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# Scope of Excellence: For All Patients

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# SCOPE OF EXCELLENCE*

## For All Patients

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The Conference's theme, *Pursuit of Excellence*, implies not only awareness of need to maintain the kind of standards that safeguard the living but perhaps eagerness to strive well to increase standards of patient care. But whatever the kind of excellence being pursued in hospital practices, and however its scope for all patients, ill or well, I shall use it to mean the proud fulfillment of performances with standards as high as the degree of knowledge and morality allows. Thus excellence is an intellectual and moral fulfillment,[1] proof of the principle that what one does for God and in service of man, one may do with quality and sense of distinction.

### SAFEGUARD OF PATIENTS

Safeguard of all patients is a hospital's moral and intellectual responsibility. This is a fundamental ethical fact and neither presupposes, nor oversimplifies, nor overassesses the kind of concern for all human-beings (regardless of color and age) as a means of doing something excellently. Thus in the scope of excellence, our attitudes and practices concerned with patients become right or wrong only in relation to the good for individual patients—not just medical good but also moral and social good.

Hospital attitudes and practices respecting human-beings are fulfilled in a variety of individual ways: from the gentleness of admission clerks and the courtesy of maids and porters to the validity of concern of nurses and supervisors. Excellence also is the sense of compassion of physicians, and of understanding by laboratory and technical personnel. And it has to do with the humaneness of hospital cashiers. But excellence for patients may be determined not by the complexity and number of diagnostic procedures but also by the simplicity and effort of diagnostic thought, not by undue and unwarranted periods of hospitalization but by the brevity, indeed the certainty of need, of hospitalization, and not by the use of needless and extraordinarily expensive therapeutic drugs but by the use of specific products (which often are the least costly)—and all with a humble respect for the special healing value of human understanding and kindness.

However idealistic, the foregoing notion of excellence aims

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simply to fulfill what is best and right for human-beings who happen to be sick and thus be our patients. But mere *talking* excellence will not create it, nor will mere pursuit; it must be captured, and then expressed in ways which are practical and real. This, of course, may be one of the reasons why there is an eternity. Nevertheless, in order to try to express excellence in ways practical and realistic for patients it often is necessary for us first to know ourselves better, and reappraise and study our own personal attitudes and practices, both old and new, that relate to patients and their care. For the value of excellence, however few who actually achieve it, is finally measured not by words but by the humble Socratic attitude: "I know that I do not know."[3] This attitude is significant, not because of its negative implication but because of its positive effect. Nor is the importance of excellence gauged primarily by intellectualism; in the long run it is determined by the kind of discipline and tenacity[4] that permits one to question and to know and understand, and to advance and raise standards—an obvious contrast to efforts that stifle excellence and to alien viewpoints of compulsive fear that everyone's fate already is sealed by the probable effects of full-blown nuclear diplomacy or lost by the dread effects of programs of papal social justice which smother individual and collective aptitudes and destroy personal initiative and rights.

#### ECUMENICAL DIALOGUE

The very heart of Catholicity permits and encourages excellence, and in order to achieve it, allows hard questions about its practices and responsibilities and permits opportunity for reform and innovation. To use an analogy, the Church, however infrequent in its long history, has held historic ecumenical councils, bringing about major adjustments, reform and innovation. At the Second Vatican Council, the first in almost 100 years, Bishops from every part of the world, in the context of a complex modern era, gather and "consider in particular," in words of His Holiness Pope John XXIII, "the growth of the Catholic faith, the restoration of sound morals among the Christian flock, and appropriate adaptation of church discipline to the needs and conditions of our times."[5]

The Church's spirit of ecumenism is of universal character. Thus it is above national and provincial interests. Nevertheless its work in Ecumenical Council is the clarification of the Church's place in modern life. But the spirit of ecumenism also is born and reared in our neighborhoods and in our hospitals and lecture-rooms. Hardly a day goes by that there is not opportunity to see our practices and attitudes through the eyes of others. And even more importantly, so that these opportunities may be worthwhile, hardly a day passes that there is not a chance to use the technic of dialogue as a means of understanding and of bringing about understanding. Dialogue, regardless of circumstances, simply is a profoundly useful way whereby persons come together and learn to know as others know, as others live, as others think, and as others understand. When carried out in an atmosphere—these are stern requirements—of intelligence, tolerance, mutual respect and confidence, the law of dialogue permits truthful communication and knowledge—not only between religious leaders and between Catholics and non-Catholics, or between administrators and nurses, physicians and patients, and teachers and students, but also between all human beings.

