INTRODUCTION

Obviously, I am delighted to be with you today at this annual conference. I hope that what we will cover here this morning will be both interesting and helpful. As the title of this paper indicates, we will be examining certain canonical issues relating to “sponsorship” of Catholic health care, a concept that has taken on many different meanings over the recent years in relation to Catholic health care.

You can ask: how can we speak of canonical issues relating to sponsorship, when Canon Law does not even refer to the term. Because of this, it is not possible to quote canons that refer directly to our topic, although later on I intend to review some of the present norms that could show us how a sponsored work should be seen. So, in relation to sponsorship itself, we will have to base our thoughts on the life of the Church and from the newer situations that had to be faced as time moved on.

It is generally accepted that, today, “sponsorship”, in one form of another, entails the use of one’s name and the exercise of certain responsibilities that arise from this use. It often also entails elements of “Catholic identity” or “mission effectiveness”. It is to these dimensions that I wish to direct my attention today. The mission of health care entails some form of sponsorship relationship.

When we speak of sponsorship, I am taking for granted that we are speaking of “Catholic” sponsorship. However, there are many ways of being “Catholic”, and not everyone agrees on what is required for authentic “catholicity”. In the USA, the various CHA studies on benchmarks relating to “Catholic identity” showed how complex the entire matter is.

In a Catholic context, sponsors must be able to articulate what they consider to be the non-negotiables for the Catholic ministry, yet be flexible enough to choose between total control and having some presence, with the power to influence. The process demands a commitment to collaboration with others in order to make the transition to new forms of healthcare delivery.

To understand better where we are heading, I believe it would be helpful to go back in history some 50 years to see first of all how we have reached the sponsorship situations we are living today (“yesterday”). From there, we could turn our attention to some
newer challenges and to new forms of relationships with others (“today”). Then, in a third part, I would like to raise some issues relating to the future of sponsorship, without having any pretense of being a prophet (“tomorrow”).

I. SPONSORSHIP YESTERDAY – HOW WE GOT TO WHERE WE ARE PRESENTLY

A. Operating under the Health Ethics Guide

The development of Catholic health care in Canada could be identified by the word “adaptation”. From the arrival of the Augustinian Sisters in the 1600s, to the present time, the delivery of health care has indeed been marked by adaptation to the various challenges that had to be faced. There were geographical and cultural challenges, financial difficulties, issues relating to qualified personnel, and so on. In more recent times, as governments became more and more involved in the financing of operations, further adaptations had to be made. Then, within the Church, changes also had to occur. For instance, while these works were often originally carried by religious institutes, the changing demographics of these communities led to the establishment of new canonical structures to ensure the Church’s continual presence in sponsorship roles. Then, in addition, as health care ethics evolved, with new discoveries and techniques, new moral issues had to be.

To set a context for this review, we could recall that, in 1915, The Catholic Hospital Association of the United States and Canada was founded.

Then, in 1921, Rev. Michael Burke prepared a document, “Surgical Code for Catholic Hospitals”, Archdiocese of Detroit. This one-page set of directives was subsequently adopted by many other dioceses, and hung on the walls of operating rooms. They prohibited anything that resulted in the destruction of fetal life or the sterilization of men or women (certain exceptions were foreseen – according to the principle of double effect).

In 1948, we saw the first edition of Ethical and Religious Directives for Catholic Hospitals in the USA and Canada, published by the Catholic Hospital Association in the Linacre Quarterly, and then (1949) as a separate booklet. A French edition for Canada was published in 1950. It was drawn up by a committee of theologians and health care professionals. It was not an official Code, unless adopted by the diocesan bishop. Although many dioceses did adopt it, not all did.

In 1954, the Canadian Government introduced a system of universal health care, and so a separate Catholic Health Association of Canada was founded to address the new issues arising from this policy. Henceforth, the ERDs would apply only in the USA. The
Canadian Bishops then officially adopted a *Code of Ethical Directives* for the hospitals under their direction.

