

The Virtuous Hospital: A Catholic Organizational Healthcare Ethics

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Abstract: *This paper addresses a perennial problem in Catholic organizational healthcare ethics. Catholic and secular ethicists have acknowledged that organizational healthcare ethics is underdeveloped. Scholars have traditionally focused on the “micro” issues arising in the clinical setting or the “macro” issues of national healthcare policy and health insurance. The “meso” or healthcare organizational level, involving both healthcare systems and hospitals has received far less attention. As a result, contemporary organizational healthcare ethics lacks a developed conceptual framework with which to analyze and guide the decision-making of HCOs. The paper responds to two specific deficiencies in the field. First, organizational ethics undertheorizes sociological realities. Second, the field employs exceedingly thin and incoherent ethical frameworks. Although scholars have introduced the term “organizational virtue,” they have yet to develop a robust account of the concept leaving healthcare leaders incapable of assessing organizational character or guiding moral decision-making. In sum, because neither “organization” nor “ethics” is well articulated, the entire project of organizational healthcare ethics loses its capacity to explain, guide, and assess human action and social outcomes. The paper directly addresses these deficiencies. First, it offers greater precision in the use of sociological terminologies, such as “structure,” “institution,” “organization,” and “culture.” Using critical realist social theory, the paper distinguishes between a social structure in the general sense, which is a “web of relations among social positions,” and an organization, which is a highly complex social structure containing positions of authority.¹ Next, it synthesizes organizational theory with virtue theory to develop an account of organizational virtue ethics capable of aiding in organizational moral decision-making and assessment. It then articulates cardinal organizational virtues, including organizational prudence, justice, beneficence, and solidarity. The paper then applies the cardinal organizational virtues to a composite case.*

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¹ Dave Elder Vass, *The Causal Power of Social Structures* (New York: Cambridge, 2010), 152.

Catholic and secular ethicists have long acknowledged that organizational healthcare ethics is underdeveloped. Scholars have traditionally focused on the “micro” issues arising in the clinical setting or the “macro” issues of national healthcare policy and health insurance. The “meso” or healthcare organizational level, involving both healthcare systems (e.g., Providence Health headquartered in Washington state) and hospitals (e.g., Massachusetts General Hospital), has received far less attention. More concretely, this means that Catholic healthcare ethics has failed to “critique the hospital as a place that shapes and contributes to systemic injustices pertaining to economics, sexism, racism, and white privilege.”² The lack of reflection on organizational ethics is doubly problematic as power within healthcare organizations (HCOs) over the past fifty years has shifted from physicians to organizational managers.³ This power shift has not been accompanied by a shift in focus in healthcare ethics. Healthcare ethics has, then, overlooked an essential aspect of healthcare delivery.

Contemporary organizational healthcare ethics lacks a developed conceptual framework with which to analyze and guide the decision-making of HCOs. Unlike clinical ethics, “no comparable and agreed-on set of ethical principles exists to guide decision making within organizations involved in healthcare.”⁴ As a result, some have urged organizational ethics to become the “next step” in the evolution of bioethics.⁵

The paper responds to two deficiencies in the field. First, all too often, organizational ethics undertheorizes sociological realities. Second, the field employs exceedingly thin and incoherent ethical frameworks. As I argue below, while scholars have introduced the term “organizational virtue,” they have yet to develop a robust account of the concept leaving healthcare leaders incapable of assessing organizational character or guiding moral decision-making. In sum, because neither “organization” nor “ethics” is well articulated, the entire project of organizational healthcare ethics loses its capacity to explain, guide, and assess human action and social outcomes.

The paper directly addresses these deficiencies. First, it offers greater precision in the use of sociological terminologies, such as “structure,” “institution,” “organization,” and “culture.” Using critical realist social theory, the paper distinguishes between a social structure in the general sense, which is a “web of relations among social positions,” and an organization, which is a highly complex social structure containing positions of authority.⁶ Second, it synthesizes organizational theory with virtue theory to develop an account of organizational virtue ethics capable of aiding in organizational moral decision-making and assessment. It then articulates cardinal organizational virtues, including organizational prudence, justice, beneficence, and solidarity.

This paper is part of a larger project within Christian ethics.⁷ Ethics traditionally has overrated the influence of individual moral character and underrated the influence of institutional and organizational character regarding the production of social outcomes. A growing number of Christian ethicists contend that the field must become more structural, ethically analyzing social structures, not solely focused on assessing and guiding individual actions.⁸ Thus, the field requires an ethics for organizations. This paper endeavors to contribute to such an ethics.

THE STATE OF HEALTHCARE ORGANIZATIONAL ETHICS

Organizational ethics “deals with value-related issues concerning an organization in the broadest sense: mission, vision, sponsorship, governance, and leadership.”⁹ It ethically analyzes an organization’s internal structure, policies, and culture.

² M. Therese Lysaught and Michael McCarthy, “A Social Praxis for US Health Care: Revisioning Catholic Bioethics via Catholic Social Thought” *Journal of the Society of Christian Ethics* 38 (2018): 111-130 at 121.

³ Riitta Suhonen, Minna Stolt, Heli Virtanen, Helena Leino-Kipli, “Organizational Ethics: A Literature Review,” *Nursing Ethics* 18 no. 3 (2011): 285-303.

⁴ Eva C. Winkler and Russell L. Gruen, “First Principles: Substantive Ethics for Healthcare Organizations,” *Journal of Healthcare Management* 50, no. 2 (2005): 109-119 at 110.

⁵ D.S. Silva, J.L. Gibson, R. Sibbald, E. Connolly, and P.A. Singer, “Clinical Ethicists’ Perspective on Organisational Ethics in Healthcare Organisations,” *Journal of Med Ethics* 34 (2008): 320-323 at 320.

⁶ Dave Elder Vass, *The Causal Power of Social Structures* (New York: Cambridge, 2010), 152.