In ecumenical dialogue on Christian beliefs, for example, it would be well for me to try to know what Protestantism is, but even more importantly what it is not. And if I know not whereof I speak, I should not jump into the very depths of theology and of doctrinal differences and shake thereby the ecclesiastical timbers of the Ordinary's office. And similarly in dialogue concerned with excellence, it would be well for me to know what excellence is and what it is not; that of which we may easily speak is not always practiced. The law of dialogue is personal contact,[6] and personal give and take. And it is equality, not superiority.[7] It simply is to listen and be heard when speaking. It is not advice, exhortation and theory, nor is its purpose to win argument, nor in religious discussion to gain converts. Indeed, dialogue is the kind of bond of communication in our professions which allows physician and nurse alike to construct a bridge of trust and understanding between themselves and their patients. It is the kind of two-way relationship that permits a child's faith in his physician and nurse to depend not falsely on distrust and threat of punishment but simply on belief in our honesty and in our ability to talk and communicate at his level of understanding. It also is the kind of attitude that may allow us to respect and admire a Jewish youth as he explains well his Jewish belief and holidays. It is the kind of atmosphere that permits me with medical students to discuss that the life of a human-being begins not at 40 nor at birth, but at conception, and thus, even though a two-month fetus looks scarcely human, I cannot suggest taking its life.

Communication between human-beings is difficult. Electronic devices of various kinds may communicate the beep-beep-beep of messages originating thousands and thousands of miles away, yet human-beings can hardly talk to one another without misunderstanding and misinterpretation. Some of us hardly communicate at all, or we practice the fallacy of the extreme judgment, or the easy answer and the pat answer. To a two-year-old child in the hospital who cries repeatedly that he wants his mommie, and we repeatedly reply, "Your mother will return in 30 minutes," our answer is easy and pat but unrealistic. A two-year-old wants his mommie now, yet he has no concept of the meaning of time, thus no comprehension of our reply. The problem here is not that the child is willful and spoiled, or that he does not trust us, but that we do not understand him. Or to tell repeatedly a young woman with cycles of deep-entrenched fear and apprehension that she only needs

'more faith' is neither dialogue nor helpful advice; atheists may never know fear and apprehension, but saintly persons may repeatedly know it.

Communication between human-beings, whether concerning Christian reunion and unity or concerning quality of interpersonal relationships often is far more difficult when accompanied by powerful emotional stakes in one or another outcome. At times we physicians may be the worst of all because the law of dialogue requires that communicative exchange be carried out in good faith and with piety, neither in suspicion nor in pettiness. Irenic talking and listening involve open-minded inquiry. Thus dialogue indicates intellectual and emotional maturity. And it is scientific because it leads to the prodigious seeking of facts.

#### SELF-CRITICISM

Although the foregoing are qualities for effective dialogue, self-criticism is the key to successful dialogue. But self-criticism is difficult. Yet it is one of the keys to successful ecumenism. It also is one of the means that leads to ways to capture and express excellence in hospital and medical care. This puts an obvious obligation on the Catholic hospital because, like the Church, its principles are well-suited not to provincialism and mediocrity but to ecumenism and excellence. Ecumenism involves all people, and the Church establishes the pattern for successful ecumenism. Moral-medical excellence involves all patients, and the Catholic hospital should establish the pattern for moral-medical excellence.

But there are old and new criticisms of Catholic hospitals. Despite the role Catholic hospitals have generally played in holding strongly to the goal of principles of moral excellence, there is the criticism that they have assiduously and paradoxically copied the worst features of secular hospitals: unnecessary hospitalization, impersonal attitudes which dehumanize human beings, unjustified diagnostic tests, nonindicated medical treatments, and unwarranted surgical procedures, or indeed, the very failure even to meet minimal hospital standards of a professional sort. And too there are Catholic hospitals that refuse to hospitalize and care for human-beings who happen to be non-white. But it would be well to note that when some of these practices exist, although approved secondarily but responsibly by the governing boards of the hospitals, they often are primarily the practices and attitudes of the medical staff. It would also be well to note that even though Catholic hospitals are noted for their well-entrenched ideas about sterilization, abortion and euthanasia, I should reply that these are neither the ideas, nor the moral doctrines of Catholic hospitals, nor even of the Catholic Church primarily, they are simply the moral doctrines of God. Thus, excellence for all patients — the fulfillment of what is intellectually best and morally right for each patient — depends not on how few hysterectomies are scored on the hospital's annual report, nor on the absence of direct sterilization and euthanasic practices, but on the quality of standards of medical and surgical practices and of social and moral attitudes which concern all human-beings.

