Brands and Religion in the Secularized Marketplace and Workplace: Insights from the Case of an Italian Hospital Renamed after a Roman Catholic Pope

Abstract

Religion is considered a cornerstone of business ethics, yet the values held dear by a religion, when professed by business organizations serving heterogeneous market segments in secularized societies, can generate conflict and resistance. In this paper, we report findings from a study of stakeholder reactions to the renaming of an Italian public hospital. After the construction of new facilities, the hospital was renamed for the recently canonized Roman Catholic Pope John XXIII. Contrary to expectations, we found no evidence of public criticism surrounding the name change. A fine-grained analysis of a sample of 734 respondents belonging to different stakeholder groups revealed that consumers (patients and citizens) predominantly supported the name change, while employees were often critical and concerned about possible religious influences on medical practice and scientific research. Moving beyond our empirical setting, we propose a process model of brand-religion alignment inspired by McCracken's (1986) meaning transfer model, which considers both the alignment process and its reception by relevant audiences. The study also presents managerial implications useful for those brand managers who wish to create effective, respectful links with religion.

Keywords: Catholic Church; hospital; marketing; Pope John XXIII; religion; renaming

Introduction

In 2013, the name of the hospital complex formerly known as Ospedali Riuniti di Bergamo (United Hospitals of Bergamo, in northern Italy) was changed to Azienda Ospedaliera Papa Giovanni XIII, in honor of one of Bergamo's most illustrious citizens, Angelo Giuseppe Roncalli (1881 to 1963), who later became John XXIII, the 261st Roman Catholic pope. In a still predominantly Catholic but increasingly secularized country such as Italy, whose republican 1946 Constitution sanctions separation between state and church, one might expect controversy around such a decision. Yet, contrary to expectations, our preliminary investigation of relevant documentation and media discourse revealed no signs of opposition to this decision. However, our subsequent investigation of consumers' and other stakeholders' reactions to the hospital's renaming – which were overwhelmingly favorable – identified concerns from doctors and other hospital workers worried about possible Church interference in the conduct of the hospital's scientific research and medical practices.

The case of the Papa Giovanni XXIII Public Hospital raises several issues at the intersection of marketing, religion, and business ethics in secularized societies. Religion is often considered a cornerstone of business ethics (Hunt and Vitell, 1986, 2006; Vitell, 2009; Weaver and Agle, 2002). Organizations can align themselves with the tenets of a specific religion and can build a corresponding market presence (Izberk-Bilgin, 2012a, 2012b; Mazumdar and Mazumdar, 2005). However, the values held dear by one religion, when professed by business organizations serving heterogeneous market segments, can generate protests and even boycotts (Al-Hyari et al., 2012; Shamir and Ben-Porat, 2007; Swimberghe et al., 2011). In the specific context of health-related issues, the Roman Catholic Church has long been associated with the provision of healthcare services but, at the same time, some of its teachings oppose medical practices that are legal in many countries and supported by the medical profession and health organizations (e.g. abortion, use of contraceptives,

extraordinary life-saving measures, embryonic stem cell research, and euthanasia) (Corbellini, 2007; Vanderpool, 1980).

However, our case study shows that, even in secularized contexts, alignment with the tenets of a country's most professed and practiced religion can be widely supported and can thus further brand legitimacy. We found that consumers and other stakeholder groups interpreted the hospital's name change, which was accompanied by a re-engineering of activities and the inauguration of new facilities, as a quality signal and a tribute to a fellow citizen whose human qualities, despite being grounded in Catholic ethics, can be seen as universal and likely to inspire better healthcare with a human touch, benefitting everyone, independent of religious considerations. Based on our emergent findings, we propose a process model of brand-religion alignment grounded in McCracken's (1986) meaning transfer model, which considers both the alignment process and its reception by relevant audiences, and highlights managerial implications for brand managers on how to create a link with religion in an effective and fair way.

The remainder of this paper is structured as follows. We begin by reviewing relevant literature on religion in business ethics, marketing, and consumer behavior, noting the dearth of research on the business ethics implications of organizations' religious associations. Next, we contextualize our study by examining the age-old relationship between religion, medicine, and healthcare with a particular emphasis on the role played by the Catholic Church over the centuries, and providing background information about Italy's healthcare system, the Azienda Ospedaliera Papa Giovanni XXIII, and Pope John XXIII. We continue with a methodological section where we report data gathering and analytical procedures, followed by research findings, which detail reactions to the hospital's name change by a sample of 734 respondents belonging to different stakeholder groups, namely patients, employees, citizens, and suppliers. We conclude by discussing our findings and their theoretical and managerial

relevance, addressing implications for scholarship in business ethics and marketing, and by highlighting our study's limits and directions for future research.

Literature Review: Religion and Business, Marketing, and Consumer Ethics

Religion, business, and consumer ethics

Scholars have long been concerned with religion's impacts on the conduct of business. The seminal works in this area are Max Weber's sociological analyses on the role of religious values in the development of capitalism. In his widely cited *Protestant Ethic* (1905), Weber observed that Northern European countries that had been through the Reformation had higher economic growth rates than the rest of Europe, which he linked to some aspects of Protestant (particularly, Calvinist) theology. His later, lesser known work on the interactions between religious ideas and economic development (Weber, 1951, 1958) further examined how certain aspects of Confucianism, Taoism, Buddhism, and Hinduism worked against the development of capitalism in China and India.

Business ethicists later joined this conversation by noting that religion, whose tenets provide individuals with cognitive resources for distinguishing between good and bad, affects ethical decision-making and conduct in the case of both businesses and consumers (Hunt and Vitell, 1986, 2006; Vitell, 2009; Weaver and Agle, 2002). Normative works in this area describe how to deal with ethical dilemmas based on the teachings of specific religions (e.g. Caccamo, 2009; Fam et al., 2009; Friedman, 2001; Gould, 1995; Pava, 1996, 1998; Piker, 1993; Rice, 1999; Williams, 1993). Empirical research has, instead, analyzed the multifaceted ways in which religious values affect the ethical beliefs and conduct of individuals (e.g. business leaders, workers, and consumers) and organizations (for a recent review, see Vitell, 2009).

However, little work has shed light on the fact that religion can divide rather than unite; a fact with a raft of implications for business ethics. At a general level, managerial decisions influenced by the tenets of one religion may clash with the tenets of others, boosting tension or resistance inside and outside the organization among consumers and other stakeholders. In one of the very few empirical papers on the topic, Swimberghe et al. (2011) show that religious consumers can engage in activist behavior and can boycott participation against companies that adopt decisions (e.g. support of gay rights) considered to be in contrast with their religious values. The case of consumer boycotts influenced by religion might be a (perhaps extreme) example of how religious values held by some consumers may affect the conduct of secularized businesses. Less is known on how brands might align with religion and how consumers and other audiences might react to such alignment.

In the next section, we turn to literature in marketing and consumer research that has analyzed how religion, marketing, and consumption interact. While such literature seldom highlights the implications for business ethics, it provides a theoretically informed basis for an analysis of brand-religion alignment in secularized marketplaces.

Religion, marketing, and ethics in a multicultural and secularized world

In this section, we review relevant research streams at the intersection of religion, marketing, and consumption with the help of the framework reported in Figure 1 (adapted from Rinallo et al., 2012a), which is based on the two key processes of the sacralization of the profane vs. the marketing and consumption of the religious (see Belk et al., 1989), and further distinguishes the key actors behind market exchanges (i.e. consumers vs. marketers). While developed outside of business ethics, the research reviewed here addresses issues that are relevant for a more thorough understanding of the sometimes peaceful, sometimes

troubled role of religion in the marketplace in a globalizing and increasingly multicultural and secularized world.

- Figure 1 about here -

On the consumption side, scholars have noticed that in secularized societies, needs previously ascribed to religion are increasingly satisfied by the consumption of profane goods, services, experiences, and brands (Belk et al., 1989; Shachar et al., 2011; see Rinallo et al., 2012a, for a review). As a whole, such work support the perhaps counter-intuitive view that religiosity can flourish in consumer culture (a point shared by work on the theology of popular culture) (e.g. Lynch, 2005) and pave the way for empirical investigation of the influence of profane brand religiosity on consumer ethics.

Although religion is often mediated by material culture (McDannell, 1998a; Morgan, 2010), the *consumption of the religious* has received little attention in marketing and consumer research to date (Iacobucci, 2001). For instance, empirical research on the consumption of religious artifacts is still very limited; exceptions include Higgins and Hamilton's (2011) analysis of the crucifix as a vessel for building a connection with God through consumption as well as Rinallo et al.'s (2012b) similar work on the rosary. In contrast, sacred spaces such as pilgrimage sites and the consumption practices around them, from shopping to gift-giving, have received considerable attention (Higgins and Hamilton, 2014; Moufahim, 2013; Scott and Maclaran, 2012; Turley, 2012; Kedzior, 2012). While not usually discussed in terms of consumer ethics, the consumption of the religious is sometimes criticized. Whether considered to be religious kitsch and in bad taste (Pawek, 1969; McDannell, 1998b) or spiritual materialism (Gould, 2006), the underlying common accusation is that consumption distracts individuals from a real connection with the divine.

The marketing of religion and religious goods is at the center of renewed interest. The economics of religion approach (e.g. see Iannaccone, 1991, 1998; Stark, 2006), which is

based on the premise that economic rationality informs the religious behavior of individuals and groups, suggests that differences in religious participation between Europe and North America can be explained by the fact that religious plurality in the latter forced religious institutions and denominations to make substantial promotional efforts to attract new members and/or retain their congregations. Other empirical works have investigated resistance to and gradual acceptance of marketing techniques and philosophies by religious organizations (e.g. Cutler and Winans, 1998; Einstein, 2008; McDaniel, 1989; Wrenn, 2010; Wrenn and Mansfield, 2002). In marketing, scholars have broadened the concept of marketing (Kotler and Levy, 1969) to include religious services (e.g. Mottner, 2008; Webb et al., 1998). However, excessive reliance on marketing practices, for instance in the context of televangelism, has attracted criticism by some observers (as evidenced by the evocative titles of work analyzing the phenomenon, e.g. *Jesus in Disneyland*, Lyon, 2000; *Selling God*, Moore, 1995; *Holy Mavericks*, Lee and Sinitiere, 2009) and may result in negative perceptions by religious consumers (Attaway et al., 1995; Kenneson and Street, 1997; McDaniel, 1986; McGraw et al., 2012).

