The Mission of the Catholic Health Apostolate: Response to Social Change in Canada

by

Maureen H. Muldoon

A thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Philosophy, University of St. Michael's College September 1987.

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For my parents,

Jack and Helen Muldoon

Contents

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INTRODUCTION

1. The Catholic Health Apostolate and Mission

Is the area of practice relating to abortion and non-therapeutic sterilization the only difference between a Catholic health care facility and a non-denominational facility? What are the characteristics which distinguish the one facility from the other? It is this line of questioning which has lead the writer to focus on the mission of the Catholic health apostolate.

The Catholic health apostolate is composed of people who continue the healing ministry of Christ. The apostolate is characterized by a wide range of participants who include bishops, priests, religious congregations and organizations which employ the services of both lay Catholics and non-Catholics.[1]

The mission of the Catholic health apostolate shares in the wider mission of the whole Church, though the exact nature of this relationship has not always been clear. According to the Second Vatican Council, The Decree on the Apostolate of the Laity states explicitly: "The mission of the Church is not only to bring people the message and grace of Christ but also to permeate and improve the whole range of temporal society".[2] The Church's mission involves many ministries. These include the ministry of preaching, campus ministry, parish ministry, the ministry of education, and

the healing ministry. Christian ministry seeks to communicate truths revealed by God through Christ, to establish community through the power of the Spirit and to offer help to those most in need. These three characteristics are essential for the ministry of healing and health care.

Drawing from the resources of the whole Church, the Catholic voluntary association can serve the Church's members, as well as others with its particular skills and expertise. Mediation occurs between church and society as these organizations project the Church's ministry into the life of society in a way which neither the hierarchical institution nor the individual Catholic is able to do.[3] These associations include religious congregations of women and men and a variety of associations representing various groupings of believers coming together to serve specific purposes.

For the religious congregation, the 'charism of foundation' is the basis of their origin. Mary Milligan, RSHM, clearly and concisely describes the 'charism of foundation' as "a grace given to an individual or to several individuals, resulting in the existence of a 'community in mission' within the church."[4] Milligan further elucidates three 'moments' in the process of foundation, which are not necessarily chronological. These moments refer to the original inspiration, the gathering of persons into a community and a process of institutionalization.[5]

Introduction

The first moment in the charism of foundation is what the Second Vatican Council called "the original inspiration".[6] Within it, one has the elements of a faith vision, a sensitivity to specific needs and the dynamism of charity.

> The faith vision is the gospel perception of the founding person...This personal understanding of the gospel was a sort of prism through which the founders and foundresses saw the specific concrete needs around them. As doers of the Word and not merely hearers, they were led to respond concretely to their own world.[7]

The second moment is the establishment of congregation. Milligan explains that "the faith vision and concrete response of the founding person provoke a response in other persons who because they share the same evangelical concerns choose to associate themselves to the founding person."[8] The third moment is the process of institutionalization. This is the articulation of values, goals and means in a stable form such as in a Constitution of the congregation. The charism of a congregation carries a mission.[9] Both charism and mission are realities which are broader than the concrete expression in their particular works.[10]

In the past, the presence of the sisters within the Catholic hospital was a visible sign of that institution's Catholicity. But at the present time, with the involvement of fewer and fewer sisters in health ministry, the absence of the visible presence of these sisters has made it more difficult to identify those characteristics which specifically constitute a Catholic hospital. With increasing numbers of lay persons assuming roles previously carried out

by the religious sisters, questions have arisen about the charism of the congregation which first led the sisters into hospital ministry, providing them with this vision and a sustaining spirituality. What is the influence of this charism on lay persons who are associated with the activities of a Catholic health facility, perhaps still sponsored by the founding congregation? If the charism of the congregation does not attract these people to a similar vision and if it does not inform their spirituality, how will Catholics foster a vision and a spirituality which is distinctively Catholic, and which is appropriate to lay persons so that the work of the health apostolate will continue? [11]

Other associations, besides religious congregations, have arisen within the Church. These serve a variety of needs: education, the provision of social services and the cultivation of spiritual life, to name a few examples. A charism does not found these associations. They may have a stated mission, though this is not always the case. Yet, these associations have a role to play in the Church's mission. Both types of organizations, the religious and the lay, participate in and operate the Canadian Catholic health apostolate along with individuals.

Certain questions concerning the continuing involvement of the Canadian Catholic health apostolate are currently being raised. What is the purpose of the Catholic health facility? How do they differ from facilities not sponsored

by a religious denomination? Do Catholic facilities still serve as a useful means for the personal and social realization of Christian and Catholic values? These major questions which are raised suffer accentuation as a result of certain forces: the increasing decline in the numbers of female and male religious, the growing unwillingness of many religious to assume administrative tasks, the presence of new regulatory legislation, the rise in costs and the acceleration of medical and biotechnical advances. Thus, to adequately respond to the current situation, persons working within the Canadian Catholic health apostolate need a clearer understanding of the relation which exists between both the apostolate to the Canadian health care system and the broader social environment. In the past, the relations which existed among these entities have not been adequately investigated and compared. The value of a study which now looks at these relations is the clarification which can result on the nature and the extent of Catholic involvement in the Canadian health care system.

2. The Expression of Mission and its Related Philosophy and Objectives

The mission, philosophy, and objectives of the health care apostolate receive an articulation which varies in the emphasis given certain points, depending on the circumstances of the historical context and the organization (religious or lay) which sponsors the articulation. The expression occurs through a variety of means and in ways which are both formal and informal. These include the

enactment and revision of constitutions and by-laws; the acquisition of letters patent and the promulgation of a community rule; the issue of policy statements and briefs which describe the mission of a concerned group; the minutes of meetings and records of administration which reveal a group's identity, and lastly, the actual practice of the group.

In a formal way, a statement of mission indicates the nature of the religious congregation or the nature of the institution which is a participant in the health care apostolate.[12] Such statements reflect a set of beliefs or a vision of faith which leads to an expression which is given in service.

In the statements of philosophy issued by a religious congregation, organization or health care institution, one finds the beliefs and principles which are the guides of corporate conduct. These include beliefs about God, the Church, the community and the individual. An anthropology of some kind is implied or stated plus a view of the world and the relations which exist among the persons who live within it.

The anthropological considerations may include affirmations about the worth of human persons, the value of human life as it extends from conception until death, the rights of an individual, the nature of sickness and health and the relationship which exists among the different kinds of healing. Another statement may speak about the eternal

destiny of each human person.

Statements disclosing views of a more general nature occur in affirmations that speak about the relation which exists between an individual and the family, the community, and the larger society. Other statements speak about the relation of the health care apostolate to the general mission of the Church; the type of management which is most appropriate; the values which pertain to the function of education; and the relevance of a legitimate concern for questions that ask about the need for social justice. Related statements may include a concern for the right relation which should exist between the human and natural environment.

In conclusion, as groups working in the health care apostolate articulate the objectives which they are to reach as concrete goals, it is with the assumption and in the belief that these goals are a fitting embodiment of the mission and the philosophy which have been professed.

3. The Mission of the Church

The Church's mission can be discussed in terms of traditional fundamental theology or in terms of newer contemporary theology. In the traditional theology, the Church's distinctive nature, its purpose and mission, were understood with a large degree of unanimity. However, in the years following the Second Vatican Council, the Church's mission has become a subject of much debate.[13] Missiologists, ecclesiologists, social ethicists, canon

lawyers, and pastoral theologians have all analyzed the question from a variety of aspects.[14] However, according to Francis Fiorenza, one can identify a theological issue which is the basis of all others: the relation which exists between the Church's religious identity and the understanding which people have of the nature of its mission. As he has stated, "no matter what activity or ministry of the Church is under discussion, the basic question remains: how does this activity or ministry relate to the Church's religious identity."[15] Accordingly, for the Canadian Catholic health apostolate, questions have arisen about the nature of its religious identity. An intimate link exists between questions about identity and questions about mission. While it is assumed that the health apostolate shares in the general mission of the Church, the nature of this relation is not always understood. In this study, two questions will be asked. The first question asks how the activities of representative groups working within the Canadian health apostolate relate to the Church which influences both its identity and its mission? The second question asks how a specific understanding of the Church's mission has an influence in the workings of the health apostolate.

In this study, the framework which has been supplied by Francis Fiorenza is adopted. He distinguished the mission of the Church as traditional fundamental theology has described it and as it has been described by contemporary foundational theology. While the traditional view of

mission has been understood in terms of the distinction between nature and supernature, the contemporary view of mission can be understood in terms of ' substitutive mission', when the Church steps in to fill a social need until a proper secular agency can assume responsibility; 'unofficial mission', where the Church acts as motivator for secular service, but not instigator; 'partial mission', where the Church's many tasks are segmented; and 'integral mission', named for the purposes of this study, where the Church sees transformation of the world as integral to the Gospel proclamation.. Each category has a validity which is its own. Yet, the validity of each category is only partial. Fiorenza understands the integral mission as a way which allows one to construct a balanced, comprehensive view.

The early sources of the representative groups of the Canadian Catholic health apostolate, examined in this study, were found as might be expected, to reflect, within varying degrees, the traditional views of mission while the later sources reflect the models of contemporary theology.

3.1 The Traditional View of Mission

The mission of the Church was linked with the issue of its foundation by the historical Jesus. In traditional fundamental theology, at both the intentional and ontological level, a correlation was established between the Church's mission and Jesus' mission. The Church was instituted by Jesus for a specific purpose and with a

definite mission. Jesus' own purpose and mission is continued by the Church. In this way, the Church is rooted in the grace and salvation present in Jesus. The origin and goal of the Church is transcendent as Jesus' origin and goal is transcendent. The Church's mission is also affected by the historical and theological problems of the foundation of the Church.[16] The mission of the Church within traditional fundamental theology can be considered in terms of the nature-supernature distinction and the implication of this for mission.

3.1.1. The Nature-Supernature Distinction

Traditional fundamental theology took as its starting point the distinction between nature and supernature.[17] Human institutions had particular natural goals. The Church had a distinctive supernatural goal which was sanctification and salvation. This supernatural goal of the Church was the reason that God sent Jesus into the world. This goal also determined the purpose and activity of the Church. The Church was viewed as a 'perfect society' within traditional fundamental theology. The attribution was not intended to express the holiness or moral perfection of the Church but rather its independence from every civil and political system.[18] As a 'perfect society', the completeness and autonomy of the Church could be underscored. It provided a framework which limited the points of theological controversy, especially, in regard to the question whether the Church has a threefold end which included the exercise

of Christian religion, the sanctification of souls and the beatific vision, or twofold end which proposed sanctification and beatific vision.[19]

What was not controversial was the belief that the Church's mission was ordered directly and primarily to a supernatural goal, the beatific vision. This belief became particularly significant during the period of the Enlightenment, characterized by deism, naturalism and rationalism. The Enlightenment refused to accept a supernatural revelation as the foundation of Christianity. Along with this position went a rejection of the Church's supernatural goal. Traditional fundamental theology at this time responded with the argument that the Church existed as a 'perfect society' with its own supernatural goal and purpose. An historical argument was offered, appealing to miracles, prophecies and the resurrection of Jesus.

The Enlightenment spurred the development of certain key concepts within the fundamental theology of the time. This was especially evident in the notion of 'supernatural'. Thomas Aquinas used the term 'supernatural', in the sense that "God so created nature and so ordered nature to the supernatural that, even though the supernatural goal is what nature cannot achieve by itself, the supernatural is still that to which the natural tends."[20] A shift took place in the post-Enlightenment period so that 'nature', came to be understood as the 'world', which was an absolute category distinct from and unrelated to the supernatural.

Also, changes were taking place in theological anthropology.[21] A double finality for human nature was posited. This anthropological perspective held that for the person, there was a purely natural goal with its supernatural fulfillment. This nature-supernature distinction affected traditional theology in other ways. The Enlightenment pointed to a natural religion underlying all positive religions whereas fundamental theology posited that in addition to this natural religion, there was a second reality, a supernaturally revealed religion.

3.1.2. Implication for Mission

The nature-supernature distinction which was made in the Post-Enlightenment period had an effect on the way that the Church's mission was understood. The Church's mission became related to the supernatural, while the social and political mission became an improper goal.[22] This theological viewpoint is expressed in numerous papal statements. Puis XI stated that "the objective of the Church is to evangelize, not to civilize. If it civilizes, it is for the sake of evangelization."[23]

As Fiorenza has pointed out, this understanding of religion is based on a dichotomous model of the relations between religion and society, church and state.[24] The categories of evangelization and civilization, transcendence and immanence, supernatural and natural, gospel and law can be separated into a proper realm for the Church and a proper realm for the world. The advantage of this model is that it

leaves no ambiguity about the Church's mission.[25]

3.2 The Contemporary View of Mission

The mission of the Church in traditional fundamental theology was understood in terms of a dichotomous model based on the nature-supernature distinction. Contemporary theology has attempted to offer a more unified vision. A number of models for relating religious identity and the Church's mission can be found among theologians today. Fiorenza describes three prominent models as "substitutive mission", "unofficial mission" and "partial mission".[26] He claims that they expand on the dichotomous model but do not free themselves of its presuppositions. They fail to address the nature of religious identity as a fundamental theological issue. He identifies a fourth model, emerging since Vatican II, which interrelates the Church's religious identity and its social and political mission. For the purposes of this study, this fourth category is called the "integral mission".[27] These models which identify different relationships between identity and mission provide a convenient framework for examining how the Catholic health apostolate has understood the relationship between its identity and mission and the identity and mission of the Church.

3.2.1. Category 1: Substitutive Mission

A substitutive mission for the Church maintains that the Church is concerned with the impact of God's kingdom upon all dimensions of human life. However, it does not have

a permanent, proper social mission.[28] The Church should engage in a social mission, formally and institutionally, only until secular agencies can assume the responsibility of meeting this social need. Well known proponents of this view include Wolfhart Pannenberg,[29] Juan Luis Segundo[30] and Richard P. McBrien.[31] McBrien has argued that "only when there is a lack of personnel or institutions to handle the imperative needs" and "only where it is clearly a matter of supplying for the deficiencies of other responsible agencies" can social action, which is formal and institutional, be justified".[32]

This category depicting a substitutional relationship between Church and society implies that, in certain aspects, society is 'immature'. The Church acts as a parent providing guidance to the 'immature' society, directing it to the necessary social action. However, the question must be raised whether, in fact, for the Church this category of 'substitute mission' adequately describes the relationship between itself and society. Catholics did not establish educational and health care institutions with the thought that they were substitute institutions, waiting to be taken over by the state. Schools and hospitals were understood as integral to the Church's mission.[33]

The category is not free of the dichotomy which is present in traditional fundamental theology. Religious and secular tasks are separated. A social mission is proper only in exceptional cases. Moreover, not all activities

which are assigned to the secular realm would be assumed by the Church if the service was not being provided elsewhere. For instance, a distinction can be made between education and mail delivery.

3.2.1. Category II: Unofficial Mission

The main advocate for the category of 'unofficial mission' as a means to overcome the dichotomy between religious identity and social mission has been Karl Rahner. It is his view that "the Church as an official church ... is not the immediate or the proper subject for realizing the concrete humanization of the world."[34] The Church lacks the qualifications for this task. Also, the world has a right to exercise its own responsibility for its development. Rahner suggests that the proper sphere of activity for the Church is to provide inspiration and motivation necessary for groups of Christians to serve the world. This was the theological supposition which informed the Catholic Social Action movement in Europe.[35]

This category of 'unofficial mission' acknowledges that every Christian has a social and political mission. However, Fiorenza points out that with this category, the dichotomy between the religious and the social is transferred to the interior of the Church.[36] The Church hierarchy, composed of bishops and priests, is relegated to the religious mission, while the mission of the laity is secular and unofficial.

By relegating the social mission to one segment of the

Church, the problem of the relationship between the religious identity of the Church, as religious identity, to the social and political mission has not been addressed.

3.2.3. Category III: Partial Mission

A third category relating religious identity to mission argues that the Church mission should not be understood as though it were a singular function. Instead the Church has many tasks. Michael Fahey and Avery Dulles exemplify this approach. Fahey suggests that it is preferable to speak about the various tasks of the Church.[37] Dulles explains that the Church can best be understood through a number of models: herald, mystical community, institution, sacrament and servant.[38] It is not possible to represent the Church adequately by any one model. Thus, the servant model which is characterized by love and service should not be made into the sole model to express the Church's mission.

This approach does integrate the social mission into the Church's legitimate tasks and does not have the same difficulties in continuing to assign the social mission to an improper, substitutive or unofficial place. What is not specified is how this 'partial mission' fits in with the other tasks. Can the social mission be relegated to a secondary function, given the Church's sacramental and kerygmatic functions?[39] Or, is the social mission a precondition or a consequence of the Church's evangelization? Also, the interconnection between the Church's many tasks is not explored sufficiently. This is

especially problematic in view of the fact, that as a concrete phenomenon, the Church is holistic. To clarify this point, Fiorenza notes that this approach divides in theory what is not distinguished in practice.[40] The category of 'partial mission' leaves unresolved the question of how the distinctive nature of the Church is exercised in its social mission.

As the Catholic health apostolate struggles with the question of its identity within the current Canadian context, one must further explore and study the relationship between the Church's social mission and the distinctive religious identity of the Church because, in fact, the Catholic health apostolate is a concrete expression of this relationship.

3.2.4. Category IV: Integral Mission

A fourth category relating social mission and religious identity for the Church can be called an 'integral mission'. An integral mission is understood to mean that the mission of the Church to transform the the world is constitutive of the gospel proclamation. It is not secondary, derivative or improper. Fiorenza claims that it is this category which is expressed in recent Church documents. I will explore the relation between religious identity and social mission from the standpoint of Fiorenza's foundational theology, which is based on the method of hermeneutical reconstruction.

The official Church documents, since Vatican II, have grappled with the relation between the Church's religious

identity and its social and political mission in an attempt to interrelate them.[41] The distinctiveness of each has been respected without reducing one to the other.

The document Justice in the World, issued by the Synod of Bishops, in 1971, is the clearest statement which expresses the relation between the Church's religious identity and its mission to transform the world. The Bishops state:

> Action on behalf of justice and participation in the transformation of the world appear to us as a constitutive dimension of the preaching of the gospel or, in other words, of the Church's mission for the redemption of the human race and its liberation from every oppressive situation.[42]

Viewing justice and liberation as constitutive of the gospel proclamation goes beyond previous affirmations. Justice and liberation are not the prerequisites or consequences of the Church's mission. On the other hand, they are not the exclusive element in the Church's proclamation. In order to be faithful to the gospel proclamation of love, a transformation toward justice is necessary.

In 1974, the Third Assembly of the Synod of Bishops produced two documents in which the relationship of evangelization and liberation was approached in a dialectical manner. Salvation encompasses liberation, but goes beyond it. On Human Rights and Reconciliation, the Synod's first document, affirms that "the promotion of human rights is required by the gospel and is central to her ministry.[43] The other Synod document, Evangelization of the Modern World also affirms the "intimate connection between

evangelization and liberation" but goes on to clarify that the "Church, in more faithfully fulfilling the work of evangelization, will announce the total salvation of humans or rather their complete liberation, and from now on will start to bring this about."[44]

The dialectic appears in the statements of Paul VI and John Paul II. In Paul VI's document, Evangelization in the Modern World, evangelization and liberation are explained as related but distinct.[45] The gospel must be interrelated with social human life to be complete. There are bonds which exist at the level of anthropology, theology and gospel. Fiorenza succinctly summarizes this relationship: "Anthropology: the human subject of evangelization is a concrete person living in social and political structures. Theology: redemption affects creation; to restore justice requires the combating of injustice. Gospel: to proclaim love for humans includes proclaiming justice and peace for them."[46]

Evangelization and liberation are distinguished in that they are not identical with one another. Evangelization, according to Paul VI, includes liberation but offers more than liberation. The establishment of God's kingdom is more universal than an improved social or political order. It strikes at sin which is the source of social and political injustice within human nature.[47]

John Paul II makes a significant contribution to the social mission of the Church by his focus on its

personalistic and christological dimension.[48] The anthropological link between evangelization and liberation, affirmed by Paul VI, is developed. John Paul II holds that at the heart of political and social distortion is a false image of human nature. Evangelization offers an image of human personhood rooted in Christ. Fiorenza explains that what John Paul II has done is to provide a christological foundation as a basis of social mission.[49] In addition, Christian liberation is original, not only because of its affirmation of the gospel but because certain personal attitudes are disclosed such as the inviolabilty of the individual or the concern for the poor. Also, personal conscientization which is the raising of awareness and increasing knowledge, and individual transformation must go hand in hand with structural change.

In conclusion, these documents affirm that the commitment to social justice is integral to the Church's mission. The struggle to relate religious identity and social mission is reflected in the official Church documents. The link between evangelization and liberation is human dignity and love.[50] The magisterial statements challenge theologians to continue to reflect on the relation between evangelization and liberation, attending to what is specific about the Church's presence.[51]

3.2.5. Fiorenza's Analysis

Fiorenza takes up the challenge posed in the Church statements.[52] He contends that in order to relate the

Church's social-political mission to its religious identity, it is necessary to raise the fundamental theological issue of the nature of religion and of Christian identity. He attempts to link the fundamental theological and hermeneutical issues surrounding the nature of religion with those of the Church's mission.

In a functional analysis of religion, religion is explained through its integrating role in society. It serves to bond society by establishing religious beliefs, basic values and civil religion.[53] An interpretative theory proposes that it is religion which provides a set of symbols which establishes moods and motivations. This is accomplished by formulating conceptions that provide a general interpretation of existence.[54] Because of the broad range of possibilities for these definitions, any general interpretation of reality is 'religious' from this perspective. There are world views, however, which provide interpretations of reality but do not make religious claims.

Fiorenza employs a combined functional and interpretative analysis of religion, while also accounting for the historical dimension within religion. He argues for the need to take into account the historical self-reflection and praxis of the religion. An adequate theological approach, for Fiorenza, does not define it exclusively in isolation from other dimensions in human life. He explains that "to describe the function and meaning of religion from the starting point of a historical religion is to show the impact of particular religious beliefs upon a particular

historical community, its self-understanding and its interpretation of reality."[55]

Fiorenza examines two particular beliefs in relation to religious identity and social mission in order to illustrate the meaning and function of Christian religious identity. First, he correlates belief in a transcendent God with the emergence of belief in the inviolability of human personhood. Not only is the belief in God and belief in the person an inviolable correlative, they have common historical roots. According to the phenomenology of religion, the category of personhood originates with the religious experience of transcendence. Pannenberg had claimed that the basis of the human personification of reality and of the human self was the experience of the ultimacy or "nonmanipulatableness" of power which makes a concrete claim upon human beings. From this, he had concluded that "the concept of the personal is originally based on a religiously determined experience of reality, or the powers governing it."[56] Fiorenza maintains that religious belief in God, as the ultimate power, radically affirms personhood and historically grounds its emergence within Western religion tradition.[57] He disputes a humanistic critique of religion which claims that belief in God as ultimate power negates human personhood.

When belief is proclaimed in a personal God, a certain vision of reality follows. This vision is important because it determines how the human and social life is structured.[58]

Fiorenza explains:

> Since belief in God provides a vision of human reality, belief in God cannot be proclaimed without, at the same time, spelling out how this vision of ultimacy affects reality. Likewise, interpretation of reality entails an interpretation of ultimacy. The images and language used to express the belief in God have profound effects on how the human self and human society is understood.[59]

The particular beliefs held about God affects the interpretation about reality while the interpretation and praxis of reality also affect the concept and image of God. These concerns are central to both feminist and liberation theology.

The second belief examined in relation to religious identity and mission deals with the identification of Jesus with the Wisdom, Logos and Power. At Nicea, Christ was defined as consubstantial with the ultimate power and wisdom of the universe. Christ was understood to be more than an intermediary wisdom figure or power. This identification of Jesus as logos and wisdom with the ultimate power of the universe was significant because it was used to bridge creation and redemption. It was this christology of the post-biblical period, capable of bridging creation and redemption, which provided the theological foundation of Church's social mission. Fiorenza explains:

> In proclaiming the meaning and power behind the world, the Church is concerned with the manifestation of that meaning and power in the world. The identification of Jesus as logos and wisdom with ultimate power and justice of the universe is of significance for the meaning of wisdom and justice."[60]

When the meaning of the historical Jesus is linked with the

universe, the Church connects the proclamation of Jesus with its political mission.

Fiorenza asks if his reference to the interpretative and functional nature of religion and to the combination of the historical Jesus and the logos and wisdom traditions in Christianity provide a resolution to the issue of the relation between the Church's identity and its social or political ministry. He proposes a basic rule which reflects an 'integral mission' as a resolution to his question. This rule is significant in the struggle of the health apostolate to understand the nature of their contemporary mission and for the forms that it might take in the future. Fiorenza proposes that "the more the social or political ministry of the Church is related to Christianity's interpretative and practical function as a religion to exhibit and to proclaim Jesus as the power and wisdom of the universe, the more constitutive, essential and distinctive this ministry is."[61] This rule is to be understood in terms of Fiorenza's methodological considerations. He explains that "the religious does not exist in isolation from other dimensions of reality; it transsects them through its interpretative and practical function of specifying the action, reality and the self."[62] Some activities are more able to be integrated within a Christian consciousness of God. Fiorenza argues that education and health are proper missions for the Church because "their proper and fullest execution engages the religious dimension of life."[63]

It will become apparent in this study that the later

sources of the two representative groups of the Canadian Catholic health apostolate reflect a view of mission which fits with the contemporary views on mission as outlined by Fiorenza.

4. The Framework and Method of the Study

The purpose of this thesis is to trace the understanding of mission which has been held over time by two representative groups of the Catholic health apostolate in Canada and to examine their relationship to the mission of the whole Church.

Two groups have been chosen for this study. One group, the religious congregation, as religious congregation, has been chosen because women religious have been involved in caring for the sick since the earliest days in the settling of Canada. Their mission and identity are important to study because they continue to be involved in the care of the sick after many societal changes and the development of the Canadian health care system.

The second group has been chosen because it is not a religious congregation, but an association which its members, either individually or institutionally, have chosen to join. Its mission and identity, as an association, had been expected to be different, but related in a supportive way to that of the religious congregations as they have had to respond to the changes in the social system and with the emergence of the Canadian health care system. Also, it has been considered necessary to study the association because

of its expertise and leadership that it currently exercises in the health care apostolate.

For the purposes of this study, Francis Fiorenza's method of hermeneutical reconstruction and his analysis of the mission of the Catholic Church have been adopted. The mission and identity of the two representative groups have been discussed in relation to Fiorenza's interpretation of the Church's mission. Fiorenza's interpretation of the mission of the Church is arrived at by means of the application of his method of hermeneutical reconstruction. This interpretation, as part of the on-going theological enterprise, is assumed by the writer as offering a valuable approach to understanding the mission of the Church. It also allows for continuity in interpreting the sources of the representative groups.

It is necessary to establish how the two representative groups of the Catholic health apostolate, the Catholic Health Association and the Congregation of The Sisters of St Joseph of Toronto constructed their mission. It is assumed that the understanding of mission, as expressed in a number of ways such as the statement of objectives and purposes in the groups' constitutions and the explicit statements of mission, establishes along with its practices the groups' identity and understanding of mission. The effect of using these kinds of sources results in a certain amount of repetition which can be tedious, but necessary to the thesis.

The Catholic Health Association in Canada had its

origin in an association founded in the United States in 1915 by Fr. Moulinier, SJ. The main purpose which was envisioned for the Catholic Hospital Association of the United States was to aid religious congregations in achieving and maintaining a high quality of medical care and technical expertise within their respective Catholic hospitals. The Catholic Hospital Association was understood as serving the nature of religious life which was designed for the personal sanctification of its members. The nature of community life characterized by seclusion limited the contact of the Sisters with lay people. Thus, they were restricted in various ways from keeping up with current developments in the hospital and medical scene. The Catholic Hospital Association was viewed as a means to help the Sisters.

Another purpose which the Catholic Hospital Association served was the protection of Catholic identity. Care of the sick meant attending to the various dimensions of the person. In Canada, the concern focused on the gradual implementation of socialized hospital and medical insurance plans. The participation of the Catholic hospital in these plans became a central concern. A 'Bill of Rights' for the denominational hospital was suggested to the Hall Commission in 1962. The Catholic Hospital Association, as it was called between 1954 and 1976, and its forerunners were to co-ordinate the activities of the various programs for the medical and spiritual needs of the sick and to foster high ideals in religious, moral, medical and nursing endeavors in

Catholic hospitals and schools of nursing in Canada.

An explicit statement of mission for this association did not exist until 1976. The concern for justice centered primarily on the rights of the Catholic institution vis-à-vis the implementation of hospital and medical insurance, not on the rights of individuals to medical care. Membership was composed largely of religious congregations and institutions. In the late 1960's and early 1970's, membership declined as religious congregations either sold their hospitals or withdrew from sponsorship. Increasing costs and fewer available qualified Sisters served to assist the process of withdrawal. The role of the laity in the ministry of healing was not a central concern prior to mid-1970's.

The Congregation of the Sisters of St. Joseph arrived in Toronto in 1851, and was engaged in a variety of social services which included visiting the sick in their homes. Their official involvement in hospital work began in 1891. According to the founding documents of the Congregation, religious life was devoted to the salvation and perfection of the Sisters. This was closely linked with their service to the sick and poor. Their mission, as implied by the charism of their founder, Jean-Pierre Médaille, SJ, was to bring about what he called a "total double union" of themselves with God, of others with God and with each other.[64] Their spiritual life was to be informed by a model formula referred to as a Consecration of the Two Trinities.

Their apostolic works followed from and were required by their understanding of their charism. These works included the establishment of hospitals and their administration and maintenance. Their mission was not explicitly stated, but their service was understood as following from the nature of religious life. Until recently, they described their service of caring for the sick and poor as charitable works for those in need and not as a requirement of justice.

Many changes have taken place in Canadian society since the Sisters of St. Joseph opened St. Michael's Hospital in 1891. The major thrust of societal change, as postulated by sociologist Roland Warren, has been the increasing orientation of local community units towards extra-community systems of which they form a part, with a corresponding decline in the bonds which make for community cohesion and autonomy.[65] Seven characteristics of this 'great change' can be isolated and considered as separate aspects, though they are dynamically interrelated to each other and are not exclusive. These aspects can be identified as: division of labour, differentiation of interests and association, increasing systemic relationships to the larger society, bureaucratization and impersonalization, transfer of function to government and profit enterprise, urbanization and changing values. Warren's description of the 'great change' in North American society can be used as a background to examine the more specific implications for the health care field and the Catholic health apostolate's involvement. The overall effect of the 'great change' in local

communities is that they become oriented to the extra community system, experience a loss of control by the individual and the local group. Emerging from this experience of a loss of control has been a growing advocacy for human rights.

One characteristic of Warren's "great change" has been the transfer of function to profit enterprise and government. An example of this is the evolution of the Canadian health care system. At one time, medical care was given on a fee-for-service basis by the local physician. Hospitals were largely funded by the municipality, supplemented by charitable donations. With the implementation of the Hospital Insurance and Diagnostic Services Act (1957) and National Medical Care Insurance Act (1966), both the federal and provincial governments have been supplying large amounts of funding to the health programs with a corresponding increase in regulation. The result has been a decrease in the autonomy of an individual health care institution to set policies. For those who operated the denominational hospitals then, the burden of funding has been relieved only to open up a whole new range of difficulties which have threatened their existence.

Government funding for hospitals and medical care has challenged the meaning of the Catholic identity. What is distinctly Catholic about a health care facility which is publicly funded but owned or sponsored by a religious congregation? What is the mission of the Catholic health

apostolate in a socialized health care system such as Canada's where almost all citizens are insured for the costs of care?

In responding to these changes, the Catholic health apostolate has been influenced and guided by a number of sources. The charism of religious congregations, the Church's long tradition of healing and caring for the sick, and modern Catholic social teaching have helped the health apostolate to respond to the changing context in which they must carry out their mission. The mission of the health apostolate was to participate in the mission of the whole Church to bring the message of Christ to humankind and to penetrate and perfect the 'temporal sphere' with gospel values. A central affirmation of Roman Catholic teaching has remained the 'dignity of the person', without exception, from conception to death. This concern for human dignity was apparent in what has been regarded as the first document in the corpus of modern Catholic teaching, the 1891 encyclical by Leo XIII, The Condition of Labor. The principle of subsidiarity, which established the criteria for determining responsibilities for various levels of government, appeared in Pius XI's 1931 encyclical, Reconstructing the Social Order. This teaching was helpful for the health apostolate in deciding what approach to adopt concerning proposals seeking implementation of a socialized health care system.

Themes present in the corpus of Catholic social teaching provide the theological grounding for explicit

statements of philosophy adapted by persons and groups working as part of the apostolate. The worth of the person, the relationship of the person to social structures and institutions, the rights and duties of persons (especially the right to medical care), the role of Catholic institutions in contributing to the creation of a just society and the relationship of charity and justice have been considerations addressed by the two representative groups in their later period.

