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Canonical Sponsorship of Catholic Health Care in the Province of Ontario, Canada: How to Retain Catholic Organizational Identity While Delivering Quality Health Care

by

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CANONICAL SPONSORSHIP OF CATHOLIC HEALTH CARE IN THE PROVINCE OF ONTARIO, CANADA: HOW TO RETAIN CATHOLIC ORGANIZATIONAL IDENTITY WHILE DELIVERING QUALITY HEALTH CARE

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Abbreviations

AA	*Apostolicam actuositatem*
AAS	*Acta Apostolicae Sedis*
AG	*Ad gentes*
AS	*Apostolica sollicitudo*
ASMH	Archives of St. Michael's Hospital
ASS	*Acta Sanctae Sedis*
c.	canon
cc.	canons
CCC	*Catechism of the Catholic Church*
CCCB	Canadian Conference of Catholic Bishops
CCEO	*Code of Canons of the Eastern Churches*
CCLS	Canadian Canon Law Society
CD	*Christus Dominus*
CDF	Congregation for the Doctrine of the Faith
CHA	Catholic Health Association of the United States
CHAC	Catholic Health Alliance of Canada
CHAO	Catholic Health Association of Ontario
CHSO	Catholic Health Sponsors of Ontario
CIC/17	*Codex iuris canonici, Pii X Pontificis Maximi iustu digestus, Benedicti Papae XV auctoritate promulgatus*
CIC	*Codex iuris canonici auctoritate Ioannis Pauli II promulgatus*

CICLSAL	Congregation for Institutes of Consecrated Life and Societies of Apostolic Life
CL	*Christifideles laici*
CLD	Canon Law Digest
CLSA	Canon Law Society of America
CSD	Compendium of the Social Doctrine of the Church
CSJ	Congregation of St. Joseph
CSJ Toronto	The Sisters of St. Joseph of Toronto
CSJSSM	The Sisters of St. Joseph of Sault Ste. Marie
CV	*Caritas in veritate*
DV	*Dei Verbum*
EG	*Evangelii gaudium*
EM	*Ecclesiae de mysterio*
ERD	Ethical and Religious Directives
ES	*Ecclesiae sanctae*
GS	*Gaudium et spes*
HEG	Health Ethics Guide
HSRC	Health Services Restructuring Commission
HV	*Humanae vitae*
LCWR	Leadership Conference of Women Religious
LG	*Lumen gentium*
LS	*Laudato si'*
MAM	Mary Aikenhead Ministries

mp	motu proprio
MR	*Mutuae relationes*
MV	*Misericordiae vultus*
NCCB	National Conference of Catholic Bishops
OGH	Ottawa General Hospital
PB	*Pastor bonus*
PC	*Perfectae caritatis*
PDV	*Pastores dabo vobis*
PJP	public juridic person
Prot. N.	protocol number
RE	*Regimini Ecclesiae universae*
RHSJ	Religious Hospitallers of St. Joseph
RN	*Rerum novarum*
SC	*Sacrosanctum Concilium*
SDL	*Sacrae disciplinae leges*
SE	*Sollicitudo omnium Ecclesiarum*
SJHS	St. Joseph's Health System, Hamilton, ON
SRS	*Sollicitudo rei socialis*
Tanner II	N.P. TANNER (ed.), *Decrees of the Ecumenical Councils*, vol. 2
USCCB	United States Conference of Catholic Bishops

INTRODUCTION

Since Vatican II, the question of the appropriate preparation of the laity to assume responsibility for the sponsorship of apostolates in the name of the Church has been a concern both for religious institutes who have participated in the evolution of sponsorship models and for the laity, whose understanding of their call to ministry in the Church following upon their baptismal promises, has continued to evolve. The changing face of Catholic health care sponsorship models in Ontario often finds lay sponsor boards struggling to define objectively their canonical rights, duties, and obligations, and querying how to ensure their appropriate fulfillment. The principal question to be answered in this study is: can the various Catholic health care sponsors in Ontario, Canada, ensure both the preservation of Catholic identity and the delivery of quality health care within a predominantly secular social and political environment?

Four chapters in this dissertation will attempt to respond to this question. Chapter One addresses the contemporary struggle of Catholic health care sponsors in their attempts to define Catholic identity. It asks whether Catholic organizational identity can be qualified and quantified, and whether the Code of Canon Law offers guidance to Catholic health sponsors attempting to ensure that Catholic identity is clearly visible within sponsored institutions. It also addresses other issues such as: how can Catholic health care continue the healing mission of Jesus in Ontario's predominantly secular and pluralistic world? Can organizational structures support a preferred Catholic identity for Catholic

health care in Ontario? How can sponsors ensure Catholic identity within their sponsored organizations and fulfill their obligations to both external and internal constituencies?

Chapter Two examines the evolution of Ontario's health care system within the Canadian context. It spells out the place of Catholic health care in the history of Canada's health care system, showing how the sponsorship of Catholic health care has changed over the years. Is asks what have been the social and political challenges experienced by Ontario's Catholic health care sponsors and how might they respond to them in new ways in a postmodern world.[1]

Chapter Three proposes some internal organizational strategies and tools which could assist sponsors in preserving key Catholic identity criteria into the future. These include determining whether Catholic health care sponsors can identify the formation needs of lay sponsors and Catholic health care leaders? It examines sponsor formation programs that have been developed in other jurisdictions which could assist Ontario Catholic health care sponsors to preserve unique Catholic identity criteria into the future. It also addresses the issue of tools the Church offers to assist sponsors to ensure that Catholic identity is supported and recognized within their sponsored organizations.

[1] See SECOND VATICAN COUNCIL, Apostolic Constitution on the Church in the Modern World *Gaudium et spes*, 7 December 1965, in *AAS*, 58 (1966), 1025-1115, English translation in Tanner II, 1069-1135, no. 4, 1070 (= *GS*).

Finally, Chapter Four identifies potential opportunities which would both support and assist Catholic sponsored health care organizations in Ontario, so that not only can they survive, but also thrive within a secular culture whose need to experience the healing touch of Jesus is no less urgent and profound than that which was evidenced in the gospels. The impact of public funding on Catholic health care's capacity to preserve Catholic identity in a pluralistic Ontario culture is addressed, noting that there are limits to its autonomy within a publicly funded and government controlled health care environment. Another opportunity concerns the determination of key ethical issues which are impacting Catholic health care in Ontario, and determining if strategies can be developed to address these issues. A significant question to be studied here is: is there a preferred sponsorship structure which could support the mission of Catholic health care into the future?

The results of previous canonical research linking Catholic identity and sponsorship of Catholic education have been presented by previous researchers, perhaps due, in no small part, to the fact that canonical obligations and rights related to this ministry are more clearly identified in the *Code of Canon Law* (cc. 793-821). Likewise, a number of previous studies have proposed strategies to maintain Catholic identity in canonically sponsored Catholic health care institutions in other jurisdictions (USA, other Provinces in Canada). For instance, among a number of such works, J. Connolly[2] explored the then relatively new phenomenon of lay involvement in sponsorship of Catholic health care, through the

[2] J. CONNOLLY, Sponsorship of Catholic Health Care: An Adult Education Model for Preparing the Laity, EdD diss., DeKalb, Northern Illinois University, 2002 (= CONNOLLY).

perspectives of current vowed and lay sponsor members. This research identified the importance of evaluating the motivation of the laity applying to serve on Catholic health care sponsor boards. It identified key criteria for selection and formation of sponsors to reflect Catholic identity characteristics of the apostolate sponsored in the name of the Church.[3]

B. Dunn[4] investigated the canonical implications of health care institutions sponsored by the Sisters of Providence in the western United States. This study identified within this jurisdiction, the evolution of canonical sponsorship since Vatican II. The first era of sponsorship focused on control of property and assets and focused on issues arising from the McGrath/Maida debate.[5] The second stage concentrated on assisting lay sponsors to assume responsibility for the mission, Catholic identity, and governance structures of the institutions. The third and last stage presented in the study presented the challenges to Catholic identity inherent in collaboration efforts with other health care providers. While the study recommended promotion of Catholic identity through continuous leadership

[3] See CONNOLLY, 126.

[4] See B. DUNN, Sponsorship of Catholic Institutions, Particularly Health Care Institutions by the Sisters of Providence in the Western United States, JCD diss., Ottawa, Saint Paul University, 1995 (= DUNN).

[5] See R. KENNEDY, "McGrath, Maida, Michiels: Introduction to a Study of the Canonical and Civil-Law Status of Church-Related Institutions in the United States," in *The Jurist,* 50 (1990), 351-368 (= KENNEDY, McGrath, Maida, Michiels).

development, mission integration, establishment of partnership guidelines, and ensuring an active relationship with the Church,[6] it did not offer strategies to achieve these goals.

P. Gonsorcik's doctoral dissertation[7] examined the implications of both private and public juridical personality on Catholic health care, and suggested strategies for supporting Catholic health care into the future, including methods to address the pressures faced today by Catholic health care leaders and sponsors, particularly when confronted with various delicate ethical and moral issues including euthanasia, patients' rights, and responding to the needs of the uninsured in the US.[8]

From the Canadian perspective, J. Murphy addressed both governance of church institutions and the protection of Catholic identity, with particular reference to Ontario, Canada.[9] Murphy reviewed the legal manner in which ownership of temporal possessions of the Church's institutions had been safeguarded for the fulfilment of its mission in English-speaking Canada. He questioned whether present civil structures of the Church's

[6] See DUNN, 196-197.

[7] See P. GONSORCIK, The Canonical Status of Separately Incorporated Health Care Apostolates in the United States: Current Status and Future Possibilities for the Public and Private Juridic Person, JCD diss., Ottawa, Saint Paul University, 2001.

[8] See ibid., 196-236.

[9] See J. MURPHY, The Governance of Church Institutions and Protection of Catholic Identity with Particular Reference to Ontario, Canada, JCD diss., Rome, Pontificia Università Lateranense, 1995 (= MURPHY, Governance).

institutions were flexible enough to adapt to societal changes, and thus permit Catholic institutions to continue to serve Canadians while maintaining and protecting Catholic identity in a secular environment.[10] In response to these questions, the author noted that "most of the church's institutions in the province of Ontario, Canada, were incorporated at civil law and are accountable to two systems of law, one canonical and one civil, with the statutes and bylaws of an incorporated apostolate determin[ing] which acts are reserved to a decision-making body comprised of canonical stewards."[11]The significance of the Second Vatican Council in offering "a new understanding of the canonical steward's role in the care of the temporal goods of an institution," the role of the diocesan bishop as it relates to shepherding the local church and its apostolates, the stewardship of canonical administrators and defining "criteria by which reserved powers are determined and exercised by the canonical stewards,"[12] were incorporated into this research.

The New Brunswick Hospital Act of 1992 unilaterally terminated collaboration, cooperation, and partnership between the New Brunswick government and the Catholic Church in the area of health care. The take-over of Catholic hospitals, the dissolution of the individual hospital boards, and the establishment of seven regional hospital corporations, challenged and even denied the Church's right to be involved in the health

[10] See MURPHY, Governance, xiv-xvi.

[11] MURPHY, Governance, 306.

[12] Ibid., 308.

care delivery system in New Brunswick. M. McGowan's research[13] noted this legislation proved unsatisfactory to the religious institutes owning hospitals in the province, to the bishops, and to the New Brunswick Catholic Health Association. On April 21, 1993, after nearly a year of negotiations, an agreement was reached whereby Catholic hospital facilities in the province would continue to be owned by the religious institutes. While administrative control of these Catholic hospitals would come under the authority of a regional hospital corporation, provisions were introduced to safeguard Catholic mission, values, philosophy, and ethics in these hospitals. The author identified various key roles necessary in preserving Catholic health care as an apostolate of the Church, including the role of the diocesan bishop, the role of the sponsoring religious institute and its members, and the role of the laity in the health care apostolate.[14] A focus for Catholic health care of continuing to search out unmet needs was a key recommendation of this study. The author hypothesized that this focus could help to shift Catholic health care in New Brunswick from a competitive stance to one of partnerships and collaboration, both with the government and other health care providers in the province. In addition, the author noted the critical need for laity formation to assume key roles which would sustain and grow Catholic health care into the future.

[13] See M. MCGOWAN, The Canonical Status of Catholic Health Care Facilities in the Province of New Brunswick in the Light of Recent Provincial Government Legislation, JCD Diss., Ottawa, Saint Paul University, 1998 (= MCGOWAN).

[14] See ibid., 198-203.

In Australia, J. H. Thornber's research[15] was most directly linked to this area: formation of the laity. He developed both qualitative and quantitative research tools which aided in identifying critical Catholic identity criteria for canonical sponsors and formation needs of lay people currently participating in canonical sponsorship roles. From this needs-based assessment, Thornber developed a theoretical framework which could be used to address these formation needs. Findings of this study indicated that there was an urgent need for bishops, leaders of religious institutes, formators, and canonical governors to understand and address formation needs of the laity who were assuming responsibilities of canonical governance. Of greatest need was the development of tools to assist in identifying individual governance formation needs.

This present research focuses on Catholic health care in Ontario, and suggests approaches to educate and support canonical sponsors in fulfilling their unique ministry obligations and their contribution to the delivery of quality health care within the province of Ontario. Both internal and external organizational strategies which could facilitate integration of Catholic identity and values at all levels of the organization's structure, and which are based on organizational design and adult education best practice models, are proposed. Because Canada's health care system has shifted from charitable works to federally mandated and provincially financed and monitored health care systems, an

[15] See J. H. THORNBER, Cultivating Fertile Soil: Formation for Canonical Governa*nce*, PhD diss., Fitzroy, Victoria, Australian Catholic University, 2012 (= THORNBER, Cultivating Fertile Soil).

evolutionary[16] and systematic analysis[17] of Canada's health care system and the Catholic health care system in Ontario offered the research design of this study.

In the course of this research, some problems were anticipated. Having worked in Catholic health care in Ontario for over 40 years and, more particularly, in various leadership roles, we anticipated a certain degree of bias. At the same time, however, such intimate knowledge of the situation revealed unspoken and often hidden obstacles to preserving Catholic identity which could have remained invisible without such personal knowledge and experience.

It is our hope that this research will assist sponsors within Ontario and in other jurisdictions, as they examine the changing world in which Catholic health care continues the healing mission of Jesus, identifying both negotiable and non-negotiable essential Catholic identity criteria for Catholic sponsorship, and developing collaborative strategies in a pluralistic and secular world, which will support the mission of Catholic health care into the future.

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[16] See C. TUOHY, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada,* New York, Oxford University Press, 1999.

[17] See S. SALMOND and A. COOPER, "Steps in the Systematic Review Process," in C. HOLLY, S. SALMOND, and M. SAIMBERT (eds.), *Comprehensive Systematic Review for Advanced Practice Nursing*, 2nd ed.,, New York, Springer Publishing, 2017, Kindle ed., loc. 644-1148.

CHAPTER ONE: CATHOLIC IDENTITY IN HEALTH CARE

Introduction

Prior to the 1983 Code of Canon Law, the question of Catholic identity within Catholic schools and hospitals founded by religious institutes on the request of diocesan bishops, was a moot point. Religious institutes, invited by bishops to care for orphans, educate children in Catholic schools and care for the sick in the 19th Century, [18] were in many instances the sole providers of education and care for those who called themselves "Catholic."[19] Religious institutes, defined then as moral persons, [20] were largely identified as the principal sponsors of apostolic works, with no distinction or separation being made between the religious institute and the apostolate itself.

God's Spirit and Vatican II changed all of that. The documents of Vatican II, both in language and in substance, redefined the Church by "speaking as a mother, a friend and shepherd rather than as an authoritarian voice from on high."[21] Catholic health care leaders,

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[18] See F. HALPENNY and J. HAMELIN, (eds.), *Dictionary of Canadian Biography*, Toronto, University of Toronto Press, VIII (1985), 299.

[19] See M. NICOLSON, "The Other Toronto: Irish Catholics in a Victorian City, 1850-1900," in *Polyphony*, summer 1984, 19-23, http://archives.commissiondesetudiants.ca/magic/mt38.html (13 July 2016).

[20] See *Codex iuris canonici Pii X Pontificis Maximi iussu digestus Benedicti Papae XV auctoritate promulgatus*, Typis polyglottis Vaticanis, 1917, English translation: E.N. PETERS (ed.), *The 1917 Pio-Benedictine Code of Canon Law*, San Franciso, Ignatius Press, 2001, cc. 99-100. (= *CIC*/17). This translation will be used for all subsequent citations of the 1917 Code of Canon Law. Unless otherwise specified, references to the canons of the 1917 Code will be styled "*CIC/17,* c." for canon and "*CIC/17*, cc." for canons, followed by the canon number(s).

[21] C. BOUCHARD, "Catholic Health Care and Vatican II: Did Anyone Realize What Was Ahead?" in *Health Progress*, vol. 96, no. 6 (2015), 17 (= BOUCHARD, "Catholic Health Care and Vatican II").

both during Vatican II and immediately after, suggested that both Catholic health care and the Church were "emerging from isolation, incorporating laity, rethinking the role and identity of religious, providing theological depth to [their] mission, forming leaders, and laying the groundwork for the discipline of health care ethics."[22] While most of these assumptions would prove to be true, the journey from the way we were to new responses to grace suggested by Vatican II, would hold challenges that would require shared reflection and formation strategies in order to prepare the ministry for the future.

The 1983 Code of Canon Law[23] (c. 113, §1) added a new concept of juridic persons, "subjects in canon law of obligations and rights which correspond to their nature." Despite this expanded definition of persons in the Church, the intimate relationship between the apostolic works and sponsoring congregations created an undeniable link to the overall mission of the Church. In most situations, it was assumed that this model of sponsorship of ministries and apostolates would continue indefinitely.

Since Vatican II, religious congregations which founded many of the health care institutions in Canada, have seen a significant decline in their numbers.[24] Recognizing this

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[22] BOUCHARD, "Catholic Health Care and Vatican II," 18.

[23] See *Codex iuris canonici auctoritate Ioannis Pauli PP II promulgatus fontium annotatione et indice analytico-alphabetico auctus,* Libreria editrice Vaticana, 1989, English translation *Code of Canon Law: Latin-English Edition, New English Translation,* prepared under the auspices of the CLSA, Washington, DC, CLSA, 1999 (= *CIC*). This translation will be used for all subsequent citations of the 1983 Code of Canon Law. All references to the canons of the 1983 Code will be styled "c." for canon and "cc." for canons, followed by the canon number(s).

[24] See E. BERRELLEZA, M. GAUTIER, and M. GRAY, "Population Trends among Religious Institutes of Women: Special Report," Washington, DC, Georgetown University, Centre for Applied Research in the Apostolate (CARA), Fall 2014, http://cara.georgetown.edu/WomenReligious.pdf (13 July 2016).

trend, many congregations adapted their ministries to this new reality (cf. c. 677, §1). Opportunities to continue in ministry by liaising with other congregations with similar charisms and ministries were identified, and the laity were invited to respond to the call of Vatican II to live out their baptismal promises in a deeper way by assuming responsibility for apostolic works in the Church that were traditionally owned and directed primarily by religious institutes (cf. c. 225, §2). The openness of congregations to permit lay involvement in more than nominal support of the religious institute's traditional apostolates, transitioned from total control by congregations, through the creation of lay advisory boards, to lay-religious governing boards. Gradually, models of two-tiered sponsorship structures emerged, in which sponsors and members were distinguished by "reserved powers." This paved the way to the creation of sponsorship of Catholic health ministries distinct from the original congregations**.**

1.1 Is Defining Catholic Identity Possible?

While mission statements may serve to identify a group's ideals and goals and may be a tool for corporate communications, management, and strategic planning, the impact of mission statements on the organization's lived identity, remains a debate.[25] Identifying the organizational lived/living identity requires examining identity in a way which balances the organization's context. The question of whether it is possible to define Catholic identity

[25] See M. BLAIR-LOY, A. WHARTON, and J. GOODSTEIN, "Exploring the Relationship between Mission Statements and Work-Life Practices in Organizations," in *Organization Studies*, 32 (2011), 427-450, http://journals2.scholarsportal.info.proxy.bib.uottawa.ca/pdf/01708406/v32i0003/427_ etrbmsawpio.xml (13 July 2016).

has been a topic for debate by many, including Church leaders, Catholic health care sponsors, administrators, and staff.

T. Fitzgerald suggests that identity defies definition and is, rather, a process of self-engaging-with-context.[26] Context is defined as the interrelated conditions in which something exists or occurs.[27] Given the importance of context, is it possible to define Catholic identity for juridic persons or sponsors in universally acceptable, discrete, and measurable terms, or should we consider the notion of Catholic identities in the plural,[28] as there is no single way of embodying what makes an individual or a work of the Church "Catholic?"[29] In our postmodern western world, the culture in which the Church and its apostolates are sponsored exists in what appears to most to be chaotic versus a stable environment or context. "No longer can we view a culture as a unifying, unchanging, and homogenizing force … [hence] individuals have a multiplicity of potential identities because the context in which they are living, working and recreating is continually changing"[30]

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[26] See T. FITZGERALD, *Metaphors of Identity: A Culture-Communication Dialogue*, New York, Suny Press, 1992, ix.

[27] See *Merriam-Webster Dictionary*, art. Full Definition of Context, http://www.merriam-webster.com/dictionary/context (13 July 2016).

[28] See G. ARBUCKLE, *Catholic Identity or Identities? Refounding Ministries in Chaotic Times*, Collegeville, MN, Liturgical Press, 2013, Kindle ed., loc. 394 (= ARBUCKLE, *Catholic Identity or Identities?*).

[29] See P. STEINFELS, *A People Adrift: The Crisis of the Roman Catholic Church in America*, New York, Simon & Schuster, 2003, 147-148.

[30] See ARBUCKLE, *Catholic Identity or Identities?* Loc. 394.

In order to continue the ministry of Catholic health care in Ontario, in no small part due to the declining number of religious who are willing and able to assume leadership and sponsorship responsibilities, sponsorship of this apostolate is transitioning from religious institutes to sponsor boards, with the majority of the membership being lay. Until recently, episcopal confidence in Ontario's Catholic health care sponsorship models was based on the fact that these institutions operated under the aegis of canonically approved religious institutes. Today however, the changing face of sponsorship models in Ontario often leads lay sponsor boards struggling to define objectively their canonical rights and obligations, and querying how to ensure their appropriate fulfillment.

1.1.1 Canon Law: Assisting to Define Catholic Identity

To be identified publicly as "Catholic" requires consent of the competent ecclesiastical authority (cf. cc. 216, 300, 803, §3, 808). This premise assumes inculturation of Catholic values and reference to the sponsor's subordination to the Church, including its adherence to the norms of canon law and the decisions of Church authorities, especially those of the diocesan bishop. When Catholic health ministries were part of a predominantly Christian society, maintaining Catholic identity did not seem to be problematic. As evidenced in other Canadian jurisdictions (e.g., Québec, New Brunswick, Newfoundland), in an increasingly secular world where health care funding is provided by governments whose primary objective sometimes appears to be re-election vs. supporting religious, value-based, quality health care, provision of health care which adheres to appropriate canonical norms may be at best suspect, and at worst, identified as a threat to non-sectarian socio-cultural values.

Of particular canonical importance is the duty to develop mechanisms to ensure that Catholic identity is both supported and promoted by sponsors. The Code does not establish criteria for Catholicity; however canon 19 does offer some direction: "If a custom or an express prescript of universal or particular law is lacking in a certain matter, a case, unless it is penal, must be resolved in light of laws issued in similar matters, general principles of law applied with canonical equity, the jurisprudence and practice of the Roman Curia, and the common and constant opinion of learned persons." The absence of performance criteria defined by the Church for Catholic health care ministry offers sponsors ample space for developing and measuring expressions of Catholic identity within their sponsored facilities. In addition, sponsors could look to their approved statutes to provide a template of broader categories which would adequately reflect both Catholic identity and the "value-added" which Catholic health care providers are able to bring to their organizations and the Ontario health care system as a whole**.**

1.1.2 Changing Context: Changing Identity

One need only reflect on the changes in our world in the last century to recognize that the reality of our world and Church is very different from that in which Catholic apostolates, so clearly identified as part of the mission of the Church, were first established. As J. Allen suggests, "issues, party lines, and ways of doing business that have dominated Catholicism in the fifty-plus years since the close of the Second Vatican Council in 1965 have been turned on their head by a series of new forces reshaping the global Church."[31]

[31] J. ALLEN, *The Future Church: How Ten Trends are Revolutionizing the Catholic Church*, New York, Doubleday, 2009, 1 (= ALLEN, *The Future Church*).

Along with relying on dogma and a Church-community to shape individuals and our society and hence Catholic identity, Catholics are being invited to use their imagination to "rethink" the Church and the role of faith in their lives. Failure to do so will result in more rigid definitions of Catholic identity being steamrolled by context challenges rather than rising to the occasion and responding in new responses to God's grace.[32]

What are these new cultural and world challenges that will require new ways of expressing doctrine and Catholic identity generally and unique Catholic identities in Catholic sponsored apostolates including Catholic health care in Ontario? The largest percentage of those who identify as Catholics has shifted in the last 50 years from Europe and North America to Africa, Asia, and Latin America.[33] It stands to reason that defining Catholic identity, which is inherently shaped by the surrounding culture, will spawn new identities in which to express the reign of God in the world in which we live.

As the Second Vatican council called for *aggiornamento*, or an "updating designed to open up to the modern world,"[34] it also sought to reclaim its essential identity in this modern world. The assumption that peoples of the world would embrace Catholicism from "cradle to grave" is being challenged by Muslims who are now identified as the world's

[32] See ALLEN, *The Future Church*, 1.

[33] See R. SAENZ, "The Changing Demographics of Roman Catholics," in Population Reference Bureau, http://www.prb.org/Publications/Articles/2005/TheChangingDemographicsofRomanCatholics.aspx (13 July 2016).

[34] EDITOR, "Pope Speaks of Unity and the Council," in *The Criterion*, vol. 1, no. 40 (1961), 1, http://www.archindy.org/criterion/files/1961/pdfs/19610707.pdf (13 July 2016).

fastest growing religious group,[35] especially in the Middle East, Africa, and Asia as well as in Europe.[36]

Given an aging North American population, the Church, which had traditionally focused on catechesis of youth, will need to share this focus with an older North American population.[37] At this point in our history in Canada, at least two generations are un-churched. Twenty-three percent of Ontarians are not affiliated with any religion. The majority of immigrants (56%) who arrived in Canada during the 1970s were either Catholic or Protestant, with 25% begin affiliated with other religions. Since 2001, approximately 40% of new Canadian immigrants have belonged to religious minorities, equal to the number of new Canadians who identify as Catholic or Protestant. "Because immigrants comprise more than a fifth of Canada's population, the rising share of immigrants who belong to religious minorities has had a substantial impact on the religious composition of the overall population."[38] In order to assist staff and Board members of health care institutions to understand the concept of the Church's mission of healing, the impact of the unchurched and other-than-Catholic formation needs will require special attention.

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[35] See M. LIPKA and C. HACKETT, "Why Muslims Are the World's Fastest Growing Religious Group," in *PewResearchCentre*, 23 April 2015, http://www.pewresearch.org/fact-tank/2015/04/23/why-muslims-are-the-worlds-fastest-growing-religious-group/ (13 July 2016).

[36] See ALLEN, *The Future Church*, 2.

[37] See B. FRAGA, "Aging's Effects on the Church," in *Our Sunday Visitor*, https://www.osv.com/OSVNewsweekly/National/Article/TabId/717/ArtMID/13622/ArticleID/687/Agings-effects-on-the-Church.aspx (13 July 2016).

[38] See "Demographic Study," in *PewResearchCenter: Religion and Public Life*, 27 June 2013, http://www.pewforum.org/2013/06/27/canadas-changing-religious-landscape/ (13 July 2016).

Due to declining vocations to the priesthood and religious life,[39] the Church, which until recent times relied on clergy and members of religious institutes to ensure Catholic identity in its apostolates, has shifted the responsibility for them to the laity. Some would say this could be considered "grace in action," as the call of the Second Vatican Council included a desire to "strengthen the apostolic efficacy of God's people … in fact modern conditions require an even more vigorous and widespread apostolate on their part."[40] Can we see the increasing role of the laity as not simply a response to the declining number of clergy and religious, but rather as an affirmation of "the vocation that all Christians share to witness to the Gospel by deeds of love and service in the world and within the Church?"[41] As Pope Francis indicated at his March 10, 2014 conference on the laity, each member of the People of God is inseparably a disciple and a missionary.[42]

In a Church which had focused its bioethical debates on issues surrounding sexuality (abortion, birth control, and homosexuality), the Church in the modern world must now attend to a seemingly limitless cadre of ethical issues which defy simple debates

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[39] See CENTRE FOR APPLIED RESEARCH IN THE APOSTOLATE (CARA), Frequently Requested Church Statistics, http://cara.georgetown.edu/frequently-requested-Church-statistics/ (13 July 2016).

[40] SECOND VATICAN COUNCIL, Decree on the Apostolate of Lay People *Apostolicam actuositatem*, 18 November 1965, in *AAS*, 58 (1966), 837-864, English translation in N. TANNER, *Decrees of the Ecumenical Councils*, vol. II, Washington, DC, Georgetown University Press, no. 6, 981 (= *AA*).

[41] CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, "Ministerial Juridic Person: The Growing Role for Laity in Canonical Sponsorship of Catholic Health Care," in *Health Progress*, vol. 95, no. 5 (2014), 60.

[42] FRANCIS, "Pope Underlines Importance of Lay Ecclesial Bodies," in *Zenit*, 10 March 2014, https://zenit.org/articles/pope-underlines-importance-of-lay-ecclesial-bodies/ (13 July 2016).

e.g., cloning,[43] genetic enhancement,[44] trans-species chimeras,[45] gender reassignment,[46] etc. When examining these important topics, can we examine them in light of the gospel and not as the antithesis of the gospel? While we must avoid participation in immoral acts, can we consider engaging in reflections and conversations with a broad array of professionals including Church leaders, ethicists, ecclesiologists, canonists, and others, as we seek new approaches to new issues being identified as science progresses, sometimes without the benefit of moral reflection and a sense of the common good? [47]

The Church, whose social teachings took shape in the early stages of the Industrial Revolution,[48] will also need to rethink these positions in light of a twenty-first century globalized world which has morphed from local industry[49] to multi-national corporations and intergovernmental organizations.[50] While the focus of the Church and its apostolates

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[43] See J. CORREA, "Reflection on Cloning," *Pontificia Academia Pro Vita*, http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pa_acdlife_doc_30091997_clon_en.html (13 July 2016).

[44] See S. ERTELT, "Pope Benedict XVI Condemns Genetic Engineering, Designer Babies," in *LifeNews.com*, 23 February 2007, http://www.lifenews.com/2007/02/23/int-191/ (13 July 2016).

[45] See "Chimeras," in http://www.ahc.umn.edu/img/assets/25857/chimeras.pdf (13 July 2016).

[46] See M. MCQUEEN, "Catholic Teaching on Transgender," in *Canadian Catholic Bioethics Institute: Bioethics Matters*, vol. 13, no. 1, (March 2016), http://www.ccbi-utoronto.ca/wp-content/uploads/2012/03/Bioethics-Matters_MMcQueen_CatholicTeaching_Transgender_March2016_Vol141_FINAL.pdf (13 July 2016).

[47] See F. MORRISEY, "Restructuring Systems: A Call for Dialogue," in *Health Progress*, vol. 94, no. 1 (2013), 67. (= MORRISEY, "Restructuring Systems").

[48] See J. HOLLAND, *Modern Catholic Social Teaching: The Popes Confront the Industrial Age, 1740-1953*, New York, Paulist, (2003). https://books.google.ca/books?id=rbMutYO8_9EC&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false (13 July 2016).

[49] See ALLEN, *The Future Church*, 2.

[50] See GOVERNMENT OF CANADA, "Global Affairs Canada: International Organizations and Forums," http://www.international.gc.ca/cip-pic/organisations.aspx?lang=eng (13 July 2016).

was almost exclusively on human beings, the Church's lens of support is broadening to include theological and moral reflection on the entire cosmos.[51]

If anthropology suggests there is no safe mooring for the individual within a dynamic culture, is there any potential for sponsors of Catholic health care institutions to define stable expressions of Catholic identity within their institutions? It is from this shifting worldview and a pluralistic Canadian social construct[52] that some degree of specificity relating to Catholic identity supported in law must be achieved. As Őrsy suggests, "The *place* of law is in the Church of Christ where the drama of our redemption is enacted; the *role* of law is to assist the people in the reception of God's saving mysteries … the Church is both a truly human community, entrusted to human beings, and a divine mystery (cf. Eph. 5:32), the work of the Spirit."[53] Both the context in which sponsorship of Catholic health care in Ontario exists as well as the framework for normative behaviour identified in the Code of Canon Law will offer guidance in attempts to clarify fluid organizational behaviours which reflect Catholic doctrine and canonical rights and obligations of persons, both individual and juridic, in the changing world in which we live.

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[51] See FRANCIS, Encyclical Letter on Care for Our Common Home *Laudato Si'*, in *Origins*, 45 (2015-2016), 113-152.

[52] See "Pluralism, Diversity, and the Future of Citizenship: The Economic Dimension," in *The Pluralism Project: Fondation Pierre Elliott Trudeau Foundation*, http://www.pluralismcanada.ca/ (13 July 2016).

[53] See L. ŐRSY, "Theology and Canon Law," in J. BEAL, J. CORIDEN, T. GREEN (eds.) *New Commentary on the Code of Canon Law*, commissioned by the Canon Law Society of America, New York and Mahwah, NJ, Paulist Press, 2000, 1. (= ŐRSY, "Theology and Canon Law," in *New Commentary*).

1.2 Sponsorship of Catholic Apostolic Works

Sponsorship of apostolates in the Church generally and the sponsorship of the apostolate of Catholic health care in the province of Ontario specifically, require a review of their genesis and evolution within the context of the scriptures, the Church in which the apostolate is identified as a continuation of the mission of Jesus, and the societal context including evolving civil legislation associated with this apostolate. Old Testament examples of caring for the sick in the community abound.[54] In Jesus' ministry, healing the sick became both a hallmark of His ministry and a core mission for those whom he called to be disciples. He instructed them to "preach as you go, saying, 'The kingdom of heaven is at hand.' Heal the sick, raise the dead, cleanse lepers, cast out demons."[55] Like Jesus' mandate to the disciples, the continuation of this mission will be dependent on persons in the Church, united in Christ through baptism and apostolates.

1.2.1 Persons by Baptism: United in Christ through Apostolates

Through baptism, Catholics are incorporated into the Church and constituted as a person in it.[56] They are the "story of the apostolates,"[57] becoming a lived expression of the Church's mission in whatever context they find themselves.[58] "We are not bystanders but

[54] See Exodus 17:12; Deuteronomy 15:11; Psalm 30:2; Jeremiah 30:17; Ezekiel 34:16.

[55] Matt. 10:7.

[56] See c. 96, "By baptism one is incorporated into the Church of Christ and is constituted a person in it with the duties and rights which are proper to Christians in keeping with their condition, insofar as they are in ecclesiastical communion and unless a legitimately issued sanction stands in the way."

[57] See J. O'MALLEY, "All is Story," in W. MADGES & M. DALEY (eds.), *Vatican II: 50 Personal Stories*, 2013, xxi.

[58] See c. 849: "Baptism, the gateway to the sacraments and necessary for salvation by actual reception or at least by desire, is validly conferred only by a washing of true water with the proper form of

rather participants in this work."[59] All the baptized are "agents of evangelization … challenged … to be actively engaged."[60] The call of the faithful to live the mystery of Christ's merciful redemption is expressed in the apostolate of Catholic health care.[61] "Jesus understands human sufferings, he has shown the face of God's mercy, and he has bent down to heal body and soul. This is Jesus. This is his heart."[62]

Like Jesus whose response to baptism led him to his ministry of salvation, all the baptized are infused with the same desire and passion to bring the kingdom of God to birth in our midst.

> Gathered together in the people of God and established in the one body of Christ under one head, the laity, whoever they are, are called as living members to apply to the building up of the Church and to its continual sanctification all the power which they have received from the goodness of the Creator and for the Grace of the Redeemer … the apostolate of the laity is a sharing in the Church's saving mission. Through Baptism and Confirmation, all are appointed to this apostolate by the Lord himself.[63]

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words. Through baptism men and women are freed from sin, are reborn as children of God, and, *configured to Christ by an indelible character*, are incorporated into the Church [emphasis added]."

[59] See D. WUERL, "Being Catholic Today: Catholic Identity in an Age of Challenge," in *Origins*, 45, (2015-2016), 71.

[60] See FRANCIS, Apostolic Exhortation On the Proclamation of the Gospel in Today's World *Evangelii gaudium*, 24 November 2013, in *AAS*, 6 December 2013, 1019-1137, English translation in *Origins*, 43 (2013-2014) 421-465, no. 120, 440 (= *EG*).

[61] See FRANCIS, *The Church of Mercy: A Vision for the Church*, Chicago, Loyola Press, 2014, Kindle ed.

[62] Ibid., loc. 3.

[63] SECOND VATICAN COUNCIL, Dogmatic Constitution on the Church *Lumen gentium*, 21 November 1964, in *AAS*, 57 (1965), 5-75, English translation in TANNER II, 849-900, no. 33, 876 (= *EG*).

1.2.2 Sharing in Christ's *munera*

Vatican II shed new light on the mission of the Church shared with all the baptized - to bring to humanity the light of Christ.[64] Through the Council, the Church reflected on its deeper foundations. "The holy people of God shares also in Christ's prophetic office; it spreads abroad a living witness to Him, especially by means of a life of faith and charity."[65]

St. John Paul II, in his apostolic constitution promulgating the 1983 Code of Canon Law, linked the participation of the baptized faithful in the threefold functions (*munera*) of Jesus, noting "likewise the doctrine according to which all the members of the people of God, in the way suited to each of them, participate in the threefold priestly, prophetic, and kingly office of Christ."[66] The notion of engaging in apostolates as an expression of and participation in the *munera* of Jesus (c. 204) is referenced in the Code as an inherent right and responsibility of all the faithful that arises from baptism and confirmation.[67] The fruit of a personal relationship with God initiated by the grace of baptism "find visible expression within the community."[68] The purpose of apostolic activity is primarily "making the message of Christ clear to the world by word and deed and to sharing his grace."[69] Such

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[64] See *LG*, no. 1, 849.

[65] *LG*, no. 12, 858.

[66] See ST. JOHN PAUL II, Apostolic Constitution for the Promulgation of the New Code of Canon Law *Sacrae disciplinae leges*, 25 January 1983, in *AAS*, 75, Part II (1983), vii-xiv, English translation in *Code of Canon Law: Latin-English Edition*, xxvii-xxxii.

[67] See c. 225.

[68] R. KASLYN, "The Christian Faithful, (cc. 204-239)," in J. BEAL., J. CORIDEN, and T. GREEN (eds.), *New Commentary on the Code of Canon Law*, commissioned by the Canon Law Society of America, New York and Mahwah, NJ, Paulist Press, 2000, 271. (= KASLYN, "The Christian Faithful").

[69] See *AA*, no. 6, 985.

apostolic activity is to be encouraged by the diocesan bishop (c. 394) and "recognized and promoted," by pastors (c. 528, §2). "The Christian's program, the program of the good Samaritan, the program of Jesus, comes from a heart that sees where love is needed and acts accordingly."[70]

1.2.3 The Apostolate of Catholic Health Care in the North American Context

Since Jesus sent out the first 72 disciples,[71] the growing significance and complexity of His healing ministry as expressed in the sponsorship of Catholic health care in both the United States and Canada is revealed in the following statistics.

> Comprised of more than 600 hospitals and 1400 long-term care and other health facilities in all 50 states, "the Catholic health ministry is the largest group of non-profit health care providers in the nation … One in six patients in the U.S. is cared for in a Catholic Hospital.[72] Catholic hospitals often provide more public health and specialty services than other health care providers. These organizations' dedication to the common good often leads them to offer some traditionally "unprofitable" services.[73]

> Catholic health care providers in Ontario include some of the largest and most prestigious and internationally acclaimed centres of excellence in tertiary level diagnosis, treatment, education, and research; non-academic acute care providers; nursing home and homes for the aged; rehabilitation; continuing complex care; mental health and addiction services; community programming; and palliative care providers. The twenty nine Ontario Catholic health providers offer programs and services in all areas of the province.[74]

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[70] BENEDICT XVI, Encyclical Letter On Christian Love *Deus caritas est*, 25 December 2005, in *AAS*, 98 (2006), 217-232, English translation in *Origins*, 35 (2005-2006), no. 31b, 553. (= *Deus caritas est*).

[71] See Luke 10:1-23.

[72] See CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES (CHA), "Catholic Health Care in the United States," Washington, DC, CHA (2016), https://www.chausa.org/about/about/facts-statistics. (10 July 2016).

[73] See CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES (CHA), "Catholic Health Care in the United States," Washington, DC, CHA (2016), https://www.chausa.org/about/about/facts-statistics. (10 July 2016).

[74] CATHOLIC HEALTH ASSOCIATION OF ONTARIO (CHAO), "Meet the Catholic Health Care Providers in Ontario," http://www.chaont.ca/links.php (10 July 2016).

The mission to heal as Jesus healed has been continued in our Church over the centuries. "The Catholic health care ministry embraces a faith that realizes Jesus' love for us is such that it can save us from the despair that can overwhelm when we encounter chaos in our lives and, in particular, the chaos of illness."[75] As noted by Pope Benedict XVI, "Being Christian is not the result of an ethical choice or a lofty idea but the encounter with an event, a person, which gives life a new horizon and a decisive direction."[76] The congruence between the message and the messenger and the power of their actions, lies in their total identification with the message they announce. Proclaiming the good news becomes not just what they say or do but who they are.[77] If the "*role* of law is to assist the people in the reception of God's saving mysteries"[78] can we seek the guidance of the law in establishing some criteria for Catholic identity in sponsorship models of Catholic health care in Ontario?

1.3 Canonical Criteria for Sponsorship of Catholic Health Care

Despite the importance and growth of this ministry of the Church, the Code of Canon Law makes no reference to health care and its various institutions, and Vatican II rarely mentioned this important apostolate explicitly. In the intervening years, efforts have

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[75] J. BERNARDIN, "What Makes a Hospital Catholic – A Response," in *America¸* vol. 174, no. 15 (1996), 9-11, http://web.b.ebscohost.com.proxy.bib.uottawa.ca/ehost/pdfviewer/pdfviewer?sid=cb834ce0-0756-4bfe-abf6-784abc61a677%40sessionmgr120&vid=1&hid=115 (14 July 2016).

[76] *Deus caritas est,* 542.

[77] See ST. JOHN PAUL II, Encyclical Letter On the Permanent Validity of the Church's Missionary Mandate *Redemptoris missio*, 7 December 1990, in *AAS* 83 (1991), 249-340, English translation in *Origins* 20 (1990-1991), 401-416.

[78] ŐRSY, "Theology and Canon Law," in *New Commentary*, 1.

been made to "connect the lived reality of the ministry of Catholic health care with canonical norms, applied and interpreted so as to adapt the law to new situations."[79]

Since the concept of sponsorship of apostolates is not directly addressed in the Code, the question that must be asked is, "What is the inherent juridic meaning of sponsorship as it relates to sponsored Catholic healthcare apostolates?" In the United States, the following definition of sponsorship, which could easily be adopted in Canada, is operative: "Sponsorship of a health care ministry is a formal relationship, guaranteed by civil and canon law, between an authorized Catholic organization and a legally formed hospital, clinic, nursing home (or other such institution), entered into for the sake of sustaining and promoting the Church's healing ministry to people in need, especially the poor."[80] Identifying clearly defined canonical norms which support the rights and obligations inherent in this relationship will be critical in defining Catholic identity criteria for this ministry.

1.3.1 The Place of the Law in Sponsorship of Catholic Apostolic Works

It might be assumed by some that the ministry of Catholic health care, given the absence of discreet juridical norms specific to this ministry is *praeter ius*: beyond or apart from the law.[81] This interpretation would leave those entrusted with this ministry

[79] F. MORRISEY, "Trustees and Canon Law," in *Health Progress*, vol. 83, no. 6 (2002), 12. (= MORRISEY, "Trustees and Canon Law")

[80] J. HITE, *A Primer on Public Juridic Persons: Application to the Health Care Ministry*, St. Louis, The Catholic Health Association of the United States, 2000, 37. (= HITE, *A Primer*)

[81] See L. STELTEN, *Dictionary of Ecclesiastical Latin*, Peabody, MA, 1995, 320.

attempting to quantify, without the benefit of juridic norms, a distinctive Catholic health care mission, a Catholic identity "born in the heart of the Church,"[82] and the unique contributions of this apostolate within the context of the broader public system of health care. This analysis becomes increasingly important as funding for health care has moved from faith-based, charitable services to services coordinated and funded by the public purse.[83] In recent years, the repeated question from the public arena has been, "Why do Canadians fund Catholic education and Catholic health care which is limited in its scope of practice by the doctrine of the Catholic Church?"[84] Rather than shield ourselves with doctrine from such debates, the Code of Canon Law offers a framework for conversation which will afford sponsors sufficient security to consider sharing and rearticulating a new and renewed Catholic identity, rooted in the gospel and faithful to our mission, even as we continue to find new expression for this apostolate in an increasingly secular and pluralistic world context.

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[82] J. BEAL, "From the Heart of the Church to the Heart of the World: Ownership, Control and Catholic Identity of Institutional Apostolates in the United States," in R. SMITH, W. BROWN, and N. REYNOLDS, *Sponsorship in the United States Context: Theory and Praxis*, Alexandria, VA, CLSA, 32. (= BEAL, "From the Heart of the Church)

[83] See CANADIAN INSTITUTE FOR HEALTH INFORMATION (CIHI), "Total Health Expenditures by Source of Finance," https://secure.cihi.ca/free_products/2.0_TotalHealthExpenditureFinanceEN.pdf (10 July 2016).

[84] See CKNW NEWS STAFF, "Faith Based Hospitals New Centre of Doctor Assisted Death Debate," Vancouver's News. Vancouver's Talk, 25 February 2016, http://www.cknw.com/2016/02/25/ catholic-hospital/ (13 July 2016), J. GIBSON and M. TAYLOR [co-chairs], "Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying," 15 December 2016, 47, http://www.health.gov.on.ca/ en/news/bulletin/2015/docs/eagreport_20151214_en.pdf (13 July 2016). Recommendation 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and, potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory," K. OGILVIE and R. OLIPHANT [joint chairs], "Medical Assistance in Dying: A Patient-Centred Approach: Report of the Special Joint Committee on Physician-Assisted Dying,' 42nd Parliament, 1st Session, February 2016, http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8120006&File=84#21 (13 July 2016).

Perhaps the support of this apostolate without explicit juridic references offers both canonists and those engaged in the apostolate of Catholic health care, the opportunity to reflect intentionally on canon 19.[85] Examining the sponsorship of Catholic health care through this lens will serve to assist those responsible for this important ministry of the Church to focus the ministry on the mission of Christ,[86] "finding the 'yes,' so we neither abandon conscience rights or moral boundaries, nor … abandon … person[s] in [their] suffering,"[87] keeping always before our eyes the Church's mission as noted in the last canon in the Code of Canon Law: " the salvation of souls, which must always be the supreme law in the Church."[88]

1.3.1.1 The Notion of Sponsorship

The etymology of the word "sponsorship" is found in the Latin "*spondere*," meaning "to make a solemn pledge"[89] or to serve as a guarantor.[90] A sponsor is defined in legal terms as "one who acts as a surety for another; a legislator who proposes a bill; one

[85] Canon 19 "If a custom or an express prescript of universal or particular law is lacking in a certain matter, a case, unless it is penal, must be resolved in light of laws issued in similar matters, general principles of law applied with canonical equity, the jurisprudence and practice of the Roman Curia, and the common and constant opinion of learned persons."

[86] See MORRISEY, "Restructuring Systems, 66-67.

[87] G. SELF, "Bridging Two Solitudes: Two Faces of the Same Ministry," in *Health Progress*, vol. 96, no. 6 (2015), 50.

[88] c. 1752.

[89] L. STELTEN, *Dictionary of Ecclesastical Latin*, Peabody, MA, 1995, 252.

[90] See F. MORRISEY, "Toward Juridic Personality," in *Health Progress,* vol. 82, no. 4 (2001), 27. (= MORRISEY, "Toward Juridic Personality").

who voluntarily intervenes for another without being requested to do so; godparents."[91] The term "sponsorship" in relation to apostolates of the Church, entered into canonical vocabulary approximately 30 years ago. Canonically, sponsorship is associated with the sacraments (baptism and confirmation)[92] in which sponsors represent the faith community, serve as a guarantor of the faith,[93] and as a person who assumes personal responsibility for the development of the faith of the individual. Similar roles are also assumed by individuals who "sponsor" apostolates in the Church through public juridic persons.

1.3.1.2 The Bridge Between Apostolic Works and Sponsorship: Public Juridic Persons

While the terms "sponsor" and "sponsorship" as they relate to the apostolate lack a formal theological or civil legal basis, they do connote a responsibility of trust and of attending to something that is sacred.[94] Sponsorship in the Church in today's world usually entails the use of one's name, the exercise of certain governance responsibilities, and some form of accountability to Church authorities, including quality control and ownership.[95]

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[91] B. GARNER, (ed.), *Black's Law Dictionary*, 4th pocket edition, St. Paul, MN, West, 2011, 707. (= *Black's Law Dictionary*).

[92] See Baptism: cc. 851, º2, 855, 872-875, 877, §1, 893; Confirmation: cc. 892-893, 895.

[93] See c. 774, §2.

[94] See M. MCGOWAN, *Sponsorship of Catholic Health Care Organizations*, Ottawa, Catholic Health Association of Canada (CHAC), 2005, 3. (= MCGOWAN, *Sponsorship of Catholic Health Care*).

[95] See F. MORRISEY, "Various Types of Sponsorship," in R. SMITH, W. BROWN and N. REYNOLDS (eds.), *Sponsorship in the United States Context: Theory and* Praxis, Alexandria, VA, CLSA, 2006, 19. (= MORRISEY, "Various Types of Sponsorship").

Sponsorship of apostolates is rooted in the canonical notion of juridic persons, which are an "artificial construct, distinct from natural persons or material goods, constituted by a competent ecclesiastical authority, for an apostolic purpose, with a capacity for a continuous existence, and with canonical rights and duties"[96] Any examination of canon law and the canonical principles that finds lived expression in the lives and ministry of God's people will find their meaning and context from a stance of faith. One of the primary motivations for sponsorship of an apostolate in the Church is to proclaim the light of the gospel. As F. Morrisey suggests, in order to survive and thrive, the concept of sponsorship of apostolic works generally and Catholic health care specifically, must have a solid doctrinal and canonical basis,[97] including clarity on the notion of juridic persons in the 1983 Code of Canon Law.

The erection of public juridic persons to sponsor the apostolate of Catholic health care calls for the fulfillment of requirements of any public juridic person (cc. 114, 116, 610), ensuring faithful stewardship for both the ministry and the assets (c. 1284, § 1) that support the mission,[98] although the requirement for ownership of assets to ensure control

[96] R. KENNEDY, "Juridic Persons, (c. 113-123)," in J. BEAL, J. CORIDEN, and T. GREEN (eds.), *New Commentary on the Code of Canon Law*, commissioned by the Canon Law Society of America, New York and Mahwah, NJ, Paulist Press, 2000, 155. (= KENNEDY, "Juridic Persons").

[97] See F. MORRISEY, "The Church as Communion, Focused on Ministry, Part II," Canon Law/Sponsorship Institute, Dallas, TX, April 13-15, 2005, 1. (= MORRISEY, "The Church as Communion").

[98] See F. MORRISEY, "Public Juridic Persons in the Church and the Sponsorship of Charitable Works", in M. CLEARY (ed.), *Public Juridic Persons in the Church*, Marsfield, Governance & Management Pty Ltd, 2009, 13. (= MORRISEY, "Public Juridic Persons").

of an apostolate[99] is shifting to a sponsor's ability to influence the larger health care system.[100] Of particular importance for public juridic persons is the duty to develop mechanisms to ensure Catholic identity is both supported and promoted by the sponsors. The Code does not establish criteria for Catholicity,[101] but canons related to Catholic education could provide important resources in this regard (cc. 795, 803, § 2). In addition, doctrinal criteria identified for education can be extrapolated from *Ex corde Ecclesiae*.[102]

While references to juridic criteria related to Catholic education offer suggestions of comparable performance criteria or legislation specifically linking Catholic identity and the Church's apostolate of Catholic education which might by some be considered as a template for the apostolate of Catholic health care, it is also important to remember that both Book III, Title III of the 1983 Code of Canon Law as well as the apostolic constitution *Ex corde Ecclesiae* were subject to the eras in which they were created. North American Catholic hierarchy and Catholic university trustees and administration struggled with original versions of both the canons related to Catholic education and *Ex corde Ecclesiae* which "indicated the overriding concern of the Roman hierarchy for particular ways that

[99] See J.K. MURPHY, The Governance of Church Institutions and the Protection of Catholic Identity with Particular Reference to Ontario, Canada, JCD diss., Rome, Pontificia Università Lateranense, 1995, 150. (= MURPHY, The Governance of Church Institutions).

[100] See F. MORRISEY, "Various Types of Sponsorship," 19.

[101] See F. MORRISEY, "Implications of Canon Law for Catholic Leaders and Organizations," in *Catholic Leadership Program*, Guelph, Catholic Health Sponsors of Ontario, 2011, 5. (= MORRISEY, "Implications of Canon Law").

[102] See J.H. PROVOST, "The Canonical Aspects of Catholic Identity in the Light of *Ex Corde Ecclesiae*," in *Studia canonica*, 25 (1991), 155-191.

bishops could control the life of the university," and hence assure that a bona fide Catholic identity was maintained.[103]

In post Vatican II years, Catholic universities, like the apostolate of Catholic health care in North America today, were struggling to understand and articulate a distinctive mission and identity that was precisely Catholic. Their challenge was to find new ways of expressing a uniquely Catholic mission which would assure academic rigor and excellence, permit public grants which demanded university independence, and assure a unique Catholic identity distinct from founding religious institutes,[104] fulfilling both the American commitment to separation of Church and state and the mandate of Vatican II to find new ways of living the Church's mission "in the world."[105] "Although ecclesial letters and papal pronouncements had often affirmed the lay vocation, it was never very clear just what was meant by that term; the definition given in the context of Catholic Action was 'the participation of the laity in the apostolate of the hierarchy'."[106] While *Ex corde Ecclesiae* did not solve the quest for an acceptable definition of Catholic identity, "the ideals it expresses regarding the nature and mission of Catholic universities have become a resource of great value."[107]

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[103] A. GALLIN, *Negotiating Identity: Catholic Higher Education Since 1960*, Notre Dame, University of Notre Dame Press, 2000, 154. (= GALLIN, *Negotiating Identity*).

[104] See ibid., 144.

[105] See *GS*, no. 2, 1069.

[106] GALLIN, *Negotiating Identity*, 20.

[107] Ibid., 155.

On the other hand, lack of performance criteria defined by the Church for Catholic health care ministries offers sponsors ample space for developing and measuring expressions of Catholic identity within their sponsored facilities that are adaptable to the particular circumstances in which the ministry is situated. In addition, sponsors could look to their approved statutes to provide a template of broader categories which would adequately reflect Catholic identity.[108]

1.3.2 The Notion of Juridic Persons in the 1983 Code of Canon Law: Physical, Moral, and Juridic Persons

Unlike the 1917 Code of Canon Law that defined only two categories of persons (physical and moral[109]), the 1983 Code identifies three categories of persons: physical, moral, and juridic. Commentators note the Church's definition of physical "persons" is intimately connected to the sacrament of baptism[110] (cc. 96, 204) by which the individual physical person is initiated into the Body of Christ, the Church. Baptism radically alters the person's condition, creating a communion between Christ and the baptized in a deeply personal way (cc 845, §1; 849).[111] The canonical effects of personhood realized through the grace of baptism form the basis of related concepts of persons who enjoy rights and obligations defined in the Code. The Code further defines the basic rights of the physical

[108] See S. HOLLAND, "Vatican Expert Unpacks Canonical PJP Process," in *Health Progress*, vol. 92, no. 5 (2011), 56-59. (= HOLLAND, "Vatican Expert Unpacks Canonical PJP Process").