Finally, and closer to our paper's goals, research has examined the multifaceted ways in which profane marketers interact with religion so as to attain commercial goals. Religion often works in the marketplace, rather than opposing it, since it can affect what should (not) be traded, how trade should be carried out, and where and when trade should occur (Mittelstaedt, 2002), affecting believers' consumption choices in pervasive ways, to the extent that leaving a religion might remarkably affect consumption habits (McAlexander et al., 2014). Specifically, some marketers are *religion dominated* (Mazumdar and Mazumdar, 2005) and specialize in religious products and services. This would include such producers of religious artifacts, kosher food producers and restaurants, and Islamic banks guided by the principles of Sharia law. Other marketers, often located in religiously homogeneous areas or

ethnic enclaves, are *religion included* (Mazumdar and Mazumdar, 2005), because while they do not specialize in religious products, religion is significant to owners, employees, and local customers, and is made visible through the inclusion of religious symbols and imagery in work and retail spaces (e.g. statues, icons, altars). Research in this context is largely found in the field of Islamic marketing, which seeks to understand Muslims as consumers and marketers (e.g. Alserhan, 2010; Arham, 2010; Izberk-Bilgin, 2012a, 2012b; Sandikci, 2011; Sandikci and Ger, 2010; Sandikci and Rice, 2011; and more generally articles published in the *Journal of Islamic Marketing*). Research in this field has also examined how religiously aligned marketers (and consumers) can question dominant global ideologies such as capitalism. Notably, Izberk-Bilgin (2012b) has investigated consumer antagonism to global brands such as Coca-Cola, Nestlé, and McDonalds, which were construed as *infidel*, while other studies have investigated local versions of global brands that comply with religious teachings or sensibilities, such as Fulla (the modestly clad version of Barbie) and Mecca Cola (Ram, 1997; Yaqin, 2007).

In contexts characterized by religious pluralism, secular marketers can be *religion accommodating* (Mazumdar and Mazumdar, 2005) by acknowledging the religious needs of heterogeneous market segments, as in the case of hospitals or airports with interfaith chapels or prayer rooms. A different approach to religion is adopted by *religion-insensitive* organizations (Mazumdar and Mazumdar, 2005) that exploit religious symbolism, art, icons, and artifacts for commercial purposes. In a globalized context, the use of religious imagery by marketers is increasingly common and not necessarily intended to be disrespectful (think of a T-shirt showing an image of the Virgin Mary or Ganesh). In the attention economy (Davenport and Beck, 2013), however, contrasting religions may result in mass mediated controversies that increase brand awareness and create identity value for rebellious consumers, a strategy that is often adopted by both pop stars (Madonna's *Like a Prayer* and,

more recently, Lady Gaga's *Judas*) and brands (for an analysis of *Dolce & Gabbana*'s rosaries, which are intended to be provocative fashion accessories rather than instruments assisting prayer, see Rinallo et al., 2012b).

To conclude, as previous research has confirmed, in the marketplace, religion can divide rather than unite. As we succinctly highlighted in our review of the literature, the potential for tension and conflict is always present when marketing and consumption interact with religion in secularized and religiously plural societies. Research has only recently begun to unpack the market dynamics inherent in marketers' relationships with religion, which – as we demonstrate – can vary in a continuum from subordination to overt contrast.

In line with this research stream, our empirical study focuses on a hospital that adopted a religious name, that of the recently canonized Pope John XXIII. At first glance, this is a case of a *religion-included* marketer (Mazumdar and Mazumdar, 2005) in a country (Italy) where the vast majority of the population declare themselves to be Roman Catholic (Eurispes, 2006; Ferrari and Ferrari, 2014). The hospital's name change (from laic to religious) has provided the opportunity to scrutinize the complex relationship between marketing and religion in a context (that of healthcare assistance) in which religions still play an important role and are a primary voice in the social debate about the ethics of medical practice.

The Empirical Setting

The Catholic Church and healthcare: An evolving relationship

Historians of medicine and theologians have often described the development of religion and healthcare as intertwined (Ackerknecht, 1982; Catanati, 2001; Cosmacini, 1987, 2005; Koenig, 2000; Vanderpool, 1977, 1980; Vanderpool and Levin, 1990). In ancient societies, physical and mental diseases were often treated with therapies consisting of

religious rituals aimed at banishing demons and other supernatural entities believed to be the cause of illness (Koenig, 2000). It was only in classical Greece (between 500 to 400 BCE) that medicine began to develop the empirical-rational basis it has today (Warren, 1970). At the time, doctors treated patients and performed surgery in their homes; there is no evidence in classical Greece of the use of hospitals in the modern sense of the word (Woodhead, 1952).

In the Western world, the first hospitals were established only with the advent of Christianity (Cosmacini, 1987). Based on the virtue of *caritas* (charity, or altruistic love) and the evangelical tenet of "*curate infirmos*" ("heal the sick", Luke 9:2), care for the sick was a sacred duty for the faithful and a moral imperative for the religious (Catanati, 2001; Cosmacini, 1987). The first ecumenical council of Nicea (325 CE) ordered the construction of a hospital in every cathedral town in the Roman Empire to care for those in need. Known as *xenodochi* and founded and staffed by religious orders, these hostels provided various forms of assistance, ranging from shelter to healthcare. Later, Saint Benedict of Nursia founded a monastery and hospital at Montecassino (central Italy, 529 CE) and established a monastic order that had – and still has – care for the sick as its primary mission (Catanati, 2001). Until the end of the 11th century, the clergy consolidated its role in healthcare assistance provision as hospitals were established across the Roman Empire.

Starting from the 12th century, however, the clergy gradually lost its influence in the provision of medical services, as the Church itself came to see medicine as a distraction from spiritual contemplation (Retief and Cilliers, 2001). In 1348, the bubonic plague, which ravaged Europe, led European sovereigns to intervene directly in the provision of medical services: hospitals began to be regarded as no longer solely a Church monopoly but also as a sign of a sovereign's responsibility toward its citizens and a valuable means for the exaltation of government. In the centuries that followed, the Church continued to lose its power and

control over medicine. Hospitals thus became places for the diagnosis of and care for disease rather than places of compassionate assistance.

Today, despite the fact that hospitals and healthcare are prevalently secular institutions under the control and direction of public authorities, the Catholic Church still plays an important role in this sector, particularly in countries where it represents a majority religion. Over the course of the 20th century, the Vatican also become an influential actor in the public debate around the ethics of medicine, with particular reference to those practices considered incompatible with the tenets of the Catholic faith, particularly in the context of techniques dealing with the mystery of human life and death, as in the case of assisted reproduction, abortion, the prolongation of life, and euthanasia (Vanderpool, 1980). A fundamental principle of Catholic bioethics is the sanctity of human life, which is believed to be a creation and a gift of God, and beyond human evaluation and authority (Markwell and Brown, 2001). Such principles are expressed in Pope John Paul II's encyclical *Evangelium Vitae*, which observed that the 20th century will be remembered as an era of massive attacks against life itself. Specifically, "[w]hatever is opposed to life itself, such as... abortion, euthanasia, or willful self-destruction [is] a supreme dishonor to the Creator" (paragraph 3); and "the various techniques of artificial reproduction... are morally unacceptable" (paragraph 14).

The provision of healthcare in Italy

In Italy, the laicization of healthcare was slower than in other European Countries. The Counter-Reformation stemming from the Council of Trent (1545) accentuated the influence of the Church (Cosmacini, 2005), particularly in the Papal States. After the unification of Italy (1861), while ecclesiastical bodies were expropriated, an 1862 law gave clerical congregations the right and duty to provide charitable and welfare services in

hospitals, under the king's control and political guidance (Catanati, 2001). In 1890, another law put an end to the clergy's role in the provision of healthcare and activated a real transition from a system based on charity to one based on public assistance. This reform was based on the constitutional right of access to healthcare assistance without distinction concerning religion or religious opinion (Cosmacini, 1987).

Despite the diminishing role played by Italy's clergy in the provision of healthcare since the end of the 19th century, Catholic institutions still play an important role in the healthcare sector, and not only in providing spiritual chaplaincy in every public hospital of the country (mandatory by law since 1978). Currently, religious hospitals account for 11% of Italy's hospitals (Carbone et al., 2014). According to ARIS, an Italian non-profit association that represents institutions (both religious and secular) that provide Catholic-inspired healthcare services and medical assistance, there are about 300 ecclesiastic institutions in Italy that provide healthcare services involving around 26,000 beds and employing about 50,000 people. These figures underline the fact that ecclesiastic institutions are the most important group of non-profit players in the provision of healthcare assistance – after state-owned facilities – and a fundamental actor in satisfying national demand for healthcare services.

In Italy, the Catholic Church also exerts moral authority (Mittelstaedt, 2002) on the conduct of medicine, to the extent that it is often accused of violation of the principle of *a free church in a free state* ratified in the 1929 Lateran Treaty between Italy and the Holy See and later incorporated into the 1946 republican Constitution of Italy (Ferrari and Ferrari, 2014). As noted by Corbellini (2007), in Italy, the Catholic Church's say in ethically contested medical practices is more prominent and has a stronger influence on legislative choices than elsewhere – a fact that generates intense debate and political opposition. There are many examples, including the recurrent call of right-wing political parties to overturn the

abortion law, which was upheld in 1981 after a referendum where the majority of Italy's voters were in favor of it, despite strong opposition from Italy's Catholic establishment. Another example is the Italian Episcopal Conference's successful opposition to a referendum proposed in 2005 by the Radical Party, which would have abrogated a previously accepted law placing strict limitations on the practice of assisted reproduction. A further example is the intense debate around euthanasia, which culminated with the Vatican's decision in 2006 to deny a religious funeral ceremony to Piergiorgio Welby who, after many years of being immobilized in a hospital bed, was allowed to die after a legal battle on his behalf fought by the Radical Party.