When one examines the recent attempts to describe the mission of the two representative groups working in the Canadian Catholic health apostolate, certain differences between the sources become apparent.

In the early sources of the representative groups, the mission is expressed implicitly in the founding constitutions and by-laws, through addresses of prominent members of the congregation or association, in the resolutions at the annual conventions and in briefs to various task forces and commissions. A philosophy is acknowledged but often not specified. An intent to carry on the healing ministry of Christ, to care for the sick and poor is expressed. The motivation for service appears as charitable 'good works' to those in need.

What is strikingly different between the early and later sources is the appearance of explicit statements of mission and philosophy. These statements are structured around the prominent themes existing within Catholic social thought, especially those articulated since the Second

Vatican Council. Mission statements, as expressed by the two representative groups share in some common goals. Both affirm their mission as the constituent of the healing ministry. Illness is viewed not only as a medical problem but also as a social problem. Health care is distinguished from sickness care. The dignity of the person from conception to death is affirmed. In continuity with Christian tradition, suffering is understood as having meaning. The role of the laity is acknowledged as significant in the later sources of the two representative groups. Their involvement in health care is viewed as a ministry and serves as a call to holiness.

This thesis attempts a reconstruction of the identity and mission of the aforementioned two representatives of the Canadian health apostolate. A religious tradition does not exist as a self-evident identity but is discerned through a process of critical discrimination which reveals what is primary and what is secondary. A hermeneutical reconstruction, as described by Fiorenza,[66] presupposes Christian convictions and practices which require interpretation. A reconstruction involves a dialectic of questions and answers, a movement backwards and forward from the considered judgments about identity to the reconstructed identity and, then, from the reconstructed identity to the considered judgments.[67] In this way, one can ascertain the identity of a group and the context of its Christian vision as it is embodied in it beliefs and

practices. In a reconstructive analysis, one must consider the reception-history, the group's origin, consequences and effects, shifts in argumentation, and the differences between paradigms.

5. Subject Matter and Sources

The primary sources of the two representative groups have been divided into early and later periods. The criteria for the division is based primarily on the distinctive features which have become apparent in the sources as the above groups have sought to respond to the challenges to their identity. An historical presentation of the involvement of these representative groups in the Canadian health care scene as well as a description of the sources is provided in order to indicate what the group took to be its special mission. Following each presentation, the emerging identity and mission is discussed in terms of a reconstructive analysis. Challenges to the identity of the Catholic health apostolate offered by the social changes in North America and the development of the Canadian health care system are outlined.

5.1 Representative Groups and their Primary Sources

5.1.1 The Catholic Health Association of Canada

The Catholic Health Association of Canada (CHAC) was chosen as a representative group working within Canadian Catholic health apostolate for two reasons. The first reason concerns the unique mission of the Association. It

came into existence in response to a perceived need among a religious congregation of women involved in hospital work in the western United States. The Catholic Health Association through its history has been involved in assisting its member congregations in their various missions, but was not founded by a 'charism of foundation'.

The second reason for choosing the CHAC is the fact that it is a national organization with a varied membership, serving as a network. In its variety, the membership serves as an excellent resource for representing the concerns of the Canadian health apostolate.

The founding organization and the intermediary forms of the CHAC have been in existence during years of social change and theological development with which we are primarily concerned.

In its history, the CHAC has expressed in informal and in formal ways, a distinct philosophy of health care and mission.

The main difficulty with considering the CHAC as a representative group is the unevenness of the primary sources. To date, the CHAC does not have an organized archive. Relevant material from a certain period cannot be easily found. Even with the generous co-operation of the CHAC staff, one's discovery of the source material was a piecemeal operation.

In order to reconstruct its identity, one must examine those documents and publications which represent its official position. Primary sources for this study have been

taken as the following: constitutions and by-laws (with revisions); the official publication of the CHAC which has had various names in its history : the CHAC Bulletin, the Catholic Hospital and the CHAC Review with a CHAC newsletter CHAC info which has communicated official policy statements; resolutions of annual conventions; and briefs from the CHAC made to various commissions and task forces.

5.1.2. The Congregation of the Sisters of St. Joseph of Toronto

The Canadian Catholic health apostolate began during the period of French rule extending from 1604 to 1760.[68] Canada's history reveals the significant contribution of Sisters who came as pioneers to care for the sick and injured. The dedication, struggle and self-sacrifice of the women and men who gave their lives to the provision of medical care is told in accounts such as those which describe the development of the Hotel-Dieu of Quebec (1639)[69] and the Hotel-Dieu of Montreal (1642)[70] Many names stand out because of the extent of their contribution and the depth of their commitment to the care of the sick, the most notable being Jeanne Mance, the foundress of the Hotel-Dieu Hospital in Montreal, and Mother D'Youville, the foundress of the Sisters of Charity Hospital General of Montreal in 1737. The congregation founded by the latter is now known as the Grey Nuns.

Many religious congregations could have been chosen as representative of the Canadian Catholic health apostolate.

Women and men who have lived according to the evangelical counsels, banded together through the charism of their mission, carrying out 'works of charity' in response to the concrete needs of the sick, especially the sick poor.

There are three reasons for choosing the Sisters of St. Joseph of Toronto as a representative of other religious congregations working within the health care apostolate.

First, their pattern of involvement in health care resembles those of other congregations. A need was perceived by a local bishop for a congregation of sisters whose mission was broad enough to allow them to engage in a variety of services for those most in need. From its origins the congregation has been involved with the care of the sick. With its establishment in Toronto, the congregation became an intricate part of the municipal social fabric, through its many works.

Second, while the congregation does not have its origins in Canada as do the Grey Nuns, the entry of Sisters of St. Joseph into health care is of a sufficiently early date in Canadian history to be representative. They have had to meet the challenge posed by recent social change and the development of the Canadian health care system.

Third, the Sisters of St. Joseph of Toronto are also experiencing a decline in Sisters who can staff the hospitals as are many other congregations. Though they retain the right of ownership and administration, increasingly lay persons are carrying out work that was once done by Sisters. However, the involvement of

increasing numbers of laity in every aspect of the health care apostolate raises significant questions about the role of the laity, the nature of future contributions by religious congregations and the understanding of mission expressed by the various participants working in the health apostolate.

The problem with choosing the Sisters of St. Joseph as a representative group for the Canadian Catholic health care apostolate is the same difficulty which faces the choice of most other congregations. Prior to the Second Vatican Council's decree, Decree on the Appropriate Renewal of the Religious Life, extensive reflection on mission and charism is not apparent. At the urging of the Decree on the Appropriate Renewal of the Religious Life to give "loyal recognition and safekeeping" to the congregation's own special character and purpose in the spirit of the founders, congregations began this task of reflection and renewal.[71] Thus, since the Council, explicit statements of philosophy and mission have appeared. However, primary sources coming from earlier years were less explicit and uneven in their quality and form.

Anne Bernice Hennessey has done an informative study on the influence of Ignatian spirituality on the primitive documents of the Sisters of Saint Joseph.[72] She outlines the problems encountered in attempting any scholarly reflection on the history and charism of the Sisters of St. Joseph. Since this study refers to their charism in its analysis,

one must consider the problems that were addressed by Hennessey.

The first problem concerns adequate information about the founder, Jean-Pierre Médaille. Little is known about him. It is possible to formulate sketches of his life, to make assumptions about his life in the Society of Jesus and to examine the documentation about his relationship with his superiors concerning the foundation of the Sisters of St. Joseph. However, significant gaps still remain.

Hennessey notes that there has not been consistent nor scholarly reflection on the history of the spirituality of the Congregation. The Sisters have not done this work nor have they sponsored others to do it. This is especially so for the early days of the Congregation and the values of the Sisters at that time. However, beginning in 1969, the Federation of Sisters of Saint Joseph in the United States have published the four primitive documents of the Congregation which had been prepared by a research team commissioned by the Federation. Hennessey describes the scholarly work which has been carried out on the primitive documents. She concludes, "there remains, however, no factual listing of historical data from which commentaries can proceed. There is no critical edition in English of the primitive documents. It is not surprising therefore, that there is little theologizing on the origins of this Congregation; what exists is sparse, occasional and non-international."[73]

The third problem is the fact that the assembling and

editing of the primitive documents has not resulted in critical editions which exist in English. One must rely on those French and English editions of the primitive documents prepared by the two research teams. [74]

To understand the charism and mission of the congregation, one must examine the primitive founding documents. Four principal documents written by Jean-Pierre Médaille for the Congregation and translated into English, are used in this study. These documents, employing three different literary forms, are essential in understanding the charism which founds this Congregation. They comprise The Maxims of the Little Institute, the Eucharistic Letter, the Règlements and the Constitutions of the Little Congregation of the Sisters of St. Joseph.

Since the Congregation has been in Toronto, they have revised their Constitutions on three occasions: in 1881, 1925, and 1984. I will consider these, plus Statements of Mission and Philosophy that have been issued which pertain to the operation of their institutions. Other sources which have been examined are the submissions and briefs produced and submitted by the institutions owned and administered by the Sisters, to government commissions and task forces. Unfortunately, these are few. The usual method of communication was by oral exchange, occurring at meetings between the Sisters or their representatives with the specific government officials.

2. The Difference Between the Two Representative Groups

The two representative groups chosen for the study differ in one fundamental way. One group is an organization open to all persons and groups interested in the Catholic health apostolate. The other group is a religious congregation. The CHAC is a national organization which includes different kinds of members, the membership consists of lay persons and provincial conferences and everything in between. A membership fee is paid and membership is granted. Priests, members of various religious congregations and lay people participate in the administration and work of the organization. One of its main tasks is to co-ordinate groups across Canada involved in the Catholic health apostolate. One such group is the Congregation of the Sisters of Saint Joseph of Toronto.

The Sisters of St. Joseph of Toronto is a religious congregation of women. One of its traditional works has been caring for the sick. Like other congregations, it arose from a 'charism of foundation'. A vision of mission and service has an intimate connection with the three evangelical counsels of poverty, chastity and obedience.

ENDNOTES

1. Francis Morrisey, "The Apostolate of Catholic Health Care Facilities", CHAC Review, (September, 1983), p. 15. Canon 298 of the new Code of Canon Law when referring to associations of the faithful sets out the objectives of the apostolate. These objectives are: to promote the perfection of Christian life, to promote divine worship and the teaching of Christian doctrine, to undertake tasks of evangelization, to carry our works of piety and of charity, and to imbue the temporal order with a Christian spirit. Code of Canon Law, 1983. Morrisey notes that Church law requires not only Canon 298 but also these three conditions: 1) the work must be under ecclesial sponsorship and recognized as such (Canons 216, 312); 2) it must be under Church ownership, unless some other arrangements have been made (Canons 634, 1255): 3) it must be subject to Church legislation or control.

2. Apostolicam Actuositatem, (Rome: Vatican, 1965), n. 5. The English translation to documents from the Second Vatican Council in this study are taken from Walter Abbott, SJ, ed., The Documents of Vatican II (New York: Association Press, 1966). For this reference, p. 495.

3. John Dearden, "The Challenge of Religious Pluralism", Origins, (October 28, 1976), pp. 294-299. "Voluntary organizations" or "intermediate associations" in society are affirmed by both Catholic social teaching and democratic political theory. A wide variety of groups are covered by the term "voluntary association" ranging from labour unions, to political parties, to religious bodies. These organized groups are distinct from the state in origin and operation. They play a mediating role in society, serving as a buffer and a channel of communication between citizens and the state.

4. Mary Milligan, "Charism and Constitutions", The Way Supplement 36 (Summer, 1979), p. 46.

5. Ibid., pp. 46-53.

6. Perfectae Caritatas, n. 2; E.T. in Abbott, The Documents, p. 468.

7. Milligan, "Charism and Constitutions", p. 47.

8. Ibid., pp. 46-47.

9. The charism is foundational to the religious congregation, however, it is not referred to in regard to an organization. As fewer members of a religious

congregation administer and staff a Catholic health care institution the question of the significance of the charism for the mission of that institution can be raised.

10. Milligan, "Charism and Constitutions", p. 49.

11. Kevin O'Rourke, OP, Reasons for Hope:Laity in Catholic Heath Care Facilities (St. Louis, Mo.:Catholic Health Association of the United States, 1983) p.77. O'Rourke defines sponsorship as the "means by which a juridical person in the Church formulates philosophy, sets policies for, promotes and governs an apostolic activity; usually involves ownership of a facility: some sponsorship rights may be delegated to other juridical persons, but sponsoring group must retain fundamental power over apostolic activity."

12. Fulvio Limongelli,"Statement of mission - a valuable working tool" Hospital Trustee, (May/June, 1985), pp. 24-25. In order for a health care facility to obtain accreditation, a mission statement has become a requirement for all types of facilities (non denominational/denominational). The Board of the Canadian Council on Hospital Accrediation approved the following Standard I: Mission Statement, Goals, Objectives and Planning in May 1986. It states:

    There shall be a clearly worded statement outlining the mission of the health care facility and goals and objectives relative to patient care, teaching, research and health promotion. There shall be documented evidence of the development of an over-all plan to address the achievement of goals and objectives, such plan to be subject to regular review and revision.

    Limongelli, executive director of the Canadian Council on Hospital Accreditation, explains that there are four components to a statement of mission. Philosophy (Culture): The traditional opening to health facility by-laws stating the beliefs and guiding principles for the conduct of the institution lay or religious. Structure and role: this section identifies the physical, material and human resources of the facility as well as the functions it fulfills. The number of beds, a description of the population served, the services offered and their limitations and relationships with other health care facilities and the community would be included. Goals: Goals can be defined as long term aspirations related to future developments. Goals have a broad focus and probably span a 10-year period. Objectives: The objectives are the steps to be taken to achieve the identified goals. They are specific, time-limited, measurable and realistic.

13. Michael Fahey, "The Mission of the Church: To Divinize or to Humanize?" Proceedings of the Catholic Theological Society of America, 31 (1976), pp. 56-69.

14. For an example of this debate refer to: Roger D. Haight, "Mission: Symbol for Church Today," Theological Studies, 37 (1976), pp. 620-649.

15. Francis Schüssler Fiorenza, Foundational Theology (New York: Crossroad Publishing , 1984), p. 195. This section relies heavily on Fiorenza's discussion of mission.

16. Ibid., p. 197.

17. Ibid., p. 198.

18. Patrick Granfield, "The Rise and Fall of Societas Perfecta," Concilium, 157 (1982), p. 3-8.

19. Fiorenza, Foundational Theology, p. 198.

20. Ibid., p. 199; For further discussion of this point refer to Roger Haight, SJ, The Experience and Language of Grace (New York: Paulist Press, 1979), pp.61-66; Aquinas, Summa Theologiae, I-II, 109, 2; I-II, 112,1.

21. See Henri de Lubac's, The Mystery of the Supernatural (New York: Herder and Herder, 1967), and Augustinian and Modern Theology (New York: Herder and Herder, 1969).

22. Fiorenza, Foundational Theology, p. 200.

23. Semaines sociales de France (Versailles, 1936), pp. 461 -462; quoted in Walter M. Abbott, ed., The Documents of Vatican II (New York: Association Press, 1966), p. 264, n. 58.

24. Fiorenza, Foundational Theology, p. 200.

25. Fiorenza, Foundational Theology, p. 207. However, recent studies have challenged this theological dichotomy, historically and systematically. It has been shown that the classical Thomist distinction between nature and grace was not intended as a point of separation, dividing the two spheres. The model also raises the fundamental theological question about the nature and specificity of the religious dimension in life. Fiorenza formulates the question in the following manner. He asks, "Is what is religious a separate and isolated experience; or is it a dimension of human experience so that religious identity is best understood not in contrast to other forms of identity,

but precisely in and through its relation to them?" Contemporary theology, in its attempt to relate religious identity with the Church's mission, grapples with precisely this fundamental theological question. For a survey see Bernhard Stockle's "Gratia supponit naturam," Geschicte and Analyze eines theologischen Axioms (Rome: Herder and Herder, 1962).

26. Fiorenza, Foundational Theology, p. 202.

27. Ibid., pp.203-04.

28. Ibid., pp. 225-239.

29. W. Pannenberg, Theology and The Kingdom of God (Philadelphia: Westminister, 1969), pp. 90-91, and "Christian Morality and Political Issues", in Faith and Reality (Philadelphia: Westminister, 1977), pp. 123-38.

30. Juan Luis Segundo, The Community Called Church, (Maryknoll, New York: Orbis, 1972), p. 96.

31. Richard P. McBrien, "The Church and Social Change: An Ecclesiological Critique", Theology Confronts a Changing World, Thomas McFadden ed., (West Mystic, Connecticut: Twenty - Third Publications, 1977), pp 41-62. See McBrien's Catholicism, vol.2 (Minneapolis: Wenston, 1980) pp. 720-722, for a more constitutive than substitutive role with regard to social justice.

32. McBrien, "The Church and Social Change", p.52.

33. Fiorenza, Foundational Theology, p. 203.

34. Karl Rahner, "The Church's Commission to Bring Salvation and the Humanization of the World," Theological Investigations, 14 (New York: Seabury, 1976), pp. 295-313.

35. Fiorenza, Foundational Theology, p. 204.

36. Ibid. p. 204.

37. Fahey, "Mission of the Church" pp. 56-69. For a similar emphasis upon plurality of tasks, see Jerome P. Theissen's The Ultimate Church and Promise of Salvation (Collegville, Minnosota: St. John's University, 1976), pp. 156-82.

38. A. Dulles, Models of the Church (Garden City, New York: Doubleday, 1976), p. 95.

39. See Dulles' emphasis on the relation between faith and social mission in "The Meaning of Faith Considered in

Relationship to Justice," John C. Haughey ed., The Faith That Does Justice (Woodstock Studies 2; New York: Paulist, 1977).

40. Fiorenza, Foundational Theology, p. 206.

41. Joseph Gremillion's Introduction to The Gospel of Peace and Justice (Maryknoll, New York: Orbis, 1976), pp. 1-38 and Yves Congar's, "The Role of the Church in the Modern World," Commentary on the Documents of Vatican II, Herbert Vorgrimler, ed., (New York: Herder and Herder, 1969), pp. 202-223.

42. "Actio pro iustitia et participatio transformationis mundi plene nobis apparent tamquam ratio constitutiva praedicationis Evangelii, missionis nempe Ecclesiae circa generis humani redemptionem et liberationem ab omni statu oppressionis."
De Iustitia in mundo, Acta Apostolicae Sedis 58:12 (Dec, 1971) n. 6; E.T. in Gremillion, The Gospel, p. 514.

43. On Human Rights and Reconciliation, n. 6; E.T. in Catholic Mind, 73, no. 1291 (March, 1975), pp. 50-51. It is argued that the relation between evangelization and social ministry is based upon human rights. This ministry is "required" and is "central" to the Church's ministry.

44. Evangelization of the Modern World, n.12; E.T. in Catholic Mind, 73, no 1291 (March, 1975), p. 55. The "mutual relationship" and the "intimate connection between evangelization and liberation" is referred to in this document. It goes on to state that the Gospel contains "profound reasons" and "new incentives for social ministry that should eliminate the unjust social and political structure flowing from sin."

45. Evangelii nuntiandi (Washington, D.C.: United States Catholic Conference, 1976), n. 31 as cited in Fiorenza,Foundational Theology, p. 241.

46. Fiorenza, Foundational Theology, p. 209.

47. Evangelii nuntiandi, nos. 34 and 35.

48. See J. Brian Benestad's, "The Political Vision of Pope John Paul II: Justice through Faith and Culture" Communio, 8 (1981), pp. 3-19.

49. Fiorenza, Foundational Theology, p. 210.

50. For a discussion which focuses on human dignity as a basis for the relation between evangelization and social mission, see Richard McCormick's, "Human Rights

and Mission of the Church" Mission Trends 4, Gerald H. Anderson and Thomas F. Stransky, eds., (New York: Paulist, 1979). pp. 37-50; reprint from Theological Studies 37 (1976), 107-119.

51. Address to the Third General Assembly of Latin American Bishops, Puebla Address, sections 1,7 and 3,2. Addresses and Homilies, (Washington:United States Catholic Conference, 1979), pp.22, 38 as cited in Fiorenza, Foundational Theology, p. 241.

52. Fiorenza, Foundational Theology, pp. 213-218.

53. Philip E. Hammond, "The Durkheim Integration Thesis Reexamined: A Study of Religious Pluralism and Legal Institutions," Changing Perspectives in the Scientific Study of Religion ed. Allan W. Eister (New York: Basid, 1974), pp. 115-142.

54. Clifford Geertz, The Interpretation of Culture (New York: Basic, 1973) p. 98-99.

55. Fiorenza, Foundational Theology, p. 219.

56. Pannenberg, Basic Questions in Theology, vol. 2 (Philadelphia: Fortress, 1970), pp. 201-33, quoted here p. 230; also The Idea of God and Human Freedom (Philadelphia: Westminister, 1973), pp. 80-89.

57. Fiorenza, Foundational Theology, p. 220.

58. Frances Schüssler Fiorenza, "Joy and Pain as Paradigmatic for Language about God", Concilium 5 (1974), pp. 67-80.

59. Fiorenza, Foundational Theology, p. 221.

60. Ibid., p. 222.

61. Ibid., p. 223.

62. Ibid., p. 223.

63. Ibid., p. 225.

64. Jean Pierre Médaille, Eucharistic Letter, p.40.

65. Roland Warren, The Community in America (3d ed.; Chicago: Rand McNally and Company, 1978).

66. Fiorenza, Foundational Theology, p. 304.

67. Ibid., p. 305.

68. J. Doyle, The Story of the Catholic Hospitals of Canada

p. 9. Also, Fr. Joseph McCowell, "Pioneers of the 18th and 19th Centuries in Catholic Hospitals in Canada," Hospital Progress 21:9 (Sept. 1940), pp. 295-298.

69. Mother Saint-Marc, "The Development of the Catholic Hospital in Canada, The Beginnings of the Hotel-Dieu of Quebec 1639, Hospital Progress 21:9 (Sept. 1940), pp. 287-290.

70. Mother Allard, "The Beginning of the Hotel Dieu of Montreal" 164 2, Hospital Progress 21:9 (Sept 1940), pp. 291-294; Charles Gerard, "The History of Hotel-Dieu de Saint Joseph in Montreal, Quebec, Canada II. The Beginnings of Montreal Hospital Progress, 23:4 (April 1942), pp. 108-112.

71. Perfectae Caritatis, n. 2: E.T. in Abbott, The Documents, p.468.

72. Anne Bernice Hennessey, CSJ, "The Influence of Ignatian Spirituality on the Primitive Documents of the Sisters of Saint Joseph" (Ph.D dissertation, Graduate Theological Union, Berkeley, 1983), p. 8.

73. Ibid., p. 14.

74. Ibid., p. 16.

CHAPTER I

The Catholic Health Association of Canada: The Early History and Mission of the Antecedent Associations

This chapter examines the early history of the Catholic Health Association of Canada. When one traces the history of the CHAC, the features of its theology of mission begin to take shape, as well as its distinctive identity as a part of the Catholic health apostolate. The relationship between this theology of mission of the Association and the theology of the mission of the Church can then be explored.

The early accounts of the settlement of both Canada and the United States acknowledged Catholic involvement in the provision of care for the sick.[1] By the turn of this century, many hospitals existed across North America, some of which were owned and administered by Catholics, usually religious congregations of women. It was in the ferment of this period that the need arose for an association for Catholic hospitals.

The very nature of what constituted a hospital was undergoing change. Medical knowledge was increasing. Technology was being developed to help in the treatment and cure of many ailments. A movement toward specialization within the medical profession was taking place as a result of these advances. The Flexner Report on Medical Education was released in 1910 in the United States.[2] This report

initiated a reform in medical schools which inevitably affected all aspects of practice and procedure within the medical field, especially in hospitals. It proposed the adoption of a general standard which would be used to investigate and rate all health care institutions. Hospitals with high ratings could thus attract a larger number of medical students. At the same time, the American College of Surgeons was advocating the adoption of minimum standards that would govern the practice of surgery within hospitals. In 1911, the American Nurses Association was organized. The need for better nursing education became an issue which had to be addressed.[3] Organizations working within the medical field became the agencies which assumed the major responsibility for determining adequate standards for medical schools, hospitals, and schools of nursing.

Religious congregations involved in hospital work followed these developments with a degree of apprehension. They realized the necessity of keeping in step with the new emphasis on medical education as stressed by the Flexner Report and with the observance of norms regulating the practice of surgery advocated by the American College of Surgery.[4] The Sisters acknowledged that if they were too slow in responding, these changes could threaten the existence of their institutions.

1.<u>The CHA of the United States and Canada 1915 - 1939</u>

These complex factors present in the health care scene in 1915 created the context in which the earliest antecedent of

the CHAC was founded. A number of Sisters in the St. Paul Province of the Sisters of St. Joseph of Carondelet brought their concerns to Rev. Charles B. Moulinier, SJ, after a retreat he directed for them. Father Moulinier, the regent of the School of Medicine of Marquette University, was well aware of the problems which were facing hospitals at that time. He, along with the Sisters, decided that an organization was needed for those involved in Catholic hospital work which would promote and foster programs arising from the recommendations for reform and, thereby, maintain high standards for Catholic hospitals. Father Moulinier suggested that a "Catholic Hospital Association" be formed. Father R. Shanahan, a historian of the CHA explains that: "in the mind of Father Moulinier, the Catholic Hospital Association was destined to have a mission of fusing hospital activity with the viewpoints and motivations of education. Development of the Sisters and their hospitals was to come through enlarged and deepened educational activity."[5] Because of advances in medicine and health care, adequate and responsible care for the sick could be offered only if the Sisters became educated and kept up to date about current developments. The mission of the CHA was to help the religious congregations in hospital work continue their mission.

The first convention, which was to become an annual event, was held in Milwaukee, Wisconsin in August 1915. The name of the Association was officially chosen, officers were elected and a constitution was written. This new

organization was called the "Catholic Hospital Association". The words "... of the United States and Canada" did not appear in the first name adopted officially by the delegates. In fact, no Canadian representatives attended the convention. However, geographic location for membership in the Catholic Hospital Association was not intentionally limited in any way .[6]

1.1 Constitution, 1915

The first Constitution and By-Laws of the Catholic Hospital Association described its objectives. It indicated the Association's mission in its early period. The Association was to help Catholic hospitals maintain up-to-date and high standards of medical care, to foster a co-operative spirit among all health care workers, help educate hospital workers, facilitate communication and co-operation among the various congregations, and raise funds. The first objective focused on the promotion of 'scientific' efficiency and economy in hospital management.[7] This was in response to the hospital standardization movement originally launched by the American College of Surgeons.[8] It is interesting to note that even though this objective may have been the primary motive for the Association's formation, other objectives soon replaced it in importance. The second objective stated in this Constitution spoke about the need "to encourage the spirit of cooperation and mutual helpfulness among hospital workers".[9] At the time of founding, tensions existed between the denominational and

non-denominational hospitals. It has even been acknowledged that tensions existed among the various religious congregations. It was hoped that the Catholic Hospital Association could help overcome some of this divisiveness.[10]

The nature of religious life posed problems for the Sisters who worked in hospitals. The Sisters, who owned the hospitals and worked in various capacities within them, lived a community life which was designed to effect the personal sanctification of its individual members. This life limited the contact of the religious with other lay people, including those who administered and worked in the hospitals. Thus, in the early twentieth century, the Sisters did not participate actively in other health organizations and hospitals. The Catholic Hospital Association made it possible to hold conventions, sponsor regional meetings, and produce publications which could address specifically the difficulties which the Sisters encountered because of their religious seclusion.[11]

Education was the Association's third objective. Though it was not stated explicitly, it was implied that the practice of medicine had a distinct moral orientation which needed to be conveyed. The Association was to educate with "thoroughness and correct moral tone" those who worked in the field of medicine.[11] Education was to take the form of studies, conferences, discussions, and publications. This Constitution stated that there could be "advancement of medical science by encouraging interns and members of the

staff and by the use of equipment and unhampered use of technical and clinical material."[12] In 1915, the first educational program offered was a school training program for medical techicians given at the School of Medicine of Marquette University. Beyond the establishment of hospitals, the period of 1915-1922 was a time devoted to the promotion of educational programs.[13] This educational task, even though it has taken many forms and covered many areas, has remained a central concern of the Catholic Hospital Association.

The final objective, stated in the founding Constitution, implied a commitment to serve the public. The historical context of the Catholic hospital as a private charity which needed to solicit resources, indicated that this service as mission for the Catholic apostolate was important and needed support.[14]

Bernard McGrath, who has written on the history of the CHA, has noted that another concern was important in the early years, though it was not identified as an objective within the founding Constitution. This was the fostering of a Catholic identity. The term Catholic hospital was intended to imply that the viewpoints and policies which permeated all aspects of the operation were to be characteristically Catholic. A hospital was Catholic merely because it was owned and administered by a group of religious belonging to the Catholic Church.[15] Because of the rapid changes occurring in the hospital field, the Association was seen to be an appropriate vehicle to

foster this identity. That the objectives of the founding Constitution made no explicit mention of this suggested the non-problematic nature of Catholic identity in this period.

The founding Constitution thus committed the Catholic Hospital Association to a number of tasks. Its objectives defined the Association's mission to help religious congregations achieve their mission. The Association addressed the difficulties which arose for nursing Sisters because of the nature of their religious life. In other words, it seemed that the CHA had a secular mission whose precise object was the support of the mission of the various religious congregations.

In 1935, a new Constitution was approved by the CHA of the United States and Canada, the name which it had acquired by this time. The objectives remained essentially the same. However, the promotion of the medical, social, economic and religious development of its members was included in its 'Objectives'. This inclusion was significant because it involved a new self-understanding for the CHA : the CHA was to promote the religious development of its members.[16]

The affairs of Catholic hospitals in Canada were considered together with those of their American counterparts from 1915 until June 1939. Regional or provincial conferences were established. The first conference established was the Western Canada Conference of 1921, but in 1924, it was disbanded. The Maritime Conference

was established in 1922. Soon afterward, the Ontario Conference and the Prairie Provinces Conference were formed.[17] The various congregations of nuns, and orders of brothers and priests had an international membership or, at least, they had members in both the United States and Canada. Hospitals were managed in relation to the distribution of members of a congregation and not according to citizenship.

2. The Canadian Advisory Board, 1939

In June 1939, a special meeting of the Canadian Conferences was held in Milwaukee. It had become apparent that the problems facing Catholic hospitals in Canada were different in some respects from those in the United States. The preliminary step toward independence was taken when a decision was made to create a Canadian Advisory Board, though the Catholic Hospital Association was to continue as a single organization. The Board was to act as a intermediary between the Executive Board of the CHA and its institutional members in Canada. Special provisional by-laws were formulated to govern the functioning of this Board.[18]

The resolutions of the Twenty-Sixth Annual Convention indicated the nature of the concerns which the Canadian Advisory Board brought to the attention of its parent Association. Discussions had been taking place in Europe and in North America about the adoption of national social security plans for sickness, unemployment and old age.

Canada was moving more quickly in this direction than the United States.

The Canadian Advisory Board's initial response to the possible implementation of a socialized health insurance plan was guarded. Fears existed that voluntary hospitals, as Catholic hospitals were designated, might not enjoy equal funding with public hospitals, or that they might lose their autonomy. At stake for Catholic hospitals was the ability to maintain high standards of care and operate according to Catholic principles. Without the funding necessary to provide good quality care, Catholic hospitals would not be able to compete.

The Association re-affirmed its commitment to "the maintenance of a system of voluntary hospitals side by side with a system of public hospitals".[19] This relation was visualized as one of complete understanding and intimate cooperation on levels of complete equality between the two systems of hospitals. In order for Catholic hospitals to exist, it was necessary that they receive equal funding along with public hospitals.

In another resolution, the Association expressed its disapproval of procedures which sought to socialize hospital service through public legislation and which sought to make the hospital care of indigent persons and other groups the sole responsibility of the state.[20] This concern indicated the role which government in Canada was to assume in providing health services to the general population. Given the principle of subsidiarity which is

affirmed by Catholic social teaching, the Association argued that the government should only assume responsibility for services which cannot be provided by lower levels of government or by other local agencies. For instance, hospital service to the indigent and to other groups of the population could be provided by the voluntary associations and not necessarily by the government.