[109] *CIC/17*, c. 99.

[110] See MCINTYRE, "Physical and Juridic Persons," 138-176, G. WOODALL, *A Passion for Justice: An Introductory Guide to the Code of Canon Law*, King's Lynn, MPG Books Group, 2011, 47; (= WOODALL, *A Passion for* Justice), F. MORRISEY, "Public Juridic Persons," 15.

[111] See WOODALL, *A Passion for Justice*, 49.

person which are rooted in their inherent condition and which are impacted by age, use of reason, domicile, relationships, and rite.[112] While physical persons receive their status in the Church through baptism, the Code further defines strata of persons (moral and juridic) who enjoy additional, yet related, rights and responsibilities.

The Catholic Church, the Apostolic See in particular (excluding the Congregations, Councils and Tribunals), are noted in c. 113, §1 as having the character of a moral person by divine ordinance.[113] Moral persons include those institutions that have come into existence without the aid of a human legislator (e.g., the Catholic Church).[114] Robert Kennedy defines a moral person as a "mental construct, a collectivity thought of as a single entity which cannot be conceived of apart from the people who compose it, although moral persons can also be an accumulation of material goods or assets."[115] Although the concept of moral persons is referenced only in c. 113, §2, the existence of moral persons is implied in canons relating to associations of the faithful that have not been established as juridic persons.[116]

A canonical definition of juridic persons in general and public juridic personality specifically reveals an interesting evolution in thought and understanding related to the

[112] See cc. 96-111.

[113] See c. 113, §1.

[114] See MORRISEY, "Toward Juridic Personality," 29.

[115] KENNEDY, "Juridic Persons," 154.

[116] See ibid.

shared responsibility of all the baptized for the apostolate and mission of the Church. In the 1983 Code, juridic persons are distinct from both physical persons and material goods, and are a "creation of the law which enables people to come together to perform a work or carry out a mission they would not be able to do on their own."[117] Unlike moral persons, they are artificial, legal entities (cc. 114, §1; 115, §2; 116, §1; 121; 313), established either by law (*ex ipso iuris praescripto)* or by a competent authority (*ex speciali competentis auctoritatis concessione per decretum data)* (c. 114).

1.3.2.1 Differentiating Types of Juridic Persons: Public and Private

The distinction between public and private juridic persons was established in the 1983 Code. All juridic persons are composed of aggregates of persons (*universitates personarum*) or aggregates of things (*universitates rerum*) (c. 115). A *universitas personarum* requires at least three persons for constitution.[118] A *universitas rerum*, also known as an autonomous foundation, consists of spiritual or temporal goods or things directed according to the norms of law and statutes by one or more physical persons or a college (c. 115, §3). Juridic persons are further differentiated into private and public juridic persons. While they share some similarities, significant hallmarks distinguish important juridic differences related to foundation, mission, purpose, control of temporal goods and accountability structures.[119]

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[117] MORRISEY, "Toward Juridic Personality," 28.

[118] See MORRISEY, "Public Juridic Persons in the Church," 19.

[119] Ibid., 18-25.

1.3.2.1.1 Private Juridic Persons

Private juridic persons, whose genesis is often found in a private association of the faithful (c. 298), are constituted only by special decree of the competent authority for a particular work deemed compatible with the Church's mission.[120] The work of such groups of Catholics, while supporting the Church's mission, is accomplished without a delegated mission or mandate from the Church to the group. Statutes, recognized or approved by the competent authority, define juridic relationships and accountabilities, including the private juridic person's mission, governance structures, reporting requirements and criteria for extinction. Composition of the private juridic person, including the number of persons required for initial and ongoing ministry and accountability for temporal goods, are also defined in the statutes. This is particularly important, as the temporal goods of private juridic persons are not considered ecclesiastical goods (c. 1257, § 2). These assets are owned by the private juridic person whose statutes govern limitations on accrual, use, and disposition upon dissolution of the entity.

1.3.2.1.2 Public Juridic Persons

Public juridic persons can be constituted by law or decree of the competent authority (c. 116, § 2). Unless defined as public juridic persons in law (as, for instance, seminaries [c. 238], parishes [c. 515, § 3], and religious institutes [c. 634]), statutes describe the composition, mission, purpose, governance, and accountability structures of public

[120] See MORRISEY, "Public Juridic Persons in the Church," 18. An example of a private juridic person is the Knights of Columbus.

juridic persons within the Church.[121] To obtain official ecclesiastical recognition, the purpose (mission) of the juridic person must be deemed to offer a useful service to the Church (e.g., the spiritual or corporal works of mercy).[122] In addition, those applying for the status of juridic person must demonstrate the existence of sufficient assets (both temporal and spiritual) to achieve the foreseen goals (c. 114, § 3). Engaging in apostolic works on behalf of (in the name of) the Church, they also function within the norms of universal Church law and within the parameters of approved statutes (c. 117).

The goal of the public juridic person is to support the realization of the Church's mission to bring about the Kingdom of God through enhancement of the common good (c. 116). While responsible for mission operationalization and realization, some responsibilities may be "reserved" to another authority (e.g., "diocesan bishop or major superior of the original sponsoring organization"[123]). Ecclesiastical designation as a public juridic person also brings with it accompanying rights and obligations, including the right to sue in ecclesiastical courts as well as the potential for a suit to be brought against it.

Further distinctions within the notion of juridic persons are based on the character of decision-making processes (c. 115, §2). Collegial juridic persons, by law or by statutes, afford members participation in decision-making processes to varying degrees (e.g., conferences of bishops; the general chapter of a religious institute). As noted in c. 454,[124]

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[121] See c. 94.

[122] See "Corporal and Spiritual Works of Mercy," in *New Advent*, http://www.newadvent.org/cathen/10198d.htm (13 July 2016).

[123] See MORRISEY, "Public Juridic Persons in the Church," 18-25.

[124] Can. 454, §1: "By the law itself, diocesan bishops, those who are equivalent to them in law, and coadjutor bishops have a deliberative vote in plenary meetings of a conference of bishops. §2. Auxiliary

there is no need for equal participation in a juridic person's decisions. Participation can be direct or indirect through elected representatives. Non-collegial juridic persons include the diocese and parish, although some requirements for consultation are required for certain decisions.[125] While a clear delineation of collegial/non-collegial juridic persons would facilitate juridic processes, neither life nor canon law is ever that clear-cut. There are instances in which physical persons participate in decisions made by the juridic person, although the decisions are made by the legal representatives or members who act on behalf of a juridic person, and situations in which these same persons do not participate in the decision-making process (e.g., decisions made solely by the general superior of a congregation). Such distinctions are guided by the statutes of the juridic person (c. 115, §2).

Concurrent to application for official granting of juridic personality, statutes which must identify the juridic person's purpose, constitution, governance, and manner of accomplishing its mission (c. 94),[126] are submitted for approval to the competent authority. The status of juridic persons, granted by the competent authority, results in associated

bishops and other titular bishops who belong to a conference of bishops have a deliberative or consultative vote according to the prescripts of the statutes of the conference. Nonetheless, only those mentioned in §1 have a deliberative vote in drawing up or changing the statutes."

[125] Can. 500, §1: "It is for the diocesan bishop to convoke the presbyteral council, preside over it, and determine the questions to be treated by it or receive proposals from the members. §2. The presbyteral council possesses only a consultative vote; the diocesan bishop is to hear it in affairs of greater importance but needs its consent only in cases expressly defined by law. §3. The presbyteral council is not able to act without the diocesan bishop who alone has charge of making public those things which have been established according to the norm of §2."

[126] See J. FOX, "Introductory Thoughts About Public Ecclesiastical Juridic Persons and Their Civilly Incorporated Apostolates, in *Public Ecclesiastical Juridic Persons and Their Civilly Incorporated Apostolates in the Catholic Church (e.g., Universities, Healthcare Institutions, Social Service Agencies) in the U.S.A.: Canonical-Civil Aspects*, Rome, Pontifical University of Saint Thomas Aquinas, 1998, 243.

rights and obligations (c. 113, §2) which include the right to acquire, retain, administer, and alienate temporal goods (c. 1255). Juridic persons can sue and be sued before ecclesiastical tribunals (c. 1400, §1, °1) and, like civil corporations, they are able to act only through the physical persons identified in universal law or in their statutes.[127]

Inherently perpetual, juridic persons must transcend the lives and works of the physical persons associated with them,; they continue until they are terminated by either a decree of suppression (by the competent authority that created it or his successor) or the juridic person's inactivity for a period of a hundred continuous years (c. 120, §1). However, if only one member of a collegial public juridic person survives, the juridic person is not extinguished (c. 120, §2). Some acts of suppression require the involvement of a higher authority, for instance, suppression of institutes of consecrated life or societies of apostolic life that are reserved to the Holy See (cc. 584, 732), or the suppression of the only house of a religious institute (c. 616, §2). Certain acts of suppression require prior consultation (cc. 320, §3; 616, §1; 733, §1), with failure to consult resulting in invalidity of the act (cf. c. 127).

[127] While this can serve to protect legally the physical persons who give the juridic person life, it also poses a problem in dioceses which are constituted as a corporation sole. In these situations, the sole representative of the juridic person is the diocesan bishop. While this juridic arrangement was disapproved by the Holy See for dioceses in the United States (see SACRED CONGREGATION OF THE COUNCIL, letter addressed to the Ordinaries of the United States, 20 July 1911, in *CLD*, vol. 2, 443-447), problems with this corporate civil structure are also shared in Canada, and have been the source of many financial problems for dioceses throughout the country that have been burdened by multiple civil claims related to sexual abuse of minors. In Canada, the process of moving away from the corporation sole model has recently begun.

1.3.2.1.3 Relationship to the Church's Hierarchy

Designation of juridic status is not a right, but a concession granted by a competent authority. Through granting this status, the Church fulfills in a unique way the divine mandate to bring about the Kingdom of God on earth. Although identification of the ecclesiastical authority competent to grant juridic personality is not determined in the 1983 Code, it is implied. As McIntyre states, "since such conferral affects the public order of the Church by creating new subjects of canonical rights and obligations … a decree of issuance which is an act of executive power (cc. 35, 48) is strongly indicative of episcopal or at least quasi-episcopal power."[128] Those who enjoy such power include the Holy See, conference of bishops, and diocesan bishops. The Church establishes specific accountability measures, which both define the juridic person and assure the Church's hierarchy that the juridic person's mission, endorsed or shared by the Church, is being realized.

The category of the juridic person suggests the competent authority who would grant juridic personality for those not designated by law. The Pope, by virtue of his supreme power (c. 331), is the competent authority to grant international or universal public juridic person status. In addition, "the offices of the Holy See, the Conferences of Bishops, and the diocesan bishop for his diocese [and those granted an apostolic privilege related to associations of the Christian faithful] can also grant juridic personality to an entity."[129]

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[128] MCINTYRE, "Physical and Juridic Persons," 158.

[129] See J. F. HITE, S. HOLLAND, and F. G. MORRISEY, *A Guide to Understanding Public Juridic Persons in the Catholic Health Ministry*, St. Louis, MO, Catholic Health Association of the United States, 2012, 28. (= HITE, HOLLAND, AND MORRISEY, *Understanding Public Juridic Persons*).

Within these ecclesiastical superstructures, public juridic persons can assume varying configurations. For instance, the organizational structure of juridic persons will, of necessity, change to meet the changing nature of the Church's needs. They can be:

1) united in federations and confederations, in which each member retains its juridic identity with limited union of functions;
2) divided into separate juridic persons;
3) merged, involving one or more juridic person being absorbed by another juridic person;
4) dissolved or suppressed by competent authority, with consolidation of identity, mission, and assets in a newly created juridic entity to create a new juridic entity.[130]

[130] See D. CASTRILLON-HOYOS, "The Assets of Merged Parishes," in Origins, 36 (2006-2007), 190-191. The question of the applicability of the concept of an extinctive union, sometimes referenced when parishes are realigned by the competent authority, offers an interesting comparison for those instances in which Catholic health care sponsors are consolidated to strengthen the ministry in a newly created juridic entity. In 2006, the Congregation for the Clergy wrote to U.S. Bishops clarifying the notion of "*unio extinctiva"* or amalgamation or merger of parishes and the transfer of assets and liabilities. U.S. bishops were cautioned to consider the distinction between parish mergers or amalgamations (subject to c. 121) in which the assets and liabilities of the original juridic persons which were merged would be assumed by the new juridic entity to which they were joined, and the extinction of a public juridic person in which allocation of goods, patrimonial rights and obligations which are not governed by law or the statutes of the public juridic person would be assumed by the immediate superior, without prejudice to the intention of the founders and donors and acquired rights (c. 123). Comparable *"unio extinctiva"* was realized through the creation of the Catholic Health Sponsors of Ontario.

In 1997, three religious institutes in Ontario (the Sisters of St. Joseph of Toronto, the Grey Sisters of the Immaculate Conception, the Sisters of St. Joseph of Sault Ste. Marie), and the Catholic Health Association of Ontario came together to form the Catholic Health Sponsors of Ontario (CHSO). CHSO received pontifical public juridic person status as well as separate corporate civil status. The sponsorship of the apostolate of Catholic health care was merged while the founding religious institutes maintained their distinct pontifical juridic status. While the founding religious institutes made a financial contribution to the establishment of the new public juridic person that would assume Catholic health care formerly sponsored by the founding congregations, these congregations did not transfer assets – e.g., hospital buildings and land. Because the health care institutions owned and operated by these religious institutes had previously been civilly separately incorporated, civil responsibilities and liabilities had already been assumed by the individual civil corporate entities.

The "redesign" of public juridic persons including their assets and liabilities is a distinct juridic act accomplished in accordance with the principles of justice and equity versus a strict mathematical computation.[131] Moreover, in any public juridic person reconfiguration,[132] temporal goods and financial obligations are subject to canonical norms (cc. 638 §§3, 4; 1291-1294). In all transactions related to assets, the intentions of the founders must be carefully and faithfully fulfilled.[133] In all of these groupings and configurations of public juridic persons, the diocesan bishop continues to exercise responsibility for the works of the Church within his diocese (c. 394, §1). As the composition of persons responsible for apostolic works in the Church changes, appropriate formation with a focus on limits of executive authority also becomes increasingly important. To this day, the authority of the Church to direct and control apostolates granted public juridic personality must be reinforced, lest civil corporate status disenfranchise the Church's primary position of responsibility for the ways its mission is carried out.

For public juridic personality to be granted by competent authority (as distinct from such personality granted by law) the entity must have statutes, i.e. its internal governing documents. Like civil articles of incorporation, these statutes outline the purpose, organizational structure, authority, governing principles, and modes of operation of juridic

[131] See KENNEDY, "Juridic Persons," 170.

[132] *Black's Law Dictionary* offers the following definition of consolidation of corporations, which by analogy could be applied to unification and merger of public juridic persons: "The unification of two or more corporations or other organizations by dissolving the existing ones and creating a single new corporation or organization" (*Black's Law Dictionary*, 151).

[133] See cc. 121, 1257-1259, 1267, §3, 1284, §2, 4º.

persons (cc. 94, 304, 451). They include the rights and duties of members, relationships with the founding institute(s), the diocesan bishop and the Holy See, and identify the types of financial transactions that are considered acts of extraordinary administration (c. 1281, §1), and thereby subject to invalidating laws. The manner in which finance councils or financial advisors assist in the administration of goods are also identified in the statutes. Unlike private juridic persons who operate in their own name and not in the name of the Church and whose assets are, in principle, not considered Church property,[134] public juridic persons act as stewards for both the Church's mission and assets. Assets (temporal holdings) are not owned by the individual physical persons who relate in some fashion to the juridic person. The members access resources that are rightly owned by the Church, and have been procured to accomplish a specific apostolate, thereby realizing through this particular apostolate, the mission of the Church. These assets are owned by a single legal construct - the juridic person who acts on behalf of the Church.[135]

The disposition of assets upon dissolution or wind-up of a public juridic person requires special attention. Like private juridic persons, public juridic persons can be extinguished by decree or inactivity for one hundred continuous years. However, a private juridic person "is dissolved according to the norm of its statutes or if, in the judgement of the competent authority, the foundation has ceased to exist according to the norm of its

[134] See HITE, HOLLAND, AND MORRISEY, *Understanding Public Juridic Persons* 33.

[135] See J. J. DANAGHER, "The New Code and Catholic Health Facilities: Fundamental Obligations of Administrators," in *The Jurist*, 44 (1984), 143.

statutes."[136] Allocation of temporal goods can also be mandated by proper law. If there is no designation by universal or particular law,[137] and the allocation of assets is not addressed in the statutes of the public juridic person, these assets and liabilities are transferred to the immediate superior public juridic person (c. 123). Of special importance to Catholic health care sponsors is the fact that this relationship of superiority exists only among hierarchically ordered juridic persons. Dioceses are juridically subject to the Holy See; religious houses are juridically subject to their province or generalate. Other juridic persons, such as public associations of the faithful, universities, and hospitals that have been erected as public juridic persons or autonomous foundations, do not have a superior juridic person. This same issue was noted in the 1917 Code. Commentaries on *CIC/17*, c. 1501 recognized this and proposed the solution that, upon dissolution, the assets and liabilities of the juridic person should be transferred to the ecclesiastical authority who issued the decree of erection.[138]

R. Kennedy suggests jurisprudence developed under prior law should be followed (cf. c. 6, §2). The assets and liabilities of public juridic persons which have no immediate superior, upon extinction, are transferred therefore to the diocese, the conference of bishops, or the Holy See. It is important to note that, if sponsors expect assets of a hospital, college, or other institution erected by a religious institute to return to the founding

[136] Canon 120.

[137] The Code reserves to the Apostolic See the responsibility for determining the disposition of temporal goods in the case of the suppression of institutes of consecrated life, societies of apostolic life and the suppression of the only house of a religious institute (cc. 584, 732, 616, §2, respectively).

[138] See T. BOUSCAREN and A. ELLIS, *Canon Law: A Text and Commentary*, Milwaukee, WI, Bruce Publishing, 1951, 804.

religious institute upon suppression of the juridic person, such stipulations must be embodied in the statutes of the juridic person. Otherwise, the assets and liabilities, according to canonical tradition, would be subject instead to transfer to the diocese.[139] The disposition of assets is also subject to provisions noted in applicable civil legislation. This highlights the importance of carefully drafting the statutes and civil corporate bylaws.

1.4 Particular Criteria to Be Applied in Catholic Health Care Institutions

Sponsorship of apostolates generally, and of health care apostolates specifically, requires more than good hearts and willing spirits. Juridic sponsorship demands knowledge and skill in both canonical and civil domains. When religious institutes were invited to dioceses by local bishops and asked to care for the people in the community who were injured or ill, they responded to their baptismal and religious vocation to do as Jesus did, bringing healing to the physically, emotionally, and spiritually poor.[140] At the same time, those engaged in sponsored apostolates have seen their ministry transition from those locally focused good works to national and multi-national ministries that demand both political and business acumen, rooted in the gospel. This is no small order for anyone, especially in today's political and pluralistic society.

[139] See KENNEDY, "Juridic Persons," 172.

[140] See Matt. 11: 4-5.

To examine those areas that require special attention by Catholic health care sponsors, institution boards, and administration, it will be important to focus on three main areas in which the Church offers both norms and supportive guidance:

1) Catholic identity;
2) Opportunities and limitation of partnerships in general and specifically, partnership with non-Catholic entities including ethical reflection and adherence to the Catholic *Health Ethics Guide*[141] or equivalent documents which will be dealt with later in this dissertation; and
3) Safeguarding ownership of ecclesiastical goods.

1.4.1 Fundamentals of Catholic Identity: Lived vs. Prescribed

The Congregation for Institutes of Consecrated Life and for Societies of Apostolic Life has established norms for application for juridic status,[142] but "There is more to the life of the Church than simply laws and institutions. The law presupposes both faith and commitment."[143] As noted by Brodeur, one of the greatest challenges for the apostolate of Catholic health care is not simply to address the complex difficulties of modern health care institutions, but to incorporate these institutions into the larger healing ministry which includes sacramental life, issues of justice and charity, and the other social ministries of the Church.[144] Apostolates of the Church must promote the common good.[145] Specifically,

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[141] See CHAC, *Health Ethics Guide*, Ottawa, CHAC, 2012 (= CHAC, *Health Ethics Guide*).

[142] See HITE, HOLLAND, and MORRISEY, *Understanding Public Juridic Persons,*70-71.

[143] See MORRISEY, "Implications of Canon Law for Catholic Leaders and Organizations," 6.

[144] See BRODEUR, "Catholic Health Care," 9.

[145] See ibid., 10.

Catholic health care must exhibit a preferential option for the poor, ensure "that work provides opportunities to break down the barriers between those who have power – often the owners and managers – and those who have less power … evidence solidarity … appropriate stewardship of resources, justice and economic matters both for employees … for patients and their families … [and] reflect subsidiarity."[146]

Francis Morrisey[147] notes that the canonical obligations of sponsors are directly related to the institution/group/ministry, authorized by a competent ecclesiastical authority in order to be identified as "Catholic" (cc. 216, 300, 803, §3, 808). Catholic identity must be clearly distinguished. This includes inculturation of Catholic values and reference to the sponsor's subordination to the Church, including its subjection to the norms of canon law and to the decisions of the Church authorities,[148] especially the diocesan bishop. The faithful in the community being served must perceive the work of the public juridic person as "Catholic" (operating under the auspices of the Church). From this perception, they may view both the sponsor and the apostolate as meriting their trust. While not prescribed in law, external signs of Catholicity (Catholic traditions, religious signs, the name of the organization) should establish an overt expression of the apostolate's existence in the Church and serve as an expression of the Church's mission (operating in the name of the Church).[149]

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[146] Ibid.

[147] See MORRISEY, "Implications of Canon Law," 6-9.

[148] See J. RENKEN, *Church Property: A Commentary on Canon Law Governing Temporal Goods in the United States and Canada*, New York, St. Paul/Alba House, 2009, 11 (= RENKEN, *Church Property*).

[149] See MORRISEY, "Implications of Canon Law," 6.

1.4.2 Linking Public Funding and Canonical Responsibilities

The ministry of Catholic health care has evolved within a publicly subsidized political system. Competition for scarce resources including government interventions has encouraged or mandated partnerships with non-faith-based providers. In some situations, this has proven to be a great opportunity, and in others, an insurmountable obstacle. Establishing parameters for negotiating partnerships is critical for ensuring that the Catholic mission and ministry are not compromised. Sponsored apostolates must reflect the Church's desire to heal as Jesus healed, responding to situations of illness and suffering by caring for the whole person versus healing of symptoms,[150] and respect for life in all of its moments.[151]

The Church in its wisdom has recognized and sought to address both canonical and civil legal ramifications of evolving models of sponsorship, redefining both obligations and rights of public juridic persons concomitant with increasing involvement of the laity, both in response to the call of Vatican II for shared responsibility for the apostolate with the laity, and secondary to diminishing numbers of religious who were willing and able to provide the leadership and direction required.[152] As the role of laity has increased, a question often asked by the Church has been, "Are the laity prepared to take on this responsibility, and "Do the laity who serve on sponsor boards understand their canonical

[150] See Matt. 9:2-8.

[151] See Matt. 6:38-42.

[152] See MORRISEY, "Public Juridic Persons," 26-28.

rights and obligations? [153] In an age and in an environment where Catholic health care is no longer considered by the general public as an apostolic work of charity and an expression of the Church's mission to continue the healing ministry of Jesus, but rather is often viewed simply as a civilly funded and legislated public service, are there limits to what sponsors of Catholic health care can consider?

1.4.2.1 Partnership Opportunities and Limitations

Sponsorship of apostolic works through designation of public juridic person status requires a formal association with the Church and identification of the apostolate as a ministry of the Church (as distinct from the work of Catholics). These requirements will subsequently influence the apostolate itself as well as external relationships and partnerships that can be considered. A *dubium*[154] or question regarding partnerships between sponsored Catholic health care ministries and non-Catholic health care providers was raised by the then president of the United States Conference of Catholic Bishops, Cardinal Timothy Dolan regarding partnerships between Catholic and non-Catholic health systems that could lead to the transformation of a Catholic health system into a non-Catholic health system.[155] Rather than responding directly to the questions raised by the USCCB, Cardinal Gerhard Müller, prefect of the Congregation for the Doctrine of the Faith (CDF), issued a letter outlining a set of principles entitled, "Some Principles for

[153] HOLLAND, "Vatican Expert Unpacks Canonical PJP Process," 59.

[154] See L. STELTEN, *Dictionary of Ecclesiastical Latin*, Peabody, MA, Hendrickson, 1995, 91.

[155] See P. CATALDO, "A Commentary on Collaboration with Non-Catholic Entities in Health Care Services," in *Origins*, 44 (2014-2015), 432 (= CATALDO, "A Commentary on Collaboration").

Collaboration with Non-Catholic Entities in the Provision of Health Care Services."[156] While affirming that sponsors of Catholic health care services are morally prohibited from cooperating with evil, the document offers a moral guide to defining cooperation.[157]

Formal cooperation is always impermissible due to the intention to support the immoral act of the principal agent "either as the ultimate goal or as a means to a good end."[158] In other words, the "good" ends cannot justify "immoral" means.[159] The CDF then distinguishes a new category of material cooperation which does not intend the principal act and the cooperation is not essentially bound to the essential circumstances of the immoral act itself and has a proportionate reason.[160] Of greatest importance in this document is the CDF recognition that, "In today's world, due in no small part to advances in medical technology and related costs, effective engagement in healthcare often calls for collaboration with non-Catholic healthcare institutions, even establishing joint working arrangements in which the Catholic and non-Catholic entities are full partners."[161]

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[156] See CONGREGATION FOR THE DOCTRINE OF THE FAITH, "Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services," in *National Catholic Bioethics Quarterly*, Summer (2014), 337-340 (= CDF, "Some Principles for Collaboration").

[157] See CATALDO, "A Commentary on Collaboration," 432.

[158] See ibid.

[159] See P. HARRIS, "Machiavelli and the Global Compass: Ends and Means in Ethics and Leadership," in *Journal of Business Ethics*, 93 (2010), 131-138, http://journals1.scholarsportal.info.proxy.bib.uottawa.ca/pdf/01674544/v93inone_1/131_matgceamieal.xml (13 July 2016).

[160] See CATALDO, "A Commentary on Collaboration," 432.

[161] CDF, "Some Principles for Collaboration," 337.

Such partnerships may leave both the Church's hierarchy responsible for ensuring the Catholic apostolate reflects Catholic identity, social teaching, and ethical principles (c. 394), as well as the laity engaged in new sponsorship models of partnership, querying "how far can we go" before a particular partnership suggests formal cooperation with immoral acts? As the CDF suggests, those involved in oversight and governance of Catholic institutions "must do everything they can to ensure that the witness of the Church is not adversely affected … [ensuring] that the Church's involvement in healthcare does not give scandal, whether to fellow Catholics and Christians or to other persons of good will who look to the Church, however obliquely, for moral guidance."[162]

The CDF offers principles for bishops, sponsors, boards, and administrators of Catholic health care institutions which can serve as a template for reflection prior to engaging in partnership relationships with non-Catholic institutions for the sake of the mission.[163] In addition, further comments on these principles are offered by Peter Cataldo, chief health care ethicist for the Archdiocese of Boston, which were included in remarks made at the 29 August 2014 consultation on the CDF principles, sponsored by the Catholic Health Association.[164]

While the "Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care" is generally a welcomed guideline for all Catholic health care sponsors,

[162] CDF, "Some Principles for Collaboration," 337-338.

[163] See ibid., 338-340.

[164] See ibid.

boards, administrators, and staff, it is clear that the complexity of ethical reflection required prior to engaging in partnerships with non-Catholic entities and throughout the duration of such formalized relationships, would require the support of well-trained ethicists, canonists, and ongoing dialogue with diocesan bishops responsible for Catholic apostolates in their diocese.

1.4.3 Safeguarding Ownership of Ecclesiastical Property

The concept of canonical ownership refers to the notion of *dominium* in Roman law. "Ownership, in the developed law, may be defined as the unrestricted right of control over a physical thing, and whoever has this right can claim the thing he owns wherever it is and no matter who possesses it."[165] The Church as a moral person (c. 113, §1), has the right, under the supreme authority of the Roman Pontiff (c. 1256),[166] to own temporal goods for the support and realization of their mission[167] (see c. 1254, § 2). For public juridic persons (c. 116), temporal goods are referred to as ecclesiastical goods (c. 1257, §1).[168]

Accordingly, canonical ownership is defined as a four-fold juridic relation of the Church to temporal goods and includes the capacity to acquire (obtain ownership), retain

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[165] H.F. JOLOWICZ, *Historical Introduction to the Study of Roman Law*, Cambridge, MA, University Press, 1952, 142.

[166] See J.O. MUDD, "Leaders Hand on the Tradition: More Questions, Needs Emerge," in *Health Progress*, vol. 92, no. 2 (2011), 133.

[167] See J.A. RENKEN, "The Principles Guiding the Care of Church Property," in *The Jurist*, 68 (2008), 136.

[168] See J. RENKEN, "To Care for Church Property Today: Canonical Responses to Common Contemporary Challenges," in *Proceedings of the Seventy-Seventh Annual Convention*, Washington, DC, CLSA, 2016, 272 (= RENKEN, "To Care for Church Property Today").

(keep goods as possessors), administer (use goods for their proper purposes and to bear fruit), and alienate (lose ownerships or to convey them to other owners)[169] temporal goods in order to fulfill the purposes which are proper to the Church (see c. 1254, §1).[170] Fulfilling juridic obligations related to ecclesiastical goods usually requires administrators to act in an "ordinary" fashion as noted in c. 1284. Further details regarding parameters of authority for administrators dealing with ecclesiastical goods should be delineated in statutes (c. 1281, §2) and policies of executive limitation,[171] which would normally define acts that are "extraordinary," and should indicate that the administrator would need the involvement of one or more other physical persons, whether as individuals or as members of a group, to perform the act according to law.[172] Reference to the requirements of cc. 1291-1294 should be included in the statutes of public juridic persons, and must be observed in cases of alienation of ecclesiastical goods as well as in any transaction which may worsen the patrimonial condition of the juridic person (c. 1295).[173]

The questions of how to define stable patrimony and how to determine if stable patrimony is jeopardized have been raised by many charged with the responsibility of canonical oversight (sponsorship) of a public juridic person. All aggregates of persons (*universitates personarum*) or aggregates of things (*universitates rerum*), prior to receiving

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[169] See RENKEN, "To Care for Church Property Today," 273.

[170] See MURPHY, The Governance of Church Institutions, 133.

[171] See J. CARVER and M. CARVER, "Executive Limitations Policies: Tow Errors to Avoid," in *Board Leadership: Policy Governance in Action*, January/February (2006), http://journals2.scholarsportal.info.proxy.bib.uottawa.ca/pdf/10614249/v2006i0084/1_elpteta.xml (20 July 2016).

[172] RENKEN, "To Care for Church Property Today," 273; See also c. 1295.

[173] See RENKEN, "To Care for Church Property Today," 290.

designation as a public juridic person from a competent ecclesiastical authority, must provide evidence that their intended purpose is truly useful, and, all things considered, that they possess the means which are foreseen to achieve the designated purpose.[174]

As J. Renken notes, "competent ecclesiastical authority, by a positive act of the will and according to the law, must designate an ecclesiastical good as belonging to the stable patrimony of a public juridic person. Stable patrimony does not come into existence 'by accident'."[175] If there is no proof that an ecclesiastical good has been legitimately designated as stable patrimony, a presumption is made according to c. 1584 which offers administrators the capacity to make a "probable conjecture about an uncertain matter," concluding that the ecclesiastical good is non-stable patrimony. No method other than lawful designation exists to distinguish stable from non-stable patrimony. However, certain goods, by their very nature, are included in the stable patrimony of public juridic persons: these include buildings (health care facilities) and other immovable goods on which the current and future existence of the public juridic person depends for its existence.[176] While the argument could be made that the designation of stable patrimony could be established by custom,[177] discussion of this passive model of designating stable patrimony exceeds the scope of this dissertation. In the final analysis, we would suggest that stable patrimony of

[174] See c. 114, §3.

[175] See J. RENKEN, "The Stable Patrimony of Public Juridic Persons," in *The Jurist*, 70 (2010), 149. (= RENKEN, "The Stable Patrimony of Public Juridic Persons").

[176] RENKEN, "The Stable Patrimony of Public Juridic Persons," 149.

[177] See J. HUELS, "Title II, Custom, (cc. 23-28)" in J. BEAL, J. CORIDEN, and T. GREEN (eds.), *New Commentary on The Code of Canon Law*, commissioned by the CANON LAW SOCIETY OF AMERICA, New York and Mahwah, NJ, Paulist Press, 2000, 86-87.

movable and immovable ecclesiastical property must be clearly designated (cc. 1285, 1291-1294).[178] Authority competent to designate stable patrimony should be identified in the statutes of the public juridic person (c. 117)[179]

While the Code attempts to remind all the baptized that temporal goods require careful stewardship to ensure the Church has the necessary resources to achieve its mission, history suggests that interpreting the definition of ecclesiastical property can be subject to personal bias. The now-famous McGrath-Maida debate[180] evolved around the ownership of ecclesiastical property if/when the status of the religious institute was expanded to include civil incorporation, such as has occurred with universities and health care institutions. In 1968, Monsignor John McGrath, associate professor of comparative law at Catholic University, Washington, DC, published a book on the civil and canonical status of institutions "operating under Catholic auspices and incorporated civilly. He contended that civilly incorporated institutions are juridically distinct from the Church … therefore, they are not subject to the norms of Church law on temporal goods, although they are 'Church-related'."[181] Therefore, civil incorporation of these institutions established separation of the apostolate from Church jurisdiction and legislation, severing any Church claim of legitimate authority over the temporal goods of these organizations. For McGrath, canon law considered temporal goods as ecclesiastical only when an ecclesiastical moral

[178] See RENKEN, *Church Property*, 23-24.

[179] See KENNEDY, "Juridic Persons," 162.

[180] See KENNEDY, McGrath et al, 351-368.

[181] RENKEN, *Church Property*, 42.

person owned them. In his opinion, civil incorporation nullified any ecclesiastically established juridic relationship, making the apostolate subject only to civil law with no recognition nor protection of assets on the part of ecclesiastical authorities and norms.

This definition led some Catholic universities and hospitals in the United States to alienate property and assets without appropriate canonical approvals. Once dispersed, Church control over sold goods was legally lost to the realm of civil law, and canonical control was called into question. Only careful and planned rebuttals prepared by Father A. Maida (then finance director of the Diocese of Pittsburgh) showed that separate civil incorporation had no canonical effect on ownership of temporal goods.[182] This debate was, in all likelihood, a motivating factor in the Church's efforts to state more clearly in the revised Code of Canon Law, canons specifically intended to guide all the faithful in the protection and care of Church property (see, for instance, c. 1284, § 2, 2º).

Sponsorship involving public juridic persons requires the care and protection of ecclesiastical (temporal) goods through reserved powers[183] referring both to non-stable patrimony (liquid capital) and stable patrimony (destined for the long-term support of the members and the ministry) (see c. 1254). Canon 1283 requires a detailed inventory of all

[182] See A. MAIDA, *Ownership, Control and Sponsorship of Catholic Institutions: A Practical Guide*, Harrisburg, PA, Pennsylvania Catholic Conference, 1975, 32-35. Maida noted that the apostolic works of sponsors are part of the assets and apostolate of the founding religious body, despite separate incorporation in civil law.

[183] See HOLLAND, "Vatican Expert Unpacks Canonical PJP Process," 52.

property, listing three categories of assets: immovable property, moveable objects (precious or of cultural value), and other goods (to be described and appraised).[184]

1.4.4 Accountability to Ecclesiastical and Secular Authorities

The Code points out that public juridic persons have both rights and obligations (c. 113 § 2).[185] Inherent with any rights are presupposed obligations. Public juridic persons have both ecclesiastical and secular authorities who demand accountability.

While the Church would consider civil law as subordinate to Church law,[186] accountability frameworks for both ecclesiastical and secular authorities are essential to ensure transparency, order, and realization of the Church's mission within a social context. In addition, the designation of the Church generally, and of public juridic persons specifically, as registered charities within the civil domain, compounds opportunities and accountability requirements.[187]

All public juridic persons have canonical accountability requirements that are defined by the competent authority who has granted juridic personality, be they juridic persons of pontifical, national, or diocesan right. Accountability requirements are enshrined in canonical statutes and civil bylaws. Traditionally, the authority competent to

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[184] See F. G. MORRISEY, "What is Stable Patrimony?" in *Health Progress*, vol. 89, no. 2 (2008), 14.

[185] See J.A. ALESANDRO, "The Code of Canon Law: Twenty-Five Years Later," in *New Theology Review*, vol. 21, no. 2 (2008), 8.

[186] See ibid., 12.

[187] See CANADA REVENUE AGENCY, Policy Statement, Reference Number CPS-022 (2 September 2003), http://www.cra-arc.gc.ca/chrts-gvng/chrts/plcy/cps/cps-022-eng.html (12 January 2013).

grant juridic personality also approves the public juridic person's statutes and authorizes certain acts of alienation of goods. For apostolates of religious institutes of pontifical right, the Holy See, specifically the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life (CICLSAL),[188] has exercised this function. Designation as pontifical public juridic persons (including Catholic charities)[189] brings with it an inherent accountability to the Holy See. Although no canons identify specific reporting structures to fulfill this responsibility, by analogy, these conditions can be inferred in c. 816 § 2. Reports to the Holy See will typically include those areas identified in approved canonical statutes.

Bishops exercise authority over ministries in their dioceses which are identified as Catholic and which fulfill the Church's saving mission (c. 394). While the supreme moderators of religious institutes maintain authority for the apostolic works of their congregations (c. 622), each institute remains faithful and accountable to both the diocesan bishop (cc. 738, § 3, 790, § 1) and to the Holy See (cc. 589, 590, §1). Moreover, public juridic persons maintain a close affinity and accountability mechanism with the founding congregation(s). The extent of this relationship is determined in the statutes of the public juridic person.

[188] See HITE, HOLLAND, and MORRISEY, *Understanding Public Juridic Persons,* 68.

[189] See BENEDICT XVI, Apostolic Letter issued Motu Proprio On the Service of Charity *Intima Ecclesiae natura,* 11 November 2012, in *L'Osservatore Romano,* Italian ed., 1 December 2012, English translation in *Origins,* 42 (2012-2013), 441-445.

In addition to canonical accountabilities, as recognized corporations, public juridic persons are also subject to civil legislation, especially those that receive public funding for Church ministries.[190] In Canada, public juridic persons that have assumed sponsorship of health care ministries make applications for corporate status under the *Canada Not-for-Profit Corporations Act* reporting criteria.[191] In addition, in Ontario the provincial Ministry of Health and Long Term Care legislates civil requirements for individuals or groups who are licensed to provide hospital-based or long-term care within the province. Administrative policies and procedures internal to each organization are added to the cadre of responsibilities for those who assume responsibility for health care ministry. Failure to comply with canonical or civil regulations could result in penalties up to loss of canonical and/or civil status. It is noted with interest that some canonical accountability criteria parallel civil ones.

1.5 Expressing Catholic Identity in Internal Governance Structures

Over time, Catholic health care sponsors and their apostolates showed an evolving level of trust and inclusion of lay board members in decision-making authority, longed for by lay collaborators and traditionally retained by congregations.[192] While some reserved powers have remained the purview of the founding religious institute(s), the gradual delegation of additional responsibilities to public juridic persons has afforded them the

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[190] See D. FOSTER, "Religious Conscience and Secular Rules," in *National Review Online*, 1 Feb 2012, http://www.nationalreview.com/corner/289898/religious-conscience-and-secular-rules-daniel-foster (4 Feb 2012).

[191] See GOVERNMENT OF CANADA, *New Legislation, Canada Not-For-Profit Corporations Act*, 13 October 2011, http://www.ic.gc.ca/eic/site/cd-dgc.nsf/eng/cs04956.html (20 January 2013).

[192] See MORRISEY, "The Church as Communion," 14

opportunity to be prepared to assume the responsibility of their mission mandated to them by the Church, and indeed mandated by Christ himself. Identifying and maintaining a clear relationship between sponsors and sponsored apostolates, which includes reserved powers, requires clear distinctions between governance and sponsorship. In a sense, it could be said that the goal of governance is to ensure the efficiency of the institutional operation through clearly defined and assigned lines of accountability, and the operationalization of the mission, traditionally safeguarded by the sponsors. For their part, the sponsors' focus is to realize through their shared ministry, the mission of the Church to bring Christ's healing power to the world, and to maintain formal linkages with the Church.

1.5.1 Catholic Health Care: Changing Structures for Changing Times

Francis Morrisey has noted significant changes in models of Catholic health care apostolate sponsorship over the years, with transition from direct *dominium* implying the right to control,[193] to an emphasis on systemic influence versus control.[194] The faithful who accept the responsibility to work through participation in public juridic persons to bring about the kingdom of God through participation in governance models, also assume an obligation to ensure sufficient resources for the pursuit of the Church's proper ends (c. 1254).[195] These resources extend beyond the realm of temporal goods, and are stipulated in the canonical statutes of the juridic person (c. 115, § 3). Sponsors serve as the "corporate

[193] See MORRISEY, "Various Types of Sponsorship," 20.

[194] See ibid., 22.

[195] See F. MORRISEY, "Trustees and Canon Law," 7.

conscience,"[196] and must exert meaningful control reserving the establishment of the organization's philosophy; changes to the corporate charter or bylaws; appointment/approval of the sponsor board of directors; and approval to sell, lease, or encumber corporate real estate in excess of defined amounts (c. 1292).[197]

The development of public juridic persons to sponsor apostolates in the Church has created many opportunities, including preserving and enhancing Catholic presence in the area of mission and ministry; offering a united front to the world; providing a vehicle which allows founding religious institutes to remain involved in the mission of the Church despite declining membership; enhancing the participation of the laity; protecting Catholic identity by bridging the gap between health care sponsored by religious congregations and Catholic healthcare as a bona fide mission of the broader Church; establishing a forum for collaboration among institutions; providing for the local economy; serving as an instrument for maintenance of Catholic health care; providing and coordinating educational opportunities; and finally, offering a means of holding and protecting the Church's temporal goods.[198]

Along with the opportunities that it offers to the Church in its efforts to bring the gospel through the apostolate of health care, public juridic personality also creates some challenges which must be considered congruent to the petition to establish juridic

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[196] BEAL, "From the Heart of the Church" 42.

[197] See ibid.

[198] See MCGOWAN, *Sponsorship of Catholic Health Care Organizations,* 8

personality. Where founding congregations as sponsors were intimately involved both with the ministry and the needs for health care in the communities in which they served, the transition to other types of sponsorship which have included board members who are unknown entities or names on a piece of paper, can spark fears of the unknown within traditional sponsored apostolates.

Like a great symphony, the journey of public juridic person status weaves its way through many movements that reflect both major and minor modes; moments of anxiety and consolation; and "emotions that range from the *De Profundis* of 'out of the depths I call to Thee, O Lord, Lord hear my prayer' to 'the Lord is my shepherd, He will guide and lead me in the right path'."[199] This change in relationship with a new sponsor may spark a sense of intransigence in relation to policy formation. Policies, which had previously reflected the individual character and needs of the public juridic person's mission, may be generically consolidated, in an effort to enhance efficiency, while failing to recognize and support individual mission nuances specific to the geographic region or population served.

Into the mix of challenges is the reality that new sponsorship models sometimes demand coordination and involvement of different diocesan bishops. As sponsorship trends have evolved over time, various sponsor groups have joined to support these ministries. While diocesan bishops knew and trusted religious congregations who traditionally sponsored health care ministries in their diocese, the roles and responsibilities of newly

[199] C. RIGBY, "The Journey So Far: Catholic Healthcare Ltd.," in M. CLEARY (ed.), *Public Juridic Persons in the Church*, Marsfield, Governance & Management Pty Ltd, 2009, 39.

established public juridic persons could seem less sure, leaving the diocesan bishop with a sense of lack of knowledge and control regarding this important ministry in his diocese which canonically and juridically requires his vigilance (c. 394). To reduce the potential for conflict, it will be important for public juridic persons to ensure the subsidiary relationship between the public juridic person and the diocesan bishop is articulated, evaluated, and supported in concrete ways. This could include provisions for ongoing dialogue, regular reports that highlight mission realization and the organization's support for the Church's ethical standards and norms, and presentation of annual reports to the Holy See and to diocesan bishops.

One issue that has become increasingly important to both diocesan bishops and Catholic health care organizations who accept public funding or who are engaged in partnerships with non-Catholic institutions rests, in the area of Catholic identity and assurances that Catholic ethical guidelines are adhered to. Dialogue between the Church's hierarchy and public juridic persons responsible for health care ministry requires special attention. In order to realize the invitation of Vatican II to continue to be the "Church in the world" and not "the Church and the world,"[200] partnerships for mission will be afforded a place on the agenda as opportunities to enhance and realize the Church's mission while remaining cognizant of potential limitations in partnership negotiations. Major health care ethics issues must be identified and addressed with diocesan bishops to ensure a common

[200] See MORRISEY, "Restructuring Systems," 66.

ground for negotiations with other providers and funders, rather than entertaining such debates in the media.[201]

1.6 Sponsorship of Catholic Identity

Vatican II shed new light on God's call to all the baptized which has resulted in a permanent change in understanding rights and obligations. "The holy people of God shares also in Christ's prophetic office; it spreads abroad a living witness to Him, especially by means of a life of faith and charity."[202] As *Lumen gentium* noted,

> Gathered together in the people of God and established in the one body of Christ under one head, the laity, whoever they are, are called as living members to apply to the building up of the Church and to its continual sanctification all the power which they have received from the goodness of the Creator and for the Grace of the Redeemer … the apostolate of the laity is a sharing in the Church's saving mission. Through Baptism and Confirmation, all are appointed to this apostolate by the Lord himself.[203]

In Vatican II decree *Apostolicam actuositatem*, the Council helped to define the vocation of the baptized (persons), noting, "no less fervent a zeal … is called for today; present circumstances in fact, demand from them [the baptized][204] a more extensive and more vigorous apostolate."[205] As the mission of the Church is shared by all the baptized, church law is required to assist them in fulfilling this mission. In *Deus caritas est*, Pope Benedict XVI reminds us that the Church is a "manifestation of Trinitarian love,"[206] and

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[201] See M. CLANCY, "Phoenix Diocese Strips St. Joseph's Hospital of Catholic Status," in *The Arizona Republic*, 22 December 2010, http://www.azcentral.com/community/phoenix/articles/ 2010/12/21/20101221phoenix-diocese-strips-st-J. s-hospital-catholic-status.html? (20 January 2013).

[202] *LG*, no. 12, 858.

[203] *LG.*, no. 33, 876.

[204] Emphasis added.

[205] *AA*, no. 1, 981.

[206] See BENEDICT XVI, *Deus caritas est*, 554.

that reflected love is therefore, manifested in the service that the Church carries out.[207] The motivation for charitable activity in the world comes from "a heart that sees where love is needed and acts accordingly."[208]

St. Paul writes in his letter to the Corinthians, "If I give away everything I own, and if I hand my body over so that I may boast but do not have love, I gain nothing."[209] Pope Benedict notes, "This hymn must be the Magna Carta of all Ecclesiastical Service."[210] Catholics committed to supporting the Church in the realization of its mission through apostolates sponsored by public juridic persons continue to respond with generous and loving hearts to God's invitation and anointing to bring good news to the poor in a world so desperately in need of healing.

1.7 Catholic Identity: Linking Theory to Praxis

In previous models of sponsorship of Catholic health care, Catholic identity seemed obvious, and found expression in symbols (crucifixes, statutes), sacraments (regular Mass schedules, priests available for the sacrament of reconciliation and anointing of the sick) and personnel (members of religious institutes in habit who served in all levels of the organization; schools of nursing and other allied health professions where students were educated, not only in the academics of their profession but also in the philosophy and

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[207] See BENEDICT XVI, *Deus caritas est*, no. 19, 548.

[208] Ibid., no. 31b, 553.

[209] See 1 Cor 13:3.

[210] BENEDICT XVI, *Deus caritas est*, no. 34, 554.

mission of Catholic health care; and designated staff to minister to the spiritual needs of patients/residents and staff). All who entered the portals of Catholic health care facilities did not doubt that their foundation, mission, and values were rooted in the gospels and the teachings of the Catholic Church.

North American's views and tolerance of values and practices rooted in religious traditions have changed.[211] Overt identification of obvious differences reflective of Catholic identity have brought direct challenges to the "right" of the Catholic Church both to be engaged in the ministry of health care in Ontario and the expectation that this ministry would be funded from the public purse.[212] However, we would suggest that if there are no identifiable differences between Catholic and public health care facilities, then the suggestion by some that public funding for Catholic health care institutions should be merged into public institutions gains credibility. The question which continues to plague some Catholic health care sponsors, trustees, and senior executives remain. What are the clear and measurable identity markers of Catholic health care in Ontario? Does Catholic health care have a distinctive value in the context of Ontario's public health care system which is recognizable to all, not only the 'converted' who minister within the Catholic health care system?

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[211] See J. EPP BUCKINGHAM, "The Relationship Between Religions and a Secular Society," in *Diversity Magazine,* 9 (2012), Ontario Human Rights Commission, http://www.ohrc.on.ca/en/creed-freedom-religion-and-human-rights-special-issue-diversity-magazine-volume-93-summer-2012/relationship-between-religions-and-secular-society (25 August 2016), A. DEVALK, "Catholic School Boards Bowing to Secularism, in *Catholic Insight*, vol. 15, no. 9, 13-14.

[212] See A. MEHLER PAPERNY, "Right to Die: Should Public Hospitals Have Freedom of Religion?" in *Global News*, 26 February 2016, http://globalnews.ca/news/2542562/right-to-die-should-public-hospitals-have-freedom-of-religion/ (25 August 2016).

In a 2007 research study conducted by HBS Marketing for the Catholic Health Association of Ontario Branding project, nine internal stakeholders were polled on a series of questions aimed at establishing what insiders see as the strengths, weaknesses, aims, preferred five-year vision, and possible impediments to achieving Catholic health care goals in the current health care environment. Twenty external stakeholders/observers were asked the same questions to affirm or challenge the insiders on these questions. Both insiders and the external groups identified the spiritual dimension to health care as being a needed and distinguishing dimension of Catholic health care. Both identified compassion as an important characteristic, but the external group suggested there would be backlash if Catholic health care attempted to "own" this characteristic. External observers saw an established system that could lend its expertise at working as a system to the LHINs, while internal observers did not see Catholic health care as a cohesive body in Ontario. External observers noted the innovation and creativity of Catholic health care, while internal observers did not mention these attributes.[213] In addition, external stakeholders suggested that Catholic health care providers' greatest strength lay in its underlying culture, values, and people, as well as their pride in service to others. Other strengths noted were the ability to focus on mission, spiritual guidance to "do the right thing, ethically and clinically," and the leadership and expertise Catholic health care providers offered to the broader public

[213] See CHAO, "Minutes: Catholic Identity Committee," 16 November 2007, Toronto, CHAO, available in the private archives of the General Superior of The Sisters of St. Joseph of Sault Ste. Marie, North Bay, ON.

health care system.[214] Some of the many insights offered by this research were both the congruence and the disparity between internal and external constituents assessing key Catholic health care identity factors. It appeared that some of these identity factors noted by research participants external to the Catholic health care system were invisible to those who were serving in the system. This research would suggest that further efforts to discern and establish Catholic health care identity markers will be required.

1.7.1 Discerning Identity

As noted by St. John Paul II, Catholic health care should offer "places where suffering, pain and death are acknowledged and understood in their human and specifically Christian meaning."[215] The public can sometimes reduce the identity of Catholic health care organizations to what they do not do (abortion, euthanasia) [216] versus what they do, e.g., definition of Catholic health care as a healing relationship characterized by such issues as dignity, respect, and ethical reflection;[217] commitment to support life in all of its moments,

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[214] See B. ANTONELLO, "Articulating the Catholic Health Care Brand in Ontario," PowerPoint Presentation, Toronto, CHAO, 2008.

[215] See St. JOHN PAUL II, "Identity of Catholic Health Care Institutions," 7 November 2002, in *Fédération Internationale des Associations de Médecins Catholiques,* http://www.fiamc.org/texts/identity-of-catholic-health-care-institutions/ (25 August 2016). (= St. JOHN PAUL II, "Identity of Catholic Health Care Institutions).

[216] See P. SIMONS, "If Covenant Health Won't Obey Law, It Shouldn't Get Public Funds to Run Public Hospitals," in *The Edmonton Journal*, 13 February 2016, http://edmontonjournal.com/opinion/columnists/paula-simons-if-covenant-health-wont-obey-law-it-shouldnt-get-public-funds-to-run-public-hospitals (25 August 2016).

[217] See CHAC, *Health Ethics Guide*, Ottawa, 1-5.

from conception to natural death;[218] and commitment to justice[219] and collaboration.[220] In our efforts to not offend those who do not share our faith tradition, trustees and administration teams of Catholic health care institutions may have overlooked the development of public relations strategies that could assist both the government and the public to see the "value-added" which Catholic health care institutions bring to this ministry and to the public domain. In some ways, we may have suffered from "hiding our light under a bushel basket."[221]

We would suggest that formation, defined as an arrangement of a body or group of persons or things in some prescribed manner or for a particular purpose,[222] is critical to recognizing both the presence of Catholic identity markers as well as its absence. This requires the definition of observable and measurable criteria of Catholic identity.

Several "Catholic" identity criteria, based on both canonical and civil responsibilities and obligations, could help to shape the organization's decision-making processes and ensure Catholic values and traditions are incorporated within the facility. The following broad relationship categories would not only help to solidify a sense of

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[218] See CANADIAN CONFERENCE OF CATHOLIC BISHOPS, "Pastoral Letter on Catholic Health Ministry and the Catholic Church in Canada," 10 February 2005, http://www.cccb.ca/site/eng/media-room/official-texts/pastoral-letters/1626-cccb-pastoral-letter-on-catholic-health-ministry-and-the-catholic-Church-in-canada (25 August 2016).

[219] See CHAC, *Health Ethics Guide*, 7-9, 30-42.

[220] See ibid., 97-98.

[221] See Matt. 5:15.

[222] See *Merriam-Webster Dictionary*, http://www.merriam-webster.com/dictionary/formation (25 August 2016).

corporate Catholic identity, but offer a framework for an evolving covenant relationship between Catholic health care organizations and key stakeholders, both internal and external to the organization. The following identity foundations are suggested.

- Obligations to external constituencies including the Ministry of Health and Long Term Care (MOHLTC), Local Health Integration Networks (LHINs), the Church, sponsors, and the community at large.
- Obligations to internal constituents including trustees, staff, patients, and families.

1.7.1.1 Obligations to External Constituencies

Catholic health care is not a ministry that "stands alone." Catholic health facilities in Ontario are mandated by civil law, in order to ensure all appropriate regulations are adhered to.[223] The relationship of Catholic sponsored health care facilities to the Church includes defined obligations and limits of organizational decision-making authority, and accountability processes identified in both canonical norms and reserved powers[224] included in statutes of public juridic persons. (e.g., alienation of property,[225] coordinated responses to legislation contrary to divine law or Church doctrine,[226] incorporation of the

[223] See GOVERNMENT OF ONTARIO, Ontario Public Hospitals Act, R.S.O. (1990), O. Reg. 900/965, https://www.ontario.ca/laws/regulation/900965 (25 August 2016).

