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Catholic Hospitals in American Healthcare

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Today's healthcare market offers a wide array of choices when it comes to hospital care. Making up a significant portion of American hospitals, Catholic hospitals total over 600 across the country and treat one in six hospitalized patients (Catholic Health Association, 2016). The prevalence of Catholic hospitals may raise questions regarding their origins and the factors that have caused them to become so widespread as well as the implications their numbers have on patient care. The purpose of this paper is to explore the history of Catholic hospitals and how their roles, functions, and values have evolved over time; additionally, it seeks to evaluate today's Catholic hospitals and examine the qualities that set them apart from other hospitals.

History of Catholic Hospitals

Catholic hospitals, though preceded by Christian healthcare institutions in Europe over a thousand years ago, had their true beginning in America around the time of the country's birth. Created largely by Catholic sisterhoods, Catholic hospitals were intended to meet the needs of the sick who were too poor to be cared for in their own homes. Over time, Catholic hospitals have expanded in size and function and have spread across the country, becoming a substantial portion of American healthcare.

Early Christian Hospitality

Although hospitals as we know them are relatively new to society, hospitals have been around in some form for thousands of years. Some of the earliest Christian institutions dedicated to providing care for those in need were the hospices of the early Middle Ages (Nasalli-Rocca, McPadden, Flanagan & Donley, 2003). Hospices were founded on the principle of hospitalitas, or hospitality, which, in some early cultures, meant the courteous treatment of guests and usually involved reciprocation between parties; the Christian concept of hospitality was similar to that of

the ancient Egyptians and the Jewish, focusing on the care of those who were less fortunate (Nasalli-Rocca et al., 2003; Risse, 1999). Hospices served a variety of functions, providing shelter, food, water, and some basic nursing care to the sick, the poor, orphans, travelers, and others in need of assistance (Nasalli-Rocca et al., 2003; Risse, 1999).

Other early institutions that provided hospitality to those in need included xenodochia, xenones, katagogia, and nosokomeia (Risse, 1999). These institutions began in and around the Byzantine Empire and spread through Europe (Nasalli-Rocca et al., 2003). The names of these institutions are Greek in origin and indicate their functions as places that cared for those in need. The root “xeno,” found in xenodochia and xenone, means “stranger,” while “noso,” seen in nosokomeia, means “disease” (Nos, n.d.; Xen, n.d.).

The purposes of these institutions were very similar as they all provided care to travelers, the poor, the sick, and other needy populations, although there was some slight variation in their primary functions. Some of these focused more on sheltering pilgrims, and others were mainly concerned with looking after the sick. Xenones and katagogia seem to have been used more frequently as lodges for travelers and were conveniently located along roads (Risse, 1999). Conversely, xenodochia and nosokomeia came to direct their efforts toward caring for the sick (Nasalli-Rocca et al., 2003). Xenodochia were typically maintained by a deacon, who was associated with the church but served a medical function under the supervision of a bishop (Nasalli-Rocca et al., 2003). Monasteries also cared for the sick in their infirmaries, appointing a monk or a nun with skills in healing as the infirmarius who spent all his or her time nursing the sick and disabled (Risse, 1999). Xenondochia, nosokomeia, and monastic infirmaries offered healing through prayer as well as diet, rest, and herbs (Risse, 1999).

Early hospitals throughout Europe were often served and sometimes founded by Hospitallers, religious orders of men and women whose primary purpose was nursing (Butler, 2003). Two of the most active nursing orders were the Alexian Brothers and the Knights of St. John of Jerusalem (Butler, 2003). Both of these groups spread across parts of Europe and opened a number of hospitals. The Knights of St. John of Jerusalem eventually became a military order better known as the Knights of Malta, but they were famous for their nursing care and the hospitals they built, including one in Jerusalem which was in use from 1108 to 1187 and one at Rhodes that was completed in 1440 (Butler, 2003; Nasalli-Rocca et al., 2003; Risse, 1999). The Alexian Brothers remained a nursing order that is still involved in hospital work today (Butler, 2003).

Over time, European hospitals grew larger and more numerous. England's hospitals, for example, numbered around 980 by the year 1350 (Butler, 2003). Other European countries with larger populations, such as Italy, would have had many more hospitals with as many as 30 in a single city, as was the case in Rome and Florence (Butler, 2003; Nasalli-Rocca et al., 2003). The affiliations of hospitals with the Church evolved over time as well. Changes in the Church, the economy, and the social climate in Europe led to many hospitals becoming secularized between the 14th and 16th centuries (Nasalli-Rocca et al., 2003). Additionally, hospitals continued to become more focused on curing illness. Although they were known for their poor conditions and did not always effectively treat the sick, the hospitals of the 18th century were primarily used to care for the sick; few hospitals remained that were used exclusively to house the poor (Nasalli-Rocca et al., 2003).

Spread of Catholicism to America

The American Catholic Church, like the country as a whole, was built by immigrants. Many Catholics arrived in the 1800s as large numbers of immigrants came from countries such as Germany, Ireland, France, and Italy, which were primarily Catholic in religion (Levin, 2011; Oates, 1995). By 1850, Catholicism was the largest religious denomination in the country due to immigration (McGuinness, 2013). However, smaller numbers of Catholics had been around and were making an impact in America long before then.

Many of the most influential people in the early American Catholic Church were women in religious communities. These women, referred to as either nuns or sisters, were devoted to living lives of charity, chastity, and poverty in order to serve God and the Church. While the term “nun” describes a woman who remains cloistered, living away from the rest of the world, sisters actively go out into the world finding ways to serve others (McGuinness, 2013). The first sisters to arrive in what would become America were twelve French sisters of the Ursuline community, settling in New Orleans in 1727 (McGuinness, 2013). They were followed by four Carmelite nuns who arrived in Port Tobacco, Maryland in 1790 (McGuinness, 2013). In the years that followed, more sisters of various countries and religious communities settled in different parts of America where they performed ministries such as teaching and nursing.

First Catholic Hospitals in America

Hospitals existed in the American colonies as early as 1633 when a hospital was built for soldiers on Manhattan Island; however, American hospitals were only temporary establishments until later on in the 1700s (Nasalli-Rocca et al., 2003). In the years after the United States became an independent nation, there were few government regulations to control institutions (Levin, 2011). It was not necessary to get approval from fire and health departments or go

through other official processes to validate an institution (Levin, 2011). As they looked for ways to serve communities, Catholic sisters saw a need for places to care for those who were sick and without homes, and the lack of regulations made it easy for them to found new hospitals.