However, in Montreal at a special June 1942 Meeting of the Canadian Catholic Hospitals, O.C. Trainor pointed out that the various levels of Canadian government had usually relied on the existence of voluntary hospitals to provide care for the indigent. He stated that "the almost unvarying policy of government in this country -- federal, provincial and municipal -- has been to utilize to the fullest extent the facilities of the voluntary hospitals in the general field, rather than to embark on projects for the construction of government-owned and operated institutions for the care of indigents".[21] He pointed out that "this fact is important and will bear consideration not only on its own merits but as an augury of what may be expected in the future."[22]

In the same year, when reviewing the principles governing general health insurance (formulated by the Canadian Hospital Council), the Committee on National Health Insurance of the newly named Catholic Hospital Council of Canada[23] accepted the principle that the hospitalization of indigents should be provided for under the Plan, and that

they should receive the same care as other persons.[24]

3. The Catholic Hospital Council of Canada

At the Advisory Board Meeting of October 18, 1942 at St. Michael's Hospital in Toronto, a suggestion was made to establish an autonomous Catholic Hospital Council of Canada, Prime Minister Mackenzie King had appointed a Dr.Heagerty to look into the possibility of a national health insurance plan and Dr. Heagerty stipulated that only wholly Canadian organizations would be invited to participate in discussions leading to new legislation. Because of the substantial proportion of Catholic hospitals which existed in Canada and, also, because of the large number of Catholic schools of nursing which supplied the nursing profession, the Canadian Catholic health apostolate believed that it was essential to have sufficient Catholic representation on Dr. Heagerty's Committee which sought to develop a Canadian Health Insurance Program.

The new name, unanimously accepted for this organization, was "The Catholic Hospital Council of Canada".[25] This was the first step in separating the CHA of United States and Canada. As solely a Canadian organization, the Catholic Hospital Council could carry out what it saw as its mission. This mission could be described as lobbying to maintain equitable treatment of Catholic hospitals, and, by proposals and criticisms, to influence the development of a a national insurance plan that would serve the interests of the Canadian public.

On the one hand, the question of the extent of government responsibility for providing health services had to be addressed. But, on the other hand, the belief that a National Insurance Plan was going to be instituted in some form in the near future quickly superseded concern with the first question. Catholics in a position to influence policy had to decide what they should do to maintain a Catholic health apostolate and what features a good insurance plan should have if it was to serve the best interests of the Canadian people. The meetings of the Canadian Advisory Board and the Catholic Hospital Council displayed an awareness among the members of the potential challenges that a National Insurance Plan could pose to the maintenance of a Canadian Catholic apostolate.[26]

Another issue which revealed a concern for the protection of the Catholic identity in the Canadian health apostolate centered around the relationship of the Catholic Hospital Council of Canada and the Canadian Hospital Council. While the Canadian Hospital Council saw itself as a protector of Catholic hospitals, the Catholic Hospital Council suggested that it have a representative on the National Council on Health Insurance. However, in the interest of hospital unity the Canadian Hospital Council suggested that there should be two representatives from its Council, one of which was chosen by the Catholic Hospital Council of Canada. If the Canadian Hospital Council moved in directions which the Catholic Hospital Council could not accept, the latter could protest and deal with the

situation in an internal way. It was thought that the interests of all hospitals could be best served in this manner. The Catholic Hospital Council of Canada adopted the following resolution,

> Resolved, that the Catholic Hospital Conferences of Canada pledge by their membership in the Canadian Hospital Council, their co-operation and support and accept the spokesmanship of the Canadian Hospital Council which has formulated its position and concerns which the Catholic Hospital Conference have given their affirmative vote. When, however, in the judgment of the Catholic Hospitals of Canada, a particular program involves the social mission of the Church or her teaching the Catholic Hospital Conferences accept the Catholic Hospital Council of Canada as their spokesman. By virtue of its character, the Catholic Hospital Council of Canada must at all times retain its right and obligation to formulate its position and to voice its decision before appropriate bodies, and to have representation before legislative bodies separate from that of the Canadian Hospital Council. In the judgment of the Catholic Hospital Council of Canada, the National Health Insurance Act involves a problem affecting the social mission of the Church and her teaching.[27]

Since no one could expect the Canadian Hospital Council to speak for the interests of the Catholic Hospital Council and its member conferences, the latter needed to speak for their own interests.

4. <u>The Catholic Hospital Association of Canada</u>

In 1954, the name changed to the 'Catholic Hospital Association of Canada'. The minutes of meetings prior to 1954 record the establishment of a number of committees dealing with by-laws and the approval by the Executive Committee of more than one draft <u>Constitution</u>. However,

by-laws were not officially adopted and approved by the Canadian Catholic Conference until 1953. In 1960, the association decided to become a corporation and to proceed with a revision of the existing Constitution and By-laws.

4.1 Brief to the Royal Commission on Health Services, 1962

In 1962, the federal government established a Royal Commission whose task was to examine the health care needs of Canadians. The Catholic Hospital Association of Canada presented a Brief to the Royal Commission on Health Services. The Hospital Insurance and Diagnostic Services Act had been in effect since 1957, and though availability of hospital insurance for all Canadians had changed the financial relation between the hospitals and the general public, according to the CHAC, the essential characteristics which defined a Catholic hospital had not changed.

In this Brief to the Royal Commission, the Catholic hospital was characterized by a philosophy of life and an understanding of disease. Catholic hospitals are described in the following way:

> The personnel of the Catholic Hospitals dedicated individually and collectively, guided by the doctrine of the Church and its tradition, maintains in our institution a Christian atmosphere. We believe our hospitals should continue in existence and be available to all people who consider spiritual and physical care essential factors of health recovery.[28]

The Brief to the Royal Commission explains that Catholic hospitals, being guided by Church doctrine and

tradition, have a Christian atmosphere and provide both spiritual and physical care. Features of this Christian atmosphere are not described. Spiritual and physical care, as essential factors of health recovery, are not developed. Compared to later statements of philosophy by the health apostolate, this description of Catholic hospitals seemed vague. However, in practice, it may not have been necessary to specify what was distinctively Catholic at this time because most people already knew something about the nature of Catholic institutions due to the high visibility of the Sisters, still in their habits and the presence of articles (crucifixes and statues) which bespoke faith.

The Brief includes an excerpt from an address by Alphonse Schwitalla, SJ, a president of the CHAC, on the concept of disease. His view is held as representative of the Association. He states:

> . . . there is a fundamental difference between our institutions and other institutions not only with reference to a philosophy of life but also specifically with reference to the concept of disease. The Catholic hospital does not accept the interpretation of disease as an unmixed or an absolute evil. It recognizes the place of suffering in the supernatural economy of God's dealings with men. It recognizes the hand of Providence in the permission that through secondary causes men might succumb to illness and to death. It sees in suffering an opportunity for supernatural grace which raises man from the mere level of his physical existence to a higher plane and evokes in man the manifestations of his noblest and his most unselfish and his most ideal traits . . .
>
> Does this viewpoint diminish the zeal of the Catholic hospital for the cure and the prevention of illness? By no means, rather it accentuates

> that zeal not only because it supplies the highest possible motivation but also because through the administration of services to the sick, the Sister nurse, the physician, feel a new dignity in the thought that they are serving as ministers of an all loving God in the working out of the destinies of those whom they have under their care . . .
>
> Insight into the eternal meaning of suffering does not destroy care for suffering but rather increases and intensifies that care because it shows to the person giving these ministrations the great purpose which she is carrying out in making real the plans of God in His dealings with the individual soul.[29]

Disease and suffering are not seen as an absolute evil but as a part of God's plan of salvation for the person. The work of the Nurse Sister and the physician has a 'new dignity' because it makes them ministers of God in helping their patients 'work out their destinies' or their salvation. The CHAC, in representing its institutional members who express this concept of life and disease, is still primarily carrying out a secular mission. The Association is advocating on behalf of its institutional members to allow them to continue with their religious mission. Catholic hospitals are understood as being a place not only to obtain care when one is sick, but also where health care workers and patients can work out his or her salvation.

The CHAC Brief to the Royal Commission stresses the vital role of the Chaplain and the chapel for the Catholic hospital. Financial arrangements at that time did not make funds available for either. The Brief to the Royal Commission argues that in order to safeguard the essential

character of the Catholic hospital, a source of revenue must be made available to such voluntary institutions so that which is essential to their particular philosophy can be preserved.

The secular mission of the CHAC as an advocate for its institutional members in its Brief to the Royal Commission, urged the Government to establish a 'Bill of Rights' for non-profit institutions under private ownership. The effect of this Bill would "produce in those institutions the sense of security and serenity so necessary for their continuation, development and effectiveness".[30] At this time, in 1962, Catholic hospitals were making a substantial contribution to the provision of health care. The CHAC Brief to the Royal Commission indicated that religious congregations owned 314 of the 1,361 institutions in Canada. This represented 59,013 beds on a total of 198,517 beds. In calling for a 'Bill of Rights', the CHAC asked the government to recognize their present and past contributions in providing health care so that, in the future, Catholic hospitals could be maintained, "without suffering invidious comparison with publicly-owned institutions".[31] Presumably, such a Bill would safeguard institutions under private ownership by enabling them to maintain their essential characteristics and by providing funding which would enable them to provide a standard of care comparable to publicly-owned institutions.

4.2 Constitution and By-laws, 1964

1. CHA: Early History and Mission

The Canadian health care scene was very different in 1964 than it was in Milwaukee in 1915 when the CHA first began. In Canada, an insurance plan covering the hospital costs was already in place. The Royal Commission on Health Services had just held hearings across Canada to explore the possibility of a plan to cover the costs of all medical care. The antecedent associations of the CHAC had been successful in obtaining financial support for their hospitals on a comparable basis with the public hospitals. Some dispute continued over the financing of chapels and chaplains, which had been considered as essential components for a Catholic hospital.

Within this context, the CHAC drafted a new Constitution. As stated, the purpose and objectives of the Association indicated a growing recognition of the religious mission as compared with the founding Constitution. Not only was there a commitment to promote and realize efficacious programs for the corporal care of the sick, but there was also a commitment to promote programs for the spiritual care of the sick in health care institutions designated as Catholic.[32] This indicated a realization of the need to address this aspect of Catholic hospitals in an explicit way.

The fostering of high ideals in all phases of the hospital and nursing endeavour was reiterated. The study of the philosophy and the religious life of hospitals in all of their aspects, became one of the objectives of the CHAC. This philosophy had been affirmed and practiced throughout

the history of Catholic hospitals but had not been specified as such. That this philosophy should now become a subject of study suggests that this is the point when Catholics became more reflective about the distinct manner in which they should care for the sick and operate their hospitals: it could no longer be taken for granted.

The other objectives, stated in the new Constitution, outlined the more secular nature of the Association's mission. These included coordinating the activities of the various Catholic hospital organizations; representing CHAC members in those matters of general or national interest which concerned their welfare; cooperating with governments or other bodies to promote the health and welfare of people and the improvement of hospitals; educating through a variety of forms and accepting assistance to further the objectives of the the CHAC.

In 1967, because of certain changes that were occurring in society and culture, the CHAC became more reflective about its principal goals and its raison d'etre. Many Catholic hospitals had been sold and their numbers were declining, especially in Quebec.[33] The CHAC was concerned about this loss of institutional members. At the 1967 Meeting of the Board of Directors, a decision was made to draw up and send a questionaire to each provincial conference, soliciting the opinions of each conference on the Association as it then stood, and more importantly, asking each Conference what it thought could be added to or

deleted from the functions of the Association in order to meet the current needs and purposes of Catholic hospitals in Canada.[34]

4.3 Constitution and By-laws, 1971

As a result of the responses to the questionaire sent to the provincial Conferences in 1967 and subsequent discussion, a new Constitution and By-laws was adopted. The purposes of the Association remained unchanged except for one new purpose. The Association would now promote and foster pastoral services as an integral part of patient care. In the 1964 Constitution as well as in this 1971 Constitution, one purpose of the Association was cited as promoting "a more efficacious program for the spiritual and corporeal care of the sick".[35] However, what this meant in practice was not specified. The promotion of pastoral services can be seen as a specification of the spiritual care given the sick.

The 1972 Laval Report placed a great deal of emphasis on the importance of pastoral services. A study requested by the CHAC was carried out by Father J.P. Rouleau, SJ, at the Center for Research in Religious Sociology at Laval University, Quebec. This intensive study was undertaken of Catholic health care institutions to determine what characteristics constituted their specific identity. The Laval Report suggested two orientations that were needed in Catholic hospitals. Firstly, pastoral activity should become an integral part of the hospital's professional service. Secondly, special emphasis should be given to a

deeper understanding of religious faith and to the development of personalized forms of spiritual service. The mandate of service for spiritual care included welcoming of patients, giving them spiritual care, training of personnel, and counselling administrators in such matters as "the humanization of the milieu" given the many technological and administrative changes which threatened the human and spiritual atmosphere of life.[36]

Unfortunately, this Report was never widely circulated. However, it did exert some influence on the revision of the CHAC by-laws. This will become apparent.

In May 1972, a Programming Document was presented to the Board of Directors for approval. The CHAC was described as an association that linked together 272 Catholic hospitals and homes for the aged in Canada.[37] This need for contact was identified by the CHA as a means of safeguarding the values and principles of the philosophy of the Association, based on the charity which Christ extended toward the sick and poor. The objectives and purposes cited in this Programming Document were those which had appeared in the 1971 Constitution. The recommendations for pastoral services made in the Laval Report were taken into consideration.

The programming of activities for the period between 1972 - 1977 was directed to the objectives that advocated pastoral services for the sick, the infirm, and the aged. In the past, the CHAC had recognized and affirmed the

spiritual dimension of each person and had emphasized the spiritual as well as the corporeal care of the sick. As indicated in their earlier documents, this was understood as integral to their philosophy. One way of contributing to the maintenance of this spiritual care was to lobby for funds for chapels and chaplains. However, this Programming Document indicated that the CHAC was increasingly becoming involved in its own religious mission. Not only was this inseparably linked with the mission of its members but it was assuming a character of its own and it was to have direct influence on the spiritual lives of many people. The second objective stated in the Programming Document dealt with the representation of CHAC members in discussions which touched on matters of general or national interest respecting their welfare. Thus, the CHAC remained an association which sought to support the mission of its members.

4.4 The Liaison Committee's "Working Document", 1974

An example of the CHAC representing the interests of its members occurred through its involvement with what became known as the Liaison Committee. This Committee was to be an advisory committee to the following parent bodies: the Canadian Catholic Conference which is the official hierarchy, the Canadian Religious Conference which represented religious congregations and orders, and the CHAC which represents its own institutional and individual members involved in hospital work.[38] The operation of the health apostolate was an object of much concern at this

time. A number of hospitals were ceasing to be Catholic because of government intervention. Catholic hospitals were feeling the effects of a decline in religious personnel. Interpretations of Vatican II recognized a greater role for lay persons in operating hospitals and this raised the question of sponsorship.[39]

The terms of reference for the Committee were extensive in their scope. They indicated the range of problems which the three bodies identified as needing study and clarification. The advisory committee was asked to understand the role of the Catholic hospital in Canada in relation to the mission of the Church; to encourage the continued ownership by a Catholic organization, either religious or lay; to provide a means of continued study of health and moral standards and their pastoral implications in relation to current advances in medical science and technology; to identify and recommend means by which lay, religious and clergy were able to fulfill the apostolate in the health care field; and to discuss such other aspects relating to the philosophy of Catholic health institutions. What this committee was asked to do in their terms appears very similar to the objectives of the CHAC at that time. It is not clear why it was decided that these issues needed to be addressed by an advisory committee of the three parent bodies and not solely under the auspices of the CHAC.

The Liaison Committee's Working Document, in addressing the issues outlined in the terms of reference, contains

certain basic affirmations about the role of the Catholic health apostolate which are reiterated and developed later in the mission statements of both the CHAC and those of Catholic sponsored institutions. The Working Document was not widely circulated nor did it become an officially expressed statement of mission. It is therefore difficult to assess its actual influence on later statements of mission.[40]

The 1972 Programming Document described the need of Catholic hospitals and homes for the aged to be associated as a unified group in order to safeguard their Catholic values. The Document also pointed out that if the CHAC was to achieve its aims it would need a solid and well-balanced organization based on reliable administrative principles.[41] The Liaison Committee's Working Document acknowledged the speed with which society was moving in the direction of secularism and pluralism. It asked if, in fact, the Church was carrying out its mission in health care in the Spirit of the Gospel.

In 1974, faced with the need to examine the mission of the Catholic health apostolate in Canada, and with the recognition of the importance of the Association in linking its institutional members as a way of protecting their Catholic values and the threat to these values posed by secularism, the CHAC set up a Task Force to evaluate its current situation and to make recommendations with regard to its future structuring. The Report of the Task Force, New Needs - Renewed Responses, was presented to the members in

1976, and included the first proposed statement of philosophy.[42] Even though the CHAC remains as a support for the mission of the religious congregations, it increasingly takes on its own religious mission as will become apparent in Chapter 4.

In summary, this section has examined the objectives, aims, purposes and philosophy as expressed by the CHAC and its forerunners from its founding until 1974. The main reason for its founding was to maintain high standards of health care within Catholic hospitals. The Association was at the service of religous congregations, in order to help them carry out their mission. In the early period, Catholic hospitals were founded and staffed by members of religious congregations. Nursing schools were under the auspices of the Catholic Church, providing nurses who were trained in nursing as well as in Catholic philosophy. Appeals were made to the public, especially to Catholics, to support their hospitals. The identity of their institutions was not threatened in view of the easily visible signs of its Catholic nature. However, with the implementaton of government-sponsored insurance plans, increasing costs, secularism and pluralism, and with fewer Sisters available for hospital work especially since the post-Vatican II period, there was mounting concern regarding the identity and viability of these institutions. The CHAC experienced a decreasing institutional membership which served as a warning signal that there were major problems. The period

from the early 1960's to 1976 marked the beginning of serious and systematic reflection on the mission not only of the CHAC but of the whole of the Catholic health apostolate. An informal and largely implicit understanding of their mission would no longer be sufficient within this new context. It was not readily apparent that the Catholic health apostolate was, in fact, offering service which was different from non-denominational hospitals. Without a clear understanding of their mission, the viability of Catholic health institutions was threatened.

5. The Identity and Mission of the Catholic Health Association of Canada

A hermeneutical reconstruction presupposes Christian convictions and practices in need of interpretation. A reconstructive analysis needs to consider the reception-history, the consequences and effects, shifts in argumentation as well as differences in paradigms.[43] This section focuses on the identity of the CHAC from its founding in 1915 until the early 1970's.

When the Catholic Health Association of the United States and Canada was founded, its main objective was to help religious congregations which owned and administered hospitals to maintain high standards of care compared to other hospitals and to keep pace with rapid technological change. The Catholic Health Association of the United States and Canada provided an opportunity for religious congregations to share information and develop strategies to deal with problems as they arose. With the accumulated

experience of its members, the CHA of the United States and Canada was able to educate both members and Catholic health workers for a wide variety of services necessary to operating a hospital. An essential aspect of this education was its Catholic dimension. This dimension was supposed to permeate every aspect in the control and conduct of such a hospital. However, the essential characteristics of the Catholic hospitals were not specified.[44] The identity of the CHA at this early stage could be described as 'taken for granted' and functional. Consistent with Fiorenza's description of the Church's mission within traditional fundamental theology, the CHA served primarily the social goals of the individual religious congregations, enabling them to carry out their missions.

The Constitution approved for the CHA in 1935 contains the first expansion from the solely secular mission expressed within the founding Constitution to include the religious development of its members.[42] This was a new dimension for the CHA.

The health care scene changed rapidly in Canada in the late 1930's. The Canadian Advisory Board was set up to represent the concerns of the Canadian institutional members of the CHA to the parent organization.[45]

The debate in Canada over the adoption of national social security plans for sickness, unemployment and old age brought about a serious challenge to the religious congregation mission. Religious congregations traditionally

set up hospitals when there was a need for this service in the community and no other agency, government or private source was providing it. As one of their works of charity, religious congregations provided care to disadvantaged groups within the community, such as the poor or new immigrants. During this period, hospitals had 'charity wards' specially designated for those who could not pay. Government- sponsored hospitals and a medical care insurance plan would eliminate the need for this kind of charity.

In the early stages of the debate, it was not clear how the proposals would affect Catholic hospitals. Answers were needed to several important questions: Would they receive funds from the government? Would they get the same amount as the non-denominational public hospitals? Would they be able to remain autonomous? Could they maintain their Catholic philosophy? If in fact they did receive equal funding, how would this affect their identity? What was at stake was the ability of Catholic religious congregations to continue in the health apostolate through hospital involvement.

The Canada Advisory Board and later the Catholic Hospital Council of Canada responded in a cautious way to the proposals.[47] The implementation of the health insurance plan was viewed by the Catholic Hospital Council as an issue which affected the social mission of the Church, conflicting with the principle of subsidiarity, established in Catholic social teaching. According to this principle, the government should not interfere if hospital service to the

indigent and other groups can be provided by voluntary associations such as hospitals owned and operated by religious congregations.

However, this was not a unanimous view. The minutes of Council meetings indicate that a wide variety of opinions was expressed on this.[48] For example, the question of whether the Plan should cover all citizens was not unanimously settled. It was only in 1942 that the Committee on National Health Insurance of the newly named Catholic Hospital Council of Canada decided that the hospitalization of indigents should be provided under the Plan and that indigents should receive the same care as all other Canadians. Through discussions among themselves and with other groups such as the Canadian Hospital Council and the Canadian Medical Association, members of the Committee had become convinced that universality of coverage held advantages over the other possible options, such as only covering the low income groups, allowing a uniform standard of services to be offered to Canadians.

Because Canadians were beginning to see health care as a right, the Committee recognized that government would have to assume the duty making the exercise of the right possible. Administration of the Plan would be easier without the need to determine if some people had the means to pay for services while others did not. However, because it was clear that the government was going to implement some form of insurance plan, the contribution of the Catholic

Hospital Council was made to promote its own interests, not to pressure the government to implement the Plan.

The social mission of the Church was involved, according to the Catholic Hospital Council, because the support and protection of the denominational hospitals were threatened. The protection of their interests would have to be negotiated with the government.[50] Thus, the ability of religious congregations to continue their apostolate through maintenance of their hospitals was at stake and they believed that they played a significant role in providing services to Canadians through their hospitals, schools of nursing and other activities. They did not question the value of this form of health care apostolate until the late 1960's.

In its Brief to the Royal Commission on Health Services in 1962, the CHAC asserted that health insurance changed the financial relations between Catholic hospitals and the people but did not change the essential characteristics of the Catholic hospital.[52] A Catholic atmosphere was taken for granted because of the visible presence of the Sisters and chaplains and the articles of faith within the institution. There is a further aspect of the mission of the Catholic hospital as explained by Fr. Schwitalla. The religious and social dimensions of the mission are inseparable as health care workers help their patients 'work out their destinies', or salvation. This role brings dignity to the work of the health care giver and, according to the CHAC, is what is different and thus threatened in the Catholic hospitals.[53]

The Association itself, at this point, had not yet taken on as part of its formal mission the task of reminding health care workers that they are called to be healers. However, awareness began of this dimension, which became a part of the CHAC's mission within the next twenty-five years.

The CHAC served as advocate for its institutional members in its Brief by urging the government to establish a Bill of Rights for non-profit institutions under private ownership. This Brief was an example of the CHAC's commitment to maintain and further its' members mission.

The 1964 Constitution of the CHAC indicated that a shift from the 'taken for granted' identity of Catholic hospitals was taking place.[53] The CHAC took on the objective of the study of the philosophy and religious life of hospitals. A more consciously reflective understanding of the Catholic health apostolate was needed. As religious congregations moved away from hospital ownership, the number of the CHAC institutional membership declined. The 1971 Constitution, which is similar to the one that preceded it, emphasized that an essential feature which needed to be stressed was pastoral care of the patient.[54] The 1972 Laval Report and the 1972 Programming Document and the 1974 Liaison Committee's 'Working Document' all identify the development of pastoral service as a necessary direction for the hospital apostolate.[55] Whereas, previously the CHAC had been predominantly concerned that Catholic hospitals be maintained within the emerging health insurance plan, the

focus was redirected toward establishing the distinctive features of a Catholic philosophy of health care.

In the past, the visible presence of the Sisters and chaplains (and chapels) as well as articles of faith served to identify the Catholic nature of an institution. This was no longer the case by the early 1970's, because there were fewer Sisters who were involved in bedside nursing and service was being rationalized among various hospitals in a region under government direction. This government intervention posed a potential threat in some cases to the moral stance followed by Catholic institutions over such issues as therapeutic abortion and sterilization.[56] On the other hand, it posed a threat to the autonomy of the administration to set priorities and direction for Catholic institutions, including the distinctive emphasis placed on pastoral care services as an integral component of Catholic health care.

In the early period, the forerunners of the CHAC served primarily to support the mission of religious congregations in health care. These antecedent associations were concerned with maintaining quality standards in the institutions and with representating their institutional members in order to influence government policy and to advocate for recognition and fair treatment by government. As the distinctiveness of Catholic health care became obscured with the development of a health care bureaucracy, specialized technology and fewer sisters, the CHAC's antecedent associations increasingly began to reflect on the

specific nature of a Catholic philosophy of health care. Beginning in the early 1960's, in the days of the Royal Commission on Health Care (1962-1964) and Vatican II (1963-1965), the CHAC, while retaining its role as advocate, resource and liaison, added another dimension to its identity. It became more explicitly concerned with the distinctive Catholic nature of the health apostolate.

With the implementation of health insurance, works of mercy which involved meeting the immediate needs of the sick poor were, to a large extent, no longer necessary. So why, then, should Catholics, more specifically religious congregations, continue in their health apostolate? The models of substitutive, unofficial and partial mission provide a starting point for examining the responses of the CHAC to the changes in the Canadian health care system. If the model of a substitutive mission was adopted, Catholics would no longer continue in their health apostolate despite the Church's social mission, because under this model the Church should formally and institutionally engage itself only where secular agencies, such as government, do not.[57] If a model of unofficial mission was adopted, Catholics involved in the health apostolate would be carrying out the unofficial social mission proper for laypersons. The Church's hierarchy would carry out the official religious mission, proper to bishops and priests.[58] In view of the Canadian health system, what would be the point of lay Catholics carrying out their unofficial social mission?

Would they not be redundant? Another model which might have been adopted was that of partial mission.[59] By continuing their health care apostolate, Catholics, especially religious congregations, would be carrying out one of the tasks of the Church. However, as with the unofficial mission model, it is not clear what needs within the Canadian health care system would be met and also, as partial mission, it is not clear as to how the Church's many tasks should interconnect. For instance, how should the social mission be related to the task of proclaiming the Word? In view of changes taking place in the Canadian health care system, the Catholic health apostolate needed to come to terms with these questions. The CHAC was instrumental in helping the apostolate to address these questions and move beyond them practically, as will become apparent in Chapter 4. The CHAC had moved much closer to participating in the 'religious mission' of the Church than its antecedent associations.

ENDNOTES

1. M.G. Doyle, "The Story of the Catholic Hospitals in Canada, CHAC Bulletin, 9:5 (May 1967), pp. 6-10.

2. Robert J. Shanahan, SJ, The History of the Catholic Hospital Association 1915 - 1965, Fifty Years of Progress (St. Louis, Missouri: Catholic Hospital Association of the United States and Canada) p. 1.

3. Ibid., p. 3.

4. Ibid., p. 4.

5. Ibid., p. 11.

6. Ibid., p. 13.

7. CHA of the United States and Canada,Constitution and By-Laws, Article 11, Sec.1. Transactions of the Catholic Hospital Association, First Annual Conference C.S.T. (St. Louis, Missouri: the Modern Hospital Publishing Co. 1915), p. 21.

8. Robert Shanahan, The History of the Catholic Hospital Association, p. 19.

9. CHA of the United States and Canada,Constitution and By-Laws, (1915), Article II Section II.

10. Presidents of the Protestant and Catholic Hospital Association, with the Board of Trustees of the American Hospital Association, Minutes, (April, 1930).

11. Alphonse Schwitalla, SJ. "Presidential Address, 1929". Hospital Progress, 10 (June 1929), p. 227.

12. CHA of the United States and Canada,Constitution and By-Laws, (1915), Article II, Sec. III.

13. Robert Shanahan, The History of the Catholic Hospital Association, p. 14.

14. CHA of the United States and Canada,Constitutions and By-Laws, (1915), Article II, Sec. IV.

15. Bernard McGrath, "The Catholic Hospital Association: A Brief Review of Its History", Hospital Progress, 3 (June, 1922), p. 213.

16. CHA of the United States and Canada, Constitution and By-Laws , (Milwaukee Wisconsin), 1935, p. 2. In

1935, a new Constitution was approved. The objectives (Article II) remain essentially the same as the founding Constitution; however, Sec. I has been modified to include the promotion of medical, social, economic and religious development of its members. As in the founding Constitution, the furthering of scientific efficiency and skill in hospital management remain as objectives.

17. Sister Janet Murray, "Some Facts about the History of the Catholic Health Conference of Ontario", (October 23, 1980), printed sheet.

18. Constitution and By-Laws, (April, 1966) Foreword. Article II of these special by-laws states: The function of this board is to act as an intermediary between the Executive Board of the Catholic hospitals in Canada. In pursuance of this purpose this Board will assemble data for, and suggest policies to, the parent organization regarding the interests of the Catholic hospitals of Canada, and will interpret to the latter the policies and procedures of the parent organization. Finally, the Board will deal in an advisory capacity with Ecclesiastical Authority as occasion may arise, and with the hospital members of the Association.

    The minutes of the Association meetings record the establishment of a number of committees on By-Laws and the approval by the Executive Committee of more than one draft Constitution. However, it was not until October, 1953 that the first by-laws were officially adopted by the voting members of the Association and approved by the Canadian Catholic Conference.

19. Canadian Advisory Board, Minutes, (Sept 10, 1941), Resolution 32.

20. Canadian Advisory Board, Minutes, (Sept 10, 1941), Resolution 33.

21. O.C. Trainor, "The Relationship of Voluntary Hospitals to Government". Paper read at The Special Meeting of the Canadian Catholic Hospitals, Montreal, Quebec, June 1942. Hospital Progress, (March, 1943), p. 83.

22. Ibid., p. 83.

23. Canadian Advisory Board and Committee of the CHA of the United States and Canada, Minutes, St. Michael's Hospital, Toronto, Ont. (Oct. 18, 1942). During this meeting the name "The Catholic Hospital Council of Canada" was recommended and unanimously accepted. It was agreed that this proposal be recommended to the Executive Board.

24. Committee on National Health Insurance of the Catholic Hospital Council of Canada, Minutes, Hotel Dieu, Montreal, P.Q. (Nov. 28, 1942).

25. Refer to footnote 23.

26. For example, Catholic Hospital Council of Canada and its Committee on National Health Insurance, Minutes, Ottawa General Hospital, (Sept. 8, 1943).

27. Catholic Hospital Council of Canada and its Committee on National Health Insurance, Minutes, (Sept. 8, 1943), section entitled, "Future relationships of the Catholic Hospital Council of Canada and the Canadian Hospital Council", Aug. 23, 1943.

28. CHAC, Brief to The Royal Commission on Health Services Montreal, Canada, (April 17, 1962), p. 14.

29. Alphonse Schwitalla, Hospital Progress , 29: 6 (June 1940), p. 203, quoted in CHAC, Brief Presented to The Royal Commission on Health Services, p. 14. Schwitalla's address discusses two other differences between Catholic and non-Catholic hospitals not mentioned in the Brief but of relevance to the study. He explains that those who serve the sick in the institution, do so under the sanction of an obligation in conscience. The text seems to refer especially to Sisters. The quality of their service is related to their salvation and not to the pain of loss of preferment or loss of professional standing. The other difference lies in the insistence upon hospital service and sickness care as vehicles for influencing souls. He states "The difference, therefore, between our institution and others does not lie in the purposes of The Catholic hospital as a hospital but it lies precisely in the fact that the Catholic hospital cannot be a hospital unless it emphasizes those viewpoints and carries them out for the motives which are implied in the Catholicity." p. 204.

30. CHAC, Brief to the Royal Commission, Recommendation 3, p. 4.

31. Ibid., Conclusion p. 7.

32. These draft Constitutions and By-Laws could not be located.

33. Canadian Catholic Health Care Leaders face the Issues, Government Relations, Sponsorship, Catholic Identify, Medical Moral Problems, Health Insurance Programs (Fr. MacNeil), Hospital Progress, (October, 1980), p. 35.

34. Brief, Review of CHAC Boards of Directors since Inception along with the Highlights of Previous Board of Directors Meetings (1967), printed sheet.

35. CHAC, Constitution and By-Laws, (September, 1971).

36. P.J. Rouleau, SJ, "Sociological Research on The Catholic Hospitals of Canada", Catholic Hospitals 1:1 (March-April, 1973), p. 17.

37. CHAC, Programming Document presented to the Board of Directors, (May, 1972), pp. 1-6.

38. CHAC - CCC - CRC Liaison Committee, Proposed New "Working Paper" Incorporating Recommendations from the CCC Representative, October 1, 1973.