[224] See HITE, HOLLAND, and MORRISEY, *Understanding Public Juridic Persons,* 2012, 66-69.

[225] See CANADIAN CONFERENCE OF CATHOLIC BISHOPS (CCCB), Decree No. 38: Maximum Amount for Alienation of Church Property, 22 March 2016, http://www.cccb.ca/site/eng/media-room/official-texts/decrees/3093-decree-no-38-maximum-amount-for-alienation-of-Church-property (25 August 2016).

[226] See CCCB, "Statement by CCCB President on The Recent Approval of Bill C-14 Legalizing Euthanasia and Assisted Suicide," http://www.cccb.ca/site/eng/media-room/statements-a-letters/4523-statement-by-cccb-president-on-the-recent-approval-of-bill-c-14-legalizing-euthanasia-and-assisted-suicide (25 August 2016); See also G. LACROIX, "Assistance in Dying: No Deadline for Dignity," in *Origins*, 46 (2016-2017), 92; M. SWAN, "Catholic Hospitals Adamant They Won't Kill Patients," in *The Catholic Register*, 3 March 2016, http://www.catholicregister.org/item/21870-catholic-hospitals-adamant-they-won-t-kill-patients (25 August 2016).

Church's social teachings into the day-to-day work of Catholic health care providers,[227] etc.) These additional checks and balances should offer both government officials and the general public a greater sense of confidence in the internal organization, accountability, and transparency of Catholic health care organizations. Creating a list of canonically required accountability requirements could be shared with MOHLTC and LHINs officials, which would both help to educate the government, trustees and the general public, and highlight the commitment of the Church and Catholic health care providers to ensure accountability and transparency in all activities.

As noted in canon 394, the diocesan bishop's responsibilities include fostering various forms of the apostolate. While diocesan bishops desire to fulfill their episcopal duties to the best of their ability, few bishops have received formation on sponsorship of Catholic health care. Some diocesan bishops have noted their reliance on sponsors to fulfill this ministry in the name of the Church.[228] We would suggest inviting diocesan bishops to formation sessions for sponsors, trustees, and senior administrative staff, to assist bishops in both understanding the complexity of Catholic health ministry within their diocese and within the broader Ontario health care system, and offer them assurances that the organization is ensuring Catholic identity that continues to be supported at all levels of the organization. In addition, it would be imperative that regular reports (annual reports required by civil law and distributed broadly to the local communities in which Catholic

[227] See USCCB, "Seven Themes of Catholic Social Teaching," http://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/seven-themes-of-catholic-social-teaching.cfm (25 August 2016).

[228] See c. 116.

health care providers serve)[229] as well as sentinel events[230] be communicated to the diocesan bishop as soon as possible.

1.7.1.2 Obligations to Internal Constituencies

Trustees, administration, and front-line staff require ongoing education to assist them to formulate, articulate, and disseminate measurable Catholic identity criteria. Many trustees and administration staff have been successfully recruited based on expertise and training in administration and business. Numerous authors have noted the essential role of formation of the laity to assume leadership roles in the Church's apostolates. This formation must obviously move us from mere legislation and mandating criteria in governance, policies, and practices, to the creation of a new shared vision among all of God's people that comes from a new heart.[231]

Those who have been engaged in the ministry and mission of Catholic health care often believe formation does occur within their organizations. However, we would suggest that new coordinated models of formation will be required to address the need for ongoing

[229] See ST. MICHAEL'S HOSPITAL, "2015-2016 Annual Report," Toronto, Medical Media Centre, St. Michael's Hospital, 2016.

[230] See D. WATSON, "Sentinel Events," in *Association of Operation Room Nurses' Journal*, 90 (2009), 926-929, http://journals2.scholarsportal.info.proxy.bib.uottawa.ca/pdf/00012092/v90i0006/926_se.xml (25 August 2016).

[231] See Isaiah 43:19.

evangelization,[232] even of the baptized faithful.[233] At the present time, four Ontario sponsors offer formation programs for sponsors, trustees, senior executives, and front line staff in their organizations. Planning and educational synergies and support could be realized if a coordinated and collaborative formation program was developed and marketed to all Ontario sponsors.

During orientation of trustees and administration staff, reference is made to the Health Ethics Guide.[234] Some organizations provide copies of the Health Ethics Guide to new trustees and senior executives within organizations. The guide provides information on:

> Moral obligations for the sponsors/owners, boards, members of ethics committees and personnel of Catholic health and social service organizations … [and] presents Catholic teachings and outlines the values that are to be respected by those who work within the organization … a framework to structure and articulate their own decision making. It also informs them about what to expect from care providers who function according to such a vision of care.[235]

We would suggest that coordinated education sessions with all sponsor boards, Catholic health care trustees and administration, reviewing the *Health Ethics Guide (HEG)*, would assist trustees and administrative staff in developing performance criteria for decision-making which would reflect the teachings of the Church.

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[232] See P. MURPHY, "Moving Toward a Catechesis of Encounter," in CANADIAN CONFERENCE OF CATHOLIC BISHOPS, OFFICE FOR EVANGELIZATION AND CATECHESIS (eds.), *Encounter: Evangelization and Catechesis of Children, Youth & Families*, 1 (2015), http://www.cccb.ca/site/images/stories/pdf/Encounter_Volume_1_Issue_1.pdf (25 August 2016).

[233] See W. BYRON and C. ZECH, "Why They Left: Exit Interviews Shed Light on Empty Pews," in *America*, vol. 206, no. 14 (2012), 17-19.

[234] See CHAC, *Health Ethics Guide*.

[235] CHAC, *Health Ethics Guide*, x-xi.

Trustees and staff at all levels require assistance in the practice of ethical reflection.[236] While the *HEG* is offered as a resource tool for trustees and administration, in our experience we have not seen a coordinated program of education on the implications of the *HEG* on the day-to-day operation of a Catholic health care facilities in Ontario. Funding a shared education tool for use of the *HEG* at all levels of Catholic health care organizations in Ontario including tools for ethical reflection could solidify resources and maximize the use of skilled ethicists on a case-by-case basis as well as through coordinated regular education sessions.

We live in a culture that denies suffering, that establishes laws which would free our nation from those who are dependent, weak of body, mind or spirit; that suggests that suffering at any level has no redemptive qualities; and that notes that the individual, and the individual alone, has a right to self-determination including the right to end one's life. Catholic health care has the responsibility to speak for the most vulnerable whom we serve in a coordinated fashion that reflects not only the values inherent within individual Catholic health care facilities, but their promise to respect life in all of its moments, from conception to natural death. Speaking with one voice on behalf of all Catholic health care in Ontario regarding such matters as physician assisted suicide would offer the general

[236] See K. KLINT JENSEN, E.M. FORSBERG, C. GAMBORG, K. MILLAR, and P. SANDØE, "Facilitating Ethical Reflection Among Scientists Using the Ethical Matrix, in *Science and Engineering Ethics* (17 (2011), 425-445; See also CHAC, *Health Ethics Guide*, 102-112.

public a cohesive message based on our shared values, promising those whom we serve to respect and support them throughout the natural course of their life journey.

As health care costs increase and resources diminish,[237] Catholic health care trustees and administration are often faced with dilemmas such as reducing nursing staff versus maintaining chaplain services.[238] In these kinds of ethical dilemmas, decisions must be made based on shared values.[239] These choices are rarely right or wrong, black or white. Standards for religious and spiritual care for health services in Canada have been identified by the Catholic Health Alliance of Canada (formerly known as the Catholic Health Association of Canada).[240] They have recommended that "spiritual and religious care is essential to sustain and restore the health of individuals and communities."[241] When faced with budget reductions, some health care organizations in Ontario have chosen to reduce or eliminate positions responsible for religious and spiritual care, opting to access these services through volunteers from various faith traditions. Catholic health care trustees and administrators are called to a standard of ethical reflection that references not only the bottom line, but the facility's commitment to those whom they serve to ensure support of

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[237] See A. APPLETON, "Ontario's Budget Doesn't Look Good for Hospitals," in *Health Debate Opinions*, 9 March 2016, http://healthydebate.ca/opinions/ontarios-budget-hospitals-community-care-reforms-2016 (25 August 2016).

[238] See M. OLIVER, "As Hospitals Cut Costs, Do Chaplains Have A Prayer?" in *The Orlando Sentinel*, 3 December 1994, http://articles.orlandosentinel.com/1995-12-03/news/9512040464_1_chaplains-maberry-spiritual-care (25 August 2016).

[239] See C. FARRELL, "Your Budget Reflects Your Values," 6 July 2013, *CBS Money Watch*, http://www.cbsnews.com/news/your-budget-reflects-your-values/ (25 August 2016).

[240] See CHAC, "Standards of Spiritual and Religious Care for Health Services in Canada," Ottawa, CHAC, 2000, http://www.chac.ca/alliance/online/docs/brochure_standards_en.pdf (25 August 2016).

[241] Ibid., 4.

the whole person (body, mind, and spirit) throughout their course of treatment. It is in situations such as this that values-based decision making requires commitment, prayer and reflection. Balancing the bottom line must reflect what we truly value, or Catholic values and a distinctive Catholic identity will mean very little.[242]

Finally, the commitment of Catholic health care to support the whole person and their support systems including family and friends, is a critical component of the healing process. In the scriptures, Jesus often responded to the needs of the sick who were brought to him.[243] Our commitment to those whom we serve is to care for the patient's support system including family, friends, and care givers.

1.8 Closing Reflections

The mandate of Catholic health care and the essence of its identity has been noted by St. John Paul II:

> The identity of Catholic Health Care Institutions has great relevance for the life and mission of the Church. In fact, in carrying out the work of evangelization, in the course of the centuries, the Church has always associated the assistance and care for the sick with the preaching of the Good News (cf. *Motu proprio Dolentium hominum*, n. 1).[244]
>
> To understand the identity of such care institutions fully, one must go to the heart of what the Church is, whose supreme law is love. Catholic health care institutions thus become powerful witnesses to the charity of the Good Samaritan because, in caring for the sick, we fulfill the Lord's will and contribute to realizing the Kingdom of God. In this way they express their true ecclesial identity … Above all they should be places where

[242] See P. LENCIONI, "Make Your Values Mean Something," in *Harvard Business Review*, vol. 5, no. 7 (2002), 113-117, R. RYMARZ, "Religious Identity of Catholic Schools: Some Challenges from a Canadian Perspective," in *Journal of Beliefs & Values*, 31 (2010), 299-310.

[243] See Mark 2:1-12; Luke 5:17-39; Matt. 9:2.

[244] St. JOHN PAUL II, Apostolic Letter Issued Motu Proprio Establishing Pontifical Commission for the Apostolate of Health Care Workers *Dolentium hominum*, 11 February 1985, in *AAS*, 77 (1985), 457-461, English translation in *Origins*, 14 (1984-1985), 761-762.

> suffering, pain and death are acknowledged and understood in their human and specifically Christian meaning.[245]

This mandate will be evident as we examine the evolution of Catholic health care sponsorship in Canada and specifically in Ontario in Chapter II and adult formation needs reviewed in Chapter III.

[245] St. JOHN PAUL II, "Identity of Catholic Health Care Institutions."

CHAPTER II: THE EVOLUTION OF CATHOLIC HEALTH CARE IN THE PROVINCE OF ONTARIO

2.1 Introduction: The Canadian and Ontario Context for the Apostolate of Catholic Health Care

It might be said that Canada's growing belief in the responsibility of a just society to support ideologically and financially a public health care system which offers universal access to all of its citizens, was first envisioned in the gospels as Jesus mandated his disciples to follow the example of the Good Samaritan and "go and do likewise."[246] The apostolate of Catholic health care in Ontario is not specifically referenced in the Code of Canon Law nor in civil law. However, canon 19 offers "a remedy for a *lacuna legis*,"[247] with the opportunity to examine laws issued in similar matters and general principles of law applied with canonical equity. As will be noted in Chapter III, civil laws regulating services offered in public health care systems, may at times conflict with divine law. In these situations, "when civil law conflicts with divine or canon law, the latter prevails."[248] "Interpretation of every human law must be governed by the theory of relativity: the whole

[246] See LUKE 10:37.

[247] See J. HUELS, "Cases Involving Lacunae, Canon 19," in J. BEAL, J. CORIDEN, and T. GREEN (eds.), *New Commentary on The Code of Canon Law*, commissioned by the CANON LAW SOCIETY OF AMERICA, New York and Mahwah, NJ, Paulist Press, 2000, 77-80. Canon 19, "If a custom or an express prescript of universal or particular law is lacking in a certain matter, a case, unless it is penal, must be resolved in light of laws issued in similar matters, general principles of law applied with canonical equity, the jurisprudence and practice of the Roman Curia, and the common and constant opinion of learned persons."

[248] See J. HUELS, "Canonization of Civil Law," in J. BEAL, J. CORIDEN, and T. GREEN (eds.), *New Commentary on The Code of Canon Law*, commissioned by the CANON LAW SOCIETY OF AMERICA, New York and Mahwah, NJ, Paulist Press, 2000, 85. Canon 22: "Civil laws to which the law of the Church yields are to be observed in canon law with the same effects, insofar as they are not contrary to divine law and unless canon law provides otherwise."

universe is in motion and we are moving with it. But this is not an invitation to relativize all truth."[249] This will prove to be of particular importance as medico-moral issues which challenge divine law but have been incorporated into federal legislation, impact on the ministry of Catholic health care within the civil realm.[250]

2.1.1 The Canadian Health Care System: Transitioning from Christian Charity to Societal Values to Legislation

In 2004, the Canadian Broadcasting Corporation asked viewers to vote on who they believed should be considered the greatest Canadian. Leading the list was Tommy Douglas, the founder of the new Democratic Party, and considered the "founder" of the Canadian health care system.[251] When teaching Canadian Politics at McGill University, A. Maioni asks her students what makes Canada unique. Their answers include, as A. Maioni describes them, the three "H's": (Tim) Hortons, Hockey, and Health Care.[252] Canadians may consider themselves, through Tommy Douglas, as the innovator of social policies which include health care, but historical reflections suggest a deeper foundation for this ministry. In order to understand both the advent of Catholic health care sponsorship in the province of Ontario, Canada, as well as necessary juridic support for this essential ministry of the Church, it is important to examine this ministry through the lens of changing

[249] See L. ŐRSY, *Theology and Canon Law*, 64.

[250] See CARTER V. CANADA (Attorney General), 2015 SCC 5 (2015), https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do (8 July 2016). (= CARTER V. CANADA)

[251] Who is the Greatest Canadian, Canadian Broadcasting Corporation (CBC) Poll, 2004, http://www.jjmccullough.com/greatest%20Canadians.htm (25 March 2016).

[252] A. MAIONI, *Health Care in Canada*, Don Mills, Oxford, 2015, 7. (= Maioni, *Health Care*)

Canadian societal values. Was care for the sick as mandated by Jesus in the gospels[253] always a value in our Canadian society?

2.1.2 Health Care in Canada: Founded by Religious Institutes

A sense of social responsibility for health care for all was initiated in Canada in and through the Catholic Church. Jesus mandated His Church to heal the sick and care for the most vulnerable in our midst,[254] and this mandate was realized through health care apostolates established in Canada by religious institutes. The first hospital on the continent north of Mexico,[255] L'Hôtel-Dieu de Québec,[256] was established by the Augustinian Sisters in 1639. They would be followed by the Religious Hospitallers of St. Joseph who arrived in Montréal in 1659, and worked with Jeanne Mance in the Montréal infirmary she established.[257]

Jesus' healing mission continues to this day in Catholic sponsored apostolates throughout Canada.

> Catholic health ministry sees care for the sick as a sacred ministry pursued in fidelity to the example and teaching of Jesus Christ. It is dedicated to the relief of suffering within the constraints of divine law. It gives primacy to man's spiritual destiny as well as his temporal well being. Contemporary culture for its part also seeks to relieve suffering and to improve the quality of human life. Its restraints, however, are imposed by human

[253] See Matt. 25:34-40; Lk. 4:40; Matt. 4:23.

[254] See Matt. 10:8.

[255] See "La Fiducie du Patrimoine culturel des Augustines," http://www.augustines.ca/en/augustines (21 August 2016) (= La Fiducie).

[256] See G. BROWN (ed.), *Dictionary of Canadian Biography*, vol. I, Toronto, University of Toronto Press, 1966, 347-349.

[257] See RELIGIOUS HOSPITALLERS OF SAINT JOSEPH, Montréal History, http://www.rhsj.org/en/history_360_-21.php (25 March 2016).

> law, and its end is primarily the quality of man's material life, without reference to divine law.[258]

While a sense of shared social responsibility for the needs of the poor and sick are characteristics common to the current culture, they were not always the hallmark of Canadian society, nor is there any guarantee the belief that we "are our brothers [and sisters] keepers"[259] will continue to be a shared value inherent to the Canadian ethos, the object of public responsibility and recipient of public respect and resources. Will we continue to judge our Canadian society, "on the basis of how it treats its weakest members – the last, the least, the littlest … Or will fundamental human values be negotiated away at bargaining tables for partisan advantage? Will the language of the "right to choose" continue to drown out the language of commitment to the common good?"[260]

Such debates were evident, even in the early years of Canada's settlement. The sick, poor, widows, and orphans were part of the social landscape from the beginnings of time and have a special focus in the ministry of the Church.[261] It is from this sense of responsibility that Canada's health care system grew into the one which is applauded by many throughout the world.[262] "A convergence of social, economic, and political factors

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[258] E. PELLEGRINO, "Catholic Health Care ministry and Contemporary Culture: The Growing Divide," in *Urged on by Christ: Catholic Health Care in Tension with Contemporary Culture. Proceedings of the Twenty-First Workshop for Bishops*, Philadelphia, The National Catholic Bioethics Center, 2007, 14.

[259] See Genesis 4:9.

[260] R. MAHONY, "Creating a Culture of Life: A Reflection," 12 November 1998, in *Priests for Life*, http://www.priestsforlife.org/magisterium/mahonyelectionltr.htm (3 July 2016).

[261] See James 1:27.

[262] See "Why Canadian Health Care is Better," in *Best Health*, November/December (2009), http://www.besthealthmag.ca/best-you/health/why-canadian-healthcare-is-better/ (3 July 2016).

brought about Medicare in Canada,"[263] which ensured health care would be provided on the basis of need, not income.[264]

Early settlers found this country far from an idyllic place to live. D. Butler-Jones notes, "Before the benefit of mass immunization, generations of Canadians lived with the threat of a range of frequent and debilitating and life-threatening diseases. Waves of cholera and typhus killed large numbers of early settlers, while the Indigenous population experienced epidemics of smallpox, tuberculosis, diphtheria, typhus, measles, and syphilis."[265] Before the British North America Act of 1867, "health care was not considered a part of the public realm … Instead, family, community, and Church were the main sources of succour for the ill or infirm …."[266]

Canada's Constitution, originally known as the British North America Act, set out the powers of the federal, provincial and territorial governments. The *Constitution Act*[267] identified federal and provincial lines of authority and responsibility for health care.

> [The provinces were given constitutional or fundamental authority] for establishing, maintaining and managing hospitals, asylums, charities and charitable institutions, and the federal government was given jurisdiction over marine hospitals and quarantine. The federal government was also given powers to tax and borrow … to spend such money as long as this did not infringe on provincial powers. The federal department of Agriculture

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[263] T. BRYANT, *An Introduction to Health Policy*, Toronto, Scholars' Press, 2009, Kindle ed., loc. 3073. (BRYANT, *An Introduction*).

[264] See BRYANT, *An Introduction,* loc. 3066.

[265] D. BUTLER-JONES, "A Reflection on Public Health in Canada: Applying Lessons Learned for the Next Century of Public Health Practitioners," in *Canadian Journal of Public Health*, 100 (2009), 165-166.

[266] MAIONI, *Health Care*, 17.

[267] GOVERNMENT OF CANADA, Constitution Act, 1867, An Act for the Union of Canada, Nova Scotia and New Brunswick, and the Government thereof, 29 March 1867, http://laws-lois.justice.gc.ca/eng/const/FullText.html (10 January 2016).

> covered federal health responsibilities from 1867 to 1919, when the department of Health was created. Before World War II, health care in Canada was, for the most part, privately delivered and funded.[268]

Although provincial governments seem to have a long history of subsidizing health care and ensuring the capacity to treat all patients, regardless of their ability to pay, the province of Ontario's Charity Aid Act of 1874[269] required all non-profit-making municipal, charitable and faith-based (mainly Catholic but also Protestant and Jewish) hospitals to accept some regulatory oversight in return for per-diem reimbursements. The increased number of municipal and non-profit-making hospitals that voluntarily met identified public need and public scrutiny resulted in few state-owned or controlled hospitals.[270] The only exception to this template were provincially administered mental hospitals that emerged in the 20th century, primarily due to the poor state of private and non-governmental asylums.[271]

The genesis of Canada's embrace of societal responsibility for the health of its citizens began in earnest only after World War I.[272] In 1919, the Liberal government

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[268] GOVERNMENT OF CANADA, "Evolution of Our Health Care System," http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php#a1 (10 January 2016) (= GOVERNMENT OF CANADA, "Evolution").

[269] GOVERNMENT OF ONTARIO, "An Act to Regulate Public Aid to Charitable Institutions," in *Statutes of the Province of Ontario Passed in the Session Held in the Thirty-Seventh Year of the Reign of Her Majesty Queen Victoria, Being the Third Session of the Second Parliament of Ontario*, Toronto, John Notman, 1874, Google Books, 257-262, https://books.google.ca/books?id=QcKwAAAAMAAJ&pg=PA258&lpg=PA258&dq=Province+of+Ontario+Charity+Aid+Act+1874&source=bl&ots=cb1dCM95cI&sig=Ut8tcqNheKvtzPmtP8gXpg-glK0&hl=en&sa=X&ved=0ahUKEwjAjY_NruvNAhUi4IMKHVSfARIQ6AEITTAJ#v=onepage&q=Province%20of%20Ontario%20Charity%20Aid%20Act%201874&f=false (11 July 2016).

[270] See G. MARCHILDON, *Health Systems in Transition*, Toronto, University of Toronto Press, 2013, 23 (= MARCHILDON, *Health Systems*).

[271] See E. DYCK, "Dismantling the Asylum and Charting New Pathways into the Community: Mental Health Care in Twentieth Century Canada," in *Histoire sociale/Social history*, 44 (2011), 182.

[272] See MARCHILDON, *Health Systems*, 23.

adopted a policy that supported "an adequate system of insurance against unemployment, sickness and dependence in old age,"[273] although the federal government did not immediately implement a national health care policy.[274] Municipal hospital plans were established in Manitoba, Saskatchewan, and Alberta in 1921 and in 1936, British Columbia and Alberta passed health insurance legislation.[275] In 1947, Saskatchewan's Premiere Tommy Douglas and his newly elected Co-operative Commonwealth Federation (CCF) government established the first universal hospital care plan in North America.[276] In response to provincial alliances lobbying for a federally coordinated and funded system of universal health care in Canada, Prime Minister W. L. Mackenzie King "delayed while appearing to move … he created a Royal Commission, the Rowell-Sirois Commission, to study federal-provincial relations, especially fiscal relations." The commission "recognized that Ottawa could collect premiums from employers for health care but thought health insurance was really a provincial matter."[277]

Until the 1950s, provincial and federal governments had few policies and programs on which they agreed or cooperated.[278] More conciliatory relationships between the federal and provincial governments developed in the immediate post-war era.[279] It would not be

[273] K. BRYDEN, *Old Age Pensions and Policy-Making in Canada*, Montreal, McGill-Queen's Press, 1974, 66.

[274] See BRYANT, *An Introduction,* loc. 3073.

[275] See GOVERNMENT OF CANADA, "Evolution."

[276] See BRYANT, *An Introduction,* loc. 3073.

[277] See J. SIMPSON, *Chronic Condition: Why Canada's Health-Care System Needs To Be Dragged Into The 21st Century*, Toronto, Penguin, 2012, Kindle ed., loc. 958. (= SIMPSON, *Chronic Condition*).

[278] See BRYANT, *An Introduction,* loc. 3091.

[279] Ibid.

until 1957 that five provinces, including Ontario, would pass legislation noting their accession to federal participation in hospital insurance which was to begin in 1958.[280] The medical profession, insurance companies and businesses opposed the program, and in 1960, the Canadian Medical Association launched a lobby on behalf of all physicians in Canada, opposing all publicly funded health care in Canada.[281] Despite opposition on many fronts, by 1960 Canada's ten provinces[282] had introduced hospital insurance programs under the Hospital Insurance and Diagnostic Services Act.[283]

Health care in Canada's three territories grew in a distinct fashion from the rest of Canada. The area previously included in the Northwest Territories which is now Nunavut, was "under the purview of religious-based health services, especially from the Anglican and Catholic Churches, well into the 20th century."[284] The government of Canada appeared to be unclear whether health services for the Inuit fell under the responsibility of the Indian Act. Medical services in the Canadian Arctic began only after World War II, with Inuit health services being integrated under the Northern Health Services in the Department of National Health and Welfare by 1954.[285] Public health concerns including tuberculosis epidemics which had a devastating effect on population health and the foundational fabric

[280] See MAIONI, *Health Care*, 24.

[281] See BRYANT, *An Introduction*, loc. 3091.

[282] See MAIONI, *Health Care*, 25 which notes that Québec signed on only after the defeat of the *Union Nationale* by the Liberal Party, and hospital insurance became one of the first measures associated with the Quiet Revolution.

[283] See ibid., 25.

[284] See MAIONI, *Health Care*, 96.

[285] See ibid., 97.

of community and family life were, at times, treated through medical evacuation and relocation.[286] Residents and settlers of the North West Territories (NWT) accessed primary health care services at nursing stations which were staffed by non-Indigenous people. The cost of providing secondary, tertiary and quaternary health care[287] to remote locations throughout Canada's north was funded by the federal government.[288] Responsibilities for health care for the settlers and Indigenous people of the Yukon was assumed by that region in 1972,[289] and responsibility and control of health services for the Northwest Territories was transferred to that territory in 1988.[290]

While the advent of public responsibility for health care and physician insurance in Canada was laudable, it was not without its struggles. "But for one poor province, flattened as no other by the Depression, willing to take a political chance on a form of agrarian socialism, there might never have been a model for what became Canadian Medicare."[291] Saskatchewan physicians expressed their concerns about retaining some semblance of professional autonomy which precipitated a public media campaign against "socialized medicine."[292] The dispute between Saskatchewan physicians and the provincial New

[286] See MAIONI, *Health Care,* 97.

[287] See T. TORREY, "Primary, Secondary, Tertiary, and Quaternary Care," in *Patient* Empowerment, 20 June 2016, https://www.verywell.com/primary-secondary-tertiary-and-quaternary-care-2615354 (30 June 2016).

[288] See MAIONI, *Health Care,* 97.

[289] See ibid., 112.

[290] See W. WONDERS, "Northwest Territories," (18 May 2011), revised by K. ANDERSON and E. JAMES-ABRA (22 May 2015), http://www.thecanadianencyclopedia.ca/en/article/northwest-territories/ (3 July 2016).

[291] See SIMPSON, *Chronic Condition,* loc. 983.

[292] See MAIONI, *Health Care,* 25.

Democratic Party (NDP) went to arbitration and resulted in the 1960 Saskatoon Agreement that permitted doctors to extra-bill their patients above fees negotiated with the provincial government. [293]

In 1965, Prime Minister L. B. Pearson outlined the pre-requisites for federal contributions to provincial health plans which would include (1) public administration, (2) comprehensive benefits, (3) portability (standard coverage in all provinces), (4) universality (no Canadian citizen would be denied access to insured health care), and (5) accessibility (all insured persons would have reasonable access to physician and health care facilities).[294] In an attempt to allay physician fears of loss of professional autonomy, Saskatchewan's Chief Justice, Emmett Hall, chaired the Royal Commission on health services and financing,[295] and supported not only a national medical insurance program, it recommended expanding the program to include home care, mental health, pharmaceuticals, and dental and optical programs for children.[296] Both the Saskatoon Agreement and the Emmett Hall Report provided a framework from which the 1966 Medical Care Act would require provincial governments to become the single payer of all comprehensive physician and hospital services, with Ottawa cost-sharing 50 percent of provincial health care costs and the provinces paying the other 50 percent.[297] Provinces

[293] See BRYANT, *An Introduction,* loc. 3091.

[294] See MAIONI, *Health Care,* 35-42.

[295] E. HALL, *Royal Commission on Health Services*, Ottawa, Queen's Printer, 1964, https://positivelivingbc.org/wp-content/uploads/2015/03/hall-report.pdf (8 March 2016).

[296] See BRYANT, *An Introduction,* loc. 3110.

[297] See ibid., *loc.* 3091.

were required to comply with the five principles of Medicare, or national standards for health programs which would ensure access and equity to health services across the country.[298] The principles included the following:

1) **Public Administration**: The provincial and territorial plans must be administered and operated on a non-profit basis by a public authority accountable to the provincial or territorial government.
2) **Comprehensiveness**: The provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners and dentists working within a hospital setting.
3) **Universality**: The provincial and territorial plans must entitle all insured persons to health insurance coverage on uniform terms and conditions.
4) **Accessibility**: The provincial and territorial plans must provide all insured persons reasonable access to medically necessary hospital and physician services without financial or other barriers.
5) **Portability**: The provincial and territorial plans must cover all insured persons when they move to another province or territory within Canada and when they travel abroad. The provinces and territories would develop some limits on coverage for services provided outside Canada, and would consider requiring prior approval for non-emergency services delivered outside their jurisdiction.[299]

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[298] See BRYANT, *An Introduction,* loc. 3110.

[299] See GOVERNMENT OF CANADA, "Evolution."

In 1972, health care legislation broadened the scope of funding to include primary care, integration of health and social services based on community access, and decentralized decision-making.[300] Following the principles outlined in the Royal Commission on Health, the Canada Health Act of 1984[301] physician extra-billing or user-fees were ruled out. Provinces which failed to adhere to the criteria established in the legislation would suffer financial penalties.[302]

Despite Ontario physicians' resistance to government regulation expressed through strike action, the Canadian population has continued to support the policy of public responsibility and accountability for the health care of its citizens. In fact, Medicare is considered by some to be the third rail of Canadian politics. "Touch it and you die."[303] Of all public programming, Canadians seem to embrace their public health care system more passionately than any other.[304] If Canadians generally and Ontarians specifically have come to embrace the value of a public system of health care, what was the history that led to this metanoia from absolute personal autonomy and responsibility for one's own health to a shared responsibility which this author would suggest is rooted in the gospels and divinely bestowed upon the Church as one of its primary apostolates?[305]

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[300] See MAIONI, *Health Care*, 28.

[301] GOVERNMENT OF CANADA, Canada Health Act, R.S.C. 1985, c. C-6, Ottawa, Minister of Justice, http://laws-lois.justice.gc.ca/eng/acts/c-6/fulltext.html (10 December 2013).

[302] See MAIONI, *Health Care*, 28.

[303] See SIMPSON, *Chronic Condition*, loc. 83.

[304] Ibid.

[305] See Matt. 10:8.

2.2 The Original Sponsors of Catholic Health Care in Ontario

Some would suggest that the first Catholic hospital in Canada was "sponsored" at the Jesuit mission of Saint-Marie-among-the-Hurons.[306] The Church in its missionary endeavours and ministry saw the mandate to heal as Jesus healed as integral to its mission. As the wilderness of Canada gave way to explorers, so too the Church felt the call to bring the light of the gospel to this new world. The zeal for souls found tangible expression in its loving care for the sick.

In 19th Century Ontario, the wealthy were cared for in their homes. The first sick to be cared for in Kingston, were housed in blockhouses and later in an empty brewery warehouse, owned by the Female Benevolent Society, an ecumenical group which provided the only hospital care to the poor.[307] Catholic health care matured as the nation was inhabited primarily by settlers from France and England. The invitation of bishops throughout the provinces was extended to three principal congregations: the Religious Hospitallers of Saint Joseph, Les Sœurs Grises de la Croix, (later known as Les Sœurs de la Charité d'Ottawa), and the Sisters of St. Joseph.

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[306] "Saint-Marie among the Hurons, Home of Canadian Martyrs," in *The Toronto Star*, 27 June 1987, H10, https://global-factiva-com.proxy.bib.uottawa.ca/ha/default.aspx#./!?&_suid=146982158056605320113073176482 (2 January 2016).

[307] See J. DESLAURIERS, "Hotel Dieu Hospital, Kingston, 150 years: 1845-1995. The House of Tender Mercy Continuing to Serve," Kingston, Brown & Martin, 1995, in *The Great Canadian Catholic History Project,* Digitized March 2015, 5, http://www.chac.ca/about/history/books/on/Kingston_Hotel%20Dieu%20Hospital_150th.pdf (2 January 2016) (= DESLAURIERS, "Hotel Dieu").

2.2.1 The Religious Hospitallers of St. Joseph

The desire of the Church to continue Jesus healing mission was evident in Jerôme Le Royer. Born in 1597 in France, Le Royer noted that although the wealthy in France were cared for in their homes by servants, the sick poor depended on whatever charitable organization was prepared to help. In 1630, he recounted a vision in which God told him to establish an order of nursing Sisters to care for the sick, poor and most needy, to be called the Religious Hospitallers of St. Joseph (RHSJ) in honour of the Holy Family.[308] In May 1636, Marie de la Ferre and Anne Foureau formed a community at the Hotel-Dieu with three servants of the poor already on the site.[309] The new order was canonically established in 1643 and noted as their mission, "To announce the good news of Jesus Christ by service to the poor and the sick."[310] The title "religious hospitallers" dates to the Crusades, when "hospitallers" was the designation of an Order of military monks or Knights who served as a military medical corps for the Christian forces trying to rescue the Holy Places from the hands of the "infidels."[311]

Le Royer later recruited colonists to settle in New France under the leadership of Paul de Chomedey de Maisonneuve, gentleman, officer, member of the Société Notre-

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[308] See G. BROWN (ed.), *Dictionary of Canadian Biography*, Toronto, University of Toronto Press, 1 (1966), p. 214, (= BROWN, *Dictionary*, vol. 1), J. DESLAURIERS, "Hotel Dieu," 1-3.

[309] See RELIGIOUS HOSPITALLERS OF ST. JOSEPH, "Foundations," http://www.rhsj.org/en/france_330_-21.php (25 March 2016).

[310] See RELIGIOUS HOSPITALLERS OF ST. JOSEPH, "France, La Fleche Community," http://www.rhsj.org/en/france_330_-21.php (25 March 2016).

[311] See DESLAURIERS, "Hotel Dieu," 1-3.

Dame de Montréal, founder of Ville-Marie, and first Governor of the island of Montréal.[312] Included in the first group of settlers was Jeanne Mance, who volunteered to travel to Montréal[313] specifically to care for the sick[314] and establish a hospital. Mance is considered the foundress of the Canadian nursing profession.[315] Shortly after her arrival, Jeanne Mance opened a dispensary in the fort. In 1644, she had the first Hotel-Dieu built.[316] In 1659, Sisters Judith Moreau de Brésoles,[317] Catherine Macé[318] and Marie Maillet[319] arrived in Ville-Marie and established the first religious community of women in Montreal. With Jeanne Mance, they began the long tradition of lay-religious collaboration.[320] Mance's Montréal infirmary would form the precursor of l'Hôpital Général des Frères Charron, later known as the Montréal General.[321] Responsibility for the hospital was transferred to the RHSJ in 1676 who administered it until 1973. The hospital itself was expanded and also rebuilt after three major fires, and served as the only hospital in Montréal until 1822.[322]

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[312] See BROWN, *Dictionary*, vol. 1, 212.

[313] Ibid., 483.

[314] See J. DESLAURIERS, "Hotel Dieu," 1-3.

[315] J. NOEL, "Jeanne Mance," in *Historica Canada*, 27 Feb 2008, http://www.thecanadianencyclopedia.ca/en/article/jeanne-mance/ (25 March 2016).

[316] See RELIGIOUS HOSPITALLERS OF SAINT JOSEPH, Montreal History, http://www.rhsj.org/en/history_360_-21.php (25 March 2016).

[317] See BROWN, *Dictionary*, vol. 1, 512-513.

[318] See ibid., 478.

[319] See ibid., 480.

[320] See RELIGIOUS HOSPITALLERS OF SAINT JOSEPH, Montreal History, http://www.rhsj.org/en/history_360_-21.php (25 March 2016) (= RHSJ, Montreal History).

[321] See HÔPITAL GÉNÉRAL DES FRÈRES CHARRON, http://digital.library.mcgill.ca/hospitals/search/arch.php?id=020 (25 March 2016).

[322] See RHSJ, Montreal History (25 March 2016).

In 1827, Irish settlers arrived to work on the Rideau Canal. Given the poverty of the time and lack of sanitation, disease became rampant. The first major outbreak of cholera noted in Upper Canada struck Kingston in 1832, and precipitated the construction of Kingston General Hospital.[323] In 1841, Bishop Remigius Gaulin[324] begged Bishop Ignace Bourget of Montreal[325] to send him Sisters to open a hospital in Kingston. Bishop Bourget came to Kingston to investigate the credibility of the request and found the poor sick almost totally abandoned. Bishop Bourget returned to Montreal and told the RHSJ of the difficulties of extreme poverty and the atmosphere of bigotry. "You must depend solely on Divine Providence," and assured them that God had never failed those who placed their whole trust and confidence therein.[326]

In 1845, the Bishop of Kingston welcomed the RHSJ to care for the sick the poor and the most needy. This was to be the first foundation outside of the Sisters' arrival in Montreal in 1659. Sister Amable Bourbonnière was chosen as the foundress with Sisters Hugette Claire Latour, Louise Davignon and Émilie Barbara as assistants. Upon their arrival, they were greeted by the new Bishop of Kingston (Bishop Patrick Phelan) and the Vicar General Angus Macdonell. Bishop Phelan purchased property for the Sisters to begin their ministry.[327] The local citizens of Kingston recognized the value the Sisters would

[323] See DESLAURIERS, "Hotel Dieu," 61.

[324] See F. HALPENNY AND J. HAMELIN, *Dictionary of Canadian Biography*, Toronto, University of Toronto Press, vol. VII (1988), 549. (= HALPENNY and HAMELIN, *Dictionary*, vol. VII).

[325] See ibid., 8.

[326] See DESLAURIERS, "Hotel Dieu," 4.

[327] See ibid., 5.

bring to their community in their ministry to the sick. The Secretary-treasurer of the Seamen's association and President of the Sailors' Society began a fund-raising campaign for more than $4,000 that the Vicar General believed would be necessary to enlarge and furnish the two small stone houses to be used as a hospital.[328] Unofficially, the Sisters also cared for patients from the prison.[329]

Throughout the years of ongoing renovations and new construction, the Hotel Dieu expanded to provide for the spiritual and physical care of citizens of Kingston and surrounding area, without discrimination regarding religion, race or class. Additional foundations of Hotel Dieu were established, upon the invitation and with the approval of the local bishops, in St. Catharines,[330] Cornwall,[331] and Windsor.[332]

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[328] See DESLAURIERS, "Hotel Dieu," 10.

[329] See ibid., 96.

[330] See K. KORCHOK, *Great Beginnings: The First 50 Years of Caring at Hotel Dieu Hospital, St. Catharines*, Kingston, Religious Hospitallers of St. Joseph, St. Joseph Region Archives, http://www.chac.ca/about/history/books/on/St%20Catherines%20_Hotel%20Dieu%20Hospital%2050th.pdf (12 January 2016) (= KORCHOK, *Great Beginnings*).

[331] See D. KANE, *Caring People, Caring Hands: The Religious Hospitallers of Saint Joseph of Cornwall, 1897-1997*, Gananoque, 1000 Islands Printers, 1996, in Religious Hospitallers of St. Joseph, St. Joseph Region Archives.

[332] See RHSJ, History, Ontario, http://www.rhsj.org/en/ontario_352_-21.php (25 March 2016), Religious Hospitallers of St. Joseph, *Record of Hotel-Dieu of St. Joseph's Hospital, Windsor, Ontario, 1888-1928*, Kingston, Religious Hospitallers of St. Joseph, St. Joseph Region Archives, 1928, http://www.chac.ca/about/history/books/on/Windsor_Hotel%20Dieu%20of%20St.%20Joseph's%20Hospital_40th.pdf (15 January 2016).

2.2.2 Les Sœurs de la Charité de Montréal

The progeny of one of the first settlers to New France, Marguerite Dufrost de La Jemmerai,[333] was destined to become one of Canada's saints in no small part due to her dedication to the poor and sick in this new country of Canada. St. Marguerite d'Youville was born in 1701, educated in Québec, and married François-Madeleine d'Youville who served as part of the entourage to the Governor of Montréal. D'Youville's activities extended beyond his regular employment, and included the illicit and disreputable trade in liquor to Canada's indigenous Peoples.[334]

Coupled with a marriage that could be considered as far from idyllic, four of St. Marguerite d'Youville's children died in infancy. Eight years after her marriage began, François-Madeleine d'Youville died in 1730,[335] leaving St. Marguerite at twenty eight years old with two sons, many debts and the public infamy of his activities. It was at this point that she determined to devote her life to God as a member of the Confraternity of the Holy Family of Notre Dame Church. From here, she began to visit regularly the lonely and destitute who inhabited the Old Montréal General Hospital.[336]

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[333] See "History of the Grey Nuns of Montreal," in http://www.sgm.qc.ca/data/soeursgrises/files/file/history_of_the_grey_nun_of_montreal.pdf (25 March 2016), D. HAYNE and A. VACHON, *Dictionary of Canadian Biography*, Toronto, University of Toronto Press, 2 (1969), pp. 110, 135, 202, 378, 414, 673 (= HAYNE and VACHON, *Dictionary*, vol. 2).

[334] See E. ILES, "Ask the Grey Sisters: Sault Ste. Marie and the General Hospital, 1898-1998," Toronto, Dundurin Press, 1998, in *The Great Canadian Catholic Hospital History Project*, Ottawa, CHAC, Digitized May 2015, 27 (=ILES, "Ask the Grey Sisters"), http://www.chac.ca/about/history/books/on/Sault%20Ste.%20Marie%20General%20Hospital_100th.pdf (2 January 2016), HAYNE and VACHON, *Dictionary*, vol. 2, 673.

[335] See HAYNE and VACHON, *Dictionary*, vol. 2, 673.

[336] See ILES, "Ask the Grey Sisters," 27, F. HALPENNY, *Dictionary of Canadian Biography*, Toronto, University of Toronto Press, vol. III (1974), 195 (= HALPENNY, *Dictionary*).

Hearing the call to serve the poor, imprisoned, sick, and believing that in so doing they were serving Christ himself, three like-minded women joined Marguerite in her ministry and decided to consecrate themselves completely to this task by welcoming anyone in need. Because new religious communities could not be founded in New France at the time by order of the King who financially supported approved French congregations both in France and in the New World, and according to the testimonies of the first Sisters, this consecration was made in secret on 31 December 1737.[337]

This new community of women moved into a stone house on Notre Dame Street in Montréal[338] which historically has been considered the origin of the religious order she was to found. The charitable ladies did various kinds of handiwork to ensure their subsistence.[339] In January 1745, fire destroyed this first foundation and its inhabitants were forced onto the streets. Two days later, Marguerite and her companions signed a new agreement called "Original Commitment" which placed all their possessions in common. One of the clauses in this commitment was "to receive, feed, and shelter as many poor as we can take care of."[340] Over the course of the next two years, this committed group of women had to move four times.[341] In their ministries, they were openly jeered as les Sœurs Grises (the tipsy nuns), an allusion to François d'Youville's association with the liquor

[337] See "History of the Grey Nuns of Montreal," http://www.sgm.qc.ca/data/soeursgrises/files/file/history_of_the_grey_nun_of_montreal.pdf (25 March, 2016) (= History of the Grey Nuns of Montreal).

[338] See HALPENNY, *Dictionary*, vol. III, 486.

[339] See History of the Grey Nuns of Montreal.

[340] Ibid., 1.

[341] See ibid.

trade. “We are servants of all for the sake of the poor,” she told her companions, “and everyone must know that we never refuse to serve.”[342] The first person welcomed by Marguerite d’Youville in the autumn of 1737 was a blind woman in her sixties, the widow Françoise Auzon.[343]

In 1747, Marguerite and her companions were given control of the aging and bankrupt Montréal General Hospital[344] which, through their dedication and efforts, they brought back to life. In the terminology of the seventeenth century, a “general hospital” was an institution that took in old people, the ill, and the poor. Health care, on the other hand, was dispensed at the Hotel Dieu.[345] It was only when the Sisters assumed responsibility for the hospital that its doors were opened to female patients as well as to men and to smallpox victims.[346] During this period, there was no one to take care of women in difficulty, some of whom were disabled, widowed, or without family support. This problem was serious because the Montreal General Hospital only welcomed men.

In 1753, the group of women who had joined Saint Marguerite d’Youville were recognized by the Church as a religious order, officially known as the Sisters of Charity of the General Hospital (commonly and affectionately known as Les Sœurs Grises, The Grey

[342] See ILES, “Ask the Grey Sisters,” 28.

[343] See History of the Grey Nuns of Montreal.

[344] See History of the Grey Nuns of Montreal, HALPENNY, *Dictionary*, vol. III, 195.

[345] See History of the Grey Nuns of Montreal.

[346] See ILES, “Ask the Grey Sisters,” 28.

Nuns).[347] The community was at last recognized by King Louis XV. In June 1753, the King signed the Letters Patent of the community, and St. Marguerite, called the Widow Youville, officially became the administrator of the General Hospital. By order of Bishop de Pontbriand,[348] the Sisters received the Rule that organized the community's life. People on the streets were heard saying, "Go to the Grey Nuns; they never refuse anything."[349]

Fire destroyed the Montréal General Hospital in 1753. In St. Marguerite's letter to her spiritual advisor, she notes, "My dear Father, pray that God will give me the strength to bear all of these crosses and to make saintly use of them. So much at one time: to lose one's king, one's country, one's possessions."[350] Within 20 years, St. Marguerite would be called to her heavenly reward and the Sisters of Charity of the General Hospital would be established as les Sœurs de la Charité de Montréal.

Élizabth Bruyére, the foundress of the first foundation of the Sisters of Charity in Ottawa, entered the Montréal Grey Nuns in 1839. In 1844, Fr. Pierre-Antoine Telmon[351] wrote to Mother McMullen, mother Superior of the Montréal General. He noted, "The city of Bytown is in great need of good schools … and the adults have a great need of good example and prayers that a few nuns would be able to give. I will do all I can in order to

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[347] See ILES, "Ask the Grey Sisters," 28, HALPENNY, *Dictionary*, vol. 3, 487.

[348] See F. HALPENNY, *Dictionary*, vol. III, 192-199.

[349] See "History of the Grey Nuns of Montreal."

[350] See F. HALPENNY, *Dictionary of Canadian Biography*, Toronto, University of Toronto Press, vol. IV (1979), 238 (= HALPENNY, *Dictionary*, vol. IV).

[351] See F. HALPENNY and J. HAMELIN, *Dictionary of Canadian Biography*, Toronto, University of Toronto Press, vol. VIII (1985), 66.

obtain them."[352] In 1845, Sister Élizabth Bruyére, then only twenty-six years old, led the group who had been selected for the Ottawa mission.[353] Upon their departure from Montréal, the Bishop offered this blessing, "Go, daughters of the cross," and in his blessing bestowing on them the name by which they would become popularly known – the Grey Sisters of the Cross. The Bytown Sisters would be governed originally by the Sisters of Charity of Montreal.[354] The first Ottawa General Hospital was opened as both a school and a hospital.[355] In 1850, Bishop E. Guigues, the first Bishop of the Diocese of Ottawa, gave the Sisters a building erected during the 1847 typhus epidemic better known as the "Emigrants' Hospital."[356] From here, the Sisters established hospitals in Pembroke,[357] Mattawa,[358] Sudbury,[359] Penetanguishene,[360] and Sault Ste. Marie.[361]

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[352] See CHAC, "Ottawa General Hospital, 1845-1980," in *The Great Canadian Catholic Hospital History Project*, Ottawa, CHAC, Digitized July 2005, p. 15, http://www.chac.ca/about/history/books/on/Ottawa_General_Hospital_1845-1980.pdf (3 January 2016) (= CHAC, OGH).

[353] See HALPENNY and HAMELIN, *Dictionary*, vol. VII, 59.

[354] See ILES, "Ask the Grey Sisters," 29.

[355] See CHAC, OGH, 5.

[356] Ibid., 21.

[357] See "Grey Sisters of the Immaculate Conception Pembroke, Ontario Twenty Years After," Pembroke, Archives of the Grey Sisters of the Immaculate Conception, http://www.chac.ca/about/history/books/other/Grey%20Sisters%20Pembroke%2020th.pdf (3 January 2016).

[358] LADIES OF THE MATTAWA HOSPITAL AUXILIARY, History of the Mattawa General Hospital, 1878-1978, Mattawa, Mattawa Hospital, 1978, http://www.chac.ca/about/history/books/on/Mattawa%20General%20Hospital_100th_EN.pdf (7 January 2016).

[359] See H. PARENT, "*L'Hôpital Saint-Joseph de Sudbury*," Ottawa, Archives des Sœurs de la Charité d'Ottawa, 1985, Digitized December 2013, http://www.chac.ca/about/history/books/on/Sudbury_St.%20Jospeh's%20Hospital%20thesis.pdf (2 March 2016).

[360] See D. SHIRRIFF, "Penetanguishene General Hospital, 1911-1971," Penetanguishene, Penetanguishene General Hospital, 1971, http://www.chac.ca/about/history/digital_e.php#ON (24 January 2016).

[361] See ILES, "Ask the Grey Sisters."

2.2.3 The Sisters of St. Joseph

In Le Puy-en-Velay, France, there was an institution for orphan girls and young widows. Around 1646, Bishop de Maupas arranged for Françoise Eyraud to take charge. She was soon joined by five others who formed the nucleus of a new community. In 1650, they made simple vows and were given canonical status by the bishop. In the following year, they were legally constituted by an Act of Association. Father Jean Pierre Médaille SJ assisted the original six women to form a community who would offer their lives to minister to the neediest in their area – the "dear neighbour."[362] They ministered to the sick and poor, visiting these people in their own homes with healing remedies for body and soul. They took in street children, orphans and poor girls for whom prostitution seemed the only way to survive. The Sisters taught them to do embroidery and make lace and ribbons to support themselves. They also visited women prisoners, bringing food and clothing as well as spiritual solace. The Sisters would also teach school-age girls to read and write when no one else was doing it. [363]

The French Revolution (1789-1794) saw the dissolution of the communities, the confiscation of properties and the dispersal of the Sisters, several of whom were guillotined.[364] Among the prisoners was Jeanne Marie (Mother St. John) Fontbonne,

[362] See SISTERS OF ST. JOSEPH OF TORONTO, "A Timeline of Historic Milestones, 1650 Early History," in http://www.csj-to.ca/history (25 March 2016) (= CSJ Toronto, "A Timeline").

[363] See CSJ TORONTO, "A Timeline," 1648, http://www.csj-to.ca/history (25 March 2016).

[364] See CSJ TORONTO, History, French Revolution, http://www.csj-to.ca/french-revolution (25 March 2016).

superior of the Monistrol community. She returned to her family in 1794 and with a few companions, continued working among the poor for the next 13 years.[365]

At the request of the Bishop of Lyons, Mother St. John was able to refound the community in 1807.[366] She worked to restore the congregation as she knew it before the Revolution: little groups of Sisters living close to the people, wearing ordinary dress, visiting the homes of people who were sick and poor and helping all in need. Soon, the Sisters were required by the government to organize into a new pattern, much of it contrary to the vision of the founding Sisters. Their major work would be education. Formerly independent small houses would be no more, and a centralization into diocesan congregations would become the norm.[367]

In 1836, six Sisters of St. Joseph, led by Mother Delphine Fontbonne[368] arrived in America at the request of Bishop Joseph Rosati, the first bishop of the Diocese of St. Louis.[369] As had been the direction of the King of France, the Sisters' ministries in the New World focused on education. Just 11 years after the American foundation of the Sisters of St. Joseph, thirty thousand "famine Irish" flooded into Toronto. Diseases such

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[365] See CSJ TORONTO, "A Timeline," French Revolution, http://www.csj-to.ca/history (25 March 2016).

[366] See CSJ TORONTO, "A Timeline," 1807, Lyons, France, http://www.csj-to.ca/history (25 March 2016).

[367] See CSJ TORONTO, "Refounding," http://www.csj-to.ca/refounding-congregation (25 March 2016).

[368] See F. HALPENNY and J. HAMELIN (eds.), *Dictionary of Canadian Biography*, Toronto, University of Toronto Press, vol. VIII (1985), 298-299 (= HALPENNY and HAMELIN, *Dictionary*, vol. VIII).

[369] See CSJ TORONTO, "A Timeline." http://www.csj-to.ca/history (25 March 2016).

as cholera, typhus, and diphtheria, spread. Fever sheds were set up on the original grounds of Toronto General Hospital to care for the new arrivals.[370] Many who attended the sick fell victim to the typhus themselves, including the hospital superintendent and the first Catholic bishop of the Toronto Archdiocese, Michael Power.[371]

It was into this environment that Bishop Charbonnel came as the Roman Catholic bishop in 1850. Familiar with the works of the Sisters of St. Joseph in St. Louis, he requested that Sisters, again led by Mother Delphine Fontbonne, be sent to Toronto, to assist him in his ministry to his new diocese.[372] In a letter to Mother Delphine's brother in France after Mother Delphine had succumbed to typhus, Bishop Charbonnel expressed his appreciation for Mother Delphine's worth: "This excellent and worthy niece of his saintly aunt, Mother Saint-Jean, in five years had established in Toronto a novitiate, an orphanage, and a house of temporal and spiritual succour, and several other (establishments) in the dioceses … Very sensible and wise, she … possessed sound judgement, perceptiveness, and foresight. She was industrious, active, and provident."[373] From this beginning in the Archdiocese of Toronto,[374] the Sisters of St. Joseph established both congregations and

[370] See HALPENNY and HAMELIN, *Dictionary*, vol. VII, 705-706.

[371] See CSJ TORONTO, "A Timeline," 1847, http://www.csj-to.ca/history (25 March 2016).

[372] See CSJ TORONTO, "A Timeline," 1850, Bishop Charbonnel," http://www.csj-to.ca/history (25 March 2016).

[373] See HALPENNY and HAMELIN, *Dictionary*, vol. VIII, 299.

[374] See D. BISSON, *Compassion Builds a House: The Legacy of Caring at Providence Centre, Toronto*, Toronto, Providence Centre, 1998, in Archives of the Sisters of St. Joseph of Toronto, http://www.chac.ca/about/history/books/on/Toronto_Providence%20Healthcare%202000.pdf (24 January 2016), I. MCDONALD, *For the Least of My Brethren: A Centenary History of St. Michael's Hospital*, Toronto, Dundurn Press, 1992 (= I. McDonald, *For the Least of My Brethren*), E. SMYTH and L. WICKS, *Wisdom Raises Her Voice: The Sisters of St. Joseph of Toronto Celebrate 150 Years*, Toronto, Transcontinental Printing, 2001.

hospitals in the following dioceses: Hamilton (1852),[375] London (1868),[376] Peterborough (1890),[377] Pembroke (1921),[378] Sault Ste. Marie (1936).[379] Other congregations which

[375] See P. SAVAGE, *To Serve with Honour: The Story of St. Joseph's Hospital, Hamilton, 1890-1990*, Toronto, Dundurn Press, Archives of the Sisters of St. Joseph of Hamilton (1990), http://www.chac.ca /about/history/books/on/Hamilton_St.%20Joseph's%20Hospital%201890-1990.pdf (5 January 2016), M. SPENCE, "History of the St. Joseph's Hospital & School of Nursing, Guelph, Ontario: 1861-1940 & 1900-1940," Guelph, St. Joseph's Health Centre, 2002, http://www.chac.ca/about/history/books/on/Guelph_ St.%20Joseph's%20Hospital%20&%20School%20of%20Nursing.pdf (7 January 2016), C. RUTTY, *St. Mary's General Hospital, Kitchener, Ontario: A Circle of Care, 75 Years of Caring*, Kitchener, St. Mary's General Hospital, 1999, http://www.chac.ca/about/history/books/on/KitchenerSt.%20Mary's%20Hospital _75th.pdf (12 January 2016), P. ROSSER, *The Sisters of St. Joseph of Hamilton: Leaders in Health Care*, Hamilton, the Sisters of St. Joseph of Hamilton, http://www.chac.ca/about/history/books/sisters/Sisters %20of%20St.%20Joseph%20of%20Hamilton%20%E2%80%93%20Leaders%20in%20Health%20Care_20 16.pdf (23 March, 2016).

