Bridging the Gap

Catholic Health Care Organizations Need Concrete Ways to Connect Social Principles to Practice

Catholic health care has become more of a business than a ministry. As health care has become increasingly expensive, quite complex, and ever more sophisticated, we necessarily have had to become more focused on economic, technological, systemic and complex medical realities in a predominantly acute care setting. Could it be that, despite our best intentions and efforts, these forces may distract us from an interiorization of the vision of health care as a sign of hope? —Cardinal Joseph Bernardin[1]

Executives in Catholic health care have to wrestle regularly with the difficult issue of Catholic institutional identity. What is it that makes a health care institution recognizably and distinctively Catholic? How can those distinguishing characteristics and practices be implemented without undermining the institution's financial viability? In recent years, a great deal of time and energy has been invested in attempting to find adequate, actionable answers to these questions.

Among the resources the Catholic Health Association (CHA) has used to help define Catholic identity is the Catholic social tradition. This multifaceted body of thought and practice draws on Scripture; official church teachings; the reflections of theologians, philosophers, political scientists, economists, and sociologists; and the lived witness of Catholic organizational leaders, workers, and activists. The Catholic social tradition contains a wealth of insights into human work: its meaning and purpose, how it should be organized, what it should provide for the larger community, and how people are affected—for better and for worse—by the work they do and the conditions under which they do it. The fact that the tradition has developed over the course of many centuries gives it a clarity of vision and breadth of perspective that most current analyses of social and organizational issues lack.

As with much big-picture thinking, however, the Catholic social tradition historically has focused on overarching themes rather than behavioral specifics.* Moreover, the usual approach to communicating the tradition's content is to boil it down to a list of abstract principles—as few as three and as many as 10, depending on who is doing the summarizing. What these principles—"the common good," "human dignity," "stewardship," among others—mean in practice often is not self-evident. Executives and managers are left with the daunting task of figuring out how to apply the principles in the real-world circumstances in which their organizations operate. What is needed, then, is a sustained effort to translate the meaning of the Catholic social tradition into specific organizational policies and practices that will address a range of compelling issues, such as the expectations of the

* This lack of specificity is partly intentional, out of a conviction that, with respect to the details, specific analyses and the determination of appropriate courses of action are best left to the people on the spot.

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FIGURE 1
Sources of the 3IP

Ethical and Religious Directives for Catholic Health Care Services, concerns surrounding care at the beginning and end of life, and the questions of just wages and community benefit.

To help meet this need, the authors of this article are developing a method of organizational assessment and enhancement that uses a process known as "progressive articulation" to translate the standards of the Catholic social tradition into detailed behavioral benchmarks for Catholic health care.[2] We call our approach the "Identity Inquiry and Improvement Process" (3IP). It is derived from two sources (see **Figure 1**). The first source is the Catholic social tradition. The second is an organizational assessment process developed by the Malcolm Baldrige National Quality Program and refined within the Self-Assessment and Improvement Process (SAIP), a method designed to help businesses conduct their affairs in an ethically responsible manner.*

The 3IP is not a "quick fix" for the challenge of Catholic institutional identity. Furthermore, it does not mechanically prescribe a menu of static, predetermined routines. Rather, the 3IP builds upon the SAIP's method, which entails translating specific benchmarks for organizational conduct into a structured set of questions. In the case of the 3IP, answering these questions helps a Catholic health care institution assess the degree to which its current policies and procedures are consistent with the aspirations of the Catholic social tradition. By illuminating critical gaps between the detailed behavioral requirements of the social principles and its present practices, the 3IP enables an organization to creatively modify these practices in a way that brings them into closer alignment with the principles' demands. Thus the 3IP catalyzes an ongoing process of critical reflection upon an organization's current state, a process that also yields practical improvements guided by the Catholic social tradition.

Although a number of tools have been developed to aid Catholic health care institutions in assessing and promoting Catholic identity internally,* the 3IP is, we believe, particularly helpful in determining *specific criteria* for evaluating and improving the extent to which organizational policies and practices authentically reflect the vision of the Catholic social tradition. And we believe that unless Catholic health care ministries

SUMMARY

Establishing and maintaining institutional identity is a challenge for leaders in Catholic health care. A process known as "progressive articulation" can be used to help leaders assess how well their organizations reflect Catholic social tradition and help them apply this tradition toward specific organizational practices.

The particular approach described here is called the "Identity Inquiry and Improvement Process" (3IP), and it takes Catholic social principles and translates them into criteria and benchmarks for assessing an organization's interactions with internal and external stakeholders. In other words, 3IP seeks to make mission measurable and concrete.