39. "Canadian Catholic Health Care Leaders," (McNeil) Hospital Progress, (October, 1980) p. 35.

40. Board of the CHAC, Minutes, (February 25-26, 1974). This 'Working Paper' went through many drafts among the three parent bodies. At the Board Meeting of the CHAC in February 1974, a brief report on the Laison's Committee was to be included in the Executive Director's Annual Report to the General Assembly. The 'Working Paper' itself was to be made available to the Major Superiors attending the meeting with the CHAC.

41. CHAC, Programming Document, May 1972, p. 1.

42. Report of The Task Force Committee of the Catholic Hospital Association of Canada, "New Needs - Renewed Responses", Catholic Hospital, 5:2 (March-April, 1977), p. 4-10.

43. Fiorenza, Foundational Theology, p. 305.

44. See, this Chapter, Section 1.1.

45. Ibid., Section 1.1.

46. Ibid., Section 2.

47. Ibid., Section 2.

48. Canadian Advisory Board, Minutes, (September 10, 1941).

49. See this Chapter, Section 2.

50. Ibid., Section 3.

51. Ibid., Section 4.1.

52. Ibid., Section 4.1.

53. Ibid., Section 4.2.

54. Ibid., Section 4.3.

55. For the Laval Report, see this Chapter, Section 4.3; for the 1972 Programming Document, see this Chapter, Section 4.3; and for the Liaison Committee's "Working Document" 1974, this Chapter 4.4.

56. CHAC, Medico -Moral Guide,(Ottawa, 1971).

57. Fiorenza, Foundational Theology, pp. 202-04.

58. Ibid., pp. 204 - 05.

59. Ibid., pp. 205 - 07.

CHAPTER II

The Congregation of the Sisters of St. Joseph of Toronto: Early History and Mission

This chapter presents the early history of the Congregation of the Sisters of St. Joseph of Toronto and examines its primary sources from the point of view of how they have understood their mission. The conditions which prompted the Sisters to begin their association with hospitals are also described.

1. The Founding of the Congregation

The Congregation of the Sisters of St. Joseph was founded in France by Father Jean-Pierre Médaille, SJ. Monsignor de Maupas, Bishop of Le Pay-en-Valey, was responsible for giving this group of women ecclesiastical status for their religious life in 1650.[1]

1.1 The Founding Documents

In the course of his missionary travels in the Massif Central, Médaille met a number of women who wanted to devote themselves totally to God. Because they lacked the necessary financial assets, they were not permitted to enter a monastery. While at the College of St. Four in 1646, Médaille proposed an association entitled the "Little Design" in one of his early writings called the Eucharistic Letter.[2]

In this first association, the women were instructed to lead a consecrated life in the world without distinct dress and without cloister. Each community consisted of only three to six members. They were put under the protection and safe-keeping of St. Joseph and given his name. Médaille wrote the Règlements for those communities in the rural areas.

Bishop de Maupas was told about the plight of the women belonging to the association, the "Little Design", founded by Médaille. He realized that they desired religious life but were too poor so he encourged the creation of a new institute. He personally founded this new congregation and, on October 15, 1650, ecclesiastical status was given. This is sometimes referred to as the Second St. Joseph while Médaille's association, the "Little Design" is understood to be the First St. Joseph.

The founding Constitutions for the Little Congregation was written by Father Jean-Pierre Médaille. It is his vision of the appropriate spiritual life for religious women which is expressed in the early documents. His spirituality is informed largely by the founder of the Jesuits, Ignatius Loyola. Ignatian spirituality is "apostolic", or directed towards service.[3]

The Sisters of St. Joseph did not have a formal statement of charism. Rather, the spiritual vision expressed for them in their founding documents served as their original inspiration. The most significant aspects of

their spiritual life were expressed by Médaille in a model-style consecration formula addressed to the Blessed Trinity and to the Holy Family which he referred to as the "created and uncreated Trinities", or the Two Trinities. This model is found in "The Goal and Purpose of the Association" in the Règlements. In the primitive Constitutions for the Little Congregation, the model can be found in the "summary of objectives".

Bernice Anne Hennessey, CSJ, has done a comprehensive study of this Trinitarian Model and its significance to the Congregation's spirituality. She undertook a careful and chronological reading of the model as it appears in the early documents written by Médaille for the Congregation.[4]

She found that in the six statements of Consecration to the Two Trinities, there are the following virtues: God the Father as the model of perfection; the incarnate Son as the model of self-emptying humility; the Holy Spirit as the exemplar of love; Jesus as the model for the zeal of the glory of God; Mary as the model of fidelity and grace; and Joseph as the model of cordial charity. The Sisters were to emulate these six virtues in their spirituality which would orient them to a life of service.[5]

Of particular interest for this study are the implications for the mission of the Congregation found in Médaille's view of Joseph as the Model of cordial charity. Hennessey points out that the distinctive feature of Médaille's practical expression of charity is its

universality.[6] He writes:

> ... Whatever you do for the dear neighbour, do it with the same feeling of devotion and charity as if you were doing if for the very person of Jesus Christ.[7]

This refers to charity both within and beyond the Congregation. He intended that zeal for unity be a ministry of the Congregation. This theme is repeated in all four founding documents. Breadth of ministry is expressed in the description of perfect love of neighbour "which loves every kind of person, purely, constantly and equally in God and for God".[8] The Règlements speaks of the zeal for union with God among the Sisters and "with every kind of neighbour".[9] The Eucharistic Letter indicates that the Congregation is to offer "different services ... proportionate, proper and adopted to the differences of sex, social class and age".[10]

Médaille offered a spiritual vision which was social in character. The relational dimension flows from the models of the Trinity and the Holy Family. His goal for the Congregation was the advancement of unity among people from all social (including all economic, educational, religious and cultural) groups. The "total double union" of the Eucharistic Letter provides a clear statement of his vision:

> Here, is the purpose of our selfless congregation; it tends to achieve this total double union -- of ourselves and the dear neighbour with God, -- and of ourselves and all others, whoever they may be, -- of all others among themselves and with us, but totally in Jesus and in God his Father.[11]

Taken together, the primitive documents of the

Congregation of the Sisters of St. Joseph are: the Maxims of the Little Institute, the Règlements, the primitive Constitutions of the Little Congregation, and the Eucharistic Letter.

The charism of a congregation implies a mission. Pursuing a mission results in concrete practical responses to those people who are in need. This mission of the Congregation of the Sisters of St. Joseph, imparted by Jesuit Jean-Pierre Médaille is apostolic.

The early sources reveal that the Sisters were to bring souls to their perfection and sanctification, rather than simply their salvation. The Règlements state:

> In honour of the Saviour Jesus,
> zealous for souls,
> they with the help of God, will live and die
> in an insatiable and indefatigable zeal
> not so much for the salvation as for the
> sanctification of souls.[12]

In the Eucharistic Letter Médaille describes the purpose of this community of women :

> For it seems to me that 'our little nothing' has for its end to procure a great perfection of souls rather than simply their salvation.[13]

The primitive Constitutions explains that:

> ... the Sisters of St. Joseph will bring numerous souls to salvation and perfection, aiding them in the practice of virtue.[14]

Closely related to bringing souls to perfection is the apostolic work of the Congregation. The primitive Constitutions state:

> The Congregation ... will endeavour ... with a deeply hidden humility, to practise what it knows

> to be most pleasing to God, in every kind of interior and exterior perfection and in every kind of zealous endeavour for the good of souls and the relief of the needy.[15]

Employing moral language, it can be said that an "ethics of character" establishes the moral basis for the Congregation's activity.[16] Character in this context means the moral orientation of the self. Through each Sister's formation and spiritual life, certain virtues are impressed upon her, which then direct her to the apostolic mission of the Congregation. Mission becomes associated with specific ministries, called works of mercy. The primitive Constitutions states that:

> They will devote themselves, after providing for their own salvation and perfection, to pious works of mercy; namely hospital work and care of the sick; the visiting of prisoners; the care of orphan girls, and other similar works.[17]

First, the sisters are to do what is required for their own salvation and perfection, as well as to serve the sick and the poor.[18] In view of Médaille's understanding of the "total double union", it is appropriate to read this text as indicating a closely related, and perhaps, an inseparable relationship between the sisters' concern for their salvation and their pious works. They are to provide spiritual direction and educate women where established religious are not already doing so. Médaille explained that the end of the Congregation is "to practise all the spiritual and corporal works of mercy of which a woman is capable and which will most benefit the souls of our dear

neighbour."[19]

The works which express the Congregation's mission are works derived from the virtue of cordial charity extended towards all classes of neighbour[20] as if "for the very person of Jesus Christ".[21] The works are directed to the concrete needs of people such as the sick, poor, orphans and prisoners.

One reference in the primitive Constitutions instructs the Sisters to address the social causes of the prevailing disorders of their time. The primitive Constitutions states:

> Their zeal should, as far as possible, extend to the prevention of an offense against God. Therefore, they will divide the city into various sections and either by visiting the sick personally, or through the associates of the Congregation, they shall make every effort to learn what disorders prevail in each quarter, so that they may remedy them either by their own efforts if they can do so, or through the mediation of those who have some power over the person guilty of these disorders.[22]

This is the only reference to such a mission and, according to Marius Nepper, SJ, in certain manuscripts this passage was crossed out carefully, probably because this directive may have threatened some Superiors.[23]

It was not until 1674 that the approbation of King Louis XIV was obtained and the royal decree was registered in the Letters Patent by the Parliament of Toulouse. The Congregation during this time spread into other dioceses across France, and the Sisters continued to involve themselves in various types of charitable works ranging from care of the sick and poor to education. These new

communities of the Congregation were governed autonomously but maintained relations with Le Puy.

The French Revolution brought suppression for these congregations, as for most other religious houses. Many new autonomous communities arose after the end of the French Revolution. In 1807, at St. Etienne, a town on the upper Loire, the Congregation of St. Joseph underwent its reorganization. At this time, an effort was made to unite these new communities. The primitive Constitution was revised at this time.[24] The spirit of this founding Constitution was preserved.[25] In 1816, the Congregation moved to Lyon.

In 1836, at the request of Bishop Rosati of St. Louis, a group of the Sisters of St. Joseph came to North America and began their work in the St. Louis diocese. The first house was established at Carondelet, a small town near St. Louis. During the same year, another establishment was founded at Cahokia.[26] In 1847, the Congregation was asked by the Bishop of Philadelphia to take charge of an orphanage there.

2. The Invitation of the Congregation to Toronto, 1851

In Toronto, Bishop de Charbonnel introduced a number of religious congregations to serve the different religious, social and educational needs of the laity. The congregations which he invited to the city were selected specially because of particular expertise that would be helpful in meeting the needs within the Toronto diocese.[27]

Bishop de Charbonnel was looking for a congregation of Sisters to carry out a variety of charitable works among the poor of the city. He became aware of the works of the Sisters of St. Joseph when he was visiting Philadelphia and asked the Congregation if there were members who were willing to come to Toronto. Arrangements were made for Mother Delphine Fontbonne, a Sister who had been trained at Lyon, in the original spirit of the Congregation and was of a well-known French family, to come to Toronto along with three other sisters.

In 1851, the Sisters took over the administration of the Elmsley Orphanage and, in 1852, the responsibility for the parochial schools. By 1856, with the help of Bishop de Charbonnel and the St. Vincent de Paul Society, the Sisters established the House of Providence of St. Vincent de Paul which came to be a center of Catholic social action. It is from here that most of the Catholic social institutions in Toronto developed.[28]

The Sisters relied on their own efforts to support themselves and to obtain funds to continue their work. One means of obtaining money was by begging and the Sisters of St. Joseph began this practice in Toronto with the intention of procuring food for the orphans and medicines for the poor. Other sources of income were sought. These included: dowries brought to the Congregation by the Sisters, donations from the priests and other individuals, proceeds from the sale of books, money from authorized collections in

the churches and payment for the laundry, mending and sewing done by the Sisters. As time went on, the Sisters gained in financial experience and became quite good at administration. As they became more established, they were left bequests of money and land.[29]

The Sisters branched into a variety of social and educational work. Besides taking over the work of the orphanage, they taught children at parish schools, performed visitations and helped the city's poor, new immigrants, and those in prison.

The Sisters visited the homes of the sick and cared for them there. In Toronto, prior to 1850, chaplains were appointed to minister to Catholics in public and military hospitals.[30] The movement towards separate Catholic hospitals was gradual due to the lack of financial resources and trained personnel.

When the Toronto General Hospital was in financial trouble in 1865 and threatened with closure, Bishop Lynch twice suggested to municipal officials that the Sisters of St. Joseph take over its domestic managment. However, these proposals were rejected due to the strong anti-Catholic climate of the period. In 1867, the Toronto General Hospital was closed for one year, leaving the public with only the care provided at the House of Providence. In 1873, Bishop Lynch suggested setting up a supplementary hospital administered by the Sisters for the poor because he was concerned they did not have sufficient hospital care.[31] However, the Sisters did not begin their hospital ministry

until 1892.

2.1 The 1881 Constitution

After becoming established in Toronto, the Sisters revised their Constitution. These revisions were approved by Pius IX in 1877. The purpose of the revisions was to embody "additions, rules and ordinances of Superiors, regarding the particular offices and employments of Sisters, as are expected to increase the mutual support and dependence of the various houses."[32] In 1881, Archbishop Lynch of Toronto approved the 1877 edition of the Constitution for the Sisters of St. Joseph of Toronto with some modifications.[33]

Despite the revisions, the charism and mission remained essentially the same as expressed in the primitive Constitutions of Médaille. The Congregation was consecrated to "the Most Holy Trinity, and is placed under the protection of the Holy Family" and the Sisters, through imitation of their example, can promote the glory of God by the exercise of all virtues.[34]

As in the primitive Constitutions, after novitiate, the three simple vows of poverty, chastity and obedience were made along with the protestations of humility and charity.

The 1881 Constitution states that the Sisters are to "devote themselves to the attainment of Christian perfection and to the service of their neighbour".[35] The end for which the Congregation of St. Joseph had been established was the sanctification of its members "by the acquisition of

Christian and religious virtues and should at the same time assist their neighbour."[36]

The 1881 Constitution outlines the general means which the Sisters should adopt to acquire perfection. It states:

> In order to attain their own perfection, the Sisters must exactly observe their rules and Constitutions; as also their vows and the virtues in regard to which they make at their profession a special protestation or declaration.[37]

In their protestation, humility is the first and charity the second virtue which the Sisters promise to practise, both internally and externally. In the consecration in honour of Joseph who is not addressed by name but as "glorious Patiarch", the Sisters are to make a "profession of an entire union and of an unalterable charity among themselves. By supporting and assisting one another with sweetness and affection, they should undertake the works of charity on behalf of their neighbour".[38] In the section of the Constitution on 'Charity towards the Neighbour', Jesus Christ is the model presented for imitation.[39] Because Jesus Christ took the form of a servant and he served with such charity that he gave up his life in order to help deliver humankind from temporal and eternal evils, the Sisters must not be content with their own sanctification. They also have a duty to consecrate themselves to the service of their neighbour, which leads them to willingly undertake works of charity and mercy.

In the primitive documents which express the sixth

statement of the Consecration to the Two Trinities, Joseph is the model of cordial charity based on his love for Mary and Jesus and the Sisters are to serve as if they were doing it for the very person of Jesus Christ. In the 1881 Constitution, Jesus Christ is the model to be imitated. Because Jesus Christ took the form of a servant, it thus becomes the duty of the Sisters to consecrate themselves to the service. The moral tone of the primitive documents when referring to 'cordial charity' is that of a virtue to be fostered with the help of grace. The Sisters become 'informed' by the virtue so that the virtue becomes manifested in their concrete activities.

> In honour of their most glorious Patriarch Saint Joseph, who was all charity for Jesus and Mary, they shall profess the most perfect unity and charity possible among themselves as well as complete charity and mercy, according to God's will and the directives of their Little Institute, towards everyone. This, of course, will proceed from the sovereign help of grace without which we are nothing.[40]

With the introduction of 'duty' language in the 1881 Constitution, the moral tone changed from that of virtue to that of obligation:

> In imitation of this divine model, the Sisters must not content themselves with the care of their own sanctification, because it is also their duty to consecrate themselves to the service of their neighbour.[41]

In referring to the Sisters' work of education and instruction of young girls, the 'duty' language is used again:

> This duty requires peculiar qualifications of those who are employed therein.[42]

The theme of the primitive documents which equate service to neighbour as service to Jesus Christ is continued.[43] The neighbour is a member of Christ's mystical body.

> That the Sisters may persevere and increase in zeal which is necessary for doing fervently and suffering all that is difficult and revolting in the service of their neighbour, they should frequently reflect that it is Jesus Christ himself whom they serve, and that all those whom they assist[44] are the true members of his mystical body.

One of the most important works of charity was considered to be the education and instruction of young girls. This greater emphasis on the Sisters' role in education is markedly different from the primitive Constitutions where the Sisters were engaged in education only in those places where established religious are not doing so.[45]

> The Sisters are to take charge of orphan asylums and to direct houses of refuge. They were to watch over the conduct of those young women who are either unprotected and without support, or those who are exposed to lose their virtue.[46]

Other works of charity and mercy, which the Sisters were to undertake were described as "visiting the sick and the prisoners, exhort the sick to penance and resignation, pray and ask alms for them, prepare remedies prescribed by the physicians, keeping a supply of the usual remedies for the

poor".[47] The 1881 Constitution states that the Sisters were to serve the sick in hospitals, even though they did not then own or administer any. However, this was not the situation for long.

3. The Beginning of Hospital Ministry

In 1891, the people of Toronto suffered a high incidence of diptheria. The Toronto General Hospital was overcrowded so it was necessary to establish an Isolation Hospital on Broadview Avenue. However, this hospital was difficult to staff because many nurses dreaded caring for patients with diphtheria. City officials approached the Sisters of St. Joseph and asked them to organize a special unit to care for the afflicted within the Isolation Hospital.[48] The Sisters proved competent and efficient in caring for their patients. The Chief Medical Officer of Health, Dr. Norman Allen, was very appreciative. He and Archbishop Walsh proposed to the Sisters that they should open their own general hospital in Toronto. This hospital was named after St. Michael, the Patron of the Archdiocese of Toronto.[49] On July 2, 1892, the first patients were admitted and in September, the hospital was officially opened. At the suggestion of Dr. R. J. Dwyer, Medical Chief of the Hospital, the Sisters inaugurated a School for Nurses at this time, connected with the hospital.[50]

3.1 The Letter to the Mayor and Members of City Council, 1894

At this time, the City of Toronto praised and encouraged this new endeavour, granting the usual allowance made to City hospitals, which was 40 cents per patient per day. However, in late 1894, this grant was withdrawn because the Sisters were accused by some officials of not maintaining high standards of care within their hospital by some officials. In response, the Sisters wrote to the Mayor and members of City Council, presenting their case for the reinstatement of the grant.[51]

By not receiving the grant, Catholics, who were in a minority position in the city, were faced with a double burden. A portion of the taxes from Catholic rate payers went to support city charities, so if Catholics wanted to keep their hospital, they also had to contribute to its upkeep. Not only did Catholics want their hospital, they also wanted a "fit appropriation to be made to St. Michael's by the city". The Sisters' Letter indicates that those who were sick and poor, especially Catholics, preferred to be cared for at St. Michael's Hospital. They were able to "more readily receive in St. Michael's all the consolations that the Church gives to the sick and dying".

Protestants were received into the hospital, even after the grants were withdrawn. The Sisters stated that "charity demands that all seeking admission be received, irrespective of creed or country". What is more, the religious freedom of the Protestant patients was respected by "their clergymen regularly visiting the Hospital".

In this Letter, the Sisters demonstrated their commitment to carry out the mission to serve their neighbour which, according to the 1881 Constitution, was that "they shall serve the sick in hospitals".[52]

The respect shown for the religious practice of the Protestant in their hospital reflected in some degree the universality which was a distinctive feature of Médaille's practical expression of charity. This concept is expressed in the description of perfect love of neighbour "which loves every kind of person, purely, constantly and equally in God and for God".[53]

The concern expressed regarding the double burden which had to be carried by Catholic ratepayers was not urged on the basis of justice. The Sisters requested the reinstatement of the grant so that they could continue their service to the sick and poor "in the spirit of Christian charity".[54] The grant was reinstated.

After St. Michael's Hospital was opened, others followed, establishing the Sisters firmly in the hospital ministry involving ownership, administration, nursing and other health fields and teaching. In 1921, St. Joseph's Hospital was opened in the west end of the city. In 1913, the Sisters were asked to start a hospital in Comox, British Columbia. Our Lady of Mercy Hospital was opened in Toronto in 1925 by the Sisters to care for the 'incurable' patients from the House of Providence. Also, a hospital in Winnipeg, named St. Joseph's was opened in 1923 to meet the needs of the new immigrants settling in that city.

4. The Constitution, 1925

During the time the Sisters were establishing themselves in their hospital work, the Bishop urged them to begin revising their 1881 Constitution following the requirements of the Normae. In 1925, this new revised Constitution of the Sisters of St. Joseph of Toronto was approved. In this revision, there were significant changes from earlier constitutions. The revised Normae to the new Code of Canon Law had been promulgated in 1917, with the effect of changing the constitutions of all religious congregations due to the strong centralizing tendency in the Church. Milligan has claimed that as a result of revisions dictated by the Code of Canon Law, constitutions lost much of their unique character.[55] However, this writer has not been able to provide documented evidence of this claim. This may be the case because Milligan's claim may be invalid; this evidence has not been established and documented; or the writer simply has not been able to locate it.

With this Code of Canon Law, the 'primary aim' of all Congregations became uniformly crystallized as the "personal sanctification of its members". The 'secondary aim' of the individual congregation could be differentiated from other congregations by stating the existing works of the congregation. However, according to Milligan, this created the possibility of producing a misleading identification between the mission of a congregation and its works.[56]

In the 1925 Constitution, the general end of the Congregation of the Sisters of St. Joseph is presented as the "sanctification of its members by the observance of the simple vows of obedience, chastity and poverty and the present Constitution".[57] The special end of the Institute is described as "the instruction and Christian education of the young, and the direction of works of charity, such as orphanages, hospitals and homes for the poor and aged". The vows of obedience, chastity and poverty, characteristic of all religious congregations were retained, but the protestations found in the 1881 Constitution for the virtues of humility and charity were not included.

The 1925 Constitution remained unchanged until 1984. As a result of the Second Vatican Council, the Decree on the Appropriate Renewal of the Religious Life was issued urging religious congregations to return to the original inspiration behind their community and to adjust the community to the changed conditions of the times.[58] The 1984 Constitution of the Sisters of St. Joseph is examined in Chapter 5.

5. The Identity and Mission of the Sisters of St. Joseph of Toronto as Health Apostolate

In the previous section, the history of the Congregation of the Sisters of St. Joseph is described. A hermeneutical reconstruction is more than a description of events. It seeks to ascertain the meaning and identity of beliefs and practice as to what constitutes the Christian

vision, by examining the considered judgments of Christians, both present and past. The reconstruction involves a criss-crossing, from the considered judgments about identity to the reconstructed identity and then, in a reciprocal manner, from the reconstructed identity to the considered judgments.[59] This section offers a reconstruction of the religious identity of the Sisters of St. Joseph of Toronto in their health apostolate from their foundation to the early 1960's. The religious identity of the Congregation was found in the charism, the relationship between the sanctification and perfection of the Sisters and their works of charity, the mission of the Church and the context in which the Congregation was able to serve as health apostolate.

One of the most important elements of the identity of the Sisters of St. Joseph was provided by their founder, Jean Pierre Médaille, SJ, in his original inspiration, the charism of the Congregation. In the mid-seventeenth century, religious congregations were forced to choose between official acknowledgement and apostolic availability. Francis de Sales, the founder of the first Visitandines, in 1610, chose official recognition. The congregation, begun by Vincent de Paul, opted for apostolic openness[60]. Jean Pierre Médaille, SJ, initiated this apostolic congregation of women who made the simple profession of the evangelical counsels of chastity, poverty and obedience, but whose lives were not cloistered.[61] The primitive documents which express the charism of the Congregation reflect the vision

and ethos of this new style of religious life. The purpose of the Congregation was inseparable from apostolic service. As cited earlier, Médaille states:

> Here, is the purpose of our selfless congregation; it tends to achieve this total double union -- of ourselves and the dear neighbour with God -- and of ourselves and all others, whoever they may be, -- of all others among themselves and with us, but totally in Jesus and in God his Father.[62]

With this emphasis on the unity of the sister with her neighbour and with God, an identity was established for the Congregation, characterized by worldly involvement through service.

The emphasis on of the perfection and salvation of the Sisters reflects the position expressed in Fiorenza's interpretation of traditional fundamental theology regarding the mission of the Church.[63] In traditional fundamental theology, the starting point is the distinction between nature and supernature. The Church has its own supernatural goal of sanctification and salvation, human institutions have particular natural goals. The Church's mission was ordered directly and primarily to a supernatural goal, the beatific vision. Any religious congregation which received juridical recognition by the Church would also be directed towards this goal. Thus, the Sisters were attentive to their the supernatural goal, as well as works of charity. It appears that for this Congregation these two goals are related.

The apostolic service or the work of charity of the

congregation was not directed to one particular group but looked to all others, whoever they may be". Thus, Médaille's vision is not only social but universal. These works were directed to meet the needs of people such as the sick, the poor and orphans. This 'charity' approach neglected the systemic causes of these social problems, even though the primitive Constitutions refers to the need to address the social causes of the prevailing disorders of the time.[64] This was not a predominant emphasis.

The Sisters' works of charity were closely related to the purpose of the Congregation to bring souls to their perfection and sanctification rather than simply to their salvation.[65] This focus on the care of souls also stems from the relationship of the Congregation's mission to the traditional fundamental mission of the Church, with the primacy of its supernatural goal.

After its foundation, the Congregation increased in numbers and spread across France. Women were attracted to this form of religious life which offered them a path to their sanctification and salvation, and allowed them to serve many needy sectors of the population. After the French Revolution, the Congregation was able to reorganize itself, preserving the original spirit found in the primitive Constitutions. The Sisters of St. Joseph came to the United States in 1836 and to Canada in 1851.

The Congregation was invited to Toronto because Bishop de Charbonnel believed that those Sisters were able to serve

a variety of needs within the diocese. In fact, because of their versatility and adaptability, they were able to offer a wide variety of skills and talents to the people of Toronto after their arrival. Médaille's founding vision for the Congregation included flexibility in the types of works to which the Sisters devoted themselves. However, the Sisters did not immediately begin their involvement with hospitals upon arriving in the city but cared for the sick in their homes. When the Toronto General Hospital was in financial trouble in the early 1860's, Bishop Lynch tried to persuade the City and hospital officials to permit the Sisters of Toronto to take over the domestic management. The proposal was rejected.[66]

Even though the Congregation was not involved in hospital administration or ownership, the 1881 Constitution acknowledges that the Sisters were "to serve the sick in hospitals", clearly establishing such service as one of their many types of ministry.[67] The stage was set for the Congregation to become a full participant in the Catholic health apostolate.

In the 1881 Constitution the Sisters gain sanctification "by the acquisition of Christian and religious virtues and should, at the same time, assist their neighbour".[68] Following Jesus Christ as a model for imitation, as one who helped deliver humankind from temporal and eternal evils, the Sisters cannot be content with their own sanctification but are obliged to serve their neighbour. The language of duty appears in this Constitution.[69] Thus,

for the Sisters, there is an inseparable relationship between the supernatural goal, their perfection and salvation, and the natural goal, their form of ministry. This relationship which integrates the supernatural goal of the Congregation is similar to the integral model of the mission of the Church, as suggested by Fiorenza's contemporary interpretation of theology.[70]

The hospital ministry of the Sisters of St. Joseph began in 1891 in the midst of a diphtheria epidemic in Toronto. Their first hospital was opened in 1892. In 1894, funding for the hospital was withdrawn by the City Council because of alleged claims that the hospital was not meeting the required standards. However, these claims must be seen in the context of the time, when there were no uniform hospital standards and a strong anti-Catholic sentiment existed in the city.

The Sisters' Letter, written in response to the withdrawal of funding by the City defends their ministry and states their philosophy of care. This philosophy of care was characterized, due to Médaille's vision, by the Congregation's notion of universality in those who are served. Service was not dependent on creed or country. Religious freedom of Protestant patients was respected.[71]

During the early part of this century, the Sisters expanded their hospital ministry. Although the problem of procuring sufficient funds necessary to operate their hospitals persisted, the identity of the Sisters' hospitals

was not put into question in the early part of this century. The hospital's name, the crucifixes on the wall, special wards for the poor, lay nurses trained by the Sisters, and the Sisters themselves nursing at the bedside provided visible representation of the mission of the Sisters and their institutions.

When the Sisters began their hospital work, they were also largely autonomous from governments in the administration of their institutions and provision of care for the sick. The Sisters provided medical attention to those unable to pay for services. As the government-sponsored hospital and medical insurance plans were introduced, nearly all the Canadian population became insured, theoretically. Implementation of the insurance plan posed a significant threat to the Sisters' understanding of mission. Even though their hospitals remained under their ownership and administration, one of the traditional and most obvious reasons for their association with hospitals was removed by universal insurance. The works of charity which included the care of the sick poor in hospitals followed from the 'original inspiration' of their founder. When the government assumed this responsibility, the Sister's traditional works of charity were no longer necessary. This led the Sisters in the 1960's to question whether their mission remained in the ownership of Catholic health institutions or if they could better offer their services in living out their charism in another way.

The social changes taking place in North America as a whole affected health care. Every aspect of health care underwent change in the late 19th century and throughout the 20th century. There was increased medical knowledge, more technology, developments in health professions, specialization and increased bureaucracy. All these changes affected the hospitals in which the Sisters served. These changes also posed a threat to the identity of the Catholic hospital and challenged the Sisters to rethink their identity as a Congregation which, as one aspect of its mission, cared for the sick and especially the sick poor.

In conclusion, the religious identity of the Congregation of the Sisters of St. Joseph in this period has been determined through their attempts to understand the charism of the founder, described in terms of the total double union. An essential aspect of their identity is their apostolic orientation to service.

The period which this chapter covers spans a time when there were many changes, not only within the Church but within European and North American society and within health care systems. The Sisters of St. Joseph began their involvement in hospitals, convinced that they were serving the needs of the people of Toronto, especially the sick poor who could not pay for service. Their health apostolate was grounded in and followed from their interpretation of their charism, characterized by the 'total double union' and the 'Consecration to the Two Trinities'.

ENDNOTES

1. Manuscript Committee, Soeurs de Saint Joseph, Textes Primitifs, Introduction (Clermont-Ferrand, France: Siman, 1981), trans. Anne Bernice Hennessey CSJ, in Anne Bernice Hennessey, CSJ, "The Influence of Ignation Spirituality" (Ph.D dissertation, Graduate Theological Union, Berkeley California, 1983), Appendix p. 187.

2. The founding documents written by Jean Pierre Médaille, SJ, are: Constitutions for the Little Congregation of the Sisters of St. Joseph, translation commissioned by the Federation of Sisters of Saint Joseph, and made by the Intercongregational Research Team under the direction of Marius Nepper,SJ, Le Bouchet par Villers-Collerets, France, July 31, 1969; The Maxims of the Little Institute, translation and commentary by the Intercongregational Research Team, commissioned by the Federation of Sisters of Saint Joseph, USA, under the direction of Marius Nepper, SJ, (Erie, Pennsylvania: Villa Maria College, Summer, 1975); Règlements and Eucharist Letter, translation commissioned by the Federation of Sisters of Saint Joseph, USA, and made by the Intercongregational Research Team under the direction of Marius Nepper, SJ, Le Puy, Summer 1973, (Erie, Pennsylvania: Villa Maria College, 1975).

3. Hennessey, "The Influence of Ignatian Spirituality," Chapter 2.

4. Ibid., pp. 98 -101. Hennessey explains the reasons for choosing the Consecration as the basis for study of the founder's spirituality. The model appears four times in Médaille's writings for the congregation. It is found in the Maxims of the Little Institute (#2, #3, #4, #7, #15, #55), in key statements elaborated upon throughout the one hundred maxims. In the Reglements, the model appears as a formula and is presented as an indication of the aim of the Institute. In the Constitutions, the formula motif is preserved (and appears twice there). Here, the model of the Two Trinities serves as a summary of the objectives at the end of the Second Part of the Constitutions, and is listed under "Practices of the Year" at the end of the Directory. Another reason besides frequency of repetition is the recurrence of the virutes proposed in the model throughout Médaille's writings. Hennessey states that the model becomes a synthesis of Médaille's spirituality when one examines the total body of his exhortations to the

congregation. The final reason for choosing the consecration is the content of the model, which are the virtues recommended. Hennessey points out that the six qualities are at the heart of apostolic spirituality in their concept of God and the response of individuals elicited by that conception.
The problems in using the Consecration are outlined as: The problem of source and its relation to the Eucharist in Médaille's spirituality and the problem of terminology for the twentieth-century reader.