⁷ See, for example, the Society of Christian Ethics themes in 2017 and 2022. In 2017 President Cristiana Traina dedicated the annual meeting to a consideration of “Structural Evil, Individual Harm, and Personal Responsibility.” In 2022 President James Keenan invited society members to present papers on “Examining the Ethics of Our Institutions: The Academy and the Church.” The *Journal of Moral Theology* has contributed to this development as it devoted issues to ethical issues within Catholic healthcare organizations (2019) and universities’ ethical culture (2020).

⁸ See especially the work of Catholic ethicists in *Moral Agency within Social Structures and Culture*, ed. Daniel K. Finn (Washington D.C.: Georgetown University Press, 2020).

⁹ Gerard Magill and Lawrence Prybill, “Guidelines for Organizational Ethics,” *Health Progress* July-August (2001): 12-14 at 12.

A small number of Catholic ethicists have taken up the topic of organizational healthcare ethics since the emergence of the field in the early 1990s. Ron Hamel, Thomas Nairn, Jan Heller, Gerard Magill, and Lawrence Prybill each contributed to the initial development of the literature.

In an early article on the topic, Gerard Magill and Lawrence Prybill invite ethicists to construct practical guidelines to create a virtuous HCO. They contend that healthcare organizational ethics aims to “foster a virtuous organization, in which ethical principles inspire appropriate decision making and moral behavior among all its personnel.”¹⁰ Although they recognize that Catholic healthcare is an “ecclesial ministry,” they prescind from developing a thick ethical lens and instead take a pragmatic and proceduralist approach to organizational ethics.

In one of the finest early articles on the topic, Jan Heller rejects individualist accounts of organizational life and instead focuses on how the culture, policies, and procedures of an HCO shape the choices of its members. These aspects comprise the HCO’s moral “character.”¹¹ Heller notes that individual conduct and character are “enabled and constrained” by the HCO.¹² He then recommends the formation of organizational ethics committees, distinct from clinical ethics. Like Magill and Prybill, Heller does not develop a substantive account of the values and virtues that Catholic HCOs should promote and embody.

Ron Hamel has authored or co-authored several articles addressing organizational ethics. Three themes emerge in his work on the topic. First, Hamel emphasizes that the purpose of a Catholic HCO is to continue the healing ministry of Jesus Christ.¹³ Therefore, all organizational structures, policies, and decisions should reflect and promote this Christ-inspired healing ministry. Second, Hamel turns to the virtue of justice and the principle of the preferential option for the poor to ensure that organizational decision-making aligns with the ministry’s goals.¹⁴ Finally, Hamel concurs with Magill, Prybill, and Heller that an HCO’s “character” is a central concern within organizational ethics.¹⁵

Similar to Heller, Thomas Nairn argues that a Catholic HCO is not an aggregate of persons but a community with a mission and enduring ethical culture.¹⁶ Nairn’s piece echoes Heller’s claim that organizations enable and constrain the actions of their employees, but Nairn’s analysis of the organization-human agency relation goes a step further. For the first time in the literature, Nairn turns to a school of social theory, critical realism, to explain what an HCO is and how HCOs shape human actions. There he follows Daniel Finn’s notion that organizations themselves cannot act but that they enable and constrain the actions of the individuals in the organization. “Catholic health care institutions are social structures that influence the behavior of those who are a part of them, whether they are employees, physicians, or patients. They do this by means of a series of restrictions, enablements, or incentives.”¹⁷ Nairn’s work points toward a more sociologically sophisticated approach to the nature of an organization.

In the introduction to their book on Catholic biomedical ethics and social justice, MT Lysaught and Michael McCarthy note that the field has failed to adequately critique the hospital’s role in perpetuating economic injustice, white privilege, and sexism. They suggest that Catholic biomedical ethics should expand its focus to include the structures and systems that cause injustice. In particular, they note that neither Catholic nor secular bioethics contains the “conceptual tools necessary for engaging the social dynamics, largely fraught with injustices, that shape almost every aspect of health care delivery in the US.”¹⁸ They turn to Catholic social thought for its ability to helpfully surmount “the current boundaries between clinical ethics, organizational ethics, and political advocacy.”¹⁹

Three promising themes emerge in the work of these authors. First, Heller and Nairn each maintain that the actions of those within a HCO are enabled and constrained by the HCO’s structure. Heller’s suggestion that the HCO is a collective moral agent requires scrutiny, especially in light of his earlier claim that individual agents’ actions are enabled and constrained by the organization. Nairn objects to claims that an HCO is a collective agent with a conscience. Notably, he is the only ethicist to draw

¹⁰ Magill and Prybill, “Guidelines,” 12.

¹¹ Jan Heller, “Organizational Ethics in Catholic Healthcare: Conduct, Character, and Conditions,” *HEC Forum* 13 (2001): 132-137 at 135.

¹² Heller, “Organizational,” 135.

¹³ Ron Hamel, “Catholic Identity, Ethics Need Focus in New Era,” *Health Progress*, May-June 2013: 85-87

¹⁴ Michael Panicola and Ron Hamel, “Catholic Identity and the Reshaping of Health Care,” *Health Progress*, Sept-Oct 2015: 46-56.

¹⁵ See: Ron Hamel, “Org Ethics—Why Bother,” *Health Progress*, Nov-Dec 2006: 4-5; and, Ron Hamel, “Catholic Identity, Ethics, and Audits,” *Health Progress* Jan-Feb 2013: 68-69.

¹⁶ Thomas A. Nairn, “Does a Catholic Health Care Organization Have an Institutional Conscience?” in *Conscience and Catholic Health Care: From Clinical Contexts to Government Mandates*, 2017, 69.

¹⁷ Nairn, “Institutional Conscience,” 77.

¹⁸ M. Therese Lysaught and Michael McCarthy, “Catholic Bioethics Meets Catholic Social Teaching: The Problematic, a Primer, and a Plan,” *Catholic Bioethics and Social Justice: The Praxis of US Healthcare in a Globalized World*, ed. M. Therese Lysaught and Michael McCarthy (Collegeville, MN: Liturgical Press, 2018), 3.