* The SAIP was developed by a group of senior business executives and management scholars. It uses the normative foundation of the Caux Round Table's *Principles for Business* (see www1.umn.edu/humanrts/instree/cauxrndtbl.htm). In language and form, the *Principles for Business* draw heavily upon *The Minnesota Principles,* a statement of business behavior developed by Minnesota executives that, through the contributions of Robert Kennedy and Kenneth Goodpaster of the University of St. Thomas, St. Paul, MN, echoes some of the core tenets of the Catholic social tradition (see www.cebcglobal.org/ publications/principles/ minnesota principles.htm).

Committed Catholic practitioners and scholars, most notably, Jean-Loup Dherse and Goodpaster, also helped formulate the *Principles for Business.* It is our conviction that Catholic social principles could provide the SAIP with a more coherent and robust normative grounding than it currently possesses. At the same time, the SAIP offers the Catholic social tradition a much-needed path toward practicality, a way to help translate its aspirations into action.

See, besides the Goodpaster, Maines, and Rovang article mentioned above, K. E. Goodpaster, T. D. Maines, and A. M. Weimerskirch, "A Baldrige Process for Ethics?" *Science and Engineering Ethics,* vol.10, no. 2, April 2004, pp. 243-258. A more informal introduction to the SAIP is provided by Goodpaster, Maines, and Weimerskirch, "Ethical Re-Engineering," *Minneapolis Star-Tribune,* December 1, 2003, p. D3. The SAIP also is featured on the website of the Koch Chair in Business Ethics (www.stthomas.edu/cob/about/ethics /resources/saip.asp).

achieve this kind of specificity in their application of Catholic social principles, the drive to promote Catholic institutional identity will tend to drift to the periphery of organizational concern. To borrow a notion from Cardinal Bernardin, our goal is to help both individuals and organizations "interiorize" the meaning of the Catholic social tradition, and hence make it a living, ongoing, and effective reality.

In this article, we will illustrate how progressive articulation can be harnessed to aid the vital task of strengthening Catholic institutional identity. First, we will briefly sketch what we see as the critical Catholic social principles for organizational life. Second, we will discuss some of the major stakeholders of Catholic health care in light of these principles. Third, we will explain how the 3IP translates the principles into criteria and benchmarks for assessing an organization's interactions with each stakeholder. The 3IP's development is yet in its early stages, but we believe the process holds sufficient promise to warrant attention by Catholic health care institutions.

Six Principles

Catholic social principles are not a set of foreign ideas that have been imposed on us to make our work more difficult. Rather, they are focal points of Christian identity. They help us remember who we really are and what we are really about—that we are created in God's image and likeness; that, although fallen, we are destined through Christ for life with God; and that we journey together to God by growing in Christian holiness, love, and virtue. The principles remind us of the source of our truest good and ultimate happiness; they present a rightly ordered hierarchy of values; they draw attention to unacceptable behaviors and give general guidance about how common human problems should be remedied; and they constantly challenge us to a higher degree of integrity.

We have chosen here to highlight six principles of the tradition that we believe are especially important to the life of any organization claiming to be authentically Catholic.[3]

Human Dignity At the heart of the Catholic social tradition is the conviction that each individual human being possesses intrinsic worth simply by virtue of his or her existence as human. This is not merely a matter of belonging to a highly evolved biological species; men and women possess an inherent dignity precisely because they are made in God's image and are destined for union with God. This God is personal, and so every human being is a *who,* not a *what;* a some*one,* not a some*thing.* Because God is infinitely wise and loving, human beings show forth the image of God more fully to the extent that they themselves become wise and loving persons. Recognizing the individual in this spiritual light, we begin to see the infinite potential of development and growth for each person.

The ultimate value of everything within the organizational realm, therefore, rests on the degree to which it honors or undermines human dignity. This principle lies behind the Catholic social tradition's insistence on the priority of people over things and of labor over capital. Each person is intrinsically valuable and sacred; hence leaders should seek the authentic personal development of people associated with the organization. At a minimum, people ought never be treated as merely a means to the execution of some organizational plan.