Since then, there have been three official editions of what is now known as the *Health Ethics Guide* (1991, 2000, 2012). With each new edition, practices in the delivery of health care in Canada had to be re-examined. But these did not touch the evolving sponsorship structures as such.

We could ask ourselves, “What is the canonical status of the *Health Ethics Guide* in Canada?”

Simply taken as a document, the *Guide* has no force. However, since many of the principles contained therein are a repetition of standard church doctrine, these individual articles could well be binding on Catholics, not because they are now in the *Guide* but because of their content.

It is well-established canonical principle that the CCCB cannot make laws binding on each diocese unless it is either a case foreseen in the law for the Conference to act (“Complementary Norms”), or where the Holy See has authorized particular law (as was the case in the USA with the Dallas norms).

So, in order for the document to be binding, as such, in a particular diocese, it must be promulgated as law in that diocese. A number of dioceses have already done so, either directly or explicitly.

However, even though the document was never formally promulgated in a given diocese, we can say that Catholic healthcare institutions in the Canada abide by the *Guide* in their practice.

Personally, as a canonist, I see a great advantage having the *Guide* (or some similar document) promulgated as binding in the diocese. This is because there is great pressure from some circles today to say that a provider must do anything requested, provided that it is legal. Some even go further: those who will not provide certain procedures cannot participate in federal and provincial programs. There must be an objective basis upon which to justify the denial of certain procedures in a Catholic institution.

The *Guide* should not be seen as a series of negative precepts. They have very positive values and goals. Only a very few articles contain a prohibition. Rather, they are intended to be the ethical standards of behaviour in health care that flow from the church’s teaching about the dignity of the human person.
B. The evolution of sponsorship structures in Canada (and elsewhere)

Indeed, when we look at the evolution of forms of sponsorship in the fifty years since the Second Vatican Council, we tend to take it for granted that these were normal developments. Yet, each of them, in one way or another, called for lengthy deliberations, study and prayer. They were not easy decisions to make at the time, because they implied a certain separation from the past. Even though we are now relatively at ease with the present-day situation, we cannot forget that the evolving decisions were all taken, in one way or another, to ensure that the Church’s health care mission could continue, while taking new situations into account.

The most common form of sponsorship in the past derived from direct ownership of the property and the active presence of many persons identified with the sponsor (for instance, religious women on staff). The name of the sponsoring institute was often found in the name of the institution. In a sense, the sponsored work operated as though it were a family business. We were mostly dealing with stand-alone health care institutions. The sponsors were also directly involved in the actual delivery of health care.

Then, after the Vatican II period, more emphasis began to be placed in Church circles on the dignity of the baptismal vocation, moving away from an almost exclusive reliance on the vocations of priesthood or religious consecration. This change in thinking opened the doors for more and more lay persons to become involved, at least initially as members of advisory boards. At the same time, the number of available religious began to show signs of diminishment.

With time, and also because of the factor of diminishment, the duties of sponsorship became more identified with those of the board of directors and the establishment of policy, rather than with actual delivery of healthcare services.

Later, certain works acquired a civil recognition (incorporation) distinct from that of the sponsoring religious institute. This lead to the distinction between “members” and “directors”, and the establishment of separate boards of directors, with the “membership” often overlapping with the leadership of the sponsoring institute.

Then, there came about a further separation as a two-tiered structure was put in place: a clear distinction was made between the “members” of the corporation, and the board of directors. Relations between the “members” and the “board” were governed by the use of reserved powers.

Although the Code of Canon Law makes little reference to what are now known as “reserved powers”, when these were first being considered as an acceptable mode of operation, some fourteen or so powers were considered to be essential, since institutes
did not feel that they could or should let go of their institutions too easily. Among such powers, at the time we found: approval of the operating budgets, the ratification of appointments to various offices (and not just the appointment of the CEO and of board members), approval of the auditor, etc.