In his book, *Morals and Medicine*, Reverend Joseph Fletcher, Professor of Pastoral Theology and Christian Ethics at the Episcopal Theological School in Cambridge, Massachusetts, writes: "There is practically nothing in the teaching of Jesus about the ethics of sex. He said nothing about birth control, . . . fornication and premarital sexuality, sterilization, artificial insemination, abortion and the like."[8] Mr. Fletcher also states he does not hold that "the foremost concern of the Christian ethics is with souls, that the soul is a 'supernatural something' made for heaven and eternity."[9] Indeed, his view is just the opposite; he puts "the priority on personality, and frankly views with skepticism the claim for a soul . . ."[9] "The very word 'soul'," according to Mr. Fletcher, "is in the same dubious, murky condition that we have found in the term 'natural law'. It is too obscure . . . to deserve any further use in either common-sense or Christian ethics."[10]

One of the confused concepts of our society is that identifying morality with religious practice. Yet neither Calvin nor Luther nor even Fletcher guide and teach on the morality of issues in medical and hospital care, thus one of the reasons why a system of medical morality is needed. It also is the reason why, in an age often offering no hope of a moral future, the Catholic hospitals, perhaps like the monasteries of old, must keep alive the moral laws of God and show those around them the purpose of a spiritual way of life. As Chesterton — I paraphrase him — put it aptly (he often put things aptly), "I need not the help and guidance of a system that is right when I am right; I need it when I am wrong."

#### ALOOF AND EXCLUSIVE

Imagined or real, there exists an image that Catholic hospitals are aloof and exclusive, or worse still, dominated and controlled by the clergy and Bishops as part of a great authoritative monolith called "Romanism." Thus Catholic hospitals are hierarchical and a dangerous threat to everyone around them. Now nothing tends to arouse more antagonism than the notion that someone is aloof and exclusive. But if we are, and wholly uninterested in those around us, or if confused notions about our hospitals still exist, we should talk to one another. But, "to talk to each other," Father Gustave Weigel obviously reminds us, "we must come together for conversation. Good conversation requires sincerity on the part of the speaker. Evasiveness and ambiguities do not make good talk."[11]

But often there is not the notion that Catholic hospitals are aloof but actually a respect of the inexorable, deep-seated logic and, above all, the sense of timelessness of the religious. Indeed there also is the objective knowledge that any complex organization must be more or less hierarchical. Nevertheless it is well for us to know if we are really aloof or not, or convincingly ego-

tistical towards those around us, and show a way and manner toward non-Catholic patients clearly different from that noted toward Catholic patients. After all, there are Catholic persons who think that only non-Catholics ever receive any of our professional attention and personal consideration. But what really is our ecumenical attitude toward a hostile patient who happens also to be a Jehovah's Witness. How Christian is our concern for human-beings who really put to test the concept of right of individuality of conscience. Or are we far more Christian, kindly and ecumenical toward the patient who is the town's leading Catholic, or toward the ideal patient who is not sick and has no complications, and bothers neither nurse nor physician except to thank them profusely for the generosity of their kind and humane attention. Despite the miracles of our scientific and intellectual skills, is not the whole purpose of hospital and medical care lost if we don't convey to our patients, regardless of their belief, financial holdings, — yes, even their color — the kind of spiritual challenge which is the very core of Christian ecumenism and excellence?

The spirit of ecumenism is not to foster a state of separateness, it is to promote reunion. The spirit of excellence is not to hold weekly novenas on the hospital lawn, nor to attain states of continuous mental prayer while ignoring the needs of patients, but to show with warmth and feeling and interpersonal vitality the importance of good example and model in fulfilling works of corporeal and spiritual mercy.

