

Modeling Cultural Contours in a Catholic Hospital

A Facility Can Affirm Its Religious Identity by Adopting Religious Practices

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Leadership formation for Catholic health services will be a challenge in the coming decades. Significant Catholic cultural upheaval will serve only to heighten that challenge. *Culture* is the accustomed way in which a particular group of people interacts. Every culture involves three integral components: 1) people whose actions shape the culture; 2) content or beliefs that define the boundaries of the culture; and 3) rituals that enable people to recall and make present the things they consider important.

Today's Catholic health ministries have Catholic cultures that are in flux. Three dramatic changes continue to modify the new Catholic culture emerging in Catholic health care institutions in our day.

Organizational Transformation Recent decades have brought a seismic transformation in the way hos-

pitals and other health care organizations operate. All by itself, this transformation necessitates enormous cultural adjustments by institutions hoping to sustain their Catholic mission, character, and identity.

LAICIZATION OF CATHOLIC HEALTH CARE

Religious congregations no longer provide personnel for health services in any significant numbers. For much of the church's history in the United States, members of religious congregations staffed and led the Catholic institutions they founded. Those days are now long gone. Going forward, most Catholic institutions will be led by the generous laymen and laywomen who have taken up where sisters, brothers, and priests left off.

Shifts in Faith Practice The ways lay Catholics practice their faith, and the extent of their knowledge about that faith, have also shifted in the past 40 years. For example, 70 percent of Catholics regularly attended Mass in the United States in the 1960s. Today, less than 30 percent attend regularly.¹ Attendance in parochial schools has also fallen off, and at least three generations of Catholics know little if anything about their faith and what it teaches. There is no reason to believe that Catholics working in health care organizations are very different from other Catholics. This means that, on average, Catholics working in these institutions attend Mass less frequently and know less about what the church teaches than did their counterparts of 50 years ago.

Diverse institutional leadership today is faced with the challenge of developing a new Catholic culture within Catholic health care organizations. In our research on Catholic culture, the authors of this article distinguish between *Catholic cultural catalysts* and *Catholic cultural citizens*. Cultural citizens are those who live and process



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the culture, whereas cultural catalysts are those cultural citizens who lead and direct necessary cultural change and adaptation. Any effective culture relies on both citizens and catalysts. In Catholic health care, it is the physicians, administrators, nurses, and staff who comprise the body of cultural citizens and are the cultural catalysts that will develop and sustain Catholic culture.

For 20 years, the mantra in Catholic health care has been “hiring for mission.” And the authors expect that most people hired are enthusiastic about the mission. But these individuals are brought into an institutional way of doing things—a culture—that should make it possible to *realize* the mission.

Most systems have a senior administrator in charge of promoting Catholic mission, character, and identity. Such administrators develop systemwide initiatives that highlight the particularly Catholic values that are supposed to animate the institution. They also suggest practices that bring these values to life in the day-to-day operation of the institution. (Later in this article, we will describe additional religious practices that mission officers might wish to consider adding to the array of activities that make their institutions distinctive from secular ones or from those of other faith traditions.)

Each Catholic institution has its own way of making Catholic culture visible and effective. Many claim that culture is more “caught” than “taught.” While that is true to some extent, culture does have content that has to be conveyed. Formal programs are the mechanisms that most health care organizations use for that purpose. Such programs identify and reinforce cultural content and measure the performance and effectiveness of cultural activities. Although formal programs vary in their effectiveness, they are an essential part of transmitting and reinforcing cultural beliefs, values, and norms. Well-designed and effective measurement and reward-and-recognition programs are critical ways of making sure that culture is actually conveyed.

Religious practice and moral or ethical practice are essential elements of Catholic culture. The *Ethical and Religious Directives for Catholic Health Care Services (ERDs)*, for example, provide the guiding principles for the interplay of these cultural components in the operation of Catholic health care organizations and social service agencies. Ethical components are particularly prominent in the *ERDs* and help distinguish Catholic enterprises from other-than-Catholic

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ones, affecting as they do not only patient and client care but the way employees are treated as well. Ethical issues also are the focus of a fair amount of public media attention. The *ERDs*' religious elements tend to have a lower profile, but they are equally important to the mission of any institution that does its work in the name of the church.