The Azienda Ospedaliera Papa Giovanni XXIII

This study focuses on the Papa Giovanni XXIII Hospital. Before describing it, we will provide some information concerning the overall organization of Italy's healthcare system. Health cover for the whole population is assured through a tax-based National Health System model in which healthcare services are delivered and managed exclusively by the 19 regional administrations and the two autonomous provinces composing the country. Each region is responsible for managing and financing the public hospitals under its political authority and has full autonomy to identify the number and size of the public hospitals operating in their territories, to define their geographical boundaries, to allocate resources to them, and to appoint their general managers. Owing to the wide range of responsibilities the law assigns to them, regions can be paralleled to parent companies, with public hospitals as their subsidiaries (OECD, 2014). Italy's central government and the Ministry of Health have the responsibility to define the general objectives of the National Health Service, to allocate the overall state budget to each region, and to set the essential levels of care, i.e. the minimum healthcare assistance level that must be uniformly available to all the country's residents

regardless of their region of residence.

The Papa Giovanni XXIII is a public hospital located in Bergamo. It is managed and financed by the Lombardy region. It is recognized by Italy's Ministry of Health as an institution of national relevance and high specialization, and it has a good reputation in the international scientific community for the quality of its research. It is a member of the Health Promoting Hospitals (HPH) network initiated by the World Health Organization's European Office.

Although it is now a public-owned, laic hospital, the Diocese of Bergamo's role has been relevant since the hospital was founded. In the area, the first shelters and hospices for the sick were created during the Middle Ages by religious organizations. During the 12th century, at least 11 small hospitals were built in Bergamo and surroundings. In 1455, during one of the Venetian dominations of the area, under the auspices of Bishop Giovanni Barozzi, and with the approval of Venice's government and Pope Pious II, the new Ospitale Grande (great hospital), dedicated to St. Marc, Venice's patron saint, was established. An entirely rebuilt facility, the Ospedal Maggiore (main hospital), this time dedicated to the Princess of Piedmont, was inaugurated in 1930. During the 1970s, following a merger with other local hospitals, the healthcare complex again changed its name, to Ospedali Riuniti di Bergamo (United Hospitals of Bergamo).

The decision to use a religious name and name the organization after Pope John XXIII was taken in 2003, when the President of the Lombardy region – who, by the power vested in him or her by law – can address public hospitals' management choices, asked the hospital's CEO to dedicate the structure to this prominent figure in the Roman Catholic Church to whom the local community was particularly attached. The proposal was welcomed and received the support of the diocese's bishop who, in the same year, on the occasion of the celebrations for the anniversary of Pope John XXIII's death, officially announced to the

dedication of the new hospital to the local community. In 2003, the hospital management officially signed the act for the new name; this was enacted contextually by the move to the new hospital in December 2012.

In addition, a large church dedicated to the (now Saint) Pope John XXIII is located near the entrance to the hospital. The church, built with financial contributions from the Italian Episcopal Conference (i.e. the assembly of Italian Bishops) and the Fondazione Banca Popolare di Bergamo (a local banking foundation), was sought by the city's diocese in view of the pope's canonization in 2014. Designed by the French architect Aymeric Zublena, the monumental church is intended as a place of meditation dedicated to the sick and the suffering, and can be reached directly from the hospital through an internal passage that provides convenient access for patients. Situated on a lower level, the Franciscan monks' pastoral center includes two meeting rooms, toilets, a small apartment, and spaces made available to monks inside the hospital.

The church and the pastoral center are not the only visible artifacts of religion in the hospital complex. Others include the Lourdes Grotto, with a statue of the Virgin Mary in memory of the 1981 Marian apparitions in the French town; a statue of the widely worshipped Italian Saint Pio of Pietrelcina (near the parking lot); and countless crucifixes in patients' rooms and other public spaces in the hospital, purchased with financial assistance from various donors.

Pope John XXIII: A brief biography

Born in 1881 in Sotto il Monte, a tiny village in Bergamo that was later renamed Sotto il Monte Giovanni XXIII, Angelo Giuseppe Roncalli became the Catholic Church's 261st pope in 1958, at the age of 77. He was canonized as a saint in 2014. The successor to Pious XII, Roncalli chose the name of John XXIII partly in memory of his father, Giovanni

Battista, and partly in honor of Saint John the Baptist, Sotto il Monte's patron saint. Nominated a subdeacon in 1903, and ordained as a priest in 1904, a year later he was appointed secretary to the bishop of Bergamo, Giacomo Radini-Tedeschi and a faculty member at the seminary of Bergamo. With Italy's entry into WWI in 1915, he was called to the army medical corps as a stretcher-bearer and a chaplain and was made sergeant. After the war, he was ordained a bishop in Rome (1925) and appointed as titular Archbishop of Areopolis and apostolic visitor to Bulgaria, then to Turkey and Greece in 1934. Upon the outbreak of WWII, he was in Greece, where he helped save many Jews by arranging transit visas issued by the Apostolic Delegation. In 1944, he was appointed nuncio to Paris and became the first permanent observer of the Holy See at UNESCO. In 1953, he became cardinal-patriarch of Venice until 1958, when, after Pius XII's death, he was called to Rome to participate in the conclave that elected him pope.

John XXIII is often remembered for some aspects of his personality and pontificate that are key elements in the popular memory and devotion crystallized around his figure: his revolutionary reform of the Church; his goodness and disdain for wealth and hierarchy; and his special link to Bergamo. Despite the brevity of his pontificate, which only lasted five years, John XXIII is considered by Church historians to be among the most influential personalities in Vatican history. The convocation of the second Vatican Council, announced only three months after his election, is considered the most revolutionary – and, in a way, reckless – act of his pontificate. The Council, which was completely unforeseen, since Roncalli was expected to be a 'stop-gap' pope, sparked a renewal process in the Church and changed the defensive and inflexible stance that had characterized much of Catholic thought and practice since the Protestant reformation (Trevor, 2000).

However, most people remember Roncalli for his human qualities, rather than his role as reformer of the Church. Often referred to as *il papa buono* (the good pope), in contrast to

his more distant predecessors, he was perceived as a humble, spontaneous person, with a remarkable sense of humor, and close to 'ordinary' people. Since his first public speeches and liturgies, it was immediately apparent that Pope John "was more loving grandfather than stern uncle" (Martin, 2006; p. 191). He often disregarded papal etiquette, interacting spontaneously with people from all walks of life, including visiting schools, ordinary parishes, prison inmates, and the sick in hospitals. As the Archbishop of Westminster once commented, "pope John was not a mythical character; the pope I knew was much more like a parish of a rural village, full of goodness" (Tornielli, 2000; p. 11). His disdain for hierarchy and wealth contributed to make him one of the most beloved popes of all time, also to non-believers (Melloni, 2009). In his last will, Pope John XXIII wrote "born poor, but of humble and respected folk, I am particularly happy to die poor. I thank God for this grace of poverty to which I vowed fidelity in my youth… which has strengthened me in my resolve never to ask for anything – positions, money, or favors – neither for myself nor for my relations and friends" (translation ours).

In Italy, Roncalli is also well known as the *papa bergamasco*, the pope from Bergamo. His biographers stress how certain aspects of local culture affected his character and papacy (e.g. Benigni and Zanchi, 2000). "I want to be like those good old priests of Bergamo, whose memory lives in blessing, and who did not and did not want to see further than the pope, the bishops, the common sense, the spirit of the Church," wrote Roncalli in his personal diary in 1903 while he was at the seminary in Bergamo (Oggioni, 1983, p. 7). In 1921, called to the Holy See by Pope Benedict XV to be Italy's president of the central council of the Society for the Propagation of the Faith, he moved to Rome with Bergamo in the heart (Oggioni, 1983). He never forgot Bergamo and maintained sound connections with the local diocese, the bishops, and the priests serving in the local parishes. This strong link with Bergamo is confirmed by the number of letters he wrote to the parish priests of Sotto il

Monte and to local bishops, and by his willingness to regularly take part in local religious celebrations during his holidays in Sotto il Monte. According to his secretary, Monsignor Loris Francesco Capovilla, during the last days of his life, Roncalli kept a list of the 1,706 priests of Bergamo who died between 1889 and 1962 close to his bed; he added many biographical and chronological notes. Looking at this list, he commented: "If I were a painter, I could portray at least 1,500 of them as I have had personal relationships with them all" (Oggioni, 1983, p. 43). It came as no surprise to find that the people of Bergamo think of Roncalli not just as pontiff (and now saint) of the Catholic Church, but as a former citizen of Bergamo who made the city proud.

Preliminary Study

This study investigates stakeholders' acceptance of the new, religion-inspired name of the Papa Giovanni XXIII Hospital and their underlying motivations for doing so. As recommended in the case study research, to ensure the reliability and validity of our findings, we combined multiple data sources (Eisenhardt, 1989; Yin, 2003) (see Table 1 for an overview). First, we reviewed internal documentation, with the goal of reconstructing the corporate renaming process, which took place over an extended period from 2003 to 2013 and involved several actors. Overall, we examined 13 internal and external documents (corporate social responsibility reports and official deliberations by the hospital's CEO, the province of Bergamo, the Lombardy region, and the National Board of Italian Mayors). We also interviewed hospital officials (the CEO, head of public relations, the purchasing manager, heads of clinical departments, and head physicians) and conducted field observations at the hospital complex both before and after the name change. This initial phase enabled us to report the hospital's recent history and identify the artifacts of religious presence in the new hospital complex (see the previous section). We also analyzed the

reasons for the name change, as communicated by the hospital during the announcement; these were very briefly mentioned as being dependent on the local community's attachment to Pope John XXIII and his excellent work as a chaplain at military hospitals during WWI.