5. Ibid., pp. 106 - 148. Hennessey employs the following method of analysis for each of the six statements in the model: she looks at the basic statement of the model, noting significant differences between versions, and at corroborating statements throughout the four documents. Implications inherent in each are considered in two directions: "inwards" to Médaille's concept of the person who is the model/ideal, and "outward" to the life of the individual sister of the Congregation. In the instances of the Father, Incarnate Son and Jesus, the titles which Médaille uses for them are examined as indicative of his theology and christology; similarly, his reference to Mary is studied as pointing to his Mariology and titles given to Joseph are noted as indications of his attitude toward the Patron. She also mentions Médaille's congruence with or divergence from Ignatian spirituality. Finally, those qualities which modify each element and the totality of the model are discussed.

   Collaborating references are made to the Eucharistic Letter when applicable.

6. Hennessey, "The Influence of Ignatian Spirituality", p. 149.

7. Médaille, Maxims of the Little Institute, p. 49.

8. Ibid., p. 100.

9. Médaille, Règlements, p. 6.

10. Médaille, Eucharistic Letter, p. 40.

11. Ibid., p. 22.

12. Médaille, Règlements, p. 5.

13. Médaille, Eucharistic Letter, p. 32; see also pp. 34, 39, 40.

14. Médaille, Constitutions for the Little Congregation, p. 10.

15. Ibid., p. 2.

16. Stanley Hauerwas, "Towards an Ethics of Character," Vision and Virtue, Essays in Christian Ethical Reflection (Notre Dame, Indiana, Fides Publisher's Inc., 1974) p. 62.

17. Médaille, Constitutions for the Little Congregation, p. 7.

18. Ibid., p. 41.

19. Médaille, Constitutions for the Little Congregation, p. 5.

20. Ibid., (2) p. 57.

21. Médaille, Maxims of the Little Institute, p. 49.

22. Médaille, Constitutions for the Little Congregation, p. 17.

23. Marius Nepper, SJ, "Aux Origins", Closely trans. by the Canadian Médaille Team, The Heritage of the Sisters of Saint Joseph (Toronto: Sisters of Saint Joseph, 1973), p. 84.

24. This revised Constitution of 1807 was not examined for this study.

25. Sister Mary Agnes, CSJ, The Congregation of the Sisters of St. Joseph (Toronto: Saint Joseph Convent, 1951) p. 34.

26. Ibid., p. 51.

27. Murray Nicholson, "The Catholic Church and the Irish in Victorian Toronto" (Ph.D dissertation, University of Guelph, 1980), p. 251.

28. Community Annals of the Sisters of St. Joseph, Vol. I (1851-1914) pp. 6 - 7; M.W. Cullinan, "Centenary of the Foundation of the Congregation of the Sisters of St. Joseph of Toronto", Saint Joseph Lilies, Vol. XL, (1951), pp. 107 - 117.

29. Nicholson, "The Catholic Church and the Irish," pp. 258-258.

30. Toronto General Hospital Petition, March 21, 1846; Appeal, Oct. 26, 1865, Lynch Papers, Archives of Archdiocese of Toronto; The Canadian Freeman, Nov. 9, 1965; The Globe, Dec. 6, 1865; Nov. 8, 1864.

31. Nicholson, "The Catholic Church and the Irish", p. 178.

32. Sisters of St. Joseph, Constitution and Rules, Introduction, 1881, pp. 9-10.

33. Sisters of St. Joseph, Constitution and Rules, Approbation, 1881. Some corrections in the style, and a few additions called for by the pecular circumstances of the Congregation in the Archdiocese, namely, that all the Houses are under one Mother Superior are alluded to in this edition.

34. Sisters of St. Joseph, Constitution and Rules, 1881, pp. 12 - 20.

35. Ibid., p. 11.

36. Ibid., p. 19.

37. Ibid., Chapter Two, Section 1:3.

38. Ibid., p. 21.

39. Ibid., Chapter Two, Section 6:2.

40. Médaille, Constitutions for the Little Congregations (1) p. 12.

41. Sisters of St. Joseph, Constitution and Rules, 1881, Chapter Two, Section 6:2.

42. Ibid., Chapter Two, Section 6:3.

43. For example, Médaille's, Maxims of the Little Institute, p. 49.

44. Sisters of St. Joseph, Constitution and Rules, 1881, Chapter Two, Section 6:7.

45. Médaille, Constitutions for the Little Congregation, pp. 16 - 17.

46. Sisters of St. Joseph, Constitution and Rules, 1881, Chapter Two, Section 6:6.

47. Ibid., Chapter Two, Section 6:5.

48. Sacred Heart Orphanage, Record of Events, Nov. 27, 1891, Sister of St. Joseph Archives.

49. Sr. Mary Agnes, CSJ, The Congregation of the Sisters of St. Joseph, pp. 169 - 170.

50. A description of life in the nursing school is provided by John Murray Gibbon, Three Centuries of

Canadian Nursing(Toronto, The Macmillan Company, 1947), pp.158-59. The quote is from The News of St. Michael's Hospital, August, 1942.
Miss Harrison, a graduate of Bellevue Hospital, New York, was appointed Directress of Nurses, and the first two-year course resulted in five graduates. One of these, Miss Elizabeth O'Leary, has given an account of her experiences:

> "I started my training as a nurse at St. Michael's Hospital in the autumn of 1892, about four months after the hospital opened its doors. The course was then two years, and as a rule, we were on duty twelve hours a day. However, you must remember that there were not many trained nurses available anywhere in those days and we thought nothing of staying on duty till ten or eleven o'clock at night, or getting up in the middle of the night to watch sick patients or relieve a nurse who had taken ill.
> "Reverend Mother M. de Chantal was the Superior of the Hospital, and Miss Harrison, a graduate of Bellevue Hospital, was the first Directress of Nurses, followed later by Miss Margaret Kelman. The Sisters in charge of the wards and floors were Sister M. Francis de Sales (Surgical Ward), Sister M. Anne, Sister M. Rosalie, Sister M. St. Felix (Medical Ward), and Sister M. Columba, in the Pharmacy. Lessons were given in anatomy and Medicine by our beloved Chief Physician, Dr. John Roach, and others. Practical work was taught by Miss Harrison and the Sisters. Our Residence consisted of two large rooms on the main floor of the hospital, one used as a sitting-room and the other as a dormitory. There were no ward maids or dietitians, but I remember the delicious food, prepared by the Sister in charge of the kitchen. It tempted many a sick patient's appetite. We made our own dressings and bandages, and sterilizing was at first done on a stove, but later we had what was then a very modern sterilizer. Aseptic technique was as important then as it is now. We had not heard of oxygen tents or intravenous infusions, but we were taught how to make a sick person comfortable and to treat him with kindness."

51. Sisters of St. Joseph in charge of St. Michael's Hospital, Letter to His Worship the Mayor and the Members of City Council Toronto, Feb. 25, 1895. St. Michael's Hospital, Toronto.

52. Sisters of St. Joseph, Constitution and Rules, 1881, Chapter 1, Section 6:3.

53. Médaille, Maxims of the Little Institute, p. 100.

54. There is one other submission which could be located for this study. However, it deals with the practical aspects of hospital operations. St. Michael's Hospital, Submission to the Royal Commission on Health Services, Hearings, Vol. 65, No. 372, (1964).

55. Milligan, "Charism and Constitutions", p. 52.

56. Ibid., p. 52.

57. Sisters of St. Joseph, Constitution and By-Laws, 1925.

58. Perfectae Caritatis, n.2; E.T. in Abbott, The Documents, p. 468.

59. Fiorenza, Foundational Theology, pp. 304 - 5.

60. Hennessey, "Influence of Ignatian Spirituality," p.187.

61. Ibid., p. 26.

62. Médaille, Eucharistic Letter, p. 22.

63. Fiorenza, Foundational Theology, pp. 198 - 202.

64. Nepper, The Heritage of the Sisters of St. Joseph, p. 84.

65. Médaille, Eucharistic Letter, p. 32.

66. See, this Chapter, Section 2.

67. Médaille, Constitution and Rules, 1881, Chapter Two, Section 6:6.

68. Ibid., p. 11.

69. Ibid., Chapter Two, Section 6:2.

70. Fiorenza, Foundational Theology, pp. 214 - 238.

71. See this Chapter, Section 3.1.

CHAPTER III

The Context for the Reconstruction of Identity and Mission: Social Change and the Canadian Health Care System

The mission and identity of the Canadian Catholic health apostolate were challenged by changes taking place in society in general and the development of the Canadian health care system. In order to provide the context in which the two representative groups were forced to reconstruct their mission, these changes are described in this Chapter.

1. Societal Change

Sociologist Roland Warren provides a framework through which the changing nature of today's society can be examined.[1] It is his thesis that the 'great change' in community living "includes the increasing orientation of local community units towards extracommunity systems of which they are a part, with a corresponding decline in community cohesion and autonomy."[2] The 'great change' includes seven major types of change described as: 1) division of labour; 2) differentiation of interests and association; 3) increasing systemic relationships to the larger society; 4) bureaucratization and impersonalization; 5) transfers of function to profit enterprise and government; 6) urbanization and suburbanization; and 7)

changing values.[3]

Warren does not view these seven changes as exclusive. However, he considers them to be the most significant changes taking place today in the Western world. Even though they overlap in their effects, the changes are each reviewed separately along with significant implications for health care.

1.1 Division of Labour

Division of labour takes place when functions become more narrowly defined and, as a result, work becomes more specialized. The individual develops one specific and narrow task in which he or she becomes the specialist. What results is a complex system of highly specialized individuals who are units of a system. People become functionally interrelated as parts through a complex inter-dependent network of specialized effort, rather than by sharing the same occupational skills and points of view. There are many implications from this division of labor. For instance, individuals may fail to understand or appreciate the whole society of which they are a part. The result may be a fragmentation in delivery of goods and services.[3]

In health care, scientific advances have created an increasingly complex technology, resulting in a high degree of specialization and subspecialization of the labor force. Many health care occupations have become professionalized.

Dr. John Romano has emphasized the growing complexity

of hospital medical practice by contrasting the hospital records of two patients with similar diseases, one admitted in 1908, the other to the same hospital in 1938. He states:

> The record of the first patient occupied two and one-half pages and comprised observations made by two clinicians (the attending and the house officer) and a pathologist - bacteriologist. The record of the second patient consisted of 29 pages: the observations of the visiting physicians, 5 house officers, 10 specialists, and 14 technicians, a total of 32 individuals.[5]

The situation has only increased in subsequent decades. This specialization contributes to a functional view of the person, where the sickness is treated in isolation from the totality of the person.

1.2 Differentiation of Interests and Association

In the process of differentiation of interests and association, the principal basis for social participation shifted from locality to interest. In the past, many of an individual's interests and associations centered on the immediate locale. As society changed, interests and associations unrelated to locale increasingly tend to dictate the basis of an individual's loyalty and participation. Place of employment, union, church or club are examples of associations which people may have outside their neighbourhood. Individuals spend time with people whom they do not necessarily know well but with whom they share an interest in a particular segment of the larger culture. The result is that association with neighbours declines and individuals find themselves strangers in their own localities. Their relationships become categorical (nurse-

patient, lawyer-client, salesperson-customer) rather than personal. Individual lives can become segmented, and because the total person is not known, lack of care and concern for all the needs of the person may occur.[6]

In the health care sector, there are two types of non-localized associations which influence health care organizations. These are the professional and occupational associations and the blue- and white- collar trade unions. The medical profession acts in many ways as a pressure group to control the health care industry.[7] The doctors' strike in Saskatchewan is an example of the effect that a professional association may exert on the production-distribution of a particular service.[8] A non-localized influence has been made by the unionization of blue collar and white collar workers.

> The union movement in the hospital sector has been increasingly vigorous whereby presently virtually all hospital employees in Canada (with limited exceptions) are represented for collective bargaining purposes by a union or association.[9]

Unions have the power to resist changes which could benefit patient care, or to lock employees into certain job functions rather than allowing for allocation on the basis of current need.

Janet Storch raised another problem which arose from the differentiation of interests and association.[10] This is the problem of various groups representing their own interests in the rationalization of health services. Professional associations and unions were included but the problem is broader than both. R.M. Battisella explained,

> Whether consciously or unconsciously, professionals structure programs to suit their own need and convenience, and select problems which appear most exciting from the standpoint of expertise.[11]

A need is created to have all participants in the health care sector represented, including patients, housekeeping staff, technicians and professionals alike. Otherwise in the absence of some sort of representation, it is likely that an individual's interests will be overlooked.

1.3 Increasing Systemic Relationships to the Larger Society

As communities have become more internally differentiated, their parts have become linked with provincial and national systems. Whereas the local community at one time sustained a high degree of independence from outside influence and domination, communities today are often subject to decisions concerning them made from outside. Community-based units such as the local bank, local Church, local supermarket or local school system now belong to two worlds: the world of the local community and the world of their respective national or international extracommunity systems. The seat of decision-making may be at a district or national level and centralized to promote co-ordination of various parts of the system, not within the local community.

This centralization affects the individual in a number of ways. For example, the individual's relationship to the organization may be more permanent than his or her relationship to the community. Community autonomy is also

impaired when decision-making is conducted elsewhere. Goals valued at the extracommunity level are not likely to be valued equally or similarly and pursued at the local community level.[12]

One result of these systemic linkages of local professional associations to provincial, national and perhaps international health professional associations is the rapid communication of changing patterns of care. This also happens in a similar fashion for unions. Such communication, however, is not necessarily beneficial to the level of care provided within the health care system.

The Sisters of St. Joseph in health care apostolates, even though related to the larger Congregation of the Sisters of St. Joseph, lived within the local community in which they began hospital work. Their hospitals became increasingly subject to government intervention which came hand in hand with the present health care system. The 1976 CHAC Task Force Report, in its sketch of the health care situation, states that "health care facilities offer a potpourri of ownership styles, but for the most part are public institutions subject to a diversity of provincial health plans and statutes." It also makes the point that these "facilities across the nation are involved in some type of regionalization, consolidation, consortium or collaboration, using a programmatic base rather than an ownership base."[13] Because of these increasing systemic relationships to government, a real threat exists to the

capability of the individual Catholic health care facility to maintain a distinctive identity.

The CHAC, on the other hand, began and remains as an extracommunity system with one of its main purposes as facilitating communication among various regional and local association and members. The CHAC does serve as a means of helping these individual health care facilities develop their identity in view of their mission precisely because it is an extracommunity system for its members.

1.4 Bureaucratization and Impersonalization

In sociology, the term 'bureaucracy' is employed to describe a particular type of social organization which is characteristic of the complex extracommunity systems that penetrate the local community.[14] Max Weber characterized bureaucracies by a hierarchy of authority, specialization of functions, a system of rules and impersonality.[15] They have become widespread in the Western World because they are the most efficient means for organizing the complex institutional systems of contemporary society.[16] The CHAC describes the health care system as "highly bureaucratized and organized and is controlled by government and political strategies."[17]

The hierarchy of authority exists to provide a procedural and structural vehicle of communication to gain and transmit information. Decisions made at the higher levels of authority can be handed down through the appropriate channels with some degree of speed and

precision. However, from the point of view of the health care consumer or patient the lines of authority to the top are not always clear, sometimes necessitating considerable red tape. Specialization of function demands that there be effective co-ordination among the various participants. A system of rules ensures that the workers in the lower echelons conform to prescribed standards, which may have the effect of fostering inflexibility.

Impersonality which is engendered within a bureaucracy is intended to ensure the detachment necessary to carry out administrative decisions, but can be criticized on a number of accounts leaving it with an overall derogatory hue. Failure to respond to the needs of the population it claims to serve, poorly organized service techniques, dehumanization, wasteful use of public and private resources are common accusations directed toward a bureaucracy.

Because impersonalization is meant to lessen favoritism, personal whim and the misuse of power, the need for justice is crucial in a bureaucracy. Warren explains that for the individual, just treatment is the price of impersonality. For example,

> If the parent does not know the school teacher personally as a neighbor, it is important to gain the assurance that his or her child will be treated on an equal plane with any child the school teacher may happen to know personally.[18]

When an individual in the bureaucracy must 'follow the rules' there may be situations when doing so forces that individual to act towards another person in a different way than if he or she were a friend or a neighbour. The ability

to meet 'human needs' may have to be made at the risk of going against the rules.

In contemporary society where so many aspects of human life are performed by impersonal bureaucracies, the conflict between the just exercise of official duty and the obligation which a person owes a friend or neighbor is also one of the crucial dilemmas facing the Catholic health apostolate. Works of charity were carried out by congregations as service to their neighbour. Even though neighbour meant 'each person', the word 'neighbour' implies a personal relationship between those serving and those served. The apostolate often describes their task as humanizing the system so that the individual still counts.

The theological debate concerning the relationship of love to justice can be raised in the context of bureaucratic functioning. Theologian Emil Brunner maintained that love must transcend justice.[19] In other words, it is necessary for love to meet the requirements of justice and then go beyond. Lorne Rozovsky, a Canadian lawyer commenting on patients' rights, points out that the law "cannot enforce morality, kindness, charity, tenderness or human responsiveness."[20] The most that the law can do is to set the terms for justice.

In dealing with a complex bureaucratic structure, justice as fairness is important. The cost, though, is impersonalization and possibly dehumanization. The goals of bureaucracy take on a dynamic of their own, not

necessarily serving those who first put them into motion.

These factors pose a challenge for those who speak for the Catholic health apostolate. In view of the bureaucratic nature of health care, the conflicts arising from the competing demands of justice and the necessity of some degree of impersonalization, and from the need to respond to the many dimensions of the person as "embodied spirit" must be resolved.

The hospital is one of the major bureaucracies in health care. Technology within the hospital increases the threat imposed by impersonalization. Compared to other service organizations, the hospital operates with a highly developed technology[21]. The dilemma of technological efficiency versus human service presents a continuing challenge to the delivery of high quality health care. Health professionals may experience a conflict between their commitment to the goals of the bureaucracy and to their own professions.[22] The problems faced by the professional in bureaucracies originate from two sources, according to W. Richard Scott:

> First, professionals participate in two systems -- the profession and the organization -- and their dual membership places them in a rational manner with respect to its own goals. Second, the profession and the bureaucracy rest on fundamentally different principles of organization, and these divergent principles generate conflicts between professionals and their employers in certain specific areas.[23]

Moreover, Hepner and Hepner point out that professional workers tend to identify more strongly with their profession

than with the institution, even though the institution is dependent upon their service.[24] E. Freedson places the responsibility for depersonalization and loss of dignity on the individual working in the system; not on the bureaucracy but on the professional organization.[25] Leaving the reason for it aside, it is most important that the interdependent relationships and patterns of work are well coordinated. Hepner and Hepner stress that "interaction and role performance are extremely important, for individual and group relationships as they exist within the hospital are among the most powerful factors in determining the level of patient care."[26]

1.5 Transfer of Functions to Profit Enterprise and Government

There are five possible groups within a society which can assume responsibilities to accomplish certain tasks, according to Warren. These are: individuals and families, special ad hoc groupings larger than the family, voluntary associations, business enterprises and governments.[27]

Another aspect of the 'great change' intimately related to the division of labour is the transfer of responsibility for many tasks to profit enterprise from the family and other groupings. The voluntary sector often serves as an intermediate stage in the process.[28]

Education of children, care of the sick and the elderly, recreational activities, food preparation and the making of clothes are examples of activities for which the

family at one time had primary responsibility and control. Gradually, schools, hospitals, homes for the elderly, recreation centres, restaurants and merchants have largely brought these services out of the family and placed them in the control of other groups such as voluntary associations, business and government. The division of labour goes hand in hand with this transfer. As individuals specialize in their function or activity, they depend on others to accomplish those functions they are no longer able to carry out, often at a financial cost.

Closely related to the institutionalization of health care has been the shift of responsibility in health care from the individual and family to the voluntary association and to the government. This has been the case in Canada. Voluntary associations do offer some opportunity for local involvement, allowing for a certain degree of local autonomy and citizen input. In addition, they can serve as mediating structures. P. Berger and R. Neuhaus define mediating structures as those institutions which stand between the individual in his or her private life and the large institutions of public life. Mediating structures are grounded in and reflect the communities from which they come.[29] They can provide meaning and identity for an individual vis-á-vis the larger institutions and bureaucracies of society.

Voluntary associations and agencies carry out tasks and services which the government or business enterprise can not, either because they are not considered as their proper

role or the mechanisms for action are not in place. Private charities were heavily relied on in the last half of the nineteenth century and early part of the twentieth century.[30] Catholic hospitals and other charitable organizations of various religious denominations acted as mediating structures. Today, the extent to which a large hospital, owned and administered by a religious congregation but financed through government arrangements, serves as a mediating structure remains unclear. The community health care center may more adequately fill this need.

L. Levin and E. Idler elucidate the importance of mediating structures which are constituted by non-professional lay people as health care providers.[31] Family, neighborhoods, voluntary associations such as self-help groups, ethnic subcultures and church groups perform a wide range of health care functions for themselves, but these are often overlooked or taken for granted. Levin and Idler argue that this hidden health care system is too essential not to be protected.[32] However, not to underestimate the relevance of this hidden health care system, the delivery of health services has been institutionalized in this century and transferred largely to government. Because of the influence that this transfer has had on the Canadian Catholic health apostolate, it is considered in more detail in Part 2 of this Chapter.

1.6 Urbanization and Suburbanization

One of the most striking aspects of recent history has

been the growth of cities. Warren stresses the significance of this change by making the assertion that urbanization is so intimately intertwined with the other aspects of the great change that it is, in fact, inseparable from them.[33] Urbanization and suburbanization are part of the same process of spatial distribution of a population within metropolitan areas.

Louis Wirth described three salient aspects of urbanism: large numbers of people, a density of population and a heterogeneity of people.[34] Richard Dewey has concluded that the product of Wirth's three aspects of urbanism on personality and social organization are 1)anonymity, 2) division of labours, 3) heterogeneity induced and maintained by points 1 and 2; 4) Impersonal and formally prescribed relationships and, 5) symbols of status that are independent of personal acquaintance.[35] Warren notes the close relationship between Dewey's list of the characteristics of urbanism and the five trends so far discussed as responsible for the great change. He explains that the characteristics brought on by the five trends are embodied ideally in the social organization of the city.[36] Suburbanization, even though it is part of the same process as urbanization, is a reaction to some of the effects of urbanization. The suburbs provide an alternative to city living with its attendant problems of anonymity, high land costs, loneliness and formalized status.[38]

The decades following Confederation in Canada witnessed

growing urbanization and industrialization. The need for health care and welfare became acute during this period, with the arrival of migrants from other countries and from Canada's rural areas. Family support diminished and people became dependent on factories for employment.[38] Rural Canada also experienced the need for adequate medical care, because the population was sparse and medical personnel largely unavailable. The clustering of population in a city allowed for a wide range of services and resources which were not usually available in isolated areas. Hospitals were dependent on a large population base for support services such as medical laboratories, radiological clinics, rehabilitation centers and psychiatric clinics.[39]

1.7 Changing Values

The term 'value' as employed by social scientists, denotes "the capacity to satisfy a human desire that is attributed to any object, idea or content of experience."[40] Such values are the underlying principles by which choices are made. They are a product of culture. Warren reviews some basic American values, which to a certain degree are shared by Canadians. He lists: freedom, individualism, practicality, science, education, progress, happiness and humanitarianism.[41] The history of Canada bears witness to these various values with the relative importance assigned to them determined by Canada's own social cultural and political development. Canadian identity is commonly associated with "peace, order and good government", the

well-known summary stated in the Preamble to the British North America Act of 1867.

Warren perceives four major value changes in society. Even though he is referring to American society, they can be identified with certain trends in Canada as well. He outlines his perceived changes to be: 1) gradual acceptance of governmental activity as a positive value in an increasing number of fields; 2) gradual change from a moral to a causal interpretation of human behaviour; 3) change in community approach to solving social problems from that of moral reform to that of planning; and 4) a change of emphasis from work and production to enjoyment and consumption.[42]

The first value change mentioned by Warren is of major relevance to this study. In Canada, the health insurance plans which are administered by the provincial governments enjoy wide popular support in spite of the many constraints and problems.[43] The changed orientation from a 'theological - moral' explanation of life to a 'rational - causal' explanation of life is closely related to the growth of bureaucracy and impersonalization. Warren asserts that it is "part of the larger development from 'sacred' society to 'secular' society."[44] Canadian society is officially multi-cultural in nature, characterized by a pluralism of beliefs. This raises difficulties for Catholic health care facilities which are publicly funded and adhere to a moral code which is not shared by everyone. This is the context in which the Canadian Catholic health apostolate finds itself today.

1.8 Implication of Changes for the Health Care System

Warren contends that the overall result of the 'great change' is that local communities are now oriented to the extra-community system and the local activities are controlled by outside interests. The individual and the local group experience a serious degree of loss of control of their lives. This loss of control has been central to the interest in human rights concerns.

M. Montgomery comments on certain concepts which are being incorporated in the changing health care system to minimize or counteract this loss of control. The four concepts are: regionalization, consumer involvement, regulation of the professions and the community health center. Because of the nature of the health insurance plans in Canada the changes affect the health care system at the provincial level.[45]

Regionalization of health services requires each province to develop and equitably distribute a network of facilities and services. Numerous reports published throughout the country since 1948, including the Hall Commission, the Federal Report of the Task Force on Health Costs and the Ontario Council of Health Report, have recommended the establishment of health regions. Health planning based on regionalization was favored by its proponents because they saw it as an approach which was able to identify health needs within a region and to respond to those needs with a balanced and integrated system of health

care facilities. Local people are best able to determine the needs at the grassroot level and proceed with health planning within the provincial system.

Critics of regionalization have pointed out that the creation of another level of government results in a lack of efficiency, increased economic costs and public confusion. Regionalization appears to be an attempt to remedy some of the outcomes of the great change whereby local communities are oriented to extra-community systems, and control is from the outside, even though this may not in fact be the case.[46]

Consumer Involvement is a response to the loss of control experienced by the individual or local community regarding medical care and planning of health services. The consumer-rights and patient-rights movements are an attempt to regain a voice and a degree of control over the type and quality of health care available.[47]

There has been a growing devaluation of professional and institutional authority in society which has been felt in the health care field. This authority has come into question in individuals' relationships with their physicians and in the government's relationship to the professions. Physicians have been accused of paternalism in their treatment of patients. Government has grown concerned about the regulation of professions.

The regulation of professions is a sensitive area in the health care field. Traditionally, regulation has been carried on internally as a matter of professional right.

However, for government, the pivotal issue about regulation concerns whether self-government can work to the benefit of the public interest. The Royal Commission Inquiry into Civil Rights in Ontario explains, "The relevant question is not, 'do the practitioners of the occupation desire the power for self-government' but 'is self-government necessary for the protection of the public?'"[48]

The Community Health Center is another change in the approach to health care in Canada. Hastings and his colleagues perceived the community health center as a subsystem of the larger social services system. The center takes the form of an independent facility or interdependent group of facilities which are able to provide high quality, accessible health services to individuals, families and communities, by a team of health professionals.[49] As pointed out by Warren, the community health center is an example of a community-based unit which as a part of the provincial health care system, demonstrates the systemic relationship between the community and the larger society.[50]

2. Development of the Canadian Health Care System

This part of the chapter briefly reviews the history of Canadian health policy and the emerging health care roles assumed by government. The principles on which the system is based are then presented. Finally a discussion of the emergence of rights concerns and the limits of legal rights is considered.

The Canadian health insurance system theoretically provides coverage for the cost of specified health care services for the majority of residents in the provinces and territories, even though distribution of resources and access problems remain. This transfer of function to the government has coincided with the belief in health care as a right rather than a privilege. A report of the Science Council of Canada notes:

> Health care in Canada has been in a state of major transition for over a quarter of a century. The transition is from a mainly private [personal] responsibility for health care, supported by charity in cases of hardship, to an increasingly comprehensive public responsibility.[51]

The following section traces this development.

2.1 A Survey of the Development of the Health Care System in Canada

It is not possible within the scope of this study to record the evolution of organized health services in Canada in detail; however, this has been done elsewhere.[52] This evolution is only summarized here.

The earliest providers of medical care were the religious sisters who came to the French settlements along the St. Lawrence in the early seventeenth century. Before Confederation, the individual was largely responsible for his or her own health care. This attitude reflected the rugged individualism of the pioneers in a new and developing country. The early settlers prided themselves on their

self-sufficiency, initiative and enterprise to survive. When necessary they could rely on family or neighbourly support. Access to medical care was often impossible. If a hospital was accessible and deemed necessary, then payment for care came from the user's own pocket. If payment for services was not possible, then it would be provided as charity. The first known contract for medical insurance was signed in what is now the City of Montreal in 1665, between a master surgeon and 17 men and their families.[53]

As early as the 1840's the Legislative Assemblies of Lower and Upper Canada acknowledged in principle the responsibility of the state for the care of the sick. Even though this support was modest, it included: grants for the construction of general hospitals; direct support for voluntary and religious charities; and contributions to the training of medical students.[54] The subject of health care was not a central issue at the time of the drafting of the British North America Act of 1867, in part because good government was understood at that time to be small, inexpensive and non-interfering. However, the Canadian population, about 3 1/4 million at the time, was subject to recurring epidemics of cholera, typhus and smallpox. It became apparent that some responsibility for health measures would have to be delegated to various levels of government.[55] The federal government was assigned responsibility for "quarantine and the establishment and maintenance of marine hospitals" in the British North America Act. The provinces were given jurisdiction for "the

establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions in and for the provinces, other than marine hospitals." The provinces could also delegate various responsibilities to municipalities or private organizations.

The period from 1871 to 1901 was one of economic hardship and depression for the people of Canada. The federal government concentrated its efforts on economic nation-building enterprises, considering the health and social well-being of the people only in light of the economic costs to the country.

The turn of the century marked a period of wheat boom, rapid population and economic growth and the trend to urbanization. During these times, wealth and increased incomes were enjoyed by many; however, social and economic inequalities were also experienced. As Montgomery has noted, "this increased industrial development, with its concomitant socio-economic dislocations, accelerated the demand by the people for the federal government to assume greater leadership in the provision of social services rather than focusing primarily on economic expansion."[56] As an example, their debates in Parliament reveal a concern with tuberculosis:

> private charity has not yet been able to cope with the difficulty to any extent (1905, p. 1354), and "no greater obligation devolves upon the House than to provide some means of lessening this great evil. If we wait for municipalities and private charities to come to the rescue of these unfortunate people, many of them will die. . . . Besides being fatal, this disease costs the people of the Dominion millions of dollars

every year (1905, p, 1355).[57]

Problems in regard to health become glaringly apparent in the first two decades of this century. Recruiting statistics revealed over half of the adult males of military age were physically unfit for active service. Morbidity and mortality rates were higher in Canada than in most countries in Europe. Unrest built up as soldiers returned from the war, new immigrants were settling in, war widows became an identifiable group and an influenza epidemic swept the population.[58]

The government was petitioned for action by various interest groups. As a result, in 1919, a bill was drafted at the federal level to establish a Department of Health. The powers of the minister administering the department extended to and included all matters and questions relating to the promotion or preservation of the health and welfare of the people of Canada over which the Parliament of Canada had jurisdiction (1919, p. 843). This department was given responsibility for such issues as child welfare, venereal-disease control, statistics, provision of leadership to provinces, and coordination of efforts at all levels to preserve and improve public health, along with existing federal health responsibilities.[59]

The Depression had disastrous effects on every aspect of Canadian life. The provincial and municipal governments found it difficult to collect taxes from their citizens. This, in turn, impeded the amount of welfare assistance

which could be provided to those in need. Physicians provided care for little or no payment.[60]

Many countries after the Second World War envisioned the development of a national health service as an important reconstruction measure.[61] Canada was influenced by a number of voices which echoed through the Western World, advocating the need for greater social justice. A report from the U.S. National Resources Planning Board in 1942 pointed to the need for improved social security provisions.[62] In the same year, the Beveridge Report on Social Security from Britain had a significant influence upon Britain's allies who were also concerned to develop reconstruction policies.[63] The Report focused on self-help underpinned by social insurance and comprehensive social security and reflected British Liberal Party philosophy. From these currents and the threat of the increasing popularity of the Cooperative Commonwealth Federation, the Liberal Government under Prime Minister Mackenzie King commissioned reports on health[64] and welfare.[65] An overall policy commission report was produced for the Dominion-Provincial Conference in 1946. The 'Green Book Proposals' were the Government's design for a new post-war Canada.[66]

Two federal-provincial conferences in 1945-1946 were held to consider these proposals in addition to the Rowell-Sirois Commission, which was concerned with constitutional revision.[67] These plans would have translated into an integrated system of health and welfare for Canadians but they were put on hold at that time, having become dependent

upon a complex negotiating package. Thus the federal government continued to influence provincial planning for health services but in a more piecemeal fashion.[68]

National Health Grants were offered to the provinces in 1948. This money could be used for conducting health surveys for program planning, building hospitals, or establishing mental- and public-health services. In 1957, with prodding from provincial governments who realized they needed federal support to meet hospital-operating costs, the federal government enacted the Hospital Insurance and Diagnostic Services Act.[69] Under its terms, payment of hospital in-patient and out-patient services were covered for Canadians.