Hospitals created by sisters often did not result from long periods of planning, but rather came into being as the need arose. Sisters offered their services as nurses in times of epidemics, disasters, or wars, and then might continue to serve the community with the creation of a more permanent hospital (McGuinness, 2013). For example, the Sisters of Charity in Philadelphia were not involved in nursing until their help was needed during a cholera epidemic (McGuinness, 2013). In other cases, the sisters themselves did not start the hospital, but were welcomed by the community and took over the operation of hospitals that were already up and running. This was the case with the Ursuline Sisters in New Orleans, who were asked by the colonial governor to help improve the poor conditions in the public hospital when they arrived in 1727 (Levin, 2011; McGuinness, 2013). Occasionally brotherhoods were also involved with hospitals, as was the case with the Alexian Brothers, who had been actively serving in hospitals in Europe for hundreds of years already (Wall, 2011). Upon coming to America in 1866, a group of Alexian Brothers continued their legacy by starting a hospital for men in Chicago (Wall, 2011). As people moved west across the American frontier, sisters also moved into new territories, opening hospitals in order to care for those who were more prone to accidents in the hazardous new environments (McGuinness, 2013).

Some of the difficulties faced by sisters in opening hospitals were due to disagreements with local bishops. Although they had a certain amount of freedom and independence, sisters needed approval from the bishop in order to open a hospital, and when they did not meet the specific wishes of the bishop, they might be denied approval (Levin, 2011). Many sisters also

found themselves in areas where there were few Catholics compared to other religions. This caused a different set of challenges as sisters faced persecution and sometimes violence from members of the community, which, in many areas, was not resolved until after the Civil War (McGuinness, 2013). Despite these challenges, Catholic sisters continued to open hospitals throughout the 1800s, and between 1866 and 1926 started almost five hundred hospitals across the country (McGuinness, 2013).

Many of the hospitals that were operated by Catholic sisters served multiple functions. Sisters also served communities by opening schools, orphanages, and other establishments, and sometimes these were all included under one roof (Oates, 1995). This was the case for many institutions well into the 19th century. In Salem, Massachusetts in the 1880s, the City Orphan Asylum was used as an orphanage, a hospital, and a place for unemployed and elderly women to stay (Oates, 1995).

Funding and Operation of Catholic Hospitals

As many new hospitals opened in the late 1800s, a hospital opened by a sisterhood had to be paid for by the sisterhood (Oates, 1995). Although sisters were supposed to live in poverty, they had access to funds that would enable them to serve others. However, because hospitals required extensive funds to build and operate, sisters had to find ways of bringing in more money, including donations from individuals or fairs and benefits that were organized by lay people (Oates, 1995). There were also many times when sisters had to borrow money or take out loans in order to meet the costs of building or expanding hospitals (Oates, 1995).

The costs of operating hospitals were less than the costs of building. The sisterhoods that opened a hospital typically had ownership of the hospital, so it was up to them to figure out how to keep costs low and cover the costs they incurred (Oates, 1995). Sisters were not paid for the

work they did in hospitals, including nursing and administrative roles; they did not need the money because all their basic needs were met by the sisterhood (Levin, 2011). However, there were other hospital staff to pay, and there were supplies and equipment to buy. Sisters wanted to provide the best possible care to those they served, so they often used high quality supplies (Wall, 2011). It quickly became impossible to supply hospitals with everything they needed without charging patients for their care (Oates, 1995).

Patient payment was a matter of debate in Catholic hospitals for some time. Many saw the practice of charging patients as contrary to the charitable values Catholic hospitals were founded on (Oates, 1995). There were also concerns that if patients who were able were required to pay, then those who could not pay would be turned away in favor of those who could (Oates, 1995). However, there were benefits to asking for payment aside from lifting some of the financial burden of operating the hospital. Historically, hospitals had been utilized more by those who were impoverished and did not have homes where they could be treated by physicians, causing people to associate hospitals with the poor. It was argued that small fees for people who could pay would remove some of the stigma of poverty associated with hospital care (Oates, 1995). Patient payment eventually became commonplace in hospitals, but the poor who visited Catholic hospitals continued to be treated free of charge.

For over a century, most Catholic hospitals were owned by sisterhoods, so although a bishop needed to approve the opening of a hospital, the bishop had little or no control over the hospitals' corporate boards, and therefore had little influence over the way in which the hospital was run (Oates, 1995). However, in a male-dominated world, executive boards for Catholic hospitals were typically headed by a priest (Wall, 2011). Sisters did practically everything else

for the hospital, from heading committees and hospital units to making decisions about hospital policy (Wall, 2011).

Care Provided in Catholic Hospitals

From their creation up to the mid-1900s, Catholic hospitals were staffed mainly by sisters. They had many different roles in hospitals, one of which was nursing, which meant it was the sisters themselves who provided direct care for patients in the hospital. Care provided was both physical and spiritual in order to heal the whole person.

Physical care of the patient was the first priority of the sisters because it was only after their physical needs were met that patients could think of their spirituality (Kauffman, 1999). The physical care that the sisters provided throughout the 1800s included distribution of meals and medications (McGuinness, 2013). They could also assist patients in some simple ways, but they had little direct contact with patients; there were strict rules regarding sisters' behavior around male patients, and they could not touch men even for the purposes of taking a pulse (McGuinness, 2013). Similarly, brothers who worked in hospitals could have no contact with women. The Alexian Brothers in Chicago did not admit women to their hospital until 1962 for this reason (Wall, 2011).

Spiritual care in the 1800s differed depending on the religion of the patient. Catholic hospitals were intended to serve anyone in need of hospital care, and although they were affiliated with the Catholic Church, they attempted to accommodate a variety of religions (Kauffman, 1999). For Catholic patients, Catholic hospitals were intended to be a shelter from proselytization that might occur in other institutions (Oates, 1995). At the same time, Catholic hospitals were not intended to openly encourage conversion among their Protestant patients, although they might promote conversion in some subtle ways (Kauffman, 1999; Oates, 1995).