With time, however, the number of essential reserved powers was diminished, as sponsors become more comfortable with the idea of having others directly involved in their ministry, and these powers now focused on documents (corporate documents, by-laws, mission statements), on persons (CEO and Board) and on property (alienation). We often refer to these categories as the three “P”s – paper, persons, property!

Then, to facilitate coordination and to reduce expenses, “systems” began to be established, grouping several institutions sponsored by the same religious institute (the *Sisters of St. Joseph of Hamilton Health System* was one of the first such ones in Canada). This resulted in a further refinement of reserved powers, with some being operative at a lower level, rather than at the level of membership. I should note here that I am using the term “system” in its broadest sense, and not necessarily in the formal sense we find used in many places.

Not surprisingly, as a next step, in certain places, a number of religious institutes came together to sponsor their works jointly. through forms of inter-congregational systems. When these types of systems first came into being, the reserved powers were often initially exercised separately for institutions originally owned by one institute, as distinct from those under another sponsor; then later, because this arrangement proved to be quite cumbersome, many of the reserved powers were delegated jointly on a permanent basis to the new board governing the jointly sponsored works, with only the property issues, such as ownership, alienation, and stable patrimony, being reserved to the original sponsors.

Today, canonists are still struggling to refine thinking about what is required relating to property ownership and stable patrimony. Before 1983, the concept of “stable patrimony” was not one that was in general use. So, while previously, buildings as such were considered to be the equivalent of stable patrimony, today they are often considered to be liabilities because of insurance payment plans, etc. Also, closer investigations showed that many of the funds identified with a hospital or another health care institution were not congregational funds as such, but rather were trusts from the public administered by the sponsors.

A further step occurred when certain dioceses asked whether they could become partners in the systems, particularly in relation to charitable activities and to subsidized and long-term housing units they sponsored. This was particularly evident in Alberta and Saskatchewan. It became important, then, to make clear that the diocese came in as one equal partner, and not as a superior one. This called for delicate crafting of the governing documents.
As a consequence, once institutes and dioceses came together to operate institutions and works jointly, it became appropriate to establish new distinct church corporations – known as “juridic persons” – to assume sponsorship of the joint works. The works then took on a life of their own, distinct from that of the original sponsoring entities. The Archdiocese of Edmonton was one of the first in Canada to use this method.

Because such systems often overlapped diocesan limits, it eventually became necessary to have a higher authority grant canonical recognition. Thus, the involvement of the Holy See in granting new types of recognition, commonly known as “PJP”s. Contrary to the USA, we must keep in mind that since the delivery of healthcare is under provincial jurisdiction, there was a need for provincial entities. Catholic Health Sponsors of Ontario is an example of such an arrangement, where Bishops and major superiors were initially involved. Nevertheless, by exception, Catholic Health International operates also outside Canada.

At the same time as these developments were taking place, other factors began to make themselves felt. For instance, various forms of partnerships or joint operating agreements were no longer exclusively with Catholic providers. Sometimes, they were with other faith-based providers; sometimes, with community organizations that had no particular religious traditions in their background.

Looking at these arrangements, at times, the Catholic sponsors were but a small factor in a larger system, especially those mandated by Government authorities (such as LIHNs); at other times, the size factors were rather equal; at times, the Catholic system predominated. The arrangements made in such circumstances varied from place to place.

As Catholics began to partner more and more with groups that were not Catholic, especially under Government pressure to coordinate services, the issues revolving around moral theology began to take on more importance, since the major canonical issues (relating to the three “P”s) had pretty much been resolved for the time being. Beforehand, these moral questions were simply taken for granted since all adhered to the same teachings and practices. A positive commitment now had to be made towards a number of values, many of which were enshrined in the Health Ethics Guide.