The Common Good The principle of the common good highlights two realities of our existence. The first is that human beings are by their very nature relational, living and developing not in isolation but within communities and institutions. The second reality is that whatever our current state of division and fragmentation, God intends the human race to be a family. God has created us with an orientation not only toward our own good but toward the good of others as well. This innate disposition reaches its full realization when we achieve solidarity with one another. This solidarity in community, as John Paul II has written, is "a firm and persevering determination to commit oneself to the common good; that is to say, to the good of all and of each individual because we are all really responsible for all."[4]

Organizations contribute to the common good in two ways. First, they serve the "external" common good of the wider community when they produce goods and services that meet legitimate human needs and wants, when they operate responsibly in their relationships with their stake-

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* CHA sponsored a program called "Living Our Promises, Acting on Faith," wherein a series of metrics indicated the degree to which the health care ministry was actualizing its Catholic identity. In 2000, CHA published a baseline report summarizing the findings of this program (see Ed Giganti, "Living Our Promises, Acting on Faith," *Health Progress,* January-February 2001, pp. 32-33, 50). The elements of Catholic identity measured by the program are Organizational Culture, Holistic Care, Care for Poor and Vulnerable Persons, Care of the Dying, and Relationship with the Church. Multiple indicators were applied to each of these elements of Catholic identity. For example, Care for Poor and Vulnerable Persons was measured by a variety of data, including unreimbursed charity care as a percent of operating cost.

holders, when they provide employment that enables people to enjoy a decent standard of living, and in other similar ways. Second, organizations promote their "internal" common good to the extent that they foster the emergence of a sense of real community among their employees, so that people find fulfillment as persons precisely by engaging with others in the pursuit of the external common good—a shared goal that is truly worthwhile and larger than themselves.

Subsidiarity The term comes from the Latin *subsidium,* which means "assistance" or "help." As a concept, it means that, whenever possible, decisions in hierarchical institutions should be made by those who are most affected by them and that higher authorities ought to provide whatever help those at lower levels need to make and implement those decisions. Subsidiarity is implied by the principle of human dignity: If human beings are images of God, then they can develop authentically only if they are allowed to use the intelligence and freedom that God has bestowed on them.

As an organizational principle, subsidiarity guides the distribution of authority, responsibility, and accountability within an organization. It implies that organizations should be structured in such a way as to push control to the lowest appropriate level and to provide the requisite support, including training and development, to all levels of the organization.

Justice God gave humanity the Earth and all it contains to support and sustain the life of all humans, excluding no one. All creation—the world's resources, property, capital, and so forth—thus has etched upon it a "social mortgage."[5] Denying legitimate access to the fruits of the Earth is a distortion of God's command to humanity to care for, cultivate, and realize the potential of the natural world through our work.

Organizational leaders must account for this social dimension of created goods when they set prices, allocate wages, distribute community benefit, and perform similar actions. Their decisions should aim at a just distribution of resources that meets people's needs and rewards their contributions, while at the same time sustaining the organization's financial health.

Stewardship A good steward, as Scripture points out, is productive with the goods that have been placed in his or her care (Mt 25:14-30). Everything we have received is part of our patrimony, and we will be judged on how well we have used it.

In Catholic organizations, stewardship can mean at least three interrelated things. First, it involves the effective use of resources, as indicated by reasonable levels of revenue, margin, market share, productivity, efficiency, and so forth. Second, stewardship includes care for the Earth and all its resources. Human beings must understand and respect the created order, and patterns of production and consumption must be evaluated regularly to avoid misusing and dissipating resources of all kinds. Third, stewardship demands fidelity to the task of sustaining and developing the mission inherited from the founders.

Solidarity with the Poor The poor have the most urgent moral claim on our conscience: "The Church appeals to everyone to recognize a special obligation to the poor and vulnerable to defend and to promote their dignity and to ensure that they can participate fully in society."[6] Furthermore, solidarity implies that we share most deeply with the poor and marginalized when we are "with" them in their plight and not only doing things "for" them.

An organization honors the claim of the poor principally through the work it creates and the products and services it provides. Although most organizations are not called directly to solve the problem of poverty, their resources often position them to play a critical role in mitigating poverty and its consequences. This can occur not only through philanthropy but also by providing health care to underserved populations and through programs that actually integrate the poor and vulnerable into the organization itself—programs, for example, that hire and utilize appropriately the mentally handicapped, former prisoners, or individuals transitioning from public assistance.

Taken together, these six principles can serve as resources for generating a rich moral and spiritual understanding of organizational life that can open up members of Catholic health care to renewed forms of effective action. They are not meant to be mere abstractions or to serve simply as policy checklists or instruments; rather, they remind us that Catholic health care is called to foster a divinely intended purpose.