- Table 1 about here -

We continued our preliminary study with an analysis of printed and online news sources, to track the media discourse surrounding the hospital name change. Based on the principle that during corporate renaming processes, the media can influence stakeholder acceptance (Hatch and Schultz, 2001; Muzellec and Lambkin, 2006), we sought to understand how hospital management communicated the name change and how the media and the actors they gave a voice to responded to the announcement. We searched three primary Italian newspapers with national distribution (*Corriere della Sera*, *Il Giorno*, *Repubblica*, and *Il Giornale*) and a local newspaper (*L'Eco di Bergamo*) for articles containing relevant keywords (i.e. 'Pope John XXIII' and 'hospital'; 'Roncalli' and 'hospital'; 'Bergamo' and 'hospital') between 2003 and 2013. Most articles focused on describing the new hospital, its capacity, construction costs, the recurring postponement of the inauguration of the new facilities, and the consequent legal repercussions. Thus, of the 120 articles initially identified, only 23 were retained and considered relevant to the study's goals. Even this smaller corpus yielded limited indications of controversy about the new hospital name. Additionally, more focused search rounds, conducted separately by the authors and research assistants, supported the view of positive acceptance of the name by key actors as if its religious connotation were a non-issue. Below, we report two examples of these non-controversial accounts found in newspapers.

> Bergamo's new hospital will be ready in 2009[1]: the Ministry of Health has green-lit the funding for the new hospital in Bergamo (€241 million). The new name of the hospital was inspired by Pope John XIII, Angelo Roncalli, born in Sotto il Monte, a

small village in the province of Bergamo. An international pool of architects, led by Aymeric Zublena, will provide the hospital with the most pioneering structures for the healthcare of patients… (*Corriere della Sera*, December 23, 2008, translation ours).

'We are going to Pope John's...'. These will be the words that the population of Bergamo will pronounce in the spring of 2010 when they go to the local hospital. Bergamo's new hospital will bear the name of the local population's beloved Pope John XXIII […]. The infrastructure will be ready in one year. The investment is huge: €370 million, 320 square meters, 226 ambulatories, 956 beds, 4,000 square meters for the emergency room, 36 operating rooms, and 88 intensive care units (*Il Giorno*, October 23, 2008, translation ours).

Other articles (e.g. the one that follows) faithfully report the hospital's reasoning behind the name change as expressed in internal documentation. Here, selected elements of Roncalli's biography are woven together to highlight his commitment to alleviating suffering, as well as his wartime experience as a chaplain in military hospitals.

The green light will have to be given by the regional council, but it is certain that Bergamo's new hospital of Bergamo will change its name from Ospedali Riuniti [United Hospitals] to Pope John XXIII… It was the hospital's Board of Directors that formally asked the regional council for the name change after gaining consent from the province of Bergamo and the conference of the mayors of Bergamo province. […]. During WWI, Angelo Giuseppe Roncalli (Pope John XXIII) was a military chaplain. He was strongly committed to the assistance of the wounded at military hospitals. During his pontificate, he demonstrated a strong interest in people's suffering (*Il Giorno*, May 27, 2010, translation ours).

Main Study

Data gathering procedures

Bearing in mind that the media often offer a distorted mirror of reality and parrot official sources, we conducted an empirical study to measure the acceptance of the new hospital name by a sample of stakeholders: citizens (residents in the hospital's catchment area), consumers (hospitalized patients), employees (administrative, medical, and nursing staff), and suppliers. We also investigated the motivation for acceptance (or lack thereof) and the perceived influence of the new name on the hospital's corporate image and medical practices. Given the exploratory nature of this research, we did not propose formal hypotheses. However, based on our theoretical understanding of the problematic intersection of branding and religion in the marketplace, we were surprised by by the lack of media-reported criticism on the hospital name's religious nature. We expected a more nuanced view to emerge from a fine-grained analysis of the perceptions of consumers and other stakeholders.

Data gathering was conducted in the fall of 2011 – a year after the media announcement of the new hospital name but before the inauguration of the new hospital facilities in December 2012. While alternative timeframes for this research would have been possible, we conducted the research before the completion and opening of the new hospital to avoid respondents' bias owing to their perceptions of the new hospital facility and to provide better insights into the images, values, and concerns the new name evoked.

The questionnaire was structured as follows. First, we obtained demographic information (gender, age, place of residence, education, and – when possible – professed religion[2]). Second, drawing on research on the acceptance of brand extension strategies (Broniarczyk and Alba, 1994; Hem and Iversen, 2009; Keller and Aaker, 1992; Muthukrishnan and Weitz, 1991), we developed a three-part question on the new name's

acceptance level (The responses were anchored by 1 = *strongly disagree* and 5 = *strongly agree*). We also inquired about the perceived impact of the hospital's name change on its image and medical practices. Respondents were invited to rate that impact on a five-point scale (anchored by 1 = *not at all* and 5 = *completely*). We continued with three open-ended questions that investigate the reasons for respondents' acceptance and the effects (if any) that the new Catholic name could have on hospital's image and medical practices. The use of multiple question types reduces common item bias effects (Conway and Peneno, 1999), and the inclusion of open-ended questions results in a more nuanced identification of the primary reasons behind support for (or lack thereof) the hospital name change. Answers to quantitative questions were analyzed using SPSS18 and answers to open-ended questions were analyzed by means of NVivo 8 software.

We reached each stakeholder group through different channels.

- Citizens were contacted through the hospital website, where there was a link to the online version of the questionnaire, and by the hospital's newsletter. The questionnaire was posted on the websites of several local sports, arts, business, and charity associations during October and November 2011. Of the 269 questionnaires collected, 24 were discarded owing to missing data, yielding 241 usable questionnaires.
- Patients were contacted directly in the hospital by one author, who was authorized by the hospital administration to collect data; 174 patients in nine different hospital departments completed the questionnaire. All the completed questionnaires were retained.
- Hospital employees (N = 3,600) were contacted by the hospital administration via email. A link to the questionnaire was also included in the hospital's internal electronic newsletter. A total of 266 questionnaires were collected, of which 259 were usable.

- Finally, the hospital administration provided the authors with a list of 324 active suppliers of the hospital, who were contacted via email with a link to the questionnaire; 69 questionnaires were received from this group.

To avoid non-response bias, two reminders were sent to each stakeholder category. Using the technique advocated by Armstrong and Overton (1977), we evaluated non-response bias by comparing the subject responses received during the three waves. No significant differences were found regarding independent variables, criterion variables, or demographic data.

A total of 743 usable questionnaires were collected (Table 2). Almost all (99%) the respondents were Italian. Concerning religion, the large number of blank responses obtained (455, representing 60% of the sample) was mostly due to hospital policies, which prevented us from posing this question to employees and suppliers; when considering only the citizen and patient groups of the sample, the percentage of non-respondents was approximately 30%. The subsamples of citizens and patients are representative of the population in the hospital's catchment area: 48% were female and 52% were male[3]; the average age was 44.52[4]; and the education level was medium to high (6% primary school, 14% secondary school, 46% diploma, 28% degree, and 4% Master's or Ph.D.)[5]. Concerning hospital employees, 39% of respondents in this category were medical personnel, 29% were healthcare assistants, 25% were office workers, 5% were technicians, and 2% were managers. In this case, the sample is representative of the hospital employee population. Thus, even though the sample is self-selected, the distribution of respondents per stakeholder category indicates that we obtained a well-balanced presence of all the typologies considered.

- Table 2 about here -

Main findings

Overall (see Table 3), the sample we investigated was in favor of the new hospital name (mean of 3.85 on a scale of 1 to 5), and people believed it could contribute to improve the hospital's image (M = 3.56); at the same time, however, respondents expressed more limited support for the idea that the hospital renaming would be accompanied by a change in medical practices (M = 2.48). One-way ANOVA tests highlight differences across stakeholder groups. Concerning the acceptance of the new name, such differences are statistically significant ($p < .001$). Specifically, patients strongly supported the new name (M = 4.19), as did employees (M = 3.66) and suppliers (M = 3.65). No statistically significant differences across respondent typologies emerged regarding the influence of the new name on the hospital's image (see our analysis of open-ended questions below). Finally, despite the low perceived impact of the hospital's dedication to Pope John XXIII on its medical practices in general, we observed a statistically significant difference ($p < .05$) between citizens (M = 2.29) and the seemingly more concerned employees (M = 2.60) and patients (M = 2.61).

- Table 3 about here -

We further investigated the reasoning behind the answers to the above questions through open-ended questions, which we content-analyzed and independently codified by the. In this step, we reduced respondent answers to a finite number of four to five general categories. We asked two assistants who were not involved in the research to attribute respondent answers to these categories. The reliability of the codification process (intercoder reliability (e.g. see Lombard et al., 2002) was assessed by means of Cohen's kappa coefficient (Cohen, 1960, 1968). Based on the threshold values suggested by Landis and Koch (1977), interrater reliability for questions A and C was excellent (i.e. greater than 0.75) and good for question B (i.e. between 0.40 and 0.75) (see Table 4, column 1).

- Table 4 about here -

The first open-ended question investigated the reasons for the (lack of) acceptance of the hospital's new name (Table 4, question A). Only 71% of respondents (N = 527) provided an answer; of these, we considered only the 464 answers that coders unanimously attributed to the same category. In line with previous results, respondents in favor of the name change outnumbered those critical of it. Among the latter, some respondents (16%) were concerned about the investment linked to the name change; only in a few cases (11%) was lack of support motivated by the fact that the respondent felt the hospital should be non-denominational. In the words of our informants, the new name is "too linked to the Catholic community, which does not represent everybody; the hospital is a non-denominational public facility and it should present itself as such." Another respondent said that "a hospital is and must be a scientific institution... In a hospital, scientific solutions – not supernatural ones – are sought. Even patients who are believers, in my view, trust doctors more than the saints (otherwise they would go to a retreat, not to a hospital). Why not erect a monument to the illustrious saint from Bergamo? … but giving his name to the hospital is an offense towards non-Catholics and a really unscientific declaration of intent."