While Catholic undertakings would not enter into partnership agreements with providers that offered abortions, end of life hastening procedures, and the like, when other partnerships were considered, there was not the same general policy, as, for instance, in relation to gay-related issues, sterilizations and other means of contraception. Nevertheless, this has not taken on the same political importance as it has in the USA.

In spite of this, the February 17, 2014 Vatican document on “cooperation” will force us to sit down are review certain policies (although, given its realistic stand, I do not see this document as having any negative effect in Canada). To a certain extent, practices are now becoming more and more harmonized in relation to what is deemed to be an
acceptable form of partnership. Yet, just as one point seems to be settling down, new issues are arising on the horizon and which have not yet been fully addressed, such as cloning, in vitro fertilization, gene experimentation, and so forth. These too will have to be considered delicately, yet clearly.

In addition to establishing alliances with providers who were not Catholic, there was also the pressure of entering into agreements with providers who were operating on a “for profit” basis, thus risking a change in the nature of the work from that of an “apostolate” to a “business”. Special collaboration with private clinics in Quebec and in Alberta opens the door to such possibilities.

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From a canonical perspective, then, what is interesting, is the fact that most of these structures – except possibly the original stand-alone facilities – were not directly provided for in Canon Law. They were the result of constructs, with which people became more familiar and at ease. We are now on the verge of even newer structures, as some of our present ones seem to become somewhat dated in their approach.

II. SPONSORSHIP STRUCTURES TODAY – NEW SKINS FOR NEW WINE

A. PJPs today

For the past ten or fifteen years, it looked as though the “Public juridic person” (PJP) approach was one that would provide a sound canonical basis for sponsorship, at least for the foreseeable future. Many different approaches were taken in this regard, according to local situations. We now have diocesan or pontifical PJPs in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, and New Brunswick. They enabled the transfer from sponsorship in the hands of the original sponsoring institutes, to highly committed law peersons who were willing to assume such responsibilities in the name of the Church.

However, I wonder if we are not already starting to show signs that we are “growing out” of the PJP model as we originally knew it. Three areas in particular come to mind.

(1) In practice, our present pontifical PJPs were recognized by the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life. As long as the original sponsoring religious institutes remained involved to some extent, CICLSAL had jurisdiction to oversee these groups. However, lately, some of the original PJPs have now petitioned the Holy See to transfer to self-perpetuating boards (Catholic Health Sponsors of Manitoba is an example of this). If a religious institute is no longer in any way involved, which Roman department will be in a position to exercise oversight on the
works? This question is being studied at the present time, and I have no idea of the eventual outcome of these discussions. This takes on particular significance today, given the fact that there are now new persons in charge of CICLSAL who are sparing no effort to become more aware of the various historical backgrounds leading to our current structures, but who also have to provide answers for the future.

Also, it is important to keep in mind that not all PJPs are for healthcare either. Some are multi-purposed (healthcare, education, social services); others are limited to one specific area of the apostolate (Catholic social services, education, healthcare, etc.). Solutions that the Holy See would eventually wish to adopt would have to be applicable throughout the entire Church and its various missions, at least as far as the general principles are concerned.

(2) There is a second factor to consider. Because the current *Health Ethics Guide* (pp. 11-12) calls for the intervention of the diocesan bishop when new partnerships are being envisaged, this has led to a whole new dynamic in relation to the delivery of Catholic health care and Catholic identity. Such partnerships are inevitable, but, in some places, there are not that many acceptable partners to choose from, especially in certain geographical areas. In other words, new arrangements will call for direct collaboration on the part of diocesan authorities.

A complication arises from the fact that as new partnerships are being developed today, the place of the PJP is one that is causing concern. It is not considered appropriate for a PJP (or one or more Church entities) to sponsor directly activities that are not in conformity with the *Health Ethics Guide* – or the applicable similar document in other countries. So, then, what does the PJP actually sponsor today?

(3) A third development concerns the persons involved. When PJPs were being promoted, the baptismal and confirmation status of those involved became the basis for their membership on the PJP. However, today, in addition to persons who belong to other Christian denominations, we also have non-baptized persons who are members of some PJPs. So, it will be back to the drawing board in relation to the theological justification for these new entities.