Persons outside Catholic hospitals may not accept Catholic hospitals, but they expect more of them — that they should not only show the scientific gains in medicine but also be the summit of all gains in human and spiritual understanding. Persons outside Catholic hospitals may distrust them, and even think the Sisters are something scarcely normal or human. For there also exists the curious notion that non-Catholic patients in Catholic hospitals are regarded as adversaries of Christ and must consequently be captured and pressed into conversion. Such notions express provincial understanding — a limited provincialism at that — and are a caricature even of the attitudes of a distant ancestor. At times, however, such notions are the paradoxical expression of what really is felt — trust and confidence, and indeed, because of the religious in the hospital, the kind of responsibility, selflessness, lofty purpose and saintly attitudes that are the very means of helping innumerable persons recover their life's purpose — not by imposing a belief on them but by understanding them through dialogue and example.

#### THE NEED

Catholic hospitals are not strangers in our midst, but in our midst are strangers to the once glorious tradition of Catholic hospitals. The oldest in Christendom, they are medicine's forefather. Indeed, in early times both hospitals and most universities and medical schools were under Catholic religious auspices. But custom and practice change. Now Catholic hospitals and medical schools, however excellent their leadership in the ancient moral issues of contraception, sterilization and direct abortion, no longer are great leaders in medical care and learning. Indeed, today the need for initiative in the Catholic medical world is crucial. There is need to recapture the sense of medical and educational mission which survival itself may demand. There is need for Catholic hospitals to strike out in full ecumenical spirit and define new goals, innovate new practices and establish new concepts in an era of intense scientific activity in medicine and hospital care. Should Catholic hospitals not repursue and capture their past roles in medical and educational achievement, and in a partnership of moral and intellectual excellence assume the responsibility of guiding and controlling the enormous power of medical technology and science. Or do Catholic hospitals dare to become involved in a new age in medical history and by the eternal standards of right and wrong, make themselves heard in the needs of mankind? Excellence is an idealistic goal. But few really pursue it, let alone achieve it, Nor is it thrust upon us, it must be worked on and fostered. More importantly it must be insisted upon.

But Catholic hospitals are rich in educational opportunity; and the extent and vitality of their richness should not be underestimated. Catholic hospitals, as a source of wondrous good in medical education and in training, would be capable of raising standards in medical care. Indeed, there are opportunities in general hospitals that provide the kind of wisdom born of experience and ethic which often is beyond that gained in elementary ways in medical schools and in university or medical center hospitals.

Medicine now is in an era looking to the social and behavioral sciences, and also to moral science, for knowledge and guidance to help explain man's health. Medicine again is pointing up the need to stop the present fragmentation and specialization of human-beings either by part or by disease. Not only is there great universal need to put fragmented religions back together again, there also is great ecumenical need to put man back together again, and in our hospitals bring about a reunion between patient concern and medical education. Medical research is necessary and important to medicine, but patient care is the keystone to medical learning. Indeed the need is great to accord the teaching and study of patient care the same priority hitherto accorded research in fundamental mechanisms of disease processes.

The Catholic hospital is uniquely suited to programs of this kind. But a stout barrier — part real and part unreal — is said to exist between Catholic hospitals and medical education, and between Catholic institutions and secular institutions. This barrier may in part exist because of a supposed dichotomy between Catholicism, humanism and science. But real science is neither anti-humanistic nor anti-Catholic. Nor is humanism and Catholicism anti-scientific. Humanism and Catholicism and sci-

ence are complimentary; there need be no alternative. There need not be the plight of decisive choice that faced the worldly young monkey who escaped from the zoo and was found later by his keeper in the city library reading both the *Bible* and Darwin's *Origin of the Species*. His question of the zoo keeper was this: "Am I thy brother's keeper, or, am I thy keeper's brother?"

Inside hospitals the most intimate activities embrace all people and have to do with medical welfare and also with spiritual, social and cultural welfare. And humanistic physicians and scientists are fully capable of perceiving and appreciating and of effecting the kind of social and religious values which are important to human-beings; indeed they are being called upon more and more "to help make policy decisions of great social and moral consequences."[12] Thus, in its purest way, however applied to the intellectual, social and scientific advances of society, the extent of excellence achieved by a culture ultimately depends upon society's scholars. And the extent of excellence achieved by a hospital for all its patients ultimately depends upon the hospital's medical and scientific scholars.