For Catholic patients, spiritual care included prayers and rituals. These were especially important when a patient was near death because he or she might lose faith and hope (Kauffman, 1999). Sisters would light candles, sprinkle holy water, and pray at the bedside of those who were critically ill (Kauffman, 1999). Additionally, a priest was summoned for the patient's last rites when death was expected to occur soon (Kauffman, 1999).

When a patient was asked his or her religion and replied that he or she was a Protestant, sisters were supposed to say no more about the subject and focus on the patient's physical needs (Kauffman, 1999). They did not discuss the matter of conversion, but they silently prayed for their Protestant patients to convert (Kauffman, 1999). Sometimes, they might also use religious medals to bring about a conversion; the miraculous medal, a medal of the Immaculate Conception, was placed under the pillow or enclosed in the pillow of a critically ill Protestant patient in the hopes that it would bring about a deathbed conversion (Kauffman, 1999).

Over time, care within hospitals, Catholic and secular alike, improved as advances were made in science and medicine. In the 1870s, more emphasis was placed on cleanliness in all areas of the hospital, and sterile techniques were used routinely in invasive procedures (Levin, 2011). Physicians became more involved in hospitals and used them increasingly as a place to diagnose and treat patients (Levin, 2011). Nurses began to seek more education so that they could provide their patients with better care (Wall, 2011). Overall care within hospitals improved as they became more modern, and eventually they became places to get well instead of places to be ill.

Impacts of Politics and Society on Hospitals

As America's political and social climates have changed, so have America's hospitals. Among the many events that impacted hospitals were America's wars. The Civil War had a

major impact on Catholic hospitals because there was a great need for nurses in the war, and many sisters offered their services (Levin, 2011; McGuinness, 2013). This meant that sisters returning to hospitals after the war had more experience and could better carry out their responsibilities as nurses (Levin, 2011).

World War II also impacted Catholic hospitals. At the end of the war, returning soldiers were given incentives to move to the suburbs, increasing the population of suburban areas. The Hill-Burton Act was passed, giving grants and loans to hospitals so that they could be built in the suburbs to meet the needs of the people there (Levin, 2011). Formerly, hospitals had been almost exclusively located in urban areas. In some cases, new hospitals were built in the suburbs and were affiliated with existing hospitals in the cities; in other cases, the old hospitals in the cities were abandoned in favor of the suburban setting (Wall, 2011). New sciences and technologies developed after WWII also increased the demand for hospitals as prospects of hospital care continued to improve (Wall, 2011). These factors contributed to a major increase in the number of Catholic hospitals.

The Civil Rights Movement also had an impact on Catholic hospitals, especially in the American south. Catholic hospitals had always claimed to accept any patient regardless of race, religion, income, or other factors. However, this claim was not always accurate. Catholic hospitals located in northern states were desegregated early in the 1900s; for example, Providence Hospital in Seattle, Washington, was desegregated by 1902 (Wall, 2011). Southern hospitals, Catholic and non-Catholic, were segregated until the 1960s. Southern Catholic hospitals either did not admit black patients or confined them to a separate wing, and there were rarely black staff members (Wall, 2011). Catholic sisters, some of whom disagreed with segregation, did make attempts to meet the needs of southern black communities. In 1944, the

Sisters of Saint Joseph from New York established a black hospital in Selma, Alabama (Wall, 2011). Some sisters actively protested segregation (McGuinness, 2013). In 1964 with the passage of the Civil Rights Act, any hospitals receiving funds from the government were required to admit patients of all races; hence, this was the point at which southern Catholic hospitals largely became desegregated (Wall, 2011).

The passage of Medicare and Medicaid in 1965 also had some implications for Catholic hospitals. Like the Civil Rights Act, Medicare and Medicaid disallowed discrimination in hospitals (Wall, 2011). They also increased hospitals' incomes and allowed for expansion (Wall, 2011). However, Medicare also caused some problems for Catholic hospitals. Catholic hospitals traditionally incorporated religious icons and symbolism into their decorating, but hospitals receiving Medicare funding were not supposed to place religious objects in the building in order to maintain the separation of church and state (Wall, 2011). Catholic hospitals eventually became exempt from this rule, but the religious decorations that could be seen after 1965 were not as abundant as they were before.

Influences from within the Catholic Church also greatly impacted Catholic hospitals. One of the most significant events in the Catholic Church was the meeting of the Second Vatican Council, or Vatican II, from 1962 to 1965. Vatican II caused changes in many areas of Catholic life, but the biggest implication for Catholic hospitals was that suddenly leadership positions could be filled by lay people (Wall, 2011). Prior to Vatican II, leadership positions were filled by religious sisters, priests, and bishops. After Vatican II, the laity was encouraged to fill these positions (USCCB, 2009). This was the beginning of a decline in the number of religious persons in the management of Catholic hospitals.

Organization of Catholic Health Care

Over time, Catholic hospitals have grown from haphazard establishments that appeared when they were needed to larger, systematized institutions. This has been due in part to the creation of the Catholic Hospital Association, or the CHA, in 1915. The purpose of the CHA was to help standardize care within Catholic hospitals while discouraging competition and promoting teamwork between Catholic hospitals (McGuinness, 2013). The CHA also set higher standards that improved care and offered a code of ethics for all Catholic hospitals to follow, which was originally approved in 1921 (Risse, 1999). Eventually the code of ethics put forth by the CHA became the *Ethical and Religious Directives for Catholic Hospitals*, a document created by the United States Conference of Catholic Bishops in 1949 that outlined what could and could not be done in Catholic hospitals in accordance with Catholic teaching (Risse, 1999). The ERD was revised in 1971 and continues to guide practice within Catholic hospitals (Risse, 1999).

Another aspect of the organization of Catholic hospitals is the formation of hospital systems, or groups of hospitals within a larger organization. Sisterhoods and brotherhoods that managed hospitals often managed more than one, so there was a natural progression into the practice of incorporating multiple hospitals in a system (Wall, 2011). Many hospitals transitioned from existing on their own to functioning within a system in the 1970s and 1980s (Wall, 2011). By 2001, there were 61 systems in America that were classified as Catholic health care systems (Nasalli-Rocca et al., 2003). These often included not only hospitals, but other services as well, such as hospice programs and senior housing services (Nasalli-Rocca et al., 2003). In more recent years, many Catholic hospitals have also undergone mergers in order to remain open in the competitive health care field (McGuinness, 2013; Risse, 1999).