C. Present-day canonical requirements for sponsorship of Catholic institutions
1. **Canonical elements of sponsorship today**

Leaving aside for the moment issues relating to the *Health Ethics Guide*, we could see what the current canonical legislation might have to say in relation to works that are operating under Catholic auspices.

As we know, it has generally been held that, for a work to be able to be identified as “Catholic”, it must, in one way or another, be related to a Church entity, such as a diocese, a religious institute, one of its provinces, or even one of its established houses (canon 634). While, in general, this statement is obviously true, we must keep in mind that, indeed, there could be exceptional situations in which no formal canonical entity is involved and yet the work is considered by the diocesan bishop to be “Catholic”. In spite of this possible and rather rare exception, we can nevertheless proceed today under the general presumption that, indeed, there is to be a canonical sponsor in order for a work to be considered as fully within the ambit of the Church’s mission.

As various theological and historical studies have shown, the term “sponsorship” is relatively new in Church circles.¹ It was originally given wide circulation as part of a threefold approach to health care works: ownership, sponsorship, control. “Ownership” referred to holding title to the property; “sponsorship” usually referred to the body under whose name it operated; and “control” referred to the internal governance.

With time, though, the distinctions among these three dimensions have come more and more blurred. For instance, we can have sponsorship with or without ownership; ownership with or without control, or with very little control; and degrees of control with various forms of sponsorship.

It is rather advantageous for us that Canon Law does not define “sponsorship”, because we are not bound by any special legal parameters. Through the course of time, as we have just seen, various forms of sponsorship in the Church have been tried and tested. No one form has proven to be the only correct one, with the others being inferior, or even bad. The forms are simply different, and nothing more.

Therefore, it is not possible to quote directly from canons that would tell us definitively what is required for a Catholic sponsored work today. So, we have to find the seeds of answers in certain canons that are not directly referring to sponsorship. Canon 19 of the *Code of Canon Law* tells us that if, on certain matters, the law does not have a direct provision, then, among other possibilities, we look at laws in place for related matters and at the common teachings and practices of the Holy See and of specialists in the matter.
So, in this perspective, I have selected canons that I consider to be appropriate for our purposes here. Other canonists and persons involved could certainly come up with different ones.

2. Qualities to be found in a sponsored work

A clear distinction is to be made between “Catholic works” and the “works of Catholics”. The former are undertaken “in the name of the Church” (canon 116.1), with all the guarantees of the Church behind them. On the other hand, works of Catholics are those undertakings of Catholics which might have an ecclesial relationship, or might be totally secular in their nature. A number of very “Catholic” activities are, indeed, works of Catholics and not “Catholic works” as such; I am thinking more particularly about the activities of the St. Vincent de Paul Society, or those of the Knights of Columbus, and so forth.

Here, obviously, I am speaking of “Catholic works”, and not of “Works of Catholics”.

1. First of all, a canonically sponsored work must have a spiritual purpose (see canon 114). Such a purpose can be either a work of piety, a work of the apostolate, or a work of charity. Canon 676 speaks of lay religious institutes participating in the pastoral mission of the Church through the spiritual and corporal works of mercy. It is not difficult to see how the healthcare or educational ministries fit into a number of these categories of “mercy”.

The words of Jesus (Matthew, 25: 35-40) and those recorded in Matthew, Chapter 5, vv. 3-10 (“The Beatitudes”) have led to what have been traditionally considered in the Church to be “the corporal works of mercy”: (1) to feed the hungry; (2) to give drink to the thirsty; (3) to clothe the naked; (4) to shelter the homeless; (5) to visit and care for the sick; (6) to visit those in prison; and (7) to bury the dead.

But, if the purpose is purely “business”, with no apostolic component, then the work should most likely not be sponsored by Church-related institutions.