[376] See R. STEPHEN and L. SMITH, *St. Joseph's Hospital 1888-1988: Faith and Caring*, London, St. Joseph's Health Centre of London, 1988, http://www.chac.ca/about/history/books/on/London_ St.%20Joseph's%20Hospital_100th.pdf (12 January 2016), ST. JOSEPH'S HOSPITAL, *St. Joseph's Hospital 1890-1990: Sharing the Journey, Chatham, Ontario*, Chatham, St. Joseph's Hospital, 1998, http:// www.chac.ca/about/history/books/on/Chatham_St.%20Joseph's%20Hospital_100th.pdf (23 January 2016).

[377] See A. WILSON, "Peterborough and St. Joseph's Hospital: An Historical Appreciation," Peterborough, St. Joseph's Hospital, http://www.chac.ca/about/history/books/on/Peterborough_ St.%20Joseph's%20Hospital_100th_Wilson.pdf (24 January 2016), M. MCDONALD, *Saint Joseph's General Hospital Peterborough, Ontario: 100 Years: A Commemorative Publication*, Peterborough, Saint Joseph's General Hospital, 1990, http://www.chac.ca/about/history/books/on/Peterborough_St.%20 Joseph's%20Hospital_100th_McDonald.pdf (24 January 2016).

[378] See J. STEVENSON, St. Francis Memorial Hospital Barry's Bay, Ontario, Celebrating 50 Years of Community Caring 1960-2010, http://www.chac.ca/about/history/books/on/Barry's%20Bay%20_St.%20 Francis%20Memorial%20Hospital%201960-2010.pdf (3 May 2016).

[379] See T. PATTERSON, *64 Years of Caring, 1931-1995, St. Joseph's General Hospital, North Bay, ON*, North Bay, St. Joseph's Hospital, 1995, http://www.chac.ca/about/history/books/on/ North%20BaySt.%20Joseph's%20Hospital_1931-1995.PDF, (1 January 2016), *The Marymount School of Nursing, Sudbury General Hospital of the Immaculate Heart of Mary 1957 Yearbook*, Sudbury, Sudbury General Hospital, http://www.chac.ca/about/history/books/on/Sudbury_General%20Hospital%20 Marymount%20School%20of%20Nursing%201957.PDF (4 May 2016), G. CAMPBELL, "The Spirit, the Lamp and the Key: A Brief Chronicle of St. Joseph's Hospital, Thunder Bay During Its First 100 Years, Thunder Bay, St. Joseph's General Hospital, 1984, in Archives of the Sisters of St. Joseph of Sault Ste. Marie, North Bay, ON.

The Sisters of St. Joseph of Sault Ste. Marie voluntarily transferred St. Joseph's General Hospital, North Bay, St. Joseph's Hospital, Blind River, and St. Joseph's General Hospital, Little Current, to the public hospital system in order to avoid medico-moral issues related to abortion and sterilization, dwindling numbers of Sisters willing and available to assume leadership roles within the hospitals and to avoid competition for scarce public health care resources.

Sudbury General Hospital of the Immaculate Heart of Mary was constructed by the Sisters of St. Joseph of Sault Ste. Marie at the request of local physicians and Sudbury business people and opened in 1950. In 1997, the Health Services Restructuring Commission ordered amalgamation of all three health care facilities in Sudbury to form the Sudbury Regional Hospital, a non-denominational hospital. After a protracted legal challenge, a role for the Sisters of St. Joseph of Sault Ste. Marie was identified in Sudbury.

established hospitals in Ontario included the Sisters of Providence of St. Vincent de Paul,[380] Les Sœurs de la Providence,[381] Les Filles de la Sagesse,[382] and the Misericordia Sisters.[383]

2.3 The Evolution of Sponsorship of Catholic Health Care in Ontario

While sponsorship of Catholic Health care in Ontario was facilitated by the response to the needs of their time by many religious institutes, the rationale for engaging in the ministry of health care was rooted in the gospel mandate of Jesus to his Church to bring the good news of salvation to the entire world. The Sisters' ministry preceded any formalized law outside of each congregation's mission and constitution, yet their ministry roots and expansions have been expressed in current canonical norms.

In recognition of its new role and mandate, the name of the hospital was changed to St. Joseph's Health Centre, Sudbury. After prolonged efforts to work in partnership within the Sudbury public hospital system, services originally designated to be delivered by St. Joseph's Health Centre (Complex Continuing Care, Religious and Spiritual Care, and Ethics,) were relocated to a newly constructed site on property leased from Laurentian University. Sudbury Regional Hospital retained rehabilitation services which was originally to be coordinated by St. Joseph's Health Centre, and later withdrew from their agreement to purchase Religious and Spiritual Care and Ethics services from St. Joseph's Health Centre. St. Joseph's Health Centre later expanded and constructed St. Gabriel's Villa in Valley East, Sudbury.

[380] See V. MEGRATH, "St. Vincent de Paul Hospital, 1887-1987, Brockville, St. Vincent de Paul Hospital, 1987, in the Archives of the Sisters of Providence of St. Vincent de Paul, Kingston, http://www.chac.ca/about/history/books/on/Brockville_St.%20Vincent%20de%20Paul%20Hospital_100th%20Anniversary.pdf (4 February 2016), SISTERS OF PROVIDENCE OF ST. VINCENT DE PAUL, "St. Mary's of the Lake Hospital, Kingston, ON, nd, http://www.chac.ca/about/history/books/on/Kingston_St%20Marys%20on%20the%20Lake.pdf (4 February 2016), in the Archives of the Sisters of Providence of St. Vincent de Paul in Kingston.

[381] HÔPITAL NOTRE-DAME, HEARST, "Hôpital Notre-Dame de Hearst, Histoire d'une Fondation," Hearst, Hôpital Notre-Dame de Hearst, 1992, http://www.chac.ca/about/history/books/on/Hearst_Notre%20Dame%20Hospital_Histoire%20Nov%202002.pdf (3 June 2016).

[382] L'HÔPITAL MONTFORT, "Célébrons Montfort, 22 octobre 2003, Ottawa, Hôpital Montfort Hospital, 2003, http://www.chac.ca/about/history/books/on/Ottawa_Hopital%20Montfort%2050e%20Celebrons%202003.pdf (3 July 2016), *l'Hôpital St-Jean-de-Brébeuf*, Sturgeon Falls, ON, 30 novembre 1947, http://www.chac.ca/about/history/books/on/Sturgeon%20Falls_St.%20Jean%20de%20Brebeuf%20Hospital%201947.pdf (4 July 2016).

[383] See F. CRONIN, "End of an Era: The Story of Scarborough General Hospital," Toronto, Scarborough General Hospital, 1974, http://www.chac.ca/about/history/books/on/Toronto_Scarborough%20General%20HospitalEnd%20of%20an%20Era%201974.PDF (4 July 2016), in the Archives of the Institute of the Sisters of Misericordia.

1) In each instance, the establishment of a religious institute to respond to the needs of a diocese was preceded by a formal invitation as well as personal support of the diocesan bishop. (cc. 375, 381, 383, 394)

2) Members of religious institutes were consecrated through the profession of the evangelical counsels into a "stable form of living," and were committed to "building up the Church, and to the salvation of the world." (c. 573, 607)

3) Each congregation:

i. received canonical approbation by a competent authority of the Church. Religious institutes grew and flourished according to the spirit of the founders and sound tradition. (c. 576)

ii. observed faithfully the mind and designs of their founders regarding nature, purpose, spirit, and character of an institute (c. 578).

4) Religious institutes in each diocese were erected by canonical decree by the competent ecclesiastical authority. (cc. 608, 609)

5) Institutes, when canonically separated from their founding congregations, developed their own proper laws which were reviewed and approved by proper ecclesiastical authorities. (cc. 587, 595)

6) Each canonically established religious institute was deemed to have a useful purpose for a particular Church. (c. 610)

7) Canonical approbation offered the religious institutes the freedom to "exercise the works proper to the institute …" (cc. 611, 2°, 612, 677, 681)

8) Original diocesan institutes remained under the special care of their diocesan bishop until they petitioned to become institutes of Pontifical right. (cc. 593, 594, 678, §§1, 3)

While congregations began health care ministries in response to real needs of the communities in which they were called to serve, the model of shepherding or sponsoring these important apostolates would be destined to change along with the times. New models of sponsorship would be needed, and even now, continue to evolve based on changing times, changing cultures, and changing needs.

2.3.1 The Evolution of New Sponsorship Models

The evolution of sponsorship is reflected in the writings of two authors. R. Kealy[384] published his work when Catholic sponsorship of ministries and juridical interpretations of sponsorship models focused on Catholic education were relatively new. Controversy over the Catholic identity of Church-sponsored institutions, especially hospitals and universities, caused both Church authorities and those responsible for shepherding these ministries, to pause to consider if these ministries still held essential elements of hierarchical oversight and juridic accountabilities. Events such as the sale of St. Louis University Hospital to a for-profit health chain, created an adversarial relationship between the Archbishop of St. Louis and the St. Louis province of the Jesuits who sponsored the institution.[385] Fr. James Tunstead Burtchaell, former Provost of Notre Dame University, published a book, *The Dying of the Light*,[386] documenting and analyzing "the disengagement of 17 colleges and universities from their founding Christian Churches, who had lost their moorings under the watch of a single, charismatic president."[387] The questions raised was, if this can happen when there are good presidents of any Catholic sponsored apostolate, how can transfer of these apostolates to the secular realm be anticipated and avoided? The answer suggested by Fr. Burtchaell and included in Kealy's assessment, was to safeguard the authentic authority of the Church for all sponsored

[384] R. KEALY, "Canonical Aspects of Catholic Identity in the Institutional Setting," in *CLSA Proceedings*, 61 (1999), 195-209 (= KEALY, "Catholic Aspects")

[385] See KEALY, "Catholic Aspects,"195.

[386] See J. T. BURTCHAELL, *The Dying of the Light*, Grand Rapids, Eerdmans, 1998.

[387] See KEALY, "Canonical Aspects," 196.

apostolates, by maintaining control over key aspects of finances, mission integration, and religious identity etc.[388]

Fr. "Monk" Molloy, the president of Notre Dame University in his book *Monk's Reflections: A View from the Dome*, noted, "At some point, the governing board or the administration or president or the alumni or some combination thereof considered the religious heritage outdated."[389] Because it is crucial for the Board to embrace Catholic identity and mission fully, "they must be chosen well and properly instructed, which usually means a formal procedure of ongoing education, because 'very few boards of modern Catholic institutions are entirely Catholic, although it might seem desirable for them to be so, in name and in life commitment'."[390] The Board must be reminded that one of the greatest strengths of Catholic institutions, is their Catholic identity.[391] While reminding the Board of the importance of Catholic identity, objective proof or evidence of identity criteria may assist it in fulfilling its corporate oversight of mission and Catholic identity with special diligence. Special diligence is defined as "the diligence expected from a person practicing in a particular field of specialty under circumstances like those at issue."[392] For sponsors of Catholic health care organizations, this will include establishing

[388] See KEALY, "Canonical Aspects," 196.

[389] See E. MALLOY, *Monk's Reflections: A View from the Dome*, Kansas, Andrews McMeel, 1999, Kindle ed., 183 (= MALLOY).

[390] See MALLOY 191.

[391] Ibid.

[392] *Black's Law Dictionary*, 231.

and measuring Catholic identity "best practices" suggested "in light of laws issued in similar matters [and] general principles of law applied with canonical equity."[393]

Francis Morrisey offers a depth and breadth of lived experience in the ministry of Catholic health care in various jurisdictions.[394] The evolution of sponsorship of Catholic health care in the 50 years since Vatican II seems to reflect a natural evolution of grace. However, every decision taken was made with a purpose: "to ensure that the Church's health care mission could continue, while taking new situations into account."[395] As the numbers of religious willing and prepared to assume positions within traditional apostolic endeavours dwindled, recognition of the laity who are anointed for ministry through baptism and confirmation (cf. c. 225) has become both a response to Vatican II's call to all the baptized to bring about the Kingdom of God, and a welcomed infusion of the lay faithful into apostolates. While laity share leadership roles in the administration of apostolates, working collaboratively with founding religious congregations to realize the mission of the Church, founding religious congregations continue to exercise diligence and some degree of control through reserved powers. In addition to shared governance, administration, and ministry duties, religious institutes have begun to join to pool resources

[393] See c. 19.

[394] See F. MORRISEY, "Our Sponsors: Yesterday, Today, and Tomorrow," in *Health Progress*, vol. 94, no. 4 (2013), pp. 57-66 (= MORRISEY, "Our Sponsors").

[395] See MORRISEY, "Our Sponsors," 57.

and skills to enhance their apostolates through recognition of new public and private juridic persons, dependent on the needs of the apostolate and of the group.[396]

In all of these groupings and configurations of public juridic persons, the diocesan bishop continues to exercise responsibility for the works of the Church within his diocese (c. 394, §1). As the composition of persons responsible for apostolic works in the Church changes, appropriate formation with a focus on limits of executive authority also becomes increasingly important. To this day, the authority of the Church to direct and control apostolates granted public juridic personality must be reinforced, lest civil corporate status disenfranchise the Church's primary position of responsibility for the ways its mission is carried out in the Church.

Despite the eras in which these men have offered reflections on the sponsorship of apostolates in the Catholic Church, they share the same foundation. The Church's mission is to continue the mission of Jesus in our world. The fundamental tenets of sponsorship of apostolates are shared, even as the apostolate foci (education, social services, or health care) may appear to be very different. In the end, all of the Christian life and canonical norms intended to support the faithful on the journey to intimate union with God for eternity, which can be summed up in the final canon in the Code of Canon law: "the

[396] See P. SCHAEFFER, "The Changing Face of Leadership," in *Health Progress*, vol. 95, no. 5 (2014), 42-51.

salvation of souls, which must always be the supreme law in the Church, is to be kept before one's eyes."[397]

God's Spirit inspired the Council Fathers to give a renewed call to the People of God to fulfill the Church's mission: "No less fervent zeal on the part of lay people is called for today; present circumstances, in fact, demand from them a more extensive and more vigorous apostolate."[398] However, this continued zeal for the mission of the Church as expressed through sponsored apostolates does not continue in a vacuum. Just as the first bishops of Ontario recognized the needs in their particular Churches for the ministry of healing, so too the needs of all God's people must both inspire and shape sponsored apostolates in the Church.

2.3.2 Sponsored Apostolates: Responding in Faith in a Changing World

The question of how Catholic health care in Ontario can offer an expression of God's healing love (Catholic identity and mission) to a broken world, and how the Church can support this ministry, becomes more critical as our world becomes more secular and pluralistic. Throughout history, caring for the sick, the poor, widows, and orphans, was identified as a tangible expression of the covenant relationship between God and His chosen people. Unlike the gods of the Greeks and Romans whose favour was to be purchased through sacrifices,[399] each encounter between Yahweh and God's chosen

[397] See c. 1752.

[398] *AA,* no. 1, 981.

[399] See F. NAIDEN, *Smoke Signals for the Gods: Ancient Greek Sacrifice from the Archaic through Roman Periods,* New York, Oxford, 2013.

people began with the same phrase, "Do not be afraid."[400] Hebrew Scriptures, Jesus' parables, and New Testament accounts of the early Christian communities[401] offer tangible expressions of where support and healing within the community or *communio* would be found.[402] While individual experiences of God's healing grace abound, God reminds the early Church that it will find healing within the community of believers. It was in this community that they would be instructed to care for the sick, the imprisoned, the widowed and orphans.

The early Christian communities could easily identify the structure and objectives of the community of believers. As the Church grew and society became increasingly individualistic and a sense of communal or shared values became less evident,[403] it became necessary to look for definitions of "community." Örsy defines "community" or *communio* as "all external manifestations of unity, such as collegiality and solidarity."[404] Over time, with the expansion of the Church into various areas of the known world and different cultures, the Church created external structures and norms to express, to

[400] Isaiah 41:10

[401] Deuteronomy 10: 12-18; 14:20; 24:17, 20-21, Ps. 146:9, Job 20:12, Exodus 22:22, Isaiah 58:7

[402] Matt. 6:1-4, John 14: 15-21, Acts 20:35

[403] See D. RAPHAEL, A. CURRY-STEVENS, and T. BRYANT, "Barriers to addressing the social determinants of health: Insights from the Canadian Experience," in *Health Policy*, 88 (2008), 222-235.

[404] See L. ŐRSY, *Receiving the Council: Theological and Canonical Insights and Debates*, Collegeville, MN, Liturgical Press, 5 (= Őrsy, *Receiving the Council*).

promote, and to sustain the internal bond of *communio*."[405] The intent of the law was to "assist the people in the reception of God's saving mysteries."[406]

The Church's expansion throughout the world brought with it growing concerns related to individual and local community interpretations of "God's saving mysteries."[407] The experience and understanding of the Holy Spirit's graces would sustain communities of the faithful in the Church, which required hierarchical structures, laws, practices and doctrinal explanations to justify them.[408] Despite efforts to centralize and in some ways control (or as interpreted by the Church, appropriately mediate) the work of God's Spirit in the community of believers, areas which could not be easily structured or limited were the temporal and corporal works of mercy.[409]

The rationale for the Church's participation in health care throughout the world and specifically in the province of Ontario is clearly expressed in Pope Francis' Bull of Indiction for the Holy Year of Mercy *Misericordiae vultus.*[410] Expressions of God's mercy become living expressions of Jesus of Nazareth among us.[411] Mercy is reflected in the

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[405] Őrsy, *Receiving the Council*, 5.

[406] L. ÖRSY, "*Theology and Canon Law*," in BEAL, J.P, J.A. CORIDEN, and T.J. GREEN (eds.), *New Commentary on The Code of Canon Law*, commissioned by the CANON LAW SOCIETY OF AMERICA, New York and Mahwah, NJ, Paulist Press, 2000, 1. (= ÖRSY, "*Theology and Canon Law*")

[407] Ibid.

[408] See ÖRSY, *Receiving the Council*, 3.

[409] See A. TORNIELLI, *The Name of God is Mercy: A Conversation with Pope Francis*, English translation O. STRANSKY, New York, Random House, 2016, Kindle ed., loc. 807, 812.

[410] FRANCIS, Bull of Indiction for Holy Year of Mercy *Misericordiae vultus*, English translation in *Origins*, 44 (2014-2015), 744 (= FRANCIS, *MV).*

[411] See FRANCIS, *MV*, no. 1, 745.

interpenetrating love of the Trinity and is the bridge that connects God with all of creation.[412] God's mercy is intended to be a concrete reality, and not an abstract or theoretical discourse of the possible.[413] It is an expression of "visceral love [that] gushes forth from the depths naturally, full of tenderness and compassion, indulgence and mercy,"[414] and the foundation for the Church's pastoral life, caught up in the tenderness in which God's presence is made present to believers.[415] The Church is to bring the light of the faith (*Lumen Fidei)*[416] into a world which, as St. John Paul II highlighted, "seems opposed to a God of mercy and in fact tends to exclude from life and to remove from the human heart the very idea of mercy."[417] Throughout the scriptures, God's mercy is concretely expressed. "Is not this the fast that I choose … to share your bread with the hungry … when you see the naked, to cover him …."[418] If the joy of the gospel fills the heart of all believers,[419] then pastoral ministry and the works of love, "directed to one's neighbour are the most perfect external manifestation of the interior grace of the Spirit."[420] What more perfect expression of discipleship[421] than to be in Catholic healthcare ministry,

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[412] See FRANCIS, *MV*, no. 2, 746.

[413] See ibid., no. 6, 747.

[416] Ibid.

[415] See ibid., no. 10, 749.

[416] See FRANCIS, Encyclical The Light of Faith *Lumen Fidei*, 29 June 2013, in *AAS*, 105 (2013), 555-596, English translation in *Origins*, 43 (2013-2014), 161-180.

[417] ST. JOHN PAUL II Encyclical Letter God Who is Rich in Mercy *Dives in Misericordia*, 13 November 1980, in *AAS*, 72 (1980), 1177-1232, English translation in *Origins*, 10 (1980-1981), 401-416.

[418] Isaiah 58: 6-11)

[419] FRANCIS, *EG*, 421-466.

[420] Ibid., no 37, 428.

[421] See F. CHULLIKATT, "*Evangelii Gaudium*: A New Path for the Church's Journey," in *Origins*, 43 (2013-2014), 672.

the "word made flesh?"[422] Through the evolution of Catholic health care in the province of Ontario, God's saving presence continues to be made manifest.

2.3.3 Canonical Sponsorship Strategies: Responding in Faith to Shifting Political and Social Demands

The purpose of Catholic health care ministry is to offer a living, breathing expression of God's presence among us. While medicine and health care in our contemporary world have become focused on scientific and technological advances, the essence of healing is found in the experience of touch,[423] and so poignantly expressed in Pope Francis' embrace of the disfigured man.[424] In both touch and embrace can be found the essence of the ministry of Catholic health care in Ontario. The scriptural mandate to continue the healing ministry of Jesus has remained consistent over time. In every environment in which the Church has found herself, she has been sensitive to cultural differences and changing societal norms, always placing the mission of the Church to bring all of creation into union/communion with the Father as the primary goal.[425]

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[422] John 1:14.

[423] D. KELTNER, "Hands On Research: The Science of Touch," in *Greater Good: The Science of a Meaningful Life*, 29 September 2010. http://greatergood.berkeley.edu/article/item/hands_on_research (22 February 2016); See also S. JAYSON, "Human Touch May Have Some Healing Properties," in *USA Today*, (29 September 2008), 07D; M. RENZ, "Healing Touch: The Importance of Maintaining Physical Contact with Patients," in *Nursing*, vol. 24, no. 11 (1994), 46.

[424] CNN, "Meet the Disfigured Man whose embrace with Pope Francis went Viral," in *CNN Wire*, 27 November 2013, http://www.cnn.com/2013/11/26/world/europe/pope-francis-disfigured-man/ (22 February 2016).

[425] See John 17:21.

The world in which Jesus ministered and in which the Church continues her ministry has changed dramatically, through Roman times, the Renaissance and Age of Discovery, Modern, and Post-Modern times. In each stage of civilization's development, the pervasive cultures and beliefs evolved, and with it, the Church's mission evolved. The transition from a modern to postmodern North American culture offers a theoretical construct from which to analyze sponsorship of apostolates, past, present, and future.

2.3.3.1 Modernism to Postmodernism

In order to grasp the significant shift in society from modernism to postmodernism, some understanding of the each is important. Descartes' modern era premise broke from the medieval belief that faith was revealed only through authorities and tradition, and proposed that all humans were thinking beings, capable of knowing the truth from an autonomous station in life. Kant's theory of enlightenment assumed human autonomy offered an opportunity for each person to interact with the world/culture in which he lived and with which he would interact by knowing, acting and feeling, while Thomas Bacon proposed all aspects of the world could be understood and controlled, much in the same way as a machine.[426] "Evil would be eliminated. God had no place in this theory."[427]

The advent of modernism brought an increased professionalism of medicine and the rise of a "medical" model of care whose focus shifted from compassionate care of the

[426] See S. DENIG, "Between a Rock and a Soft Place," in *Christian Higher Education*, 11 (2012), 46 (= DENIG, "Between A Rock and a Soft Place").

[427] See R. STIVERS, *Evil in Modern Myth and Ritual*, Athens, GA, University of Georgia, 1982, 22-24, 28.

sick using limited pharmacological or surgical remedies to curing disease of body and mind.[428] Despite the modernists' belief that all illness and disease could be eradicated, the healing of spirits would remain elusive and could not be conquered by modern scientific theory.

From the security of modernism that defined knowledge and relationships, and assumed the potential of human control over all aspects of the environment, postmodernism offered a worldview which could be considered, not only beyond that of the modern world, but the antithesis of it. Just as the Church was preparing to transition into the modern world of the 1950s and late 1960s,[429] the age of postmodernism broke into the world's consciousness.[430] The individual and the world in which he existed was in constant communication, or a constant form of relationship which can be described as malleable at best, and boundary-less at worst.[431]

> This new age has been characterized as a transition from a mechanistic to organic society in the division of labor in its pathological inducement of *anomie* and suicide, the transformation of a social order from a community of intimates to a society of strangers, the disenchantment of the world by rationalization and the social construction of the economic system in its calculative determination and the political system in its extensive bureaucratization and the indomitable fragmentation of modern life … If the structure and process of education in the United States, including Catholic higher education was constituted on the ideals of the enlightenment project, the question now arises, and if the challenge of postmodernism is the reversal of the foundational convictions of the modern world – what then would its implications be for Catholic education?[432]

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[428] See G. ARBUCKLE, "Ministry and Postmodernism," in *Health Progress*, vol. 82, no. 2 (2001), 14. (= ARBUCKLE, "Ministry and Postmodernism").

[429] See ARBUCKLE, "Ministry and Postmodernism,"15.

[430] See ibid., 14.

[431] See DENIG, "Between A Rock and a Soft Place," 48.

[432] Ibid., 50.

In light of the shift to a postmodern world reality, is it possible to assume millennials (those born after 1981) would understand or consider as rational the concept of dogma and Church tradition? If postmoderns develop knowledge based on their own beliefs and experiences, "truth yields to opinion, beauty to taste, and goodness to preference. There are no criteria on which to make such determinations, nor can the determinations of one group be better than those of another."[433] Into this world of subjective definitions of truth, is it even possible to define core beliefs or the concept of a magisterium able to prescribe fundamental truths through divine revelation? Is it possible to convey and support the fundamental gospel principles of care for our neighbour [434] let alone suggest that those born in this postmodern world could ever support or assume responsibility for Church sponsored apostolates? Can Catholic health care carry on a dialogue with postmodernism?

Arbuckle suggests that the effects of postmodernism on the ministry of Catholic health care may produce negative effects for the ministry itself and for the development of sponsorship models to support the ministry into the future. Secularism,[435] the diminishment of religion in the personal life of North Americans, and the Church's response to sex abuse scandals have seriously damaged the Church's credibility.[436] In Canada's 2001 census,

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[433] See DENIG, "Between A Rock and a Soft Place," 51.

[434] See John 13: 34-35

[435] See MERRIAM-WEBSTER online dictionary, http://www.merriam-webster.com/dictionary/secularism (25 March 2016). Secularism is defined as the belief that religion should not play a role in government, education, or other public parts of society.

[436] See H. SCHLUMPF, "A Church at the Crossroads: Sex Abuse Scandal, Priest Shortages, Celibacy, Ordaining Women: The Issues Roiling the Catholic Church Offer Challenges – and Hope? – for the Future," in *Sojourners Magazine*, 34 (2005), 12, http://go.galegroup.com.proxy.bib.uottawa.ca/ps/

8,413,495 Ontarians self-identified as Christian, of which 46.49% or 3,911,760 self-identified as Catholic. Of perhaps equal importance was 1,841,290 Ontarians who self-identified as "No religious affiliation."[437] Only 20% of Canadians reported regular attendance at weekly Church services.[438]

Into this milieu, evolving models of Catholic health sponsorship cannot assume meaning on key values such as justice, compassion, and mercy.[439] The postmodern emphasis on measuring success in terms of financial profit alone, the over-emphasis on the individual, and expectations for immediate gratification of needs, could require significant catechesis, let alone evangelization, of Catholic sponsors, boards and staff prior to discussions focusing on the Church's interpretation of the common good.[440]

Catholic leaders in this postmodern world can focus on the negative realities (declining strength of religious institutes, retreat from any reference to "Catholicity" in favour of more generic identification such as "faith-based).[441] In the end, it will be impossible to adapt the mission to our changing cultures. What will be important will be creating ongoing and more meaningful opportunities for faith to be experienced and lived

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i.do?&id=GALE|A129811577&v=2.1&u=otta77973&it=r&p=AONE&sw=w&authCount=1# (25 March 2016).

[437] See STATISTICS CANADA, Population by religion, by province and territory, 2001 Census, http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo30b-eng.htm (25 March 2016).

[438] See "Religious Similarities and Differences Between Americans and Canadians," http://www.religioustolerance.org/canus_rel.htm (25 March 2016).

[439] See ARBUCKLE, "Ministry and Postmodernism," 16.

[440] Ibid.

[441] See ibid., 17.

at all levels of the organization. The assumption has been that the mission, vision, and values of Catholic sponsored health care facilities will be "caught," even as the modern world transitions to the postmodern world in which these essential foundations must be taught on an ongoing basis. Just as modern social realities have given way to our postmodern world, the concept of "teaching" value-based ethical reflection will not result in a command performance compliance.[442] Catholic sponsors and health care administration will require new skills including those identified by C. Martini, of listening to the word of God (*Lectio divina*), self-abdication (believing and recognizing that frank opposition to desires sometimes brings more joy than endless concessions to everything that seems desirable), silence (slavery to rumors and endless chattering personally or electronically), and humility (a recognition that it is not up to us to solve the great problems of our time). We must leave room for the Holy Spirit.[443]

2.4 Canonical Sponsorship Challenges

The question facing Catholic health care sponsors is whether the ministry will become isolated and self-absorbed, or continue to respond to the challenge of the mission in creative ways and in cultures that seem no less adverse to religion (particularly the Catholic religion) than in the days when the ministry was first founded. The founders of Catholic health care in Ontario recognized the importance of establishing communities of

[442] See J. POST, "Reflections on an Ethical Church Culture: Reflections on Ethics, Organizations, and Church Culture," in J. BARUNEK, M.A. HINSDALE and J. KEENAN (eds.), *Church Ethics and its Organizational Context: Learning from the Sex Abuse Scandal in the Catholic Church*, 2006, Kindle Edition, loc. 3746.

[443] See C. MARTINI, "Teaching the Faith in a Postmodern World," in *America*, (23 May 2008), 20.

believers who created infrastructures to respond to the needs of immigrants and the poor, as the ascending class of Catholics would assimilate gradually into North American life.[444]

As in Jesus' time, the Catholic Church and the original founders of Catholic health care in Ontario experienced their own adversity and struggle. When attempting to expand Hotel Dieu in St. Catharines, ON to meet the health care needs of that growing population, some of the members of the local community expressed negative feelings about the plan and publicly stated their support for the expansion of the public hospital only.[445] Upon the arrival of the Sisters of St. Joseph in Toronto, anti-Catholic and anti-Irish crusades were waged by the press.[446] In 1894, Toronto City Council withdrew its commitment of 40¢/day funding to St. Michael's Hospital after trustees of Toronto General Hospital wrote, "No denomination shall seize on public funds to propagate their religion under the guise of caring for the sick poor."[447] So deep ran the feelings of bigotry, when Bishop J. Walsh[448] arrived to take possession of his See, his carriage was stoned by gathered crowds. Later, the Sisters of St. Joseph convent on Bond St. was also stoned by those embracing anti-Catholic sentiments.[449]

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[444] See D. NYGREN, "Troubled Waters: Remaining a Beacon amid Change," in *Health Progress*, vol. 94, no. 4 (2013), 15.

[445] See L. RUSSO, *The Hotel Dieu, St. Catharines, ON, From the Dream in 1944 to the End of an Era*, St. Catharines, Hotel Dieu Hospital, 1980, 23, http://www.chac.ca/about/history/books/on/St.%20Catharines_Hotel%20Dieu%20Hospital_1980.pdf (24 January 2016).

[446] See J.M.S. CARELESS, "The Voice of Upper Canada, 1818-1859," in *Brown of the Globe*, vol. 1, Toronto, MacMillan, 1959, 155-179.

[447] See I. MCDONALD, "For the Least of My Brethren," 34.

[448] See F. HALPENN and J. HAMELIN, *Dictionary of Canadian Biography*, Toronto, University of Toronto Press, vol. XII (1990), 1083-1088.

[449] See I. MCDONALD, "For the Least of My Brethren," 31.

The potential to continue the ministry of Catholic health care in postmodern, secular, individualistic Ontario seems improbable if not impossible, unless we adopt Denig's argument that it is in the sphere of sponsored ministries (Catholic education and Catholic health care and social services) that the voices of those on the periphery can be brought forward and heard. It is only in the act of respectful listening to the multiple perspectives promoted in our postmodern culture and offering stabilizing truth of the gospel that the world and the Church will continue its consciousness evolution, allowing God's grace to transform all of creation into God's image and likeness. What would this mean in the ministry of Catholic health care?

In the traditional modernists' view, the world and humans were reduced to objects to be controlled by medical science. The adage of many surgical residents was, "Cut and Cure." This focus on curing diseases or ailments in the absence of a more holistic assessment and interaction with the whole person (body, mind, spirit) continues today. Our postmodern world would demand relational interactions in order to engage the body, mind and spirits of our sponsors, boards, administration and staff, in a dialogue on Catholic tradition, ethics, morality, values, etc. These are not subjects to be imposed, but topics in which the relationship of conversion occurs and where one's innate curiosity can be both tweaked and satiated.

As G. Arbuckle notes, the Church's mission and ministry in a postmodern world brings specific implications to the apostolate of Catholic health care which are both positive

and negative.[450] The days of kind women religious welcoming the poor and sick into their homes or hospitals seem to have been replaced with models of business that focus on profit margins and the realization of goals, which of themselves are not negative, but when they are subtly shifted from secondary to primary importance, the place of the Church's mission and ministry may be lost. As Arbuckle note, "Business operations must always be measured by the demands of the healing mission of Jesus Christ and the Church's ethical and social teaching."[451] Our responsibility as the baptized and bearers of the tradition of the founding congregations, is to bridge the gap between our culture and the call or vocation to serve as Jesus served.[452]

2.4.1 Canonical Sponsorship Strategies: Responding in Faith to Shifting Political and Social Demands

Historically, religious institutes were invited to various dioceses in Ontario to provide health care and education prior to the advent of socialized medicine and publicly funded education. Hospitals, nursing homes, and orphanages were founded and funded by religious congregations and generous donors. Despite the challenges faced by these apostolates, each religious institute and the people they served knew without a doubt, that the Sisters' intent was to fulfill the mission of the Church by continuing the healing mission of Jesus. The fact that these institutions were Catholic was evident throughout the environment, and included crucifixes, regular liturgical services, and a dominant presence

[450] See ARBUCKLE, "Ministry and Postmodernism," 14-18, 79.

[451] See ibid., 14.

[452] See Matt. 20:28.

of religious sisters who worked, often without compensation, in order to sustain the apostolate to the poor and marginalized. The ministry was intimately connected to the mission and apostolate of the congregation. One could at times not distinguish any difference between the congregation and its apostolate.

Prior to the late 20th century, the term "sponsorship" in relation to Catholic health care was a foreign concept. Key components of current requirements of sponsorship (use of one's name, governance [exercised through the major superior and council of religious institutes], accountability to Church authorities)[453] were evident, but coordination, control, and support of this ministry fell primarily to the jurisdiction of the founding congregations.

2.4.1.1 First Attempts at a New Model of Sponsorship

One of the first attempts to examine an alternate sponsorship model in Ontario was identified by the Sisters of St. Joseph of Toronto. Their experiences would echo efforts to develop alternate sponsorship models to respond to changing congregational demographics.

In 1986, the Sisters of St. Joseph of Toronto established the Sisters of St. Joseph Health System. The intent was to develop a federated model with five member institutions, each governed by its own Board, but with a parent Board over the whole. The goal at that time, was to develop a structure whereby the health system's board had extensive authority

[453] See MORRISEY, "Various Types of Sponsorship," 19.

to monitor and coordinate activities and to determine policy, but with minimum loss of autonomy for the member institutions.[454] While these initial efforts met with some degree of success, individual member institutions resisted any change of this nature or magnitude.

In a 1988 address to the Board of St. Michael's Hospital, the Health System President, Sister Janet Murray, expressed her deep commitment to the Church's mission in health care and sketched a probable future in which the congregation might no longer be there as a symbol of the driving force and presence of the Church in this field. The Board would then be the driving force. The Board expressed their satisfaction with a "holding company" model as had been established in St. Joseph's Health System Board. The physicians present at the meetings expressed their view that any move toward integration between St. Joseph's Hospital, Toronto, and St. Michael's Hospital, Toronto, could result in negative consequences for their programs due to loss of independence in budgeting matters.[455]

In an effort to gain an independent perspective on the potential of restructuring the sponsorship of the largest Catholic health care provider in Canada, the Sisters of St. Joseph of Toronto hired Touche Ross to offer a candid and unbiased assessment of the current situation. The "Report to St. Joseph's Health System," noted loyalties of the Boards, CEOs, management, and medical staff lay with their own institutions rather than with St. Joseph's Health System. They suggested a federated model might be sustained and strengthened,

[454] See I. MCDONALD, *For the Least of My Brethren*, 316.

[455] See ibid.

noting it would take years to bring about the change and create a sense of pride and ownership of St. Joseph's Health System within the member institutions.[456]

After considering the report, the General Council of the Sisters of St. Joseph of Toronto resolved to moved towards integration of St. Michael's Hospital and St. Joseph's Health Centre. Sister Imelda Cahill, the General Superior, noted that Providence Villa, because of its unique character, did not fit within the Council's vision of integration. An interim Board was created and charged with conducting a search for a president of the integrated system. While a system board was not quite a new model of sponsorship, it was clear the congregation could foresee a day in which the responsibility for this sponsored apostolate which the congregation had gladly undertaken for over 100 years, would of necessity, be transferred to another model of sponsorship that was yet to be defined.

2.4.1.2 Collaboration Efforts Continue

In September 1993, the Catholic Health Association of Ontario (CHAO) convened a meeting of the Owners' Alliance committee. The committee consisted of the general/provincial superiors of the nine religious congregations who sponsored Catholic health care institutions in the Province and representatives of CHAO. The meeting focused the discussions on the ministry of Catholic health care in the Province of Ontario, the capacity of congregations to continue sponsorship of these ministries, and investigation of the potential of creating an alliance of sponsors for Catholic health care in the Province. It

[456] TOUCHE ROSS, "Report to the St. Joseph Health System," June 1988, Archives of St. Michael's Hospital (ASMH), in I. MCDONALD, "For the Least of my Brethren," 317.

was hoped that collaboration through a single sponsorship model for the Province of Ontario would "strengthen, preserve, and enhance the Catholic presence in health care in the Province.[457] The purpose of the Alliance would be "to address both the internal and external challenges to the Catholic health ministry today."[458] A proposed organizational structure was developed, and supported by the participating congregations with the proviso that further consultation in each congregation would be required prior to moving forward with the model. When the meeting of the Owners' Alliance was reconvened, most congregations noted that, following consultation with their councils and members, they would not be able to proceed with a single provincial sponsorship model at this time. Some of the sponsors of Catholic health care in Ontario, continued to discuss ways of moving forward to sponsor this ministry in a canonically appropriate fashion. The group examined sponsorship models which involved creation of a juridic person which would be established by the competent ecclesiastical authority.

2.4.1.3 Choosing A Sponsorship Model

Choosing an appropriate model of sponsorship to meet both the needs of the founding religious institutes and administratively support both the trustees and administration responsible for the day-to-day operation, would be a key factor in discernment related to transfer of sponsorship of an apostolate. Religious Institutes in Ontario would need to choose between two models of sponsorship, which would define the

[457] CATHOLIC HEALTH ASSOCIATION OF ONTARIO, "A Proposal for the Implementation of a Provincial Collaborative Sponsorship Entity," 28 September1994, 1, in The Sisters of St. Joseph of Sault Ste. Marie Archives, North Bay, ON (= CHAO, "A Proposal").

[458] Ibid., 3.

competent authority to grant the decree of Public Juridic Person (PJP),[459] forming either a pontifical PJP or diocesan PJP.

2.4.1.3.1 Catholic Health Sponsors of Ontario (CHSO)

Three congregations (the Sisters of St. Joseph of Toronto, the Sisters of St. Joseph of Sault Ste. Marie, and the Grey Sisters of the Immaculate Conception), and CHAO continued to meet to investigate the advisability and feasibility of marshaling resources (human, financial, and spiritual) in their efforts to continue to sponsor Catholic health care in the Province of Ontario.

This proved to be a turning point for the apostolate of Catholic health care in Ontario. Religious institutes which had founded, funded and formed staff in their sponsored hospitals and long-term care facilities across the province, contemplated sharing control and support of this ministry with others. When change of this magnitude is anticipated, it goes without saying that its precedents include prayer, discernment, consultation, and strategic planning.[460]

After consultation with their leadership teams, congregations and facility boards, on 30 June 1997 the above mentioned congregations, along with CHAO submitted a joint

[459] See cc. 113-123.

[460] See R.J. WICKS and T. BUCK, "Reframing for Change: The Use of Cognitive Behavioral Therapy and Positive Psychology in Pastoral Ministry and Formation," in *Human Development*, vol. 32, no. 3 (2011), 14.

petition[461] to the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life (CICLSAL),[462] requesting that the status of public juridic persons of pontifical right be granted to the Catholic Health Sponsors of Ontario (CHSO). The petition, while preempting later definitions of prescribed content, reflected application requirements for pontifical public juridic persons.[463]

In response to the first petition, CICLSAL requested additional information supplementing the original petition to include provision for CHSO's "direct involvement in the governance of facilities" with accommodation for future transfer of assets to CHSO; establishment of "any concrete relationship between the juridic person and the 12 separately incorporated institutions to be co-sponsored," and specific reference to reserved powers to be noted in CHSO's statutes.[464] The decree granting the status of pontifical public juridic person was signed by Cardinal Eduardo Martinez Somalo on 24 November 1997.[465] The last paragraph of the decree is of special importance: "In the virtue of this concession, Catholic Health Sponsors of Ontario is subject to those rights and obligations

[461] See SISTERS OF ST. JOSEPH OF TORONTO et al., Dossier for Consideration by the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life: For the Granting of the Status of Public Juridic Person of Pontifical Rite, Guelph, Catholic Health Sponsors of Ontario, 1997.

[462] See ST. JOHN PAUL II, Apostolic Constitution on the Roman Curia *Pastor Bonus*, 28 June 1988, in *AAS*, 80 (1988), 841-934, English translation in *CIC*, 679-751.

[463] HOLLAND, "Vatican Expert Unpacks Canonical PJP Process," 55.

[464] E. MARTINEZ SOMALO [Cardinal Prefect of the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life], letter to R. Marr, President of CHAO, 5 September 1997, prot. no. T. 145-1/97, in The Sisters of St. Joseph of Sault Ste. Marie Archives, North Bay, ON.

[465] E. MARTINEZ SOMALO, Decree Granting Pontifical Public Juridic Person Status to CHSO, 24 November 1997, prot. no. T. 145-1/97, in The Sisters of St. Joseph of Sault Ste. Marie Archives, North Bay, ON.

which pertain to public juridic persons in the Church, and shall be governed in accordance with Canon Law and its own approved statutes as it pursues its purpose 'to embody the Mission of the Healing Ministry of Jesus in the Roman Catholic Church'."

Catholic Health Sponsors of Ontario (CHSO) and its associated civil corporation, the Catholic Health Corporation of Ontario (CHCO), were created in 1997 as a partnership model to continue the sponsorship of the health organizations of the Grey Sisters of the Immaculate Conception, Pembroke; the Sisters of St. Joseph, Sault Ste. Marie; and the Sisters of St. Joseph, Toronto. The fourth original partner in this sponsorship was the Catholic Health Association of Ontario. In 2003 the Sisters of Charity of Ottawa became a partner and the Sisters of Providence of St. Vincent de Paul of Kingston joined in 2006. In 2009, CHSO welcomed the Missionary Sisters of the Precious Blood. In 2010, the Catholic Health Sponsors of Ontario accepted the transfer of sponsorship of two institutions in Peterborough from the Fontbonne Health Care Society established by the bishop in Peterborough, bringing CHSO sponsored corporations to nineteen and the number of boards of organizations that CHSO works with to sixteen. In Ontario, three other sponsors of Catholic health care have been approved by decree.

2.4.1.3.2 Catholic Health International (CHI)[466]

In March of 1992, the provincial government of New Brunswick announced a new plan for health care delivery in that province. This was the beginning of health care reform

[466] See R. STEWART, Sponsorship Roots, 21 March 2016, personal email, bmaclellan@csjssm.ca.

across Canada as we know it. Because of these drastic changes, one Religious institute formed a Healthcare Advisory Task Force to advise their General Council on questions pertaining to sponsorship for health ministries by:

- identifying the responsibilities of sponsorship within the context of the complex realities of health care in the different milieus;
- proposing new corporate structures within the context of civil and canonical requirements;
- establishing standards for due diligence and accountability regarding Catholic identity of their institutions;
- developing effective succession plans for the transmission of the mission and values of their institutions in light of the sponsoring congregation's reality of congregational demographics;
- submitting a strategy for the implementation of this succession planning.

After much discernment, a decision was made to move forward with a new Public Juridic Persons (PJP) of pontifical right. Because of the number of facilities operating in the province of New Brunswick and because a member of the Task Force was the Executive Director of the Catholic Health Association of New Brunswick, an organized structure was put in place to test the development of a new PJP.

Catholic Health Partners Inc., the civil corporation operating as Catholic Health International, was constituted by decree of the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life on 23 March 2001, to succeed and carry on the health

care ministries conducted by the following congregations: the Religious Hospitallers of St. Joseph, the Sisters of Charity of the Immaculate Conception of St. John, Les Religieuses Filles de Jésus, Les Religieuses de Notre-Dame-Du-Sacré-Cœur, and the Catholic Health Association of New Brunswick. CHI sponsors 39 Catholic health care institutions in Ontario, New Brunswick, Nova Scotia, and the United States.

2.4.1.3.3 St. Joseph's Health Care Society, London, ON

On 30 October 1991, Sister Theresa Marie Caillouette, General Superior of the Sisters of St. Joseph of London, wrote to Cardinal Jerome Hamer, Prefect of the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life, requesting permission of the Holy See to transfer the sponsorship of three health care facilities in the Diocese of London to a Public Juridic Person to be established by the bishop of London and to be known as St. Joseph's Health Care Society.[467] The three facilities were separately incorporated under the laws of the Province of Ontario. As noted in the correspondence:

> For over 100 years the Sisters of St. Joseph have been involved in health care in the Diocese. During the last 10 years, two factors have forced the congregation to examine carefully its continued commitment to institutional health care:
>
> 1) The declining number of Sisters in the congregation, especially in institutional health care; and
>
> 2) The increasing complexity of governing large multi-faceted institutions, in the light of increased government pressures.
> … the moral and ethical concerns in the fields of medicine, employee relationship, social justice, etc., require a great deal of time and study … To

[467] See T. CAILLOUETTE, General Superior of the Sisters of St. Joseph of London, letter to Cardinal Jerome Hamer, Prefect of the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life, 30 October 1991, in The Sisters of St. Joseph of Sault Ste. Marie Private Archives of the General Superior, North Bay, ON. (= CAILLOUETTE)

> do this effectively requires a commitment of a large portion of the time and energy of the General Council.
>
> Following the teachings of Vatican II the Sisters of St. Joseph have always striven to work with other persons in all of their ministries and apostolic endeavors … We have become convinced that Catholic health care will be better served by being more broadly governed by a Society composed of a variety of persons accountable to the Bishop of London … The [sponsorship transfer] texts would provide that if, at any time, the Society was dissolved, any assets it may have acquired would be distributed according to the directions of the then Bishop of the Diocese of London. The equity of the Congregation of the Sisters of St. Joseph of the Diocese of London in the three health care centres is presently determined to be approximately $70,640,000 …[468]

The Congregation for Consecrated Life and Societies of Apostolic Life sought clarification from the Sisters of St. Joseph of London related to whether the lands and assets registered under separate corporation, would remain the property of the Sisters of St. Joseph of London.[469] CICLSAL granted approval to the diocesan bishop, John Sherlock, to establish the PJP. They also noted "The only permission needed from our Congregation is that which we have granted to the Sisters to alienate their property."[470] On 8 September 1993, Bishop John Sherlock granted Diocesan PJP status to St. Joseph's Health Care Society and approved their statutes.[471]

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[468] See CAILLOUETTE.

[469] See F. OSSA, Secretary to Cardinal Jerome Hamer, Prefect of the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life, Letter to the Congregation in response to their request for permission to transfer sponsorship of three health care facilities to St. Joseph's Health Care Group, 5 December 1991, in The Sisters of St. Joseph of Sault Ste. Marie Private Archives of the General Superior, North Bay, ON. (= OSSA, Letter to the Congregation).

[470] See F. OSSA, Letter to the Congregation, in The Sisters of St. Joseph of Sault Ste. Marie Private Archives of the General Superior, North Bay, ON.

[471] See J. SHERLOCK, Bishop of the Diocese of London and A. HERNANDEZ, Chancellor of the Diocese of London, "Statutes: St. Joseph's Health Society," 8 September 1993, in The Sisters of St. Joseph of Sault Ste. Marie Private Archives of the General Superior, North Bay, ON.

2.4.1.3.4 St. Joseph's Health System, Hamilton, ON

In 2008, St. Joseph's Health System (SJHS) Board of Directors endorsed a corporate review process which included extensive consultations with key stakeholders to examine the following:[472]

- sponsorship models;
- governance models that strike and appropriate balance between corporate stewardship and local autonomy;
- management models that maximize effectiveness and efficiency;
- separate incorporation of member sites;
- international outreach programs;
- role and scope of decision making for SJHS Chief Executive Officer.

The goal of the review was to determine, "What is the most appropriate governance/management model to ensure that the Mission, Vision and Values of SJHS continue to be realized?" Brian Guest noted:

> With the introduction of Local Health Integration Networks (LHINs) and issues arising such as their mandate to integrate services, one must consider if this is the first step toward the implementation of Regional Health Authorities (RHAs). Additional considerations include the potential impact of a slumping economy on Ministry of Health and Long Term Care (MOHLTC) funding, our ability to retain/recruit staff at all levels and the need to maximize opportunities with SJHS.[473]

The methodology used to complete the project included a literature review of comparable health care systems (including efforts to find the most appropriate match in terms of programs and services delivered – e.g., Long Term Care (LTC), acute care, home

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[472] See B. GUEST, "Executive Summary," in *Corporate Review: An Opportunity for Renewal*, Hamilton, St. Joseph's Health System (2008), in The Sisters of St. Joseph of Sault Ste. Marie Private Archives of the General Superior, North Bay, ON.

[473] See B. GUEST, "Corporate Review," Memo to Brian Guest, 22 May 2008, in The Sisters of St. Joseph of Sault Ste. Marie Private Archives of the General Superior, North Bay, ON (= GUEST, "Corporate Review).

care, mental health, rehabilitation), environmental scan, internal stakeholder consultation, Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of the SJHS model, external stakeholder consultation/interviews, and a review of other health systems in Canada and the Unites States.[474] When the review was complete, the following recommendations were made to SJHS President and Chair, the General Superior of the Sisters of St. Joseph of Hamilton, and the bishop of the Diocese of Hamilton:

1. That a Diocesan Public Juridic Person be formed with respect to SJHS;

2. That the following reserved powers be transferred to the bishop of the diocese of Hamilton and the Chair of SJHS (Sister Anne Anderson) to 2013 and to the bishop of the Diocese thereafter:
    i. Decisions related to the control and disposition of proceeds from any sale of SJHS assets or expropriation of business settlement from the MOHLTC or private corporation. Proceeds would normally go to the Congregation or successor organization;
    ii. Approval of nomination of Officers of SJHS Board;
    iii. Ability to dismiss any member of SJHS Board of Directors;
    iv. Approval to appoint the SJHS CEO;
    v. Approval of appointment of the Director of Spiritual Care and Director of Ethics position for SJHS.[475]

On 16 July 2010, the Public Juridic Person of The Diocese of Hamilton was given corporate status by the province of Ontario.[476] The objects of the corporation were noted:

1. To conduct its charitable undertaking in a manner consistent with the teachings and laws of the Roman Catholic Church.

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[474] The methodology noted these initial health systems would be consulted: in Canada (Providence Health Care [BC], Caritas Health Care [Alberta], University Health Network) and the United States (Kaiser Permanente, CA, Catholic Health System, Upstate NY, and Sisters of St. Joseph of Orange County, CA).

[475] See GUEST, "Corporate Review," Executive Summary.

[476] See GOVERNMENT OF ONTARIO, Ministry of Government Services, Letters Patent, Ontario Corporation Number 1824727, 16 July 2010, in The Sisters of St. Joseph of Sault Ste. Marie Private Archives of the General Superior, North Bay, ON (= Hamilton PJP Corporate Letters Patent).

2. To support health care facilities, programs, and services intended to improve the health of individuals.[477]

Special provisions were noted as follows: "The corporation shall be carried on without the purpose of gain for its members, and any profits or other accretions to the corporation shall be used in promoting its objects."[478] The corporation's charitable status requirements and corporate bylaws and governance roles and responsibilities were clearly differentiated.[479]

The choice of juridic person status (pontifical or diocesan) made by the original sponsors of Catholic health care, reflects the unique historical and geographic realities of each religious institute. Despite the differences in juridic personality types, the type of juridic person established does not prohibit the function of offering a unified, strong voice for Catholic health care in the province of Ontario. The desire to speak with one voice must be inherent to each sponsor group as they reflect on ways to strengthen Catholic health care in Ontario. Efforts to strengthen one sponsor vis-à-vis other Catholic sponsors can serve to limit or eradicate a unified voice for Catholic health care. Despite the efforts of Catholic Health Association of Ontario (CHAO) to serve as the secretariat for the four Catholic health sponsors in Ontario, finding a methodology to create one voice for Catholic health care has not be successful. With God's grace and perseverance of all sponsors of Catholic health care in Ontario, strategies to continue this ministry through collaboration and

[477] Hamilton PJP Corporate Letters Patent, 2.

[478] Ibid., 4.

[479] Having been actively engaged personally in the ministry of Catholic health care in the province of Ontario for more than 40 years, the process leading up St. Joseph's Health System's transition to the Public Juridic Person of the Diocese of Hamilton was the best decision-making process with the most engagement this author has seen in the province.

hopefully the creation of a unified voice and structure for Catholic health care will be realized.

2.4.1.3.5 Catholic Health Association of Ontario (CHAO) and the Ontario Sponsors' Group[480]

In 2010/2011, CHAO undertook and implemented an organization redesign process. As part of this redesign, collaboration and coordination efforts between CHAO and Ontario's four Catholic health care sponsors were to be enhanced. The strategy to accomplish this goal was actualized on many levels.

1. Governance Level
    a. Each of Ontario's Catholic health care sponsors was invited to appoint one member to the CHAO Board. The purpose of these ex-officio designations was to enhance collaboration between CHAO and the four Ontario sponsors.
2. Staff Level:
    a. An Ontario Sponsors' Group was established to enhance collaboration among the four sponsors and with CHAO. Group membership included the four Ontario sponsor CEOs or their delegates and the CEO of CHAO. A memorandum of Understanding was approved by all Ontario sponsors.
3. CHAO President to Serve as Secretariat for the Ontario Sponsors' Group
    a. After consultation with all sponsors, the Board of CHAO developed a profile/skills matrix that would be required by a new CHAO-CEO. Ron Marr, who had served in this position for more than 25 years and who was known and trusted by past and current sponsors of Catholic health care in the province, had announced his retirement. This would necessitate a search strategy for a new CEO for CHAO.
    b. To assist the CHAO Governance Committee in their strategy to recruit a new CEO, the CEOs of the Ontario sponsors and the President and Vice President of CHAO developed a list of functions for the Secretariat of the Ontario Sponsors' Group. It was also recommended that, once a new CEO had been recruited to CHAO, that a more detailed list of functions be developed by the Sponsor Group and CHAO.
        i. Logistical Coordination of the Ontario Sponsors' Group

[480] R. MARR, CHAO Sponsor Secretariat, 13 July 2016, personal email, ronmarr@bell.net.