¹⁹ Lysaught and McCarthy, “Social Praxis,” 125.

upon a social theory; critical realism. Nairn has shown a promising direction in turning to critical realism. Below I develop a robust critical realist account of what an organization is and how it relates to the human agency of those who inhabit positions in the HCO.

Second, several thinkers (Hamel, Heller, Magill and Prybill) suggest that ethicists turn to virtue/character to evaluate organizations. Because organizations exhibit something analogous to moral character, these authors find virtue language to be a fitting metaphor for ethical evaluation. However, questions remain regarding what is an organizational virtue or vice. At present, “organizational virtue” is a rather vague metaphor that needs development into an ethical framework capable of assessing organizational moral character and guiding organizational moral deliberations.

Finally, ethicists interested in organizational ethics have turned to the Catholic social tradition. In particular, Hamel, and Lysaught and McCarthy draw on the value and principles of Catholic social thought to analyze the larger systemic and more local organizational structures that enable or constrain the moral mission of the Catholic health facility. Several theological ethicists have called for a turn to social ethics in healthcare ethics. Marcio Fabri dos Anjos has urged healthcare ethics to engage with the social ethics and the experience of the poor to go beyond only asking questions that pertain to the wealthy.²⁰ Lisa Cahill “endorses and promotes healthcare reform guided by the priority of the preferential option for the poor, within an ethics of the common good.”²¹ Shawnee Daniels-Sykes argues that because “American healthcare is a racist institution” it has failed to perpetuate injustices on Black persons.²² Daniels-Sykes proposes the creation of new positions in hospitals dedicated to ensuring that Black patients receive the care they justly deserve. Brazilian theologian Alexandre Martins urges bioethicists to listen to the unique insights of the poor regarding injustices in healthcare access.²³ These scholars challenge the field of Catholic organizational ethics to draw more deeply from the well of insight of Catholic social ethics.

Drawing on these three themes, this paper intends to develop an ethical framework that guides organizational decision-making. The framework will synthesize a critical realist account of an organization with an account of the virtues inspired by Catholic social thought.

A THEORY OF ORGANIZATIONS

As demonstrated above, healthcare organizational ethics often has undertheorized the nature of an organization. Following the lead of Nairn, this section draws on critical realist social theory to articulate a vision of what an organization is and how organizations influence human action. The use of critical realism in theology has increased during the past decade. Margaret Archer, a foundress of the theory, is the past president of the Pontifical Academy of Social Sciences. Recently, several Catholic theologians have turned to critical realism to explain the relation between social structures and human agency.²⁴ The section begins with the critical realist account of structure, then considers the relationship between structure and culture according to this theory.

Critical realism is best explained through an example. Imagine a new oncologist, Bridget, joins a hospital's oncology practice. During her orientation, she immediately learns the “org chart,” consisting of her supervisors and support staff. The hospital's Chief Medical Officer (CMO) then hands her a copy of the hospital's rules and regulations, which he subsequently asks her to learn and follow. He tells her that her medical practice must be in line with the hospital's regulations and follow the standards of care of her specialization; oncology.

A critical realist explanation of Bridget's first day would focus on the relations among the social positions of the organization and the norms of the individual positions. First, Bridget has entered into a social structure, which, according to critical realism, is a preexisting web of relations among social positions or roles (I use these latter terms interchangeably in this article).²⁵ An organization is a special kind of social structure that tends “to be strongly structured by specialized *roles*; and secondly, they are marked by significant *authority* relations between at least some of these roles.”²⁶ Although not every structure is an organization, all organizations are structures. The organization of a hospital is composed of the relations among the social positions of nurse, physician, board member, custodian, administrator, and so on. As the example shows, the position of oncologist is in relation to

²⁰ Marcio Fabri dos Anjos, “Bioethics in a Liberationist Key,” in *On Moral Medicine*, 83-91 at 89-90.

²¹ Lisa Sowle Cahill, *Theological Bioethics: Participation, Justice, Change* (Washington D.C.: Georgetown University Press, 2005), 252.

²² Shawnee M. Daniels-Sykes, “Code Black: A Black Catholic Liberation Bioethics” *Journal of the Black Catholic Theological Symposium* 3 (2009): 29-61 at 57.

²³ Alexandre Martins, *The Cry of the Poor: Liberation Ethics and Justice in Health Care* (New York: Lexington Books, 2020).

²⁴ See *Moral Agency within Social Structures and Culture: A Primer on Critical Realism for Christian Ethics*, ed. Daniel K. Finn (Washington D.C.: Georgetown University Press, 2020).

²⁵ Douglas Porpora “Who is Responsible? Critical Realism, Market Harms, and Collective Responsibility,” *Distant Markets, Distant Harms: Economic Complicity and Christian Ethics*, ed. Daniel K. Finn (New York: Oxford University Press, 2014), 3-24 at 14.

²⁶ Elder-Vass, *Causal Power*, 152.

medical supervisors, such as the CMO, and support staff, such as receptionists. The organization's structure is not made of the *individuals* who happen to hold the position of oncologist at this moment, such as Bridget, but the *position* of oncologist itself. When a person joins a hospital, she enters a pre-existing position connected to a durable web of social relations with other social positions.

Critical realism also calls our attention to the norms that direct the actions and activities of the position of oncologist. Each position is partially defined by the norms and practices expected of the position-holder, called the "position-practice system."²⁷ Each social position, such as CMO or receptionist, has been socially constructed to contain characteristic practices, activities, norms, rules, and exemplars for the inhabitant to follow.

As a physician-oncologist Bridget "is responsible for the timely preparation and completion of the patient Medical Record."²⁸ This norm directs her action. Her supervisor, the CMO, may punish her if she fails to complete a medical record in a timely fashion. Critical realists contend that such norms enable, reward, constrain, and punish the actions of position-holders.

Notice that the moment Bridget enters the organization, she finds her actions enabled and constrained. Due to the scheduling services provided by the receptionist, Bridget is enabled to have a consistent flow of patients into her office. She is constrained from tardily submitting medical records due to her relation to the CMO and his enforcement of the rules woven into her social position.