The spiritual purpose is exemplified also in the efforts of the sponsored work to protect and enhance its Catholic identity, based on its mission, sponsorship arrangements, concern for holistic care, and conformity to approved ethical principles.

2. Secondly, a work carried out in the name of the Church must answer a need. Canon 114 even speaks of a “genuinely useful purpose” (when dealing with juridic persons). It could have happened in the past that some Catholic institutions were established, not because there was a real apostolic need, but rather to “fly the flag” because other groups were carrying out a similar mission in the same geographic area.
Fortunately, in many places, the time for such undue rivalry and competition has passed. Of course, what was, at one time, a particular need, might not be so today because of changing circumstances.

3. A third condition mentioned in the Code is that the undertaking have **sufficient means** to achieve its purposes (see canons 114, §3 and 610). We all know that, in many circumstances, some works were simply unable to prosper because of lack of funding. On the other hand, we are all well aware that there are many instances of foundresses of religious institutes who made do with almost nothing and, through faith, enabled the works to flourish. The necessary means are not limited to financial assets; a spirit of faith and a willingness to work diligently are also part of the necessary means. Likewise, having sufficient qualified personnel is a prerequisite.

4. Fourthly, works carried out in the name of the Church are expected to have a certain **perpetuity or stability**. We are not involved in fly-by-night operations. It takes a long time to nurture a bud so that it becomes a tree in full bloom. Of course, if the need to which the Church has been responding no longer exists, then the principle of sound administration would call for the closure of the work.

5. Fifthly, canon 116 refers to tasks or missions that have been “entrusted” to those who are to carry out a work. Those who have been so “entrusted” are to carry out their tasks as good stewards, caring for the work and its assets (see canon 1284, §1). So, the responsible stewardship of the temporal goods entrusted to a work of the Church, and the resulting need for appropriate accountability, are major components of good sponsorship.

But, if the people selected for this mission are not given the appropriate preparation, we cannot expect them to approach their work in a spirit of ministry. It simply is not fair to have this expectation, without providing means for it to become a reality.

6. There is a sixth and most important characteristic that we find mentioned in canon 806. While this canon does not apply directly to healthcare institutions – indeed, there is no mention of these in the Code – it applies directly to educational activities in the Church, and, by analogy (in accordance with canon 19) could – and perhaps should – be applied to our various hospitals and related healthcare institutions, as well as to our social services. With appropriate adjustments, we could say then that the canon notes that those in charge of a Catholic work are to ensure that, under the supervision of the local Ordinary, the care given in it, or the works being carried out, are in their standards, at least as outstanding as those in other similar institutions in the region. In other words, if the name of the Church is to be attached to a specific undertaking, **this work must be one of quality.**
Indeed, if an activity is not of the highest quality, serious questions ought to be asked about whether or not it should continue. There is no place for second-rate activities. This does not mean that activities have to have the latest technological instruments and facilities, but what it does mean is that the apostolate carried out there be of fine quality.

7. In many areas, providing a work of quality calls for special preparation. Canon 227.1 refers indirectly to this. Just as we would not let a physician practice who has not been prepared, duly licenced, and who remains up to date, so too those in charge of mission and related areas must also be duly prepared and remain well-informed. It is difficult to improvise in such situations. Possibly, today, the one area that is going to call for even great quality and preparation is the area of ethics, with its various dimensions. As issues become more and more complex, and the pressure to regard simply the financial implications of decisions rises, it is not always easy to have quality ethical decisions in the workplace. A good ethical decision does not necessarily mean the strictest one possible. Rather, it is one that takes into account all of the factors that are operative in the situation. It is interesting to note that Pope Benedict XVI, in his Encyclical, Caritas in Veritate, speaks of “intergenerational justice” as one of the facts of ethics to be kept in mind today when making decisions (No. 48) – what impact will our decisions have on future generations?