- Organize meeting including obtaining agreement on timing, location and agenda items for each session;
- Preparation and distribution of meeting agendas and background material;
- Preparation and distribution of meeting minutes;
- Ensure minutes etc. are maintained in appropriate archival space.

ii. Ontario Sponsors' Group Policy/Program Coordination

- Serve as primary lead for the development and drafting of materials/documents related to projects and programs agreed upon by sponsors and CHAO.
    - Facilitate sharing among sponsors and CHAO;
    - Distribute information on specialized programming to meet the needs of the poor and marginalized;
    - Develop
        - board-skill matrix templates;
        - programming including shared resource opportunities related to mission development,
        - education and formation programs;
    - Establish a joint work plan for the Ontario Sponsors' Group including a possible plan for resource coordination to accomplish objectives of mutual benefit.

iii. Communication

- Support the effective flow of information and important communications between the CHAO Board, CHAO staff, and sponsors.

Because of staff changes at CHAO, this strategy has not yet been completely implemented. It is hoped that these goals will continue to be operationalized by the new CEO of CHAO. The goal of a unified voice for Catholic health care in Ontario, will be critical for the continuation of this ministry in the province of Ontario.

2.5 Closing Reflections: Sponsorship in the Future

F. Morrisey's question regarding sponsorship is critical in the current North American context. Have we outgrown the traditional public juridic person structure and model developed in the late 1990s, or do we need to shift our focus from traditional "hot button items" such as abortion and end of life issues, [481] and continue our efforts to bring Jesus' healing presence into the world? [482] Is this to become the essence of Catholic identity whose mission is to bring light to the darkness and new ways of proclaiming the gospel message? Rather than opting to provide health care that appears on first glance to be a carbon copy of health care provided by any health care institution throughout Canada (treating diseases with success but at times, degrading human dignity), the question of how Catholic health care can distinguish itself by acknowledging that God is the source of healing, thus "humanizing the health care experience and redressing socioeconomic inequalities of modern health care."[483]

In Ontario's pluralistic society which includes multiple communities of faith that differ in their interpretations of the ultimate questions of life, how might we as leaders in Catholic health care protect the religious freedoms of every community while not compromising our own faith traditions and beliefs and begin to define collaboratively a

[481] See F. MORRISEY, "Our Sponsors," 59.

[482] See ibid.

[483] See D. SULLINS, "The Healing Community: A Catholic Social Justice Critique of Modern Health Care," in *The Linacre Quarterly*, 81 (2014), 172, http://journals1.scholarsportal.info.proxy.bib.uottawa.ca/pdf/00243639/v81i0002/172_thcacsjcomhc.xml (11 July 2016).

shared moral agreement to be the "foundation of law and policy for civil society?"[484] Is not the "value-added" of Catholic health care the ministry's capacity to combine layers of tradition into its understanding and moral responsibility for life that is distinctive from the contemporary world view?[485] Our question for the future of Catholic health care remains the same as it has been since the beginnings of our Church in Jesus' time: "How should communities of faith engage the world, the state, and civil society?"[486]

The history of Catholic health care in Ontario finds its roots in the care offered by the Good Samaritan, who "captures our conscience because of his compassion and generosity, a compassion that transcends boundaries of faith and ethnicity, and a generosity which reflects the lavish goodness of God,"[487] thus offering us a template for ministry. The Hebrew prophets offer Catholic health care sponsors the mandate to speak about contemporary structural issues of society which impact the poor and downtrodden of our times, demanding justice, fairness and public choice.[488] The ministry of Catholic health care is not and never has been a ministry of individual bishops, religious institutes, or new sponsorship models. "The priests and Sisters in religious orders were the entrepreneurs, the adventurers, the experimenters who broke new ground, founding hospitals and colleges, staffing primary schools, launching missionary efforts, starting publications and guiding

[484] See J. HEHIR, "Catholic Health Care: The Ministry's Future in a Turbulent World," in *Health Progress,* Vol. 91, no. 5 (2010), 72-79, 74. (= HEHIR, "Catholic Health Care")

[485] See HEHIR, "Catholic Health Care," 75.

[486] See ibid., 76.

[487] See ibid., 75.

[488] See ibid.

new organizations for lay people."[489] The fundamental question which will require careful examination is, "Can we identify internal criteria which will assist Ontario's Catholic health care sponsors to face external pressures as they look towards a future which God promises will be full of hope?[490]

[489] P. STEINFELS, *A People Adrift*, 108.

[490] Jer. 29:11.

CHAPTER III: INTERNAL CRITERIA FOR THE PRESERVATION OF CATHOLIC HEALTH CARE IN ONTARIO

Introduction

In order to understand and preserve a unique Catholic identity in Ontario's Catholic health system, sponsors, trustees, and senior administration need to understand clearly unique Catholic health care identity markers which extend beyond requirements of Church apostolates, including the coordinating power of the local bishop and oversight and control of the Holy See.[491] As O'Rourke has suggested, "In order to specify and define this [Catholic] method of providing health care, more concrete characteristics and objectives are needed. To define and describe these characteristics and objectives is the meaning of Catholic identity."[492]

The purpose of this chapter is to examine the content of internal systems to support staff who continue the healing mission of Jesus. The Code of Canon Law is silent on norms for canonical sponsorship of Catholic health care, other than those related to public juridic persons in general (cc. 113-123), the obligations of the faithful to assist in apostolic works (c. 222, §1), delegation by God of apostolates to all the baptized and confirmed (c. 225, §1), the formation of laity to assume responsibility for apostolates (c. 229, §1), sponsorship by associations of the faithful including lay and private associations of the faithful (cc. 298, §1, 311, 323, §2, 329), the responsibility of bishops (both diocesan and the conference of

[491] See cc. 116, 331, 634, 678.

[492] K. O'ROURKE, "Catholic Hospitals and Catholic Identity," in *Christian Bioethics*, 7 (2001), 15-28.

bishops) to promote, support and evaluate both apostolates within their jurisdiction, and the religious institutes which function in the diocese (cc. 673-683).

Catholic health care has seen significant changes over the years. Founded on the predominantly Christian belief that we are our brothers' and sisters' keepers[493] and the Church's mission to care for the sick,[494] health care in Canada and specifically in Ontario has become a shared, government-funded, social responsibility. With enhanced public support for universal access to health care[495] has come enhanced government-mandated and monitored accountability structures. Public funding of any health care offered in the province is contingent on signed accountability agreements which are contracts with the government and with the people of Ontario whom Catholic health care is privileged to serve, and which address services to be offered, funding, planning and integration, performance, reporting and accountability practices, liability limits, indemnification, insurance, etc.[496] Catholic health care sponsors and senior leaders will also need to ensure adherence to Church teachings and its accountability structures.

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[493] See GENESIS 4:9.

[494] See LUKE 10:37.

[495] See M. MENDELSOHN, *Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation*, Kingston, Queen's University Press, 2002, 25.

[496] See ST. MICHAEL'S HOSPITAL MULTI-SECTOR SERVICE ACCOUNTABILITY AGREEMENT, April 1, 2014 to March 31, 2017, https://www.stmichaelshospital.com/pdf/corporate/MSAA-Signed.pdf (17 January 2017).

The Church does offer guidance and mechanisms to support Catholic health care to fulfill its social and Church accountabilities. This chapter will address key foci to support Catholic health care and include a rationale for ongoing formation in the areas of Church teachings and traditions, foundations for ethical decisions based on the Church's social, moral and ethical teachings, and criteria for partnerships (negotiable and non-negotiable). Areas for consideration which will support Catholic health care ministry into the future would include the following.

1. Defining Formation Needs: Beyond Leadership and Management Skills
2. Responding to Identified Formation Needs:
    a. The nature and structure of the Church;
    b. Authority for mission;
    c. Role of the diocesan bishop;
    d. Catholic social teaching: Foundation for ministry;
    e. Application of the *Health Ethics Guide*: A system of support for Catholic health care leaders;
3. Framework for Formation: Where Theory and Praxis Meet

3.1 Formation Needs: Beyond Leadership and Management Skills

Like the early Christians,[497] Ontario's Catholic health leaders are faced with the challenge of preserving a unique Catholic identity within a larger secular culture. We face

[497] See Romans 8:35; 1 Cor. 4:12; 2 Cor 12:10; 1 Thess. 3:4; 2 TimothY 3:12; 1 Peter 4:12; 1 Peter 4:16.

today the formidable task of passing on the faith to the next generation,[498] evangelizing a modern and sceptical culture, and inspiring individuals to serve in the Church's ministries. [499] Speaking of the Gospels is increasingly difficult in a secularized and polarized world.[500] Contemporary Catholic health care leaders may only recall Catholic health care's founding stories only as a footnote in the business of health care, incorporated and inculturated into a secular environment. The question of defining and identifying of formation needs to support the contemporary ministry of Catholic health care will be required.

3.1.1 Defining Formation

Formation has been defined as "a reflected development on one's gifts and how the gifts contribute to the need in hand providing an holistic preparation of a person for a role – human, spiritual, intellectual, pastoral – including reflection on the experiences of their own life which might highlight some lacks in development or knowledge that are essential for meeting that need."[501] Because Catholic health care extends beyond geographical or organizational boundaries, requirements for leadership formation are shared universally, and are based on Jesus' invitation to all the baptized to "go and do likewise."[502] Through

[498] See J. ABELES, "Leadership Formation: A Call to Action. How Can the Next Generation of Leaders Carry Jesus' Healing Ministry in Catholic Health Care?" in *Health Progress*, vol. 89, no. 2 (2008), 32-37 (=ABELES, "Leadership Formation).

[499] See M. GALLAGHER and J. REID, "New Mission Leaders in Catholic Health Care" in *Health Progress*, vol. 92, no. 2 (2015), 64-68.

[500] See B. CUPICH, "Walking on Water in a Skeptical Age," in *Origins*, 44 (2014-2015), 427.

[501] J. H. THORNBER and M. GAFFNEY, *Governing in Faith: Foundations for Formation*, Ballarat, VIC, Australia, 2014, Kindle ed., loc. 835 (= THORNBER & GAFFNEY, *Governing in Faith*).

[502] LUKE 10:37.

their baptismal incorporation into the Church, lay persons share gifts and graces to build up the Church from within. In cooperation and under the direction of the Church's hierarchy,[503] their roles often require additional formation which may include academic preparation, certification, credentialing and a formation that integrates personal, spiritual, intellectual, and pastoral dimensions.[504]

What seems to be clear is that formation for ministry in Catholic apostolates goes beyond education in a particular professional discipline or support position. It will, of necessity, include engagement of each person's heart and soul, personality, spirit, and intellect, and be rooted in concern and service for others.[505] "Our capacity to sustain Catholic health care as a ministry of the Church depends on our realization that all our activities must flow from the core of who we are, that is, from our spirituality … as ministry, we must provide witness as well as service because the call to be mission in the world is also the call to build up the kingdom of God within."[506] We must ask ourselves, "Are we fully capable of serving as agents of Jesus and his healing ministry to those that come to us, and for those that we seek out to fully engage in the promise of the healing

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[503] St. JOHN PAUL II, Instruction approved *in forma specifica* On Certain Questions Regarding the Collaboration of the Non-ordained Faithful in the Sacred Ministry or Priest *Ecclesiae de Mysterio*, 15 Aug 1997, in *AAS*, 89 (1997), 852-876, Vatican City, http://www.vatican.va/roman_curia/pontifical_councils/laity/documents/rc_con_interdic_doc_15081997_en.html, Articles 1, 2 (25 November 2016) (= *EM*).

[504] See UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (USCCB), *Co-Workers in the Vineyard of the Lord*, Washington DC, USCCB, 2005, 12 (= USCCB, *Co-Workers in the Vineyard)*.

[505] See THORNBER & GAFFNEY, *Governing in Faith*, 70.

[506] J. DEBLOIS, "The Mission Imperative: Our Foundation and Market Advantage," in *Health Progress*, vol. 78, no. 2 (1997), 24-27.

ministry?"[507] The question of how to prepare those who support the mission of Catholic health care in our contemporary world is a key component of any formation program, because, "the work of those in Catholic health care is no small task: 'We're trying to provide quality care and we're trying to change the world around us'."[508]

Concern for the formation of the laity in preparation to assume increased responsibilities for Church apostolates has grown in inverse proportion to the decline in religious in the world.[509] It would be simplistic to suggest a particular formation strategy, because one size cannot fit the needs of all the baptized called to the ministry of Catholic health care.[510] We are being invited to live with the tension between the unchanging Christ and the reality of the changing cultures in which we are called to minister, and which will form the context and define some of the content of formation program development.[511]

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[507] ABELES, "Leadership Formation," 32.

[508] B. TAYLOR, "CHA gathering explores future direction of leadership formation," 15 January 2016, https://www.chausa.org/publications/catholic-health-world/article/january-15-2016/cha-gathering-explores-future-direction-of-leadership-formation (3 January 2017).

[509] See J. MCKENNA, "Number of priests and nuns in marked decline," in *The Telegraph*, 6 June 2013, http://www.telegraph.co.uk/news/worldnews/europe/vaticancityandholysee/10103961/Number-of-priests-and-nuns-in-marked-decline.html (3 January 2017).

[510] See J. HOUSTON, "The Future of Spiritual Formation," in *Journal of Spiritual Formation and Soul Care*, 4 (2011), 133 (= HOUSTON, "The Future").

[511] HOUSTON, "The Future," 135.

3.1.2 Formation Needs Assessment: Responding to the Data

J. H. Thornber initiated a doctoral research study[512] to identify formation needs of the laity who would undertake canonical governance (sponsorship). This study researched the formation needs of lay people which would prepare them to undertake canonical governance roles, and sought to develop a needs-based formation framework.[513] His research questions were: "What are the formation needs of canonical governors in the existing and emerging forms of Church governance? What is an appropriate formation framework for canonical governors for identifying and addressing those needs?"[514] The research methodology was a constructivist paradigm,[515] in which "realities are understood to be in the form of multiple, intangible, mental constructions, socially and experientially based, local and specific in nature and dependent for their form and content on the individual persons or groups holding the constructions."[516]

Two core documents, Pope John Paul II's Apostolic Exhortation on the requirements of priestly formation,[517] and the United States Conference of Catholic

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[512] See THORNBER, Cultivating Fertile Soil.

[513] See ibid., iii.

[514] THORNBER & GAFFNEY, *Governing in Faith*, 72.

[515] See J.A. ALLEN, "The Constructivist Paradigm," in *Journal of Teaching in Social Work*, 8 (1994), 31-54.

[516] M. CLEARY, *Management Dilemmas in Catholic Human Services – Health Care, Welfare and Education*, Lewiston, NY, Edwin Mellen Press, 2007, 104.

[517] See ST. JOHN PAUL II Post-synodal Apostolic Exhortation to the Bishops, Clergy, and Faithful on the Formation of Priests in the Circumstances of the Present Day *Pastores dabo vobis*, 25 March 1992, in *AAS*, 84 (1992), 658-805, English translation in *Origins*, 21 (1991-1992), 717-759.

Bishops resource for guiding the development of lay ecclesial ministry,[518] were used to identify preferred traits for canonical governors. These documents classified preferred traits under the broad dimensions of human, spiritual, intellectual, and pastoral. A list of traits identified with each dimension is noted below:

Table I: Thornber's Dimension Traits

Dimensions	**Human**[519]	**Spiritual**[520]	**Intellectual**[521]	**Pastoral**[522]

Traits	• integrity
	• judgement
	• sense of justice compassion
	• concern for others
	• personal maturity
	• self-knowledge
	• respect
	• awareness of gifts
	• ability to learn from praise
	• behaviour balance
	• ability to learn from criticism
		• one's baptismal call to mission
		• sense of vocation
		• need for spiritual formation in order to be open to the transcendent
		• see their role as a ministry
		• understanding spiritual formation is about living intimately united to the Word of God
		• commitment to the mission of the Church
		• spiritual formation aims for a daily growing in love of God and neighbour
			• Catholic faith is rooted in God's revelation
			• Catholic faith is embodied in the living tradition of the Church
			• Formation is a journey beyond catechesis into theological reflection
			• Background in
			  ○ Missiology
			  ○ Ecclesiology
			  ○ Canon law
			• Articulate the missiology which underpins ministry
			• Uses theology to understand needs of the time in light of scripture and tradition
			• Sound knowledge of
				• Understanding of ministry
				• Responsibility for ongoing Catholic identity of the ministry
				• Discern the signs of the times for the mission of the Church
				• Ability to call ministry leaders to accountability
				• Understands responsibilities of local bishops for coordinating ministerial services in the diocese
				• Uses mission-based criteria in forming future governors

[518] See USCCB, *Co-Workers in the Vineyard*.

[519] See THORNBER & GAFFNEY, *Governing in Faith*, 75.

[520] Ibid., 76-77.

[521] Ibid., 78.

[522] Ibid., 79.

Dimensions	Human[519]	Spiritual[520]	Intellectual[521]	Pastoral[522]
		• understanding they are a bridge for people to Christ • enjoying public identification with the Catholic ecclesial community • capacity to pray and practice other forms of spirituality that foster an openness to other aspects of the spiritual traits	○ Catholic social teaching ○ Catechism of Catholic Church • Seeks to develop appreciation of Catholic faith through intellectual formation	

In order to determine the applicability of the traits requiring formation attention which were identified in the core documents, Thornber's research design is noted below:

Table II: Thornber Research Design[523]

Data Collection	Participants	Data Analysis
Design & piloting of survey	Expert advisory group (Governance and survey design expertise)	• Analysis of expert advisory group responses ○ Collation ○ Qualitative Coding
Distribution of Survey	Purposeful Sampling[524] • Respondents with interest and expertise in canonical governance from Australia,	• Frequency distribution • T-Tests • Factor analysis

[523] See THORNBER & GAFFNEY, *Governing in Faith*, 73.

[524] See J. CRESWELL, *Educational Research: Planning, Conducting and Evaluating Quantitative and Qualitative Research*, 3rd ed., Upper Saddle River, NJ, Pearson Education International, 2008.

Data Collection	Participants	Data Analysis
	North American, and Ireland.	
Design and conduct semi-structured 1:1 interviews (in person or by telephone)	• Purposeful Sampling • Interviewees with interest and expertise in canonical governance from Australia, North America, and Ireland.	• Qualitative data analysis.

The online survey asked respondents to indicate their agreement or otherwise on a Likert-type scale[525] on the desirability of specific traits, and whether survey participants perceived the identified traits to be evident in current canonical governors. Significant gaps between the desired traits under each dimension of the study and the perception of these traits in action among other canonical governors were identified.[526]

One desired human trait that survey respondents noted needed attention was the ability to learn from criticism. This may in part be due to the somewhat infrequent feedback normally included in sponsor or trustee evaluations. Within spiritual traits, survey participants identified a need to have a deepened awareness of their baptismal call, a sense of vocation to this ministry, and a recognition of the nature and significance of spiritual formation required to support them in their ministry. For some survey participants, reference to "a sense of baptismal call," was a source of concern. As some interviewees noted, "Do we exclude good people because they are not Catholic? Do we include

[525] See R. ASÚN, K. RDZ-NAVARRO and J. ALVARADO, "Developing Multidimensional Likert Scales Using Item Factor Analysis: The Case of Four-Point Items," in *Sociological Methods & Research*, 45 (2016), 109-133; See also K. BRAUNSBERGER and R. GATES, "Developing inventories for Satisfaction and Likert Scales in a Service Environment," in *Journal of Services Marketing*, 23 (2009), 219-225.

[526] See THORNBER & GAFFNEY, *Governing in Faith*, 89-90, 106-108, 133-135, 171.

Catholics simply on the basis of a baptismal certificate?"[527] The Catholic Church at its best is inclusive. For both the baptized and unbaptized, an understanding of a baptismal call is essential for the ministry of canonical sponsorship and leadership in Catholic health care.[528] The key factor in choice of both Catholic health care leaders will be their commitment to participate in spiritual formation.[529]

When examining intellectual formation traits, clear gaps in knowledge became more evident. Gaps in knowledge were noted in respondents' understanding of faith, theology, and church teaching, commonly referred to as Catholic Intellectual Tradition and defined as "a style of thought and a worldview where the former defines the way knowledge is appropriated, processed and passed on and the latter refers to the application of this knowledge to various regions of reality – to God, humanity, society, and the Church."[530] Other key areas which were noted as requiring focused formation included defining Catholic identity and understanding what they are being asked to be responsible for, particularly as it applies to and is impacted by Church structures and operations, the role of the diocesan bishop, and church law. As noted by one interviewee, "You cannot be involved in governance as a canonical governor without some background in what the Church is, how the Church is structured, how the Church is governed, and how the bits of

[527] THORNBER & GAFFNEY, *Governing in Faith*, 113.

[528] Ibid., 114.

[529] Ibid., 129.

[530] W. GRASSI, Is There Really a Catholic Intellectual Tradition? Montréal, American Academy of Religion Annual Meeting, 7-10 November 2009, 2, http://philpapers.org/archive/GRAITR-2.pdf (13 November 2016). (= GRASSi, "Is there really …")

the Church fit together."[531] Given our current health care environment, the approach to Catholic health care ministry could easily become refocused on qualitative and quantitative government mandated benchmarks, with little or no reference to the founding virtues of Catholic health care. Focusing our formation programs to address gaps of knowledge will assist Catholic health care sponsors and leaders in ensuring appropriate preparation to fulfill both clinical, business, and canonical accountabilities. Formation programs that have been developed in the United States, Australia, Ireland, and Canada will be reviewed.

3.2 Focusing Formation Programs

The influence of formation bears fruits beyond individual sponsorship expertise and, by its nature, impacts individual participants, the organization as a whole, as well as the broader community which is served. Formation opportunities offer senior leaders in Catholic health care inspiration for ongoing personal and leadership growth, provide tools to assist participants apply principles of Catholic identity in their day-to-day responsibilities, and have a transformative impact on individuals, the organization, and communities served, enabling Catholic health care ministry to flourish into the future. The importance of solid formation programming cannot be overestimated and requires organizational commitment and funding to support the ministry, allowing sponsors, trustees and Catholic health care leaders to "know and confidently act on behalf of the Church's healing mission."[532]

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[531] THORNBER & GAFFNEY, *Governing in Faith*, 150.

[532] D. HEWITT, "Exploring Formation with Other Organizations," in *Health Progress*, vol. 97, no. 2 (2016), 20.

The mission of Catholic health care which is to ensure healing of the whole person in the context of family and community, remains as our formation foundation, and will include strategic, fiduciary, and generative concepts essential for direction and continuation of the ministry.[533] Thornber's research identified fundamental gaps in knowledge and skills for some Catholic health care leaders which we present for your consideration. These pillars of Catholic Apostolates will assist in identifying key formation foci, and will include the nature and structure of the Church and its canonical underpinnings, the Church's social and ethical teachings, the moral teachings of the Church, and the place of the Catholic health care in today's world.

3.2.1 The Nature and Structure of the Church

The Church's foundation has always been Jesus Christ, and the ultimate goal of the Church of Christ on earth, the salvation of souls, is noted in Canon 1752 of the Code of Canon Law.[534] However, as has been indicated by numerous authors in organizational development, form should follow function.[535]

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[533] See R. CHAIT, W. RYAN and B. TAYLOR, *Governance as Leadership: Reframing the Work of Nonprofit Boards*, Hoboken, NJ, John Wiley and Sons, 2005.

[534] See Can. 1752, "In cases of transfer the prescripts of can. 1747 are to be applied, canonical equity is to be observed, and the salvation of souls, which must always be the supreme law in the Church, is to be kept before one's eyes."

[535] See T. BERRY, "In Business Planning, Form Follows Function," in *Entrepreneur,* 15 July 2010, https://www.entrepreneur.com/article/207406 (8 November 2016); See also R. ROSS, "Organizing IT – Form Follows Function," in *Business Finance Blog*, 28 May 2009, http://businessfinancemag.com/blog/organizing-it-form-follows-function (8 November 2016); L. SISNEY, "The 5 Classic Mistakes in Organizational Structure: Or, How to Design Your Organization the Right Way," in *Organizational Physics: Systems Thinking for Breakthrough Business Performance*, 9 January 2012, http://organizationalphysics.com/2012/01/09/the-5-classic-mistakes-in-organizational-structure-or-how-to-design-your-organization-the-right-way/ (11 November 2016); D. YANOW, "Form Follows Function?" in *Public Administration Review,* 70 (2010), 156-158.

The vision of the Church of Vatican II is a Church (*ecclesia*) of *communio*. As Őrsy suggests, an understanding of *communio* was first experienced by the Council Fathers when St. John XXIII "refused to impose on the bishops his own ideas, the prepared schemata, but he let the bishops take the initiative … [stating] the Church was first and foremost a 'communion,' '*communio*,' a union of persons in a unique sense – created by the Spirit of Christ … [giving] the people of God priority over the hierarchy" in the Dogmatic Constitution on the Church, *Lumen Gentium.*"[536] This was a theological watershed moment for the Catholic Church.[537] However, the impact of the Council on the day-to-day life of the Church was only to be revealed through gradual transformations in organizational structures or ecclesiology[538] which would not be legislated by the Council Fathers.[539]

The quasi-imperial pre-Vatican II stature of the papacy, the reference to cardinals as princes of the Church, and to diocesan bishops who ruled over their flock, were replaced with a sense of the equality of all believers,[540] thus abandoning a vision and definition of the Church as an unequal society, comprised of clergy and laity.[541] In the documents of

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[536] L. ŐRSY, *Receiving the Council: Theological and Canonical Insights and* Debates, Collegeville, MN, Liturgical Press, 2009, 4 (= ŐRSY, *Receiving the Council*).

[537] See G. DUNCAN, "The 'enemy within' the post-Vatican II Roman Catholic Church," in *Theological Studies*, 69 (2013), 212 (= DUNCAN, "The Enemy Within").

[538] See DUNCAN, "The Enemy Within," 212.

[539] See E. KILMARTIN, "Lay Participation in the Apostolate of the Hierarchy," in J. Provost (ed.), *Official Ministry in a New Age, Washington*, DC, 1981, 93.

[540] See *LG*, no. 32, 875; See also R. GAILLARDETZ, "Power and Authority in the Church: Emerging Issues," in R. GAILLARDETZ and E. HAHNENBERG, *A Church with Open Doors: Catholic Ecclesiology for the Third* Millennium, Collegeville, MN, Liturgical Press, 2015, Kindle ed., loc. 2017 (= GAILLARDETZ, "Power and Authority").

[541] See GAILLARDETZ, "Power and Authority".

Vatican II,[542] the Council suggested that through the sacraments of initiation (baptism, confirmation, Eucharist) all of the faithful are "assumed into the 'body of Christ,' a corporate body created by his Spirit … where there are no superiors and no inferiors: all are God's people."[543] It is here where we join the *communio* of the saints.[544] The eschatological orientation of the church as pilgrim was affirmed.[545] The council encouraged the development of synods,[546] and episcopal conferences,[547] with the latter being granted some authority over liturgical matters.[548] The bishop's role shifted from the pre-Vatican II notion of vicar of the pope to pastor of the local church.[549]

The vision of the inclusive, non-hierarchical Church of Vatican II would create a conflict of ecclesiologies between those committed to maintaining the hierarchical status quo of centralized control versus a more democratic church, open to the modern world. While some attempted to ensure the documents of Vatican II and published statements authored during the Council reaffirmed strict papal primacy over the whole Church, this

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[542] See TANNER II.

[543] See ŐRSY, *Receiving the Council*, 7.

[544] Őrsy, *Receiving the Council,* 7; See also *LG*, nos. 9-17, 855-862.

[545] See *LG*, no. 48, 887.

[546] See SECOND VATICAN COUNCIL Decree Concerning the Pastoral Office of Bishops in the Church *Christus Dominus*, 28 October 1965, nos. 5, 36, in *AAS*, 58 (1966), 673-701, English translation in Tanner II, 922, 936 (= *CD*).

[547] See *LG*, no. 23, 867; See also *CD*, nos. 36-38, 936-937.

[548] See SECOND VATICAN COUNCIL, Constitution on the Sacred Liturgy *Sacrosanctum Concilum*, 4 December 1963, in *AAS* 56 (1964), 97-138, English translation in Tanner II, 820-843 (= *SC*).

[549] See *SC*, no. 41, 829; See also *CD*, no. 11, 924; *LG*, no. 23, 867.

position was balanced by those who sought a greater sense of collegiality amongst bishops which would be reflective of a college of apostles with the pope as a central member.

The new ecclesiology of Vatican II is grounded in the shared baptism of all Christians (including non-Catholics), "joined with Christ in its visible structure by the bonds of the profession of faith, the sacraments, and ecclesial governance,"[550] according to each one's condition and function.[551] The definition of the Church as the people of God and reflected in both the Dogmatic Constitution on the Church[552] and the Pastoral Constitution on the Church in the Modern World,[553] identifies the Church as a "pilgrim people directed to the reign of God."[554]

In the Code of Canon Law, the Church's foundation in the heart of Jesus Christ finds juridic parameters to support the people of God, bonded together to continue the salvation of the entire world, where "the drama of our redemption is enacted."[555] "This Church, established and organized in this world as a society, subsists in the Catholic Church, governed by the successor of Peter and the bishops in communion with him, although outside its structure many elements of sanctification and of truth are to be found

[550] c. 205.

[551] c. 208.

[552] See *LG*, 849-898.

[553] See *GS*, 1069-1135.

[554] See P. LAKELAND, *A Council That Will Never End: Lumen Gentium and the Church Today*, Collegeville, MN, Liturgical Press, 2013, xxix (LAKELAND, *A Council*).

[555] ÖRSY, *Theology and Canon Law*, 1.

… .”[556] The intent of the Church’s organizational structure is to support the movements of the Holy Spirit in the Church. The collegial character and nature of the Church is evident in councils that were convened to offer a model by which matters important to the Church and any Church apostolate could benefit through shared wisdom.

The Church and its structures and models of operation, commonly known as ecclesiology, have been in the process of re-formation since the apostles were sent to go out and preach the good news after Jesus’ ascension.[557] Since Vatican II, the Church’s ecclesiology or organizational structure, has shifted dramatically.[558] “While there is a hierarchical structure to orders in the Church indicating levels of responsibility to serve, it should never be interpreted in terms of power, still less of levels of holiness attached to strata of power, if the Church is truly the Church of God.”[559]

To understand the Church’s organizational structure, the concepts of *communio* within the universal *communio* warrants consideration. Through baptism, all Christians share in the mission of the Church - the salvation of souls, and it is through baptism that we discover the *communio* in the inner life of God “who is one God in three persons. In

[556] *LG*, no. 8, 854, See also J. BECKER, “The Church in Vatican II’s ‘Subsists in’ Terminology,” in *Origins* (2005-2006), 514-522.

[557] See MATT. 28:19-20.

[558] See L. ŐRSY, “The Church of the Third Millennium: An Exercise in Theological and Canonical Imagination,” in *Studia Canonica*, 38 (2004), 8.

[559] P. LAKELAND, *Catholicism at the Crossroads: How the Laity Can Save the Church*, New York, NY, Continuum, 2007, 54.

God there is unity in diversity and diversity in unity."[560] From this shared *communio* with the persons of the Trinity, we find a model for the Church's structure and a model to support the Church's apostolates (e.g., Catholic health care in Ontario). "Among human beings, composed of spirit and matter, the internal and invisible mystery needs to manifest itself externally and visibly. One cannot exist without the other, not in this universe where the Word has become flesh."[561] This, then, becomes the prototype or template of the Church's organizational structure and the desired structure which supports the Church's apostolates. To support the Church's mission, charisms and particular vocations for the building up of the Body of Christ are given to individual members of the Church.

For some, the vocation will be to the single or married life. To others, the lived expression of their vocation will be found in God's call to consecrated life or ordained ministry. No vocation is more important or higher than another. All work in *communio* to achieve complete union in the Mystical Body of Christ. "It is the whole Christ, present in those reborn in baptism and living by the Spirit of Christ. That is what Paul in the New Testament and the Church in its official teaching have not hesitated to call the Mystical Body of Christ."[562] For those called by God to the sacrament of orders, they are lifted up and incorporated into the "*communio* of the 'servant shepherds' to serve and lead the

[560] See ŐRSY, *Receiving the Council*, 5.

[561] Ibid.

[562] M. HELLWIG, " 'The Reign of God Is Among You:' Biblical and Theological Themes for Lay Leadership," in Z. FOX and R. BECHTLE (eds.), *Called and Chosen: Towards a Spirituality for Lay Leaders*, New York, NY, Sheed & Ward, 2005, Kindle ed., 48.

community."[563] The *communio* of the ordained has its own structure and includes bishops, priests, and deacons, all of whom share a common gift of being of one mind and one heart in Christ.[564]

3.2.2 Authority for Mission: Church Structures and Canonical Norms Supporting the Mission.

While the position of the pope (primacy, infallibility) was a major thrust of Vatican I, an ecclesiology built on collegiality among the pope, the bishop of Rome, and bishops throughout the world was a major thrust of Vatican II.[565] The rationale for identified structures and operations of the community of faith is revealed in the law,[566] and more often than not, in the history of the development of the Church's structures. The intent of the Church's structures is to support the Church's journey as a pilgrim people who, like John the Baptist, embrace the mission of all the baptized as evangelizers.[567]

The juridical status of the pope and the college of bishops is addressed in cc. 330-341, and mirror the unity of Peter and the Apostles and the pope and bishops noted in *Lumen gentium*.[568] This responsibility which the Lord gave uniquely (*singulariter)* to Peter

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[563] See ŐRSY, *Receiving the Council*, 8.

[564] ŐRSY, *Receiving the Council*, 8.

[565] See K. WALF, "The Supreme Authority of the Church (cc. 330-367)" in J. BEAL et al (eds.), *New Commentary*, 423 (= WALF, "The Supreme Authority").

[566] See ÖRSY, *Theology and Canon Law*, 1.

[567] See *EG*, no. 111, 439 (= *EG*).

[568] See WALF, "The Supreme Authority," 426.

continues (*permanet*) in the person of the current Bishop of Rome, pastor of the universal Church on earth, the Pope, who "… as the Bishop of Rome … [is anointed by God] to watch over the unity of the universal church and to encourage in charity the journey of all the particular churches toward ever greater knowledge, faith and love of Christ."[569]

In his position, the pope has supreme,[570] full,[571] immediate,[572] universal,[573] and ordinary[574] power in the Church which he is able to exercise freely (c. 331). The threefold *munera* (gift, duty, responsibility)[575] of sanctification (*munus sanctificandi*), teaching (*munus docendi*) and governing (*munus regendi),* given to the Church by Jesus, is shared by all the people of God according to their own state and condition (c. 216). The *munus* of teaching has been given in a unique way to the Bishop of Rome. As noted in c. 835, §1, the pope is one of the "principal dispensers of the mysteries of God."[576] The duty to teach

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[569] FRANCIS, "U.S. Visit: Meeting with the U.S. Bishops," in *Origins*, 45 (2015-2016), 320 (= FRANCIS, "Meeting with U.S. Bishops").

[570] No appeal can be made against a papal judgement or decree (c. 333, §3); Every member of the faithful can bring his or her contentious or penal case before the Holy See for judgement in all instances (c. 1417, §1); The pope is recognized as the head of the college of bishops (c. 336), supreme shepherd and teacher (c. 749, §1) and can be judged by no one (c. 1404).

[571] Two official institutional authorities in the Church enjoy full power: the pope and the college of bishops. The pope is able to exercise this power freely (c. 331). The college of bishops can exercise this power only with its head, the pope. The pope receives full power when he accepts his legitimate election together with his episcopal ordination (c. 332, §1).

[572] The pope's immediate power allows him to intervene directly on all levels of ecclesial jurisdiction (c. 333, §1).

[573] Universal power refers to the universal Catholic Church and not simply to the Latin Church.

[574] Two offices in the Church have ordinary, proper power: The pope and the diocesan bishop (c. 381, §2). Vicar generals have vicarious or delegated powers (c. 132, §1).

[575] See L. STELTEN, *Dictionary of Ecclesiastical Latin*, 2nd ed., Peabody, MA, Henrickson Publishers, 2009, Kindle ed., loc. 6693 (STELTEN, *Dictionary*).

[576] See WALF, "The Supreme Authority," 435.

the people of God is expressed infallibly by the Pope "by virtue of his office when as the supreme pastor and teacher of all Christian faithful … [he] proclaims by definitive act that a doctrine of faith or morals is to be held" (c. 749, §1).

In addition to the characteristics and competencies of the pope noted in the law, Pope Francis has expressed the pastoral mission of the successor of Peter.

> The heart of the pope expands to include everyone. To testify to the immensity of God's love is the heart of the mission entrusted to the successor of Peter, the vicar of the one who on the cross embraced the whole of mankind. May no member of Christ's body and the American people feel excluded from the pope's embrace. Wherever the name of Jesus is spoken, may the pope's voice also be heard to affirm that 'he is the savior … may the pope be not simply a name but a felt presence, sustaining the fervent plea of the bride: 'Come, Lord!'! Whenever a hand reaches out to do good or to show the love of Christ, to dry a tear or bring comfort to the lonely, to show the way to one who is lost or to console a broken heart, to help the fallen or to teach those thirsting for truth, to forgive or to offer a new start in God … know that the pope is at your side, the pope supports you. He puts his hand on your own, a hand wrinkled with age but by God's grace still able to support and encourage.[577]

In his ministry to the Church, the pope is supported by cardinals, the Roman curia, and bishops throughout the world.[578]

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[577] FRANCIS, "Meeting with U.S. Bishops," 319.

[578] See T. GREEN, "The Cardinals of the Holy Roman Church (cc. 349-359)," in J. BEAL et al., *New Commentary,* 464-475. The college of cardinals, predominantly a Latin vs. Eastern ecclesiastical institution with a long tradition of papal service, exercise significant influence in the Church, in no small measure due to their responsibility to elect the pope, usually from among their ranks. The Code of Canon Law indicates the cardinals are appointed freely by the Roman Pontiff, (c. 351) and form a special college which accomplishes the following purposes: (c. 349). election of the Roman Pontiff according to the norms of special law; and assist the Roman Pontiff collegially or when they are convoked to respond to questions of major importance or to provide counsel to the Roman Pontiff upon his request, and especially in the daily care of the universal Church (c. 358). In recent years, pontiffs have increasingly sought their counsel in addressing significant issues in the Church such as curial reform and Vatican finances. In addition, cardinals often assume positions of responsibility in the curia and govern major apostolic sees throughout the world.

3.2.3 The Notion of Particular Churches (cc. 368-374)

The importance of particular churches offers the framework for understanding the Church of Christ.[579] Normally defined by territories,[580] the Catholic Church is divided into particular churches defined by law,[581] and further defined: dioceses (c. 369), territorial prelatures (c. 370), territorial abbacies (c. 370), apostolic vicariates and apostolic prefectures (c. 371, §1) as well as apostolic administration of a particular church erected by the Supreme Pontiff in a stable manner (c. 371, §2). As a rule, particular churches are territorially defined and include all the faithful living in that territory (c. 372). After consulting with the conferences of bishops, the support of the faithful requires more focused attention for a special reason, a particular church can be established by the pontiff and distinguished by rite or some other reason within a particular territory (c. 372, §2). Two such particular churches which were established by the pontiff for an identified particular reason are the military ordinariate,[582] and the personal ordinariate of former Anglicans.[583] Each particular Church is then further divided into distinct parts or parishes,

[579] See J. RENKEN, J., "Particular Churches and Their Groupings (cc. 368-572)," in J. BEAL, J. CORIDEN, and T. GREEN (eds.), *New Commentary*, 501 (= RENKEN, "Particular Churches").

[580] In some instances, a particular church may be determined by criteria other than a defined geographic territory, and be created through other criterion (e.g., the rite of the faithful, culture, language, etc. – c. 372).

[581] See c. 368 "Particular churches, in which and from which the one and only Catholic Church exists, are first of all dioceses, to which, unless it is otherwise evident, are likened a territorial prelature and territorial abbacy, an apostolic vicariate and an apostolic prefecture, and an apostolic administration erected in a stable manner."

[582] See ST. JOHN PAUL II, Apostolic Constitution By Which a New Canonical Organization is Given for the Spiritual Care of the Military *Spirituali militum curae*, 21 April 1986, in *AAS*, 78 (1986), 481-486, English translation in *Canon Law Digest*, vol. 12, 312-317.

[583] See BENEDICT XVI, Apostolic Constitution Providing for Personal Ordinariates for Anglicans Entering into Full Communion with the Catholic Church *Anglicanorum coetibus*, 4 November 2009, in *AAS*, 101 (2009), 985-990, English translation in *Origins*, 39 (2009-2010), 387-390; See also Congregation for the

which can be organized by groups or vicariates forane (c. 374), by the diocesan bishop. Only the supreme pontiff may erect a particular church which, when erected, possesses juridic personality by law.[584]

3.2.3.1 The College of Bishops (cc. 336-341)

The bishop's office is collegial, because individual bishops are joined in the college of bishops.[585] It is not the individual bishop that succeeds the apostles. The successor to the college of the apostles is the college of bishops.[586]As noted in canon 749, §2, the college of bishops possesses infallibility, but only when exercising their teaching office under certain conditions.[587] *Lumen gentium* notes bishop are "authentic teachers endowed with the authority of Christ."[588] The task of preaching the gospel has been primarily entrusted to the pope and the college of bishops (c. 756, §1). The power and responsibility of governing the entire Church has been given without reserve to the pope, to the college of bishops

Doctrine of the Faith, "Complementary Norms for the Apostolic Constitution *Anglicanorum coetibus*, English translation in *Origins*, 39 (2009-2010), 390-392.

[584] See *c*. 373.

[585] See K. MCDONNELL, "Walter Kasper on the Theology and the Praxis of the Bishop's Office," in *Theological Studies*, 63 (2002), 718 (= McDonnell, "The Bishop's Office").

[586] See *LG*, no. 19, 863.

[587] See c. 749, §2. "The college of bishops also possesses infallibility in teaching when the bishops gathered together in an ecumenical council exercise the magisterium as teachers and judges of faith and morals who declare for the universal Church that a doctrine of faith or morals is to be held definitively; or when dispersed throughout the world but preserving the bond of communion among themselves and with the successor of Peter and teaching authentically together with the Roman Pontiff matters of faith or morals, they agree that a particular proposition is to be held definitively."

[588] *LG*, no. 25, 869.

when they act "together with the head and never without the head,"[589] and to each bishop in his particular church.

3.2.3.2 Synod of Bishops (cc. 342-348)[590]

If Vatican II invited new expressions of a Church of *communio*, these expressions of synodality were to be further defined by the affirmation of synods of bishops. The seven canons referencing the synod of bishops find their source of law in the 1965 motu proprio *Apostolica sollicitudo*,[591] which offers detailed prescriptions concerning the nature, purpose, and procedures of the institute. The document *Ordo synodi episcoporum*, originally issued prior to the celebration of the 1967 synod,[592] was later revised,[593] and

[589] See c. 336 "The college of bishops, whose head is the Supreme Pontiff and whose members are bishops by virtue of sacramental consecration and hierarchical communion with the head and members of the college and in which the apostolic body continues, together with its head and never without this head, is also the subject of supreme and full power over the universal Church."

[590] J. JOHNSON, "The Synod of Bishops," in J. BEAL, J. CORIDEN, and T. GREEn (eds.), *New Commentary*, 454-463.

[591] PAUL VI Apostolic Letter Issued Motu Proprio Establishing the Synod of Bishops for Universal Church Issues *Apostolica sollicitudo*, 15 September 1965, in *AAS*, 57 (1965), 775-780, English translation, http://w2.vatican.va/content/paul-vi/en/motu_proprio/documents/hf_p-vi_motu-proprio_19650915_ apostolica-sollicitudo.html, III (12 November 2016). (= *AS*)

[592] PAUL VI, Order of the Synod of Bishops to be Celebrated Issued Motu Proprio *Ordo Synodi Episcoporum Celebrandae*, in *AAS*, 59 (1967), 91-103, English translation, http://www.vatican.va/roman_ curia/synod/documents/rc_synod_20050309_documentation-profile_lt.html (30 November 2016).

[593] BENEDICT XVI, Order of the Synod of Bishops *Ordine Synodi Episcoporum*, 29 September 2006, in *AAS* 98 (2006), 655-770, English translation, http://www.vatican.va/roman_curia/synod/ documents/rc_synod_20050309_documentation-profile_lt.html (30 November 2016).

includes norms about the structures and procedures of the Synod. Canons 342[594] and 343[595] define the synod and specify its function and authority. Canon 344 notes the synod's relationship with the pope,[596] and canons 345 and 346 identify forms of assembly and membership in the synod. Canon 347 articulates norms associated with the conclusion or suspension of an assembly of the synod, canon 348 identifies permanent staffing patterns to support the synod. Called together to deliberate on questions and express various points of view and individual preferences, the synod does not resolve issues or issue decrees unless delegated to do so by the pontiff who exercises supreme authority[597] and who must ultimately ratify any decision made by the synod.[598]

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[594] Canon 342, "The synod of bishops is a group of bishops who have been chosen from different regions of the world and meet together at fixed times to foster closer unity between the Roman Pontiff and bishops, to assist the Roman Pontiff with their counsel in the preservation and growth of faith and morals and in the observance and strengthening of ecclesiastical discipline, and to consider questions pertaining to the activity of the Church in the world."

[595] Canon 343, "It is for the synod of bishops to discuss the questions for consideration and express its wishes but not to resolve them or issue decrees about them unless in certain cases the Roman Pontiff has endowed it with deliberative power, in which case he ratifies the decisions of the synod."

[596] Canon 344 ,"The synod of bishops is directly subject to the authority of the Roman Pontiff who:
1º convokes a synod as often as it seems opportune to him and designates the place where its sessions are to be held;
2º ratifies the election of members who must be elected according to the norm of special law and designates and appoints other members;
3º determines at an appropriate time before the celebration of a synod the contents of the questions to be treated, according to the norm of special law;
4º defines the agenda;
5º presides at the synod personally or through others;
6º concludes, transfers, suspends, and dissolves the synod."

[597] See *PAUL VI Apostolic Letter Issued Motu Proprio Establishing the Synod of Bishops for the Universal Church Apostolica sollicitudo, 15 September 1965, in AAS, 57 (1965), 775-780, English translation http://w2.vatican.va/content/paul-vi/en/motu_proprio/documents/hf_p-vi_motu-proprio_19650915_apostolica-sollicitudo.html, III (12 November 2016)*.

[598] See c. 343.

3.2.3.3 Conferences of Bishops: *Communio* Among the Bishops (cc. 447-459)

In 1998, St. John Paul II promulgated his *moto proprio Apostolos suos*, on the theological and juridical nature of the episcopal conference."[599] This was an effort to translate Vatican II theology into canonical language,[600] by defining episcopal conferences as juridical entities created by the Holy See. At the same, through *Apostolos suos*, St. John Paul II established norms for the regulation of the conferences of bishops throughout the world.

> It defined both the attitude and policy of the Holy See toward the conferences and the individual bishops … [and] it discourages … bishops from thinking and acting *as a corporation* … In order that the doctrinal declarations of the conference of bishops … may constitute authentic magisterium and be published in the name of the conference itself, they must be unanimously approved by the bishops who are members or receive the *recognition* (review) of the Apostolic See if approved in plenary assembly by at least two thirds of the bishops … The rule could not be clearer: the bishops can join their voices 'in conference' but *the conference*, as such, has no voice."[601]

The doctrinal position of *Apostolos suos* can be summed up in this way: "the bishops can join their voices 'in conference' but *the conference*, as such, has no voice;"[602] however, they should be animated by a "collegial spirit," or "affective collegiality,"[603] which is a disposition to deliberate and to act jointly."[604]

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[599] See ST. JOHN PAUl II, Apostolic Letter On the Theological and Juridical Nature of Episcopal Conferences *Apostolos suos*, 21 May 1998, in *AAS*, 90 (1998), 641-648, English translation in *Origins*, 28 (1998-1999), 152-158 (= AS).

[600] See ST. JOHN PAUL II, Apostolic Constitution on the Promulgation of the new Code of Canon Law *Sacrae Disciplinae Leges*, 25 January 1983, in *AAS*, 75 (1983) *Commentarium Officiale*, 75, Part II (1983) pp. vii-xiv, English translation in *CIC*, pp. xxvii-xxxii.

[601] ŐRSY, *Receiving the Council*, 18.

[602] Ibid.

[603] Ibid, 19.

[604] See ibid., 19-29,

3.2.4 Implications of the Church's Hierarchy for Catholic Health Care

As demographics have changed in religious institutes in North America,[605] more religious institutes are transferring to public juridic persons the responsibility of sponsorship of apostolates. As noted in Chapter I, the juridic process for transferring sponsorship of apostolates which are continued in the name of the Church includes application to the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life. The Church's organizational structure exists to support the realization of the Church's mission through identified apostolates which are the responsibility of all the baptized.[606]

As was evident in the overview of the development of Catholic health care in the province of Ontario, religious institutes were invited to various areas of the province with a focus on ministry, including care for the sick through the founding of hospitals. Inherent in this invitation was the bishop's consent to erect a house and carry on works proper to it.[607] In other situations, bishops entrusted particular ministries to religious institutes in his diocese.[608] Religious assigned and serving in the apostolate particular to the charism of the religious institute or the apostolate entrusted to them, served in obedience to their

[605] See M. LIPKA, "U.S. nuns face shrinking numbers and tensions with the Vatican," in *PewReseach*, 8 August 2014, http://www.pewresearch.org/fact-tank/2014/08/08/u-s-nuns-face-shrinking-numbers-and-tensions-with-the-vatican/ (9 December 2016).

[606] See cc. 216, 713.

[607] See c. 611, §2.

[608] See c. 681.

superiors and the diocesan bishop.[609] A clear understanding of the bishop's responsibility for all apostolates sponsored in the name of the Church including the ministry of Catholic health care, forms an important aspect of formation of leaders.

3.3 The Role of Diocesan Bishops in Catholic Health Care

The divine institution of the office of bishops who "succeed to the place of the Apostles through the Holy Spirit,"[610] confers to each bishop the role of pastor in the Church and the power to sanctify, teach, and govern which are "exercised in hierarchical communion with the head and other members of the college of bishops."[611] Vatican II characterized the bishop's office by three essential attributes: pastoral (because it is a ministry of proclamation, sanctification, and leadership), collegial, and sacramental. More than a ministry of administration, the bishop's office is a ministry of a shepherd.[612]

3.3.1 Bishops in General

Canon 376 notes that bishops to whom the care of souls is entrusted are called diocesan bishops while all others are called titular bishops. Some titular bishops are appointed to a titular see but others are not, and may hold a title such as bishop emeritus (a

[609] See c. 678, §§ 1-2.

[610] c. 375.

[611] c. 375, §2.

[612] See *LG*, no. 18, 862.

retired bishop) or coadjutor bishop of a particular diocese to which he will succeed to become the diocesan bishop.[613]

Bishops are freely appointed by the Supreme Pontiff (c. 377, §1). In order to be considered for the ministry of bishop of a particular church, an individual is judged to be a potential candidate for the episcopacy.[614] At least every three years, bishops in an ecclesiastical province or the conference of bishops, after counsel and in secret, compose a list of presbyters (sometimes including members of religious institutes of consecrated life) who are suitable for the episcopate. These names are submitted to the Apostolic See, without prejudice to the right of individual bishops to make known to the Apostolic See individually, the names of presbyters whom they consider worthy of and suited to the episcopal function. (c. 377, §2) The metropolitan and suffragans of the province to which the diocese belongs and the conference of bishops offer suggestions for candidates to the episcopacy. (c. 377, §3) Some bishops who determine the need for additional support from an auxiliary bishop in order to fulfill the needs of their diocese, present this request to the Apostolic See along with a list of at least three presbyters suitable for this office. (c. 377, §4) The human qualifications and talents needed to be a bishop are noted in canon 378.[615] The final decision on the episcopal appointments rests with the Apostolic See.

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[613] See J. RENKEN, *Particular Churches and the Authority Established in Them: Commentary on Canons 368-430*, Ottawa, Saint Paul University, 2011, 75-76.

[614] See J. RENKEN, "Particular Churches and Their Groupings (cc. 368-572), in J. Beal, J. Coriden, and T. Green (eds.), *New Commentary on the Code of Canon Law*, New York/Mahwah, N.J., Paulist, 2000, 514 (= Renken, "Particular Churches").

[615] c. 378 §1., "In regard to the suitability of a candidate for the episcopacy, it is required that he is:

3.3.2 Diocesan Bishops

Although some of the powers of the diocesan bishops or others who lead particular churches (c. 381, §2) may be reserved by the Supreme Pontiff,[616] once they have taken possession of their office (c. 382), they normally have by law ordinary (related to the office of the diocesan bishop), proper (exercised in his own name, not vicariously in the name of another), and immediate power (directed toward all of the diocese without the mediation of another) needed for the pastoral care of their diocese.[617] This reflects the teaching of Vatican II which explains that bishops are not to be considered papal emissaries, but are vicars and legates of Christ who are anointed through their episcopal consecration to exercise power in their own right and are "prelates of the people they govern."[618] The diocesan bishop's power of governance, used to fulfill his mission in the Church and to lead, shepherd, and model through his life to the people of his particular Church, includes legislative, executive, and judicial authority (c. 391, §1). However, the supreme authority

1º outstanding in solid faith, good morals, piety, zeal for souls, wisdom, prudence, and human virtues, and endowed with other qualities which make him suitable to fulfill the office in question;
2º of good reputation;
3º at least thirty-five years old;
4º ordained to the presbyterate for at least five years;
5º in possession of a doctorate or at least a licentiate in sacred scripture, theology, or canon law from an institute of higher studies approved by the Apostolic See, or at least truly expert in the same disciplines.
§2. The definitive judgment concerning the suitability of the one to be promoted pertains to the Apostolic See."

[616] c. 381 §1. "A diocesan bishop in the diocese entrusted to him has all ordinary, proper, and immediate power which is required for the exercise of his pastoral function except for cases which the law or a decree of the Supreme Pontiff reserves to the supreme authority or to another ecclesiastical authority."

[617] See RENKEN, "Particular Churches," 518-519.

[618] Ibid., 519.

of the Church can control and limit the exercise of this power, whether by law or by decree of the Supreme Pontiff.[619]

As noted by Kasper, "Vatican II did not offer a new theology of the bishop's office, but retrieved the early church's tradition, bringing the unfinished work of Vatican I to its conclusion … The council wanted to follow in the path of the early Church, balancing and completing the doctrine of papal primacy with the doctrine of the bishop's office, together with collegiality in the bishop's office. In this way the council wanted to overcome curial centralization."[620] *Lumen gentium* sees the office of bishop as flowing from Jesus and therefore of divine institution. It is foundational in that its existence and essential form is not a matter which can be legislated, but is rather, divinely established.[621]

Bishops are constituted as shepherds in the Church and as successors to the apostles. "This means that both the bishop's office in its existence and in its essential form is removed from the Church's competence. The office of bishop cannot be abolished nor be restricted in its functions, either by the successors of Peter or by episcopal conferences, or by post-conciliar diocesan councils."[622]

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[619] See *LG* 24; *CD* 8.

[620] McDonnell, "Bishop's Office," 716.

[621] See ibid., 717.

[622] Ibid.