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INHERITABILITY AND DISTINGUISHABILITY

Any viable culture has to be handed on from one generation to the next. In order for a culture to survive, the next generation must engage in patterns of activity that define the current culture and make it their own. Simply put, culture has to be *inheritable*.

As a normative principle, “inheritability” means that the changes introduced into a culture should be those that are likely to be accepted not only by current participants in the culture but also by succeeding generations. In Catholic health care organizations, Catholic practices have to be inheritable by the staff as well as by a sufficiently large number of patients. In that way, demand by patients for Catholic services generates sufficient economic resources for the institution to survive.

Cultures must also be *distinctive*. They cannot be so subtle that they go unnoticed. People should be able to distinguish one culture from others. Thus the second principle of lasting cultures is “distinguishability.” This means that, for a person reasonably familiar with the operations of a health care institution, the pattern of core activities prevalent in Catholic culture A must be

perceived and experienced as different from those in other-than-Catholic culture B.

In this article, the authors explore some cultural differences that are perhaps not common in Catholic hospitals but do make Catholic hospitals distinguishable from their other-than-Catholic counterparts of similar size, activity, and setting. We certainly affirm the importance of Catholic hospitals welcoming people of different religious faiths, and practically all Catholic hospitals do this nicely. We intend, however, to identify certain hospital practices that are *distinguishably Catholic* and explain why some Catholic hospitals might adopt or adapt these practices.

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A vibrant culture is both distinguishable and inheritable. The goal of distinguishability pushes a ministry's corporate stakeholders—its cultural catalysts—to make the Catholic difference apparent to patients. In doing so, they draw upon the wealth of current or past Catholic practices and adopt and adapt those that best fit their environment and personnel. If the stakeholders are successful, a patient who is reasonably familiar with a particular Catholic facility will perceive its primary health services as different from those offered at an other-than-Catholic institution. If, on the other hand, a reasonably familiar patient detects no significant differences between the services of the two facilities, the Catholic hospital cannot claim to be even minimally Catholic.

One can identify two threads in the distinguishability principle: ease of perception and centrality of activity. In terms of perception, a person reasonably familiar with the main activities of an institution characterized by culture A should be able to easily note the differences between it and one characterized by culture B. As for centrality of activity, the differences between institutions A and B should be apparent in the core or primary functions of each.

Ease of recognition and the primacy of activities are both important. If ease of recognition

were the only criterion, a Catholic hospital would be Catholic if, for example, it had the word "Catholic" prominently displayed in its title. It would also be sufficient to have the leader of the sponsoring congregation or the bishop come once a year for a splashy visit, schmoozing with various members of the staff. However, nice as such visits might be, they would not make the institution a Catholic hospital. On the other hand, even if the hospital were to change its core activities significantly, those changes might not be perceived by patients. In order for the differences to matter, they must be differences in the hospital's *primary* activities and also easily perceived by a patient familiar with the operations of the hospital.

Even though our emphasis is on the reasonably familiar patient, outcomes and their measurement by hospital administration are also important. Outcomes can and should be shared with patients so that those who are reasonably familiar with the hospital will become more aware of its Catholic particularity.

The principle of inheritability addresses the way an organization's mission endures over time. An organization that becomes shortsighted is almost certain to lose its way. Consider an example outside health care—the dramatic collapse of Enron in 2001. Enron, which had become overly focused on retaining investor confidence, doctored its short-term financial results. Ironically, the short-term doctoring did not serve a long-term goal. Enron had no persuasive data to indicate that it was cultivating the long-term interests of the general reasonably informed investor. Consequently, the company's short-term obfuscations, once revealed, unveiled long-term problems, and investor confidence was eventually lost.

If an organization is to survive, it must adopt elements or patterns of behavior that concretize its values within its culture. In Catholic health care, this means ensuring that succeeding generations of physicians, nurses, and staff both know and internally appropriate the Catholic values as part of their corporate identity. Everyone has to care about inheritability—human resources, trustees or directors, administrators, line workers, and the patients, families, and the general community the organization serves. If the culture cannot be passed on, it will disappear.