In contrast, among those who supported the new name, the largest percentage (36%) evoked the strong link between Pope John XXIII and the city of Bergamo, expressed in a variety of ways; these included: "our good pope", "a pope from our country", "a symbol of Bergamo", "an illustrious citizen of Bergamo", "a world-class personality, born in the territory of Bergamo", and "a great person who brought to the world the positive values of our country". Others (30%) said their support was motivated by the fact that, on a human level, Pope John XXIII was an exemplary personality: "a very good man", "a symbol of goodness and charity", "a person of great relevance, representing universal values", "a pope who used to go and visit the sick" and "talk to the people", "a person of great humanity", "a person rich in humanity and care for the people, which is what you expect from a hospital",

and “a man, before being a pope! A man capable of entering the heart of every man, great and humble, like the convicts and children he used to visited at hospitals… Moreover, he was a man capable of creating links with every culture, religion, and race.” Very few answers referred to the fact that saints are traditionally associated with miraculous healings and, according to the doctrine of the Catholic Church, can intercede with God in this regard (Brown, 2015; Congregation for the Doctrine of the Faith, 2000). Indeed, some informants noted that it would have been good to have a saint “to watch over the hospital” and “protect the sick”, but this motivation is not as prevalent as we might have expected in a predominantly Catholic country such as Italy. We can speculate that the belief in miracles is pervasive but not easily expressed in secularized societies, perhaps to avoid the stigma associated with what some consider superstitious beliefs.

Despite the overall support for the name change, most respondents did not believe that the new name would have an impact on the hospital’s image (Table 4, question B). Only 51% (379 out of 743) offered an answer to this question (we base our analysis on the 301 responses for which the condition of interrater agreement was satisfied). More than half of the respondents (57%) believed that a name, no matter how well chosen, would not change the hospital’s image: for them, the image of a healthcare institution depends on the professionalism of its employees (doctors, nurses, administrators) and the quality of the services it offers. Only a minority believed the name change would negatively affect the hospital’s image. A few (3%) hinted at the risk of losing the positive image associated with the previous brand name, while others (8%) highlighted the negative impact of a religious name on image. Comments included: “medicine and faith should not go together”, “science has nothing to do with the supernatural”, “it might improve the image in the case of the elderly, but not in the case of the young and the immigrants”, “the name might be appropriate for a private hospital, but not for a public one”, “is not evocative of a non-confessional

institution catering to the needs of a multicultural society", "reminds me of a religious image, which is also to a certain extent discriminatory", "will not be liked by supporters of laicism, agnostics, atheists, and those with different religions", "will not be unifying for the population", "given the plurality of faiths, naming the hospital after a pope is a risky choice", "the new name will reinforce the view that Bergamo is a town where the Church has excessive influence", and "one might believe in a greater involvement of [Bergamo's Episcopal] Curia".

Among the respondents who believed the name change would have a favorable effect on the image of the hospital were 10% who suggested that religious values such as compassion could contribute to rehumanize the practice of medicine or, in the one informant's vivid words, "provide a sense of the sacred that fills the heart… something that is getting lost in this multicultural world". However, for many respondents (22%), the positive image transfer was not linked to Christian values generally, but to the specific ways these values were manifest in the life and deeds of Pope John XIII. In other words, in a manner similar to celebrity endorsement models (McCracken, 1989), selected elements of Pope John XXIII's image (e.g. a good and altruistic person, animated by love, close to people, and a passionate worker), his fame, and the positive emotions associated with him (e.g. "loved by the people of Bergamo", "loved by all") can be transferred to the hospital's brand image and can trigger specific expectations in terms of service quality (e.g. "greater attention to the sick in a hospital that bears the name of the 'good pope' "). More generally, many respondents argued that an association with Roncalli, by serving as an inspiring role model for administrators, doctors, and other employees, would affect the way the entire organization was managed and the value it creates for patients and for the local community. As an informant suggested, "he was and still is the good pope par excellence, and today more than

ever we need good people inspired by love who do their job with passion and as a mission. If we use him as a model, we are on firm ground."

Finally, we investigated the respondents' perceptions of the influence of the new name on the hospital's medical practices (Table 4, question C). We collected 295 answers to this question (40% of the sample); our analysis is based on the 249 answers unequivocally attributed to the same category by the two independent coders. In line with findings obtained from closed questions (see Table 2), most respondents (62%) did not believe that a name change would affect the hospital's medical practices: "it is an irrelevant fact" and "the name does not identify the hospital's mission", among others. On the other hand, a few respondents (9%) suggested that the name change could signal changes in healthcare practices (e.g. could create obstacles to certain therapeutic practices and scientific experimentation) owing to greater Church interference. Some respondents (14%) highlighted the importance of the religious values of assistance and charity in medicine and the centrality of Europe's Christian roots. Others (15%) linked a positive effect not to religion generally, but to Pope John XXIII's personality and human qualities, which are of universal appeal. Significantly, for some of these informants, naming the hospital after a great man could encourage the personnel to do more, to do better, or to be more responsible.

Differences among stakeholder groups

Given our goal of investigating differences among stakeholder groups, we further analyzed the primary reasons behind acceptance (or lack thereof) of the new hospital name and its perceived impact on the hospital's image and medical practice (Table 5). Concerning question A (agreement of disagreement with the new hospital name), we found that citizens and patients supported the name change – whether owing to the link between Pope John XXIII and the Bergamo area or because they consider him a positive person – more than

employees and suppliers (citizens: 40% + 30% = 70%; patients: 41% + 49% = 90%; employees: 35% + 19% = 54%; suppliers: 21% + 23% = 44%). In other words, *insider* stakeholder groups with professional relationships with the hospital tended to be more critical of the new name, not only for the need to keep religion and medicine separate but also for the costs associated to the renaming (e.g. change in supplier databases, in letterheads and stationery, etc.) and the loss of the equity of the former, established brand name (25% of employees and 32% of suppliers mentioned this as a reason behind their lack of support). We also observed that patients were overwhelmingly in favor of the name change (only 8% disagreed).

Concerning question B, we found that patients (77%) and employees (60%) tended to be more skeptical of the possible impacts of the name change on the hospital's image. As noted, whether relating to the receiving or giving hand of healthcare services, these more involved stakeholder groups believe that it is the professionalism of the people working for the hospital that makes a difference. Among those who believed the name change would have a negative impact on the hospital's image, the limited sample size prohibits us from making significant observations on the possible differences among stakeholder groups. In contrast, citizens are the stakeholder group that believed most strongly in a positive image change. Finally, concerning question C, we observed that employees (14%) and suppliers (22%) were more afraid of possible changes in medical practices and were worried about potential interference from the local clergy.

- Table 5 about here -

To add interpretive depth to our analysis, we regrouped respondents based on their perceptions about the new name. With this goal in mind, we developed a finite mixture model (FMM), a statistical technique that combines factor analysis and latent class analysis (Nylund et al., 2007) for respondents' open questions using LatentGold 4.5 software. The analysis

identified two distinct respondent clusters; further clusters could not be identified since the statistical information criteria commonly used to determine the number of clusters in mixture modeling (i.e. Akaike's information criterion (AIC), Akaike, 1987; Bayesian information criterion (BIC), Schwarz, 1978; and consistent Akaike's information criterion (CAIC) scores, Bozdogan, 1987) get worse as the number of clusters increases (see Table 6).

- Table 6 about here -

As shown in Table 7, cluster 1 (69.64% of respondents) was predominantly in favor of the new hospital name and believed it would have a positive impact on the institution's image and a neutral or positive impact on its medical practices. In contrast, cluster 2 (30.36% of respondents) were skeptical of the new name and feared a possible deterioration of the hospital's image and possible interference of the Church in medical practices.

- Table 7 about here -

A second latent class analysis – employing the stakeholder group to which the respondents belonged as a covariant variable of the clustering model (Table 8) – shows that patients and citizens were definitely more likely to belong to the *positive* cluster; the same is true for the suppliers, but with a smaller probability. Employees were instead quite equally distributed between the positive and negative clusters. Further analysis of the respondents who expressed their religious affiliation (not reported here for the sake of brevity and owing to the small number of non-Catholics) suggests that both Catholics and members of other religions were more likely to belong to cluster 1, while atheists tended to be more negative towards the hospital name change and were concerned about its impacts on bioethics issues. As an informant noted, "decisions related to life and death should not be taken based on Catholic values", particularly in the case of abortion, which – in Italy – doctors can refuse to perform based on moral or religious reasons.

- Table 8 about here -

Discussion

This study has analyzed the responses of consumers, citizens, employees, and suppliers to the renaming of a public hospital in honor of a religious figure. Based on our readings of key contributions at the intersections of marketing, business ethics, and religion, we expected that the dedication of the hospital to a pontiff, even in a traditionally Catholic country such as Italy, would have generated controversy, but this assumption proved unfounded. Strongly supported by religious authorities, the hospital's name change was also welcomed by the media and the public. Furthermore, our analyses demonstrated overwhelmingly positive reactions; informants explained that Pope John XXIII was a "good man" who could inspire doctors and other staff to carry out their duties with passion and a spirit of service, in such a way as to rehumanize medicine. Informants critical of the change suggested that medicine and faith do not mix well, particularly in the case of a secular institution, and that the choice is not politically correct and ultimately disrespectful to non-Catholics. When we examined differences among stakeholder groups, we observed that employees were generally more critical of the name change and concerned of possible Church interference in medical practices. Finally, even if this finding should be interpreted cautiously owing to the limited number of non-Catholic respondents; we also found that atheists were more critical of the name change and its possible impact than Catholics and members of other religions.