The organization within individual hospitals changed as more lay staff acquired management positions and fewer religious persons became involved in management. The number of religious sisters has declined over the years, meaning that there have been fewer to take on the management positions in hospitals that they traditionally held (Levin, 2011; McGuinness, 2013). Since the Second Vatican Council allowed and encouraged lay people to work in management in Catholic hospitals, there became less need for the small number of sisters who remained to dedicate themselves to hospital work (USCCB, 2009). By 2011, there were no sisters remaining in hospital management in the United States as they found ways to use their limited time and talents elsewhere (McGuinness, 2013). This has contributed to Catholic hospitals becoming increasingly similar to secular hospitals.

Contributions of Catholic Hospitals to American Healthcare

Catholic hospitals have impacted healthcare in America as a whole in several ways. Two of these that can be clearly seen are the impacts on nursing and on public health policy. Catholic sisters were some of the country's first nurses and have contributed greatly to the growth of the profession. Many sisterhoods that operated Catholic hospitals saw the importance of training sisters as nurses, and as a result opened schools of nursing to go with their hospitals (McGuinness, 2013; Wall, 2011). Nursing schools associated with Catholic hospitals became better over time, many eventually evolving into collegiate programs (Wall, 2011).

Catholic hospitals have also helped in shaping public health policy in America. The Catholic Hospital Association and some of the sisters working in hospital management have become political lobbies attempting to influence policies regarding controversial issues such as abortions and assisted suicide (Wall, 2011). They have also been advocates for universal health coverage so that the needs of all people can be met in hospitals (Wall, 2011). As the focus of

healthcare has shifted to larger systems, Catholic healthcare leaders have also expanded their visions of healthcare possibilities.

Catholic Hospitals over Time

Catholic hospitals have both impacted and been impacted by trends in religion, politics, and healthcare in America. They have evolved and grown to meet the needs of different populations across the country. The number of Catholic hospitals nationwide reached its peak around 1960 at approximately 800 hospitals (Wall, 2011). Since then, there has been a slow and gradual decline. As of 2014, the number of Catholic hospitals nationwide was reported at 639 by the American Hospital Association (as cited by the Catholic Health Association, 2016). In the future, Catholic hospitals may continue to thrive and work on their missions of serving communities in need, or American healthcare as a whole may become more secularized.

Catholic Principles and Values in Caring for the Sick

Catholic healthcare is founded on the belief that we are all supposed to do good for one another and care for one another. Much of what Catholics believe about the responsibility of caring for the sick comes from lessons taught in the Bible, and while views about healthcare have changed somewhat over time, the goal of serving those in need has essentially stayed the same. Catholics value human life in all forms, and it is this value and a few other important principles that guide the missions and services provided in Catholic hospitals.

Biblical Foundation for Christian Healing

All Christians, Catholics included, are taught to show their love for God and for one another by serving the poor and the downtrodden. Throughout the Bible, there are many references to caring for those who are in need. Many important examples of this are seen in the New Testament, where it is made evident that doing a good deed for another person is the same

as doing so for God (Perrin, 2003). A particularly prominent description of the services people should do for each other that can be seen in the New Testament is in Matthew's works of mercy (Perrin, 2003; Risse, 1999). This is where Christians are told to give food to the hungry, drink to the thirsty, welcome to strangers, clothes to the naked, and visits to prisoners (Matthew 25:34-40 The New American Bible; Perrin, 2003). Most importantly for hospitals, there is also an instruction to care for the sick (Matthew 25:34-40; Perrin, 2003).

There are also numerous examples in the Bible of Christ healing. In Capernaum, Jesus healed a Centurion's paralyzed servant because the Centurion had great faith (Matthew 8:5-13). Shortly after this, he healed Peter's mother-in-law, who was ill with a fever (Matthew 8:14-15). At another time, a woman with hemorrhages was cured by touching Jesus' clothes; when Jesus realized this had happened, he told her that her faith had saved her (Mark 6:25-34). For a boy with convulsions who was possessed by a demon, Jesus cast out the demon and provided healing (Luke 9:38-42). People with afflictions of many kinds came from all over to see Jesus and experience his healing for themselves: "Great crowds came to him, having with them the lame, the blind, the deformed, the mute, and many others. They placed them at his feet, and he cured them" (Matthew 15:30). There are many other examples of Jesus healing those who were ill. For those who try to model Jesus in their lives, caring for the sick is one way to do it. The ability to cure with a touch or a word is not needed to provide comfort and promote healing in those who need it.

In addition to healing the sick, Jesus was a teacher and told people what they should do in order to live as God wants them to. One of the many stories he used to teach people was that of the Good Samaritan. In the story, a traveler is robbed, beaten, and left to die; when three men have the opportunity to help the man, it is the Samaritan who tends the man's wounds, takes him

to an inn, and provides care for him (Luke 10:30-37). Christians are encouraged to do the same, showing mercy to those on whom misfortune has fallen.

Early and Modern Beliefs about Caring for the Sick

Early on in Church history, particularly during the Middle Ages, there was some debate as to whether it was right to attempt to cure sick patients using medicine. Some religious people believed that it was wrong to attempt the use of medicine as a cure because faith alone should be enough, and the use of medicine meant that a person lacked faith (Risse, 1999). Furthermore, medicine treated only the body, and caring for the soul was what was truly essential (Risse, 1999). However, many argued against this position, saying that God had created humans who were weak in body, so He had also provided remedies and the capacity in humans to learn how to use them (Risse, 1999). Gradually, the general stance on medicine came to be that it was an acceptable practice.

With the development of modern medicine and technology, there are cures and treatments for nearly all kinds of ailments. Nowadays, there is usually no question about whether someone should receive treatment; when one is ill, one typically seeks medical assistance. Today, the Catholic Church accepts medical science as complementary to faith in its ability to mend people (USCCB, 2009). Because medicine is intended for the good of all people and seeks to free people from suffering and despair, it is seen as beneficial (USCCB, 2009).