In today's competitive health care market, most organizations seem focused on questions of inheritability. However, the worries engendered by market pressures are often more about institu-

tional survivability than about cultural inheritability. And in situations in which the two are confused, cultural distinguishability can be compromised or even jettisoned in an attempt to keep the enterprise open and operating.

DISTINGUISHABILITY IS NEVER PERIPHERAL

The Catholic identity of health services such as home health, hospice, senior services, outpatient services, or hospital-based services can be associated with or linked to an organized sponsoring group of practicing Catholics. *Health Progress* articles often discuss various structural relationships involving sponsors. Some of these relationships are formalized through such church norms as canon law. Others are a result of more informal arrangements. Visible association is one thing, but it does not address the second component of distinguishability—connection to central activities. Catholic distinguishability must exist in core Catholic health care activities. Whatever these activities are, they must engage the facility's personnel, policies, and practices. They also must be identified as the work of the church and produce measurable outcomes.

As with any claim made by a health care organization, the Catholicity of a Catholic organization must be demonstrable. Outcomes are important in achieving multiple goals. By measuring outcomes, Catholic hospitals demonstrate accountability to the larger church in whose name they operate. Outcomes can also clarify the ways an institution is distinguishably Catholic. If these outcomes are positive they can attract people—staff members as well as patients—to the facility.

The need for demonstrable Catholic outcomes is not just a private concern, as some recent court decisions have made clear. For instance, Catholic identity in social and health services was challenged and found wanting in California and New York court cases involving Catholic Charities.* These verdicts suggest that at least some courts think the basis for our Catholic identity is too narrow, too vague, and/or too peripheral to warrant consideration. While it is true that Catholic hospitals do not perform abortions, sterilizations, or mercy killings, the courts are inclined to judge institutions, including hospitals, by what they *do*,

*The supreme courts of those states have ruled that their Catholic Charities agencies do not qualify as "religious employers" under relevant state law and must therefore include prescription contraceptives in the medical insurance they provide to employees.

not by what they *don't do*. Unless patients are able to identify Catholic culture in a hospital's core activities, the hospital's Catholic identity may also be found wanting. U.S. courts clearly have some serious questions about the distinguishability of many Catholic institutions.

The *ERDs* are a treasured and necessary component of Catholic institutional identity in health care institutions. Some directives are quite general, however, and the more specific ones indicate what is not permitted in Catholic health care, rather than what should happen. As a result, many staff members, as well as most people availing themselves of Catholic health care, are not aware of the directives. Catholic health care must find ways to make Catholicity more visible in the treatment and cure of patients who frequent its institutions.

AN INTEGRAL DIFFERENCE

What a Catholic hospital does, and how it does it, distinguish it as Catholic. When a hospital's core activities are closely associated with the mission of the Catholic Church—that is, realized in the church's sacraments, preaching, and loving service—it will be clearly seen as Catholic. When both health care providers and patients want to be associated with the service *because* of these Catholic activities, the organization's Catholic identity is making a difference.

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Culture changes slowly over time. Consequently, if a health care ministry wants to effect a change in its culture, patience is required. It will simply not happen overnight. Consider a hospital that has a good local reputation but wants to make inroads into a larger market or region. This can be done, but it will likely be years before the actual changes have an internal impact. It will take even longer for the general populace to understand what is going on. The time lag can be a problem unless the hospital's leaders effectively manage progress toward the goal. The goal has to be clear and easily conceived. Everyone involved needs to know that it will take time to

accomplish. They also need to know that incremental successes are not only possible but integral to ultimate success. Institutional attention will not wander from the goal if all gains are linked to particular targeted initiatives.

This approach to general cultural change is exactly what Catholic institutions must adopt to enhance their character, mission, and identity. There are, in our opinion, a number of ways that Catholic hospitals could—by focusing on religious activities that are closely linked to diagnosing, healing, and medical care—become distinguishable from their other-than-Catholic counterparts.

WHAT MAKES A HOSPITAL CATHOLIC?

It is vital that a Catholic hospital specify its religious goals. Because culture changes slowly over time, religious goals must be clearly profiled before steps can be taken to realize them. This is true both for the hospital's management and the entire staff. Mistakes will inevitably be made in the goal-profiling process. But when goals are made crystal clear, everyone involved can see when they are achieved and when they are not.