Therefore, each Catholic hospital should play a role, however individual its separate role, in bringing about harmony in medicine, education and science, and in integrating doctrines of morality with doctrines of medicine and science. But Catholic hospitals face a problem. The problem is not of morality taking over where science and biology end, nor of staking out doctrinal claims only in areas where medical science is ignorant or nonexistent. Nor is the problem simply one of Catholic hospitals tolerating, or living in fear of the material advances taking place in medicine and medical science. The problem is whether the Catholic hospital is going to participate actively in medical education programs and in scientific activities, and in addition contribute adequately to them.

#### REFORM AND INNOVATION

Today's challenge is exceedingly great — what is the Catholic hospital's effort in educating and training a scientific breed of physician caught in the inexorable bind of his material and biological self, even his psychological self. What is the Catholic hospital's effort in medical education in interpreting — not subjectively to our individual selves, because in our exclusiveness we know this well — in imaginative and in inspiring ways the modern age of nuclear and genetic medicine. Is there not need for an ecumenical attitude — in the full spirit of ecumenical reform and innovation — to self-criticize well, and above all, not to abandon what we know and teach well but also to be enthusiastic for what is new and unknown.

How might the foregoing be achieved in a time of changing concepts of medical thought and practice? Not by today's programs that train intern and resident physicians unless these programs undergo total renovation. Nor simply by labeling hospitals major teaching, minor teaching, or non-affiliated. Modern hospital administrators know well the beneficial role of learning and teaching programs and of research activities in hospitals, but they must depend on their medical staffs for the strength, as well as the weaknesses, of these programs. Therefore the nature and extent of training plans often finally depend on the motivation and experience of the medical staff. But one just doesn't decide to establish a training program; indeed the creative process may be long and evolutionary, growing sometimes by plan, and sometimes by accident.

Nevertheless educational exchange is the kind of dialogue in medicine that is the lifeblood of a hospital. The result often is the kind of contagious standard that spreads throughout an organization, stirring the air, invigorating attitudes and practices, and strengthening patient care programs. But educational exchange can be bought neither by salary nor by fringe benefits. Neither can it be purchased by the program of a paper organization nor by a program of rote service to staff physicians; it can be bought only by opportunity for quality training.

In medical education there is a diversity of learning programs. There also is a diversity of hospitals and physicians to provide the learning and training opportunities. Each, however, should develop its own individuality, and in its individualism strive for excellence in a context of usefulness for all. This is one answer to the obvious need to avoid and also decrease the needless duplication of separate programs and facilities. In addition, it puts to advantage all the obvious but natural differences which exist between hospitals and between physicians, thus one of the simplest means of achieving unity of excellence in a framework of diversity.

In recent years more and more young physicians have sought their training in university and medical center hospital programs; there is full awareness of the advantages and disadvantages to this trend. The competition for house officers, between all hospitals, indeed between medical centers, is real, and however unfortunate, more and more general hospitals, both secular and religious, have abandoned their unfilled training programs and relinquished this responsibility to those hospitals and institutions oriented to a spirit of training and learning.

#### TRAINING AND LEARNING

In medicine there is an enormous need to put man back together again; this is part of medicine's challenging future. Both patients and our religious have said for years and years: reclaim in medicine man's social, moral and spiritual being. The Catholic hospital is eminently suited to this task. Therefore it is uniquely suited to establish in medicine the kind of training programs in family medicine and practice that actually claim a right to the wholeness of man. There are medical students and interns who want to practice this kind of medicine and provide their patients continuous and personal care, and would serve in hospitals providing a training ground thought out well, and organized and geared to quality.

And really effective training and learning of this kind should be conducted in the general hospitals. But few places today are well-suited or well-established to this purpose. Most university and medical center hospitals are not primarily suited to this task.* This does not mean a lack of interest in patient care; it means a lack of experience in patient and family care and an emphasis primarily on elementary foundations of medicine and the advanced specialty training programs.