These principles, found here and there throughout the Code, can serve as guidelines for those who are carrying out their mission in the name of the Church. This mission is not just a personal activity; rather, it is part of a much larger plan, one that will eventually lead those sharing in it to the fullness of life in faith and in joy.

III. SPONSORSHIP TOMORROW – WHERE ARE WE HEADING?

In the January 2013 issue of Health Progress, I published a short column relating to the possible future of Catholic health care in the USA, and I asked the very serious question of whether or not we are painting ourselves into a corner. With certain adaptations, the same principles could apply to Canada.

My experience in following the approval process for the Health Ethics Guide leads me to raise a certain number of very delicate issues.

As most of you know, for many years now, I have been actively engaged in the canonical side of the re-structuring of many Catholic health care systems in Canada, the USA, Ireland, Australia, and so forth. Indeed, in the coming months and years, we should not be surprised to find that a number of our present systems and PJPs will be actively seeking for new forms of partnerships and relationships.
However, in many instances, when considering possible new arrangements, we come up against certain moral issues, such as the question of sterilizations, or relations with clinics dealing primarily with homosexual patients. These have become, in many ways, the major point to be considered when dealing with new alliances and forms of cooperation. But, I wonder if instead it shouldn’t be the mission that is of primary importance.

To understand where I am coming from, we have to go back once again some fifty years in time, to the beginning of the Second Vatican Council and its decree of Ecumenism and its Declaration on freedom of conscience. Before the Council, when dealing with Christians who were not in full communion with the Church, the basic operating principle seemed to be that of Pius IX: “error has no rights.” And, it followed, that since they were “in error”, then they had no rights as far as the Church was concerned. But it took someone like Father John Courtney Murray, S.J., to break the deadlock, by showing that even if error in itself didn’t have rights, persons did, and especially as a result of their baptism. This lead to an entirely new approach in regard to ecumenical matters, and the fifty years since the Council began show us clearly the benefits of a new approach. Of course, this doesn’t mean that there are still not “messy” areas that would have to be addressed – intercommunion and ordination being two of them. But, these obstacles did not prevent the Church from moving forward with dialogue and many concrete acts of ecumenism in life. This was indeed a breath of fresh air for the Church and the entire Christian community.

Jumping ahead to today and especially to tomorrow, when it comes to the reorganization of health care in Canada, I wonder if we are not painting ourselves into a corner similar to that we were in before Vatican II.

I would hope that there would be a way out of this impasse which faces many health systems today. If only we could find another Father Murray to shed new light onto our approach, and lead us in a dialogue that could open the door to numerous future possibilities.

Although the various eexual issues seem somehow to have become the principal focus in our negotiations, I wonder if we could not shift our focus somewhat to the mission of Christ, to determine how we can be present in the community and also in the hearts and minds of so many people who come to us seeking healing and good health. The Catholic Church is an “evangelical” Church, based on the Gospel. We are not like the Amish who seem to have withdrawn from today’s world. But, if we are in the world, among the sheep, we have to be willing to smell like the sheep, as Pope Francis keep reminding us. Our mission is grounded in our vision of Church. Usually, we refer to “ecclesiology” when speaking of the theology of the Church. It seems to me that ethics which are not grounded in sound ecclesiology risk leading us down the road of casuistry or into a corner.
Vatican II tells us clearly that Christ is the light of all nations, and that the Church is the sign of unity with Christ and of the unity of all humanity (see *Lumen gentium*, No. 1). Our living of this sign today has to build on our social, technical and cultural bonds. We speak of “the Church in the World”, and not of “the Church and the World”, as if the two were totally opposed. Therefore, any approach we adopt would have to keep these perspectives in mind.