Critical realists argue that whoever enters the position of oncologist, whether Bridget or someone else, will find her actions enabled and constrained through the relations she has to other position holders and the norms she is expected to follow. Certainly, Bridget could choose to flout the conventions of her position by failing to submit medical records and practicing beneath the standards of care. However, she should expect to face punishments from the CMO for doing so.

Here we find that social structures themselves do not act. Instead, structures contain well-defined and durable social positions and norms that functionally enable, constrain, reward, and punish the actions of the individuals who hold those positions. Individual members of the organization do not lose their agency but rather experience it as channeled and constrained by the "relations those individuals now have with others in the organization."²⁹ Individuals who consistently violate the norms and practices of their positions should expect to be disciplined or terminated by those in positions of authority. Conversely, those who practice the position well should expect to be rewarded for such actions.

The point is that an organization's values, norms, and practices significantly influence the actions of its members. For example, Bridget's consistent, timely submission of patient medical records cannot be fully understood without reference to 1. The norms that direct the performance of her position, and 2. Her relation to an authority figure, the CMO, who can punish and terminate her.

A healthcare organization's structure should be distinguished from its culture. An organization's culture is found in the ideas that are endorsed within the organization.³⁰ Critical realist scholar Dave Elder-Vass argues that although only individuals can hold beliefs, "only groups have the power to designate those beliefs as elements of shared culture."³¹ Culture, then, is a *shared* set of practices, rituals, material artefacts, texts, ideas, and images.³² The culture of a Catholic healthcare organization is found, for instance, in its mission statement, its public displays of crucifixes and religious art, and the language it forbids to be used about patients (e.g., racial slurs and other degrading terms such as "drug-addict," "frequent flyer," and "vegetable"). An organization's structure (relation of social positions) and culture (ideas that are endorsed and enforced) can mutually support each other or can work at cross purposes. A Catholic hospital's organizational structure should reflect its theological and moral culture. That is, the organization's structure should promote the mission, values, and norms embedded in the Catholic healthcare tradition.

The above presentation of critical realism contains three key points. First, structures are durable webs of relations among social positions. Organizations are a type of structure that contains well-defined positions of authority. Second, each organizational position (e.g., doctor or nurse) contains practices and norms its holder should follow. These practices and norms influence the actions of those who hold positions in the organization because rewards and punishments are offered or imposed on those who comply or flout the organization's norms. Position holders are free but enabled and constrained when acting from within their

²⁷ Roy Bhaskar, *Possibility of Naturalism: A Philosophical Critique of the Contemporary Human Sciences* (Atlantic Highlands, NJ: Humanities Press, 1979), 221.

²⁸ This line is taken from Stanford Health Care's *Medical Staff: Rules and Regulations*, 3, accessed July 6, 2022, <https://stanfordhealthcare.org/content/dam/SHC/health-care-professionals/medical-staff/policies/shc-rules-and-regulations-6-19.pdf>.

²⁹ Elder-Vass, *Causal Power*, 159.

³⁰ Dave Elder-Vass, *The Reality of Social Construction* (New York: Cambridge University Press, 2012), 44.

³¹ Elder-Vass, *Reality*, 44.

³² Elder-Vass, *Reality*, 38-39.

position. Finally, an organization's culture is those beliefs and values endorsed and enforced within the organization. An organization's structure and culture can be aligned or misaligned.

Armed with an understanding of what an organization is and how it influences its members' actions, we are prepared to ask, what do the norms and relations of an HCO enable and reward, and what do they constrain and punish? What are the values, core beliefs, and images contained within an organization's culture? However, before answering such questions, we need a moral lens through which we can morally evaluate the structures and culture of a Catholic HCO.

ORGANIZATIONAL VIRTUE

Catholic HCOs exist to continue the healing ministry of Jesus Christ and are virtuous when they recognize and promote human dignity, wellbeing, and the common good. First, virtuous HCOs recognize and respect each human person's inherent and normative dignity.³³ Inherent human dignity means that each person is of "transcendent worth."³⁴ The value of the person derives from the fact that "God sees the divine image in each being; embryo, disabled, etc...."³⁵ *The Ethical and Religious Directives* recognize the universality of human dignity when they write that each person, regardless of health status, is a "unique person of incomparable worth."³⁶ Dignity in its normative sense places moral demands on individuals and social structures. Because each person is transcendentally valuable, each person should be treated as transcendentally valuable and not as something less than a person.

Second, virtuous HCOs promote human wellbeing. The United States Catholic bishops write, "Health in the biblical sense means wholeness—not only physical, but also spiritual and psychological wholeness."³⁷ Here the bishops describe essential aspects of integral wellbeing, which involves every aspect of a person's life. Similarly, Pope Paul VI noted that the integral human development of the person includes physical, educational, social, and spiritual goods.³⁸

Finally, virtuous HCOs contribute to the common good. The common good is the "conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfillment."³⁹ This account contends that the common good emerges when social structures enable persons to achieve integral wellbeing. The common good is not the aggregation of individual goods but rather a social situation that facilitates every person's health and integral wellbeing.

A concern for the poor and vulnerable cross-cuts each of these values. A Catholic HCO should first consider how their organizational structure and culture affect the dignity, wellbeing, and participation in the common good of the poor. Directive #3 of the ERDs codifies a particular concern for the poor.

In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees.⁴⁰

Catholic HCOs that recognize and promote human dignity, integral human wellbeing, and the common good are metaphorically virtuous.⁴¹ A virtuous person consistently does the good with ease and joy. Analogously, a virtuous organization regularly promotes the positive values mentioned above. Organizations, unlike agents, do not, themselves, deliberate or act. However, as I argue below, the enablements and constraints that organizations impose on their members privilege and reward specific actions and impede and penalize others. Organizations can be morally evaluated in light of what actions and outcomes they enable and reward and those that they constrain and penalize.

³³ Darlene Fozard Weaver conceptualizes the distinction between inherent and normative dignity in her article, "Christian Anthropology and Health Care," *Health Progress* (2018): 1-6.