In this section, we move beyond the case of a specific Italian hospital and propose a general model for the meaning transfer that occurs when brands align with religion and the possible consequences for consumers, employees, and other stakeholder groups. Such a model extends research on the relationship between brands and religion (Mazumdar and Mazumdar, 2005; Swimberghe et al., 2011) and offers a more nuanced view of how brand managers can align with religion in culturally sensitive ways. Speculating on the contextual

characteristics of Italy and the healthcare industry, we also propose some possible triggers of consumer/stakeholder reactions to religious alignment, which should be confirmed by further research on the topic. We conclude by highlighting our theoretical contributions and then discuss the limitations of our study.

The meaning transfer process in the religious alignment of a brand

Figure 2 shows our proposed model of the meaning transfer process at play when brands' meanings are aligned with religious values. Our model is inspired by McCracken's (1986) meaning transfer and its subsequent reformulations, which take into consideration marketers' shaping of popular memories and counter-memories (Thompson and Tian, 2008). At the center of our model, we placed the actions that managers can take to align their brands and organizations to a specific religious signifier (in our case, John XXIII; stage 1) and those of consumers and other stakeholders, who make sense of such religious alignment in various manners (stage 2). Following macro-marketing debates on the reciprocal influences between religions and markets (Mittelstaedt, 2002), and recent calls for more contextualized interpretations of research findings (Askegaard and Linnet, 2011), we also consider the cultural, historical, social, political, and religious factors that affect the religion-brand alignment process and its reception by relevant audiences. In this way, as we explain below, our model lends itself to analytical generalization beyond the context we explored.

- Figure 2 about here -

Before describing our two-step meaning transfer process, we highlight how, in a culturally constituted world, religious signifiers come to acquire meaning. Religions such as the Catholic Church are institutions with rich traditions that are often centuries old. Such traditions result in complex webs of interrelated memories and meanings. Literature on popular memory (Halbwachs, 1992; Fowler, 2005) suggests that social groups (including

religious groups and institutions) can build community by actively constructing a sense of a shared past through the circulation of collective memories often centered on historical protagonists (e.g. ancestors or cultural heroes) and places (e.g. sacred landmarks or pilgrimage sites). Institutions with as long and varied history as the Catholic Church can produce large reservoirs of meanings and memories, some of which may even appear to contradict each other or to be negative when examined through contemporary sensibilities (e.g. the violence of the Crusades or the Inquisition).

It is worth noting that in the Western world, as a result of the secularization of societies, many areas of social life such as science, art, literature, education, and politics that were previously the domain of religion are now the responsibility of independent, lay, and self-regulating institutions (see Berger, 1967; Turner, 2011, among others). This means that the history of these now separate social spheres is strongly intertwined with that of religion and bears the marks of a historical processes of separation that occurred antagonistically, thus generating oppositional meanings (e.g. the Enlightment's fight against dogma, blind faith, and superstition; the principle of separation of church and state; and the emergence of public hospitals, as detailed in this paper). Within the constellation of religious meaning, some signifiers (we use the term in a broad sense, to refer to people, places, organizations, and any other cultural object) come to be strongly associated with a specific subset of meanings and memories. These signifiers can be strategically employed by religious institutions (as well as by brands and other commercial organizations) to shape audience sensemaking in favored or favorable directions. For example, Cardinal Jorge Maria Bergoglio chose Francis as his papal name after his election as new pontiff of the Roman Catholic Church in 2013 as a tribute to St. Francis of Assisi, "the man of poverty, the man of peace, the man who loves and protects creation", in his desire for "a Church which is poor and for the poor" (Catholic Herald, 2013).

As our review of the literature describes, marketers' alignments to religion can be problematic in a secularized society. Some of the meanings associated with religion generally and specific religions may be evaluated differently by various social groups and individuals; to some, religion can be the opiate of the masses, to others, it is the only way to save one's soul. A similar process applies to specific cultural objects; some dislike the Vatican clergy and some bishops for their roles in covering up pedophile priests' activities, while others might hold the Franciscan Order in high esteem. The specialized sets of meanings attributed to these specific cultural objects are, to a great extent, part of their specific histories (or rather, the parts of those histories that are retained in public memory) within society generally and within the religious field in particular. For instance, meanings related to the Franciscan Order reflect those attributed to the monastic movement, which is based on renunciation of the secular world and dedication to spiritual pursuits, and specifically to the life and deeds of St. Francis of Assisi and his early followers, which sets apart the Franciscans from other orders such as the Jesuits or Dominicans.

When brands align with religion (stage 1 in our model), the key managerial challenge is to transfer meanings that are considered favorably by relevant market segments and stakeholder groups, while at the same time minimizing negative image associations. To do so, both for-profit and non-profit organizations should: (1) select appropriate religious cultural objects the history and images of which trigger favorable meanings and memories in relevant stakeholder groups; and (2) adapt those meanings and memories to the specifics of the product category and brand, to create a cognitive link and facilitate meaning transfer from the cultural object to the brand. Most likely, in the context of our study, the choice to rename a public hospital in honor of any other exponent of the Catholic Church would not have gone unchallenged. The hospital management largely avoided negative responses by selecting a cultural object strongly linked to the Bergamo area and by further validating their choice by

making explicit the links between Pope John XXIII and healthcare (notably, his solidarity with those who suffer and his service as military chaplain during WWI).

Finally (stage 2), relevant audiences make sense of the religiously aligned brand in ways that reflect their prior knowledge and their attitudes to the brand, the industry in which it operates, the specific image associated with the cultural object, and the religious field as a whole. Unlike others who have adapted McCracken's (1986) meaning transfer model (e.g. McCracken 1989; Gwinner, 1997), we extended the framework beyond consumers to include other relevant stakeholder groups such as employees, business partners, citizens, and the general public. We demonstrated that responses to brand-religion alignment can range from enthusiastic acceptance, to neutrality, to overt opposition, and are accompanied by relevant sensemaking processes. We view consumers and other audiences as agents (see Arnould and Thompson, 2005; Livingstone, 1998; Hall, 1973; Fiske, 1989; Radway, 1984) who actively create meanings that reinforce or contrast with those of brand managers (Thompson et al., 2006), ultimately supporting the *official* staged representation of history or, instead, diffusing counter-memories that propagate a different understanding of key events and characters (Foucault, 1977; Fowler, 2005; Lipsitz, 1990; see also Hall, 1973, on dominant, negotiated and oppositional decoding). These audiences' active meaning co-creation activities – whether positive, mixed, or negative – resonate with relevant personal or professional identity projects (see Mick and Buhl, 1992). In our study, for instance, some informants supported the name change, since it reinforced their religious identity, but also owing to their having a sense of pride in the local community; others deconstructed the image of Pope John XXIII and focused on his human qualities that transcended his role as pontiff in the Roman Catholic Church. Among those who did not support the new hospital name, some (notably among employees and suppliers) recalled the paradigmatic incompatibility between science and religion; others were afraid of possible religious interference with medical practices through

moral condemnation by the Church. In sum, unfavorable audiences' resistance is based on the circulation of oppositional meanings and counter-memories that focus on selected signifiers and key historical facts that are then adapted to the specific industry in which a brand operates.

Both the brand managers' actions and the audiences' meaning co-creation activities are situated in a nexus of macro-level structures that both enable and constrain their agency. Macro-level structural trends that are relevant to the religion-brand alignment process are those pertaining to religion, the nation, and the specific industry characteristics, which – in the specific context of the Catholic Church and healthcare in Italy – assume specific conformations (see again Figure 2). Concerning religion, key aspects that play a role in the context we analyze are the secularization of society (Berger, 1967; Turner, 2001), which can be understood as declining religious authority (Chaves, 1994), and the fact that an increasing number of people in Western countries today "believe without belonging" (Davie, 1994), that is, affirm that they believe in God without going to church or engaging in other religiously prescribed practices. In this general context, Italy is still a predominantly Catholic country where, despite the constitutionally sanctioned separation between state and church, the Catholic Church still enjoys special consideration by Italy's state over other religions (Ferrari and Ferrari, 2014). While immigration has contributed to an increased religious diversity than in the past, the country is not as multicultural as many of its European neighbors, and religious minorities are not very vocal in asserting their identities as in other countries. As our historical analysis shows, despite the secularization of healthcare and the emergence of public hospitals and science-based medicine, in Italy, the Catholic Church continues to be involved in healthcare service provision and, more importantly, still exerts its moral authority on medical practice, paving the way for the fears of possible undue interference, as highlighted by the medical staff in our analysis. At the same times, the presence of religious

symbols and figures, perhaps associated with the long tradition of miraculous healings associated with saints and other religious figures, can help comfort patients and their families when they experience suffering.

In countries that are more multicultural than Italy or that are dominated by other religions, a different web of structures would have shaped the systems of constraints and opportunities for the brand-religion alignment process. Similarly, in contexts other than healthcare, which deals with human suffering and the 'mysteries' of life and death, consumers and other stakeholders' responses might have been very dissimilar to those we have reported. By situating micro-level managerial decisions in the broader context of macro-level structures affecting religions and markets, in our view, our model can provide guidance to systematically map the system of influences affecting the brand-religion alignment, also in different countries and product groups.

Theoretical and managerial contributions, limitations, and further research

This paper explored business ethical issues at the intersection of marketing and religion in secularized and religiously diverse societies by examining stakeholder responses to the dedication of a public hospital to a religious figure. Many consider religion to be a cornerstone of business ethics. Yet, as the current literature review demonstrated, it can be problematic in secularized societies characterized by the not-always-peaceful co-existence of atheists, supporters of laicism, and followers of different religions in workforces and marketplaces. Organizations and brands can deliberately choose to align themselves to the tenets of one religion but, at the same time, they risk alienating, or simply being disrespectful to those (consumers, employees, and other stakeholders) who do not follow that religion. The business ethics literature has not yet thoroughly examined the implications of organizations and brands that demonstrate a religious alignment in secularized contexts. By raising this

issue, our paper is a modest first step in this direction. In addition, research in this context has typically focused on either employees or consumers, as if a company's internal organization and marketplace presence were independent of one another. We show that employees feel more strongly about issues that are of limited relevance to consumers. By adopting a multistakeholder approach, our study hints at the fact that spanning boundaries across disciplinary divides can produce a deeper understanding of the phenomena under examination.