STAKEHOLDERS

As important as Catholic social principles are to organizational leaders, they can do no more than orient us to the good. Like highway signs, they point the way; but they do not take us to our destination. If we are to begin exploring the specific relevance of Catholic social principles for Catholic health care institutions, it will help us to consider briefly some of these institutions' chief

stakeholders. In each case, it is possible to see both the nobility of the work that Catholic health care organizations do and the gaps that exist between the social principles they espouse and some of their actual practices. We recognize that this list of stakeholders is only partial. Our aim is merely to illustrate the application we are proposing.

Patients Americans' concerns about health care often operate at two levels. People ask, first: Do I have access to high-quality, affordable health care? And, second: Assuming I do have access, will I be treated with competence, respect, and compassion by those providing my care?

At the first level, Catholic health care continues to work heroically to provide health care to the underserved through its care of the poor, community outreach, and national advocacy programs. Even so, more than 45.8 million Americans have no health insurance coverage. Arguably, from the uninsured patient's perspective, the United States has one of the worst health care systems in the industrialized world.

At the second level, Catholic health care struggles to differentiate itself from the for-profit sector. For example, Press Ganey Associates, a major surveyor of patient satisfaction, has reported only a slight difference between religious and nonreligious hospitals in patients' rating of the "degree to which staff addressed your emotional/spiritual needs."[7] This may be an indication that the mission and identity of Catholic health care have been affected by the pressures of operating in a competitive environment in which health care tends to become a commodity, as our epigraph from Cardinal Bernardin suggests.

Associates and Physicians There is an increasing dissatisfaction with the culture of health care on the part of physicians, nurses, and other employees. As a common quip puts it, "There is no shortage of nurses in America; it's just that they've all left health care."

One challenge is the difficulty of establishing cooperative practices in which all caregivers collaborate in a way that respects each individual's ability to contribute toward a good they share in common. Associates and physicians alike report a reduced sense of meaning in the work they do, brought on by financial pressures, the lack of time to provide hands-on care, and an increasingly litigious patient population.

The disenfranchisement of associates leads at times to friction between "management" and "labor" and to greater employee interest in unionization. In some cases, Catholic hospitals' need to compete financially has led them to suppress wage levels to the point that associates cannot afford insurance to pay for the health care their employer provides. And there are instances in which physicians have established new organizations that directly compete with Catholic hospitals to which they admit patients.

The principles are not meant to be mere abstractions or to serve simply as policy checklists or instruments; rather, they remind us that Catholic health care is called to foster a divinely intended purpose.

Sponsors The sponsors of Catholic health care in America face a significant and problematic question: In the face of declining numbers and an increasingly aged membership, how can they ensure that the ministries they began will continue in a manner consistent with Catholic identity and the vision of their founders? The answer typically involves an increased lay involvement in leadership and even sponsorship roles. However, formation of the laity who have assumed these roles has been, until recently, largely absent. More than 20 years ago, some people identified a need to promote meaningful and sustained development of lay leaders' understanding of and commitment to health care as a ministry, to Catholic social teachings, to ethics, and to spiritual care. Yet only in the past several years have such programs emerged in any systematic manner. How effectively sponsors and their lay partners can harmonize the ministry, business, and clinical excellence of Catholic health care remains an open question.

The Community Community benefit is often tracked by Catholic health care systems in terms of care for the poor, outreach programs intended to improve public health, advocacy for improved access, and the provision of quality services. These efforts clearly demonstrate a commitment to Catholic social principles. However, because Catholic health care systems are in a highly competitive market, strategic decisions can be driven more by concerns about market share than concern for community benefit. Leaders of health care ministries must continually discern the

motives that underlie their strategic plans, to ensure that the well-being of those they serve remains paramount.

There are of course many other important stakeholders that should be discussed: the church, insurance companies, suppliers, legislatures and government agencies, unions, professional associations, and others. What our brief discussion demonstrates is that the task of determining concretely how Catholic social principles should be applied in Catholic health care institutions cuts across the entire enterprise.

Turning Principles into Action

What is needed is a way to transform Catholic social principles into coherent patterns of actions relative to particular stakeholders. The 3IP is designed to help organizations do this (see footnote, p. 44). The 3IP is a multistage process involving data collection, scoring, feedback, and action. It begins with an organizational self-evaluation that entails a careful examination of the institution's current policies and practices.

By facilitating both qualitative and quantitative analyses of the self-assessment's results, the 3IP ultimately leads to the formulation and implementation of improvement initiatives that can help health care institutions realize more fully the aspirations expressed in the principles of Catholic social thought. Woven into an institution's processes, the 3IP establishes a discipline of continual learning and improvement that helps to build and sustain Catholic identity.