A Royal Commission was set up by the federal government in 1962 to examine the health care needs of Canadians and to consider if it was feasible for medical care to become one of the Federal-Provincial cost shared programs. This Commission, whose term was from 1962 to 1964, accepted the principle that all Canadians had a right to health care. In order to ensure this right, the Commission proposed that Canada move away from a private enterprise system of financing physician's services toward a political economy of health care.[70]

In 1966, the National Medical Care Insurance Act was passed, following extensive Federal-Provincial bargaining about administrative mechanisms for financing the scheme. It was implemented in 1968.

This act created the framework for the existing health care structure. Because of the division of federal-provincial powers, there are in effect ten different but related health systems in Canada. Uniformity to a certain degree is maintained through the federal government's placement of conditions on cost-sharing with the provinces.[71] The rigid criteria set out in the Hospital Insurance Diagnosis Services Act (1957) were replaced with five principles: comprehensive coverage, universality, accessibility, portability and public administration.[72]

In 1974, the Minister of National Health and Social Welfare, Marc Lalonde, released a working paper titled A New Perspective on the Health of Canadians.[73] It marked a redefinition of policy and orientation adopted by the government. It was hoped that health care costs could be reduced if people assumed more personal responsibility for their own health. The paper acknowledged that what were usually called health care services were really sickness or treatment services. Further improvement in the health of Canadians was dependent on a better knowledge of the human body, environmental quality, lifestyle and the increased efficiency by which health care was provided by health professionals and hospitals.

The high costs of maintaining the health care system continued to plague both federal and provincial governments. In the late 1970's the practice of extra-billing by physicians challenged the principle of reasonable access. In view of these difficulties, the federal government

commissioned a review of the health programs. The review, "Canada's National-Provincial Health Program for the 1980's", conducted by Justice Emmett Hall, found wide support from across the population. He stated,

> I found no one, not any Government or individual, not the Medical Profession or any organization, not in favor of Medicare. There were differences of opinion, it is true, on how it should be organized and provided, but no one wanted it terminated. . . . The nationwide demand for Medicare is an accepted fact."[74]

The review examined arrangements for finances between the federal and provincial governments and contained suggestions to relieve interprovincial inequalities. Extra-billing was seen as violating the principle of reasonable access to care[75]. The review urged the government to prevent physicians from using this tactic. In response to Hall's review, in the spring of 1984 the Canada Health Act, which imposes penalties on provinces that allow extra-billing by physicians and hospital user fees, was passed.[76]

2.2 Principles of the Canadian Health Care System

A Health Charter for Canadians was enunciated in 1964 by the Royal Commission on Health Services. The Charter identified the right of Canadians to good health services, and the obligation of the government to ensure this right.

> The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilites and actions. This

> objective can best be achieved through a comprehensive, universal Health Services Programme for the Canadian people . . .[77]

In 1966, the National Medical Care Insurance Act was passed federally, with implementation at the provincial level taking place over the following five years. The introduction of national health insurance in Canada was based on the premise that all individuals should have equal access to health services, regardless of their health status. The National Medical Care Insurance Act established in principle the right to health care and the right to equal access to health care for Canadians. However, R. Badgley and C. Charles have pointed out that "what is meant by social equality in health services has been narrowly, if ever clearly set out in Canadian legislation. In fact equal access has not become a reality in practice".[78]

The Federal government shares the cost of provincial health-insurance plans so long as the provinces meet certain conditions designed to maintain national standards in health. These program conditions have become known as the the five principles of Canada's health insurance system.

Universal Coverage means that adequate health services are to be made available to all residents wherever they reside and whatever their financial resources, within limitations imposed by geographic factors. The principle of accessibility requires that insured services are delivered in a manner which does not impede or preclude reasonable access by charges (for example, extra-billing, user-fees)

made to insured persons directly or indirectly. Comprehensiveness means that the provinces must provide the range of health services as specified in the hospital and medical insurance acts. Portability means that a province must cover the cost of insured services for its residents visiting another province as well as for those who have moved to another province and are waiting to be insured under their new province's Medicare plan. The final requirement states that health insurance must be administered and operated on a non-profit basis by a public agency of the provincial government.[79] While it is not in the scope of this study to examine each principle in practice, many references point out problems which exist in application.[80]

These principles are significant for this study in that they indicate government policy which claims to insure a national standard of health care services to the Canadian people. This standard is not always realized in practice. These principles have dramatically changed the context in which the Canadian Catholic health apostolate carries out its mission. This context must be reassessed to determine what needs of people are within the existing health care system. Catholics must ask how they can translate their mission into service within this changing context.

In this chapter, the development of the Canadian health care system is surveyed. In principle, Canadians now have the right to equal access to health care. The provincial health care system, is the governmental attempt

to ensure this right. The aspects of the 'great change,' detailed by Warren, have prodded and shaped the health care system during its development. Issues such as the impact of urbanization, the growth of bureaucracy, roles of professional associations, division of labour through specialization and the transfer of function to government are major and persistent concerns. However, one effect of these changes is the loss of control experienced by individual hospitals and persons within the health care system.

The right to equal access to health care provides the majority of Canadians the opportunity to receive health care services. Once entry has been made into the health care system, concerns about rights emerge. These are usually named 'patients' rights' or 'consumers' rights'. Depending on the terminology chosen, a particular set of meanings for the relationship between the health care professional and the person who seeks health care is established.[81] J. Storch points out that much needs to be done to correct the structural, social, attitudinal and behavioral aspects of the health care system that interfere with attention to patients' rights and the promotion of humanized care.[82] Structural constraints result from the division of labor in response to advancing technologies. This division is hierarchical and physician -dominated. However, this does not always work well in a health care team consisting of other health professionals and para-

professionals.[83]

The bureaucratic nature of large health care organizations is another constraint. Service is provided according to universal rather than particularized criteria. Problems characteristic of bureaucratic organizations such as apathy, alienation of employees, rigid adherence to rules, conflicting interests and goals among health professionals and multiple lines of authority contribute to the failure to attend to patients' rights.[84]

Storch suggests interim strategies while corrections to these problems can be made within particular organizations and throughout the system. She views the consumer rights movement in health care and other patient advocacy programs, including a patients' bill of rights, as an attempt to gain some degree of control for the individual who is seeking health care.[85]

However, it is difficult to enforce many of the rights claimed by advocates of patients' rights. Such rights include the rights to be informed, to be respected and to participate, to name a few. Certainly there is legal history which surrounds the right to be informed. L. Rozovsky points out that Canadians already have many of the rights, claimed by advocates, and these are embodied in common law. As mentioned before, however, it is not possible to legislate such qualities as kindness, charity, tenderness and human responsiveness.[86] Yet, these qualities are necessary to ensure respect for the dignity of the person.

All the changes in Canadian society described are

significant because they have challenged the Catholic health apostolate by changing the context in which their mission had been previously understood. This new context has created a situation where the unique contribution of the apostolate is no longer immediately apparent, but is now rather ambiguous. Health care facilities under Catholic sponsorship do not appear physically different nor is there a difference in the goal of providing a high standard of medical care.

Without a clear understanding of their identity within the health care system, their viability is at stake. Viability has not been threatened because of government opposition to continuing Catholic sponsorship, but from the Catholic sponsors themselves who are uncertain as to how to continue the healing ministry of Christ within a highly bureaucratized health care system.

It has been necessary, as the next two chapters indicate, for the Catholic Health Association of Canada and the Sisters of St. Joseph, to rethink their mission by first identifying, in an explicit way, their philosophies.

ENDNOTES

1. Roland Warren, The Community in America (3d. ed. Chicago: Rand McNally and Company, 1978), p. 53. These changes are assumed to be taking place in North American society in general.

2. Ibid., p. 52.

3. Ibid., pp. 52-54. Warren's use of the term 'great change' refers to a series of changes that have been taking place over a period of decades, even centuries. Various movements have arisen in response to the 'great change' to combat, reverse or slow this change. The 'rights movement' such as civil rights or consumer rights are a part of this countertrend.

4. Ibid., pp. 56 - 58.

5. J. Romano, "And Leave for the Unknown", Journal of the American Medical Association, (Oct. 26, 1964), p. 283.

6. Warren, The Community in America, pp. 58 - 62.

7. M. Taylor, "The Role of the Medical Association in the Formulation and Execution of Public Policy", Canadian Journal of Economics and Political Science 26 (February, 1960), pp. 112 - 114.

8. Robin F. Badgley and Samuel Wolfe, Doctors' Strike (Toronto: Macmillan of Canada, 1967).

9. Maurice Le Claire, "The Canadian Health Care System," National Health Insurance: Can We Learn from Canada? ed., Spyros Andreopoulos, (Toronto: John Wiley And Sons, 1975) pp. 62 - 64.

10. Janet Storch, "Consumer Rights and Nursing", (Ph.D. disseration, University of Alberta, 1979), p. 49.

11. R.M. Battisella, "Rationalization of Health Services: Political and Social Assumptions", International Journal of Health Services, 2 (August, 1972), p. 334.

12. Warren, The Community in America , pp. 62 - 66.

13. CHAC, Task Force Report, "New Needs-Renewed Responses", Catholic Hospital, 5:2 (March-April 1977), pp. 5 - 6.

14. Warren, The Community in America, p. 66.

15. Warren refers the reader to the chapter on "Bureaucracy" in From Max Weber: Essays in Sociology, trans. and eds., H.H. Gerth and C. Wright Mills (New York: Oxford University Press, 1946), p. 244.

16. Ibid., pp. 214-16.

17. CHAC, Report,"New Needs-Renewed Responses", p. 6.

18. Warren, The Community in America, p. 69.

19. Emil Brunner, Justice and the Social Order, trans. Mary Ottenger (New York: Harper and Brothers 1944), esp. chapter 15.

20. Lorne E. Rozovsky, "A Canadian Patients' Bill of Rights", Dimensions in Health Service 51:10 (December 1974) p. 9.

21. Storch, "Consumer Rights' and Nursing", p. 51.

22. W.R. Rosengren and M. Lefton, Hospitals and Patients (New York: Atherton Press, 1969), pp. 4 - 44.

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CHAPTER IV

The Catholic Health Association of Canada: From Hospital Association to Health Association

This chapter looks at the evolution of the identity of the Catholic Health Association of Canada. In the 1976 Report of the Task Force,[1] the need for a new identity was expressed. For the first time in the history of the CHAC, the Report contained a proposed Statement of Philosophy and Objectives. In its early documents, the CHAC's mission had to be inferred because its mission as such was not discussed. However, since 1976, the CHAC has been in the process of discerning its mission. As a result, explicit statements of mission have been issued.[2] These are examined in this chapter, together with the "Presentation to the Hall Inquiry 1979-1980"[3] and the "Statement on the Proposed Canada Health Act" in 1983.[4]

1. The Catholic Health Association

1.1 The Report of the Task Force, "New Needs - Renewed Responses", 1976

In 1974, a Task Force was called together by the CHAC to examine and evaluate the current structure of the CHAC and to make recommendations with regard to future structuring. The Task Force, chaired by Sister Louise Demer, CSJ, understood its purpose as: "to articulate a new

identity for the CHAC in a changing world".[5] Whatever model the CHAC would eventually adopt, it was agreed that the Association must incarnate itself in Canadian culture, be an integral part of social progress and attempt to impregnate society with the values of the Kingdom of God.[6] Early in its deliberations, the Task Force recognized the need of the CHAC to adapt its form and function to the signs and needs of the times in order to be a meaningful sign of God's and of Christ's message.

What is the social reality to which the CHAC had to adapt? The health care situation was described within the Report in the following manner: Health care was no longer solely a charitable endeavour, rather it was an insured service for 95% of Canadians;[7] health care facilities offer a potpourri of ownership styles, but for the most part were public institutions, subject to a diversity of provincial health plans and statutes;[8] these facilities care for all persons based on the service program approved for a particular facility or group of facilities;[9] they involve some type of regionalization or collaboration;[10] the health care system aimed to give the best possible care with the funds available,[11] it was bureaucratized and organized[12] and was controlled by government and political strategies;[13] health care facilities employed people from every strata of society regardless of race, colour or creed and as employers were subject to applicable provincial statutes; and health care currently involved technological advances, collective bargaining and complex organizational

arrangements.[14]

When the situation of CHAC was considered, six issues were identified by the Task Force: (1) the CHAC was perceived as a unilingual association;[15] (2) its membership structure was oriented primarily towards institutional membership;[16] (3) as a result of decreasing institutional membership, the CHAC was facing some financial difficulties;[17] (4) the system of voting did not adequately represent the total membership;[18] (5) there was inadequate liaison and communication among Conferences themselves and between Conferences and the National Offices;[19] (6) because of the CHAC orientation to institutional membership, it had not extended its service to concerned Christians in other health care endeavours.[20]

A methodology for change was formulated after lengthy deliberation by the Task Force and the Board of the CHAC. The methodology required development of an Interim Organization Structure (1976-1977) and a Long-Term Organizational Structure (1977-onwards). The long-range plan involved adoption of a new statement of philosophy and objectives, but in the interim, the purposes of the Association as outlined in the 1971 by-laws remained in effect.

1.1 The Proposed Statements of Philosophy and Objectives

The new Proposed Statements of Philosophy and Objectives was considered by the CHAC as a preliminary statement, to be replaced when a new statement could be prepared for the future. The Proposed Statement of

Philosophy and the Proposed Statement of Objectives were presented separately, presumably because the Task Force envisioned some Catholic organizations adopting either one or the other statement as a working model in order to develop their own statements. For the CHAC, both statements had to be taken together.

The Proposed Statement of Philosophy is divided into five sections. The first section acknowledges that the CHAC participates in "the common brotherhood of mankind". Talent, expertise and knowledge are understood as being gifts from God to be shared.[21] The second section addresses the meaning of being Catholic. The CHAC shares Christ's universal concern for health as a condition for the total and integral development of man. Because of this belief, there is the need to research and shape the Catholic position on the totality of human development.[22] The third section articulates the meaning of human dignity, human rights, and human morality based on knowledge of human development and advances in medical science.[23] In the fourth section, the CHAC commits itself to a climate of openness and trust[24] and the fifth section indicates its responsibility to the future.[25]

The Proposed Statement of Objectives of the CHAC identifies constitutive and operational objectives. The CHAC was founded and exists to promote and stimulate concern for health. The maintenance, restoration and extension of health is seen as part of the total development

of the human being.[26] The CHAC is to mediate or build bridges between different groups in our society on health matters,[27] to stimulate and awaken the consciousness of society for health, to prepare the contemporary Christian community for the critical health problems of the future, and it is to stimulate and support research towards the fundamental root diseases and crippling illnesses of contemporary society.[28] Also, the CHAC, in cooperation with other groups in society, is to intensify the humanizing of health care by way of symposia, research, and so forth.[29] The operational objectives commit the CHAC to establish adequate feedback mechanisms to assist with the diagnosis of societal ills,[30] to establish think tanks and diagnostic teams to advance research into health-threatening areas and to encourage debate and discussion between official groups on such areas.[31]

A predominant theme throughout these statements is the view that health is a total process. The CHAC commits itself in a number of ways to teach and promote health care based on this concept. A new focus for the CHAC is the orientation to a structural analysis related to health, in that responsibility for health is more than an individual concern and society has a part to play in health and illness.

The Task Force Report outlines for consideration an integrated membership structure for the Association between the Conferences and the national office.[32] The new structure would admit options, encourage debates and

differences, searches for complementarity of gifts and talents, seek to reflect the multi-faceted face of Canadian culture, reach for ways and means of identifying the needs of a pilgrim people. The Task Force recommended that the title of the CHAC reflect its relationship with the Conferences, its national point of reference, its Catholic concern, its concern for health and its dialogic mentality. The title of "Catholic Health Conference of Canada" was suggested. On June 3, 1976, the General Assembly passed a resolution changing the name of the Association to "Catholic Health Association of Canada".

The Task Force Report indicated a new direction for the mission of the Association. The emphasis was on health as a total process, as reflected in the Association's first proposed Statements of Philosophy and Objectives. From the Task Force's point of view, the description of the health care situation in Canada was, in fact, a description of the changes which had taken place in the provision of health services during the preceding three decades. These changes gave rise to concerns about the manner in which the CHAC provided care and they threatened the viability of the institutions of the Catholic health apostolate. It was not clear whether the Statements of Philosophy and Objectives addressed these concerns. Rather, there was a closer link between the analysis of the CHAC's situation and the suggestions for an integrated membership structure.

In the early period, the CHAC and its antecedents were

a support group for the religious congregations and their institutions in carrying out their own distinct missions. There were some indications in the period between 1974 and 1976 that the CHAC was beginning to discern another orientation to mission which was different than that envisioned by its founders. The promotion of the spiritual dimensions of health care was increasingly emphasized as an area for more direct involvement by the CHAC. In the 1976 Report, health as a total process became a central affirmation of the CHAC. In later mission statements and documents, health as a total process remains a major tenet of the CHAC philosophy of health care, but is placed alongside other affirmations.

1.2 Statement of Mission, 1979

The Task Force Report intended the 1976 proposed Statements of Philosophy and Objectives to be preliminary and called for the development of a new statement of philosophy and objectives. In 1979, a new Statement of Mission was accepted by the Board of Directors.

According to this Statement of Mission the overall purpose of the CHAC was to serve as a national resource center for education, communication, inter-provincial liaison, interaction with government and inter-faith relations.[33] Its mission was to witness to the healing ministry and abiding presence of Jesus. This mission was discussed in terms of what were identified as CHAC's principal ministries. Respect for the inherent dignity of

each person was to be promoted and reverence given to the unique experience of life, sickness and death. Drawing from the 1976 statements, the CHAC was to promote concern for health as a total process, including the maintenance, restoration and extension of health as part of the full development of persons and of society. Also, help was to be provided to develop structures which foster holistic health while respecting those who were sick, aged, disabled and dying. The CHAC's mission includes mediating between different groups in society that were involved in having an effect on health as a total process.

As an ecclesial community, the CHAC is supportive of current social-justice concerns, particularly those with health care implications. Support is expressed for research on the fundamental root diseases and crippling illnesses of society, as well as on methods of health care and its delivery. The Association is also to intensify the humanizing of health care in cooperation with other groups in society and to assist in preparing the contemporary Canadian community for the critical health problems of the future. The CHAC maintains its commitment to pastoral care. Guidelines for action are to be provided on ethical issues in the life sciences in collaboration with the magisterium of the Church.

The Statement of Aims of the Association corresponds to the Statement of Mission. Some of these aims outline the relationship of the CHAC to government. Because it is considered important to act as a strong Catholic presence at

the federal level, the CHAC aspires to: influence national socioeconomic policy in health matters; promote an approach to health care whereby services are not imposed on voluntary health agencies and those agencies do not impose services on recipients; facilitate the promotion of programs and/or agencies to provide care for the unrecognized needy; and to solicit broad collaboration in fulfilling its mission without attempting to impose its own religious beliefs on these collaborators; and cooperate with other Churches, with national and international organizations, as well as with governments at various levels as required.

One significant aim is to facilitate the integration and internalization of the mission and aims of the CHAC on the part of prospective and current staff members of Catholic health care agencies. This is one of the most important shifts in orientation in the mission of the CHAC. It is now the mission of the CHAC to provide their vision of Catholic health care to the Canadian health apostolate. The relationship between the CHAC's mission and the missions of the religious congregations is discussed in the following section.

1.3 Statement of Mission, 1981

On December 4, 1981, the Board of Directors of the CHAC approved a new mission statement. Why was a revision to the 1979 Statement of Mission necessary so soon? The period between 1979 and 1981 was a period of intense reflection on

the mission of the health apostolate. Two national colloquia[34] on Catholic hospitals were sponsored by the CHAC: the CHAC Convention[35] and a new health care organization in Quebec which was launched during this period. These influences resulted in the CHAC identifying two new ministries for itself in 1981. In the realization of its mission, the CHAC is firstly to remind the followers of the Gospel of Jesus Christ of their vocation and apostolate as healers, and secondly, it is to develop programs to assure the viability of Catholic health care facilities and to actualize the spiritual potential in them. Besides these changes, this mission remains essentially the same as described in 1979.

The first National Colloquium was held in Montreal in February 1980 to focus on the Catholic health care facility in Canada's pluralistic environment. A number of recommendations were made to the various participants who included the CHAC and religious congregations. These recommendations were based on the assumption that if Catholic hospitals were to thrive in the 1980's they needed clear statements of mission and aims. Thus, it was recommended that religious congregations sponsoring such institutions should develop and communicate these statements within their hospitals. The CHAC was to give guidance in this process by establishing a good mission statement.

The need to remind followers of the Gospel of their vocation as healers and to promote the viability of Catholic

institutions was made apparent again at the Second Colloquium on the Future of Catholic Hospitals, held in Ottawa in March 1981. It focused on two issues: how to enhance appreciation within the Church for the value of Catholic health facilities; and how to strengthen the position of these institutions within the broader health care system.[36]

The May 1981 Annual CHAC Convention in Quebec City addressed the issue of Actualizing the Spiritual Potential through the Health Care Institution.[37] Interest and enthusiasm for this issue was stirred by the publication from the Catholic Hospital Association of the United States of Evaluative Criteria for Catholic Health Care Facilities[38] and the creation of a new health care organization in Quebec called Carrefour des Chretiens du Quebec pour la Sante. The central concern of this organization was the humanizing and christianizing of the health care milieu.

The CHAC's Research, Education and Pastoral Affairs Committee, in preparation for the 1981 Convention, began by asking: How does one become motivated to humanize or christianize a health care milieu? Once committed and motivated, how are Christians affirmed in this apostolate? Underlying the work of the Committee was the assumption that Christians are called to be healers, to share in Jesus' ministry of healing. Each one has a unique role to fill in this ministry.[39]

Under the influence of these activities, the new direction of calling Christians as healers became a

significant aspect of mission for the CHAC. This mission has now taken on religious overtones which were not indicated in the purposes and objectives of the CHAC forerunners. The adoption of the term 'ministry' to describe its mission supports this new self-awareness of the Association. Calling Christian religious and laity to the healing ministry is a new form of promoting vocations.

In religious congregations, people are attracted to the charism or the orginal inspiration of the founder. A mission follows from this vision. However, it is argued in this study that the CHAC, recognizing the decline in the number of religious, has discerned an alternative approach to provide a vision of Christian-healing ministry as a vocation which can include all health workers, religious and laity, professionals and non-professionals. The increased contribution of the laity, in continuing the health care apostolate, is recognized as essential in this new ministry of the CHAC.

The 1981 Statement of Mission acknowledged as part of the mission of the CHAC the need to develop programs to assure the viability of Catholic health care facilities.[40] However, plans were already underway to put these programs into practice. In January 1982, a third Colloquium was held. The CHAC's Health Care Institutions Committee determined that the focus for Colloquium III would reflect on the conclusions of the two earlier colloquia. This was to help the CHAC decide on implementation of four

recommendations made to the 1981 Annual Assembly of the Association. These recommendations were directed to: the consulting function; models of ownership; governance of a denominational facility as contrasted with a secular one; and an examination of the feasibilty of establishing a separate corporation that might help facility owners in the consultation or management area or in an extreme case assuming actual ownership.

The Health Care Institutions Committee met after the colloquium and made a recommendation to the CHAC Board of Directors. It was recommended "that the Board make an immediate announcement to the CHAC members that the coloquium procedure was seen as a very positive process and has led to a two phase follow-up".[41] The CHAC was to sponsor a major educational session centered on the mission/identity uniqueness of the Catholic health care facility. Secondly, a task force was to be set up to study possible options for assisting Catholic health care facilities through appropriate consultation, management, or ownership structures at either the federal or provincial levels or both.[42]

In December 1982, the CHAC Board adopted a document entitled "Report of the Task Force on Organizational Structures". It was a blueprint for the Association in its working relationship with its institutional members. Its intent was precisely to help assure the viability of Catholic health care facilities in Canada and to assist them in exercising a leadership role in offering service.[43]

Special consulting services, educational programs, a communication and information resource center and management and ownership models and structures were areas addressed.

Mission statements make explicit the philosophical perspective of the Assocation. They direct the Association to certain kinds of activities and provide a framework to direct, evaluate and critique their own work as well as others. This is apparent in the CHAC's Presentation to the Hall Inquiry, Health Services Review 1979-1980 and the Statement on the Proposed "Canada Health Act", of March 1983.

1.4: Presentation to the Hall Inquiry, 1979-1980

During the 1970's, a crisis in the cost of health care in Canada became increasingly obvious. The costs of providing adequate levels of health services were steadily increasing. Doctors began extra-billing, that is, charging their patient a certain amount above the fixed fee that would be reimbursed from the provincial health - insurance plan. Some hospitals, especially those in Alberta, were charging user fees, special fees for using the facilities. The federal payments to the provinces for their health insurance plans were no longer specifically directed to the plans. Provinces were provided with blocks of funds, which then could be allotted by the province into any number of purposes - universities, business or health services. This became known as 'block-funding'. As a result there was competition for these funds. Many Canadians perceived the

health-insurance plans as eroding. Emmett Hall led the inquiry called "Canada's National-Provincial Health Program for the 1980's" which investigated the current problems of the health care system.

In the CHAC's Presentation to the Hall Inquiry, the CHAC identified itself by reference to its 1979 Statement of Mission and Aims:

> Guided by our understanding of the Christian gospel, this Association "strives to have a universal concern for health as a condition for full human development". We aim to "promote and stimulate concern for health as a total process ... as a part of the full development of the human person and of our society". In order to "intensify the humanizing of health care in cooperation with other groups in society", the CHAC seeks "to strengthen relationships with provincial and regional associations" and "to influence national socio-economic policy in health matters."[44]

The Presentation was clearly political in nature. Using the CHAC's mission as its mandate, it offered the Inquiry an analysis of and made recommendations to deal with the difficulties that had arisen within the Canadian health care system. The CHAC was not arguing for benefits, privileges or rights for its own members. Rather the Presentation was concerned with the extent to which the goals proposed by the Royal Commission in its 1964 Health Charter for Canadians were being achieved in 1979-1980. The Introduction to the Brief Notes by Justice Hall stated that the CHAC's presentation had "helped to elevate the dialogue" above the level of self-interest pleadings.[45] In order to continue to

care for the sick in Canadian society, the CHAC felt it necessary to take on the role of political advocate.

The CHAC's position was guided by two principles, which can be summed up as:

> the two-fold measures of fairness and freedom: fairness in terms of reasonable access to comprehensive health service of a high quality available in every province under uniform terms and conditions through even-handed public administration; reasonable freedom for those providing the services who in turn are reasonably remunerated for their services.[46]

The Association acknowledged that fairness and freedom existed in tension in public policy decision-making.

The Presentation outlined the problems facing health care services across Canada. Problematic aspects were identified as block-funding, provincial service cutbacks, premiums, user-deterrent fees, additional professional charges, the opting out or in of physicians, and the costs of services. The Presentation's conclusion, drawn from the analysis of the situation, was that the present state of affairs was contrary to the declared principles on which the Canadian health care system was based.

The CHAC proposes immediate, medium-range and overall recommendations to the Hall Inquiry. The CHAC envisioned these as being passed on as recommendations to the Minister of National Health and Welfare and for Parliament. Immediate steps were designed to correct problems such as provincial premiums, deterent user fees, block-funding arrangements as well as opting out and extra-

billing by doctors. The block-funding arrangements that existed at the time were to be re-examined. Also, the opting-out of physicians was to be reconsidered. On the other hand, medical practitioners and other professional and para-professional personnel were ensured that they would receive a fair income. These recommendations were made in support of what was taken to be a right to adequate levels of health care and the right to a just wage. Medium range steps called for the introduction of health services to reduce costs, expand coverage to include dental services and prescription drugs for all citizens and establish an independent Health Council of Canada to carry out continuing studies of health needs and services. There were two overall measures suggested. The Presentation recommended that health-service policy be integrated within a comprehensive strategy of social and taxation policy for Canadians. The second measure, noted as the most important, was the establishment of clear and concise minimum standards applicable across Canada which were in keeping with the criteria for pre-paid health services first proposed by the 1964 Royal Commission.

1.5 Statement on the Proposed "Canada Health Act", 1983

In 1982, the Hon. Monique Begin, the Minister for National Health and Welfare, outlined the government's proposals for a new Canada Health Act which would replace the Hospital Insurance and Diagnostic Services Act, the Medical Care Act and Established Programs Financing Act.

4. CHAC: Recent Period

Begin indicated that this new Canada Health Act would set reasonable minimum standards for insured health care and mechanisms for monitoring the maintenance of these standards.[47]

The CHAC Statement was offered as a response to the proposed Canada Health Act. Its purpose was to bring to the discussion of the bill the values and perspectives of the members of the Association.[48] Many positions expressed in this Statement were first presented to the Hall Inquiry, where they were explained in greater detail.

The Statement by the CHAC supported "the federal government's intention of clarifying in one piece of legislation minimum standards of insured services as well as an acceptable monitoring system for maintaining these standards".[49] The CHAC identified five principles on which an appraisal and restructuring of Canada's health care system should be based. These principles were: 1) the right to health; 2) the right to be involved in health care decision-making; 3) the right to health care; 4) the priority of human and social values in making health care decisions; 5) the fostering of personal initiative and responsible lifestyles whenever possible, and the use of government planning whenever necessary. These principles should underlie the legislation which was to be articulated in the proposed Canada Health Act in terms of: universality of coverage, comprehensiveness of insured services, accessibility, portability, and public administration.[50] The conclusions of the Statement were basically the same as

those expressed in the recommendations made by the CHAC to the Hall Inquiry.[51]

2. The Identity of the CHAC: The Recent Period

As indicated in the analysis of the early period of the CHAC, the Association was going through a process to discern its identity and mission, which had been placed into question because of the changes within the health care system and Canadian society, as outlined in Chapter 3. The identity and the mission of the CHAC were directly involved with the concurrent discernment of identity and mission of the members' health care institutions. The Catholic health apostolate was asking "What should be the future of the Catholic health apostolate in Canada and what forms should it take?" The assumptions which underlie the emerging model of mission chosen by the CHAC contained the answer to this question. This section analyzes the construction of the identity and mission for the CHAC beginning with the Task Force Report in 1976. The assumptions of this new identity are examined.

The sources considered in this section differ from the early-period sources in a number of ways. First, the Constitutions and By-laws, up until this time, contained objectives, purposes and aims which indicated the mission of the Association. Even though as early as the 1964 Constitution, the CHAC took as one of its objectives the study of all aspects of the philosophy and religious life of hospitals, it was not until 1976, in the Task Force Report

that there were proposed Statements of Philosophy and Objectives. It was not meant to be a definitive statement but rather as a beginning for reflection and discussion. It was also suggested that member institutions might adapt the Statement of Philosophy and Objectives for their own use. The proposal provided an opportunity to discern a mission for the CHAC and its members in the current health scene in Canada. The result of this discernment process was an explicit and public statement of the Association's mission. In 1979, the first Statement of Mission was published as a pamphlet which could then be easily made available.

A second feature which is different about these sources compared to the earlier sources is the degree of appropriation of current Catholic social teaching of the period. The 1976 Proposed Statement of Philosophy and Objectives and subsequent Statements of Mission appeared to have appropriated the major tenets of Catholic social teaching articulated by Vatican II.[52] An examination of how these tenets have become embodied in the Association's objectives indicates that it is possible to argue that the mission of this Association has become linked directly with a specific understanding of mission for the Church.

The third difference between the early and later sources is an enlarged perspective. The Association remained committed to the concerns of its institutional members. However, there was a shift in emphasis from an institutional concern to a personal focus. A key concept

was the health of the person in a holistic sense, mind, body and spirit.[53] This focus served to unify the personal and social and political dimensions of the CHAC's philosophy and mission.

Why was it necessary for the CHAC to have an explicit philosophy and mission as expressed in the later sources? The Task Force acknowledged, in articulating a new identity for the CHAC, that it was necessary to assess the social reality in which the health apostolate operates.[54] The context out of which the CHAC arose was very different from that when it began its involvement in hospitals. The change in philosophy was accounted for by changes in the Canadian health care system and changes brought about in the Catholic Church as a result of the Second Vatican Council.

As presented in Chapter 4, 1.1.1., the Report of the Task Force, health care is an insured service for most Canadians and no longer a solely charitable endeavor. This service is controlled by government and political strategies. There exists a number of ownership styles. Subject to provincial health plans and statutes, health care institutions must care for all persons based on an approved service program while employing people from every strata of society.