The general goal of a Catholic hospital is to imitate Christ in his love and compassion.

Aside from important ethical approaches, what are some genuine differences that distinguish the core activities of a Catholic hospital from an other-than-Catholic facility. The ERDs emphasize that Catholic health services continue the healing ministry of Jesus Christ. The general goal of a Catholic hospital is to imitate Christ in his love and compassion. Such an imitation of Christ means aiming for the comprehensive healing—spiritual as well as physical and psychological—of the hospital's patients.

The Gospels relate numerous stories of Jesus' healing people with various ailments. Whether we understand every one of these events as miracles is not really what matters. What does matter is that, as even the enemies of Jesus acknowledge, he worked many miracles. The healings, as well as the other miracles, are presented in the Gospels as extraordinary signs that awakened great interest in Jesus and his teaching. Each miracle seemed to increase the "cure demand" for more

miracles by those who had ailments.

Of particular importance in these stories is the role of faith and forgiveness in each miraculous recovery. Jesus often commends the faith of those individuals about to be healed. In the case of the paralytic lowered down through the roof, Jesus assured him that his sins were forgiven (Mk 2:1-13). Only then did Jesus restore his legs to health. The physical cure served as a sign to those who questioned Jesus' ability to forgive sins. Since Jesus often worked miracles after he had concluded preaching to a crowd, such miracles took place in a context of faith and commitment to him. In general, Jesus' physical healings were combined with spiritual healing that emphasized faith and forgiveness. In fact, faith was so bound to miracles that, as Mark reports, Jesus was unable to work many miracles in his hometown of Nazareth because the inhabitants lacked faith (Mt 13:53-58).

Another aspect of Jesus' healing ministry was its limited scope. Jesus did not cure every afflicted person who sought him out. He did empower some of his disciples to cure people, but nowhere in the Gospels does he suggest that a main component of his mission is physically healing most people of their illnesses. Many people remained infirm even though they desired to be cured by him, and even though, we assume, they had faith in him. Even though limited in number, Jesus' miracles engendered hope and confidence that he truly would usher in the very Kingdom of God that he preached.

Despite their considerable prowess, the contemporary physicians, nurses, and staff members working in Catholic hospitals do not have the same type of healing power that Jesus possessed and shared with his disciples. Nor can clinicians see as clearly as could Jesus the faith and desire for forgiveness of those who come to be healed. However, physicians and nurses do possess extraordinarily powerful techniques and medicines that have the potential to heal the sick. Catholics today also have access to the church. This institution was started and is sustained by Christ to spread the "good news" and make present, through the sacraments, participation in divine life.

Jesus linked physical cures with faith and forgiveness. One important way that Catholic institutions can continue that ministry is by linking their commitment to physical healing with faith and forgiveness, now made available through the church. Wherever it is feasible in a Catholic hos-

pital, physical healing should be sought as a true healing of the entire person. A Catholic hospital must have highly competent physicians and nurses and offer the best possible medical care. But no matter how excellent the hospital, not all of its patients will experience physical healing. All, nonetheless, can experience the spiritual healing Jesus wants for each of us. The challenge for each Catholic hospital is to translate these reflections on the healing message of Jesus into a measurable strategy that fits the particular context in which it operates.

TWO CATHOLIC HOSPITAL MODELS

Not all clinicians in a Catholic hospital share the Catholic faith. However, let us assume that the ideal Catholic facility has an identifiable group of Catholic physicians, nurses, and other staff members who consider their healing mission in terms

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of the passion, death, and resurrection of Jesus Christ. Furthermore, let us suppose that this understanding of their mission provokes them to prayers of gratitude and petition and a desire to share their understanding in an appropriate way with those who are receptive to the message.

As we know from the preaching of Paul, the passion, death, and resurrection of Jesus were the core of Paul's saving mission, and it was these events that brought faith, hope, and love to those who believed in Christ. In the ideal modern Catholic hospital, the caregivers who believe in Christ would acknowledge this and strive to situate their activities as healers in terms of Christ's mission of love, reconciliation, forgiveness, and joy. If this acknowledgement of faith could be made visible in appropriate ways, it would constitute a distinguishing Christian difference.