The 3IP's self-assessment structure is systematic and comprehensive. It translates each of the six Catholic social principles described above into a set of specific reference standards for the organization's conduct. By expressing these standards as questions, the process transforms the six social principles into six assessment categories. Within each category, the organization's performance is considered from the perspectives of each of the four stakeholders. The result is a six-by-four provisional assessment matrix (see **Table 2**).

The assessment matrix lies at the heart of the 3IP. Each cell in the matrix contains a statement, called a *criterion.* The criterion articulates the fundamental subjects or themes addressed by the cell's questions. The questions themselves, known as *benchmarks,* elaborate the criterion by addressing more specific dimensions of the cell's themes, thereby giving the inquiry process greater depth.

Consistent with the Baldrige methodology, the benchmarks in each cell focus on three performance dimensions:

- First, the questions require the organization to reflect on how it addresses the requirements of the principle in question—that is, what *approach* (policy, method, or practice) it employs for each requirement (A).
- Second, the questions inquire into how broadly the approach is used inside the institution. In other words, they examine the extent of the approach's *deployment* throughout the organization (D).
- Finally, the questions consider the specific *results* or outcomes the organization has achieved as a consequence of employing a particular approach (R).

Table 3 shows the criterion and a set of benchmarks selected from cell 1.1 of the 3IP's provisional assessment matrix. Cell 1.1 examines how a Catholic health care institution addresses the requirements of human dignity in its relations with patients. The cell's criterion, in italics, identifies three areas for inquiry:

- How the organization meets certain fundamental standards for respectful treatment
- How it promotes care that recognizes the multidimensional nature of the human person
- How it encourages the development of caring, respectful relations between care providers and patients

As highlighted by the questions featured in **Table 3,** the benchmarks in cell 1.1 require the organization to consider, among other things, the policies or practices it uses to ensure that interactions between caregivers and patients are open, empathetic, and conducive to trust; to address patient complaints and use these complaints to identify and implement improvements in its care systems; to discern a patient's unique physical, psychological, social, and spiritual

TABLE 2
Provisional 3IP Assessment Matrix

	1 Patients	2 Associates and Physicians	3 Sponsors	4 Commmunity
1. Human Dignity	1.1	1.2	1.3	1.4
2. Common Good	2.1	2.2	2.3	2.4
3. Subsidiarity	3.1	3.2	3.3	3.4
4. Justiice	4.1	4.2	4.3	4.4
5. Stewardship	5.1	5.2	5.3	5.4
6. Solidarity with the Poor	6.1	6.2	6.3	6.4

needs; and to integrate these needs into a holistic plan of care, ensuring that all providers account for them appropriately as they attend the patient. In all cases, the benchmarks ask the institution to identify both how these aspirations are addressed and how broadly these approaches are implemented within the organization.

These benchmarks underscore a Catholic perspective on human dignity in multiple ways. Understanding the patient to be an unrepeatable instance of the *imago Dei*, the benchmarks ask Catholic health care institutions to consider how they consistently bear witness to this reality through respectful and empathetic treatment, including giving due regard to the patient's complaints and concerns. They also emphasize the multidimensional nature of the human person, especially his or her spiritual nature.

The benchmarks also look at results. They ask the organization to consider the outcomes its policies and practices yield as revealed, for example, by relevant dimensions of patient satisfaction surveys and other measures. In short, the benchmarks in cell 1.1 require an institution to examine its care systems and to evaluate both the degree to which those systems are truly designed to serve the total person—a person uniquely created and loved by God—and the degree to which they are effective in doing so, as indicated by available evidence.

Answering the questions contained within a cell of the assessment matrix creates a data-based profile of the organization's current effort to live the aspirations of a given social principle in its relationship with a specific stakeholder. The profile facilitates a *qualitative* analysis of the institution's performance in this area, one that highlights strengths and opportunities for improvement. This qualitative examination is supported and extended by a *quantitative* analysis made possible by the 3IP's scoring process. The 3IP assigns a maximum possible point total to each

TABLE 3
Criterion and Selected Benchmarks for Cell 1.1

1.1. Patients
This cell examines how the institution promotes concern for the dignity of patients, care that embraces the multiple dimensions of the human person (physical, psychological, social, spiritual), and relations between patients and providers which are characterized by mutual respect, trust, honesty, and appropriate confidentiality.