Not for a moment am I saying that the ethical considerations are not important. But, they have to be part of a whole, a greater picture. As Matthew’s Gospel (Mt: 23:23) tells us: “These you ought to have done, without leaving the others undone.” Or, the *Catechism of the Catholic Church* tells us clearly that there is a “hierarchy of truths” in relation to the way in which they relate to the foundations of the Christian faith (see No. 90; also No. 234). Likewise, the First Letter of John (I John, 5:16) tells us that not all evil is of equal significance. I think it would be necessary to avoid what could be considered to be exaggerated approaches and to restore the primacy of our mission in the Church.

Indeed, by starting from the mission – to imitate Christ who was doing good for others (see *Code of Canon Law*, canon 577) – we could then look at what are some of the issues at stake, not forgetting that, here too, we will have some “messy” elements that don’t seem to fit into place, but which should not stop us for trying to move forward.

Fortunately, when dealing with prospective partnerships, we are most clear in regard to forms of affiliation with institutions that offer abortion procedures, in vitro fertilization, euthanasia, and similar activities. Uniformly, we hold that we will not enter into partnership with groups offering such procedures, or that would force us to offer such procedures in our institutions. This sends a very clear message to others about the stand the Church is taking in relation to the protection of human life from conception to natural death. But, it could be asked whether this same stand applies to every activity that is considered to be morally unacceptable. For instance, we don’t seem to have too much difficulty in working out partnerships with groups that have union or labor troubles, or other issues relating to social justice issues. Yet, in the long run, aren’t these justice issues as important as some of the other ethical ones we are facing today?

If our positions become too hardened, then we can readily see the consequences. The most obvious temptation would be to renounce the Catholic identity of our various systems and their individual institutions, and become simply a secular undertaking. But the consequences of such a decision would have very long-term negative effects. Through the centuries, the Church has struggled much to maintain its healthcare services, and it should not be expected simply to withdraw from the market-place today because of certain issues.
We were always taught that a good ethical decision was also judged by its long-term consequences. If there is no proportion between the act and its effects, then it is difficult to say that the act or the decision was good in itself, even though it might have resolved an issue for the moment. If certain “ethical” decisions lead the Church to have to withdraw from healthcare ministry, we must sit back and ask whether these were, indeed, sound ethical decisions.

I am not an ethicist or a moral theologian, and I don’t know all the ins and outs related to some of the moral decisions being taken in relation to cooperation, but, as a canonist, and keeping in mind the last words of the Code of Canon Law: “the supreme law is the salvation of souls”, I wonder what type of ecclesial community we are preparing for tomorrow.

Therefore, would there not be place today in the Church for some type of structured dialogue among Church leaders, ethicists, ecclesiologists, canonists, and others, to see whether or not we could come up with a new approach that would get us out of the corner into which we seem to be backing ourselves? This would be important before it is too late and we have lost systems who have to face all types of legislative and community pressures when offering (or refusing to offer) various types of healthcare procedures.

Or, perhaps, has the time come when the Church in North America can no longer offer acute care services? There would, of course, still be many other healthcare needs to be met, especially in the area of senior care, rehabilitation, home nursing, palliative care, and so forth. But, it would be too bad if we had to withdraw from acute care simply because we were unable to sit down and evaluate possibilities. But this implies beginning with a different starting point.

A second point to keep in mind for the future is the on-going formation of those to whom we have entrusted the delivery of Catholic health care. It is not fair to expect them to have all the required knowledge, and, if we don’t provide it to them in an understandable way, we should not be surprised that, through no fault of their own, they make decisions which could have long-term negative effects on the delivery of Catholic health care in Canada.

CONCLUSION

As you can see, “yesterday” was easier and more directly related to canonical sponsorship. Yet, it had its struggles and its emotional issues. As for “today” we have been able to work out some possibilities which enable us to continue. But, when it comes to “tomorrow”, if we don’t do something soon, I wonder if there really will be a “tomorrow”. I don’t want to sound pessimistic, on the contrary. But there is too much at stake here and we should be able to come up with solutions that would enable the
Church’s mission to continue through appropriate forms of sponsorship, in spite of the significant pressures that we are facing from all sides.

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