In addition, this core group of physicians, nurses, and other caregivers could link their own personal commitment to Christ and his healing ministry with the Catholic Church and its central activities, including sacraments, prayer, and loving service. If this linkage were made visible (perhaps in the way we describe below), it would constitute a specifically Catholic difference, setting it apart from other hospitals.

In any hospital, Catholic or otherwise, the patient's welfare should be the most important consideration. That being so, one might argue that it is sufficient for the patient to receive good physical and psychological care from clinicians—as well as good spiritual and religious care from the pastoral care team. According to this thinking, a physician's or nurse's opinion about the relationship between medicine and the healing of the whole person is unimportant.

And, in fact, there can be two different general models for the Catholic hospital, each of which is linked to a particular strategy.

The Holistic Model In a hospital operating according to the holistic model, a group of physicians and nurses would consider physical healing a very important first step toward healing—but not the last step. Full healing would have a religious dimension and include renewed nourishment from the Gospels and the sacraments.

The Compartmental Model A second model would compartmentalize the healing of body and soul. Physical healing of the person would come (with the help of God) from the physicians, nurses, and staff, whereas spiritual healing would come mainly through the efforts of religious and pastoral experts, namely, the pastoral care team.

Whether a Catholic hospital operates on the holistic model or the compartmental model, it will need to do some cultural work. If the facility does not have a culture that encourages willing patients to experience the religious benefits it offers, those benefits will go largely untapped. Caregivers' actions and practices should make Catholic culture present and effective for patients. In any hospital, religious or secular, a so-called "medical culture" is made apparent through the actions and practices of personnel. In the same way, patients should be able to observe, and participate, in a Catholic hospital's Catholic culture.

FOUR RELIGIOUS PRACTICES

Caregivers in a Catholic hospital can invite patients to be part of the healing ministry of Jesus Christ through a variety of practices. In the past, religious sisters and brothers made the church present to the patients and their families. In what follows, we draw on that heritage and, making some adjustments, we describe certain activities that might help a particular hospital advance its healing ministry in Christ. As will be apparent, some of these activities would be pursued only by hospitals that follow the holistic model.



In many Catholic hospitals, patients can participate in daily Mass in the chapel. Those who are not ambulatory can have Mass brought to their rooms via television. This very worthwhile practice is employed in facilities that follow either the holistic model or the compartmental model. In general, the focus of the compartmental hospital is on excellent pastoral care for the patient (and family) at the bedside. Without neglecting bedside pastoral care, a holistic hospital would provide its patients with integrative religious activities that a compartmental facility would not. For instance, in a holistic hospital, some caregivers might formally pray for their patients and be visible doing so.

What follow are four religious practices that might help Catholic hospitals make the healing mission of Jesus Christ more visible in their activities.

Prayer by Clinicians Our first proposed practice involves prayer by physicians, nurses, and other staff members. The facility might, for example, schedule a daily 15-minute prayer service in the chapel and invite staff, patients, and family members to join it. An identifiable group of physicians, nurses, and other staff could commit themselves to regular participation in this service. Ideally, caregivers would lead parts of the service. At some point, physicians and nurses present would pray for a healing of their patients in soul, body, hopes, and emotions. They would also pray that their sick patients accept the challenge of their infirmities, seeing their lives as gifts from God; as tasks to be completed for God, in the manner God desires.

Celebration of Sacraments Members of the facility's pastoral care team might urge all Catholic patients to participate in the celebration of the sacraments of Reconciliation and Holy Communion during their time of sickness. Since most patients' length of hospital stay is at most only two or three days, such participation would often require collaboration between the pastoral care team and the patient's own parish. Once the patient is discharged with authorization, he or she would be contacted by someone from the parish who would offer to visit the patient at home on Sunday with the Eucharist. The parish and the patient could perhaps also make arrangements for the sacrament of Reconciliation.

Participation by the Administration The hospital administration might arrange to have a weekday Mass each month in each of the Catholic parishes in its service area. The Mass would be for the integral healing of all current and past patients at the hos-

pital. This Mass intention would be published in each parish bulletin. Ideally, hospital administrators would commit themselves to attending this special Mass when it happened to be celebrated in their own parishes. At the close of the Mass, the priest might lead the congregation in a special prayer for parishioners who were currently patients in the hospital or recovering from treatment there.