3.3.2.1 Particular Responsibilities of the Diocesan Bishop in Relation to Catholic Health Care

Although traditionally sponsored by various religious institutes who began, at the invitation of diocesan bishops, ministries in Catholic health care in Ontario, Catholic health care is a ministry of the Church. As such, this apostolate is subject to the hierarchical authority defined by the Church. As part of the diocesan bishop's tri-fold special ministry of care of souls, oversight of the public exercise of divine worship, and care for the works of the apostolates assumed by religious institutes in his diocese (c. 678, §1),[623] diocesan bishops are responsible for general oversight of all Catholic apostolates within their diocese (c. 384). Canon 209 also notes that all apostolic activity in a particular diocese must be carried out "in communion with the diocesan bishop of the place with the ministry is exercised."[624] The conference of bishops "jointly exercise certain pastoral functions for the Christian faithful of their territory … especially through forms and programs of the apostolate." (c. 447).

As noted in Chapter II, religious institutes brought resources (financial and personnel) to the ministry of Catholic health care in Ontario. As the influx of vocations to religious life who served as key personnel in these institutions throughout the Province began to wane, alternate models of continuing the apostolate of Catholic health care in the name of the Church were defined (cc. 113-123). The responsibility of the laity for

[623] See F. MORRISEY and S. HOLLAND, "Ministerial Juridic Persons and Their Communion with Diocesan Bishops," in *Health Progress*, vol. 97, no. 6 (2016), 68. (= MORRISEY & HOLLAND)

[624] MORRISEY & HOLLAND, 68.

apostolates because of their baptism and confirmation (c. 225) opened new avenues of sponsorship which have developed over the years. Initial iterations of public juridic persons, identified and approved by the competent hierarchical authority, included both laity and religious.[625] "The Holy See … has sanctioned the establishment of a number of such entities in the fields of health care, education and social services." [626] This development implies a growing trust in the preparation of the laity to assume direct responsibility for this ministry in the Province. To differentiate public juridic persons whose juridic status is granted by the competent ecclesiastical authority and those juridic persons established in the law,[627] those established to sponsor particular apostolates such as Catholic health care, are now being referred to as "ministerial juridic persons."[628] Like public juridic persons identified in the Code that can be approved by the diocesan bishop or by the Holy See, ministerial juridic persons remain "accountable to the diocesan bishops of the place where their ministry is being exercised."[629]

In Canada, some of the bishops' additional responsibilities and authority related to the ministry of Catholic health care are noted in the *Health Ethics Guide*.[630] This document mentions that the Canadian Conference of Catholic Bishops does not serve as a substitute

[625] See MORRISEY & HOLLAND, 69.

[626] Ibid.

[627] See cc. 328, §1; 373; 432, §2; 449, §2; 515, §3; 709.

[628] Morrisey & Holland, 68.

[629] Ibid.

[630] See CHAC, *Health Ethics Guide*, xi.

for the authority of individual diocesan bishops, but aims to support it. Local protocols will defer to the judgement of the local diocesan bishop when there is a question of faith or morals.[631]

Rooted in his office as teacher, priest, pastor, and coordinator of ministries in the local Church,[632] diocesan bishop provides leadership in fostering the mission of Catholic apostolates in his diocese.[633] As priest of the diocese, the diocesan bishop has the responsibility to oversee the sacramental ministry offered in Catholic apostolates. Responsibility for the care of souls in his diocese "finds practical expression in the designation of persons called upon to serve as chaplains in the institution (c. 565).[634] As pastor, he encourages the faithful who participate in the healing ministry of the Church which witnesses to the values operational within the organization of respect, dignity, trust, and justice.[635] By their nature, these duties require Catholic health care providers and the diocesan bishop to engage in "ongoing communication on ethical and pastoral matters that require his attention."[636]

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[631] See CHAC, *Health Ethics Guide*, xi.

[632] See UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, Ethical and Religious Directives for Catholic Health Care Services, 5th ed., USCCB, 17 November 2009, 5-9, http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf (3 January 2017) (= USCCB, *ERDs*).

[633] See CHAC, *Health Ethics Guide*, 11.

[634] See MORRISEY & HOLLAND, 69; See also CHAC, *Health Ethics Guide*, no. 155, 100.

[635] See CHAC, *Health Ethics Guide*, 12.

[636] Ibid.

Catholic health and social services are apostolates for which the diocesan bishop bears pastoral responsibility and authority.[637] As part of his mandate, the bishop will recognize Catholic health care as an integral part of the Church's apostolates and a sponsored ministry within his diocese.[638] While not responsible for the day to day ordering of Catholic health care organizations, he is responsible for ensuring appropriate structures are in place to monitor quality of care and that the stewardship of resources adheres to both canonical and civil accountability measures. He ensures that the organization promotes a culture which supports Catholic ethical values and spiritual beliefs, promotes spiritual and religious care for both patients and staff, and ensure the availability of sacraments. Organizational standards for medical ethics consultations are organized and respect the diocesan bishop's teaching and pastoral responsibilities.[639] Catholic health care organizations within a diocese must be Catholic in more than name: they should ensure that the mission and values of the Church are integrated, and that Catholic social teachings which demand just working conditions are applied. Adverse events related to Catholic identity or moral integrity of the organization should be reported to the diocesan bishop.[640] Christian art, signs, and symbols should be prominent throughout the facility.

Within his teaching function, the diocesan bishop is responsible for ensuring the ethical and social teachings of the Church are reflected faithfully in the apostolates in his

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[637] See CHAC, *Health Ethics Guide*, 22.

[638] See ibid.

[639] CHAC, *Health Ethics Guide*, no. 157, 101.

[640] See ibid., no. 184, 109-110.

diocese, and that the health care institution is clearly identified as Catholic.[641] "The governance structure for any organization designated as Catholic should state how the organization is related to the bishop and to the Holy See through its sponsor."[642] When issues relating to organizational partnerships within the provincially-funded larger health care system are encouraged or mandated, the "local bishop and other Church authorities should be kept informed of collaborative arrangements relating to matters of faith and morals which should not be completed without the authorization of the diocesan bishop."[643] If the organization chooses to appoint a priest or deacon to the spiritual care staff, explicit approval or confirmation of the diocesan bishop is required.[644]

3.4 Catholic Health Care in Ontario

As noted in Chapter II, Catholic health care in Ontario was founded in response to various diocesan bishops recognizing the unmet needs of the people in their diocese for quality health care services. To respond to this need, different religious institutes established Catholic hospitals in keeping with their institute's charism and mission.

Formerly identified as an impediment to sponsor collaboration, Catholic health care in Ontario is sponsored by two pontifical juridic persons (Catholic Health International and Catholic Health Sponsors of Ontario) and two diocesan juridic persons (St. Joseph's Health

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[641] See CHAC, *Health Ethics Guide*, 92.

[642] Ibid., 93.

[643] Ibid., no. 151, 98.

[644] See ibid., no. 155, 100.

System, Hamilton and St. Joseph's Health Care, London). Although pontifical juridic persons provide annual accountability reports to the Holy See, these same reports are copied and provided to the diocesan bishops in which Catholic health care facilities are located. As an example, Catholic Health Sponsors of Ontario sponsors 21 Catholic health care facilities in six dioceses (Toronto, Ottawa, Pembroke, Kingston, Sault Ste. Marie, and Thunder Bay). Despite broad geographic territories, every effort is made to ensure the ministry and accountabilities of diocesan bishops are recognized and supported.

3.5 Protocols to Support the Mission of Catholic Health Care

Given the growing complexity of health care, efforts to ensure diocesan bishops who assume responsibility for all sponsored apostolates within their diocese are kept informed and engaged in this ministry are planned rather than left to chance. Annual meetings are scheduled with diocesan bishops individually and in groups. A request to meet with the Assembly of Catholic Bishops of Ontario has been initiated. Suggesting a sponsors' meeting with the Ontario bishops would offer both the bishops and Ontario sponsors an opportunity to share activities, accomplishments, and concerns. Such a meeting could be particularly helpful as both the bishops and the Church strategize a unified response to new legislation legalizing assisted suicide.[645] In addition, all sponsors have ensured that Ontario bishops have been invited to all sponsor-forums and educational

[645] See BISHOPS OF CANADIAN ATLANTIC PROVINCES, "Pastoral Reflection on Medical Assistance in Dying," in *Origins*, 46 (2016-2017), 481-484; See also BISHOPS OF ALBERTA AND THE NORTHWEST TERRITORIES, "Guidelines for Celebration of Sacraments for People Who Consider or Opt for Assisted Suicide," in *Origins*, 46 (2016-2017), 289-299.

events such as the Catholic Health Association of Ontario annual convention and annual general meeting.

As part of their responsibilities, we have noted the bishops' responsibility to ensure the apostolates within their diocese are rooted in the Church's social teaching. In order to ensure that predominantly lay sponsor boards as well as trustees and senior leaders of Catholic health care in Ontario are aware of the Church's teachings which may stand in stark contrast to secular values, a strategy to include the hallmarks of Catholic social teaching within formation strategies for sponsors, trustees and senior leaders will be important.

3.5.1 Catholic Social Teaching: Foundation for Ministry

The Church's focus on social justice has a long tradition which is evident throughout the scriptures[646] and in the ministry of Jesus.[647] Since the publication of Pope Leo XIII's encyclical *Rerum Novarum,*[648] the Church has seen many descriptions of social justice.[649] The U.S. bishops identified seven themes which form a foundation for Catholic

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[646] See Job 12:22; Psalm 37:24-29; Proverbs 21:15; Isaiah 30:18-19; Amos 5:24; Hosea 12:6; Matt. 5:38-39; Luke 18:1-8.

[647] See Luke 6:24-26.

[648] LEO XIII, Encyclical On the Rights and Duties of Capital and Labor *Rerum Novarum*, 15 May 1891, in *ASS* 23 (1890-91), 641-670, English translation Vatican, http://w2.vatican.va/content/leo-xiii/en/encyclicals/documents/hf_l-xiii_enc_15051891_rerum-novarum.html (12 December 2016) (= *RN*).

[649] See ST. JOHN XXIII, Encyclical Letter On Christianity and Social Progress *Mater et Magistra*, 15 May 1961, in *AAS* 53 (1961), 401-646, English translation, http://w2.vatican.va/content/john-xxiii/en/encyclicals/documents/hf_j-xiii_enc_15051961_mater.html (27 October 2016); See also *GS, Deus Caritas Est, EG, LS.*

social teaching and reflect the Church's mission to build a just society by "living lives of holiness amidst the challenges of modern society."[650] These themes include the following:

> 1. **Life and Dignity of the Human Person:** There is a strong correlation between the dignity of the human person which is nourished when the common good is protected. The Catholic Church proclaims that all life is sacred, because man is made in the image of God;[651]
>
> 2. **Call to Family, Community and Participation**: The person is not only sacred but social. The organization of our society, in economics and politics, in law and policy, directly affects human dignity and the capacity of individuals to grow in community;[652]
>
> 3. **Rights and Responsibilities:** In order to ensure the protection of human dignity in our world, the rights and responsibilities of all must be protected;
>
> 4. **Preferential Option for the Poor and Vulnerable:** Jesus reminds us that the needs of the poor and vulnerable must be first.
>
> 5. **The Dignity of Work and the Rights of Workers:** The economy must serve the people, not the people serve the economy. If the dignity of work is to be protected, the basic rights or workers must be protected – the right to productive work, decent and fair wages, organization and joining unions, to obtain private property, and to economic initiative;
>
> 6. **Solidarity as one human family:** At the core of solidarity is the pursuit of justice and peace;
>
> 7. **Care of creation:** "Francis of Assisi reminds us that our common home is like a sister with whom we share our life and a beautiful mother who opens her arms to embrace us. Praise be to you, my Lord, through our Sister, Mother Earth … This sister now cries out to us because of the harm

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[650] UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, Seven Themes of Catholic Social Teaching, no. 5-315, Washington, DC, USCCB Communications, 2005, http://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/seven-themes-of-catholic-social-teaching.cfm (12 December 2016) (= USCCB, Seven Themes).

[651] See *CCC,* Article 1, nos. 1701-1715, 474-475.

[652] USCCB, Seven Themes.

> we have inflicted on her by our irresponsible use and abuse of the goods with which God has endowed her.[653]

The Church's social doctrine is an expression of justice rooted in charity. "This dynamic of charity received and given is what gives rise to the Church's social teaching,"[654] and "to desire the common good and strive towards it is a requirement of justice and charity."[655]

In addition to the foundational themes reflected in all of the Catholic Church's social teaching, the Church espouses a social tradition marked by the values of solidarity, subsidiarity, and participation, which must be incorporated into the very fabric of Catholic health care organizations and included in planning and decision-making by sponsors, trustees, senior leaders and staff.[656] Solidarity is expressed when "the intrinsic social nature of the human person, the equality of all in dignity and right, and the common path of individuals and people towards an ever more committed unity,"[657] are evident in the interdependent relationships found within the community. St. John Paul II noted that the

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[653] FRANCIS, Encyclical Letter on the Environment *Laudato si'*, 24 May 2015, in *Origins*, 45 (2015-2016), nos. 1-2, 113. 113-152.

[654] BENEDICT, Encyclical Letter on Integral Human Development in Charity and Truth *Caritas in veritatae*, 29 June 2009, in *AAS* 101 (2009), 641-711, English translation in *Origins*, 39 (2009-2010), no. 5, 131. (= *CV*)

[655] Ibid., no. 7, 132.

[656] CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, The Church, Its Social Justice Tradition and the Catholic Health Care Ministry as a Just Workplace, Washington, DC, CHA, 2011, 19 (= CHA, "A Just Workplace").

[657] PONTIFICAL COUNCIL FOR JUSTICE AND PEACE, *Compendium of the Social Doctrine of the Church*, New York, Bloomsbury, 2004, no. 192, 98 (= *CSD*).

expression of solidarity was found in one's commitment to the common good.[658] While social media has created a greater sense of connection among individuals, this connection can be superficial and lack the depth of human relationship found in genuine ethical-social solidarity.[659] Solidarity would be expressed in Catholic health care organizations through staff dialogue and participation in decision-making.[660] Through the eyes of faith, we are invited to acknowledge all are sisters and brothers, daughters and sons of God, and "all are really responsible for all."[661]

Present since the first social encyclical, subsidiarity has been a constant theme and directive of the Church's social doctrine.[662] Catholic social tradition notes the importance of ensuring the tasks of social groups are accomplished at the lowest possible lever, or as close to the people involved as possible.[663] We are to "promote freedom and human dignity, and to prefer remedies that are personal, local, and small scale, a principle the church calls subsidiarity."[664] The role of social authority is to help individuals and intermediate groups

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[658] ST. JOHN PAUL II, Encyclical Letter on the Social Concerns of the Church *Sollicitudo rei socialis*, 30 December 1987, in *AAS* 80 (1988), 513-586, English translation, Vatican, http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_30121987_sollicitudo-rei-socialis.html (12 December 2016) (= *SRS*).

[659] *CSD*, no. 193, 93.

[660] L. JANSEN, "Collaborative and Interdisciplinary Health Care Teams: Ready or Not?" in *Journal of Professional nursing*, vol. 24, no. 4 (2008), 218-227; See also F. FALLATAH and H. LASCHINGER, "The influence of authentic leadership and supportive professional practice environments on new graduate nurses' job satisfaction," in *Journal of Research in Nursing*, 2 (2016), 125-136.

[661] *SRS*, no. 38.

[662] See *RN*.

[663] See CHA, "A Just Workplace," 19.

[664] GOMEZ, J., "The Duties and Demands of Catholic Social Teaching," in *Origins*, 46 (2016-2017), 109.

to fulfill their duties and thus respect and protect the human person from abuses by high-level social authorities.[665] Pope Benedict noted:

> Subsidiarity is first and foremost a form of assistance to the human person via the autonomy of intermediate bodies. Such assistance is offered when individuals or groups are unable to accomplish something on their own, and it is always designed to achieve their emancipation, because it fosters freedom and participation through assumption of responsibility. Subsidiarity respects personal dignity by recognizing in the person a subject who is always capable of giving something to others.[666]

Subsidiarity is practiced in Catholic health care by ensuring decisions are made at the most appropriate level throughout the organization, e.g., normally, decisions related to plans for care for an individual patient are made with the patient, the family, and the care team and not administration, unless the decision made by those directly involved impacts the common good of the entire organization. While these concepts are referenced individually, having subsidiarity without solidarity "gives way to social privatism, while solidarity without subsidiarity gives way to paternalist social assistance that is demeaning to those in need."[667]

The final element of Catholic social teaching which enjoys a symbiotic relationship with subsidiarity, is participation[668] "[which] is expressed essentially in a series of activities by means of which the citizen, either as an individual or in association with others, whether directly or through representation, contributes to the cultural, economic, political and social

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[665] See *CSD*, no. 187, 94-95.

[666] *CV*, no. 57, 151.

[667] Ibid., no. 58, 151.

[668] See *CSD*, no. 189, 96.

life of the civil community to which he belongs."[669] It is essential to encourage participation of the disadvantaged, as well as "the occasional rotation of political leaders in order to forestall the establishment of hidden privileges."[670] This will assist the entire community of the faithful to focus on our shared human dignity and the common good,[671] regardless of socio-economic status. This will be evidenced in Catholic health care by a special focus on the common good,[672] especially when corporate decisions are made which will, of necessity, impact a large number of persons, e.g., closure of a medical service.[673]

The purpose of all apostolates carried out in the name of the Church is unique: to proclaim the Reign of God.[674] However, we must also recognize that living out our baptismal commitment through the lens of Catholic social teaching, will call us to personal and organization conversion and transformation.

> The first form in which this task is undertaken is in the commitment and effort to renew oneself interiorly, because human history is not governed by an impersonal determinism but by a plurality of subjects whose free acts shape the social order. Social institutions do not of themselves guarantee, as if automatically, the common good: the internal renewal of the Christian spirit must precede the commitment to improve society."[675]

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[669] *GS*, no. 75, 1122

[670] *CSD*, no. 189, 96.

[671] See *CCC*, no. 1913, 519.

[672] See D. FINN (ed.), *The True Wealth of Nations: Catholic Social Thought and Economic Life*, Oxford, Scholarship Online, 2010.

[673] See L. EGGERSTON, L, "Ontario hospitals say service, staff or program cuts may be inevitable," in *Canadian Medical Association Journal*, 182 (2010), E157-158.

[674] See CHA, "A Just Workplace," 20.

[675] *CSD*, no. 552, 278.

The Church's organizational structure and social teachings simply form the framework to actualize the mission. From this foundation, additional support is offered to those called to the vocation to continue the Church's healing mission through the development of ethical and religious directives, which have been developed and approved by conferences of bishops throughout the world, and which assist in guiding and supporting the Church's mission of healing.

3.5.2 Application of the Health Ethics Guide Approved by the CCCB

Societies that have developed on earth share one thing in common: the establishment of rules that govern the relationship between the individual and the society as a whole.[676] As noted by Őrsy, the role of the law is to "assist the people in the reception of God's saving mysteries."[677]

The Church has endeavoured to support those who continue Jesus' healing mission by establishing ethical and religious directives which give shape to the faith community's healing ministry. The following evolution of norms for ethical behaviour for all Catholics and for those appointed to shepherd this ministry will be reviewed:

1. Historical development of an ethical framework for health care;

[676] See S. WADDAMS, J. BRIERLEY, and G. GALL, "Law," 8 February 2006, in *The Canadian Encyclopedia, Historica Canada*, http://www.thecanadianencyclopedia.ca/en/article/law/ (7 January 2017).

[677] L. ŐRSY, "Theology and Canon Law," in J. BEAL, J. CORIDEN, and T. GREEN (eds.), *New Commentary on the Code of Canon Law*, New York/Mahwah, N.J., Paulist, 2000, 1.

2. Catholic Health Care Ethics Guidelines: Particular Law Guiding Health Care Decisions
3. The Canadian *Health Ethics Guide*: A Particular Overview
4. Education, Operationalization and Evaluation of the Current Canadian *Health Ethics Guide* in Ontario Catholic Health Care.

3.5.2.1 Historical Development of an Ethical Decision-making Framework for Health Care

Religion played a major role in shaping medical ethics protocols and guidelines.[678] Until recently, Catholic theologians and philosophers along with Jewish scholars, were virtually alone in the field of medical ethics.[679] Noting that healing would be most effective and ethical when it addressed the needs of the whole person, until the time of the Enlightenment of the eighteenth century, any radical separation of medicine and religion was not attempted. Most religions included physical healing in their ministry to the whole person.

Hippocrates saw medicine as part of his religion rather than as a separate and secular vocation.[680] As part of the vocation of healing, physicians believed they must treat the poor for free, care even for incurables, and consider the spiritual as well as the physical

[678] See D. KELLY, *Contemporary Catholic Health Care Ethics*, Washington, DC, Georgetown University Press, 2004, Kindle ed., loc. 99 (= Kelly, *Contemporary Catholic Health Care Ethics*).

[679] See KELLY, *Contemporary Catholic Health Care Ethics*, loc. 126.

[680] Ibid., loc. 136 - 142.

needs of their patients.[681] Monks in monasteries cared for the sick, and some bishops built hospices for travelers and indigents.[682] In the sixteenth century, theologians began to be consulted on issues arising in the practice of medicine. Theological reflections around determining when death had occurred and methods which could/should be used to prolong life were discussed. Catholic health care providers applied treatment norms agreed upon by theologians and general norms for compassionate care. However, no formal teaching of the Catholic Church concerned ethical standards for the practice of medicine and the care of patients.[683]

With the Enlightenment, philosophers such as Voltaire, Kant, Newton, Locke, and Hume began to shift the practice of medicine from the realm of a vocation that cared for the body, mind, and spirit. They stressed the importance of reason and scientific analysis. While medicine became secular, unreligious, and even antireligious, the Church recognized the need for theologians to bridge the separation of medicine from religion. From here, the concept of "pastoral medicine"[684] was developed, whereby physicians learned from theologians of the spiritual dimensions of the person and the application of the principles of moral theology to the principles of medical practice. From this interplay of medicine

[681] KELLY, *Contemporary Catholic Health Care Ethics*, loc. 150.

[682] Ibid., loc. 154.

[683] See K. O'ROURKE, T. KOPFEN STEINER, and R. HAMEL, "A Brief History: A Summary of the Development of the Ethical and Religious Directives of Catholic Health Care Services," in *Health Progress*, vol. 82, no. 6 (2001), 18 (= O'ROURKE et al., "A Brief History").

[684] KELLY, *Contemporary Catholic Health Care Ethics*, loc. 181.

and theology was born ethical reflection.[685]A recurrent theme in Christian health care ethics was the unique dignity of each person, based on the belief that humans are created in the divine image with a destiny to live with God.[686] The integrity and sacredness of the human person, body and soul, was sacred and holy because it came from God, would return to God, and hence participated in God's holiness.[687]

Reverence for each person made in God's image motivated the Church to establish health care facilities in North America, caring for the indigent poor. The ministry of Catholic health care flourished in the 19th and 20th centuries, both as an expression of Jesus' mandate to His followers to "go and do likewise,"[688] and in response to the growing number of immigrants to the new world who suffered from typhoid, cholera, and communicable diseases.[689] From this genesis, hospitals and long term care facilities multiplied in direct proportion to need, usually under the sponsorship of religious institutes[690] "but always under the jurisdiction of the diocesan bishop."[691]

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[685] See KELLY, *Contemporary Catholic Health Care Ethics*, loc. 173-204.

[686] Ibid., loc. 530,

[687] KELLY, *Contemporary Catholic Health Care Ethics*, loc. 638.

[688] LUKE 10:37.

[689] See R. RUTTY, and S. SULLIVAN, *This is Public Health: A Canadian History*, Ottawa, The Canadian Public Health Association, 2010, vi-x; See also B. MANN WALL, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace: 1865-1925*, Columbus, OH, The Ohio State University Press, 2005, 15.

[690] See T. PAPROCKI, "Caring for the Sick: The Catholic Contribution and its Relevance," in *Notre Dame Journal of Law, Ethics and Public Policy*, 25 (2011), 450.

[691] O'ROURKE et al., "A Brief History," 18.

The early decades of the 20th century marked the advent of the standardization of health care in North America, and the creation of new standards of professionalism for hospital, medical and nursing education.[692] To coalesce Catholic health care as a ministry of the Catholic Church, the Catholic Hospital Association (later known as the Catholic Health Association) was founded in 1915 "to improve the effectiveness of patient care and to protect the rights of Catholic health care facilities."[693] The American College of Surgeons established minimum standards for hospitals which were initially rejected by the Catholic Hospital Association, who feared secular standards would then become normative in Catholic hospitals.[694]

Religious institutes that sponsored Catholic health care as well as physicians and professional hospital staff, expressed a need for a uniform written statement of medical directives that would address serious moral issues that would require ethical reflection and decision-making in light of Catholic tradition and teaching.[695] Reverend C. Moulinier's 1921 President's Address to the newly established Catholic Hospital Association (later to be known as the Catholic Health Association of the United States), noted the value-based foundation of Catholic health care in Canada and the United States as well as the struggle

[692] See M. COULTER, R. MYERS, and J. VARACALLI (ed.), *Encyclopedia of Catholic Social Thought, Social Science, and Social Policy, vol. 3, Supplement*, Toronto, Scarecrow Press, 2012, Kindle ed., 101. (= COULTER et al., *Encyclopedia*)

[693] O'ROURKE et al., "A Brief History," 18.

[694] See COULTER et al., *Encyclopedia*, 101.

[695] Ibid.

and the desire to define and quantify the foundations of Catholic health care ministry, rooted in the doctrine and the tradition of the Church:

> The Catholic hospital, in its deepest essence, is a *religious* institution. This is evident to all who realize that the Catholic Sisterhoods which conduct our Catholic hospitals are what they are because of their religious faith, because of the vocation which comes to each religious woman from the Holy Spirit and because this faith and vocation get their life and strength and motivating power from the interior grace of the Holy Spirit through prayer, religious exercises, meditation and the reception of the sacraments ... Where this interior life is all that it should be, where there is intelligent, clear and honest thinking, where conscience is acute and fearless, where temperaments are schooled and directed by great fundamental Christian virtues, thought becomes deeper and broader and more penetrating ... Patients, doctors and nurses who may not believe in the deep religious dogmas that make up the religious convictions of Catholic Sisters, still see and feel and appreciate that deeper, stronger, and all pervading *something* which is so unmistakable in the Sisters' hospital where Christ and His doctrines live and move and actuate to holiness the lives of the Catholic Sisters. [696]

Responding to the desire of both bishops and the sisters sponsoring Catholic health care ministries in North America, Reverend Michael Burke, a priest of the archdiocese of Detroit, MI, wrote medical ethical norms which reflected essential Catholic doctrine and which could be used to protect the life of all who would receive care in a Catholic hospital.[697] Burke's norms primarily focused on surgical procedures, prohibiting those that destroyed the procreative potential of men and women or fetal life.[698] Certain procedures would be excepted according to the principle of double effect.[699] Accepted verbatim by many dioceses or modified slightly by others prior to promulgation, these norms

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[696] MOULINIER, C., "The President's Address," in *Hospital Progress,* 3 (1921), 300.

[697] See M. BOURKE, "Surgical Code for Catholic Hospitals of the Diocese of Detroit," in *Hospital Progress,* 1 (1920), 36-37, used with permission from the Catholic Health Association of the United States.

[698] See O'ROURKE et al., "A Brief History," 18.

[699] See F. MORRISEY, Presentation to St. Francis Health System, Honolulu, HI, 17-21 March 2014, "ERDs and Statements of Common Values." Available in the private notes of Sister Bonnie MacLellan, St. Joseph's Motherhouse, 2025 Main St. W., North Bay, ON.

concerning ethical medical practices for Catholic hospitals established a list of "dos and don'ts," but did not consider the theological and scriptural traditions and teachings underlying the ministry of healing. Such prescriptive descriptions of acceptable and unacceptable practices would suffice in early iterations of medicine and hospital care. As medicine and the subsequent ministry of Catholic health care evolved in areas of research and evidence-based practice, a new and more complete document to establish and guide standards of care based on shared theological and ethical values would be required.

In response to this need, a committee of Canadian and American theologians and health care professionals wrote a uniform set of ethical and religious directives for Catholic hospitals.[700] Prepared under the auspices of the Catholic Hospital Association of the United States and Canada, the Directives indicated that their purpose was to offer "guidance and benefit Catholic hospitals in those Dioceses which do not now have official Codes of Medical and Hospital Ethics."[701] The authors also noted the directives would not constitute an official code of medical, surgical, or hospital ethics, and would "have no authoritative status in any Diocese unless and until the Most Reverend Ordinary so directs."[702] A French edition for Canada was published in 1950. A revision of the English Directives was published in 1956, and included material on professional secrecy, psychotherapy and

[700] See CATHOLIC PHYSICIANS' GUILD, "Ethical and Religious Directives for Catholic Hospitals," in *The Linacre Quarterly*, 15 (1948), 1-9 (= Catholic Physicians' Guild, "ERDs").

[701] Catholic Physicians' Guild, "ERDs" 1.

[702] Ibid.

spiritual care for non-Catholics as well as an index and reference material.[703] While offering guidance, the revised Directives were non-binding unless approved by the diocesan bishop, who served as their interpreter.

With the adoption of universal health care in Canada post World War II,[704] Canadian Catholic hospitals recognized a need for an independent Catholic hospital association. They also identified the need for unified ethical standards to guide the care and services offered in Canadian Catholic hospitals. In 1954, the Canadian Church hierarchy officially adopted a Code of Ethical Directives for Catholic hospitals under their jurisdiction.[705] From this point onward, distinct but complementary Ethical and Religious Directives would be authored for Catholic health care in Canada and the United States.

Prior to the 1960s, Catholic medical ethics attempted to offer clear solutions to many medical issues, using a cause-and-effect analysis, "whereby each procedure was subjected to a diagnostic scrutiny through the application of double effect … and final judgment."[706] In the 1960s, a new method of moral reasoning was introduced by many influential theologians, known as proportionalism, and was defined as "doing or accepting a certain amount of 'evil' to make possible a proportionately greater amount of good …

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[703] See O'ROURKE et al., "A Brief History," 19.

[704] See O. MADORE, *The Canada Health Act: Overview and Options*, Ottawa, Parliamentary Information and Research Service, 4, http://www.lop.parl.gc.ca/content/lop/researchpublications/944-e.pdf (17 January 2017).

[705] See O'ROURKE et al., "A Brief History," 19.

[706] KELLY, *Contemporary Catholic Health Care Ethics*, loc. 763.

[and] which is anathema to moral and ideological purists. It tempers implacable principle with common sense."[707] Directives relating to direct sterilization and the distribution of contraceptives in Catholic hospitals began to be interpreted more liberally in some dioceses which led to a phenomenon known as geographic morality, where certain practices prohibited in one diocese as immoral were tolerated in another.[708]

After Vatican II, principles intended to frame ethical reflection included divine sovereignty and redemptive suffering, the relationship between creator and creature, and "the human person's role as creature and as coagent with God."[709] These principles, rather than answering specific health care questions, would guide and help in interpreting the meaning of the human person, thus avoiding either-or-dichotomies.[710]

The theological basis of contemporary health care ethics attempted to confront the creative tension that "rejects shortcuts and easy answers."[711] To offer moral guidelines in increasingly complex medical situations, the U.S. Catholic Health Association requested that the National Conference of Catholic Bishops (the former name of the United States Conference of Catholic Bishops) "compose and promulgate a set of *Directives* that would be uniform for the entire country," and hopefully eliminate issues related to "geographic

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[707] R. KAPLAN, "Proportionalism," in *The Atlantic Monthly*, vol. 278, no. 2 (1996), 20.

[708] See O'ROURKE et al., "A Brief History," 19.

[709] KELLY, *Contemporary Catholic Health Care Ethics*, loc. 797.

[710] See KELLY, *Contemporary Catholic Health Care Ethics*, loc. 801.

[711] KELLY, *Contemporary Catholic Health Care Ethics*, loc. 821.

morality."[712] This led to the publication of a new set of *Directives* in 1971.[713] Approved by the Catholic Bishops of the United States, it left the 1955 version of the *Directives* virtually unchanged despite significant medical, ethical, social, and theological developments in the intervening years,[714] and required promulgation by individual bishops.[715]

As is often the case, obtaining consensus on ethical discernment which cannot be legislated unless the matter is clearly contrary to natural or divine law, would not be attained by the U.S. Bishops. After the U.S. Supreme Court 7-2 decision[716] recognizing a woman's right to privacy if she chose abortion,[717] Cardinal John Krol of Philadelphia reminded American bishops that "they might have a difficult time using the federal conscience clause allowing hospitals to prohibit abortions and sterilizations in accord with 'religious teaching' unless they [all U.S. Catholic bishops] were on record as prohibiting such directives."[718]

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[712] O'ROURKE et al., "A Brief History," 19.

[713] See CATHOLIC HOSPITAL ASSOCIATION, *Ethical and Religious Directives for Catholic Health Care Facilities*, St. Louis, CHA, 1971; See also USCCB, "Ethical and Religious Directives for Catholic Health Facilities," in *Origins*, 1 (1971), 408-413; THE CATHOLIC THEOLOGICAL SOCIETY OF AMERICA, Catholic Hospital Ethics: The Report of the Commission on Ethical and Religious Directives for Catholic Hospitals Commissioned by the Board of Directors, 1972, 242, https://ejournals.bc.edu/ojs/index.php/ctsa/article/viewFile/2749/2389 (17 January 2017) (= Catholic Theological Society, Catholic Hospital Ethics).

[714] See CATHOLIC THEOLOGICAL SOCIETY, Catholic Hospital Ethics, 242.

[715] See O'ROURKE et al., "A Brief History," 19.

[716] See UNITED STATES SUPREME COURT Roe v. Wade, 22 January 1973, No. 70-18, http://caselaw.findlaw.com/us-supreme-court/410/113.html (17 January 2017).

[717] See THE SUPREME COURT HISTORICAL SOCIETY, "Landmark Cases of the U.S. Supreme Court," http://landmarkcases.org/en/Page/661/Summary_of_the_Decision (17 January 2017).

[718] O'ROURKE et al., "A Brief History," 19.

Questions around sterilization to avoid future disease or medical complications arising from pregnancy remained.[719] These doubts were submitted to the Vatican Congregation for the Doctrine of the Faith (CDF) and a response received,[720] which indicated that sterilization performed to avoid pathological medical conditions that might occur in future pregnancies could not be performed in Catholic hospitals, no matter what theological opinion might be put forward.[721] In 1977, the American Bishops issued a commentary on the CDF response,[722] focusing on the interpretation of material cooperation which raised more questions.[723] While the Church was focusing on reproductive issues, new ethical issues in health care such as informed consent for research, the use of advanced directives, and cooperation with other-than-Catholic health care facilities had arisen.[724]

In light of advancing medical procedures and technology, the National Conference of Catholic Bishops commissioned its Committee on Doctrine, with the assistance of several Catholic organizations, theologians and ethicists, to develop a new set of *Directives*. After 11 drafts, the revised "Ethical and Religious Directives for Health Care

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[719] See O'ROURKE et al., "A Brief History," 19.

[720] SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, Responses to questions concerning sterilization in Catholic hospitals *Quaecumque sterilizatio*, 13 March 1975, in *AAS* 63 (1976), 738-740, English translation "Sterilization in Catholic Hospitals, Statement of the Vatican Doctrinal Congregation," in *Origins*, 6 (1976-1977), 33-35.

[721] Ibid., no. 3, 36; See also O'ROURKE et al., "A Brief History," 20.

[722] See NATIONAL CONFERENCE OF CATHOLIC BISHOPS, "Commentary on the Reply of the CDF on Sterilization in Catholic Hospitals," in *Origins*, 7 (1977-1978), 399-400.

[723] See UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, "Ethical and Religious Directives for Catholic Health Care Services," in *Origins*, 31 (2001-2001), 153-163.

[724] Ibid.

Services" was approved by the United States Conference of Catholic Bishops in 1994.[725] It offered a theological basis for Catholic health care directives. It did expand the area of medical ethics beyond clinical issues to include issues related to social justice,[726] included references to the U.S. Bishops' pastoral letter on health and health care,[727] and described Catholic identity in more positive terms. The purpose of the Directives was to support a "culture in health care that focused on the promotion of human dignity in a way that was animated by the spirit of the Gospel and guided by the teachings of the Church."[728] Guidance on clinical issues that had recently developed were added to the directives and addressed issues relating to advanced medical directives, surrogate decision-making, reproductive technologies, and the provision of nutrition and hydration to patients in a persistent vegetative state. Care for victims of sexual assault was also discussed. The Directives offered a decision-making framework which would consider differing situations. In addition, partnerships with other-than-Catholic health care providers, and detailed traditional principles of material and formal cooperation were added to the Directives.[729]

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[725] See NATIONAL CONFERENCE OF CATHOLIC BISHOPS, *Ethical and Religious Directives for Catholic Health Care Services*, Washington, DC, United States Catholic Conference, 1994.

[726] O'ROURKE et al., "A Brief History," 20.

[727] See UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, Health and Health Care: A Pastoral Letter of the American Catholic Bishops, 19 November 1981, Washington, DC, USCCB, 1981.

[728] O'ROURKE et al., "A Brief History," 20.

[729] See O'ROURKE et al., "A Brief History," 20.

An appendix to the 1994 Directives which had not been completed when the U.S. Bishops submitted the document to the CDF, attempted to explain the principle of cooperation with evil, an important concept when negotiating partnerships with other-than-Catholic entities. These directives did not have the force of law until they were promulgated by the diocesan bishop.[730] In the spring of 1999, the CDF requested that the president of the CCCB review the appendix, the bishops' commentary on the CDF response, as well as norms which addressed cooperation with other-than-Catholic providers. A new version of the Directives was issued by American bishops in 2001.[731]

3.5.2.2 Canada's Health Ethics Guide[732]

Like other countries in which the ethical and religious directives have been approved by conferences of bishops, the Canadian *Health Ethics Guide*[733] the growing complexity of ethical issues faced by Catholic health care is reflected in the serious reflection and struggle the Canadian bishops experienced in order to come to consensus on the final document.[734]

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[730] See O'ROURKE et al., "A Brief History," 20.

[731] Ibid., 21; See also USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, Washington, DC, USCCB, 2001.

[732] See J. ROCHE, Notes on the Health Ethics Guide, 7 February 2017, personal Email bmaclellan@csjssm.ca.

[733] See CHAC, *Health Ethics Guide*.

[734] Because some of the documentation related to the CCCB review process of various drafts of the *Health Ethics Guide* has not been released for public review, reference to these documents will be offered in general terms without reference to comments by individual bishops.

3.5.2.2.1 Five-Year Delay in Having the Guide Approved

In order to understand approval process of the 2012 *Health Ethics Guide*, we feel it is important to grasp the evolution of the Catholic Health Association of Canada who would have responsibility for developing initial drafts of *Health Ethics Guides* to be reviewed by Canadian Bishops prior to publication, and which would provide an ethical framework for decision-making for Catholic health care workers throughout the country. [735] In 2009, the Catholic Health Association of Canada was renamed the Catholic Health Alliance of Canada.[736] A primary responsibility of CHAC was to work collaboratively with the CCCB, Catholic theologians and ethicists, to develop ethical and religious guidelines (later referred to as the *Health Ethics Guide*)[737] to assist the country's Catholic hospital sponsors, trustees, and administration in making ethical and moral decisions in keeping with the Church's doctrine and teachings.

In 1990, CHAC developed a policy which required review of the *Health Ethics Guide* every five years to determine necessary edits to address the rapidly changing health care environment. In 1995, Mr. James Roche, President and CEO of CHAC, was mandated by the CHAC Board to develop a process for the regular reviews of Canada's Catholic

[735] Between 1939 and 2009, the national Catholic Health Association was known as the Catholic Health Association of Canada. In 2009, after reviewing its mandate and recognizing the significant role of the provincial Catholic health associations in guiding and supporting the ministry of Catholic health care in each province, the Catholic Health Association of Canada was renamed the Catholic Health Alliance of Canada.

[736] See J. ROCHE, Notes to Sister Bonnie MacLellan, csj re Health Ethics Guide 2012, 7 February 2012, available in the private archives of Sister Bonnie MacLellan, 2025 Main St. W., North Bay, ON P1B 2X6. (= ROCHE, Notes)

[737] See CHAC, *Health Ethics Guide.*

Health Ethics Guide. This included "four focus group sessions in various parts of the province to undertake this assessment."[738] At that time, the focus groups that had been gathered determined a review of the *Health Ethics Guide* was warranted. The work to review the Guide took place between 1997 and 1999.[739] The revised text was submitted to the CCCB in late winter 2000, and received a *nihil obstat* (nothing stands in the way; nothing contrary to faith or morals that might prevent publication is found in the book) [740] within three months. However, as health care was becoming increasingly complex, "the approval of the Guide, which took less than three months in 2000, [would require] more than two years in the case of the 2012 version."[741]

As per the *Health Ethics Guide* review protocol established by CHAC, the *Guide* was again reviewed in 2005. The review process is noted below. [742]

1. December 2006 to September 2007
    a. More than 40 ethicists from Catholic health care in Canada, USA, Australia, and Britain were engaged to review proposed document revisions. Three to four ethicists were assigned to study each chapter of the revised *Guide.* A report on the review and revision

[738] See ROCHE, Notes, 1.

[739] See Ibid.

[740] See STELTEN, *Latin Dictionary*, loc. 12387-12397.

[741] See ROCHE, Notes, 1.

[742] Ibid., 2.

recommendations were presented to the CHAC board in September 2007.

b. From November 2007 to October 2009, a Core Group was formed to oversee revisions. The Core Group members chaired sub-committees "to complete the necessary revisions to each chapter. Two bishops participated as Core Group members. They attended all Core Group meetings over the two-year period."[743]

c. An editorial team completed final revisions to the *Guide* between October 2009 and February 2010.

d. In January 2010, civil legal counsel reviewed the *Guide* to ensure conformity with Canadian law and provincial legislation.[744]

e. In February 2010, the *Guide* revisions were submitted to the CCCB for approval.

f. From September 2010 to December 2010, comments on the revised text were received from the Doctrinal Commission of the CCCB.[745]

g. From January 2011 to May 2012, the editorial committee responded to the CCCB Doctrinal Commission's recommendations.[746]

h. On May 4, 2012, the CCCB granted its *nihil obstat* of the *Guide*.

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[743] ROCHE, Notes, 2.

[744] See ROCHE, Notes, 2.

[745] Ibid.

[746] Ibid.

The *Health Ethics Guides* have been used by Catholic health care in Canada since 1948 when the Catholic Hospital Association of the United States and Canada joined forces to develop shared ethical and religious directives.[747] The Catholic Health Alliance of Canada (previously known as the Catholic Health Association of Canada), served as the traditional publisher and distributer of the *Health Ethics Guide.*[748] While preliminary editions were prepared by the CHAC, each edition of ethical and religious directives, later referred to as the *Health Ethics Guide*, required review and a statement of *nihil obstat* from the CCCB. As Reverend Francis Morrisey noted, in the various review processes of the 2012 edition of the *Health Ethics Guide*, an important distinction was identified between the *nihil obstat* requested of the CCCB and a request for personal approval of every clause contained in the *Guide* by individual members of the CCCB. In correspondence to the CCCB, Morrisey notes, "The *nihil obstat* requested of the CCCB implies the work is free of doctrinal or moral errors. It does not mean that those giving the authorization necessarily agree with every point expressed in the document. Nor does it make the text a document of the person(s) granting the *nihil obstat.* The Guide is not a text of the Bishops' Conference."[749] The delay in the final approval of Canada's *Health Ethics Guide* was probably due to many factors, not the least of which was some confusion among CCCB

[747] See Catholic Physicians' Guild, "ERDs."

[748] See ROCHE, Notes, 2: CHAC served as publisher of the *Moral Code* (1955), the *Medico-Moral Guide* (1970), the *Health Care Ethics Guide* (1991), the Health Progress, *Health Ethics Guide* (2000) and the *Health Ethics Guide* (212).

[749] F. MORRISEY, correspondence re *Health Ethics Guide* to Rev. Msgr. Patrick Powers, 11 March 2012, available in the private archives of Sister Bonnie MacLellan, 2025 Main St. W., North Bay, ON P1B 2X6.

members regarding the implications to individuals of granting a *nihil obstat* for the document.

Because Canada enjoys official bilingual status (English and French), a French translation of the *Health Ethics Guide* was prepared in the fall of 2012 after the launch of the English version of the *Guide*. The draft translation was reviewed by a Francophone bishop assigned by the CCCB who had also served as a member of the Core Group that worked on the English version of the *Guide*.[750] His task was to ensure the French was an accurate translation of the approved English version. The French version was published and ready for distribution in February 2013. "Rather than go through a separate *nihil obstat* process for the French version, CHAC and the CCCB mutually agreed the following note would be placed in the inside of the French version. 'Le Guide d'éthique de la santé (2013) est une traduction du *Health Ethics Guide* (2012), qui a reçu le *nihil obstat* du Conseil permanent de la Conférence des évêques catholiques du Canada en mail 2012. À ce titre, le texte Anglais fera foi."[751]

3.5.3 Ethical and Religious Directives: U.S., Canada, and Australia

Currently, ethical guides have been developed and approved by episcopal conferences in the United States, Canada, and Australia. While not considered juridic norms unless they are promulgated by individual bishops, the directives or ethics' guides

[750] See ROCHE, Notes, 4.

[751] Roche, Notes, 4.

of each conference offer a framework for health care ministry that is invaluable as sponsors, trustees, and administrators attempt to fulfill their vocation as bearers of Jesus' healing ministry. Their link to canonical norms deserves attention.

3.5.4 Canon Law and Ethical and Religious Directives

The final aim of societal law is to protect the rights of the individual and the community at large.

> "A basic requirement of [the] legitimacy [of societal law] is that the government advance everyone's share of the primary social goods, their opportunity to participate in society and hence their basic rights. Rights are not only statements of ideals or entitlements but goals and tools for pursuit of those goals, means for pursuing law reform, advancing the rule of law, and enhancing society's legitimacy."[752]

The purpose of the Church's laws are to support individuals and the Church as a whole in growing in virtues of faith, hope and charity.[753] As noted by O'Rourke, "The Church exists to enable people to become friends of God, through the ministry of Jesus Christ."[754] In addition to the human persons, other persons known as juridic persons are called to assist in the realization of the Church's mission and realization of its primary goal. Laws particular to juridic persons are noted throughout the Code, and included in laws associated with parishes, schools and religious institutes which reference "the teaching authority of

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[752] S. DONNELLY, "Reflecting on the Rule of Law: Its Reciprocal Relation with Rights, Legitimacy, and Other Concepts and Institutions," in *The Annals of the American Academy of Political Science*, 603 (2006), 37.

[753] See K. O'ROURKE, "Canon Law and Ethical and Religious Directives," in *Health Progress*, vol. 87, no. 3 (2006), 42 (= O'ROURKE, "Canon Law and Ethical and Religious Directives").

[754] O'ROURKE, "Canon Law and Ethical and Religious Directives," 42.

the church, administration of temporal goods, election and appointment to offices and the proper method of settling disputes."[755]

Despite the guidance offered in the Code to both individual and juridic persons, no laws are specifically directed toward one of the Church's largest ministries supported by juridic persons – Catholic health care. The rationale for this lacuna in the Church's laws is based on three realities. Catholic health care was previously sponsored and delivered by religious orders which by law, were considered juridic persons[756] and were subject to both the universal laws of the Church[757] and the particular laws associated with the ministries of religious institutes within dioceses.[758] These norms were considered to offer sufficient guidance to ensure the protection of both the Church's mission and temporal goods.[759] However, with the transfer of sponsorship of Catholic health care to predominantly lay

[755] O'ROURKE, "Canon Law and Ethical and Religious Directives," 43.

[756] See c. 634: "§1. As juridic persons by the law itself, institutes, provinces, and houses are capable of acquiring, possessing, administering, and alienating temporal goods unless this capacity is excluded or restricted in the constitutions. §2. Nevertheless, they are to avoid any appearance of excess, immoderate wealth, and accumulation of goods."

[757] See cc. 113-123.

[758] See c. 681, §1: "Works which a diocesan bishop entrusts to religious are subject to the authority and direction of the same bishop, without prejudice to the right of religious superiors according to the norm of can. 678, §§2 and 3;" See also c. 394 "§1. A bishop is to foster various forms of the apostolate in the diocese and is to take care that in the entire diocese or in its particular districts, all the works of the apostolate are coordinated under his direction, with due regard for the proper character of each. §2. He is to insist upon the duty which binds the faithful to exercise the apostolate according to each one's condition and ability and is to exhort them to participate in and assist the various works of the apostolate according to the needs of place and time."

[759] See O'ROURKE, "Canon Law and Ethical and Religious Directives," 43.

sponsors,[760] additional formation will be required to assist them in carrying out the Church's mission to continue the healing ministry of Jesus in our world.

Another factor which may have contributed to the lack of universal juridic norms addressing Catholic health care is the diverse models of health care delivery throughout the world.[761] In countries with universal health care (e.g., Australia and Canada), sponsorship of health care by the Catholic Church is currently recognized and supported. To assist sponsors, trustees, and senior administrators in understanding the Church's ethical and religious teachings, the conference of bishops in these countries have issued ethical and religious directives.[762] Because of the Canadian government's commitment to universal health care, accommodation has, in some instances, been granted, and in others debated, regarding mandatory and optional procedures to be offered in Catholic hospitals.[763] In the United States, the Church has been allowed to sponsor health care facilities in a relatively autonomous fashion, ensuring adherence to Catholic moral and ethical codes of conduct.[764] However, their capacity to continue this model of sponsorship when government funding

[760] See D. CONLIN, "Sponsorship at the Crossroads," in *Health Progress*, vol. 82, no. 4, 20-23.

[761] See O'ROURKE, "Canon Law and Ethical and Religious Directives," 43.

[762] See CATHOLIC HEALTH AUSTRALIA, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, Catholic Health Australia, Melbourne, Catholic Health Australia, 2001 (= CATHOLIC HEALTH AUSTRALIA, *Code*); See also CHAC, *Health Ethics Guide*.

[763] See R. DALY, "Activists urge action at St. Mike's: Outrage over changes at former Wellesley site," in *Toronto Star*, 26 May 1998, 1.

[764] See O'ROURKE, "Canon Law and Ethical and Religious Directives," 43.

through the Affordable Care Act (commonly known as Obamacare),[765] or alternate government funding sources will be the object of debate.

To address issues in various countries in which Catholic health care is sponsored, episcopal conferences have prepared and approved in principle, ethical and religious directives that have been followed by Catholic health care providers in those particular jurisdictions. Ethical and Religious Directives (ERDs) on their own have no juridic force. However, many of the foundational principles of these documents repeat standard Church doctrine, and as such, are binding on Catholics. As noted by O'Rourke, "The Code is concerned primarily with discipline and order in the Church. Ethical and religious directives are concerned primarily with 'a body of moral principles that express the Church's teaching on medical and moral matters'."[766]

The work of the Catholic Health Association and the United States Conferences of Catholic Bishops in developing Ethical and Religious Directives has served as a prototype for other countries to develop ERDs which offer guidance for decision-making beyond medico-moral issues. Designed to assist Catholic institutions and those who offer health care in the name of the Church, ERDs offer "ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person."[767] The ERDs

[765] See D. VINCENT and P. REED, "Affordable Care Act: Overview and Implications for Advancing Nursing," in *Nursing Science Quarterly*, 27 (2014), 254-259.

[766] O'ROURKE, "Canon Law and Ethical and Religious Directives," 43.

[767] USCCB, *ERDs,* 4.

of the US have only 8 out of 72 individual directives that contain prohibitions.[768] The other directives are presented as positive value statements.

For the purposes of this dissertation, the ERDs prepared and approved by the Conference of Catholic Bishops of the United States, Australia, and Canada, were reviewed. All share the same foundation: the Church's basic belief in the dignity of the human person, from conception to natural death. Topics included in all ERDs are the purpose of health care as a mission of the Church, justice in health care, collaboration, the mystery of suffering, decision-making capacity, human sexuality, research, cooperation, and end of life. Australia's *Code* offers ethical guidelines on care of older persons and those with special needs.[769] Both Canada[770] and Australia[771] address directly issues of governance and administration,[772] ongoing leadership formation,[773] and offer cross references to ERDs from other jurisdictions. In addition, the ERDs of Canada and Australia provide additional context which would assist in formation of sponsors, trustees, health care leaders, physicians, and staff.

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[768] See K. O'ROURKE, "The Ethical and Religious Directives as Particular Law," in *Health Progress*, vol. 91, no. 4 (2010), 81.

[769] See CATHOLIC HEALTH AUSTRALIA, *Code*, nos. 35-41.

[770] CHAC, *Health Ethics Guide*, nos. 90-112.

[771] CATHOLIC HEALTH AUSTRALIA, *Code*, nos. 55-61.

[772] See CHAC, *Health Ethics Guide*, nos. 141-149, 93-97; See also Catholic Health Australia, *Code*, nos. 55-57.

[773] See CHAC, *Health Ethics Guide*, no. 107, 75; Catholic Health Australia, *Code*, nos. 60-61.

As noted by Cox,[774] the pervasive style of language used by the ERDs approved by the bishops can reflect the communication style reflected in Vatican II's final documents, whose "goal is the winning of internal assent, not the imposition of conformity from the outside."[775] As O'Malley notes, "A style choice is an identity choice, a personality choice, a choice in this instance about the kind of institution the council wanted to the church to be."[776]

The style of writing chosen in Canada's *Health Ethics Guide* is described by Cox as persuasive, and which "elevates core ideals and values to call attention to the goodness of those values – not to judge or direct."[777] He goes on to suggest that the Canadian *Health Ethics Guide* "avoids deliberative language … to highlight the virtues of compassion, mercy and neighborly love evident in the parable of the Good Samaritan which is mentioned frequently."[778] While suggesting that future reviews of the American ERDs might consider the language style adopted in Canada's *Health Ethics Guide,*[779] Cox identifies the *Health Ethics Guide's* "power is most fully demonstrated in the hearts and minds of the Catholic health care community understanding and celebrating this common

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[774] See M. COX, "Vatican II's Language Marks Pivotal Shift," in *Health Progress*, vol. 96, no. 6 (2015), 58-62. (= COX, "Vatican II's Language")

[775] J. O'MALLEY, *What Happened at Vatican II*, Cambridge, MA, The Belknap Press of Harvard University Press, 2008, 47. (= O'MALLEY, *What Happened*)

[776] Ibid., 305.

[777] COX, "Vatican II's Language," 58.

[778] Ibid., 59.

[779] Ibid., 61.

calling … [and] inspires one to integrate the Catholic moral tradition throughout one's life, rather than see it confined to the institutional borders of Catholic hospitals and clinics."[780]

The *ERDs* of the United States and Australia share a common purpose identified in Canada's *Health Ethics Guide* Preamble:

1. To guidance around new advances in science and medicine;
2. To ground the Guide more firmly in the Gospel message of Jesus as exemplified in the parable of the Good Samaritan;
3. To incorporate a more fully articulated vision of the social nature of health care along with the values and principles that are embedded in the parable of the Good Samaritan;
4. To assist a number of different audiences (staff, board, and administration) to become aware of Catholic tradition and the legacy of Catholic health care;
5. To outline moral obligations for sponsors/owners, boards, members of ethics committees and personnel of Catholic and social services organizations;
6. To present Catholic teaching and outline the values that are to be respected by those who work within the organization;
7. To serve as a tool by persons receiving care, their families, and anyone who seeks a framework to structure and articulate their own decision making, and to

[780] COX, "Vatican II's Language," 60.

outline reasonable expectations of care providers who function according to such a vision of care;

8. To serve as a guide for the development of policies and procedures to guide ethical reflection; and
9. To complement other initiatives in the Church's healing ministry such as spiritual and religious care, organizational mission and values integration, ethics committees and centres, and parish-based ministry and nursing.