Questions may arise, however, when an illness is terminal or there is little hope for recovery. The *Ethical and Religious Directives for Catholic Health Care* (ERD) state that while measures should be taken to preserve life, it is not necessary to take extreme measures in a hopeless situation (Morris, 2007; USCCB, 2009). Determining when it may no longer be appropriate to continue care is possible using the principle of futility and the concept of grave

burden (Morris, 2007). The principle of futility is a medical principle dating back to Hippocrates which states that if it is ineffective and life will end with or without it, then medical treatment is no longer necessary (Morris, 2007; USCCB, 2009). Physicians who are knowledgeable about the illness are able to determine when treatment is futile. The concept of grave burden is used in Catholic teaching, and as it pertains to health care, it means that while ordinary measures should be attempted, it is not necessary to use extraordinary measures to save the life of a patient (Morris, 2007; USCCB, 2009). In essence, it is preferred that at least a standard or common treatment is tried, but use of a radical or experimental procedure or medication, while also permissible, is not mandatory. Ultimately, in a hopeless situation, it is usually up to a patient or the patient's family whether care is continued or ended.

Respect for All Human Life

One of the most important concepts in both the Catholic Church and in modern healthcare is belief in human dignity and regard for human life. In the Catholic Church, it is taught that human dignity comes not from goodness or ability or any transient condition, but from being made in God's image (Morris, 2007). Human dignity is to be upheld by protecting human life in all its forms and treating all people with respect. It is also taught that human life begins at the moment of conception (Morris, 2007). These principles are important in guiding Catholic healthcare.

There are a number of procedures that are prohibited in Catholic hospitals because they go against the Catholic faith and respect for human dignity. These are laid out and explained in the ERD, and they include abortion, euthanasia, contraception, sterilization, in vitro fertilization, and artificial conception (USCCB, 2009). Any procedure that ends human life, whether it is a brand new life or a very old life, fails to uphold human dignity as defined by the Catholic

Church, which is why abortion and euthanasia are so staunchly resisted by many Catholics and within Catholic hospitals (Morris, 2007). It is also considered immoral to prevent the creation of human life through the use of birth control or procedures that cause sterilization. Life is not created solely by a man and a woman, but men and women are co-creators of life with God; to use sterilization or birth control to prevent pregnancy is to impede God's plan for creation (Morris, 2007). Instead, the Church encourages natural family planning. The use of any extracorporeal conception, such as in vitro fertilization, is also prohibited because it causes a separation between procreation and the unity attained through marriage (USCCB, 2009).

Catholic hospitals aim to uphold human dignity not only by prohibiting certain practices, but also by promoting certain approaches to healthcare. The Church attempts to promote the common good, and health is considered to be a basic human good (Morris, 2007). In 1963, Pope John XXIII listed healthcare as a right in a letter to the Church (Wall, 2011). Therefore, the Church is in favor of providing healthcare to as many people as possible and has been a supporter of universal healthcare (Morris, 2007). Catholic leaders in the United States lobby for universal healthcare at the federal level in order to bring about changes in policy that will positively affect those who do not have access to healthcare (Wall, 2011). Catholic hospitals also make it part of their missions to serve anyone regardless of age, race, religion, sex, ability to pay, or lifestyle choices. Groups who may be discriminated against are supposed to be treated without judgement in Catholic hospitals. For example, during the AIDS epidemic in the mid to late 1980s, the Alexian Brothers in Chicago welcomed AIDS patients into their hospital even when many people feared the disease and disagreed with the lifestyles of many AIDS victims (Wall, 2011). A major goal of Catholic healthcare is to reach out to the masses and promote healing and wellness in all people.

Role of Catholic Hospitals Today

The role of Catholic hospitals in America has evolved as healthcare has become more advanced. Catholic hospitals still try to maintain their values and Catholic identity, which is clear when one looks at their mission statements. In addition to following the individual objectives laid out in their mission statements, Catholic hospitals are guided by larger governing bodies. These contribute to the differences that can be seen between Catholic and non-Catholic hospitals.

Current Missions of Catholic Hospitals

While today's Catholic and non-Catholic hospitals may be similar in many of their goals and services, they differ in their motivations and the purposes that drive them. The purposes of Catholic hospitals are often illuminated by their mission statements, which give some insights as to why they do what they do and what they strive to accomplish. While mission statements may not always be lived out perfectly by hospitals, they are a way for hospitals to align themselves with the organizations by which they are sponsored, including the Catholic Church (White, Chou & Dandi, 2010). The mission statement of an individual institution or a healthcare system may also undergo frequent adjustments to better reflect the purpose of the organization as it evolves; however, over the years, the words and phrases that have been used in the mission statements of Catholic hospitals have stayed relatively consistent (Stempsey, 2001).

In a study by White and Dandi (2009), the mission statements and values statements of 50 Catholic health systems across the U.S. were evaluated and compared to see which words were the most common and which were generally emphasized the most by Catholic hospitals. It was found that the most common words within these mission statements were "health, heal, Jesus Christ, community, service, mission, and care" (White & Dandi, 2009, p. 71). The values

that were most commonly listed by Catholic healthcare systems were “respect, stewardship, justice, excellence, and compassion” (White & Dandi, 2009, p. 74). Catholic health systems were found to have very similar mission and values statements, which reflect their confluent goals of treating those who are ill within a Catholic context (White & Dandi, 2009). Their mission statements also closely matched a statement that was proposed for use in all Catholic healthcare organizations by the Catholic Hospital Association, or CHA, in 2008:

We work to bring alive the Gospel vision of justice and peace. We answer God’s call to foster healing, act with compassion, and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved, and most vulnerable. By our service, we strive to transform hurt into hope. (as cited in White & Dandi, 2009, p. 77).

This statement emphasizes many important areas of Catholic healthcare and can be adjusted by individual organizations to fit their particular objectives.

While Catholic hospitals’ goals are generally philanthropic, it is important to bear in mind that these institutions still need to function as businesses in order to remain viable. For Catholic hospitals, providing the best care possible has been a way not only of meeting the needs the communities they serve, but of attracting a larger clientele (Wall, 2011). They also incorporate marketing strategies, using their faith-based missions to draw Christians to their facilities. Within a larger healthcare field that uses competitive business models, Catholic hospitals have been forced to conform to some of the standards and strategies used in secular hospitals. However, it is emphasized that this is not the primary mission of Catholic hospitals and that other values regarding service, care, and Catholic beneficence come first (Morris, 2007).