³⁴ United States Catholic Bishops, "Economic Justice for All", 28, accessed July 6, 2022, http://www.usccb.org/upload/economic_justice_for_all.pdf.

³⁵ United States Catholic Bishops, "Economic Justice," 16.

³⁶ The United States Catholic Conference of Bishops, *The Ethical and Religious Directives*, #3, accessed July 6, 2022, <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.

³⁷ United States Catholic Bishops, *Health and Health Care*, 4, accessed July 6, 2022, <https://www.usccb.org/resources/health-and-health-care-pastoral-letter-american-catholic-bishops-november-19-1981>

³⁸ Paul VI, *Populorum progressio*, 14-22, accessed July 6, 2022, https://www.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_26031967_populorum.html.

³⁹ Second Vatican Council, *Gaudium et spes*, 26, accessed July 6, 2022,

https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html

⁴⁰ USCCB, *Ethical and Religious Directives*, #3.

⁴¹ The following account of organizational virtue is drawn from the account of structural virtue in my book, *The Structures of Virtue and Vice* (Washington D.C.: Georgetown University Press, 2021).

The remainder of this section aims to develop an account of organizational virtue capable of guiding the moral analysis of organizational healthcare structures. Just as individuals turn to the virtues to assess and guide their actions, so too can an account of organizational virtue guide and assess the structure and culture of an organization.

Structural and Cultural Expressions of Organizational Virtue

Organizational virtue is expressed structurally and culturally. In its structural expression organizational virtue is present in the relation among the positions of an organization. Broadly put, an organizational virtue is a web of relations among positions that enable position holders to promote human dignity, human wellbeing, and the common good. Virtuous organizations enable their members to promote these authentic Christian values and constrain them from undermining such values.

In order to evaluate the moral character of an organization, we will need to understand the "org chart" as well as the practices and characteristic activities of the positions (the position-practice system) that comprise the "org chart." We must understand which positions have authority over whom within the organization. Understanding the org chart provides insight into how members of the organization are (or are not) accountable to others.

At the heart of organizational virtue is moral accountability. Linda Emanuel argues that HCOs need accountability at all levels of the organization, including regular practices of feedback and organizational adjustment.⁴² James Keenan, quoting Archbishop Charles Scicluna, writes that "accountability keeps leaders vulnerable but impunity destroys that vulnerability."⁴³ I contend that organizational structures contain the mechanisms of accountability. Put differently, structures create relations of accountability in which one position-holder can penalize another position holder if she violates the practices and norms of the organization. A critical moral test of an organizational structure is this: for what does the structure hold members accountable? Put differently, what is the object of accountability? Revenue generation? Hospital rankings? Accreditation? Fidelity to the mission? Service to the marginalized in the community? Although all of these objects of accountability are of value, in a mission-driven organization such as a Catholic hospital, some should, in principle, take precedence over others.

The position-practice system helps us to understand to whom and for what a position holder is accountable. Accountability only exists when rewards and punishments are attached to actions and outcomes. A CEO, for example, is punished if the financial performance of her organization suffers. HCO leaders must ask: "What kinds of acts does the organization enable and reward, and what kinds of acts does it constrain and punish?" HCOs ought to incentivize and reward actions that their mission morally values and penalize those actions that it morally disvalues. For example, organizational policies should require that racist and sexist actions be penalized by those who hold positions of authority in the organization. In fact, the same policies should hold authority figures accountable if they fail to penalize racist and sexist actions of subordinates. Organizations that fail to penalize such actions are, in this way, vicious. Such organizations allow their members to undermine the integral wellbeing of marginalized members of the organization and in doing so, undermine the common good. Thus, a hospital CEO ought to be held accountable (rewarded or punished), for example, for how racial minorities are treated in the hospital.

Although a CEO cannot ensure that every patient who is a racial minority is treated with dignity and afforded the best medicine possible, she can (and should) create structures that enable these goods to be promoted. Recall Daniels-Sykes's proposal to create the "Advocate for Black Patients" position within the hospital. The occupant of this position would be empowered to hold others in the hospital accountable for the treatment they provide (or do not provide) to this underserved patient population. Daniels-Sykes offers an example of an anti-racist organizational structure. Here anti-racism is not simply a slogan on a training brochure or left to the goodwill of the individual members of the organization. Instead, it is woven into the structure of the HCO. Anti-racism should be identifiable in a Catholic HCOs structure, in its positions and characteristic activities and practices, as well as in the rewards and punishments that the HCO offers.

In its cultural expression organizational virtue or vice is present in the ideas that are endorsed and enforced within the organization. A culture of organizational virtue endorses and enforces ideas, language, and values that recognize universal human dignity, the value of integral human wellbeing, and the common good. For example, a vicious organizational culture promotes or tolerates medical argot that dehumanizes patients by reducing them to their medical disorder or social vulnerability, such as "drug addict," "vegetable," "non-compliant," and "homeless."

⁴² Linda L. Emanuel, "Ethics and the Structures of Healthcare," *Cambridge Quarterly of Healthcare Ethics* 9, no. 2 (2000): 151-68.

⁴³ James Keenan, "Hierarchicalism," *Theological Studies* 83 (2022): 84-108 at 97.

The AMA recently recognized the influence of language in the delivery of care and argued that “words that have the potential to create and perpetuate harm.”⁴⁴ “Person-first” language, such as “person suffering from homelessness,” recognizes that the person is more than her social vulnerability. This convention of language comports with the Catholic notion of human dignity, which resists reductionist accounts of personhood and instead emphasizes the transcendent value of each human person. Language functions in HCOs. In fact, medical professionals who referred to patients as “drug addicts” viewed them as more responsible for their drug-related illnesses than those referred to as persons with substance use disorder.⁴⁵ The same study demonstrated that the former label is more highly stigmatized than the latter, thus imposing “a barrier to treatment.”⁴⁶

The theory of organizational virtue presented above invites us to consider three aspects of a Catholic HCO. First, it turns our attention toward the relations among the organization's positions. We can ask, what are the organization's positions and how is each position related to the others? Given the Catholic HCO's mission, which positions are missing? What are the relations of accountability? Who is accountable to whom? Second, we are invited to scrutinize the practices and norms of each position. For what is each position holder accountable? What kinds of actions are rewarded, and which ones are penalized? Do the rewards and punishments align with the values of the mission? Finally, what are the cultural ideas that the organization endorses and enforces?