Such an administrative undertaking would link the comprehensive healing of patients to parish communities. One benefit of this practice is that it could easily be extended to religious congregations that are not Catholic.

A Banquet for the Less Fortunate The hospital might emphasize one of Jesus' central teachings by inviting the poor and less fortunate to participate in a banquet. Once a month or so, the hospital would host a dinner for local poor people (who could be notified of it through local parish services such as the St. Vincent de Paul Society). Prepared by the dietary staff, the dinner would be served by those physicians, nurses, and others who voluntarily choose to represent the entire hospital in this loving service.

Inviting the poor is a way to offer loving service, an activity that all of Jesus' disciples are expected to provide. In addition to fulfilling Christ's admonition to invite to dinner not just your friends but also those who cannot repay you (Lk 14:11-14), it is a visible way to make the hospital an inviting place for the poor. Also, because the physicians and nurses—the facility's direct caregivers—are involved in serving the poor, the initiative may suggest to patients that, once they have recovered, they too should share their greatest asset, their love and health, with others. The hospital might also send out cards containing a prayer for the poor and encouraging patients to donate to a charity that helps the poor. This practice would be framed as an important step in the patients' own spiritual healing.

Whatever practices the hospital chooses to emphasize its Catholic identity, it should devise some system of metrics to measure the practices' effectiveness. The metrics should give those involved in implementation confidence that the measures are pointing to fulfillment of the broad goals of faith, forgiveness, and a deeper connection with the church, the community of believers.

A DIFFERENT KIND OF HEALTH MINISTRY

The religious congregations that founded Catholic hospitals in the United States have in

recent years begun turning the leadership of those hospitals over to laymen and laywomen. As this process continues, the new leaders will find it more and more necessary to develop cultural indicators that distinguish their organizations as Catholic. The pressures to do so will be not only internal (e.g., to maintain the ministry in all its aspects, including its prioritized advocacy for the poor) but also external (e.g., government oversight, including tax policy).

How an organization advances its culture depends on the actions of both cultural catalysts and cultural citizens. The healing ministry of Jesus Christ will not continue in Catholic hospitals if they cannot attract cultural actors who understand that ministry and its close relationship to the activities of Jesus and the role played by the Catholic

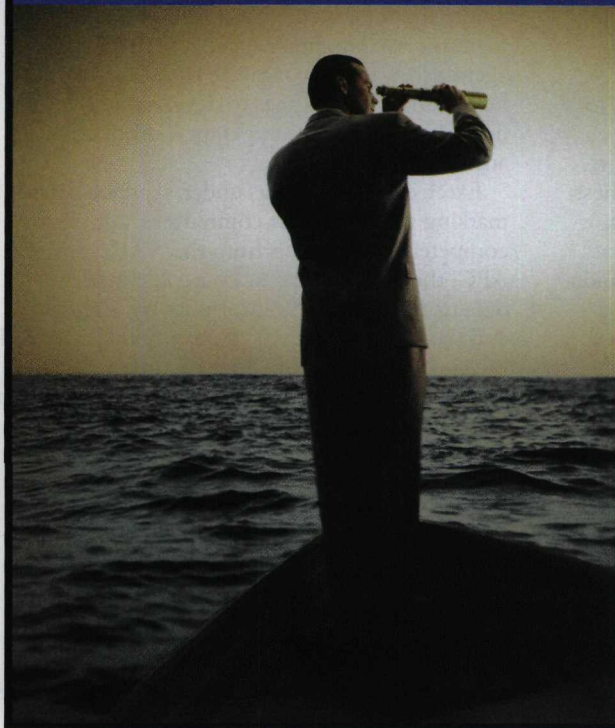
Church. It is for this reason that we have, in this article, focused on religious activities that are closely related to the Gospels and to religious practice in the church. The details of Catholic culture must be apparent in the core activities of Catholic health services and linked to the church's saving mission. Implementing such activities in a format that fits the context in which each hospital operates will make Catholic health care facilities truly distinguishable from others. ■

NOTE

1. Center for Applied Research in the Apostolate, *The Cara Report*, Georgetown University, Washington, DC, vol. 12, no. 2, Fall 2006.

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