Regulation of Catholic Hospitals

Many groups of people play important roles in governing Catholic hospitals, including the CHA, local bishops, and hospitals' lay boards. First and foremost, Catholic hospitals are owned or sponsored by the Catholic Church. In order to maintain their sponsorship by the Catholic Church and any financial aid they receive from the Church that results from this sponsorship, hospitals must adhere to specific rules and guidelines (Kutney-Lee, Melendez-Torres, McHugh & Wall, 2014). The *Ethical and Religious Directives*, created and modified by the United States Conference of Catholic Bishops through collaboration with theologians, hospital administrators, and healthcare providers, states the requirements for Catholic hospitals and provides guidance when ethical issues arise (USCCB, 2009). The bishop of the diocese where the hospital is located is responsible for ensuring that the hospital follows the directives and also has the authority to clarify the directives when disputes arise about their meaning (Stulberg, Jackson & Freedman, 2016; Swetz, Crowley & Maines, 2013; White, 2012).

Like all hospitals, Catholic hospitals have boards that oversee proceedings within the institution. In most Catholic hospitals, these boards were made up entirely of the clergy and consecrated religious until after Vatican II when members of the laity were allowed to take on leadership positions (Wall, 2011). While Catholic sisters no longer provide the same amount of oversight that they once did, some of their original missions might still guide the hospital in its current objectives, and today lay boards make the kinds of decisions that sisters used to make (White, 2012). Hospitals today also have ethical review boards solely dedicated to ensuring that nothing done within the hospital is unethical. Catholic hospitals have these boards, but they are concerned with care following Catholic guidelines in addition to following other general ethical principles (Stulberg et al., 2016).

The Catholic Hospital Association is an important organization when it comes to the regulation of Catholic hospitals because it represents all Catholic hospitals and healthcare systems as a whole and brings together hospital leaders to discuss relevant issues (White, Begun & Tian, 2006). It strives to keep Catholic hospital leaders informed about Church doctrine and hospital practices through the publication of a journal called *Health Progress* (White et al., 2006). In addition, the CHA promotes educational programs for the hospitals' staff so there is relative uniformity among Catholic hospitals (White, 2012).

In order to ensure that Catholic hospitals meet the same standards required in all other hospitals, other regulatory bodies including The Joint Commission and the National Committee on Quality Assurance oversee activities within the hospitals (White, 2012). Government policies at the local, state, or federal level may also impact Catholic hospitals (Kauffman, 1999). Although it is true that all hospitals are regulated by these and other government agencies regardless of sponsorship, Catholic hospitals and other not-for-profit hospitals must meet some additional requirements in order to maintain their tax exempt status. The expectation for charitable, non-profit hospitals is that a certain amount of their income goes toward indigent care, and any additional profit will be put back into expansion and improvement of hospital facilities, which presumably benefits the community the hospital serves (Wall, 2011; White et al. 2010).

Since the latter half of the 20th century, mergers and partnerships between Catholic and non-Catholic hospitals have complicated the regulation of these facilities. The number of hospitals that have participated in partnerships has increased over time, and that partnerships between institutions will remain an important part of hospital culture can be anticipated (Swetz et al., 2013). Church leaders have foreseen that this may cause problems for Catholic hospitals,

and in order to minimize these problems, have included a section in the ERD that addresses partnerships with non-Catholic healthcare organizations. First, it is encouraged that Catholic hospitals seek partnerships with each other before cooperating with non-Catholic organizations (USCCB, 2009). However, when collaboration with non-Catholic hospitals is the best option available, there are some guidelines for the relationships. The major requirements for partnerships include approval by the diocesan bishop and assurance that the Catholic institution will not have to cooperate in actions considered immoral by the Catholic Church (USCCB, 2009).

The ways in which some hospitals have handled these partnerships illustrates the complexity of the situation. There has been a long-standing partnership between Saint Mary's Hospital and the Mayo Clinic in Rochester, Minnesota; the fact that Saint Mary's is a Catholic hospital has placed some strains on the relationship as Saint Mary's has had to comply with rules set forth in the ERD (Swetz et al., 2013). By implementing a Sponsorship Agreement, the hospitals ensured that Saint Mary's would remain a Catholic institution and would not have to violate its Catholic principles (Swetz et al., 2013). If, in some situation, this agreement were breached and Saint Mary's became involved in activities not condoned by the Church, it could result in Saint Mary's losing the sponsorship of the Church (Swetz et al., 2013).

Another partnership formed between two hospitals in Austin, Texas in 1995 involved a more complex arrangement. When Brackenridge, a secular hospital, and Seton, a Catholic hospital, attempted a merger in which Seton would take over management of Brackenridge, they faced difficulties because Brackenridge had traditionally offered services to which the Church is opposed, namely, abortions (Wall, 2010). Church leaders could not abide by any arrangement in which abortions or other illicit reproductive services continued to be offered at Brackenridge,

although there was no other hospital in the community that could offer such services (Wall, 2010). As a solution, a new, small hospital-within-a-hospital was created on the fifth floor of Brackenridge where reproductive services would continue to be offered with no association between it and Seton (Wall, 2010). In this way, since there was no partnership between Seton and Brackenridge's fifth floor, Seton was not technically cooperating with the activities going on there and could continue on as a Catholic institution (Wall, 2010).

Differentiation of Catholic and Non-Catholic Hospitals

In today's world, all hospitals have to meet the same requirements in order to continue to function, so there is not much that distinguishes Catholic hospitals from non-Catholic hospitals. However, there are a few subtle differences that can be seen. The environment within a Catholic hospital is supposed to reflect the hospital's religious roots, so they are usually decorated with some religious symbols. Historically, Catholic hospitals were decorated with paintings, sculptures, and other religious icons with parts of the hospital looking almost like the inside of a church due to the elaborate ornamentation (Wall, 2011). In the second half of the 20th century, Catholic hospitals began to use simpler decorations including fewer paintings and sculptures (Wall, 2011). Some symbols, especially crosses, are still prominent in Catholic hospitals and remind visitors of the spiritual nature of the place, although they are not enough to overwhelm non-Catholic or nonreligious visitors.

The services that are offered, and those that are not offered, are the biggest difference between today's Catholic and secular hospitals. As discussed previously, Catholic hospitals do not offer services that violate their values of human life and human dignity. These include abortion, euthanasia, contraception, sterilization, in vitro fertilization, and artificial conception (USCCB, 2009). While Catholic hospitals forbid these practices, it is possible to find some of

them in secular hospitals. Euthanasia is illegal in most of the United States and therefore is not seen in most hospitals, but secular hospitals typically do not have restrictions on the reproductive services that they offer. In addition to refusing some services, Catholic hospitals stand out as leaders in some other areas. Many Catholic hospitals provide more pediatric and obstetric care than other hospitals, and they have been seen as leaders in palliative and end-of-life care (White, 2012).