From our perspective, health care sponsors, trustees, and administrators may have limited their use of the *Health Ethics Guide* to objectively identified ethical quandaries related to life, death, and human sexuality. We would suggest that they consider ongoing education and evaluation of ways in which the Church's ethical decision-making processes can be incorporated into every level of the organization. Organizations may consider use of the tool developed by CHA and Ascension Health which suggests objective standards of excellence in Ethics.[781]

While there is no obligation on the part of the Church for conferences of bishops to develop *ERDs*, our review of the American, Australian, and Canadian *ERDs* would suggest they would serve as a significant aid for those assuming responsibility, in the name of the

[781] See CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, *Striving for Excellence in Ethics: A Resource for The Catholic Health Ministry*, Washington, DC, CHA, 2014, 18-60. This resource offers a template for evaluating ethics expertise, ethics committees, ethics consultation and advisement, education and formation, policy review and development, community outreach, organization integration, and leadership support.

Church, for continuing the healing mission of Jesus. They offer guidance around new advances in science and medicine.[782] For Canadian Catholic health care sponsors, trustees, and staff, the *Health Ethics Guide* will complement and augment Accreditation Canada's standards of clinical and organizational ethics.[783]

3.6 A Framework for Formation

Thornber[784] identified through quantitative and qualitative methodologies, the need for additional research in the following key areas:

- Nature of the Church including roles and responsibilities;
- Role of the diocesan bishop;
- Catholic social teachings;
- Canon law and ethical guidelines for leadership.

For our purposes, we will review formation programs for Catholic health care sponsors and leaders in America, Australia, Ireland, and Canada, which address these fundamental foundations of Catholic health care.

3.6.1 Developing Formation Programs: Where Theory and Praxis Meet

The foundations of Catholic health care formation are rooted in universally embraced theoretical constructs including our shared Catholic theology, ethics, and

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[782] See CHAC, *Health Ethics Guide*, Preamble, loc. 52.

[783] See ACCREDITATION CANADA, *Qmentum* Accreditation Program, Governance Standards, 2012, http://ontario.cmha.ca/files/2012/12/accreditation_canada_governance_standards.pdf (17 January 2017).

[784] See THORNBER, "Cultivating Fertile Soil."

spirituality which link the charism and legacy of founding congregations.[785] Sponsorship models for Catholic health care have transitioned over the years from those primarily identified with founding religious institutes to ministerial juridic persons, approved by appropriate ecclesiastical authorities, and supported through the commitment of the baptized faithful. Throughout the transition years, health systems in America, Australia, Ireland, and Canada have made significant commitments to the development of well-structured, intensive leadership formation efforts.[786] Their genesis and evolution has been replicated throughout the world. Because the ministry of Catholic health care is rooted in the Church's doctrine and social teachings, related areas of formation appear to be mirror images of each other. The critical factor in the success of any formation program in various jurisdictions, is its capacity to be applied in ways that meet the needs of the local context.

3.6.1.1 American Formation Model

While many formation programs have been developed in the United States, we would like to focus attention on one formation model that has seen significant development over the past 15 years and which has been used by other jurisdictions as a formation model for senior leaders of Catholic health care. The Ministry Leadership Centre (MLC) genesis was spawned by the Alliance of Catholic Health Care in 2002. They invited the sponsors and senior executives of five Catholic Health Care systems with acute facilities in

[785] See B. YANOFCHICK, "CHA's Framework for Leadership Formation," in *Health Progress*, vol. 92, no. 5 (2011), 9.

[786] See B. YANOFCHICK, "Forward," in CHA Framework for Senior Leadership Formation: Building on Experience, Preparing for the Future (2011), 3.

California (Catholic Health Care West [now Dignity Health], Daughters of Charity Health System, Providence Health & Services, (now Providence/Saint Joseph), and the Sisters of Charity of Leavenworth Health System [now SCL Health System], as well as the California Catholic bishops in whose dioceses these ministries were sponsored, to examine major ministry challenges and to determine interest in forming an alliance to address these challenges through the development of a shared formation strategy in order to sustain and maintain the Catholic health system in California.[787] Together, they were able to develop collectively a strategy entitled, "Developing and Implementing a Leadership Program for Formation with Common Foundations."[788]

The mission of MLC focuses on forming leaders to sustain and deepen the ministry of healing and assist program participants to be grounded in the Catholic identity and tradition of its sponsors. The vision of the learning centre is to form a community of leaders who articulate and integrate a Catholic understanding of healing. Finally, the values of the MLC include ensuring program content is relevant (in a spirit of simplicity, creatively linking the work of the MLC with the lived experience of participants), collaborative (fostering cooperation between and among participating sponsoring systems), and ensuring

[787] See S. LEE, L. O'CONNELL and J. SHEA, "Ministry Leadership Centre: History and Conversation," in L. O'CONNELL and J. SHEA (eds.), *Tradition on the Move: Leadership Formation in Catholic Health Care*, Sacramento, MLC Press, 2013, 1-20 (= LEE et al., "History and Conversation").

[788] LEE et al., "History and Conversation," 2.

sufficient theological depth to ground the ministry of all participants in gospel values and the Church's core teaching.[789]

As noted by O'Connell, ministry leadership formation requires a distinctive approach to incorporating theological content and perspective.[790] The primary object of formation is personal transformation. This in turn serves to support organizational transformation grounded in informative dialogue and self-reflection. Focus on abstract theory can be a detriment to identifying practical applications of theological content.[791] In the process of MLC formation, participants are invited to compare their own values, personal attitudes (religious and non-religious) with the core values of Catholic social thought and imagination.[792] Formation for the mission of Catholic health care must identify the message which it wishes to communicate (Catholic identity) using a dialogical methodology characterized by both conviction and personal humility.[793] While emphasizing the Catholic tradition, formation programs must recognize the Church as a "partner in humanity's shared struggle to arrive at truth."[794] We are called to resonate with

[789] See LEE et al., "History and Conversation," 3.

[790] See L. O'CONNELL, "Ministry Leadership Formation; Theological Grounding and Method," in L. O'CONNELL and J. SHEA (eds.), *Tradition on the Move: Leadership Formation in Catholic Health Care*, Sacramento, MLC Press (2013), 90-117 (= O'CONNELL, "Theological Grounding and Method").

[791] See O'CONNELL, "Theological Grounding and Method," 90.

[792] Ibid., 92.

[793] See PAUL VI, Encyclical Paths of the Church *Ecclesiam suam*, 6 August 1964, in *AAS* 56 (1964), 609-659, English Translation in *The Pope Speaks*, 10 (1965), nos. 81-82. 281.

[794] ST. JOHN PAUL II, Encyclical On the Relationship between Faith and Reason *Fides et ratio*, 14 September 1998, in *AAS* 91 (1999), 5-88, in *Origins*, 28 (1998-1999), no. 2, 319.

all people of good will who share our values of justice, human dignity, and the common good.[795]

The MLC Formation Integration Team (FIT) has noted that the challenge of this model of reflective and inclusive formation, is to ensure formation which is substantive, credible, pedagogically suitable, and theologically grounded.[796] Formation facilitators require a firm grasp of Catholic tradition, the history of events and issues affecting the ministry of Catholic health care, and experience in guiding theological reflections which avoid "easy-out" solutions using simplistic formulas or pat-answers.[797] Catholic tradition sets the agenda for formation, current and past cultural information informs the agenda, and the individual and the community of learners evaluate the agenda. The mandate of formators is to "find the ways and means of renewing the religious character of our health care institutions and enabling the next generation of leaders to both own it and transmit it. … Our responsibility is to retrieve and nurture that legacy in our institutions and pass it on in its fullness to the next generation."[798]

As one of the first collaborative models of Catholic health care ministry formation programs developed in the United States, the question of its efficacy in forming Catholic

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[795] See O'CONNELL, "Theological Grounding and Method," 92.

[796] Ibid., 94.

[797] D. WHITEHEAD and E. Eaton-WHITEHEAD, *Method in Ministry: Theological Reflection and Christian Ministry*, rev. edition, Lanham, MD, Sheed and Ward, 1995.

[798] W. COX, "How to Sustain Catholic Health Care as Ministry," in *Origins*, 34 (2004), 275.

health care leaders for changing cultures and times was critical. As Shea noted, without theory, formation efforts are prone to become inconsistent and scattered, making it difficult to determine how important pieces of formation fit, what to include, not include, and how to evaluate a formation program's efficacy.[799] Defining formation as the systematic and sustained initiation into the Catholic culture of the organization,[800] it was acknowledged by both formation program developers and formation program participants that Catholic health care is not easily understood, often suffering from stereotypes, misinformation and projections. Learning how to connect the unique identity of Catholic health care's organizational culture in philosophical language of values, helped to connect it in a special way to Catholic social teaching which can be appreciated and appropriated by all people of good will.[801]

Having considered the evolution of formation programs throughout the United States, the Catholic Health Association of the United States set about the task of evaluating formation effectiveness.[802] In 2011, the CHA authored a *Framework for Senior Leadership Formation* which provided an assessment tool "looking at personal engagement, knowledge transfer and behavioural change,"[803] The Canter for Applied Research in the

[799] See J. SHEA, "The Process and Content of Leadership Formation," in O'CONNELL, L, and J. SHEA (eds.), *Tradition on the Move: Leadership Formation in Catholic Health Care*, Sacramento, MLC Press (2013), 62 (= Shea, "The Process and Content").

[800] Ibid., 68.

[801] See ibid., 73.

[802] See B. SMITH and P. TALONE, "CHA Survey Gauges Formation Effectiveness," in *Health Progress*, vol. 95, no. 4 (2014), 44-49. (= SMITH and TALONE, "CHA Survey")

[803] Ibid., 44.

Apostolate (CARA) at Georgetown University, Washington DC assisted CHA in the distribution and analysis of survey results.[804] Survey data covered the following broad categories:

- Background demographics of senior leaders;
- Types of formation programs;
- Familiarity with tenets of Catholic health care;
- Program content areas;
- Qualitative data;
- Questions re specific formation content areas deemed by respondents as useful or meaningful to the current work, and whether the content offered new knowledge.[805]

Some health systems reported they had not developed nor engaged in senior formation programs or that they had chosen to offer occasional educational models which did not ascribe to the CHA recommendations included in the CHA Framework for Senior Leadership Formation.[806] Of those who had participated in formation programs, the following core elements were identified as essential curriculum for inclusion in formation programs:

1) Heritage;
2) Tradition and sponsorship;
3) Mission and values;

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[804] SMITH and TALONE, "CHA Survey," 44-49.

[805] Ibid., 45.

[806] See ibid.

4) Vocation;
5) Spirituality and theological reflection;
6) Catholic social teaching;
7) Ethics;
8) Leadership style;
9) Holistic health care;
10) Diversity
11) Church relationships.[807]

Topics noted as contributing the most to new learning included heritage, tradition of sponsorship, leadership style, ethics, and spirituality. Topics noted as useful to their current ministry of Catholic health care leadership included those criteria noted as essential components of formation programs with the addition spirituality and theological reflection.[808]

Catholic health care in North America has rapidly been transitioning from sponsorship by religious institutes to sponsorship predominantly by laity. Many sponsor groups have developed leadership formation programs "to ensure competencies and spiritual formation to lead and further this ministry."[809] Centralized research sponsored by

[807] See SMITH and TALONE, "CHA Survey," 46.

[808] SMITH and TALONE, "CHA Survey," 46.

[809] Ibid., 48.

CHA to determine curriculum evolution, the efficacy of pedagogical methods, and the applicability of theory offered to formation program participants will be critical to ensuring Catholic identity continues to have both a qualitative and quantitative impact on care offered to those whom we are privileged to serve.[810]

3.6.1.2 Australian Formation Model

Mary Aikenhead Ministries (MAM) was established by the Holy See as a pontifical public juridic person at the request of the Congregation of the Religious Sisters of Charity of Australia to succeed, continue, and expand health care, education, and social welfare ministries founded by the Sisters of Charity.[811] The sisters' ministry was established and developed after their arrival in Australia from Ireland in 1838. Transfer of sponsorship from the sisters to lay trustees was completed to ensure that the heritage, tradition, and charism of the sisters would continue purposefully into the future.[812]

MAM leadership formation framework focuses the spirit and content of the program in the subtitle offered for the work: "Formation of the Heart." They note: "Senior leadership formation in Catholic ministry needs to be dynamic and engaging, transforming and supporting, practical and visionary, empowering leaders to respond to the sometimes

[810] SMITH and TALONE, "CHA Survey," 46.

[811] See MARY AIKENHEAD MINISTRIES, Who We Are, http://maryaikenheadministries.com.au/about-us/ (17 December 2016) (= MARY AIKENHEAD, Who We Are).

[812] MARY AIKENHEAD, Who We Are, 1.

chaotic and fragmented world in which we live and work."[813] The final line of the introduction captures the essence of all formation programs for these Australian leaders of Catholic apostolates: "Above all, leaders in Catholic ministry are called to embody the mission of Jesus as proclaimed by the Gospels."[814] Trustees are missioned to embrace a shared and collaborative leadership which seeks to respond to the needs of the poor.

3.6.1.3 Irish Formation Model

In 2007, Thomas Morris, senior vice president of sponsorship and theology for the Bon Secours Health System, Marriottsville, MD and John Pepper, who had been working with the Hospitaller Order of Saint John of God in Ireland, met to discuss the Collaborative Formation Program for public juridic persons which had been launched in 2003 by five pontifical public juridic persons[815] of Catholic health ministries.[816] Pepper requested Morris' assistance in developing board formation programming for the New Jersey branch of the Hospitaller Order of Saint John of God.

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[813] See MARY AIKENHEAD, Leadership Formation, http://maryaikenheadministries.com.au/resources/leadership-formation/ (17 December 2016), 1 (= Mary Aikenhead, Leadership Formation).

[814] Ibid.

[815] In 2004, five pontifical public juridic persons of Catholic health ministries who joined to develop a collaborative sponsorship program included Catholic Health Care Federation (Catholic Health Initiatives, Denver, CO), Covenant Health Systems (Covenant Health Systems, Lexington, Mass.), Catholic Health Ministries (Trinity Health, Novi, MI), Hope Ministries (Catholic Health East, Newton, Square, PA) and Bon Secours Ministries (Bon Secours Health System, Marriottsville, MD). In 2005, St. Joseph's Health Ministry (St. Joseph Health System, Orange, CA) and in 2009, Providence Ministries (Providence Health Services, Renton, WA) joined the collaborative program.

[816] M. HADDAD, "Sponsor Formation: Ireland Adopts U.S. Model," in *Health Progress*, vol. 92, no. 5 (2011), 87.

From this initial request, Morris was then asked to assist two Irish religious institutes to develop a shared Catholic health care formation program. The Hospitaller Order of Saint John of God sponsored health care services in more than 250 hospitals and centres in 50 countries, with a ministry focus in Ireland on care of the elderly, the disabled and the mentally ill. The Sisters of Bon Secours have provided Catholic health care in Ireland since 1861, initially offering home health care and later establishing hospitals. In 1993, they established the Bon Secours Health System to manage five hospitals in Ireland, and in 2007, Bon Secours Ireland was granted public juridic person status.

Morris and Sister Catherine O'Connor, CSB, at the time vice-president mission and sponsorship for Covenant Health System, who had worked collaboratively on formation programs in the past, began developing a formation program for Irish public juridic persons, ensuring Irish cultural sensitivities would be recognized and supported throughout the formation programs.[817] Collaboration for formation program development would demand participation by key stakeholders (founding congregations, Church hierarchy, new public juridic persons, trustees and senior administrators.) Unlike the U.S., Ireland does not enjoy a Catholic health care organizational structure comparable to CHA. This offered the Irish formation program the opportunity to learn from formation programs offered in the U.S. while developing programming specific and sensitive to the Irish culture.

[817] M. HADDAD, "Sponsor Formation: Ireland Adopts U.S. Model," in *Health Progress*, vol. 92, no. 5 (2011), 88.

During the program's continued development, it has become clear that the vocation and charism to heal as Jesus healed[818] transcends individual religious institutes. While building upon the U.S. model, the work of the Irish Formation Team has continued to influence and be influenced by the U.S. Collaborative Formation Program. Benefits have been shared, across the oceans, offering a model of global formation opportunities which will sustain and bring new life to the ministry of Catholic health care into the future.

The Bon Secours Center for Ministry Leadership is a resource center for ministry formation at Bon Secours Health System. It assumes a four levels of ministry formation model. All formation activities are designed to support the realization of identified skills and behaviours in all staff, "from the board to the bedside."[819] The Bon Secours Formation Program has identified ten characteristics of their ministry leaders and mirrors the key traits identified by Thornber:[820] authenticity, integrity, commitment to ongoing religious formation in Catholic social teaching and ethical reflection, capacity to incorporate Catholic teaching into administrative and clinical decisions, commitment to spirituality as a distinguishing mark of Catholic health care, fostering an inclusive and respectful culture, and collaboration.[821]

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[818] See JOHN 5:1-12.

[819] See BON SECOUR CENTER FOR MINISTRY LEADERSHIP, About Ministry Formation, http:// www.centerforministryleadership.org/ (3 January 2017). (= Bon Secours)

[820] See THORNBER, "Cultivating Fertile Soil," 195-196.

[821] See BON SECOUR (3 January 2017).

3.6.1.4 Canadian Formation Models

Because health care in Canada is nationally mandated and enjoys a shared national/provincial funding base, programming including formation efforts to date have been sponsor focused. The Catholic Health Alliance of Canada developed an overview of Canadian formation programs. Formation programs have been offered in Ontario. One international formation program, offered in both of Canada's official languages (English and French) was developed for organizations sponsored by Catholic Health International for their facilities located in Nova Scotia, New Brunswick, Ontario, and the U.S. A shared formation program has been developed for Western Canada (British Columbia, Alberta, Saskatchewan, Manitoba).

When we examined Canadian formation program content, all shared similar curriculum and often shared faculty presenters. Programs were normally offered over two to three sessions and included the following program content:

- Rationale for Catholic health care and formation programs;
- Catholic health care as a ministry of the Church;
- Charism and legacy of founding congregations;
- Sustaining Catholic health care in a secular culture;
- Spirituality of leadership;
- History and development of Catholic social teaching;
- Emerging issues in leadership for Catholic organizations;
- Personal and organizational spirituality;

- Canadian Catholic Health Ethics Guide;
- Canon law;
- Living the call to mission.

After review of the various formation programs, an obvious question was raised re the value-added of individual vs. shared formation program development, delivery, and evaluation. In 2007, an overview of Canadian Catholic health care leadership development needs was undertaken.[822] As the result of the Catholic Health Alliance of Canada's National Dialogue on Catholic Health Care in Canada,[823] the project purpose was to propose a methodology for effective and consistent leadership formation which would meet new formation needs for Catholic health care leaders into the future.[824] Six objectives for the study were identified:

1. Describe and define what Catholic health care leadership is: its fundamental components and development;
2. Identify what is needed to be effective now and in the foreseeable future (next ten years);
3. Investigate and recommend alternative strategies for developing and delivering credible and effective Catholic health care leadership development programs;

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[822] See M. MCGOWAN, *A Strategic Review of Catholic Healthcare Leadership Development*, Submitted to the Joint Associations and Sponsors, 15 January 2007, http://www.chac.ca/leadership/docs/strategic%20review_07_McGowan.pdf (17 January 2017) (= MCGOWAN, *A Strategic Review*).

[823] See S. PADDOCK, *Appreciative Inquiry in the Catholic Church*, Plano, TX, Thin Book Publishing, 2003, Kindle ed., loc. 521-598.

[824] MCGOWAN, *A Strategic Review*, 4.

4. Suggest roles and responsibilities for the various stakeholders in leadership development;
5. Prepare an action plan, including required resources to implement the recommendations;
6. Assemble the above material into a document that is amenable to decision making by the Joint Group of Associations and Sponsors.[825]

An action plan was prepared which differentiated classical leadership and Catholic health care leadership,[826] qualities of a leader,[827] and the fundamental components of a two-year Catholic health care leadership formation program.[828] Efforts to collaborate on formation program development and execution were limited to sharing staff and resources among the various sponsors. However, efforts at collaboration have been ongoing.

As we have examined the changing culture in which Catholic health care in the world and in Ontario specifically exists, assuming sponsors, trustees, and senior Catholic health care leaders will have shared Christian values and knowledge of the foundations of Catholic health care including Church doctrine, Catholic social teaching, Catholic ethical standards, is becoming probable. It will therefore behoove Catholic health care sponsors and leaders to ensure formation programs which support the ministry into the future. To do

[825] See MCGOWAN, *A Strategic Review*, 4.

[826] Ibid., 79.

[827] Ibid., 80.

[828] Ibid., 81.

this, we must examine possible long-term visions for this ministry that expand beyond the known and continue to be recreated and evolve in wisdom and grace.[829]

3.7 Closing Reflections

Gospel passages which serve as a touchstone for Catholic health care include the many healing miracles of Jesus in which individuals were healed physically,[830] emotionally,[831] and spiritually.[832] The founders of Catholic health care (primarily members of religious institutes) were "carriers of Catholic Christian identity, expressed through the lived life of the community in mission."[833]As health care generally and Catholic health care specifically has grown to include advances in medicine and technology that could not have been imagined by our founders, the question of how to faithfully live Jesus' mission of healing has continued to evolve.

As in the early Church, Catholic health care will continue its mission by telling the story of the founders. As the early Church discovered quickly, telling the story of historic events is not enough. The story, because it reflects the fundamental call to continue Jesus' healing mission, will be experienced in new ways within specific contemporary contexts. The story is interpreted and applied in the current context, and will require ongoing

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[829] See 2 PETER 3:18

[830] See MARK 2:1; MATT 8:1-4; 5-13; 15:30-31; LUKE 13:10-17.

[831] See JOHN 8:1-11.

[832] See LUKE 7:45; Matt. 8:28-34.

[833] See Z. FOX, "Continuing the Mission," in *Health Progress,* vol. 89, no. 2 (2008), 24.

reflection and discussion. In our increasingly secular world, who better to reinterpret the mission in this environment than the laity to whom the sponsorship responsibility for the ministry of Catholic health care is being transferred?[834]

Ontario's Catholic health care system will continue to invite individuals to care for the forgotten who have been left by the side of the road and have no one to care for them. Like the good Samaritan, sponsors and leaders of Catholic health care will be invited to express the Church's tender compassion for the sick among us, offering a viable venue to bring the healing touch of Jesus into a broken world. To support this ministry will require a significant investment by Church leaders, sponsors, trustees and senior Catholic health care leaders into the process of ongoing formation and the development of communication strategies to educate new staff and the public we serve of the value-added of Catholic health care inserted into a secular world and funded by public tax dollars. Sponsor collaboration and preferably consolidation into a One-Sponsor model, could help to dispel confusion created by multiple sponsors with multiple venues of care delivery. Given the current structure of the Ontario health care system which is coordinated by 14 regional Local Health Integration Networks whose objective is to integrate health services to meet different health needs throughout the province,[835] developing a single voice for Catholic health care will also have its challenges. However, failure to do so may lead to a weakening

[834] Z. FOX, "Continuing the Mission," in *Health Progress*, vol. 89, no. 2 (2008), 26.

[835] See GOVERNMENT OF ONTARIO, Ontario's LHINs, http://www.lhins.on.ca/ (29 January 2017).

of the distinctive "brand" of Catholic health care[836] that shares a Gospel foundation and a common story of founding by dedicated members of religious institutes. Catholic health care exists for one purpose only: to continue the healing mission of Jesus in the name of the Catholic church. In our last chapter, we will examine external pressures impacting Catholic health care and offer opportunities for future development which will support and grow this ministry in creative new ways.

[836] See ST. JOSEPH'S HEALTH CARE LONDON, Branding and Identity Guidelines, 18 November 2016, https://www.sjhc.london.on.ca/sites/default/files/pdf/branding.pdf (29 January 2017).

CHAPTER IV: FACING EXTERNAL PRESSURES AND LOOKING FORWARD

4.1 Introduction

Ensuring that Catholic health care is identifiable in a postmodern, pluralistic, and secular culture[837] can be a daunting task. The ministry of the Church and Catholic health care have always been contextually driven, and has required negotiation, achieving what at times could be considered a tenuous balance between God's call and the current political agenda.

Tensions between faith and political agendas are hardly new and can be identified throughout history.[838] Moses was called to go and bring Yahweh's message to Pharaoh saying, "Let my people go, that they might serve me."[839] Jesus's ministry, which ran counter-cultural to both the religious and secular leaders of his time, was interpreted by some as an abandonment of Jewish laws and traditions.[840] These tensions paved the path to

[837] See R. MURPHY, "Does religion have a place in public life?" in *CBC Cross Country Checkup*, 3 March 2013, http://www.cbc.ca/radio/checkup/does-religion-have-a-place-in-public-life-1.2784066 (5 March 2017); see also J. DAVISON, "Are we living in post-religious times?" in *CBC News* 20 March 2013, http://www.cbc.ca/news/canada/are-we-living-in-post-religious-times-1.1362828 (5 March 2017).

[838] See K. HEYER, M. ROZELL and M. GENOVESE (eds.), *Catholics and Politics: The Dynamic Tension Between Faith and Power*, Washington, D.C., Georgetown University Press, 2008, Kindle ed.

[839] See Exodus 9:1.

[840] See Matt. 5:17-19.

His passion and crucifixion.[841] The apostles were martyred for preaching Jesus' message in the world.[842] The early Christians were martyred for their beliefs.[843] Religious institutes that founded Catholic hospitals throughout the province of Ontario were often rejected and experienced significant discrimination simply because they were Catholic. [844] In light of this, the question which will be considered in this chapter is, "How can Catholic health care in Ontario engage in an ongoing dialogue within Ontario's secular culture, in a manner that allows the Church and its values to continue into the future, while not abandoning essential beliefs and values?"

In this chapter, we will examine some of the challenges and opportunities posed by the transition of Catholic health care from private to public funding. Included in our discussion will be certain options for resolving areas of conflict as well as possible strategies to ensure the future of Catholic health care in Ontario. The goals are to discover a methodology which supports ongoing dialogue in order to help understand the needs of a changing society in which the Church continues its ministry, and to learn the ways we may continue to respond to the needs of the most vulnerable in our midst.

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[841] See Luke 22:2.

[842] See T. SCHMIDT, "*The Apostles After Acts: A Sequel*," Eugene, OR, Cascade Books, 2013.

[843] See E. HARDY, *Faithful Witnesses: Records of Early Christian Martyrs*, New York, Association Press, 1959.

[844] See I. MCDONALD, *For the Least of My Brethren: A Centenary History of St. Michael's Hospital*, Toronto, Dundurn Press, 1992, 34 (= I. McDonald, *For the Least of My Brethren*).

The tensions which Catholic health care in Ontario is grappling with today, are directly related to the historical evolution of this ministry from a freely offered charity which reflected broadly accepted Christian values, to a government-financed, publicly demanded commodity in which any and all treatments are deemed as appropriate and necessary. The challenge central to Catholic identity is maintaining fidelity to the religious value of providing comprehensive health care to vulnerable and under-served populations. With an increasingly secularized society, public sentiments and mores may, at times, fail to reflect on the impact that medical care decisions have on the dignity of the human person, who is made in the image and likeness of God.[845] In our contemporary culture, health care decisions may be made with politics in mind and little if any reference to the Church's social teachings or to the "common good."[846]

With this backdrop, we intend to offer certain reflections on what we will call the tension that can exist between the Church's teaching and Ontario's changing social values and mores. We will also offer our reflections on possible strategies to mitigate disparities of values, focusing on the Church's original mandate – to continue the healing mission of Jesus. The following broad headings will offer structure to our reflections.

- "Whoever Pays the Piper;" The Impact of Government Financing on Health Care Decisions

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[845] *CCC*, nos. 355-357.

[846] Ibid, nos. 1905-1012.

- Mission/Margin Tensions;
- Public Demand, Government Funding, and Catholic Values:
    1) Reproductive Services;
    2) Nutrition and Hydration;
    3) End-of-Life Care;
- From Independence to Mutual Interdependence: Sponsorship Models in Support of the Mission;
- The Mission Continues: Defining a Future Full of Hope.

4.2 "Whoever Pays the Piper:" The Impact of Government Financing on Health Care Decisions

Canada's health care system has transitioned from a private, charitable ministry to a government funded "right" demanded by most Canadians.[847] Along with this perceived "right" to health care for all Canadians has come an expectation for funding from the government purse. As noted by Marchildon, 70% of health expenditures in Canada are financed through revenue received through federal, provincial, or territorial taxes.[848] Currently, Ontario spends 39% of its annual budget on health care for Ontarians.[849]

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[847] See T. REAY, "Allocating Scarce Resources in a Publicly funded Health System: Ethical Considerations of a Canadian Managed Care Proposal," in *Nursing Ethics*, 6 (1999), 240-249; see also D. DRACHE and T. SULLIVAN, *Market Limits in Health Reform: Public Success, Private Failure*, New York, Routledge, 1999.

[848] See G. MARCHILDON, *Health Systems in Transition*, Second ed., Toronto, University of Toronto Press, 2013, 19 (= MARCHILDON, *Health Systems*).

[849] See GOVERNMENT OF ONTARIO, Ministry of Finance, Transforming Health Care, 23 March 2016, https://www.thestar.com/life/health_wellness/2015/04/22/budget-will-see-tough-decisions-in-health-care.html (5 March 2017); See also E. CHURCH, "Ontario boosts hospital budgets by 1%," in *The Globe and*

From this combination of federal/provincial tax dollars, Ontario funds most of the province's hospital, long term care, and auxiliary health care services including physiotherapy, occupational therapy, assistive devices (mobility aids, respiratory equipment, hearing devices, insulin pumps, and diabetes supplies).[850] Ontario tax dollars also fund home care and drug benefits for specific populations including those 65 of age and older; those living in a long-term care home or a home for special care; and those enrolled in any of the following programs: Home Care; Ontario Works; Ontario Disability Support Programs; and Trillium Drug Program.[851] Drugs not listed in the Ontario Drug Benefit Formulary can be considered for coverage through the Ministry of Health and Long Term Care Exceptional Access program on a case-by-case basis.[852] Physicians, although practicing medicine as private contractors, negotiate fees for services in a manner similar to private contractors.[853] Given Ontario's list of funded programs, its low birth rate, and its

Mail, 25 February, 2016, http://www.theglobeandmail.com/news/national/ontario-boosts-hospital-budgets-by-1/article28923608/ (5 March 2017); T. BOYLE, "Budget will see tough decisions in health care," in *TheStar.com*, 22 April 2015, https://www.thestar.com/life/health_wellness/2015/04/22/budget-will-see-tough-decisions-in-health-care.html (5 March 2017).

[850] See Government of Ontario, Assistive Devices program, https://www.ontario.ca/page/assistive-devices-program (5 March 2017).

[851] See GOVERNMENT OF ONTARIO, Get Coverage for Prescription Drugs, https://www.ontario.ca/page/get-coverage-prescription-drugs#section-0 (5 March 2017).

[852] See GOVERNMENT OF ONTARIO, MOHLTC, Ontario Public Drug Programs, Formulary, http://www.health.gov.on.ca/en/pro/programs/drugs/odbf_mn.aspx (5 March 2017).

[853] See GOVERNMENT OF ONTARIO, MOHLTC, Schedule of Benefits, Physician Services Under the Health Insurance Act (effective 1 March, 2016), Regulation 552 of the Health Insurance Act, http://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master20160401.pdf (5 March 2017).

aging population,[854] it is not difficult to understand that funding will impact programming decisions that Catholic health care providers must make.

The question of the continued affordability of Ontario's health care system into the future is not a new debate.[855] While the post World War II transition to a publicly funded health care system in Canada was laudable, the number of tax-funded health care services in Ontario has grown over the years. Because Canada's nationally funded health care system has become one of the unique characteristics often attributed to Canada's world identity,[856] the question of how to ration services or curb costs in other ways has become a significant point of debate for politicians and the electorate. [857]

> During the 1990s, most provincial governments – in the words of one deputy minister of health – were racing two horses simultaneously: a "black horse" of cost-cutting through health facility and human resource rationalization and a "white horse" of health reform to improve both quality and access through a more managed integration of services across the health continuum, as well as rebalancing from illness care to "wellness services."[858]

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[854] See GOVERNMENT OF ONTARIO, Ministry of Finance, Ontario Population Projections update, 2015-2041, http://www.fin.gov.on.ca/en/economy/demographics/projections/projections2015-2041.pdf (5 March 2015).

[855] See T. BOYLE, "Ontario can't afford its health system, former hospital CEO warns," in *TheStar.com*, 19 March 2014, https://www.thestar.com/life/health_wellness/2014/03/19/ontario_cant_afford_its_health_system_former_hospital_ceo_warns.html (5 March 2017); See also J. HAGGERTY and J. LEVESQUE, "Development of a measure of health care affordability applicable in a publicly funded universal health care system," in *Canadian Journal of Public Health*, 106 (2016), 66-71.

[856] See W. SYMONDS, "Whither a health-care solution? Oh, Canada. (Canadian national health care system as United States model)," in *Business Week*, 21 March 1994, vol. 3363 (1994), 82-84.

[857] See R. EVANS and G. STODDART, *Medicare at Maturity: Achievements, Lessons & Challenges*, Calgary, University of Calgary Press, 1986.

[858] MARCHILDON, *Health Systems*, 123.

All province were struggling with the same issues – growing health care needs and increasing demands that all health care needs would be paid by the public purse. The question of how to meet an aging population's growing need for complex health care services would bring about significant change to what had been a stable funding source since the advent of Ontario's public funding for health care. As one Sister-CEO noted at the advent of public funding for Catholic health care, we may welcome the financial stability that will come from government funding for health the services which we in the ministry of Catholic health care have provided. However, there will come a day when we will no longer be able to define our own destiny. We will be owned by the government and by a public-opinion-based political process which will steal the soul of Catholic health care in Ontario. This day arrived when the Ontario Legislature defined the Health Services Restructuring Commission[859] mandate as follows:

1. To make decisions about restructuring Ontario's public hospitals;
2. To provide advice to the Minister of Health about which health services would need reinvestment as a result of changes to the hospital system and changing needs of the population; and
3. To make recommendations to the Minister on restructuring other components of the health care system to improve quality of care, outcomes and efficiency and help create a genuine, integrated health services system.[860]

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[859] See GOVERNMENT OF ONTARIO, The Restructuring and Savings Act, S.O. 1996 Ch. 1 ("Bill 26") Toronto, http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&link_id=5214&cf_id=68&lang=en (7 March 2017) (= HSRC).

[860] See D. SINCLAIR et al, *Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission (1996-2000, A Legacy Report*, March 2000, http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&link_id=5214&cf_id=68&lang=en (7 March 2017) (= Sinclair et al., *Legacy*).

4.2.1 Ontario's Health Care Restructuring Commission: Impact on Catholic Health Care

In every Canadian province, health service delivery has been rationalized in one form or another in response to restrictive health budgets. In the mid-1990s, the Ontario government hoped service rationalization would be achieved through the creation of an arms-length commission responsible for recommending and implementing hospital restructuring.[861] The stated rationale for Ontario's Health Services Restructuring Commission was "to deal with a set of problems that the government of Ontario and senior bureaucrats believed they could not solve themselves except at very high political cost, particularly to the premier and the minister of health, the politicians at the point of the plough."[862] The problems identified by the government were threefold:

1) Increasing expenditures in health care, constrained tax revenue, and a political imperative to shrink Ontario's budgetary deficit;
2) Health care needs (especially acute care) were exceeding other provincial funding needs for home care and long term care;
3) The need to shift resources from acute care to other sectors of the health system.[863]

4.2.1.1 Catholic Health Care in Ontario: From A Legacy Contribution to One of Many

As noted in Chapter II, Ontario's health care system was predominantly founded by dedicated members of religious institutes who were invited by diocesan bishops to care

[861] See D. SINCLAIR, M. ROCHON, and P. LEATT, *Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996-2000*, Montreal, The Institute for Research on Public Policy, 2005 (= SINCLAIR et al., *Riding*).

[862] See ibid., 9.

[863] Ibid.

for those who were sick or poor,[864] and to develop a Catholic education system in the province of Ontario.[865] When a review of Ontario's health care system was mandated by the Ministry of Health and Long Term Care in the mid 1990s, both religious and secular hospitals were examined through the same lens. While the entire HSRC process and mandate exceeds the limits of this dissertation, the Commission's impact on Catholic health care in Ontario warrants further inspection.

To understand Ontario's hospital system in the mid 1990s, one must recall a 42-year provincial history that had been guided by one person and one political party: The Honourable William Davis of the Conservative Party. Attempts to address increasing costs of Ontario's urban hospitals had been attempted by Frank Miller, then Ontario's Minister of Health. He attempted to close urban hospitals that he considered supernumerary – e.g., Doctors' Hospital in downtown Toronto. He was "pelted with snowballs by protesting patients, staff and community members. The police had to rescue him from a mob. The message was clear: mess with hospitals at your peril!"[866]

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[864] See CHAC, Catholic Hospitals Digital History Books Collection, Ottawa, CHAC, http://www.chac.ca/about/history/digital_e.php (15 January 2016).

[865] See D. MURPHY, *Catholic Education: A Light of* Truth, Toronto, Catholic Register Books, 2007; See also T. BRENNAN and L. KAY, "Roman Catholic Schooling in Ontario: Past Struggles, Present Challenges, Future Directions?" in *Canadian Journal of Education*, vol. 34, no. 4 (2011), 20-33.

[866] See SINCLAIR et al., 10.

Ontario's long-serving conservative party was succeeded by the liberal party who appointed Elinor Caplan to the position of Minister of Health. In order to address rising health care costs, she established a southwestern Ontario comprehensive health system planning commission chaired by Earl Orser.[867] The commission's goal was to develop a 10-year strategic plan for the control of health services in London in the southwestern region, and included a limited degree of devolution to the region.[868] While the commission developed a strategy for southwestern Ontario, the election of the New Democratic Party resulted in the Orser report being shelved.

Despite the change in the political party in power in Ontario, issues of rising costs for health care would not disappear. To control overall government-program spending and in an attempt to address the issue of the "common good," then premier Bob Rae attempted to negotiate a social contract with the Ontario public sector, health, community services, schools, colleges, universities, the agencies, boards and commissions, and municipalities. A monthly unpaid day would be taken by any individual who received a publicly financed salary that exceeded a defined threshold of $30,000 annually.[869] While the rise and decline of politicians and political parties exceed the mandate of this dissertation, it is important to note that while "Rae Days" were deemed as draconian by some, they were reflective of the

[867] See E. ORSER, *Working Together to Achieve Better Health For All*, London, The Commission, 1991.

[868] See SINCLAIR et al., 11

[869] See GOVERNMENT OF ONTARIO, Social Contract Act, 1993, S.O. 1993, C.5, https://www.ontario.ca/laws/statute/93s05 (5 March 2017).

Church's teaching of the "common good."[870] With growing public dismay for mandatory unpaid days to address increasing public service costs, the progressive conservative party was elected to power in Ontario in 1995. Hospitals were consuming 41% of the health budget of $17.8 billion. The Ontario health budget constituted 32% of the provincial budget which included a $10 billion deficit.[871] The new government's mantra was a "Common Sense Revolution" which promised to eliminate the deficit, balance the budget, pay down the provincial debt, and reduce the tax burden. A major strategy to accomplish these goals was to reorganize health care delivery in Ontario.[872]

In 1996, Bill 26 gave the Health Services Restructuring Commission the "power of the purses," with authority to shut down hospitals. As noted by the Commission, the great majority of hospitals in Ontario were not "public" in the sense of being publicly owned and operated. Nearly all were private institutions answerable to boards representing federally or provincially registered corporations and virtually all were charitable and operated on a not-for-profit basis.[873]

While faith based hospitals awaited the HSRC review in their community with varying degrees of trepidation, Catholic hospitals represented by the Catholic Health

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[870] See *CCC*, nos. 1905-1927.

[871] See SINCLAIR et al., 11.

[872] Ibid., 12.

[873] See SINCLAIR et al., 18.

Association of Ontario expressed grave reservations about the impact of the HSRC to change dramatically existing hospital structures which had traditionally respected the role of the Church in the delivery of health care services in the province. In two-hospital towns (Catholic/public), historical organizational relationships were frequently one of "uneasy mutual tolerance that at best, extended to watchful collaboration in a few selected programs."[874]

Catholic hospitals in particular perceived the HSRC as a threat to their very survival for two issues: (1) their need to ensure governance and sponsorship of their Catholic mission; and (2) their fear that Catholic hospitals would be ordered to offer reproductive services, specifically abortions and related procedures that ran counter to the fundamental values and teaching of the Catholic Church.[875] Three central HSRC fears were identified by CHAO: (1) the HSRC was resolved and empowered to make a choice between hospitals in two-hospital towns and cities, putting an end to competition and long-standing plans that had carefully carved out respective roles for each hospital; (2) if the HSRC needed to choose a secular or Catholic hospital in a rural community, the chosen institution would be forced to confront the question of how to meet the community's demand for abortion and related procedures; and (3) control over who sat on the hospital's board could no longer

[874] See SINCLAIR et al., 68.

[875] Ibid.

rest exclusively with the institution's owners or sponsors. It would be required to share that responsibility with the community at large.[876]

From the HSRC perspective, CHAO clearly stated that "mergers with non-Catholic entities ran counter to canon law by which the Catholic hospitals were bound."[877] The HSRC noted they had sought canonical advice from a variety of sources, and had been informed there was sufficient flexibility with canonical norms "to permit a variety of alternatives to the status quo."[878]

It must be remembered that, at this point, longer-term alternative partnership strategies between Catholic and other-than-Catholic institutions had not been considered seriously by Catholic health care sponsors, trustees, or leadership teams, nor carefully studied by canonists or Vatican officials. It was not until 2014 that some principles or guidelines would be offered on the issue of partnership possibilities and limitations between Catholic and other-than-Catholic health care facilities, as found in a 14 February 2014 response from the Congregation of the Faith[879] to a *dubium* presented by Cardinal Timothy Dolan on behalf of the United States Conference of Catholic Bishops. As noted

[876] See SINCLAIR et al., 69.

[877] SINCLAIR et al., 70.

[878] Ibid.

[879] See CONGREGATION FOR THE DOCTRINE OF THE FAITH, "Some Principles for Collaboration with Non-Catholic Entities in the Provision of health Care Services," in *The National Catholic Bioethics Quarterly,* 14 (2014), 337-340.

by Peter Cataldo, the CDF document was "not in the typical *responsum* format,"[880] but rather offered a set of principles which could be used to help to offer moral guidance on collaborative efforts between Catholic and non-Catholic organizations.[881] From this response, it was clear that an isolationist mentality by Catholic health care providers throughout the world would jeopardize the Church's capacity to continue this important ministry in the world.

In the end, the health care system in Ontario was restructured by the HSRC. The Catholic hospitals in Sudbury and Kingston were ordered to close.[882] Both the sponsors of Sudbury General Hospital (The Sisters of St. Joseph of Sault Ste. Marie) and the sponsors of Hotel Dieu Kingston (Religious Hospitallers of St. Joseph), along with other hospitals that were ordered to close, refocus their mandate, or merge with other hospitals in their community, launched court challenges. The first court challenge came in January 1997 when the Sisters of St. Joseph of Sault Ste. Marie brought an application to divisional court for a judicial review of the directions that had been issued in January of that year.[883] They argued their freedom of religion under the Canadian Charter of Rights and Freedoms[884]

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[880] See P. CATALDO, "A Commentary on Collaboration With Non-Catholic Entities in Health Care Services," in *Origins*, 44 (2014-2015), 432. (= CATALDO, "A Commentary")

[881] See ibid., 432.

[882] See SINCLAIR et al., 191-193, 202-204.

[883] See ibid., 191.

[884] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, http://laws-lois.justice.gc.ca/eng/Const/page-15.html (3 March 2017) (= *Canadian Charter of Rights and Freedoms*).

would be infringed if they were denied the right to operate a religious hospital, and that transfer of their assets to a secular hospital would contravene canon law.[885] While the HSRC consulted with other canonists who offered various interpretations of canon law, they all agreed that a Roman Catholic hospital could not be merged with a secular counterpart "without offence to canon law."[886] Over a period of months, through a process of facilitated discussions between the HSRC and the Sisters of St. Joseph of Sault Ste. Marie, the Sisters eventually decided to withdraw their application and developed a partnership with a new Sudbury hospital corporation in developing and providing long-term care, complex continuing care, and palliative care in the new facility. As noted by the HSRC, "most of the credit belongs to the Sisters of St. Joseph of Sault Ste. Marie, for courageously and sensitively balancing their faith-based principles with the need to collaborate with their secular counterparts to better meet the needs of the population."[887]

In September 1998, the Religious Hospitallers of St. Joseph brought an application to the court to "quash *Directions* issued in July, ordering the hospital to collaborate with the Kingston General and Queen's University to develop a plan whereby it would relinquish its programs to the General and close as a public hospital by the end of October."[888] The HSRC Directions were challenged on three grounds: "[the directives]

[885] See SINCLAIR et al., 192.

[886] Ibid., 192.

[887] See ibid., 193.

[888] SINCLAIR et al., 202.

were patently unreasonable in the absence of evidence that the commission's restructuring plan was viable; that they violated the Sisters' religious rights under the Charter of rights and Freedoms; and the HSRC had failed to consider provincial land used and municipal bylaws under the Planning Act."[889] The courts noted "the Commission's Directions are not an end point in the restructuring process. They are but one step along the way … the Directions were not unreasonable considering the breadth of the Commission's powers … ."[890] With regards to the Commission's order to close Hotel Dieu as a publicly funded hospital, the court ruled that "the Directions did not breach the Sisters' freedom of religion. They required only that Hotel Dieu cease to operate as a public hospital; the Sisters could continue to 'minister to the sick poor who live in the north end of Kingston' using their assets and facilities in any way they saw fit except as a publicly funded hospital."[891] The court also found that the HSRC, "while not obligated to do so, had considered matters related to provincial land-use polity."[892] The application to the court was dismissed. The Sisters sought and were granted leave to appeal the decision to the Court of Appeal. The court of appeal unanimously dismissed the appeal.[893]

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[889] SINCLAIR et al., 203.

[890] Ibid.

[891] Ibid.

[892] Ibid.

[893] See Ibid.

In two situations, court challenges to HSRC directions were initiated by secular hospitals that were ordered to close. In Renfrew county, the one hospital identified by the HSRC which would remain open was the Catholic hospital. In addition to the closure of Pembroke's secular Civic hospital, the HSRC also ordered the Pembroke General Hospital, owned by the Grey Sisters of the Immaculate Conception, to expand in order to provide a full range of hospital services to meet the needs of the population they served.[894] As one HSRC Commissioner noted, "visiting Pembroke, a handsome Ottawa Valley community, was akin to stepping back into the nineteenth century, at least with respect to the influence of religion on daily life. The city seemed to be divided, architecturally and functionally, between Roman Catholics and Protestants … ." Some of the Pembroke community members expressed anger that there would only be one hospital in their community to meet their health needs, noting "having to seek care at a hospital in which crucifixes were prominently displayed and 'Roman Catholicism will be shoved down our throats'," [895] would be the height of insult. Of special interest was the court's opinion that "the commission was right to consider Ontario's long tradition of diversity in hospital governance and that it had acted within its powers by doing so."[896] The Civic hospital also claimed the HSRC had "contravened the *Charter of Rights and Freedoms* because abortions and related reproductive services would not and could not be provided at the

[894] See SINCLAIR et al., 195.

[895] Ibid.

[896] Ibid.

General Hospital."[897] The court noted that "no abortion had been performed in either of Pembroke's two hospitals for as long as anyone could remember."[898]

The final case which we will include in this discussion, was brought forward in June of 1997 by the Wellesley Central Hospital, which challenged the HSRC order to close Wellesley Central hospital and transfer its programs to St. Michael's Hospital, the largest Catholic teaching hospital in Ontario. The HSRC Directions suggested "these two hospitals would then cooperate a new ambulatory-care hospital on the site of the former Wellesley Central Hospital."[899] The application by the Wellesley Hospital was dismissed by the court.[900]

While the HSRC was one moment in Ontario's history, it offered a moment that would change the face of Catholic health care in Ontario forever. The HSRC offered a vision of a coordinated, collaborative system of health care which would offer safe, efficient, and effective health care services to meet changing local health care needs. A hospital-centric model of health care delivery would be converted to a population needs-based system of health care. A new focus on health care integration and collaboration

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[897] SINCLAIR et al., 196.

[898] Ibid.

[899] Ibid., 197.

[900] See J. GILMOUR, "Limits of the Law: Legal Challenges to the Health Services Restructuring Commission," Toronto, Osgoode Digital Commons, 2006, http://digitalcommons.osgoode.yorku.ca/cgi/viewcontent.cgi?article=1108&context=scholarly_works (7 March 2017).

would become a priority on the government's agenda until the present day. "The political risk of restructuring these icons of health care was considered worth bearing given the province's dire financial circumstances."[901]

To serve as a catalyst for this level of organizational change, the HSRC that health planning and funding for the province's health care needs devolve to fourteen Local Health Integration Networks (LHIN).[902] As noted in the legislation, the LHIN have the "capacity, rights and power of a natural person for carrying out its objects,"[903] including initiating process to ensure coordinated health care planning and community engagement, to develop funding and accountability requirements for health care providers within their jurisdiction, to identify health care integration opportunities, and to establish networks where appropriate, ensuring "the proper management of the health care system in general; the availability of financial resources for the management of the health care system and for the delivery of health care services; the accessibility to health services in the geographic area or sub-region where the LHIN or health service provider … is located; and [ensure] the quality of the care and treatment of patients."[904]

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[901] SINCLAIR et al., 279.

[902] See GOVERNMENT OF ONTARIO, Ministry of Health and Long Term Care, Local Health System Integration Act, 2006, S.O. 2006, c. 4, https://www.ontario.ca/laws/statute/06l04 (7 March 2017).

[903] Ibid., §6, Powers.

[904] Ibid., §35, Public Interest.

As can be noted in the list of duties transferred to the LHIN, many of these would have previously been the responsibility of religious institutes which sponsored health care organizations throughout Ontario, e.g., availability of financial resources, quality of care, etc. In a presentation made to some Ontario LHINs, John Ruetz, President and CEO of the CHSO differentiated the role of the LHINs and the role of Catholic health care sponsors.[905] Sponsors of Catholic health care are responsible and accountable to the Church for the following key performance criteria. In his presentation, Ruetz suggested questions for consideration when reflecting on Catholic health care performance criteria.[906]

Mission Integration	• Is the organization functioning in a manner consistent with the indicators of Catholic identity, including: ➢ clearly recognized by staff, physicians, visitors, and the community at large, as Catholic; ➢ a preferential option for serving those most in need; ➢ a clear understanding of the role of the sponsor, the "chain of mission,"[907] and sponsor and administration obligations noted in canon law; ➢ the mission, vision and values statement as well as the CCCB *Health Ethics Guide* are clearly integrated into all aspects of the organization; ➢ regular self-assessments of mission integration.
Organizational Health	• Is trustees and leadership function within commonly accepted leadership practices, ensuring: ➢ participation in focused strategic planning, performance evaluations, risk management and organizational oversight;

[905] See J. RUETZ, "Catholic Health Care in Ontario: A Discussion with Local Health Integration Networks," 4 February 2016, available in the private archives of the Sister Bonnie MacLellan, St. Joseph's Motherhouse, 2025 Main St. W., North Bay, ON (= RUETZ, "Catholic Health Care").

[906] RUETZ, "Catholic Health Care," Slide 11.

[907] See B. MACLELLAN and R. MARR, "Giving Flesh to Dry Bones: God's Spirit in Strategic Planning," in *Health Progress*, vol. 89, no. 3 (2008), 55.

	➢ compliment of trustees reflects sufficient size and composition to support its roles and responsibilities (size, skills, tenure, turnover); ➢ commitment to leading practices for governance excellence including recruitment, orientation, training, evaluation, and continuous improvement; ➢ commitment to community engagement and relationships with system partners; ➢ stable leadership and demonstrated trust and confidence in leadership; ➢ capacity to attract and retain quality employees; and ➢ a succession plan for key leadership positions, including medical leadership.
Quality of Care	• Is the organization performing well in areas related to quality of care and patient safety, by: ➢ ensuring a comprehensive array of health care and health promotion services are available; ➢ regularly reviewing patient/client service requirements, including evaluating models of care; ➢ ensuring the organization meets its LHINs accountability agreement obligations; ➢ participating in a recognized Canadian Accreditation process;[908] ➢ ensuring all recommendations from recent accreditation surveys or government inspections have been addressed; and ➢ adequately addressing complaints, community concerns or lawsuits.
Financial Health	• Is the organization performing well in commonly accepted financial elements including: ➢ evidence of a balanced budget and financial stability; ➢ cognizance of and development of action plans to address financial performance issues; ➢ assuring appropriate capital reserves for their intended purpose;

[908] See ACCREDITATION CANADA, https://accreditation.ca/ (8 March 2017). Through establishing standards and accreditation programs, Accreditation Canada works with health care organizations to help them improve quality, safety and efficiency so they can offer the best possible care and standards. https://accreditation.ca/corporate-overview (8 March 2017).

	➢ ensuring the organization's current ratio,[909] working capital (total current assets minus current liabilities).[910]

While diocesan bishops and members of religious institutes constructed and staffed some of Ontario's first hospitals to meet the needs of indigent, poor immigrants to Canada, the ministry of Ontario's Catholic health care system is to participate in developing an integrated health system which continues to reflect canonical and ethical Church standards.

In the current Ontario environment in which health care financing decisions are sometimes based on public and political sentiment versus a sound process of ethical reflection with consideration for the common good, the continued contribution of Catholic health care to Ontario's health care system would appear to be as critical today as the day the first patients in Ontario were cared for in make-shift hospitals. Through continuing to dialogue with health care planners and other providers,[911] Catholic health care leaders will continue to influence a health care system which was founded on compassion and partnership, responding to a changing social, political, and religious provincial reality. The

[909] See E. GRIGHAM, A. KAHL and W. RENTZ, *Canadian Financial Management: Theory and Practice*, Toronto, CBS Publishing, 1982, 191. Current ratio is computed by dividing current assets (normally including cash, marketable securities, accounts, receivables, and inventories) by current liabilities (normally including accounts payable, short-term notes payable, current maturities of long-term debt, accrued income taxes and other accrued expenses.). The current ratio measures an organization's short term solvency.

[910] Ibid., 311.

[911] See F. MORRISEY, ""Restructuring Systems: A Call for Dialogue," in *Health Progress*, vol. 94, no. 1 (2013), 66-67.

"value-added" of Catholic health care providers will come in their capacity to negotiate mission/margin tensions.

4.3 Mission/Margin Tensions

The foundations of Catholic health care have often been found in Jesus' parable of the Good Samaritan.[912] Unlike the current Ontario health care financial reality, the issue of scarcity did not seem to be an issue for the Samaritan. In the gospel parable, the Samaritan pays in advance for the injured man whom he has brought to the inn for shelter and support, and promises to pay any additional charges the innkeeper may incur until the Samaritan has an opportunity to return to pay anything that is owing. [913] The question that can be raised is, "Can we still be good Samaritans in the midst of choices imposed by scarcity?" If we can expand our definition of scarcity to include concepts such as access, finances, and commodities, we may begin to see the issue of scarcity as a unique opportunity for Catholic health care to offer a process for ethical reflection related to allocation of scarce resources.[914] The reality in our contemporary Ontario environment is that "we simply do not have the resources for medicine to do all it can do all at once for all who hurt."[915] To mirror the compassion of the good Samaritan, Catholic health care providers in Ontario will have to exhibit other important qualities, including:

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[912] See Luke 10: 25-37.

[913] See A. VERHEY, "The Good Samaritan and Scarce Medical Resources," in *Christian Scholar's Review*, 3 (1994), 360-376 (= VERHEY, "The Good Samaritan").

[914] See VERHEY, "The Good Samaritan," 361.

[915] Ibid., 362.