CARDINAL ORGANIZATIONAL VIRTUES

In order to fulfill their mission, Catholic HCOs need virtues to be embedded in their structures and culture to address how they relate: to all members of their community in general, specifically to patients, and preferentially to vulnerable members of each of these groups. Organizational justice guides the HCO's relation to all members of its community, while organizational beneficence guides the organization's relation to patients. Organizational solidarity guides the HCO in its relation to vulnerable members of the community at large and those patients whose social vulnerabilities have historically been barriers to treatment and care.

Organizational Prudence

Catholic HCOs require virtuous structures of deliberation in order to create and practice the organizational virtues of justice, solidarity, and beneficence. Prudential persons take good counsel, which enables them to choose the proper means to the good end. *Organizational* prudence exists when an HCO's structure and culture enable and require leaders to take counsel with a broad constituency of stakeholders, including persons with social vulnerabilities, and to guide and assess organizational decisions in light of the organization's Catholic mission, values, and virtues.

Organizational prudence requires, following Pope Francis, “processes of encounter” to overcome the distance that HCOs create among leaders and patients, especially poor patients.⁴⁷ Mario Fabri dos Anjos, Alexandre Martins, and Michael McCarthy have argued that HCOs must listen to the suffering of those who are sick and poor to understand and develop remedies to the structural causes of their suffering.⁴⁸

A concrete practice that promotes organizational prudence is what theologian-activist Melissa Snarr has termed “inclusion monitoring.” Applied to the HCO, inclusion monitoring would require each unit to monitor who is in “the room where it happens,” to quote the musical *Hamilton*. Constituencies that are not included in decision-making (such as racial minorities, women, LGBTQ+ people, persons suffering from poverty, and immigrants) should be allotted a seat at the table. Inclusion monitoring is a structural solution that focuses on the web of relations among the position-holders who make decisions regarding a structural problem; the

⁴⁴ American Medical Association, “Advancing Health Equity: A Guide to Language, Narrative, and Concepts,” *AMA website*, October 28, 2021, accessed July 6, 2022, <https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf>. A 2018 study found that “Exposure to the stigmatizing language...was associated with more negative attitudes towards the patient. Furthermore, reading the stigmatizing language (in the medical record) was associated with less aggressive management of the patient's pain.” See Anna P. Goddu, Katie J. O'Connor, Sophie Lanzkron, Mustapha O. Saheed, Somnath Saha, Monica E. Peek, Carlton Haywood Jr., and Mary Catherine Beach, “Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record,” *Journal of General Internal Medicine* 33 (2018): 685–691, <https://doi.org/10.1007/s11606-017-4289-2>.

⁴⁵ Kimberly Goodyear, Carolina L Haass-Koffler, and David Chavanne, “Opioid Use and Stigma: The Role of Gender, Language, and Precipitating Events,” *Drug and Alcohol Dependence* 185 (2018): 339–346 at 344–345.

⁴⁶ Goodyear, et al, “Opioid Use,” 344–345.

⁴⁷ Pope Francis, *Fratelli tutti*, 217, accessed July 6, 2022, https://www.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20201003_enciclica-fratelli-tutti.html.

⁴⁸ See: Marcio Fabri dos Anjos, “Bioethics in a Liberationist Key,” in *On Moral Medicine*, ed. M. Therese Lysaught and Joseph Kotva, Jr. (Grand Rapids, MI: Eerdmans Publishing, 2012), 83–91; Martins, *The Cry of the Poor*; and Michael McCarthy, “Beyond a Bourgeois Bioethics,” *Journal of the Society of Christian Ethics* 41 (2021): 73–88 at 82.

disenfranchisement of traditionally oppressed groups. HCOs should recognize what William O'Neill calls the "epistemic privilege of the poor."⁴⁹ Just as Black people understand racism more fully than white people, women understand sexism more thoroughly than men, and those with limited access to healthcare understand healthcare injustice in a way that HCO executives do not.

Organizational Justice

Just as every human relation should be guided by justice, HCOs need a general virtue that guides their various relations. A just person habitually renders what she owes to others. *Organizational* justice exists when the culture, practices, norms, and rules of the organization's positions enable members to render what is owed to patients, the organization, and the larger community to promote personal wellbeing and the common good. Further, a just organization's structures constrain unjust activities that harm the wellbeing and common good of patients, organizational staff, and the community.

Organizational justice follows different distributional logic in different "spheres" of the HCO.⁵⁰ For example, an HCO's structure should enable hospital staff to be compensated according to merit as long as each member receives a just wage. However, such structures should distribute medical treatment to patients according to need, not merit.

Organizational Beneficence

Virtuous Catholic HCOs require a virtue to guide and assess structures of patient treatment and care. Beneficent individuals regularly promote the wellbeing of others, should the opportunity arise. *Organizational* beneficence exists when the culture, practices, norms, and rules of the organization's positions enable members to promote the integral human wellbeing of patients in the clinical care setting.

Organizational beneficence should reward medical competence and excellence and penalize its opposite. However, beneficence to patients is not only medical. A beneficent HCO promotes the patient's integral wellbeing insofar as possible. Such an organization enables its members to provide treatment and care that restores patient health and promotes non-health-related goods, such as a patient's spirituality, relationships with family and friends, and cultural and intellectual pursuits.

Organizational Solidarity

Due to their mission, Catholic HCOs should have a particular moral concern for the poor and vulnerable and therefore require a virtue, solidarity, to guide and assess the structures that pertain to the treatment and care of vulnerable groups in their community. A person possesses the virtue of solidarity when she recognizes the "scourges of our day" and is firmly committed to promoting the common good.⁵¹ *Organizational* solidarity exists when the culture and practices, norms, and rules of the organization's positions enable members to recognize the communities who have suffered injustices in healthcare delivery and to promote the integral wellbeing of the vulnerable members of these communities.