There has been some criticism of Catholic hospitals for not offering certain reproductive services to those who need them. The Committee on Ethics of the American College of Obstetricians and Gynecologists has said that if reproductive services are refused by a physician for religious or other reasons, then the physician has an obligation to refer the patient to someone else who will provide the services (Stulberg et al., 2016). However, this also goes against what the Catholic Church allows because it is considered cooperation in an immoral act (Stulberg et al., 2016; USCCB, 2009). Physicians working in Catholic hospitals are supposed to refuse prohibited services, and they are not supposed to enable patients in their pursuit of these services by providing referrals. The reality, however, is that physicians in Catholic hospitals often provide referrals for some services, including contraception and sterilization (Stulberg et al., 2016). They are less likely to help patients access abortion services (Stulberg et al., 2016). Even if physicians are willing to help patients find other providers of reproductive services, there are places where the only providers nearby are in Catholic hospitals, which poses an additional challenge when patients seek these services.

For the most part, there are few differences between Catholic hospitals and non-Catholic hospitals. Except for the few services that are prohibited in Catholic hospitals, they are able to offer the same treatments, procedures, and amenities. Since all hospitals have to meet the same

accreditation standards, there are not major differences in quality of care. The biggest differences stem from the underlying beliefs that guide and motivate hospitals' objectives.

Evaluation of Catholic Hospitals

Today's healthcare market offers many choices for patients and their families when deciding where to seek care. Patients are able to weigh their options and find a hospital that best fits their needs in terms of services and amenities offered. Because there are so many Catholic hospitals today, one might wonder if these hospitals succeed in providing exceptional patient care. This is a difficult question to answer, but research on the matter suggests that Catholic hospitals, like all hospitals, have their strengths and their shortcomings.

Evaluation Tools

Catholic hospitals can be evaluated using a couple of different tools. One of these is the Catholic Identity Matrix, or CIM, which is a framework that Catholic hospitals can use to evaluate how well their own performance aligns with six different principles of Catholic healthcare (Kurusz, Franz & Herrmann, 2014; Swetz, Crowley & Maines, 2013). These principles include caring for the poor, providing holistic care, demonstrating respect for human life, fostering a community of work and mutual respect, effectively managing resources, and acting in affinity with the Church (Kurusz et al., 2014). Hospitals look at how these principles are incorporated in different aspects of their functioning (Kurusz et al., 2014). Scores are given for each area and hospitals are intended to use this information to determine where they could improve their services. A number of Catholic healthcare systems have used the CIM to evaluate themselves as they strive to provide the best possible care within a Catholic context (Swetz et al., 2013). These scores are mainly for the hospital's use and are not typically reported publicly for use by patients or other interested parties.

Another method of evaluation that can be useful for Catholic hospitals is the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. This is a national survey that assesses all hospitals for the level of patient satisfaction they provide based on patient input (HCAHPS, 2009). HCAHPS is useful because it is a standardized survey, which allows all hospitals to be compared in terms of patient perceptions of care, and the results are reported to the public (HCAHPS, 2009). Hospitals' HCAHPS scores are used in a number of ways, including by the Centers for Medicare & Medicaid Services to determine how much a hospital will receive as an incentive payment (HCAHPS, 2009; Kutney-Lee et al., 2014).

Patient Perceptions of Care in Catholic Hospitals

A study by Kutney-Lee et al. (2014) used the 2008 HCAHPS scores of Catholic and non-Catholic hospitals to judge whether Catholic hospitals generally had better or worse patient perceptions of care compared to non-Catholic hospitals. The overall finding of the study was that patients treated in Catholic hospitals gave very similar ratings to different aspects of their care as patients treated in non-Catholic hospitals (Kutney-Lee et al., 2014). There were a few areas where patients rated their care as slightly higher in Catholic hospitals, which included good communication between nurses and patients, helpful discharge instructions, quiet rooms, rating of the experience in general, and likelihood of recommending the hospital to others (Kutney-Lee et al., 2014). The slightly higher ratings which Catholic hospitals received in these areas are not significant enough to show that Catholic hospitals are in any way superior to their competitors, and the conclusion of this study was that the overall level of patient satisfaction in Catholic and non-Catholic hospitals is essentially the same (Kutney-Lee et al., 2014).

While some studies have shown that patient perceptions of care received in Catholic and non-Catholic hospitals are inordinately similar, it is difficult to tell whether this is always the

case because there has been very little research on the subject (Kutney-Lee et al., 2014). More research might illuminate some of the differences and similarities between patient care in hospitals with different sponsorships. However, even with more research it may be difficult to determine whether Catholic hospitals are generally better or worse than non-Catholic hospitals because ultimately patient care varies from hospital to hospital regardless of organizational affiliation. Patient care in secular hospitals can range from substandard to exceptional, and this can also be the case in Catholic hospitals. Even though the general mission of Catholic hospitals is to provide outstanding care, living out this mission is another matter, and hospitals' missions are carried out with varying degrees of success (Stempsey, 2001).

Patients' perceptions of care may also be biased based on their expectations or personal feelings toward an institution. For example, a Catholic patient who is treated in a Catholic hospital may feel that he or she has been well accommodated simply because he or she shares values and beliefs with the institution and, as a result, already has positive associations with the hospital (Kutney-Lee et al., 2014). A non-religious person might not rate the institution as highly because he or she lacks this bias. This is just one factor that complicates the evaluation of patient perceptions of care in Catholic hospitals. However, it is also something positive that can be said for Catholic hospitals; patients who want their faith and spirituality to be incorporated in their care may feel more at home in a Catholic hospital, which could be a major benefit of their continued existence today.