Our paper also contributes to the limited literature at the intersection of marketing and religion. Religion and the marketplace influence each other (Mittelstaedt, 2002), and marketers can align themselves to the tenets of specific religions (e.g. halal or kosher food, Islamic banks, Catholic educational institutions, etc.). Mazumdar and Mazumdar (2005) identified several archetypes of marketer-religion interactions, including *religion-dominated*, *religion-included*, *religion-accommodating*, and *religion-insensitive* brands. Our case study can be considered a *religion-included* marketer catering to the needs of a predominantly Roman Catholic market. Yet, as our analysis shows, such a definition would not do justice to the complex relationships between the organization and its social, political, and religious contexts and the heterogeneous views held by different stakeholders and audience segments. Our model of brand-religion alignment, grounded in McCracken's (1986) meaning transfer model and subsequent revisions, offers a more nuanced view of the dynamics at play in the increasingly multicultural and political marketplace than previous theoretical accounts.

Considering both the alignment process and its reception by relevant audiences, our model also suggests several managerial implications for brand managers. These relate to the effective creation of a link with religion. Religious values, as we recall from the review of literature, can both divide and unite. Religion is not a univocal, monolithic source of meaning. Each religion contains a broad array of values, tenets, and exponents, some of

which may have a broader appeal to members of other religions and atheists alike. By selecting appropriate religious signifiers and adapting key cultural meanings and memories to the specifics of a brand and the product category in which it operates, a brand can maximize favorable image benefits and, at the same time, limit the risk of a negative reception and unfavorable responses. We acknowledge that this might be easier said than done; yet, the semiotic complexity of certain religious figures lends itself to a plurality of co-existing meanings: some consumers will privilege 'insider' religious readings, while others could instead focus on non-religious yet hopefully favorable connotations. Our model also highlights that managerial decision-making in this respect should pay attention to the structural forces that provide windows of opportunity but at the same time might trigger negative outcomes. As societies develop, the relative weight of the benefits and disadvantages of religious connotations might change. For instance, some U.S. university sport teams adopt religious symbols that are increasingly problematic for educational institutions catering to a religiously diverse audience. Mindful of this, the Wisconsin-based Maranatha Baptist University dropped the word "Crusaders" from its sport teams' names and also changed its mascot accordingly, to provide a more inclusive environment for non-Christian (notably, Muslim) students. In the future, as Italy becomes more multicultural, the adoption of a religious name by a public hospital might result in more criticism than we found in our study.

Our study has some limitations. First, given the dearth of research on issues of branding and religion, we adopted an exploratory research design and did not formulate hypotheses on expected findings. To our best knowledge, our study is one of the first to adopt a comparative, multistakeholder approach. No previous research could guide us on making predictions on how different stakeholder groups (e.g. consumers vs. employees) would react to a religion-brand alignment. Despite this, we clarified our ex ante theoretical understanding

of the issues at stake, also highlighting when research findings ran counter to our expectations. We also tentatively identified some variables that may intervene in successful religious signifier-brand meaning transfer, which could form the basis for future research adopting a hypothetical-deductive approach.

A second limitation relates to the unsystematic exploration of religion's impacts on our key variables. As noted in the methodological section, hospital policies prevented us from asking some stakeholder groups about their religious affiliation, while other informants left the question unanswered – a decision we respected. Our sample also included a limited number of non-Catholic and non-religious (i.e. atheist) respondents. Finally, a more nuanced view of respondent religiosity for Catholic informants would have been desirable. According to available statistics for Italy, while the vast majority of Italians identify themselves as Catholic, only a limited number are regular churchgoers (Eurispes, 2006) or, to use Davie's (1994) convenient expression, they "believe without belonging". Therefore, one of the many scales available to capture dimensions of consumer religiosity (for a review and recommendations, see Vitell, 2009) could have been profitably employed. However, in our view, the use of scales of this kind would have been considered invasive by the organization as well as the respondents. While our claim would have benefitted from a more nuanced understanding of respondent religiosity, in our view, even in light of this limitation, our key findings provide an interesting account of the issues at stake when brands align with religion.

Finally, our study explores a specific empirical setting – that of healthcare, which has idiosyncratic characteristics that set it apart from other industries and product categories and thus potentially limit our research findings' generalizability. In spite of this, our discussion moved beyond the empirical context and made sense of our research findings in general (and hopefully, externally valid) terms. In the empirical sections, following recent calls for a more contextualized understanding of research findings (Askegaard and Linnet, 2011), we made

sense of respondents' opinions by inscribing their views in the larger socio-historical context of the sometimes troubled relationship between religion and medicine. Given the complex issues at stake when organizations interact with religion, we felt the need to contextualize our findings in relation to Italy as well as the Catholic Church, and its past and current involvements in healthcare, medicine, and bioethics. Without such background work, our analysis and interpretation of findings would have been less profound. While different research designs are certainly possible, we recommend that future research on the interactions between marketing and religion engage with similar historical and contextual analyses that, in our view, can lead to deeper understandings of informant attitudes and responses.

Notes:

[1] The hospital, scheduled for completion in 2009 to 2010, was completed in December 2012, owing to technical delays.

[2] Data on professed religion were gathered only for patients and citizens, and not for employees and suppliers, owing to hospital policies.

[3] The local population is 47% female and 53% male; source: www.comune.bergamo.it.

[4] The average age of residents in the hospitals' catchment area is 45; source: ISTAT (2014).

[5] Data about the education level of people in the hospitals' catchment area were not available.

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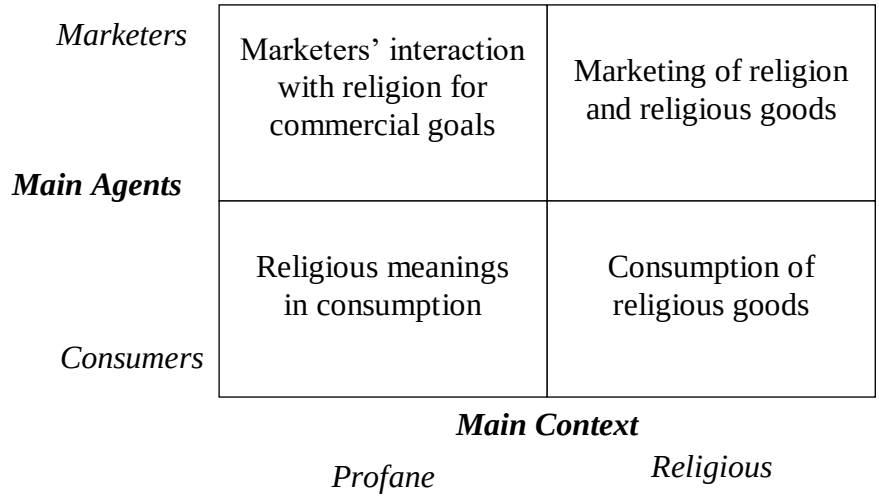
Figure 1: The Consumption and Marketing of Religion: A Framework



Source: Adapted from Rinallo et al. (2012b).