Organizational solidarity moves organizational ethics beyond a concern for patients in the clinical setting toward those vulnerable persons who are constrained from becoming patients by socio-structural and cultural realities inside and outside the hospital. Because collaboration is special feature of solidarity,⁵² HCOs possess this organizational virtue when they partner with and listen to the vulnerable populations in their catchment area.

The purpose of the above account is to provide a moral nomenclature that enables the leaders of Catholic HCOs to ethically analyze their organizations' structures and culture. Such an analysis is not act-focused but rather ethically scrutinizes the organization's positions, their characteristic practices, and the rewards and penalties attached to actions and outcomes in light of the virtues. Organizational prudence, justice, beneficence, and solidarity must be thickened to guide and assess a Catholic HCO's structure and culture. Although I consider these virtues to be cardinal for a Catholic HCO, there may be additional virtues that healthcare leaders should consider as they reflect on the moral quality of their organizations.

⁴⁹ William O'Neill, "No Amnesty for Sorrow: The Privilege of the Poor in Christian Social Ethics," *Theological Studies* 55 (1994): 638-56 at 648-49.

⁵⁰ Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (New York: Basic Books, 1983).

⁵¹ Francis, *World Day of Peace Message*, 2016, 5, accessed July 6, 2022,

https://www.vatican.va/content/francesco/en/messages/peace/documents/papa-francesco_20151208_messaggio-xlix-giornata-mondiale-pace-2016.html; and John Paul II, *Sollicitudo rei socialis*, 38, accessed July 6, 2022, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_30121987_sollicitudo-rei-socialis.html.

⁵² John Paul II, *Sollicitudo*, 39.

CASE ANALYSIS: CLOSING A HOSPITAL FOR THE VULNERABLE

This section demonstrates the above virtues' capacity to assess a Catholic HCO's structure. What follows is a sanitized, composite case.

In 2019 a large and financially stable Catholic healthcare system, Lazarus Health, considered closing a small hospital, St. Camillus de Lellis, in the Southwest United States. The hospital served Spanish-speaking immigrants from Latin America predominantly. Many of the hospital's patients were undocumented. The hospital was deemed financially unstable as it either generated small margins of "excess revenue" or incurred operating deficits. When the CEO of Lazarus Health informed the board of directors of St. Camillus that their hospital was slated to be closed, many members objected. Board members offered three reasons why the decision should be reconsidered. First, the hospital served a largely poor, immigrant, and un/underinsured population. Therefore, the hospital was a manifestation of Lazarus Health's commitment to promote the common good by serving poor and marginalized persons. Closing the hospital would negatively affect the health and wellbeing of tens of thousands of members of already-vulnerable persons. Second, the board contended that the hospital's financial underperformance was partly a result of the exorbitant "management fee" that Lazarus imposed on the hospital. Finally, the board noted that the deliberative process was flawed. The CEO had failed to engage the community in the deliberations regarding the hospital's closing. They urged her to conduct listening sessions with the community regarding the hospital. The board argued that the CEO should understand the real-life consequences for the persons living in the hospital's catchment area before making a decision.

After the meeting, the CEO removed the objecting members from the board of St. Camillus and replaced them with persons who favored the hospital's closure. She did not consult with the community regarding the hospital's future. In her presentation regarding the closing of St. Camillus to the board of directors of Lazarus Health, she cited the financial benefits that would accrue to the organization if the hospital was closed. The board of Lazarus Health supported her decision and later rewarded her with a large bonus for her work. In late 2021 St. Camillus Hospital was closed by Lazarus Health to the community's protestations.

Ethical Analysis

In this section, I endeavor to identify and ethically analyze aspects of the organizational structure that enabled the CEO and the board of Lazarus Health to close St. Camillus Hospital. Here I am more interested in an ethical analysis of the organizational structure than the individuals who executed the actions. The moral character of the individuals involved in this case is certainly pertinent. However, as I have argued throughout this paper, Christian ethicists routinely overemphasize the causal power of individual agents and concomitantly fail to appreciate the causal powers of the social structures that enable and constrain an individual's agency. Therefore, this section focuses its ethical analysis on the organizational structure that enabled the CEO and board of Lazarus Health to close a hospital that advanced the organization's Catholic mission.

Although all four cardinal organizational virtues are relevant to the case, organizational prudence and solidarity are particularly important. An assessment of the moral character of Lazarus Health invites us to ask whether its organizational structure enables or constrains prudential decision making and solidarity with the vulnerable members of the community.

Recall that organizational prudence guides HCO leaders to take counsel with a broad constituency of stakeholders, including persons with social vulnerabilities, through the allocation of seats at the "decision-making table." The organizational structure of Lazarus Health lacked such positions. In fact, the vulnerable of the community and their advocates were constrained from giving counsel to the leaders of Lazarus Health. Furthermore, the organizational structure of Lazarus enabled the CEO to remove hospital board members who objected to the decision to close St. Camillus Hospital. The organizational structure enabled the CEO to ignore appeals to the mission of local healthcare leaders. Thus, while the CEO committed a vicious action in failing to take good counsel, this action was facilitated by an imprudent organizational structure that enabled her to do so. A more prudential organizational structure would require the CEO to take counsel with the vulnerable of the community. In addition, a more prudential structure would constrain the agency of the CEO in the face of mission-based challenges to her decisions. CEOs in Catholic HCOs should not be enabled to remove and replace board members who raise mission-based critiques of a CEO's decisions. The board members of St. Camillus should have been protected from dismissal by the organizational structure, much like whistleblower protections shield from punishment employees who expose corporate malfeasance.

Recall that organizational solidarity exists when an organization enables members to recognize and promote the integral wellbeing of the vulnerable groups within the community. The organizational structure of Lazarus Health enabled the CEO to prioritize and promote the organization's financial health over human wellbeing. Further, because the board was not required to

consider the promotion of the Catholic mission when determining CEO compensation, the board of Lazarus Health was enabled to reward the CEO's prioritization of the financial health of the organization by awarding her a massive bonus for her financial effectiveness in closing St. Camillus. Only a structure lacking in solidarity with the vulnerable enables board members to reward the closing of a Catholic hospital that predominantly serves persons who are poor and undocumented.