Meeting the Needs of Vulnerable Populations

One of the major goals of Catholic hospitals is to provide care to those who are marginalized, unable to pay, or without insurance. As hospital costs have risen, it has become more and more difficult for Catholic hospitals to provide indigent care (Swetz et al., 2013; White

et al., 2010). Some studies indicate that Catholic hospitals and other nonprofit hospitals are equal in their abilities to provide care for poor and uninsured populations; all nonprofit hospitals, including Catholic hospitals, do a better job of this than investor owned hospitals (White et al., 2006). Other studies have found that a lower proportion of Medicare and Medicaid patients are served in Catholic hospitals than in non-Catholic hospitals (Kutney-Lee et al., 2014). This could indicate that fewer low-income people are treated in Catholic hospitals, but another possible explanation for this is that Catholic hospitals instead care for the most destitute patients who do not even have Medicare or Medicaid coverage (Kutney-Lee et al., 2014). The number of impoverished patients cared for in different types of hospitals is another matter that is difficult to determine, and more research would help show whether this is an area of strength or weakness for Catholic hospitals.

Some studies have looked at the kinds of services that are offered by Catholic hospitals in order to judge whether they do enough for vulnerable populations. In order to fulfil their missions of serving those in need, Catholic hospitals should be providing services directed at people with urgent healthcare requirements, including emergency and obstetric needs; stigmatized groups, such as those with mental illnesses, substance abuse problems, and HIV/AIDS; and groups at all stages of life, including the elderly and the dying (White et al., 2006). In a study by White et al. (2006), these three kinds of services were labeled as access services, stigmatized services, and compassionate care services. The study found that in 2001, Catholic hospitals did in fact offer more access, stigmatized, and compassionate care services than other hospitals (White et al., 2006). However, public hospitals and non-Catholic nonprofit hospitals have continued to add compassionate care services at a faster rate than Catholic

hospitals, meaning that Catholic hospitals may not be the biggest providers of services for the elderly anymore (White et al., 2006).

A similar study by White et al. (2010) examined hospitals' values and evaluated alignment of the services provided with these values. A major finding was that hospitals that valued justice and compassion, including Catholic hospitals, actually offered fewer services related to justice and compassion (White et al., 2010). The conclusion drawn from this finding is that the services offered often do not correspond with the values of the hospital (White et al., 2010). A better predictor of types of services offered is the location of the hospital; in this study, the hospitals that offered the most services related to justice were those located in urban areas (White et al., 2010). This is likely because there is a greater need for services related to justice in urbanized areas, and the hospitals in these areas may not be Catholic hospitals. However, the point that is illustrated by this study is that although Catholic hospitals value certain things, they may not always be able to include their values in the care they provide.

Provision of Spiritual Care

An area of care where one might expect Catholic hospitals to excel is in spiritual care. The Catholic faith includes seven sacraments that are central to Catholic tradition and are used to strengthen one's relationship with God. One of these is the Anointing of the Sick, a sacrament that incorporates prayer and anointing with oil to bring peace and healing grace to an afflicted person (Weisenbeck, 2011). This may result in the restoration of health or be used to help prepare the sick person for death and the beginning of eternal life (Weisenbeck, 2011). The Anointing of the Sick is a sacrament that ties together Catholic beliefs and healing, and it seems natural that this and other forms of spiritual care should be readily available to patients within Catholic hospitals.

Spiritual and pastoral care are important for hospitals to include as elements of holistic care because research has found a positive correlation between spirituality and healing. A meta-analysis by Jim et al. (2015) demonstrated that cancer patients with strong religion and spirituality experienced greater overall physical health and healing. Other studies have shown that faith and religiosity have positively impacted physical health in transplant patients and have also affected pregnancy outcomes (Bay, Beckman, Trippi, Gunderman, & Terry, 2007). Because of this relationship between spirituality and health, providing spiritual care is often seen as complementary to providing physical care (Risse, 1999). Supporting patients' religious and spiritual beliefs and practices can be extremely beneficial in a hospital setting.

While religious patients may be visited in the hospital by their parish clergy, chaplains are also present in many hospitals to provide a source of spiritual support to those who may not have other clergy available (Bay et al., 2007). Many hospitals employ chaplains of different religious denominations, and chaplains, like other members of the healthcare team, may have more knowledge and experience in certain diseases (Risse, 1999). Sometimes when they are asked to visit with patients, chaplains are matched with patients not by religious denomination, but in accordance with the illnesses the chaplain has the most experience with (Risse, 1999). Caregivers within hospitals often schedule chaplains' visits for times when they may be most beneficial for patients, such as after finding out the results of a critical diagnostic test (Risse, 1999). Chaplains' visits at these and other times often involve conversation about the patients' feelings, hopes, and fears as well as prayer (Risse, 1999). It has been suggested by some research that having chaplains talk with patients changes the religious coping strategies used by patients and may improve patients' spiritual and emotional wellbeing (Bay et al., 2007).

The *Ethical and Religious Directives* emphasize the importance of Catholic hospitals meeting the spiritual needs of patients (USCCB, 2009). Despite this, there is little evidence that Catholic hospitals provide spiritual care that goes beyond what is offered in other hospitals. Provision of pastoral care is widely accepted as a beneficial practice, so most hospitals have it available regardless of whether they are religiously affiliated. Instead of being a special quality of Catholic hospitals and other religious hospitals, pastoral care is common in all kinds of hospitals. This is another area where Catholic hospitals could be distinguished from other hospitals, yet fail to stand out.

Overall Effectiveness of Catholic Hospitals

Overall, Catholic hospitals seem to be about equal to their competitors in the care that they provide. However, as a group, there is little about them that sets them above the rest in terms of patient perceptions of care, services provided to poor and vulnerable populations, and inclusion of spiritual care. There may be some areas where Catholic hospitals have a slight edge, such as in their ability to make Catholic patients feel at home or in the provision of access, stigmatized, and compassionate care services (Kutney-Lee et al., 2014; White et al., 2006). Nonetheless, they should find new ways of serving their patients in accordance with their missions if they are to maintain a unique, faith-based approach to healthcare.

Conclusion

Catholic hospitals have a long history as a crucial part of American healthcare. They have spread to meet the needs of the people they serve and evolved to continue providing care at optimal levels. While they are in most ways indistinguishable from other types of hospitals, the missions that drive them continue to reflect their religious roots, and they follow strict guidelines in the care that they provide in order to live up to their high ethical standards. It is impossible to

predict what the future will hold for these hospitals. It is possible that they will continue to thrive and provide necessary care to the populations they venture to serve. It is equally possible that the things that make them different, especially in regards to services they do not permit on ethical grounds, will cause them to disappear over time in a world that seems increasingly secular. Time will tell how Catholic healthcare advances.

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