*, cited in n. 4, above p. 20.

11. Ibid., p. 93.

12. Smith, cited in n. 9, above, pp. 14–15.

13. *Sources*, cited in n. 4, above, p. 36.

14. C. Taylor, ''The Concept of a Person,'' in C. Taylor *Human Agency and Language: Philosophical Papers 1* (Cambridge: Cambridge University Press, 1985), pp. 97–114.

15. C. Taylor, ''The Nature and Scope of Distributive Justice,'' in C. Taylor *Philosophy and the Human Sciences: Philosophical Papers 2*. (Cambridge: Cambridge University Press, 1985), pp. 289–317, at p. 292.

16. *Sources*, cited in n. 4, above p. 41.

17. Ibid., p. 50.

18. Ibid., p. 58.

19. Ibid., Parts II-V.

20. F.C. Adeney, review of *Sources of the Self: The Making of the Modern Identify,'' Theology Today* 48 (1991): http://theologytoday.ptsem.edu/jul1991/v48-2-bookreview1.htm.

21. This criticism is elaborated in M.A.M. Pijnenburg and H.A.M.J. ten Have, ''Catholic Hospitals in Modern Culture; a Challenging Relation,'' *National Catholic Bioethics Quarterly* 4, no. 1 (2004): 73–88.

22. *Sources*, cited in n. 4, above, p. 18.

[23.] P. Ricoeur, "The Self and the Ethical Aim," in P. Ricouer, *Oneself as Another* (Chicago, London: University of Chicago Press, 1992), pp. 169–202.
[24.] Ibid., p. 194.
[25.] Ibid., p. 194.
[26.] P. van Tongeren, "Kollektieve verantwoordelijkheid," *Algemeen Nederlands Tijdschrift voor Wijsbegeerte* 78, no. 2 (1986): 17–34.
[27.] Ricoeur, cited in n. 23, above, pp. 195–197.
[28.] L.L. Emmanuel, "Ethics and the Structures of Healthcare," *Cambridge Quarterly of Healthcare Ethics* 9, no. 2 (2000): 151–168; J.F. Peppin, "Business Ethics and Health Care: The Re-Emerging Institution-Patient Relationship," *Journal of Medicine and philosophy* 23, no. 5(1999): 535–550; L.N. Ray, J. Goodstein, M. Garland, "Linking Professional and Economic Values in Healthcare Organizations," *The Journal of Clinical Ethics* 10, no. 3 (1999): 216–223; H.J. Silverman, "Organizational Ethics in Healthcare Organizations: Proactively Managing the Ethical Climate to Ensure Organizational Integrity." *HEC Forum* 12, no. 3(2000): 205–215; G. Khushf, "The Value of Comparative Analysis in Framing the Problems of Organizational Ethics," *HEC Forum* 13, no. 2(2001): 125–131.
[29.] J.J. Paris, S.G. Post, "Managed Care, Cost Control and the Common Good," *Cambridge Quarterly of Healthcare Ethics* 9, no. 2(2000): 182–188.
[30.] D.Pendleton and J.King, "Values and leadership," *British Medical Journal* 325 (2002): 352–1355, at 1354.
[31.] J. Rawls, *A Theory of Justice* (Cambridge: Harvard University Press 1971). p. 3.
[32.] Goia consider the notion of mutiple identities in organizations as "... perhaps a key (if subtle) point of difference between individuals and organizations." Goia, "From Individual to Organizational Identity" in *Identity in Organizations. Building Theory Through Conversations*, eds. D.A. Whetten and P.C. Godfrey (Thousand Oaks, CA: SAGE Publications, Inc. 1998), pp. 17–31, at p. 21.
[33.] See for these distinctions Goia, cited in n. 32, above.
[34.] F.J.H. Vosman, "Identiteit als praktijk van de zorginstelling," *Zin in Zorg* 5 (2003): VI–VIII.
[35.] D.C. Blake, "Organizations Ethics: Creating Structural and Cultural Change in Healthcare Organizations," *The Journal of Clinical Ethics* 10, no. 3(1999): 187–193.
[36.] E. Pellegrino offers a similar plea. See: E.D. Pellegrino, "Bioethics at Century's Turn: Can Normative Ethics Be Retrieved?" *Journal Of medicine and Philsophy* 25, no. 6(2000): 655–675.

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Department of Ethics,
Philosophy and History of Medicine
Radboud University Nijmegen Medical Centre,
232 EFG, 9101 6500 HB,
Nijmegen
The Netherlands
E-mail: m.pijnenburg@efg.umcn.nl

Department of Ethics,
Philosophy and History of Medicine
Radboud University Nijmegen Medical Centre,
232 EFG, 9101 6500 HB,
Nijmegen
The Netherlands