A structure of solidarity with the vulnerable would prioritize their wellbeing. For example, by virtue of its description of the position of CEO, the board of a Catholic hospital in New England explicitly tied CEO compensation to "mission-effectiveness." The CEO of this organization was told that he could be terminated if he did not increase the share of health services given to the poor of the community. Therefore, he was incentivized by the board to create clinics for refugees and persons suffering from homelessness, even though these clinics negatively affected the organization's financial standing. This is an example of a structure of solidarity, as the promotion of the wellbeing of the vulnerable was morally normative for the person who held the position of CEO. Here the board was obligated to consider if and to what extent the CEO promoted the integral wellbeing of vulnerable groups in the community. The organizational structure enabled board members to punish the CEO if he acted like the CEO of Lazarus Health. Clearly, the organizational structure of this New England Catholic hospital exhibits more solidarity with the vulnerable than that of Lazarus Health.

The example of Lazarus Health demonstrates that the structure of a healthcare organization can be ethically assessed according to an account of organizational virtues. Organizational prudence evaluates the moral quality of the deliberative process. Does the process enable decision-makers to take counsel with a broad consistency of stakeholders, especially those who have traditionally been marginalized in healthcare? The virtue of organizational solidarity evaluates whether or not the deliberative process accounts for the wellbeing of the vulnerable in the community. Does it prioritize the health of the poor, refugees, and immigrants or the organization's financial health? An ethical assessment of the moral character of a healthcare organization tells part of the moral story of what happens in hospitals and clinics. Certainly, individual moral agents, their moral character, and their actions are materially important in how patients are treated or not treated. This paper argues for a both-and approach to organizational healthcare ethics, one that considers the individual agent and the enablements, constraints, rewards, and penalties offered by organizations that significantly influence a person's moral choices.

Virtuous individuals would have made a difference in the case presented above. Nevertheless, a more virtuous structure that constrained the CEO from ignoring the vulnerable in the community, terminating the Board of St. Camillus, and earning a bonus based on financial health at the expense of the mission would have also made a difference in the outcome.

Catholic ethicists should avoid the temptation to reduce vicious outcomes to the work of vicious people and instead recognize the structural realities that render such outcomes possible. Catholic healthcare organizations need to create and sustain virtuous structures that enable virtuous individuals to carry out the virtuous actions they already want to perform and constrain the less than virtuous from committing acts of vice. We would do well to remember what Dorothy Day wrote: "we have to make that kind of society where it is easier for men to be good,"⁵³ and I would add, more difficult for people to be bad.

ADVANTAGES OF ORGANIZATIONAL HEALTHCARE VIRTUE ETHICS

The organizational virtue ethics developed above provides greater explanatory capacity, normative guidance, and operationalizability than previous accounts of Catholic organizational healthcare ethics. First, this account has greater explanatory capacity than previous accounts because it provides a social analysis (which has been lacking in healthcare ethics) that explains how HCOs influence the actions of their members, which then generates regularized social outcomes. This explanatory framework recognizes that the individual goodwill of members of an organization is insufficient because members of organizations often "act differently than they would do otherwise."⁵⁴ As a result, this approach applies a corrective to the traditional overemphasis on individual moral conduct and underemphasis on the importance of organizations in shaping social outcomes. Catholic HCOs striving to promote dignity, integral human wellbeing, and the common good should understand that appeals to the individual conscience of their members should be joined with structures and cultures that enable and reward actions that promote these authentic values.

The second advantage is normative. The concept of organizational virtue and vice provides a moral nomenclature with which one can guide and assess organizational structures and cultures. Based on the descriptions of the organizational virtues developed above, ethicists, healthcare leaders, and community members are enabled to categorize an organizational structure or culture as prudent or just or lacking in beneficence or solidarity. Further, the concept of organizational virtue guides toward moral

⁵³ Dorothy Day, *On Pilgrimage* (Grand Rapids, MI: Eerdmans, 1997), 151.

⁵⁴ Elder-Vass, *Causal Power*, 124.

excellence, not moral minimums. Organizational virtue guides healthcare leaders to consider how the HCO can be ever more faithful to the healing ministry of Jesus Christ.

Finally, organizational virtue is operationalizable. HCOs can audit the "org chart," the characteristic practices of each position, and the rewards and penalties attached to actions and outcomes to discern whether the organizational structure promotes dignity, wellbeing, and the common good. An audit in light of organizational virtues will enable HCOs to discover if they reward what they morally value and penalize that which they morally disvalue. Although many Catholic HCOs already perform ERD compliance audits, these tools evaluate the actions that have transpired in the organization over the previous year. An organizational virtue audit focuses on the structure and culture of the organization and is not only retrospective (structural assessment) but also prospective (structural guidance). Such an audit should listen to the insights of the organization's members; to allow them to describe the functional enablements and constraints they experience in their respective positions. Further, underserved patients should be engaged so that the HCO might discover the structural barriers to treatment and care suffered by this population. Just as Black people understand racism more fully than white people, women understand sexism more thoroughly than men, and those with limited access to healthcare understand healthcare injustices in a way that CEOs and wealthy patients do not.

CONCLUSION

This paper argues that Catholic healthcare's moral commitment to the sick, the vulnerable, the poor, and racial minorities must be realized in the structures and culture of Catholic HCOs. The concept of organizational virtue provides a normative framework to guide and assess the structures and culture of these organizations. This conceptual framework contributes to this needed "next step" in the evolution of bioethics.⁵⁵ Finally, this framework also can be adapted to suit the needs of other types of organizations, both religious and secular, such as churches, universities, social service organizations, political parties, non-profits, and businesses. Structural-level ethical analysis is lacking in organizations of all kinds. Ethicists must rise to address these critical and largely overlooked ethical challenges.

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⁵⁵ Silva et al, "Clinical Ethicists," 320.