Catholic-owned and -sponsored health facilities are a part of this system. However, in the past, religious congregations worked largely out of charity. Since the Medical Care Act in 1966, the access to health care was considered a right of citizenship by the Canadian people.

Thus ended the reality of poor wards or medical service offered as charity by hospitals or health care workers. Because many religious congregations had entered into hospital ownership, administration and bedside care long before the government assumed the responsibility for health services, the precise meaning of doing works of charity in this context needed to be rethought. Some religious congregations decided that they could stay faithful to their charism by becoming involved in other kinds of ministry and they moved out of hospital ownership.[55] The role of the Catholic health apostolate became ambiguous and difficulties arose which threatened the continued existence of Catholic involvement in institutional health care.

In view of the ever increasing expenditure on the health care system by government, the report called a New Perspective on the Health of Canadians in 1974, set a new direction for health policy. To keep costs manageable, the New Perspective on the Health of Canadians stated that it would be necessary to focus on illness prevention and health promotion. The CHAC Task Force, in considering the philosophy and mission of the Association, must have found this policy direction compatible with the traditional holistic understanding of health which is part of the Roman Catholic tradition. Thus, it is not surprising that the value of health in a holistic sense was made a central concept in the explicit Statements of Philosophy and Mission.

4. CHAC: Recent Period

Explicit statements of philosophy and mission were also a result of changes within Roman Catholic social teaching.[56] It can be shown that Catholic social teaching has provided the Canadian health apostolate with a theological framework necessary to discern its mission in view of the social changes which have occurred, enabling them to offer a response which continues the healing ministry of Christ in a manner appropriate to these new conditions. The teachings themselves have required an explicit and public statement of the Church as a social actor. Woven throughout the later sources of the CHAC are the predominant themes of Catholic social teaching since Vatican II: the dignity of the person, the establishment of a servant Church, the penetration of society with Christian institutions, the establishment of social justice, the preferential option for the poor, the call to holiness and the call to ministry of all people.

The Task Force Report, "New Needs - Renewed Responses" in 1976, was not only concerned with changes to the organizational structure but also the identity of the Association. The Task Force agreed that in choosing a model for the CHAC, it would have to be one which incarnated itself in Canadian culture. In other words, it would penetrate society as a Christian institution. Kevin O'Rourke explained that penetrating society means that Christians become the prophets, the consciences of the human endeavors or professions in which they are engaged. To be a 'conscience' means helping other people to achieve their

proper identity.[57] The Church, according to Vatican II, is willing to assist and promote institutions which provide services dependent upon and associated with its mission.[58] Thus the CHAC is aligning itself with the mission of the Church as it attempts to "impregnate society with the values of the Kingdom of God."[59]

The proposed Statement of Philosophy of the CHAC affirms that it is a participant in the Church as servant.[60] The Task Force Report states that the CHAC participates in 'the common brotherhood of mankind'. Talent, expertise and knowledge are understood as being gifts from God to be shared.[61] The CHAC shares "Christ's universal concern for health as a condition for the total and integral development of man".[62] Tied up with the mission of the Church to bring the message and grace of Christ to all people is the Church's function of influencing the human community according to divine law. So the Servant Church, concerned with the total and integral development of man, initiates activities on behalf of all people. The Pastoral Constitution on the Church in the Modern World states:

> Christ to be sure, gave His Church no proper mission in the political, economic, or social order. The purpose which He set before her is a religious one. But out of this religious mission itself came a function, a light, and an energy which can serve to structure and consolidate the human community according to divine law. As a matter of fact, when circumstances of time and place create the need, she can and indeed should initiate activities on behalf of all men. This is particularly true of activities designed for the needy, such as the works of mercy and similar undertakings.[63]

This is the theological link between the religious and social mission of the Church. The CHAC affirms its identification with this model of the Church's mission.[64]

The CHAC proposed Statement of Philosophy states that the CHAC articulates the meaning of human dignity, human rights and human morality based on the knowledge of human development and advances in medical science. The central theological affirmation which is at the foundation of modern Catholic social teaching is that each person is created in the image of God. This establishes the equality of every person. Leo XIII's encyclical in 1891 affirmed that the human soul is made in the image and likeness of God.[65] John XXIII recalled the doctrine's biblical foundation in Genesis 1:26.[66] Having been created in this way, the person is endowed with intelligence and freedom. The identification of imago Dei with the fact that human beings are endowed with intelligence and freedom provides theological justification for appealing to reason and natural law as the basis for the theory of human rights.[67] This basis of human dignity has been reaffirmed by Vatican II.[68] The CHAC, with its experience of the health care system asserts itself as the appropriate voice to speak about human dignity in the context of contemporary health care.

The central political implication of the Church's teaching on human dignity is succinctly summarized in the phrase, "Man precedes the State".[69] This means that social and political structures are to serve the person and the

worth of a person cannot be subsumed to that of a function of the system. In continuity with Leo XIII's statement, which is recognized as the beginning of modern Catholic social teaching, the CHAC, in its proposed Statement of Objectives, stressed the need to humanize health care.[70] The emphasis on health rather than a narrow focus on the institution's concerns also indicated the impact of this teaching.

The commitment to social justice is also made in the CHAC proposed Statement of Objectives. The Association commited itself to research towards the fundamental root diseases and crippling illnesses of contemporary society.[71] Vatican II affirmed the importance of human activity in transforming the world. Human achievements are a sign of God's greatness. The Council rejected the reduction of the Kingdom of God to earthly progress; however, it did affirm that progress is of vital concern to the Kingdom. As mentioned earlier, in 1971, the Synod of Bishops declared,

> Action on behalf of justice and participation in the transformation of the world fully appear to us as a constitutive dimension of the preaching of the Gospel, or, in other words, of the Church's mission for the redemption of the human race and its liberation from every oppressive situation.[72]

This concept of preaching the gospel involves achieving social justice, overcoming the causes of need and suffering and working with other Christians and people of good will. Thus, the CHAC commited itself to these tasks in its proposed Statement of Objectives. The affirmations of

modern Catholic social teaching, especially since Vatican II, were reiterated. The emerging identity can be described as an association which participated fully within an 'integral' model of mission of the Church, as described by Fiorenza.[73] Subsequent statements by the CHAC reinforce and develop this identity further.

The Task Force articulated a new identity for the CHAC. It enlarged the CHAC's perspective from its previously institutional focus to one which sought the health of persons as a primary centralizing concept. By grounding its philosophy in Catholic social teaching, the CHAC went beyond the development of statements for operational purposes and defined its own mission as an integral part of the Church's mission. The CHAC took up the challenge of the Servant Church to penetrate society with Christian institutions. It might have been decided that the CHAC could best serve by directing the Catholic health apostolate to devote their resources to pastoral services within nondenominational public hospitals and withdraw from ownership or sponsorship of its institutions. The one option that the CHAC could not follow was to remain unchanged. Institutional members were being lost and others were struggling to discern their choices. The CHAC, by enlarging its perspective beyond its institutional members and focusing on health as a central concept, provided the paradigm shift necessary to address the crisis in which its members found themselves.

4. CHAC: Recent Period

Three years after the Task Force Report, the first Statement of Mission for the CHAC was produced. It emerged out of the Proposed Statement of Philosophy and Objectives and reiterated many of the same philosophical affirmations as its ministries. The Board of Directors discussed the mission of the CHAC in terms of purpose, mission and aims. The purpose was to serve as a national resource center. The mission of the CHAC was to witness to the healing ministry and abiding presence of Christ. It is significant that at this point the Association identified its activities as ministries, not as functions or tasks. The adoption of the term 'ministry' carries with it the implied religious overtones which were once associated with priests or religious. However, the CHAC by this use of language acknowledged its own role in the mission of the Church. The acknowledgement of the ministries of the CHAC can be rooted also in Catholic social teaching. Vatican II called all people to ministry: priests, religious and laity. As the number of sisters in the health apostolate decreases, the role of the laity increases in importance. The Decree on the Apostolate of the Laity, states that, "the laity, too, share in the priestly, prophetic and royal office of the whole People of God in the Church and in the world."[74] This apostolate, through its activities of spreading the gospel attempts to penetrate and perfect the temporal sphere. The Decree goes on to state,

> The apostolate of the social milieu, that is, the effort to infuse a Christian spirit into the

> mentality, customs, laws and structures of the community in which a person lives, is so much the duty and responsibility of the laity that it can never be properly performed by others.[75]

The CHAC as an association participates in the mission of the Church but serves to allow lay people to respond to their call to ministry.

Related to this adoption of the language of ministry is a new aim of the Association.[76] There is an aim to facilitate the integration and internalization of the mission and aims of the CHAC on the part of prospective and current staff members of Catholic health care agencies. One aspect of this aim is continuation of the traditional educational task of the Association. However, never before has it been important to the Association that its mission and aims be internalized by the members of Catholic health agencies. This is new and significant. The CHAC is indicating that it is necessary that its aims be not only explicit, but internalized and integrated by the members of the health apostolate. Stepping back and taking the Statement of Mission as a whole, one finds that a theological framework for the health apostolate is provided. A vision of a healing ministry, rooted in the Gospel, appropriate to its time, is set out. It is a vision which can be shared by those who make public profession of the evangelical counsels and other Christians. It is possible to argue that at this point the CHAC offers to the Catholic health apostolate an empowering vision analogous to the traditional charism of religious congregations.

One of the aims expressed in this 1979 Statement of Mission is to "facilitate the promotion and/or agencies to provide care for the unrecognized needy, the anawim." This clearly reflects another major theme of Catholic social teaching: the preferential option for the poor.[76] Religious congregations, early in Canadian history, cared for the sick and the sick poor, if necessary, during the time when governments had not assumed responsibility for meeting this need within the population. With government health-insurance plans, the majority of Canadian citizens are insured at the present time for care.

The CHAC aims to recognize those groups within Canadian society whose health care needs are not being met. Their approach is to consider the structures of society which can either promote justice or injustice depending on how choices are made by those in power.[77]. This aim becomes more complex when access to health care is considered. Northern and rural areas do not have the same resources as the southern large urban areas. Poverty or specific cultural attitudes affect how individuals will use the health care system. Extra-billing by physicians has been shown to limit access to care.

As a result of the intense reflection on the mission of the health apostolate, two new ministries were identified for the CHAC.[78] The CHAC at this point assumed as a ministry the role of reminding the followers of the Gospel of Jesus Christ of their vocation and apostolate as healers.

4. CHAC: Recent Period

In the 1979 Statement of Mission the CHAC aimed at having its mission and aims internalized by members of Catholic health care agencies. In the 1981 Statement of Mission the CHAC went a step further in specifying their vision for the health apostolate. Followers of Jesus Christ are healers and it is their vocation, their calling, to do so. To employ the term "vocation" implies that there will be an acceptance or response. It also implies a way of life. It serves in a similar way to the function of a charism of a religious congregation. Although it does not involve taking vows of poverty, chastity and obedience, it suggests a religious framework, but it is not presented as the working out of one's destiny or salvation. The health worker does not simply have a job or career but through work he or she has a vocation or calling to serve as a healer. Earlier objectives of the CHAC included the objectives of making its members aware of the religious dimension of their work. However, this was the first time that this work was presented in terms of a vocation to healing. It was a more inclusive perspective, suggesting an orientation for one's life and the physical, spiritual, social and global dimension of healing.

Vatican II affirmed that it was the mission of the Church to call all people to holiness. Holiness can be expressed through family life, single life and secular and religious occupations. The Dogmatic Constitution on the Church stated:

> Thus, it is evident to everyone that all the

> faithful of Christ of whatever rank or status are called to the fullness of the Christian life and to the perfection of Charity. By this holiness a more human way of life is promoted even in earthly society.[79]

This personal response by individuals to this call to holiness by the Church contributes to the making of society which is in keeping with the dignity of the person. This call to holiness includes those who are not Catholics and this implies a recognition and appreciation of those who have different religious beliefs.

The translation of the ministry of healing as expressed in the 1981 Statement of Mission into practice has yet to be made. The role of healer traditionally has been attributed to a designated member of the community, either as priest or physician. For health care workers to embrace this vocation would have potentially radical possibilities for patient care, the institutions' bureaucratic structure, the professionals and unionized workers and the relationship of the health care facility within the community. The implications of putting this ministry into practice could provide the context of working out the meaning of the Gospel in the everyday lives of Christians in a manner which has not been done. Two questions are raised by the acknowledgement of this ministry. First, how does an association go about encouraging people to understand their work within the new paradigm of 'vocation as healer'? Secondly, what is the contribution of the charism of the religious congregation which founded and perhaps owns and sponsors the facility?

The recommendations made to the government via the Presentation to the Hall Inquiry and the Statement on the Proposed Canada Health Act indicate the nature of the political mission of the CHAC. The Association was acting as an advocate, not for the rights and privileges of its members as such, but for an adequate level of health care for all Canadians. The CHAC recommitted itself to the social philosophy which grounded the principles for the Canadian health care system. These principles were held to be constitutive of a Christian approach for caring for the sick within Canadian society. The Presentation to the Hall Inquiry stated, "We shall do what we can as an educative agency in the voluntary field to promote this social philosophy in the continuing task of sensitizing consciences to these human rights and social responsibilities".[80] Thus, the mission of the CHAC was not only to remind Christians of their call as healers of individual persons, it also included a political mission which involved educating Canadians to a social philosophy which endorsed a certain vision of human rights.

In conclusion, because of the social changes which had taken place within the health care system and in Canadian society, the CHAC needed a new identity. The 1976 Task Force Report served as a blueprint for this transformation.

The recognition of the various facets of the distinctiveness of the Catholic health apostolate in Canada has only gradually come to be appreciated in an explicit

manner. Attempts at articulating the increased appreciation for this distinctiveness is reflected in the various mission statements.

The major themes of modern Catholic social teaching appear in these mission statements. It can be argued that the distinctive identity of the mission of the Catholic health apostolate, in its associations and institutions, was rooted in the religious mission of the whole Church, which is to bring the message and grace of Christ to all people.

When the government-sponsored health insurance plans were first initiated, a certain degree of perplexity was created regarding the continued role of the Catholic health apostolate. In order for the CHAC to clarify its mission, it was necessary to clarify the distinctiveness between the non-denominational and denominational (Catholic) institutions. The major threat to the viability of the Catholic-sponsored health care institution is the loss of a distinctive identity. Because both non-denominational and Catholic health care institutions participate in the health care system, both are non-profit public institutions. Funding is acquired in the same manner for both. What is more, Catholic-sponsored institutions are now part of a rationalization of services and regionalization plans, determined by the provincial government. Health care costs, are covered for almost the total population by the provincial insurance plans. In this situation, the traditional idea of doing works of charity or mercy became problematic, forcing the members of the CHAC to ask if, in

fact, they care for the 'needy' in a significantly different manner than did the non-denominational hospital. What does the 'preferential option for the poor' mean for the Canadian health apostolate? What does the 'vocation as healer' for the individual and the health apostolate as a whole mean in practice in a large bureaucratized health care system? These are questions which will need to be asked again and again. The CHAC, by adopting the ministry of reminding individuals of their call as healers, has moved to a mission which clearly involves social, political and religious dimensions which are integrally related.

ENDNOTES

1. CHAC, Report of the Task Force Committee, "New Needs- Renewed Responses", pp. 4 - 10.

2. Catholic Health Association of Canada, Statement of Mission 1979, pamphlet; "New Mission Statement for the CHAC", CHAC Review (Nov/Dec 1981), p. 13.

3. CHAC, "Presentation to the Hall Inquiry, Health Services Review 1979 - 80", CHAC Review 8:2 (March-April 1980), pp. 9 - 12.

4. CHAC, "Statement on the Proposed 'Canada Health Act'" CHAC Review, (March 1983), pp. 20 - 23.

5. CHAC, Report of the Task Force, "New Needs- Renewed Responses", section 2:3.

6. Ibid., section 3.3.

7. Ibid., section 12.1.

8. Ibid., section 12.2.

9. Ibid., section 12.3.

10. Ibid., section 12.4.

11. Ibid., section 12.6.

12. Ibid., section 12.5.

13. Ibid., section 12.6.

14. Ibid., section 12.8.

15. Ibid., section 13.1.

16. Ibid., section 13.2.

17. Ibid., section 13.3.

18. Ibid., section 13.4.

19. Ibid., section 13.5.

20. Ibid., section 13.6.

21. Ibid., section 21.

22. Ibid., section 21.3 - 21.5.

23. Ibid., section 21.6.

24. Ibid., section 21.7.

25. Ibid., section 21.8.

26. Ibid., section 22.1.

27. Ibid., section 22.2.

28. Ibid., section 22.4.

29. Ibid., section 22.5.

30. Ibid., section 22.6.

31. Ibid., section 22.7.

32. Ibid., section 22.5.

33. CHAC, Statement of Mission, 1979.

34. Patrick Jamieson, "National Colloquium on Catholic Hospitals" CHAC Review 8:2 (March/April, 1980), pp. 4 - 8.

35. Patrick Jamieson, "Second Colloquium on Future of Catholic Health Care Institutions", CHAC Review 9:1 (Jan/Feb, 1981), p. 5.

36. Between 1965 and 1981, approximately 115 health care facilities ceased to be Catholic. Also, few religious personnel were available. An increasing role has been recognized for the laity since Vatican II.

37. Everett MacNeil, "Health Care with a Difference," CHAC Review 9:1 (Jan/Feb, 1981), p. 4.

38. CHA, Evaluative Criteria for Catholic Health Care Facilities (St. Louis: Catholic Health Association, 1980). The Evaluative Criteria program are written in the spirit of Vatican II.

39. In the program, the essence of Catholicity lived out by those within the healing ministry is exemplified. The Criteria document presents eight principles, addressing the following topics: the health care facility's role within the Catholic Church; Christian management; patient care; the pastoral care program; medico-moral guidance and education; social justice policy and education; and relationships to other organizations.

40. MacNeil, "Health Care with a Difference", p. 4.

41. Everett MacNeil, "Proposals to Promote the Viability and Leadership of the Catholic Health Care Facility in Canada", CHAC Review, 11:1 (March 1983), pp. 8 - 10.

42. Everett MacNeil, "Editorial: The Colloquium Process", CHAC Review, 11:1 (Jan/Feb 1982), p. 4.

43. "CHAC Board Response to Colloquium III", CHAC Review, 11:1 (Jan/Feb 1982), p. 7.

44. CHAC, "Presentation to the Hall Inquiry, Health Services Review 1979-80", p. 9.

45. Ibid., p. 9.

46. Ibid., p. 10.

47. Monique Begin, Minister of National Health and Welfare, Opening Statement to the Conference of Federal and Provincial Ministers of Health, Ottawa, May 26, 1982.

48. The information available to the CHAC on which the "Statement on the Proposed 'Canada Health Act'" was based was limited to the Opening Statement by the Minister of Health and Welfare, May 26, 1982, an official discussion paper referred to as the "Canada Health Act Paper Draft 2", and a letter by the Minister of Health and Welfare to the Editor, The Canadian Medical Association Journal, February 4, 1983.

49. CHAC, "Statement on the Proposed 'Canada Health Act'" p. 20.

50. Ibid., p. 20.

51. These recommended changes are: work towards the elimination of health premiums as a precondition to obtaining health care; provide extended health services, specifically nursing home care and the health aspects of home care, insured services as soon as possible; clearly establish the coverage of a broader range of comprehensive services; seek termination of every form of user fees; establish clear concise minimum standards applicable across Canada; assure just remuneration for all health care workers; and pursue the setting up of an independent Health Council of Canada.

52. Joseph Gremillion, ed., The Gospel of Peace and Justice: Catholic Social Teaching since Pope John, p. 1. Gremillion states,

"Catholic social teaching represents the 'conscientization' of the Roman Catholic Church as a social actor in this rapidly changing world".

53. The seriousness of the commitment to this shift is marked by the change in the name of the Association from the "Catholic Hospital Association of Canada" to the "Catholic Health Association of Canada."

54. CHAC, Report of the Task Force, "New Needs- Renewed Responses", section 1.

55. Canadian Catholic Health Care Leaders face the Issues: Government Relations, Sponsorship, Catholic Identity, Medical Moral Problems, Health Insurance Programs. (Fr. MacNeil), p. 35.

56. D. Hollenbach, Claims in Conflict, Retrieving and Renewing the Catholic Human Rights Tradition (New York, Paulist Press, 1979), p. 43. Hollenbach explains that the Christian social movement began in France around 1830 in response to the social problems and misery affecting many people in the Western World as a result of industrialization. In 1886 and again in 1888, Leo XIII had been presented with the first statements on Catholic social principles by a small group of laymen from various European nations known as the Union of Fribourg. It was at this point that the Church began to move from a stance of adamant resistance to modern Western development in political and social life to a participation in them critically. Beginning with the pontificate of JohnX XIII and the Second Vatican Council, it came to be understood that an essential part of the Christian mission is to humanize political, social, economic, cultural and technological life. The Church has a duty to seek to transform the world according to the message of Christ.

57. Kevin O'Rourke, "Long Range Planning In the Church and CHA", Hospital Progress (July 1978), p. 92.

58. Gaudium et Spes, n. 42; E.T. in Abbott, The Documents, p. 241. This states, "This Council, therefore, looks with great respect upon all the true, good, and just elements found in the very wide variety of institutions which the human race has established for itself and constantly continues to establish. The Council affirms, moreover that the Church is willing to assist and promote all these institutions to the extent that such a service depends on her and can be associated with her mission."

59. CHAC, Report of the Task Force, "New Needs -Renewed Responses", section 3.3.

60. Gaudium et Spes, n. 3; E.T. in Abbott, The Documents, p.201. This states "inspired by no earthly ambition, the Church seeks but a solitary goal; to carry forward the work of Christ himself under the lead of the befriending spirit. And Christ entered this world to give witness to the truth, to rescue and not to sit in judgment, to serve and not to be served."

61. CHAC, Report of the Task Force, "New Needs-Renewed Responses", section 21.

62. Ibid., section 21.3 - 21.5.

63. "Missio quidem propria, quam Christus Ecclesiae suae concredidit, non est ordinis politici, oeconomici vel socialis: finis enim quem ei praefixit ordinis religiosi est. At sane ex hac ipsa missione religiosa munus, lux et vires fluunt quae communitati hominum secundum Legem divinam constituendae et firmandae inservire possunt. Item, ubi opus fuerit, secundum temporum et locorum circumstantantias, et ipsa susitare potest, immo et debet, opera in servitium omnium, praesertim vero egentium destinata, uti opera misericordiae."
Gaudium et Spes, Acta Apostolicae Sedis 58:15 (Dec.1966) n. 42; E.T. in Abbott, The Documents, p. 241

64. CHAC, Report of the Task Force, "New Needs- Renewed Responses", section 21.6.

65. Rerum Novarum (Rome, Vatican, 1891), n. 40; E.T. in Claudia Carlen Ihm, The Papal Encyclicals, 1878-1903 (McGrath Publishing, Co., 1981), p. 251.

66. Pacem in Terris n.3; E.T. in Gremillion, The Gospel, p. 202.

67. D. Hollenbach, Claims in Conflict, p. 109.

68. Gaudium et Spes, n. 12; E.T. in Abbott, The Documents, p. 210.

69. Rerum Novarum, n. 7; E.T. in Carlen Ihm, The Papal Encyclicals, p.243.

70. CHAC, Report of the Task Force, "New Needs- Renewed Responses", section 22.5.

71. Ibid., section 22.4.

72. De Iustitia in mundo, n. 6; E.T. in Gremillion, The Gospel, p. 514.

73. See, Introduction, 1.3.4 for a discussion of Fiorenza's Model of Integral Mission.

74. "At laici, muneris sacerdotalis, prophetici ret regalis Christi participes effecti, suas partes in missione totius populi Dei explent in Ecclesia et in mundo." Apostolicam Actuositem, Acta Apostolicae Sedis 58:12 (Nov. 1966) n. 2; E.T. in Abbott, The Documents, p.491.

75. "Apostolatus in ambitu sociali, scilicet studium spiritu christiano informandi mentem et mores, leges et structuras Communitatis in qua aliquis vivit, adeo laicorum munus onusque est ut ab aliis numquam debite expleri valeat."
Ibid., no. 13. See Donal Dorr, Option for the Poor, A Hundred Years of Vatican Social Teaching (Maryknoll, New York : Orbis Books, 1983) pp. 2-3.
Dorr has pointed out that it has only been recently that the term 'option for the poor' has come into common usage in modern Catholic social teaching, even though the reality designated by this term has been addressed by the Church previously. The term 'option for the poor' involves a response to the structural injustice that characterizes this world. He states that "it is specifically a response at the level of wider society as a whole, a response to the unjust ordering of society". (p. 3) It must be understood, then, in the context of an awareness of how society is in fact structured.
Contemporary societies are stratified. This means that certain economic, political, cultural, and religious structures maintain and promote the dominance of the rich and powerful over the mass of ordinary people. Dorr explains that "these structures operate through agencies and institutions that are staffed mainly by the middle-class people. This group provides the professional and commercial services of society".(p. 3) It is precisely through their services that they contribute to structural injustice. The 'option for the poor' means a series of choices made personally or communally which is disentangled from serving the interests of those at the 'top' of society and instead, stand in solidarity with those, at the bottom or the poor and powerless.
The Churches provide some services which are an integral part of the institutions of society, such as the care of the sick and education. Those who participate in these Church-sponsored services need to ask whether the work which is being done, however 'charitable' it may be in itself, meets the requirement for the Church's commitment to justice.

76. See Chapter 4, Section 1.1.1.

77. CHAC, Statement of Mission, 1981.

78. These are: To remind followers of the Gospel of their vocation as healers and to promote the viability of Catholic institutions.

79. "Cunctis proinde perspicuum est, omnes christifides cuiuscumque status vel ordinis ad vitae christianae plenitudeinem et caritatis perfectionem vocari, qua sanctitate, in societate quoque terrena, humanior vivendi modus promovetur." Lumen Gentium, Acta Apostolicae Sedis 57:1 (Jan. 1965) n. 40; E.T. in Abbott, The Documents, p. 67.

80. CHAC, "Presentation to the Hall Inquiry, Health Services Review 1978-1980", p. 9.

CHAPTER V

The Congregation of The Sisters of St. Joseph of Toronto: The Later Period

1. The Congregation of the Sisters of St. Joseph

Since the Sisters first began their care of the sick in the hospitals in 1891, they have continued to offer their service despite many changes which have taken place in Canadian society, medicine, nursing and the health care system itself. The Sisters have not been passive observers of these developments, but have participated in these changes in a number of ways. They have become experts in hospital administration, have created their own Schools of Nursing, have been active in various organizations representing the interests of hospitals in general or, more specifically, Catholic concerns such as the CHAC. Sisters have trained in dietetics, housekeeping and other skills necessary to ensure their ability to offer quality health care.

Although arrangements for payments and financing of these services varied over time, they were seen as works of charity or mercy to those in need. During the 1960's this Congregation, along with many others, experienced a decline in the number of younger sisters in the novitiate.[1] The Sisters became aware that their community would experience difficulty in owning and operating institutions with

declining numbers of religious. Religious congregations and the CHAC recognized that there was a role for lay persons in hospital administration. If the Sisters were to carry on, lay persons would have to share their vision of service and help to put it into practice. In order to communicate this vision it first had to be articulated. This chapter presents a discussion of those documents which indicate the mission of the Sisters. Also, the mission statements of the Sisters of St. Joseph and the Toronto General Hospital are compared to determine the difference between them.

1.1 Statement on Catholic Philosophy in Health Care, 1983

In January 1983, a document entitled Statement on Catholic Philosophy in Health Care was published by the Sisters.[2] It provided the theological and philosophical basis for their involvement in health care. This philosophy is described as being so fundamental for a health care institution that it is their primary reason for existence.

The Sisters of St. Joseph of Toronto articulated their philosophy in terms of the following seven principles:

1. We commit ourselves as a Christian community of service, participating in the mission of the Catholic Church through the ministry of healing.[3]

The key term is a "Christian community of service". It is a community which is under Catholic sponsorship and professed identity, primarily to serve the suffering in the name of Jesus. The ministry of healing is performed according to the vision and values of Jesus, shared by

everyone (religious, laity and clergy) associated with each health care facility. Healing involves the physiological, psychological and spiritual dimensions of the person.

This "community of service" unites health care providers in an atmosphere of love and concern for those they serve and for each other. Also, services are geared to meet the changing needs of those who are served.

2. We commit our facilities to the provision of quality care for the whole person in order to heal as Jesus did.

This principle asserts the intrinsic worth of the person, having dignity given by God. The belief is expressed that the person is made in the image and likeness of God and is destined for eternal life with God.

This theological anthropology holds that the person is a unity of body, mind and spirit. It is necessary for members of the health care community to recognize the three-fold need of healing: physically, mentally and spiritually. Quality care is defined as "personalized patient care".[4] The United States Catholic Conference in their pastoral letter Health and Health Care describe personalized patient care as care for the whole person, in a way which respects human dignity.[5] The multi-faceted causes of illness should be acknowledged. Pastoral care for the person's spiritual health is highly regarded.

3. Our health care facilities provide pastoral care for patients, their families, and all persons associated with the facility.

This principle specifies pastoral care as meeting the spiritual needs of persons in the tradition of Jesus, the Good Shepherd (pastor). It is provided primarily by those especially prepared for this role, such as Chaplains, but it is shared by the whole community.

4. In the matters of ethics, our health care facilities maintain policies and procedures in accord with Catholic principles growing out of dialogue between Catholic bishops and health care providers.

Certain medical-moral issues are involved in the Catholic identity for health care institutions. In their interpretation, the Sisters state that they abide by Catholic standards of medical ethics which revere the dignity of the person from conception until death. Implications of Catholic standards of medical ethics for current clinical situations are explored in specific programs which are then included in the on-going education of those associated with their health care facilities.[6]

5. Our health care facilities maintain education and research programs consistent with and supportive of its philosophy of healing.

Educational programs include all aspects of healing: psychological, physiological and spiritual in following healing in the manner of Jesus. Education and research in the area of clinical practice is also necessary.[7]

6. Our health care facilities nurture appropriate relations with civic and religious organizations.

5. Sisters of St. Joseph: Recent Period

Civil organization is designated as a wide range of governmental, professional and private organizations concerned with the common good. The Sisters of St. Joseph acknowledge that they are guided by the Apostolate of Unity, which promotes wholeness and justice. There is a commitment to constructive cooperation with these other organizations but it is not peace at any price, meaning that the seven principles are not to be violated.[8]

7. Our facilities advance the cause of social justice.

The teachings of the Second Vatican Council and the 1971 World Synod of Bishops have instructed Catholic institutions to use their power and resources to achieve a more just society. The motivation to do this is Christian love of neighbour. This concern for the promotion of social justice is exhibited to the community-at-large by the responsible use of economic and political power for both the common good and the individual member. It is acknowledged by the Sisters that an attitude of risk-taking may be necessary to try new, untried responses to recognized needs.[9] These seven principles formed the basis for the Statements of Mission and Philosophy for Health Ministry by the Sisters in 1983.

1.2 The Statements of Mission and Philosophy for Health Ministry, 1983

The principles which were outlined in the above Statement of Catholic Philosophy in Health Care are specified in a more concrete manner in the 1983 Statements of Mission and Philosophy for Health Ministry.[10]

5. Sisters of St. Joseph: Recent Period

Religious, laity or clergy who act within or on behalf of the institutions of the Sisters of St. Joseph of Toronto participate in this health ministry. The Statements of Mission describes mission in the following manner:

> Our mission in health care is to make a positive contribution to the better ordering of human society by continuing the healing ministry of Christ through:
>
> - Unity of purpose and vision to be a Catholic presence and influence in the health care field, dedicated and faithful to the healing ministry of Christ.
> - Determination to foster the Gospel spirit of life so that our services will be characterized by compassion, concern and professional competence.
> - Respect for the wholeness and inherent dignity of each person
> - Commitment to respond realistically to changing health needs by the provision of a continuum of appropriate services.
> - Provision of efficient and effective health services of high quality with due regard to equity and without discrimination.
> - Integration of education and research with a family centered health service.
> - Adoption of whatever means are open to us to promote social justice in order to enhance the well-being of people.
> - Recognition of our obligation towards promoting a healthy, stable and life sustaining environment for ourselves and for the generations yet unborn.[11]

The Sisters acknowledge the need for a statement of philosophy which is both comprehensive and dynamic, in view of the rapid changes taking place within society. Its explicitness is helpful to those who are collaborating with the Sisters to fulfill their mission. The Statements of Philosophy and Mission expresses their philosophy in regard to four base groups constituting the network in which health ministry occurs.