Figure 2: A Meaning-based Model of Brand Alignment with Religion

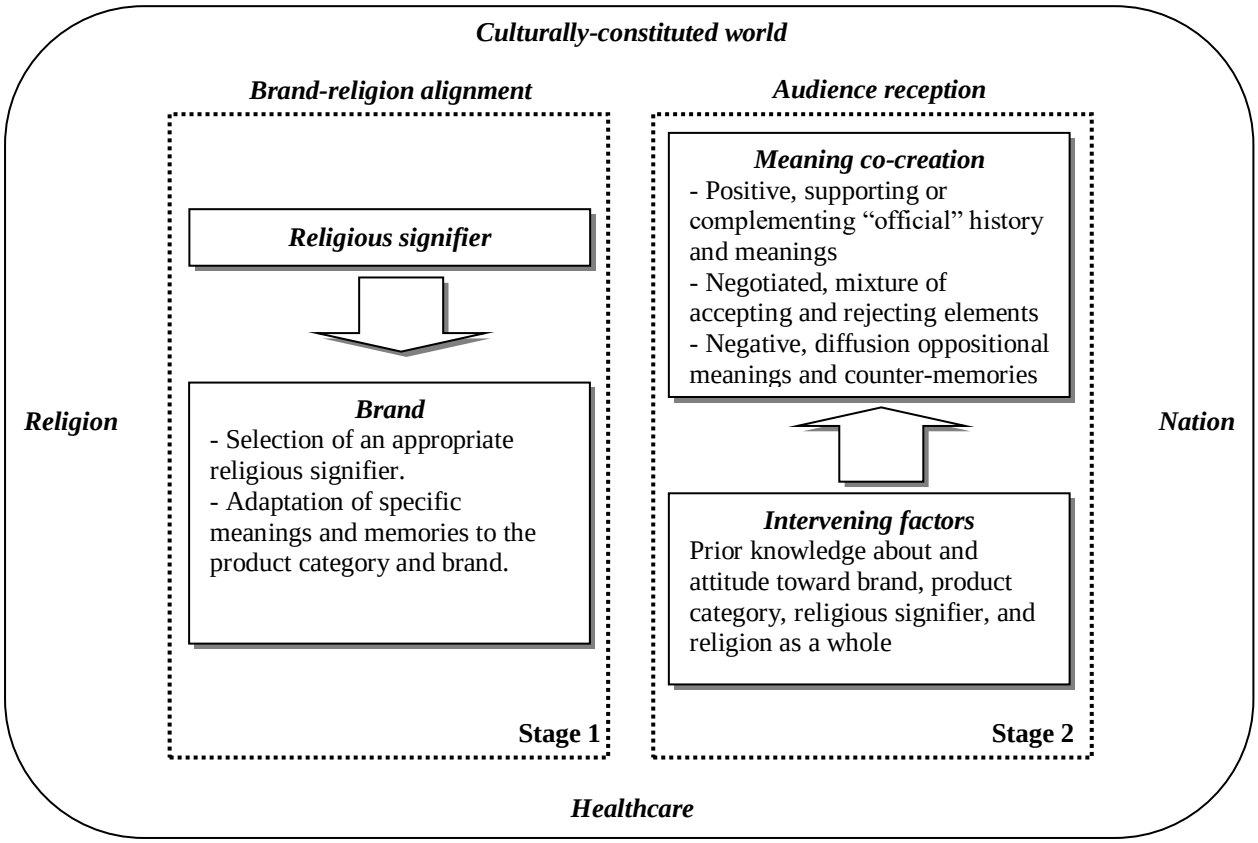


Table 1: Description of Data and Data Analysis

Data description	**Primary objective**	**Volume and type of data**	**Analytical procedure**
Review of internal documentation	Reconstructing the corporate renaming process	13 internal and external documents: three corporate social responsibility reports, six official deliberations by the hospital's CEO, positive opinions from the province of Bergamo and the Lombardy region; hospital CEO's formal request to start the renaming procedures to the Regional Committee.	Qualitative analysis (preliminary study)
Interviews with hospital officials	Identifying the reasons for the name change	11 unstructured interviews with hospital officials: the hospital's CEO, head of public relations, purchasing manager, three heads of clinical departments; five head physicians. (The interviews were transcribed verbatim.)	Qualitative analysis (preliminary study)
Field observations	Identifying the signs of religious presence inside the new hospital complex	Field observations at the hospital complex. 11 pages of field notes and 18 pictures.	Qualitative analysis (preliminary study)
News articles	Tracking media discourses surrounding the hospital name change	23 articles about the new name for the hospital based in Bergamo retrieved from three most important national (*Il Giorno*, *Il Corriere della Sera*, *La Repubblica*) and one local newspaper (*L'Eco di Bergamo*) from 2003 to 2014.	Qualitative content analysis (preliminary study)
Survey	Measuring and understanding the reasons for the acceptance level of the new, religious hospital name by the stakeholders	249 usable questionnaires from citizens (residents in the hospital's catchment area), 174 from consumers (hospitalized patients), 259 from employees (administrative, medical, and nursing staff), and 69 from suppliers.	Statistical analyses (closed-ended questions) and qualitative content analysis (open-ended questions) (main study)

Table 2: Respondents' Demographic Characteristics

N = 743	*Average age = 45.43*	
Variables	**Frequency**	**Percentage**
Respondent category		
Citizens	241	32
Patients	174	23
Hospital employees	259	35
Suppliers	69	9
Gender		
Female	378	51
Male	362	49
Education		
Master's/Ph.D.	65	9
Degree	271	38
Diploma	277	39
Secondary school	73	10
Primary school	24	3
Religion		
Catholic	271	36
Other religion	11	1
Atheist	21	3
Not available	455	60

Table 3: Acceptance of the New Name and Perceived Impacts on the Hospital's Image and Medical Practices (means, standard deviations, and one-way ANOVA test according to respondent category)

	Citizens		**Patients**		**Employees**		**Suppliers**	
	M	**S.D.**	**M**	**S.D.**	**M**	**S.D.**	**M**	**S.D.**
Do you agree with the new hospital name (Pope John XXIII)? (M = 3.85; SD = 1.349) $F_{(3.739)} = 5.94$, p = .001	3.87	1.386	4.19	1.155	3.66	1.419	3.65	1.258
How much do you think the new name will change the hospital's image? (M = 3.56; SD = 1.032) $F_{(3.739)} = 2.202$ p = .102	3.67	1.131	3.44	.927	3.58	.959	3.45	1.157
How much do you think the new name will change medical practices at the hospital? (M = 2.48; SD = 1.301) $F_{(3.717)} = 3.157$ p = .024	2.29	1.269	2.61	1.297	2.60	1.312	2.39	1.309

Table 4: Primary Reasons behind the Acceptance of the New Hospital Name and its Perceived Impacts on the Hospital's Image and Medical Practices

Question	Categories	Rater 1	Rater 2	Agreement	Percentage
A. Why do you agree or disagree with the new hospital name (Pope John XXIII)?	**A1**. I disagree because the hospital is a non-denominational institution	51	55	50	11
	A2. I disagree because the renaming costs too much	78	78	72	16
	A3. I'm indifferent	37	45	31	7
	A4. I agree because the name has a strong relationship with our area	187	198	172	36
	A5. I agree because Pope John XXIII is a positive person	174	151	139	30
Intercoder reliability = .843	*Total*	*527*	*527*	*464*	*100*
B. How could the new name change the hospital's image?	**B1**. In a negative way for religious issues	25	32	23	8
	B2. In a negative way – the loss of the reputation linked to the old hospital name	13	14	10	3
	B3. The name cannot change the image	175	187	170	57
	B4. In a positive way for the religion-related name	82	37	31	10
	B5. In a positive way because Pope John XXIII is a positive person	84	109	67	22
Intercoder reliability = .698	*Total*	*379*	*379*	*301*	*100*
C. How could the new name change medical practice at the hospital?	**C1**. In a negative way for religious issues	28	31	23	9
	C2. The name cannot change medical practices	156	169	152	62
	C3. In a positive way for religious issues	53	45	36	14
	C4. In a positive way because Pope John XXIII is a positive person	58	50	38	15
Intercoder reliability = .751	*Total*	*295*	*295*	*249*	*100*

Table 5: Primary Reasons behind the Acceptance of the New Hospital Name and its Perceived Impacts on the Hospital's Image and Medical Practices according to Respondent Category

Question	Categories	N. responses	Citizens	Patients	Employees	Suppliers
A. Why do you agree or disagree with the new hospital name (Pope John XXIII)?	**A1**. I disagree because a hospital is a non-denominational institution	50	20 (12%)	3 (3%)	22 (13%)	5 (13%)
	A2. I disagree because the renaming costs too much	72	19 (12%)	5 (5%)	43 (25%)	12 (32%)
	A3. I'm indifferent	31	9 (6%)	4 (4%)	13 (8%)	5 (13%)
	A4. I agree because the name has a strong relationship with our area	174	66 (40%)	41 (40%)	59 (35%)	8 (21%)
	A5. I agree because Pope John XXIII is a positive person	139	49 (30%)	49 (48%)	32 (19%)	9 (23%)
Intercoder reliability = .843	*Total **	*464*	*163 (100%)*	*102 (100%)*	*169 (100%)*	*39 (100%)*
B. How could the new name change the hospital's image?	**B1**. In a negative way for religious issues	23	10 (9%)	0 (0%)	8 (8%)	5 (20%)
	B2. In a negative way – the loss of the reputation linked to the hospital's old name	10	3 (3%)	2 (4%)	5 (5%)	0 (0%)
	B3. The name cannot change the image	170	52 (45%)	43 (77%)	63 (60%)	12 (48%)
	B4. In a positive way for the religion-related name	31	12 (10%)	6 (11%)	7 (7%)	6 (24%)
	B5. In a positive way because Pope John XXIII is a positive person	67	38 (33%)	5 (9%)	22 (21%)	2 (8%)
Intercoder reliability = .698	*Total **	*301*	*115 (100%)*	*56 (100%)*	*105 (100%)*	*25 (100%)*
C. How could the new name change medical practices at the hospital?	**C1**. In a negative way for religious issues	23	4 (4%)	1 (1%)	14 (14%)	4 (22%)
	C2. The name cannot change the healthcare approaches	152	62 (67%)	24 (63%)	57 (57%)	9 (50%)
	C3. In a positive way for religious issues	36	9 (10%)	11 (29%)	12 (12%)	4 (22%)
	C4. In a positive way because Pope John XXIII is a positive person	38	18 (19%)	2 (5%)	17 (17%)	1 (6%)
Intercoder reliability = .751	*Total **	*249*	*93 (100%)*	*38 (100%)*	*100 (100%)*	*18 (100%)*

* Totals do not correspond to those reported in Table 3 owing to non-responses. To increase readability, non-responses were omitted from this table.

Table 6: Finite Mixture Model Fitting Results

	L^2	Npar	P	BIC	AIC	CAIC	R^2	Class.Err.%
Independent	333.46	6	.0000	1,185.21	1,165.02	1,191.21	1.0000	.0000
2 classes	227.77	20	.05	1,154.64	1,087.32	1,174.64	.9856	.0273
3 classes	187.98	34	.73	1,169.98	1,095.54	1,203.98	.9194	.0301
4 classes	181.31	48	.79	1,228.44	1,096.87	1,276.44	.8240	.0807

L^2 = likelihood ratio; Npar = number of parameters; p = significance level; BIC, AIC and CAIC = criteria of Bayesian information; Class.Err. = classification error.

Table 7: Conditioned Probability of Acceptance of the New Hospital Name and Perceived Influence on the Hospital's Image and Medical Practices (results of latent class analysis)

Perceptual parameters (n = 214)	**Cluster 1** (69.64%)	**Cluster 2** (30.36%)
Acceptance of the new hospital name** (R^2 = 0.69)		
Negative	-2.14	2.14
Neutral	.068	-.068
Positive	2.07	-2.07
Perceived influence on hospital image** (R^2 = 0.12)		
Negative	-1.41	1.41
Neutral	.425	-.425
Positive	.988	-.988
Perceived influence on medical practice** (R^2 = 0.09)		
Negative	-.696	.696
Neutral	.1299	-.1299
Positive	.5664	-.5664

** $p < .001$.

Table 8: Probability of Each Stakeholder Type Belonging to one of the two Cluster Profiles Identified through the Latent Class Analysis

	Cluster 1 (positive)	Cluster 2 (negative)	Total
Stakeholder type			
Patients	.9514	.0486	1.00
Citizens	.7815	.2185	1.00
Suppliers	.6488	.3512	1.00
Employees	.5667	.4333	1.00