1.3 How, and to what extent, does the institution ensure that interactions between providers and the patient are characterized by respect, empathy, and openness, thus promoting mutual trust? A/D

1.7 How, and to what extent, does the institution ensure that patient/family concerns or complaints about dimensions of patient care are addressed and resolved in a timely, considerate, and empathetic way? A/D

1.8 How, and to what extent, does the institution ensure that patient/family concerns or complaints about any dimension of patient care are elicited, analyzed, and acted upon? A/D

1.9 How and to what extent does the institution ascertain each patient's unique physical, psychological, social, and spiritual needs in developing her/his health care program? A/D

1.10 How and to what extent does the institution integrate the patient's physical, psychological, social, and spiritual needs into a holistic health care program? A/D

1.11 How and to what extent are patients' physical, psychological, social, and spiritual needs integrated into the daily work practices of the entire team of health caregivers? A/D

1.13 What are current levels and trends in patient satisfaction on the following issues:
- Respectful and empathetic treatment; R
- Effectiveness of communication; R
- Quality of spiritual care? R

cell. By comparing its responses to a cell's questions against a set of quantification guidelines, the organization can develop a score that characterizes its current performance within that particular cell. By totaling its scores for all the cells, the organization can generate a quantitative indication of its overall performance against the normative requirements of the social principles. This overall score is far from determinative; however, it is a useful indicator of where the institution stands in terms of its Catholic identity.

Comparing scores from cell to cell, a health care institution can detect areas where its performance is relatively strong or relatively weak. This information suggests where improvement is needed to better align the system's conduct with the demands of Catholic social principles. In this way, the 3IP enables leaders of Catholic health organizations to identify specific improvement initiatives that will help their organization realize the principles' aspirations more fully and comprehensively. Furthermore, by sharing this information with critical stakeholders, the institution can clarify the moral and spiritual vision that guides it and improve its credibility through greater openness and transparency.

Making Mission Concrete

We have, in this article, focused on the challenge of "interiorizing" Catholic social principles in health care ministries. We have described a method, the 3IP, that we believe can be helpful in identifying gaps between those principles and current organizational practice. The 3IP can identify ways to bridge the gap between principle and practice by providing analyses that suggest the kinds of improvements needed. The 3IP also helps an institution discern and make explicit the ways in which it is already effectively implementing aspects of the Catholic social tradition.

The 3IP has yet to be used in a Catholic health care setting, although its parent, the SAIP, has been used in several businesses with effective results. We are in the process of developing benchmarks for each of the cells in the matrix, which we would gladly share with CHA members.*

We believe that the 3IP can help Catholic health care institutions examine the extent to which Catholic social principles animate their patient care, training and development programs, job design philosophy, compensation and rewards structures, evaluation methods, programs for the poor and marginalized, billing and collection policies for the uninsured, accounting and financial practices, marketing and advertising practices, and other functions. This kind of systematic, concrete application will allow these organizations to value the Catholic social tradition as an essential element of their own lives and make them more effective carriers of Christ's mission of healing in the world. ■

* For a copy of the benchmarks, as well as additional information on the 3IP, CHA member organizations should contact T. Dean Maines, president, The SAIP Institute at the University of St. Thomas, Minneapolis, at 651-962-4261 or tdmaines@stthomas.edu.

NOTES

1. J. Bernardin, *Celebrating the Ministry of Healing,* Catholic Health Association, St. Louis, 1999, p. 117.
2. The term "progressive articulation" was first coined by K. E. Goodpaster, T. D. Maines, and M. D. Rovang, in "Stakeholder Thinking: Beyond Paradox to Practicality," *The Journal of Corporate Citizenship,* no. 7, Autumn 2002, pp. 99-100.
3. For a similar list of principles, see Bernardin, p. 135, and *Living Our Promise, Acting on Faith,* at www.ascensionhealth.org/ethics/public_ assessment_ tools/cha_living_our_promises.pdf.
4. Pope John Paul II, Sollicitudo Rei Socialis, December 30, 1987, para. 38, available at www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_pp-ii_enc_30121987_collicitudo-rei-socialis_en.htm.
5. Pope John Paul II, para. 42.
6. Task Force Report on Catholic Social Teaching and Catholic Education, *Report of the Content Subgroup,* U.S. Conference of Catholic Bishops, Washington, DC, 1997, available at www.usccb.org/sdwp/projects/social teaching/subgroup.htm.
7. P. A. Clark, "Patient Satisfaction with Emotional and Spiritual Care," Press Ganey Associates, South Bend, IN, May 2004, p. 4, available at www.pressganey.com/files/rose_esn.pdf.