The first base group is made up of health care

facilities offering preventive and curative care sponsored by the Sisters of St. Joseph. These facilities are provided to maintain the Church's mission of carrying on the work of Christ in the ministry of healing. Belief in God and the value and dignity of human life are affirmed and health, suffering, and dying are placed in a faith context. A model of the Church is offered which acknowledges the laity's involvement in the development and provision of the presence of the Church in health care.

The community or society-at-large is another base group to which the Sisters of St. Joseph express their philosophy. The Sisters acknowledge their responsibility to be a spiritual, social and economic asset to the community in which they operate. This is done by: exemplary corporate citizenship in the conduct of their affairs; an attempt to carry out their work with the highest moral, ethical and legal standards; maintaining the property they use and protecting the environment and natural resources; and supporting the concept of comprehensive health planning.

The third base group addressed is the Sisters' associates, who are mostly the lay people involved in some capacity with the health care institutions. These associates are described as precious assets who build up the organizations by attending to their professional and personal development. Their needs, dignity and desire for participation in decision-making are recognized. Because of this, job opportunities are provided in conformity with the

principles of the Ontario Human Rights Code. The principles of social justice are intended to serve as the basis for personnel policies, which include the following: the management philosophy encourages participatory decision-making and collective responsibility; the work environment is such that each person can develop her or his potential through training, work experience and continuing education; and the right of associates to their own beliefs is affirmed, even though when acting within or on behalf of the institutions, associates are expected to adhere to the philosophical, moral and social tenets of the Sisters of St. Joseph.[12]

The fourth base group in the social network is those who are served. Compassionate and concerned service within the capacity of the institution is provided to those who need help on an equitable basis regardless of race, creed, sex, disability, social or financial status. Those who cannot be helped within the specific institution will be directed to appropriate care through arrangements with other service providers. Efficiency, scientific and technical excellence are intended to be combined with human concern and care for each individual and her or his family.

The Statements of Mission and Philosophy, as a statement of intention, directs the staff and set the tone for the style of health care provided within institutions sponsored by the Sisters of St. Joseph of Toronto. Measures are taken to educate staff on an ongoing basis regarding

this vision of mission and philosophy.

1.3 Comparison of Missions: Toronto General Hospital Statement and the Sisters of St. Joseph Statements

When the Statements of Mission and Philosophy of the Sisters of St. Joseph[13] regarding their institutions are compared with the Toronto General Hospital Mission Statement, the similarities and differences become obvious. Only one mission statement of a non-denominational institution was considered for this comparison.

The Statements of Mission and Philosophy of the Sisters of St. Joseph and the Toronto General Hospital Mission Statement are similar in some aspects. However, the frameworks in which their missions operate are different. The framework for the Toronto General Hospital remains largely implicit. The mission of the Toronto General Hospital is to cure disease, treat injuries and maintain health. A commitment is made to three interrelated activities: patient care, research and education of health care providers. Patient care is to be of the highest quality, provided in a humane manner in recognition of the dignity of all individuals. It is not stated on what philosophical basis this dignity of individuals is affirmed. An objective of the hospital is to be recognized for its excellence. The hospital acknowledges its wider responsibilities to the staff, the community it serves and government.

The framework for the Sisters of St. Joseph's mission statement is located within the healing ministry of Christ.

They offer an explicitly theological framework acknowledging their place within the Church and the dignity of persons with God as the source. This affirmation of the respect for the unique dignity of each person with God as the source has implications in actual health care practices regarding the understanding of health, suffering and dying. The responsibilities to patients, staff, community and Church are developed in more detail than for the Toronto General Hospital. The activity of high quality patient care, research and education are acknowledged but within a family-centered health service. Besides the explicit theological framework, a distinct difference with the mission statement of the Sisters is their assertion to promote social justice for the enhancement of the well being of people. Even though both statements acknowledge a commitment to high quality patient care, education and research, their respective missions are different. The Statements of Mission and Philosophy for the Sisters of St. Joseph indicate a religious mission while the Toronto General Hospital Mission Statement reflects a medical and health maintenance mission.

1.4 The Constitution, 1984

The most recent Constitution was proposed in 1982 and was ratified in 1984.[14] The Statements of Mission and Philosophy for the Sisters of St. Joseph described above, reflect the affirmations expressed in this Constitution. The Directory, which is used to explain and expand what is

stated in the Constitution, points out that in order to respond effectively to actual needs in the world, the Sisters keep themselves informed of major developments in society and in the Church, applying the pastoral documents of the Church to their mission and ministry.[15] In the spirit of the renewal outlined in the Decree on the Appropriate Renewal of Religious Life, the original inspiration of the founder is referred to in this document.[16] The mission, as envisioned by Jean-Pierre Médaille for the Sisters is "to become a congregation empty of self and filled with God".[17] The 'total double union' as expressed as the 'end of the institute' in the early document is reaffirmed but stated more simply. The Sisters are "to help restore the full communion of all persons in God and with God".[18]

In continuity with their earlier works of mercy, the Sisters are to try to bring about the salvation and holiness of their neighbour.[19] However, ministry is characterized by mutual relationships, that is, 'the neighbour' also contributes to the salvation and holiness of the Sisters. It is now through ministry that the Sisters are continually challenged and called beyond themselves "by those, to whom, and with whom"[20] they are sent.

In the 1984 Constitution, a central anthropological assertion affirming the freedom and dignity of every person was made.[21] This anthropology implied a certain world view. The Congregation committed itself to the promotion of social

justice and to the acknowledgement and confrontation of injustice and oppression. This Constitution, written in the first person, stated:

> We commit ourselves to promote justice,
> by acting justly,
> and by confronting causes
> of injustice and oppression.[23]

In adopting this anthropological basis, the Sisters located themselves theologically in a position where their mission involved them in social analysis to identify injustices within the system, and, in acting to alleviate them.

1.5 A Brief to the Task Force on the Allocation of Resources to Health Care, 1984

A document which is indicative of the mission of the Sisters, embodying the social analysis and a strategic response as expressed in their 1984 Constitution, is a Brief to the Task Force on the Allocation of Resources to Health Care under the aegis of the Canadian Medical Association, in the spring of that year.[25] The philosophy and mission of the Sisters is directed in their response to the issue of allocation of resources.

The Brief to the Task Force begins with an examination of the existing socio-economic, demographic, technological and political environment of health care. The world view described identified the developed world in transition from an industrial age to a post-industrial-communications era. Three significant issues resulted from

this transition. First, an unprecedented change in the social, economic, technological and political systems has been taking place in one generation. Because of such rapid changes, many aspects of life have been in turmoil, ranging from our value systems to the nature and causes of our illnesses. Second, the growth of a medical-technological industrial complex has generated new medical technology. Third, the reality of an economic slowdown in Canada has led to governmental constraints on hospital funding leading to budgetary deficits and hospital service cutbacks.[24]

The Brief to the Task Force then draws two conclusions, based on the experience of the Sisters over the last two decades. First, they believed that the emphasis on traditionally defined medical care in the "Charter of Health for Canadians" should be changed to emphasize health status and its principal determinants.[25]

Second, and following from the first, consideration must be given to making health promotion the primary objective of public involvement in health care.[26] This concern with improving the health status of Canadians, focusing on particular segments of the population provides a different premise than just ensuring access to hospital and medical care as traditionally defined. This shift in recognition to an emphasis on health from an emphasis on sickness is influenced by four issues. First, because of demographic changes, there has been a dramatic increase in the proportion of elderly in the population. This group has a high rate of utilization of health services because of the

multiplicity, chronicity and disabling nature of their illnesses.[27] Second, the major diseases afflicting the population are increasingly behavioural and life-style related. Whereas in the past, the major diseases were acute illnesses, diseases today are long lasting, disabling, gradual in onset, and caused by several interacting factors, such as environment and lifestyle. Biomedical technology, which is relied upon heavily by the health system, is largely unsuited to deal with these changing health needs. The third issue is the increasing contribution to ill-health by environmental and occupational health hazards. The fourth issue, which is based on the other three, is that promotion of good health is a necessary element of national policy.[28] This echoes the position of the CHAC.[29] What is necessary is a total health care system where attainment and maintenance of good health is as important as the care of the sick. This need exists because present and future health problems are not caused by isolated agents, cannot be prevented solely by medical intervention and because treatment is not only expensive but often only moderately successful. Thus, while continuing to ensure access to hospital and provision of essential sickness services, the Sisters stated that monetary resources must be redirected, or new resources applied, towards health promotion and conservation of health.

Four directions for health and health care were suggested to the Task Force. First, a better balance to

deal with acute and chronic diseases is needed. Second, a better balance of resources is needed between the treatment of disease and its prevention. The creation of an environment conducive to health is suggested as the third direction for change. Finally, means must be established to encourage individuals to accept responsibility for their own health.[31]

Ill health is attributed to the structure of society and individual and social behaviour. The problem which needs to be addressed is how to alter those factors which lead to ill-health. This is a social, not a medical, problem. In order to explore the question of the allocation of resources, this broader social context must be addressed, according to the Sisters. In order to improve health and the well-being of Canadians, a change in attitudes and values needs to take place. New directions and future goals depend on a national consensus by users, providers and Government. As yet, this has not been reached.[31]

These recommendations made by the Sisters to the Task Force are in keeping with the values and principles which they have articulated in most of their recent sources. However, these comments are not unique as there are other groups who have made suggestions for changes on government policy.

2. The Identity of the Congregation of the Sisters of St. Joseph: The Later Period

The later sources of the Sisters of St. Joseph differ from the earlier sources in a number of ways. Firstly,

whereas in the earlier sources the mission of the Congregation was primarily examined through its various constitutions, in the later sources there are explicit statements of philosophy and mission. Secondly, the influence of the tenets of Catholic social teaching as articulated since Vatican II and recent addresses by the Catholic hierarchy are apparent in these statements, similar to CHAC Statements of Mission. Thirdly, the mission of the Congregation is not assumed to be solely that of the Sisters but is characterized by mutual relationships with the laity and clergy.

The Statement on Catholic Philosophy in Health Care was made available by the Sisters in 1983.[32] This is a document which theologically grounds their involvement in health care. The influence of John Paul II's address "On the Health Apostolate"[33], the United States Catholic Conference, pastoral letter, "On Health and Health Care", as well as Catholic social teaching are evident in the seven principles enunciated by the Sisters.

The first principle identifies the ministry of healing with the mission of the Catholic Church. This ministry is affirmed as being in continuity with the vision and values of Jesus. The model of mission of the Church which appears to be operative for the Sisters is, in Fiorenza's term, an 'integral mission'. The Christian community of service participates in an integral mission of the Church to transform the world as constitutive of the Gospel proclamation. The mission of the Sisters in caring for the

sick is not secondary or improper but inseparable from the concern of Jesus for the sick.

It is significant to note that even though it is the Sisters of St. Joseph who have issued the Statement, it is intended to include the 'Christian community of service', meaning the religious, laity and clergy. The enlarged role of the laity in the mission of the Sisters, as indicated in this source, is a new recognition by the Sisters.

The Sisters commit their facilities to the provision of quality care for the whole person as Jesus did and they provide pastoral care for all associated with their facility. The address by John Paul II, "On the Health Care Apostolate" in 1979 affirmed the entire tradition of the Catholic approach to caring for the sick. All dimensions of the person, including the spiritual, must be attended to for healing. John Paul II explained, "care, in fact, cannot be reduced to the strictly techno-professional aspect, but must address all elements of the human being and therefore his spiritual one."[34]

Quality care is specified as 'personalized patient care' in the pastoral letter by the United States Catholic Conference.[35] The Bishops point out that Catholic identity can be distinguished from other groups providing health care by 'personalized patient care'. The whole person should be cared for in a way which respects human dignity. The multifaceted causes of illness should be acknowledged. Pastoral care is to be regarded as important for the spiritual dimensions of a person's health. It is also

indicated by the Bishops that the identity of Catholic health care facilities can be distinguished in regard to certain medical-moral issues.[36] The Sisters affirm that in matters of ethics, they maintain policies and procedures in accord with Catholic principles which have developed out of the dialogue between Catholic bishops and health care providers.

The 1983 Statement on Catholic Philosophy commits the Sisters' health care facilities to the cause of social justice. Continuity with Vatican II and the 1971 World Synod of Bishops is acknowledged. This enlarges the scope of care. Ministry of healing involves not only caring for the individual patient but caring for the way society itself is ordered. Even though the Sisters have been active in social service, as the history of the House of Providence clearly indicates,[37] this is the first time that a source which can be taken as an indication of their mission acknowledges this orientation (other than the single instance cited by Marius Nepper S.J. in the primitive Constitutions of the Little Congregation .[38]).

The 1983 Statements of Mission and Philosophy for Health Ministry reiterates and applies the principles set out earlier in a more concrete manner. The Statements of Mission describes the mission for health ministry as making a positive contribution to the better ordering of human society by continuing the healing ministry of Christ through eight aspects of care. When earlier sources (consisting

primarily of Constitutions) are considered, the mission of the Sisters was discussed as specific works of mercy. However, these were not placed within the context of the ordering of society. The ordering of the social system was not a religious congregation's major focus. So what is notable about the Statements of Mission and Philosophy is the detailed specification of these relationships.

The Sisters of St. Joseph identify four major 'publics' with whom they are in relationship: the Church, the community, their associates and those whom they serve. Their work enables the Church to have a presence in health care. John Paul II, in his address, "On The Health Care Apostolate", stated that the Christian engaged professionally in the care of the sick gives a living testimony of Christ's love and concern for the suffering.[39] The charism of the Congregation appears most explicitly in this part of the Statement of Mission and Philosophy referring to the Church, "Through the sponsorship and operation of health care services, we testify to the place of health, suffering and dying in living out our lives in union with Christ to the glory of the Father." Here, the vision of the 'total double union' is applied to health care. The laity's involvement is acknowledged in maintaining the presence of the Church in health care.

The relationship of the Sisters to the community is one which is characterized by 'exemplary corporate citizenship' which "aspires to the highest moral, ethical and legal standards." The tone is one of cooperation. It is not clear

why the commitment to social justice, as mentioned in the Statements of Mission and Philosophy, is not developed in regard to the community, where it would seem to be most appropriate. The prophetic role of witnessing to Gospel values, which may involve confrontation or resistance, is also not mentioned.

The relationship of the Sisters to their associates which includes the health care workers, support staff and volunteers is based on the principles of social justice, acknowledging the Ontario Human Rights Code and the encouragement of participatory decision making.

The Sisters state that their facilities have been developed for those who need their services. Service is provided on an equitable basis in a compassionate and concerned manner. The criterion for service is need, regardless of financial status. The affirmation of the dignity of the person is constant throughout these relationships.

Another relationship which is not usually acknowledged is that of the Sisters to the environment. Twice in the Statements Mission and Philosophy the Sisters recognize their obligation to promote a healthy, stable and life-sustaining environment. This is an extension of 'health' care, not just to the individual and to the community but also to the non-human world. In fact, this sensitivity which acknowledges the need for environmental awareness is consistent with an approach which seeks to respect the whole

person. It is a logical extension of this perspective. The relationship of the Sisters and those who work with them can be characterized by both compassion and justice. It is the conduct and quality of these relationships where the Gospel values can be made real. That which can and has the potential to distinguish Catholic facilities from non-denominational facilities is the distinctiveness of the relationships of the health apostolate with each other and to the various 'publics'.

The significance of relationships is also a predominant feature of the 1984 Constitution. The 'total double union', as it was named earlier to indicate the charism, now commits the Sisters "to help restore the full communion of all persons in God and with God".[40] The ministry of the Sisters is characterized by mutual relationships. It is through ministry with 'neighbour' that Sisters are continually challenged. They are called beyond themselves by those to whom, and with whom they are sent.

Recognizing the freedom and dignity of every person, the Sisters are committed to promoting justice, by acting justly and by confronting the cause of injustice. The mission of the Sisters supports a model of the mission of the Church, which Fiorenza has called an 'integral mission'. The charism of this Congregation, envisioned by Jean Pierre Médaille, still provides direction as can be shown by the 1983 Statements of Mission and Philosophy and the 1984 Constitution. It is a charism which because of the scope of this vision, is adaptable to changing social conditions. It

is one that can be understood by lay people. However, it is not clear to what extent it serves as a source of improvement in the relationships of the lay health apostolate who work in facilities sponsored by the Congregation of the Sisters of St. Joseph. As the numbers of Sisters who work in the health care facilities decrease, what is the role of the charism of the Congregation within the facilities? What other influences become more significant? (An example is the contribution of the CHAC made through the colloquia and conventions passed on by in-service education programs.)

The Brief to the Task Force on the Allocation of Resources to Health Care in 1984 by the Sisters contains both an extensive social analysis and a strategic response.[41] The assumptions made in the Brief to the Task Force, regarding the emphasis on health in its many dimensions and locating the achievement of health in the social context are grounded in their 1983 Statements of Mission and Philosophy. The Congregation as health apostolate, continues its mission not only by caring for the sick and promoting health but by lobbying for changes in health policy which are to serve the future needs of the Canadian population.

The Brief to the Task Force does not refer in any way to the mission of the Sisters or to what their contribution will be in sorting out the resources-allocation issue. But the submission itself reflects a commitment to improve the

ordering of society, which is tied up with a model of 'integral mission'.

ENDNOTES

1. Canadian Catholic Health Care Leaders Face the Issues: Government Relations, Sponsorship, Catholic Identity, Medical-Moral Problems, Health Insurance Programs. (Sr. Margaret Myatt, CSJ), Hospital Progress (Oct. 1980), p. 41.

2. Sisters of St. Joseph of Toronto, Statement on Catholic Philosophy in Health Care, January, 1983.

3. Ibid., p. 1.

4. Ibid., p. 3.

5. United States Catholic Conference, "Health and Health Care", Pastoral Letter of the American Bishops Office of Development, (Washington, DC: USCC, 1981), p. 13.

6. Sisters of St. Joseph of Toronto, Statement on Catholic Philosophy in Health Care, January, 1983, p. 6.

7. Ibid., p. 7.

8. Ibid., p. 7.

9. Ibid., p. 8.

10. Sisters of St. Joseph of Toronto, Statements of Mission and Philosophy for Health Ministry, January 1983.

11. Ibid., p. 1.

12. The Ontario Government passed Bill 94 on June 20, 1986 which prohibited the practice of extra-billing. The physicians began strike action to protest this legislation. The physicians at St. Joseph's Hospital were challenged by the administration and the Board. A staff was available at all times.

13. Refer to Section 1.1.2 of this Chapter.

14 Sisters of St. Joseph of Toronto, Constitution, 1984.

15. Sisters of St. Joseph, Directory, no. 65, 3. The Directory notes that the intentions of the founder have directed their apostolic choices which are described in the following manner:

to give guidance to persons who aspire to holiness life;
to help others toward the fulfillment of their vocation as children of God;
to prepare others to find and fulfill their responsibilities in family and society;
to search out and respond to spiritual and temporal needs;
to alleviate conditions that cause alienation poverty and oppression;
to provide conditions to enable persons to recover and protect human dignity;
to encourage and prepare co-workers to share and extend our ministries;
to be willing to withdraw from an apostolic work and entrust it to others.

16. Perfectae Caritatis, n. 2; E.T. in Abbott, The Documents, p. 468. Five principles to guide the renewal are set out. The second of these explains that the best interests of the Church is served if the Communities have their own special character and purpose. The spirit of the founders are therefore to be accorded recognition.

17. Médaille, Eucharistic Letter, n. 26, n. 27.

18. Ibid., n. 22.

19. Médaille, Constitutions of the Little Congregation, p. 7.

20. Sisters of St. Joseph of Toronto, Constitution, 1984, n. 79.

21. Ibid., n. 75.

22. Ibid., n. 5.

23. Sisters of St. Joseph, "Brief to the Task Force on the Allocation of Health Resources", CHAC Review (Spring, 1984), pp. 11 - 14.
The Task Force Report on the Allocation of Health Care Resources, was called, Health, A Need For Redirection (Canadian Medical Association, 1984).

24. Ibid., p. 11.

25. The "Charter of Health for Canadians" was included in the Report of the Royal Commission on Health Services, chaired by Emmett Hall in 1964.

26. Sisters of St. Joseph of Toronto., "Brief to The Task Force on the Allocation of Health Care Resources", p.

12.

27. Ibid., p. 12.

28. Ibid, pp. 12 - 13.

29. CHAC, "Presentation to the Hall Inquiry", p.11.

30. Sisters of St. Joseph of Toronto, "Brief to the Task Force on the Allocation of Health Care Resources", pp. 13-4.

31. Ibid., p. 14.

32. Sisters of St. Joseph, Statement on Catholic Philosophy in Health Care, 1983.

33. John Paul II, "On the Health Care Apostolate", Hospital Progress, (Nov. 1979) pp. 44 - 46. Reprinted with permission from L'Osservatore Romano (July 23, 1979), p. 45.

34. Ibid., p.45.

35. United States Catholic Conference, "Health and Health Care", p.13.

36. Ibid. p. 12.

37. See Chapter 2, 2.

38. See Chapter 2, 1. Endnotes 24, 25.

39. John Paul II, "On the Health Care Apostolate," p. 45.

40. Sisters of St. Joseph, Constitution, 1984, p.

41. See Chapter 4, Section 1.5.

CONCLUSION

There are two major conclusions to be drawn from this study.

1. There is a direct correspondence between the Catholic Church's understanding of its mission and the understanding by representative groups of the Canadian health apostolate of theirs. The early sources which reveal the representative groups' mission indicate that there is some correspondence with the mission of the Church as expressed in tradtional theology. However, because of the Ignatian influence contributed by the founder of the Congregation of the Sisters of St. Joseph, Jean-Pierre Médaille, expressed as the "total double union", the fit with traditional fundamental theology is not as close as might be expected. Further study on the theology of mission expressed by other congreations during this period needs to be done in order to establish a more definitive conclusion. Likewise, the later sources reflect the changing view of the mission of the Church as understood in contemporary theology. This study demonstrates the potential usefulness of looking at history ie., reconstructing history, in this fashion.

2. Because of the increase in lay participation in assuming responsibilty as health apostolate, alternate ways

of transmitting the vision of the Church's mission in health and healing have emerged, beyond the traditional 'original inspiration' or 'charism' which directs the religious congregations. For example, the CHAC has assumed the mission of reminding Christians of their vocations as healers. The contribution of this Association is becoming increasingly important for the present and future of the Catholic health apostolate in Canada.

1. The Mission of the Church and the Mission of the Catholic Health Apostolate.

In traditional fundamental theology, the Church's mission was ordered directly and primarily to a supernatural goal, the beatific vision. The Church was considered to be a 'perfect society', which referred to its independence from every civil and political system, not to its holiness or moral perfection. Then a change took place in theological anthropology beginning with classic scholastic theology and later with the post-enlightenment period which posited a double finality for human nature. Each person was now thought to have a natural goal with its correlative natural fulfillment and an added supernatural goal with its supernatural fulfillment.[1]

When the early sources of the Sisters of St. Joseph are examined, it is necessary to read the texts in view of the context in which they were both written and understood. There is a fit of the early sources of the Sisters with fundamental traditional theology to the degree that concern for the perfection, sanctification, and salvation for

themselves and those to whom they minister, is expressed repeatedly. However, when the relationship between the sanctification and salvation of the Sisters and their view of ministry is considered, it appears from the sources that there is a close relationship between them, which is perhaps inseparable. For this Congregation, in view of their founding vision, even though there is some correspondence, there is not a neat fit with Fiorenza's interpretation of the mission of the Church within traditional fundamental theology.

The mission of the Sisters supports, to varying degrees, models of the mission of the Church outlined in contemporary theology, especially the model of integral mission. The mission of the Sisters in health care apostolate as a social-political ministry is distinctive, constitutive and essential to the Church. Fiorenza set out a basic rule in order to determine if a political or social ministry was proper or improper, permanent or substantial, official or unofficial, constitutive and essential or secondary. He stated: "the more the social or political ministry of the Church is related to Christianity's interpretative and practical function as a religion to exhibit and to proclaim Jesus as the power and wisdom of the universe, the more constitutive, essential, and distinctive this ministry is".[3]

Fiorenza argued that the Church had a proper mission in maintaining hospitals for two reasons. First, the healing

that takes place in hospitals can exhibit the love and healing of Jesus and, second, the Church can offer comprehensive health care by taking into account the medical, existential and religious dimensions of serious illness. The Church's mission in health care was therefore based on the interpretative function of religion and its explication in practice of the meaning of Jesus' life-praxis in the context of modern health care.[4] Health care belongs intrinsically to the Church's mission because its proper and fullest execution engages the religious dimension of life. It is so not simply because, "as social ministries, they [education and health care] are presuppositions of the Church's evangelization or consequences of the Church's charity."[5]

The 1984 Constitution of the Sisters of St. Joseph affirms that their mission as health care apostolate is essential and constitutive of the Church's mission. The Sisters, in 1983, produced the Statement of Catholic Philosophy in Health Care, and the Statements of Mission and Philosophy for Health Ministry, because they were aware of the need to make this relationship explicit. First, they were aware that in order to continue their mission, the laity would have to take on an increasingly larger role. The mission statements could serve as an educational tool for the staff and patients and their families. Second, the question was raised publicly and within health care apostolate, as to whether Catholic health care facilities in fact offer a style of care different from that of non-

denominational hospitals. The explicit mission statement could help maintain the viability of Catholic institutions by specifying the ways in which they are distinct. However, the mission statement is only effective to the degree that its philosophy is embodied in the provision of health care in practice.

The early sources of the CHAC presented an identity which could be described as assumed, i.e. not explicit. This identity was functional, assisting religious congregations to maintain high standards in their hospitals, to keep pace with technological change and to educate. It could be argued that, in this early phase, the antecedent associations of the CHAC, even though related to the health apostolate, were not constitutive, essential and distinctive in their ministry. Rather, in the early phases, the role of the antecedent associations of the CHAC was more closely related to the 'improper' and 'secondary' ministry of the Church in its supportive role. The Association was not specifically founded to explicate "in practice the meaning of Jesus' life-praxis in the context of modern health care,"[6] but rather to support the religious congregations. In 1964, the CHAC in its new Constitution made a commitment to promote programs for the spiritual care of the sick. At this point, the Association moved more closely into a ministry which was more constitutive and essential to the Church's ministry. In the 1979 Constitution, not only did the Statement of Mission appear, but the work of the CHAC

was described in terms of ministries. This was a new shift. These ministries were clearly involved in explicating in practice "the meaning of Jesus' life-praxis in the context of modern health care." In 1981, the new Statement of Mission most clearly substantiated this identity. The CHAC identified two new ministries: the first, to remind the followers of the Gospel of Jesus Christ of their vocation and apostolate as healers and second, to assure the viability of Catholic health care facilities and to actualize the spiritual potential in them.[7]

The Church's mission entails a political ministry because of the parallel development between the religious identity, social ministry and the political structures of society.[8] Roland Warren has described the transformation of society in relation to such features as division of labour, differentiation of interests and association, increasing systemic relationships to larger society, bureaucratization and impersonalization, transfer of function to profit enterprise and government urbanization and changing values.[9] Accompanying the developments which Warren has called the 'great change' were new forms of social interaction political domination and religious institutionalization. Correspondingly, there grew a division of wealth between those who were advantaged and those who were disadvantaged. In a less structured society, the response to this situation was charity or almsgiving. In a more highly structured society, the problems of human need are addressed by organized social systems. What was previously done by the

local group has become integrated within the larger organizational pattern of society in the form of social programs, such as, health insurance or unemployment insurance. Both the CHAC and the Sisters of St. Joseph had to face this situation. What were they to do, as health apostolate participating in the mission of the Church? The response of both groups has been political. The CHAC made a Presentation to the Hall Inquiry 1979-1980 and Statement on the Proposed 'Canada Health Act' in 1983 and the Sisters submitted their Brief to the Task Force on the Allocation of Resources to Health Care in 1984.[10] These documents both critique the existing social policy and advocate an alternate direction for social planning based on their vision of what constitutes social justice. The two representative groups of the health apostolate, in both their theory (philosophy and mission statements) and praxis (political advocacy), correspond to an understanding of the mission of the Church which is expressed in contemporary theology.

2. The Christian Vocation as Healer

The original inspiration or charism of the founder of a religious congregation provided a vision of a way of life which drew people together. The vision encouraged a particular kind of service within the Church. The Sisters of St. Joseph understand their charism in terms of the total double union as expressed in the Eucharistic Letter by Jean-Pierre Médaille.[11] His vision has encouraged the Sisters to

offer service in many different ways, especially education and health care.

However, the influence of the Sisters is decreasing for several reasons. Since the Second Vatican Council (1963-65), many people have left the religious life and only a few are choosing this vocation. Thus, there has been a decline in the numbers of Sisters available to work in the health apostolate. Also, schools of nursing run by the Sisters have been incorporated into the community college system and the universities. Catholic health care facilities cannot discriminate between non-Catholics and Catholics in their hiring practices, as long as the potential employee agrees to endorse the philosophy of the facility. As a result, many people who work in these health facilities are not Catholic. The provincial government directs health services within the province. This limits the autonomy of individual institutions in the kinds of services offered. Many Sisters who do work in Catholic health care facilities serve as administrators, which decreases their visibility within the institution.

The Sisters of St. Joseph who continue in the health apostolate share in the vision of their founder as indicated in their 1984 Constitution. But how does Jean-Pierre Medaille's vision speak to the laity who work in the Sisters' health care facilities? Is it possible to maintain Catholic health facilities without a clear vision of what is distinctive about Catholic health care? The viability of

Catholic facilities depends on many factors. However, one of the most crucial is the belief that this is a service which is distinctive and valuable within contemporary society. It is precisely this task which the CHAC has assumed by committing itself to remind Christians (and no doubt, others of different faith traditions) to their vocation as healers.

In view of contemporary modes of health care delivery, this focus on the health care worker as healer can be particularly valuable in a number of ways. First, the health care worker within a Catholic sponsored facility can, through his or her personal presence as healer, transform the facility into a mediating structure. A mediating structure is an institution which stands between the individual in her or his private sphere and the large institutions of modern society. It provides meaning and identity at a personal level and it can ensure that large institutions do not lose connection to personal needs.[12] The presence of the Sisters and the staff trained by them clearly contributed to Catholic hospitals as mediating structures in the past. However, it cannot be assured that a religiously-sponsored large health care facility serves in this way today.

When the health care facility does serve as a mediating structure, it can be beneficial to the health care worker as well as to the patients. The health care worker can envision her or his work as a vocation or calling, placing it in a larger context, rather than a mere job. By reflecting on shared assumptions and their role as healers,

health care workers can enhance their social support and identity.

The revival of the image of healer recognizes the direct link between religion, health and healing which cannot be mediated through modern medicine. There are different basic models for healing which range closer to and farther away from Catholic healing traditions, but medical models of healing have their limits. All religious faiths offer something that medicine alone is not able to convey: that is, religious healing can restore the person to health and wholeness or provide an understanding of death.

The end point of medical healing is the restoration of the person to physical or mental health, as clearly indicated in the Toronto General Hospital's mission statement. However, medicine cannot offer insight or comfort when faced with the ultimate threat to human existence which is death. Medicine is limited to physical or chemical means to relieve suffering and the limited form of understanding based on cause and effect of injury and pain. Religious belief is able to place the person into a larger reality in which to understand unrelieved suffering and inevitable death. The Christian tradition provides meaning for pain through the symbol of the cross. Through the crucifixion of Jesus Christ, human beings are shown how to find redemption in their own suffering. Belief in a God who suffered, died and was resurrected locates the individual's experience of pain and suffering in a larger,

meaningful context.

This understanding of healing is directed to laity and religious alike. If in the future the sponsorship of health facilities moves from the levels of the religious congregations to that of the diocese, the means to foster a Catholic vision of health care will still remain and it will be particularly suited to large numbers of lay people. Fostering their vision will not be an easy task for the CHAC or the religious congregations to the extent that they participate through their own vision, since Catholics in Canada have not to this point been taught to think of themselves as healers. Even though healing is central to the Catholic Charismatic Renewal groups, this has not been the case for the majority of people who participate in the health care apostolate. The contribution of this charismatic perspective within health care facilities is one possible future direction for a Catholic vision of health care. However, the future of the Catholic health apostolate, as institutional sponsor and as individuals who work within health facilities will depend on the laity embracing a vision of Catholic health care as their own, and assuming their responsibilities as healers.

ENDNOTES

1. See, Introduction, Section 3.1.
2. Sisters of St. Joseph, Constitution, 1984.
3. F. Fiorenza, Foundational Theology, p. 223.
4. Ibid., p. 225.
5. Ibid., p. 225.
6. CHAC, Mission Statement, 1984.
7. See, Chapter 4, Section 1.3.
8. F. Fiorenza, Foundational Theology, p. 228.
9. See, Chapter 3, Section 1.
10. See Chapter 4, Section 1.5; and Chapter 5, Section 1.5.
11. Médaille, Eucharistic Letter, p.40.
12. See, Chapter 3, Section 1.5.

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