The general hospital, on the other hand, is oriented well to individual and to family and community health problems, and is uniquely situated to integrating and applying not only elementary medical knowledge but also advanced specialized knowledge relative to mankind's changing health problems. This is a marvelous way for a general hospital, Catholic or not, to bring home to physicians (student and intern and practicing physician) one of today's gravest problems — the problem of fragmented medicine — and give them realistic training in holding it together. I speak not *ex cathedra,* but a school of medicine with a department of family medicine chaired and staffed by physicians competent in this phase of medicine would bring about an educational affiliation between the university and hospital and also draw upon the sources of wisdom and experience of each group regardless of geographic, religious, and secular boundaries. It would allow the fulfillment of a well-recognized need for individuality and of differentiation of interest, capability and function among hospitals, as well as among physicians. The responsibility of all hospitals and physicians, after all, is the same; merely the emphasis is different. Therefore it would seem both timely and realistic for Catholic hospitals not merely to stress a philosophy of health care that integrates social, spiritual and psychological care with medical care but indeed to consider in their health services those roles challenging to their ecumenical spirit and their imaginative spirit.

* Harvard Medical School recently announced a training program for family practice at the Children's Hospital Medical Center and the Boston Lying-In and Peter Bent Brigham Hospitals.



### NEW ROLES

Today's health problems at first glance are paradoxical but they merely may reflect the changes of medical civilization. There are less and less acute illnesses but more and more chronic illnesses, and less and less mortality but more and more disability. In addition, and however unfortunate, hospitalization is apt to be decided more and more by the patient and his insurance coverage, and less and less by the physician and the patient's illness. But chronic disability and illness are limited neither to the old nor to the young; over half these persons are under 45 years of age. Yet, as medical and hospital care has assisted the prolongation of lives, neither physician nor hospital should want to fail in responsibility to habilitate those lives. Disabling illness, both physical and mental, creates a need for new ways of living, and opens up whole new roles in the medical, social and vocational aspects of health care. But extraordinarily few hospitals have the kind of habilitation services that help disabled capable persons in new ways of life, or train professional persons in ways providing increased medical care outside hospitals. Yet these very roles are uniquely suited to the heritage of the thinking of Catholic hospitals: the idea of innovation and helping those in most need. The Catholic hospital is a hospital, but it also is a religious hospital; its attitudes should be those of full esteem and consideration for all patients.

More and more hospitals, however, are modeled after hotels with diagnostic laboratories running hot and cold. But however long-standing the need to fulfill total responsibilities in medical care there also is a desperate need to reserve hospitals for patient care, in particular for the care and treatment of persons requiring hospital facilities. There is need for hospitals and physicians to come together and reclaim their rights, and in order to fulfill better their total responsibilities in medical care, to emphasize that most sick persons, and obviously those well patients obtaining diagnostic studies, often are better cared for not in hospitals but in the home. However handicapping illness and disability, there are ways of caring for the sick — the aged and the young alike — in the home so that often both the patient and family fare better. Indeed, with teams of nurses, and perhaps of medical students and intern physicians, under hospital auspices and senior medical supervision, home care programs serve also to guide and educate the patients' parents, children, and relatives in home and family responsibilities and stimulate thereby a sense of family duty and compassion.[13]

Responsibility is clearly an individual matter, but individuality is clearly a responsible matter. Innumerable hospitals will never participate in self-learning and teaching programs of any kind, nor establish nor even continue training programs for interns and residents. The monthly staff meeting may be the fullest extent in educational achievement. Hospitals, however, are fully capable of educational achievement in other areas. Visiting physicians, individuals and teams, may be invited to hold conferences, rounds and "think sessions" and carry out— in the context of dialogue — a useful role in continuing medical learning. Another hospital might establish a selective field in medicine or basic clinical and fundamental investigation and allow it to achieve such excellence that it and the hospital would not only attract research fellows but provide the foundation for advanced fellowship training in other fields of medicine. A department or institute of genetic medicine, for instance, because genetic knowledge is enormously important and complex, would be an area, perhaps thought unusual at first, in which the Catholic scientist, hospital and physician could become an established authority and a source of immense usefulness to physicians and the community. After all, a Catholic monk started the whole business of the Mendelian law in genetics.

## CONCLUSION

Opportunities for exploring ways to fulfill excellence for all patients are innumerable, but does the Catholic hospital dare to get involved? Does it dare recapture its early spirit and make itself heard in the forthcoming needs of mankind and of science? Does it dare integrate Catholic thinking with that of medicine and science? I should hope that in full ecumenical character of the times, together with the motivation of medical staffs — in the context of ecclesiastical authority — and in dialogue with experienced medical educators, the Catholic hospitals would seek out ways, both old and new, to increase the utilization of the richness of their tradition and belief, and thereby not only pursue excellence but express it in ways finally real for all patients.

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