- Truthfulness: acknowledging the truth about our world and our medicine, about limits imposed by our mortality and by the finite nature of our resources;
- Humility: acknowledging that we are not gods but creatures of God, finite and moral creatures, cherished by God and in need of God's care;
- Gratitude: thankful for the opportunities afforded to us, even in the wake of our limitations, both human and fiscal.[916]

To adopt the stance of the contemporary Samaritan, we must address the three "scarcities:" access, finances, and commodities.

4.3.1 Responding with Grace to Scarcity of Access and Funding

Caring for each other is a gesture which acknowledges our humanity, including our mutual interdependence. As the world's population grows and ages, medical advances and drugs sometimes become available only to those who are able to afford them. The disparities in relation to the distribution of resources, including the fruits of financial affluence which includes access to adequate health care services, becomes a more stark contrast.

Like death, scarcity is a fact of life. What, then, is the mission of Catholic health care in a world where there is a disproportionate distribution of assets and where the gulf between the rich and the poor becomes more pronounced? As Catholic health care providers who

[916] See VERHEY, "The Good Samaritan," 362.

have been called to emulate the selfless giving of the Good Samaritan, the reality of scarcity will call us to advocate for public policies that reflect a stance of justice. Justice will require that we give to others based on their need versus their political activism, connections, access to private resources, etc.[917]

As a society generally, and as sponsors and leaders of Catholic health care in Ontario specifically, we are uniquely positioned to engage the broader public in a dialogue which speaks truthfully about the limits and limitations of medicine to cure all of humanity's ills. While an adequate level of health care for all is a desired goal, this will not and should not include an expectation to limitless access to everything modern medicine is capable of doing. Are we, as Catholic health care sponsors and leaders, not called and indeed mandated by our baptism, to offer to the world a prophetic voice of limitation and reason in a culture which may be seduced into believing that anything is possible if one has sufficient resources to cover the costs? The Church's teachings relating to the common good would suggest that, given the wealth of the first and second world countries, everyone has a right to a decent standards of care if we adopt a sharing economy mentality.[918] As bearers of the tradition of the selfless ministry of the Good Samaritan, can we look to the Church's teachings and laws to guide decisions allocating scarce resources?

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[917] See VERHEY, "The Good Samaritan," 363.

[918] Ibid., 364.

4.3.2 Canonical Principles Address Disparities

In 2011, the Catholic Health Association of the United States focused its assembly on developing principles to be applied when trying to eliminate disparities in access and distribution of scarce health care resources. As F. Morrisey noted, while the *Code of Canon Law* does not directly speak to disparities in health care, certain principles in the *Code* can guide our resource-allocation decision-making process. We will also be guided by the doctrine and teachings of the Church, as well as the documents of Vatican II which have shaped the *Code of Canon Law*.[919]

The *Code of Canon Law* offers some sound norms to guide administrative decision-making processes for Ontario's Catholic health care sponsors, trustees, and administrators when addressing issues of justice in decisions related to disparity of scarce health care distribution. Rooted in the text of *Lumen Gentium,*[920] and Vatican II's shift from a view of the Church as a society of unequals to a *communio* ecclesiology,[921] canon 208 reminds us of the fundamental equality regarding the dignity that exists among all the Christian faithful as a result of their "rebirth in Christ" through baptism.[922] All of the baptized are responsible

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[919] See F. MORRISEY, "Canonical Principles Address Disparities," in *Health Progress*, vol. 93, no. 1, (2012), 72-73 (= MORRISEY, "Canonical Principles").

[920] See *LG*, no. 32, 875.

[921] See R. KASLYN, "The Obligations and Rights of All the Christian Faithful," in J. BEAL, J. CORIDEN, T. GREEN (eds.) *New Commentary on the Code of Canon Law*, Mahwah, NJ/New York, NY, Paulist, 2000, 258.

[922] See c. 208, "From their rebirth in Christ, there exists among all the Christian faithful a true equality regarding dignity and action by which they all cooperate in the building up of the Body of Christ according to each one's own condition and function."

for contributing, "according to their own condition and function," to the Body of Christ. While the theory is clear, the implementation of this mandate is often difficult.[923] While responsibility for caring for the sick has been mandated by Jesus to the Church, the *Code* reminds us that the parish priest ís to "help the sick, particularly those close to death, by refreshing them solicitously with the sacraments and commending their souls to God; with particular diligence he is to seek out the poor, the afflicted, the lonely, those exiled from their country, and similarly those weighed down by special difficulties" (c. 529, §1).

The *Code* also provides guidance related to roles and responsibilities of various levels of authority identified in juridic persons in the Church. We would respectfully suggest that many, if not most, of Ontario's Catholic health care administrators and trustees would be unaware of these helpful Church laws. These include defining important duties of an administrator (cc. 1282, 1283, 1284), the requirement to observe civil laws related to labour and social policy (c. 1286), the definition of helpful accountability structures (c. 1287), authority to engage in lawsuits in civil courts (c. 1288), and the authority to approve alienation of property (cc. 1291-1295). Of special value in the *Code of Canon Law* is canon 1296, which clarifies the administrative decisions that represent civilly valid but canonically invalid transactions. The objective in these laws is to offer behavioural guidelines to ensure the protection of ecclesiastical goods while still allowing for situation-specific flexibility (see c. 1297).

[923] See MORRISEY, "Canonical Principles," 72.

In addition to the guidance offered by the *Code* in addressing issues of disparity in health care resource allocations, Pope Benedict XVI's encyclical *Caritas in veritate* notes that charity is that charity which can be likened to the compassion of the good Samaritan, which is the "driving force behind the authentic development of every person and all humanity,"[924] and which forms the foundation for the Church's social doctrine of justice and the common good.[925] The mandate to continue to work for justice, the preservation of the dignity of each person, and the ministry of health care in our contemporary world, is reflected in *Gaudium et spes*, the Pastoral Constitution on the Church in the Modern World of Vatican Council II: [926] "In today's changing economic situation, as in new forms of industrial society, in which, for example automation is on the increase, care should be taken to … safeguard the means of living and human dignity especially of those for whom ill health or old age create serious difficulties." Pope Benedict also reminds us that "the economy needs ethics to function correctly … Efforts are needed … to ensure that the whole economy … the whole of finance [be] ethical."[927] In fact, this encyclical helps to ground the identity and values of Catholics in Catholic institutions, and provides the basis for actualizing our mission.[928] While faith will guide our lives, Catholic social teaching will

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[924] BENEDICT XVI, Encyclical Charity in Truth *Caritas in veritate*, 29 June 2009, in *AAS*, 101 (2009), 641-709, English translation in *Origins*, 39 (2009), 129 (= *CV*).

[925] *CV*., 131.

[926] See SECOND VATICAN COUNCIL, Pastoral Apostolic Constitution on the Church in the Modern World *Gaudium et spes*, 7 December 1965, in *AAS*, 58 (1966), pp. 1025-1115, English translation in Tanner II, 1069-1075 (= *GS*).

[927] *CV*, no. 45.

[928] See P. TURKSON, "Forming Ethical Business Leaders," in *Origins*, 43 (2013-2014), 714 (= TURKSON, "Forming Ethical Business Leaders").

guide "the choices that leaders can and need to make in the public and social sphere of human existence, including business."[929] Based on Pope Leo XIII's encyclical *Rerum Novarum,*[930] the core principles of Catholic social teaching[931] form the basis for decisions made by Catholic health care leaders. These include that each person, created in God's image and likeness,[932] has an inherent dignity;[933] that our plans must consider the common good or the effect of our plans today and for future generations;[934] that our call is to a solidarity which highlights the "intrinsic social nature of the human person, the equality of all in dignity and rights and the common good of individuals and peoples towards an ever more committed unity;"[935] subsidiarity;[936] and stewardship, recognizing that as cultivators and custodians of the goods of creation.[937] Catholic health care leaders are called to "see

[929] TURKSON, "Forming Ethical Business Leaders."

[930] See LEO XIII, Encyclical on the Rights and Duties of Capital and Labor *Rerum Novarum*, 15 May 1891, in *ASS* 23 (1890-91), 641-670, English translation, http://w2.vatican.va/content/leo-xiii/en/encyclicals/documents/hf_l-xiii_enc_15051891_rerum-novarum.html (12 December 2016).

[931] See PONTIFICAL COUNCIL FOR JUSTICE AND PEACE, *Compendium of the Social Doctrine of the Church*, New York, Bloomsbury, 2004, nos. 160-163 (= *CSD*).

[932] See Gen. 1:27

[933] See *CCC*, no. 357.

[934] See *CSD*, "Principles of the Common Good," nos. 164-170.

[935] *CSD*, no. 192.

[936] See *CSD*, no. 186: On the basis of this principle, all societies of a superior order must adopt attitudes of help ("*subsidium*") – therefore of support, promotion, development – with respect to lower-order societies … Subsidiarity, understood in the positive sense as economic, institutional or juridical assistance offered to lesser social entities, entails a corresponding series of negative implications that require the State to refrain from anything that would *de facto* restrict the existential space of the smaller essential cells of society. Their initiative, freedom and responsibility must not be supplanted."

[937] See Gen. 1:26-27.

themselves as co-creators with God and as his grateful, humble and respectful stewards in nurturing and distributing his gifts to all people."[938]

The documents of Vatican II, the Church's social teachings, and *Code of Canon Law* offer Catholic health care leaders support in making decisions which will be congruent with their mission to continue Jesus' healing ministry, the tradition of their religious founders, and expressing without apology and with great humility, their Catholic identity.[939] Our ministry as Catholic health care leaders should be different from our secular counterparts. Healthcare is not just another business on the spectrum of consumable commodities. Our work is not just a job, it is a way of living: it is our vocation. Our ministry is about life and dignity, not just dollars and cents. We are called not only to save lives but to make lives better. Catholic health care leaders, in service to the Church and its mission, are not simply another powerful lobby; our ministry is not an industry, because it is founded on the teachings of the Church and gospel of Christ.[940] It is only from this basic stance of reflection that Catholic health care leaders will be in a position to engage in ethical reflections which can balance government funding even while ensuring a sufficient margin to support the mission.

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[938] TURKSON, "Forming Ethical Business Leaders," 715.

[939] See J. LETOURNEAU, "Mission Integration and Workplace Spirituality," in *Health Progress*, vol. 97, no. 2 (2016), 31.

[940] See W. SKYLSTAD, "Catholic Health Care's Identity and Integrity," in *Origins*, 36 (2006-2007), 86.

4.4 Government Funding, Public Demand, and Catholic Values

The impetus motivating the first Catholic health care organizations was to meet unmet needs in the communities in which we served. With the advent of public funding of health care however, Ontarians have come to assume they have access to all legally available health care services in all institutions. Some procedures available in other-than-Catholic health care facilities may be considered civilly legal but morally objectionable or morally evil by the Church. As R. Hamel notes, in order to foster an ethical culture, ethical and religious directives [or reference to the Canadian *Health Ethics Guide*] are insufficient to make a Catholic healthcare organization ethical. We are called to expand our discernment beyond a singular focus of right behaviour to shaping a culture and environment that supports right behaviour.[941] Bishop Joseph Sullivan of Brooklyn said in his 1998 address to the Association of Catholic Colleges and Universities' annual meeting in Washington that, "Catholic social teaching generally has not been integrated into the church's parish life, its prayer life, its worship, its action agenda … with a pro-life agenda often being labeled conservative, right wing."[942] The question is often asked, "What is the role of the magisterium in bioethics?"

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[941] See R. HAMEL, "Fostering an Ethical Culture: Rules Are Note Enough," in *Health Progress*, vol. 90, no. 1 (2009), 10-12.

[942] J. SULLLIVAN, "Proud Heritage, Neglected Treasure" in *Origins*, 27 (1997-1998), 588.

This question was addressed by Cardinal William Levada in 2007.[943] He noted the magisterium's role is "more important than ever for those of us who are called to exercise the teaching office (magisterium) in the church … If the people of God have not been formed with the moral tradition of the church, if they do not grasp the essential connection between the principles of Catholic moral teaching the Gospel of Jesus Christ, then they will be incapable of responding adequately to the moral problems of our day."[944]

Of particular importance at this time in the history of Catholic health care in Ontario are the following:

1) Reproductive Services;

2) Nutrition and Hydration; and

3) End-of-Life Care

4.2.1 Reproductive Services

When the general public is questioned on the essence of Catholic identity, many focus on procedures considered to be morally evil and which the Church teaches attack the sanctity of life at its beginning and at its end. There are several ethical issues related to

[943] See W. LEVADA, "The Magisterium's Role in Bioethics," in *Origins*, 36 (2006-2007), 581-588 (= LEVADA).

[944] LEVADA, 581-582.

reproduction.[945] For the purposes of this discussion the areas of human reproduction[946] which will be reviewed will include contraception,[947] surgical sterilization,[948] and abortion.

Contraception, like abortion, has been present from the beginning of Christianity and was opposed by Christians as "decadent paganism that had no regard for human dignity."[949] The most common form of contraception practices today is the hormonal pill, taken by women orally to prevent ovulation and thus render the woman infertile.[950] Other forms of contraception could include the use of an intrauterine device (IUD), condoms, spermicidal contraceptive jellies and foams, and tubal ligations.

Many Catholics feel the Church's judgement of this practice as sinful is an "arbitrary rule made up by conservative clergy."[951] However, the Church opposes contraception "because it destroys the true meaning of sexual love and the "nature and ends of marriage," as defined in the *Code* (cc. 1055-1056). Pope Paul VI, in his encyclical *Humanae vitae* noted the church's teaching on contraception "often expounded by the

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[945] See B. ASHLEY, J. DEBLOIS, and K. O'ROURKE, *Health Care Ethics: A Catholic Theological Analysis*, Fifth Edition, Washington, DC, Georgetown University Press, 2005, Kindle ed., loc. 1240 (= ASHLEY et al., *Health Care Ethics*).

[946] Ibid., loc. 1433.

[947] Ibid., loc. 1459.

[948] Ibid., loc. 1523.

[949] ASHLEY et al., *Health Care Ethics*, loc. 1468.

[950] Ibid., loc. 1459.

[951] Ibid., loc. 1468.

Magisterium of the Church, is based on the inseparable connection, established by God which man on his own initiative may not break, between the unitive significance and the procreative significance which are both inherent to the marriage act."[952]

On 27 September 1968, the Canadian Bishops issued a statement at their plenary assembly held in St. Boniface-Winnipeg, Manitoba on the encyclical *Humanae vitae*. In their statement,[953] they emphasize their solidarity with the Pope,[954] and on the role of individual conscience, noting: "True freedom of conscience does not consist, then, in the freedom to do as one likes, but rather to do as a responsible conscience directs."[955] They also reaffirmed Vatican II's teaching on conscience.[956] While this statement was seen by some as heretical,[957] in a 13 September 1998 article, *Catholic New Times* referred to the Canadian Bishops' Winnipeg Statement which directed Catholics to follow their conscience in matters of birth control[958] and noted,

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[952] PAUL VI, Encyclical On Human Life *Humanae vitae*, 25 July 1968, in *AAS* 60 (1968), 481-503, English translation in A. FLANNERY (ed.), *Vatican Council II, Volume 2: More Post Conciliar Documents*, Northport, NY, Costello Publishing, no. 12, 403.

[953] See CANADIAN BISHOPS' Statement On the Encyclical *Humanae vitae*, 27 September 1968, St. Boniface-Winnipeg, MB, http://www.catholic-legate.com/articles/winnipeg.html (20 January 2017) (= CANADIAN BISHOPS, Statement).

[954] Ibid., no. 2.

[955] Ibid., no. 11.

[956] See *GS*, no. 16, 861.

[957] See M. HARTMAN, "*Humanae vitae*: Thirty Years of Discord and Dissent," in *Conscience*, 19 (1998), 8; See also J. MALLETT, "Re Winnipeg Statement," in *Catholic Insight*, 18 (2010), 4.

[958] CATHOLIC NEW TIMES, "The Winnipeg Statement," in *Catholic New Times*, 13 September 1998, 7, http://search.proquest.com.proxy.bib.uottawa.ca/docview/222803187?rfr_id=info%3Axri%2Fsid%3Aprimo (9 March 2017) (= CATHOLIC NEW TIMES, The Winnipeg Statement).

> … then-president of the bishops' conference Alex Carter received a letter from Rome's Apostolic Delegate to Canada in response to the statement. It reads, "Now I am happy to notify Your Excellency that His Eminence, Amleto Cardinal Cicognani, Secretary of State to His Holiness, has just communicated to the Delegation that the Holy Father, Pope Paul VI has taken cognizance of the document with satisfaction.[959]

The bishops were equally clear that conscience must be rooted in Christian principles.[960]

It would appear to us then, that the argument deferring to the primary role of a decision based on informed conscience made by the Canadian bishops in 1968 has been echoed by bishops in other arguments currently being made in the United States on mandatory health benefits which include funding for contraceptives for staff working at Catholic health care institutions.[961] Can conscience be conveniently turned off based on the topic of conversation? Can we demand the government insist that Catholic health care providers have a right to "follow their conscience" in decisions to contravene civil law which would requires that contraceptive prophylactics or sterilization procedures based on identified needs be made available? Is there a forum for theologians, ethicists, Church hierarchy, Catholic health care providers, and younger married couples who have struggled

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[959] CATHOLIC NEW TIMES, The Winnipeg Statement, 7.

[960] See CANADIAN BISHOPS, Statement, no. 19.

[961] See USCCB BISHOPS GENERAL COUNSEL, "USCCB Urges HHS Compromise on Contraceptive Mandate Case," in *Origins*, 46 (2016-2017), 257-262; See also CONNECTICUT BISHOPS AND HOSPITAL LEADERS, "Connecticut Catholic Hospitals Will Comply with Plan B Law," in *Origins*, 37 (2007-2008), 276-277; W. LORI, "Letter to Congress on Protection of Conscience in Health Care," in *Origins*, 42 (2012-2013), 614-616; G. NIEDERAUER, "Free Will, Conscience and Moral Choice: What Catholic Believe," in *Origins*, 39 (2009-2010), 569-570; K. TIMM, "An Examination of Conscience: The Catholic Identity of Catholic health Care," in *Health Progress*, vol. 93, no. 1 (2012), 7-11; USCCB, "Health Care Workers' Conscience Rights Should Be Protected," in *Origins*, 38 (2008-2009), 677-683.

with the Church's teachings on the issues of contraception and sterilization, to engage in a dialogue and attempt to understand the perspective of the key players?[962]

As Pope Francis has often said, "Mostly, people are looking for someone to listen to them. Someone willing to grant them time, to listen to their dramas and difficulties. This is what I call the 'apostolate of the ear,' and it is important."[963] As R. Hamel also notes, "In Catholic health care, much of our attention and energy is focused on reproductive issues … this often seems disproportionate to other concerns: the poor, the vulnerable, the disenfranchised … ."[964] Ironically, it is often the poor and vulnerable who do become the socially disenfranchised in our world.

> Precisely in an age when the inviolable rights of the person are solemnly proclaimed and the value of life is publicly affirmed, the very right to life is being denied or trampled upon, especially at the more significant moments of existence: the moment of birth and the moment of death … This denial is still more distressing … precisely because it is occurring in a society which makes the affirmation and protection of human rights its primary object and its boast.[965]

The legal definition of disenfranchise is "to deprive (a person) of the right to exercise a franchise or privilege." The general public, who may have both been insufficiently catechized in the gospel mandate and the Church's moral teachings on the

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[962] See F. MORRISEY, "Restructuring Systems: A Call for Dialogue," in *Health Progress*, vol. 94, no. 1 (2013), 66-67.

[963] FRANCIS, *The Name of God is Mercy*, English translation by O. STRANSKY, New York, Random House, 2016, Kindle ed., loc. 274 (= FRANCIS, *The Name of God*).

[964] See R. HAMEL, "A 'Disruptor' for Catholic Health Care and Ethics," in *Health Progress*, vol. 95, no. 5 (2014), 70.

[965] St. JOHN PAUl II, Encyclical Letter The Gospel of Life *Evangelium vitae*, 25 March 1995, in *AAS* 87 (1995), 401-522, English translation in *Origins*, 24 (1994-1995), 690-725, no. 18, 696.

dignity of human life from conception to natural death, may assume a stance which dismisses human dignity as an historic relic that has not kept pace with what is considered by some as more enlightened social mores which idealize "radical individualism."[966] Judging an individual's perceived contribution to society as the sole arbiter in predicting one's worthiness of receiving life-sustaining and life-preserving medical interventions, fails to recognize that all of life is a sacred gift from God which is to be treasured.[967]

While the historical mission of Catholic health care was to offer physical support to those who were ill and suffering, perhaps in this new age of an "enlightened" western world, sponsors and leaders of Catholic health care are being called to restate what was so evident throughout the gospels and in our Church: that "a person's value arises from the inherent dignity we have as human beings and not from how well we function." Perhaps it is time for the ministry of Catholic health care in the Canada and the United States to refocus its energies and, like the good Samaritan, to refocus resources by caring for the most vulnerable in our midst who may have been judged as not worthy of utilizing scarce health care resources to support or sustain life.[968] At the same time, can Catholic health care offer assistance to society at large to recognize the human life as a journey of

[966] See R. MCELROY, "Three Kinds of Erroneous Autonomy," in *Origins*, 46 (2016-2017), 545-550.

[967] See *CCC*, no. 2260.

[968] See NATIONAL CATHOLIC PARTNERSHIP ON DISABILITY, "Futile Care: Lives in the Balance," in *Origins*, 38 (2008-2009), 233-238.

transformation for each human who has been created in God's image in order to be reunited with God for eternity?[969]

4.4.2 Artificial Nutrition and Hydration

The second biomedical issue that causes great concern based on the Church's belief in the dignity of all human life, from conception to natural death, is that of artificial nutrition and hydration. Advanced technology now allows life-support, including artificially provided nutrition and hydration, to become a common health care practice, while, at the same time, creating some significant and controversial ethical concerns.[970] Determining when technologies cease being beneficial and become harmful is a major ethical dilemma.[971] Available interventions may not always be morally nor ethically appropriate as part of end-of-life care. Many health care practitioners inaccurately assume palliative patients become uncomfortable due to dehydration. This assumption would be disputed by a majority of hospice nurses who contend that providing hydration artificially would be more distressing to these patients than beneficial, noting dying patients rarely complain of thirst.[972]

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[969] See *CCC*, nos. 163, 612.

[970] See S.A. SMITH, and M. ANDREWS, "Artificial Nutrition and Hydration at the End of Life," in *MedSurg Nursing*, 9 (2000), 223 (= SMITH & ANDREWS, "Artificial Nutrition").

[971] See SMITH & ANDREWS, "Artificial Nutrition," 223.

[972] See ibid., 234.

The *Health Ethics Guide*[973] notes "medically assisted or artificially provided nutrition and hydration raise issues related to such fundamental human realities as basic nourishment, mutual interdependence, and faithfulness to those who are vulnerable and dependent."[974] While the *Guide* notes, in principle, an obligation to provide food and water, it also notes "since some pathological conditions experienced by those who are dying prevent normal food ingestion, a decision to forgo or stop medically assisted nutrition and hydration can allow the pathology to run its course without prolonging the dying process. Such a decision is not the same as 'hastening death'."[975]

A complicating factor when assessing the necessity of artificial nutrition and hydration is the ethical use of this intervention when an individual is in a persistent vegetative state.[976] As in most biomedical ethical issues, the origin of the ethical analysis on nutrition and hydration in individuals who have been diagnosed as being in a permanent vegetative state is found in the nature of the human person, made in God's image and likeness, which elevates the scenario from a simple human analysis to an experience of a sacred reality in which there is a positive responsibility to protect and promote human life from conception to natural death.[977] At the same time, there is also a "negative obligation

[973] CHAC, *Health Ethics Guide*, Ottawa, CHAO, 2012 (= CHAC, *Health Ethics Guide)*.

[974] Ibid., no. 83, 64.

[975] CHAC, *Health Ethics Guide*, no. 85, 65.

[976] See PLACE, M., "Nutrition, Hydration and Persistent Vegetative State," in *Origins*, 36 (2006-2007), 17-22 (= PLACE, "Nutrition").

[977] See PLACE, "Nutrition," 18.

to never directly attack innocent human life."[978] The Church teaches there is no responsibility to preserve life in all circumstances. The appropriate moral tool for assessing the use of artificial nutrition and hydration "is in the distinction between ordinary and extraordinary means."[979] The Canadian *Health Ethics Guide* notes: "In principle, there is an obligation to provide patients with food and water … [and] this obligation extends to patients in chronic and presumably irreversible conditions who can reasonably be expected to live indefinitely if given such care."[980] The *Guide* goes on to state that such treatments are "morally optional when they cannot reasonably be expected to prolong life or when they would be excessively burdensome for the patient or [would] cause significant physical discomfort … ."[981] This leads us to our final ethical issue which creates significant concern in Canada at this time: end-of-life care.

4.4.3 End-of-Life Care

Intimately linked to the concept of personal rights and freedoms which are protected in Canada by the Charter of Rights and Freedoms,[982] which "guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society,"[983] is the right to self-

[978] PLACE, "Nutrition," 18.

[979] Ibid., 20.

[980] CHAC, *Health Ethics Guide*, no. 84, 64.

[981] Ibid.

[982] See *Canadian Charter of Rights and Freedoms.*

[983] See ibid., no. 1.

determination, supported by new legislation which decriminalized assisted suicide.[984] The legislation, among other things, enacts the following:

> 1. Creates exemptions from the offences of culpable homicide, of aiding suicide and of administering a noxious thing, in order to permit medical practitioners and nurse practitioners to provide medical assistance in dying and to permit pharmacists and other persons to assist in the process;
> 2. Specifies the eligibility criteria and the safeguards that must be respected before medical assistance in dying may be provided to a person;
> 3. Requires that medical practitioners and nurse practitioners who receive requests for, and pharmacists who dispense substances in connection with the provision of, medical assistance in dying provide information for the purpose of permitting the monitoring of medial assistance in dying, and authorize the minister of Health to make regulations respecting that information; and
> 4. Creates new offences for failing to comply with the safeguards, for forging or destroying documents related to medical assistance in dying, for failing to provide the required information and for contravening the regulations.

Ontario discussions around physician-assisted suicide have sometimes focused on the concepts of compassion and dignity, with compassion presented by some to mean the most loving and most compassionate course for someone who is seriously ill and who will not recover is to administer drugs to cause death.[985] However, compassion is more than

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[984] See GOVERNMENT OF CANADA, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), S.C. 2016, c.3, Assented to 2016-06-17, http://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html (20 June 2016) (= MAiD).

[985] See M. CURRIE, "Reaction to Canadian Supreme Court Decision Authorizing Physician-Assisted Suicide," in *Origins*, 44 (2014-2015), 637 (= CURRIE, "Reaction"); See also H. BRODY, "Assisted Death – A Compassionate Response to a Medical Failure," in *The New England Journal of Medicine*, 347 (1992), 1384-1388; S. MARTIN, "Donald Low made impassioned plea for assisted suicide," in *The Globe and Mail*, 24 September 2013, http://www.theglobeandmail.com/news/national/donald-lows-impassioned-plea-for-assisted-suicide/article14511417/ (10 March 2017).

alleviating pain and suffering, although this is an element of confusion, and dignity is more than the right to determine how one will die.[986]

As noted in the *Health Ethics Guide*, "sickness, suffering, and dying are an inevitable part of human experience and are a reminder of the limits of human existence."[987] The ministry of Catholic health care is "called to respect the dignity of persons, to foster trust and to promote justice."[988] The *Guide* notes that "there is no moral obligation for persons receiving care to seek treatment when the goal of treatment cannot be attained or the treatment if burdensome (excessive pain, expense or other serious inconvenience.)"[989] While life-sustaining treatments may be abandoned once undertaken with the consent of the person receiving the treatment or the person's legal surrogate when there is no reasonable hope that the treatment will benefit the person receiving care or the burdens outweigh the benefits,[990] a "decision to forgo life-sustaining treatment must not mean abandonment of the person receiving care. Palliative care … should always be provided and, the dignity of the person always respected."[991] Treatment decisions can never include

[986] See CURRIE, "Reaction", 637.

[987] CHAC, *Health Ethics Guide*, 55.

[988] Ibid.

[989] Ibid., no. 77, 62.

[990] Ibid., no. 78, 62.

[991] Ibid.

actions or omissions that intentionally cause the death of another (euthanasia), or the death of one's self(suicide), as both actions are morally wrong.[992]

With the change in Canada's legislation, the question that will be of particular significance to Catholic health care leaders is whether Catholic organizations will be permitted to "choose in accord with conscience."[993] Of critical importance is the Church's teaching that "faced with a moral choice, conscience can make either a right judgment in accordance with reason and the divine law or, on the contrary, an erroneous judgement that departs from them."[994] Recent Ontario Legislation notes, "A directive shall not unjustifiably as determined under Section 1 of the *Canadian Charter of Rights and Freedoms* require the board of a hospital that is associated with a religious organization to provide a service that is contrary to the religion related to the organization."[995]

Responses from Canadian Church hierarchy responding to this new reality in which the Church is called to continue its mission have varied. Archbishop M. Currie reinforced

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[992] See CHAC, *Health Ethics Guide*, nos. 87-89, 66.

[993] See *CCC*, nos. 1786-1789; See also K. WHITE, "Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights," in *Standford Law Review*, 51 (1999), 1703-1749; J. LANDRY, T. FOREMAN and M. KEKEWICH, "Ethical considerations in the regulation of euthanasia and physician-assisted death in Canada," in *Health* Policy, 119 (2015), 1490-1498; E. PAYNE, "Catholic care groups rebel; Refuse to offer doctor-assisted suicide," in *National Post*, 1 March 2016, A4.

[994] *CCC*, no. 1786.

[995] LEGISLATIVE ASSEMBLY OF ONTARIO, Bill 41, Patients First Act, 2016, http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=4215, no. 8.1.2, 45 (16 March 2017).

the Church's support for appropriate palliative care at end of life.[996] He noted the key question which Canadians must grapple with is, "Are we for life or for death?"[997] The teaching role of the Church's bishops (c. 386) is to engage our current culture and "help them to see that choosing death is never a solution."[998] Cardinal T. Collins reaffirmed the Church's position that "patients are fully justified in refusing burdensome and disproportionate treatment that serves only to prolong the inevitable dying process, but dying is not the same as being killed."[999] The Bishops of Alberta and the Northwest Territories issued guidelines for clergy dealing with Catholics who are considering euthanasia or assisted suicide.[1000] While the guidelines could be seen by some as prescriptive and clergy would be required to refuse funerals in assisted suicide cases,[1001] when carefully examined, the guidelines also offered room for pastoral discretion.[1002] The bishops of the Canadian Atlantic provinces offered a joint pastoral reflection in which they noted the new legislation "challenges us as a church and as individuals to grow in our understanding of the Church's moral teaching on this issue, and to discern how best to

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[996] See CURRIE, "Reaction," 636.

[997] Ibid., 637.

[998] Ibid.

[999] T. COLLINS, "Statement on Euthanasia and Physician-Assisted Suicide in Canada," in *Origins*, 45 (2015-2016), 709-710.

[1000] See BISHOPS OF ALBERTA AND THE NORTHWEST TERRITORIES, "Guidelines for Celebration of Sacraments for People Who Consider or Opt for Assisted Suicide," in *Origins*, 46 (2016-2017), 289-299 (BISHOPS OF ALBERTA AND NWT).

[1001] THE CANADIAN PRESS, "Alberta and NWT Catholic bishops issue guidelines that refuse funerals in assisted death cases," in *The Calgary Sun*, 29 September 2016, http://www.calgarysun.com/2016/09/29/alberta-and-nwt-catholic-bishops-issue-guidelines-that-refuse-funerals-in-assisted-death-cases (10 March 2017).

[1002] See BISHOPS OF ALBERTA AND NWT, 297.

accompany those who find themselves struggling with illness, pain, and difficult medical circumstances"[1003] The reflective stance of the Atlantic bishops could offer sound guidance for Catholic health care sponsors, leaders, and staff. They note that each person's situation before God is a mystery which no one can fully know. Our call is to offer our compassionate presence, and not to make judgements on an individual's "responsibility and culpability."[1004]

Rather than lament the current scenario in which politically-dictated health care priorities are transferred from government regulatory bodies to health care providers, and in which public demand for a full range of health services to be offered within all publicly funded health care institutions echoes throughout our country, it may behoove Catholic health care sponsors and leaders to reflect again on the opening words of the Church's Pastoral Constitution on the Church in the Modern World, *Gaudium et spes*.

> The joys and hopes and the sorrows and anxieties of people today, especially of those who are poor and afflicted, are also the joys and hopes, sorrows and anxieties of the disciples of Christ, and there is nothing truly human which does not also affect them. Their community is composed of people united in Christ who are directed by the holy Spirit in their pilgrimage towards the Father's kingdom and who have received the message of salvation to be communicated to everyone. For this reason it feels itself closely linked to the human race and its history.[1005]

[1003] See BISHOPS OF CANADIAN ATLANTIC PROVINCES, "Pastoral Reflection on Medical Assistance in Dying," in *Origins*, 46 (2016-2017), 482.

[1004] *EG*, 448.

[1005] *GS*, no. 1, 1069.

For the Christian faithful who have been incorporated in Christ through baptism and constituted as the people of God (c. 204), sponsorship and leadership of Catholic health care is a vocation which continues Christ's work in the world.[1006] Continuing our mission in a manner that truly seeks to be in relationship may be our greatest challenge. The question of how to continue our mission, rooted in the legacy of the Hebrew tradition and the teachings of the prophets regarding the protection of orphans, widows, and strangers, will require serious dialogue and reflection, abandonment of individual agendas and organizational egos, and a recommitment to the mission of Jesus versus the mission of a particular individual or group. We would suggest that this renewed commitment to the mission of Catholic health care may offer an opportunity to consider alternate organizational models which could help to solidify our mission in Ontario's secular environment as well as solidify the voice of Catholic health care in Ontario.

In these final pages of this chapter, we will review the work to date that has been accomplished for realizing a single voice for Catholic health care in Ontario. In addition, we will offer suggestions for models of partnership and governance which will assure the continuation of Jesus' healing ministry in our world. This will include he option of creating service integration models with other-than-Catholic health care providers. It is our contention that such models, rather than weakening our presence in Ontario's health care

[1006] See C. CHAPUT, "The Future of the Catholic Health Care Vocation," in *Origins,* 39 (2009-2010), 655.

environment, will assist sponsors, trustees, and leaders of Catholic health care to engage in conscious reflection and choice of their destiny to care for the most vulnerable in our midst.

4.5 From Independence to Mutual Interdependence: Sponsorship Models in Support of the Mission

While it is not possible to quote canons in the *Code* which directly refer to the topic of sponsorship, it is possible to track Catholic health care's past, current, and future sponsorship evolution. It would be safe to assume that the only constant in the ministry of Catholic health care in Ontario will be Jesus' mandate to the apostles and to us to "go and do likewise."[1007]

As Francis Morrisey has suggested, Catholic health care sponsorship has continued to respond to the changing world needs, and can be divided into historical segments of past, present, and future.[1008] In the past, the apostolates of religious institutes has flowed from the Church's recognition of the charism of recognized religious institutes (c. 675, §3). After Vatican II, the demographics of religious institutes began to decline and the number of religious willing and capable of serving in these apostolates also began to decline. To meet the demands of shepherding Catholic health care ministries, religious institutes began to consolidate human and fiscal resources to continue sponsorship into the future. This

[1007] Luke 10: 37.

[1008] See F. MORRISEY, "Our Sponsors: Yesterday, Today and Tomorrow," in *Health Progress*, vol. 94, no. 4 (2013), 57-66 (= MORRISEY, "Our Sponsors").

required a significant degree of trust on the part of religious institutes transferring authority and responsibility for much loved ministries which had been founded on the selfless love of the Sisters as well as the partnerships that were forged with the communities in which they served. As more lay leaders were prepared through formation programs to assume responsibility for this ministry of the Church, the number of reserved powers,[1009] traditionally used to safeguard and control the essence of the apostolate, were refined and focused in three main areas: paper, people, and property.[1010] The evolution on Catholic health care sponsorship models continued to evolve in the form of inter-congregational health systems. Decisions were made by some religious institutes to transfer property and what had been considered as stable patrimony (buildings) in trust to be administered through new sponsorship models.

As government funding for Ontario's health care system has continued to shrink, political pressures to address administrative costs through organizational mergers and service integrations have been promoted and in some instances mandated. The essential components of any church sponsored apostolate continue to guide the ministry: the juridic person must be "ordered for a purpose which is in keeping with the mission of the Church and which transcends the purpose of the individuals, [serving] a truly useful purpose. In addition, the [church sponsored apostolate] must possess the means sufficient to ensure the

[1009] See J. HITE, S. HOLLAND, and F. MORRISEY, *A Guide to Understanding Public Juridic Persons in the Catholic Health Ministry*, St. Louis, MO, CHA, 2012, 66.

[1010] See MORRISEY, "Our Sponsors," 58.

realization of the stated purpose" (c. 114). Partnerships with other Catholic apostolates may be easier due to a shared value system. However, experience has shown that partnerships with other-than-Catholics will continue to be mandated by government funding sources. The mandate to avoid duplication through developing a seamless health care continuum through system integrations will affect all health care providers in Ontario, both Catholic and other-than-Catholic. The challenges will be in determining governance models which preserve Catholic identity and allow the Church to continue to seek out the most vulnerable in our midst.

For many years, Ontario's Catholic health system has flourished in a multi-sponsor system. While sponsors collaborated to a degree, new sponsorship models are evolving which integrated Catholic sponsors in new ways. In Toronto, which is the largest urban city in the province, three Catholic health care organizations who share the same Catholic sponsor, have begun discussions to create a "Catholic health care hub" within the Toronto Central LHIN.[1011] Similar efforts to create centres of Catholic health care excellence are currently under development in eastern Ontario. While geography may pose some problems, planning for a northern Ontario Catholic health care hub is also being considered.

[1011] See ST. MICHAEL'S HOSPITAL, PROVIDENCE HEALTHCARE, AND ST. JOSEPH'S HEALTH CENTRE, TORONTO, "Our Shared Purpose: Advancing the Health of Our Patients and Our Urban Communities." This communication to staff, physicians, and the communities, identified a care network built upon each individual organization's commitment to Catholic health care. This document is available in the private archives of Sister Bonnie MacLellan, 2025 Main St. W., North Bay, ON.

While creating efficiencies within one's own system may seem like a less daunting task, efforts to create one voice for Catholic health care in Ontario have been discussed for at least 15 years. After considering some of the challenges and external pressures inherent to Ontario's publicly funded health care system, the board of CHAO, with consultation from internal and external stakeholders, developed a new strategic plan. Over-arching values of commitment, integrity, collaboration, and accountability, will allow CHAO and its members to establish a single voice for Catholic health care in the province while maintaining the unique sponsorship identities.[1012] CHAO has stated its commitment to its members and sponsors to support a unified voice for Catholic health care in the province by developing a structured and administratively supported secretariat to carry out the function of identification, analysis and implementation of strategies to address common issues across sponsors group. Secretariat priorities will include the following:

1. To develop a common position and process to work within the federal and provincial Medical Assistance in Dying legislation;
2. To develop a common position and response to the MOHLTC proposed Patients First Legislation (Bill 2010);
3. To Develop "Principles of Integration" to support members as they develop partnerships to enhance the integration of care;
4. To develop a consensus building framework and processes for achieving "One Voice" on common issues;
5. To develop key performance indicators to assist organizations in the measurement of Catholic health care and its achievement of Mission.[1013]

[1012] See BOARD OF GOVERNORS, CHAO, Catholic Health Association of Ontario – Strategic Plan (1 September 2016 – 31 August 2021), Slide 4 (= CHAO, Strategic Plan 2016).

[1013] CHAO, Strategic Plan 2016, Slide 12.

In his book, *The Name of God is* Mercy,[1014] Pope Francis offered some personal reflections on Vatican II. "Walls, which for too long made the Church a kind of fortress, were torn down, and the time had come to proclaim the Gospel in a new way. It was a new phase of the same evangelization that had existed from the beginning. It was a fresh undertaking for all Christians to bear witness to their faith with greater enthusiasm and conviction. The Church sensed a responsibility to be a living sign of the Father's love in the world."[1015]

In many ways, the ministry of Catholic health care in Ontario is returning to its roots in faith. Like the early founders of Catholic health care, we are being called to be witnesses of Jesus' healing presence in our world in new ways?[1016] Considering the newness that is being brought to birth, are there new governance models which might help to shepherd Catholic health care into the future? Could we examine the recent merger between California's St. Joseph Health and Providence Health and Services, creating a new entity, Providence St. Joseph Health, as an example of newness which shares the mission of Catholic health care with others?[1017] In another example of sharing the mission to bring Jesus' healing presence into the world, St. Joseph Hoag Health

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[1014] See FRANCIS, *The Name of God is Mercy*, English translation by O. Stransky, New York, Random House, 2016, Kindle ed., loc. 866 (= FRANCIS, *The Name of God*).

[1015] Ibid.

[1016] See FRANCIS, *The Name of God*, loc. 866.

[1017] See C. PERKES, "St. Joseph Health to merge with Providence," in *The Orange County Register*, 22 June 2016, http://www.ocregister.com/articles/health-720170-joseph-providence.html (16 March 2017).

alliance created an integrated health care system for Southern California, with a "goal to attend to the body, mind and spirit of each person and build communities that remain vital and healthy."[1018] In 2011, an alliance was forged between a Catholic health care provider (Providence) and an other-than-Catholic health system (Swedish) to serve western Washington. They created a "unique structure that will allow [Providence and Swedish] to work together to coordinate care for the region while respecting … individual identities and heritages. In other words, Swedish will still be Swedish. We are keeping our name and will not become a Catholic Organization. Likewise, Providence will still be Providence. They will keep their name and maintain their Catholic identity."[1019] A similar road to a unique organizational structure saw Catholic Healthcare West restructure as a part of Dignity Health in 2012.[1020] Can we look beyond "Catholic only" models of sponsorship in order to continue Jesus' healing ministry in the world?

4.6 The Mission Continues: Defining a Future Full of Hope

Catholic health care in Ontario is on the precipice of a new era. Following in the tradition of our founders, Catholic health care will continue to seek out and minister to the most vulnerable. But who are the most vulnerable in our contemporary world? At its

[1018] See The Vision for St. Joseph Hoag Health, https://www.hoag.org/about-hoag/st-joseph-hoag-health-alliance/our-alliance/ (16 March 2016).

[1019] R. HOCHMAN, Swedish and Providence Join Forces to Improve Health Care, 6 October 2011, http://www.swedish.org/blog/2011/10/swedish-and-providence-join-forces-to-improve-health-care (16 March 2017).

[1020] See J. CARLE, "Dignity Health: New Name, Same Mission," in *Health Progress*, vol. 94, no. 4 (2013), 34.

foundation, the ministry of Catholic health care in the province met a definite need – there were few other groups who would consider caring for large numbers of immigrants who came to the new world seeking property and freedom, but who instead found poverty, hunger, disease, and often, early death. Hospitals founded by religious institutes often could do little more than accompany with compassion and love, the sick who came to them. Resources were scarce. Medications to treat diseases, or at a minimum address the pain of these conditions, were minimal or non-existent.

The parable of the Good Samaritan[1021] is often quoted as the foundational story of Catholic health care. However, the parable of the healing of the lepers also reflects the continued call of Catholic health care's ministry in the world today. When the lepers came to Jesus and begged to be healed,[1022] Jesus did not remain indifferent to their pleas. He felt compassion for them, and "let himself be involved and wounded by [their] pain, by illness, [and] by the poverty he encounters. He does not back away."[1023] In order to avoid contamination and to protect the healthy, the Mosaic law required lepers to be excluded from the city and encampments.[1024] When Jesus meets the lepers, and when the founders of Catholic health care were invited to care for the sick and suffering in Ontario, they "moved according to a different kind of logic, the logic of a God who is love, a God who desires

[1021] See Luke 10:25-37.

[1022] See Mark 1:40-45.

[1023] FRANCIS, *The Name of God,* loc. 572.

[1024] See Leviticus 13:45-46.

the salvation of all men. Jesus [and the founders of Catholic health care in Ontario] touched the lepers and brought [them] back into the community."[1025]

The roots of this parable of the lepers offers contemporary Catholic health care leaders a lens from which to see a "future full of hope,"[1026] for our ministry. Who are the "lepers" in our society today? We would suggest those who have been forgotten and neglected in our western society are the elderly, those who suffer from mental health issues, and those suffering from alcohol and chemical dependencies. Since the advent of Ontario's publicly funded health care system, long term care has been viewed as the poor-cousin of acute care.[1027] On the health/illness continuum, research indicates that people with comorbid mental and physical illness experience worse health, inadequate care, and increased mortality relative to those without mental illness.[1028] When decisions are made regarding distribution of scarce health care dollars, fewer resources are allocated for treatment of addictive behaviours than for medical treatments secondary to complications

[1025] FRANCIS, *The Name of God,* loc. 572.

[1026] See Jeremiah 29:11.

[1027] See ONTARIO HEALTH COALITION, *Violence, Insufficient Care and Downloading of Heavy Care Patients: An Evaluation of Increasing Need and Inadequate Standards in Ontario's Nursing Homes,* Toronto, Ontario Health Coalition, 2008, Digital edition, http://books2.scholarsportal.info.proxy.bib.uottawa.ca/viewdoc.html?id=/ebooks/ebooks0/gibson_cppc/2010-08-06/1/10264677#tabview=tab1 (10 March 2017); See also C. PERKEL, "Seniors in long-term care get extra 11cents worth of food daily; Latest provincial hike, to $5.57 a day, falls short of what's needed, advocates for elderly say," in *Toronto Star*, 9 July 2007, A2.

[1028] See R. MATHESON, K. SMITH, G. FAZLI, R. MOINEDDIN, J. DUNN, and R. GLAZIER, "Physical health and gender as risk factors for usage of services for mental illness," in *Journal of Epidemiology and Community Health*, 68 (2014), 971-978.

associated with these diseases.[1029] Might we be called to come together to refocus our individual and collective Catholic health care mission to focus on those who are most forgotten in our midst and who have no one who is anxious, either to care for or advocate on their behalf? In a presentation to the Catholic Health Sponsors of Ontario and the trustees and administrations of their 22 sponsored member institutions, Ontario's Deputy Minister of Health, Dr. Robert Bell, challenged those present to "get beyond its traditional institutional-based health care and think about how you can serve the most complex, the most vulnerable in the community."[1030] We would suggest that this is the new frontier of Catholic health care. As noted in the scriptures, "the poor you will always have with you."[1031] May Ontario's Catholic health care sponsors and providers have the courage and faith to continue to seek out the vulnerable, the poor, and the lost. May they be open to new ways of being the healing presence of God in our contemporary world.

[1029] See M. LEONG, "A Price tag on life? Rehab for drug and alcohol addiction can be financially damaging," in *Financial Post*, 13 May 2014, http://business.financialpost.com/personal-finance/a-price-tag-on-life-rehab-for-drug-and-alcohol-addiction-can-be-financially-damaging (10 March 2017); See also J. LAUCIUS, "Breaking Bad is the reality: Canada's opioid crisis is worsening, conference hears," in *Ottawa Sun*, 18 November 2016, http://www.ottawasun.com/2016/11/18/breaking-bad-is-the-reality-canadas-opioid-crisis-is-worsening-conference-hears (10 March 2017); K. HOWLETT, J. GIOVANNETTI, N. VANDERKLIPPE and L. PERREAUX, "A Killer High: How Canada got addicted to fentanyl," in *The Globe and Mail*, 5 January 2017, http://www.theglobeandmail.com/news/investigations/a-killer-high-how-canada-got-addicted-tofentanyl/article29570025/ (10 March 2017).

[1030] See J. RUETZ, "Catholic Health Care," Slide 15.

[1031] Matt. 26:11; Mark 14:7; John 12:8.

4.7 Closing Reflections

In Sister Helen Amos' 2013 address to the assembly of the Catholic Health Association,[1032] she notes: "We must focus on maintaining [Catholic health care] by making necessary adjustments to suit the new and evolving health care scene, … ."[1033] Catholic health care in Ontario did not begin as a calculated business venture. It began with simple gestures of kindness and charity, with responding to the needs of the sick or poor with few resources, and hearts filled with compassion. At its simplest and most profound base, the heart of Catholic health care in Ontario is called to beat as one with the people it is called to serve.

> The thing the church needs most today is the ability to heal wounds and to warm the hearts of the faithful; it needs nearness, proximity. I see the church as a field hospital after battle. It is useless to ask a seriously injured person if he has high cholesterol and about the level of his blood sugars! You have to heal his wounds. Then we can talk about everything else. Heal the wounds, heal the wounds … And you have to start from the ground up.[1034]

The place of healing is the starting point of an encounter with God. This is the place where the veil which separates us from the "holy of holies"[1035] is torn in two.[1036] In the wounds of our brothers and sisters, we can see the face of Christ. "It remains a priority of the Church to keep herself dynamically in a state of 'moving outwards,' to bear witness at

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[1032] See H. AMOS, "Living the Health Care Mission in a Changing World," in *Origins*, 43 (2013-2014), 270-276.

[1033] Ibid., 275.

[1034] A. SPADARO, *A Big Heart Open to God: A Conversation with Pope Francis*, Washington, America Press, 2013, Kindle ed., loc. 261.

[1035] Heb. 9:3.

[1036] See Matt. 27:51.

a concrete level to divine mercy, making herself a 'field hospital' for marginalised people who live in every existential, socio-economic, health-care, environmental and geographical fringe of the world."[1037]

Our mission will continue to be to seek out the lost, the broken-hearted, those suffering in body, mind, or spirit. May we continue to believe that the call of the Spirit, the call of the gospel, and the call of the Church will continue to motivate, inspire, and encourage Catholic health care sponsors in Ontario, as we continue Jesus's legacy of healing in today's world.

[1037] FRANCIS, "Message to Health Care Workers," 12 November 2016, http://en.radiovaticana.va/news/2016/11/12/pope_francis_message_to_health_care_workers/1271754 (16 March 2017).

GENERAL CONCLUSIONS

This study has attempted to show how, since the Second Vatican Council, the Province of Ontario, Canada, has seen a shift in sponsorship of Church apostolates from religious institutes to new sponsor boards composed primarily of lay persons. Its intention was to determine whether these various new Catholic health care sponsors could ensure both the preservation of Catholic identity and the delivery of quality health care within a predominantly secular and political environment and, if so, under what conditions.

The first question addressed was whether Catholic identity could be articulated, measured, and supported by Catholic health care sponsors in Ontario. It was noted that a lack of Catholic identity markers could be problematic for many lay sponsor boards who had not been sufficiently prepared, and, in some instances, catechized to fulfill their responsibilities as sponsors of Catholic health care in a changing world context.

The support of canon law, especially in the establishment of norms specific to public juridic persons, including defined obligations and accountability processes,[1038] offers assistance to lay sponsors in fulfilling their canonical sponsorship responsibilities.

[1038] See J. HITE, S. HOLLAND, and F. MORRISEY, *A Guide to Understanding Public Juridic Persons in the Catholic Health Ministry*, Washington, CHA, 2012, 66-69.

Ontario's Catholic health care sponsors are called upon to identify clearly the reason for the existence of the various systems (to continue the healing mission of Jesus in the name of the Catholic Church). This becomes all the more critical, and requires specific and ongoing attention on their part, as well on that of senior Catholic health care executives. Ensuring clinical excellence becomes only one of the performance criteria for Catholic health care sponsors. Indeed, limiting the Catholic health care mission to research and clinical excellence, falls short of the Church's key mission. Pope Benedict XVI reminds us in his encyclical *Deus caritas est* that the Church is a "manifestation of Trinitarian love,"[1039] and that reflected love is, therefore, manifested in the service that the Church carries out.[1040] Catholic health care sponsors are invited to embrace an identity that goes beyond the limits of prohibited activities (abortion, euthanasia)[1041] and to focus on key characteristics of their ministry which must, by definition, include the concepts of dignity, respect, and ethical reflection; [1042] a commitment to respect life in all of its moments, from conception to natural

[1039] See BENEDICT XVI, *Deus caritas est*, 554.

[1040] See ibid., no. 19, 548.

[1041] See P. SIMONS, "If Covenant Health Won't Obey Law, It Shouldn't Get Public Funds to Run Public Hospitals," in *The Edmonton Journal*, 13 February 2016, http://edmontonjournal.com/opinion/columnists/paula-simons-if-covenant-health-wont-obey-law-it-shouldnt-get-public-funds-to-run-public-hospitals (25 August 2016).

[1042] See CHAC, *Health Ethics Guide*, 1-5.

death; [1043] and a commitment to justice[1044] and collaboration.[1045] Pope Francis' annual messages for the *World Day of the Sick*, especially his 2014 message, bring out the significance of this ministry, imitating the Good Samaritan, and offering our services to those in need.[1046]

The evolution of Catholic health care in Ontario was examined within the historical context of the Canadian health care system. The transitions, from an expression of Christian charity, to an expression of shared societal values, and later, to a federally legislated requirement for all citizens, were presented. Canada's health care system was initiated and founded by religious institutes. In Ontario, the role of three original sponsors of Catholic health care were reviewed: the Religious Hospitallers of St. Joseph, Les Sœurs de la Charité de Montréal, and the Sisters of St. Joseph. As the world evolved, as did the Church in the world after the Second Vatican Council, so too did sponsorship of Catholic health care in Ontario. The evolution of sponsorship models, their inherent challenges and opportunities

[1043] See CANADIAN CONFERENCE OF CATHOLIC BISHOPS, "CCCB Pastoral Letter on Catholic Health Ministry and the Catholic Church in Canada," 10 February 2005, http://www.cccb.ca/site/eng/media-room/official-texts/pastoral-letters/1626-cccb-pastoral-letter-on-catholic-health-ministry-and-the-catholic-Church-in-canada (25 August 2016).

[1044] See CHAC, *Health Ethics Guide*, 7-9, 30-42.

[1045] See ibid., 97-98.

[1046] See FRANCIS, Message for the 22nd World Day of the Sick *Occasione XXII diei mundialis aegrotis dicati*, 6 December 2013, in *AAS* 106 (2014), 19-21, English translation, Rome, http://w2.vatican.va/content/francesco/en/messages/sick/documents/papa-francesco_20131206_giornata-malato.html (8 April 2017).

given the changing social context, and recommendations for sponsorship models into the future, were provided. The question of how communities of faith might engage in the world, the state, and civil society[1047] was addressed. It was noted that the pivotal parable of the Good Samaritan, who "captures our conscience because of his compassion and generosity, a compassion that transcends boundaries of faith and ethnicity, and a generosity which reflects the lavish goodness of God,"[1048] offers a template for ministry and Catholic identity in our changing world. The historical contribution of religious institutes was noted, not as the final, nor only, organizational structure for Catholic health care, but simply as one of the starting points which offers a model of continuing the healing mission of Jesus.

In this perspective of responding to new circumstances, the study shows how the evolution of sponsorship responsibilities has influenced the way in which canonical structures have been adapted. The establishment, for instance, of *Catholic Health Sponsors of Ontario*, as a public juridic person of pontifical right is an example of such evolution. Nevertheless, given current pressures and trends, it is almost inevitable that changes will be put in place in the years to come. The Church, its canonical legislation, and the structures it offers, can be defined as a "work in progress". It is good to keep in mind that, while the sponsorship structure is important – even essential for the mission – this does not

[1047] See CHAC, *Health Ethics Guide*, no. 76, 62

[1048] See ibid., no. 75, 62.

mean that the present structures will continue indefinitely; possible adaptations could be envisaged down the road.

Parallel to the canonical structures, in the Church's effort to support lay sponsors of Catholic health care, guidance and support mechanisms have been created, and include provisions ongoing formation of Catholic health care sponsors in the areas of the Church's doctrine and traditions, reflective decision-making based on the Church's social, moral and ethical teachings, and criteria for eventual partnerships. Significant attention was given to the content of these formation programs. At the present time, there are a number of them being offered in Ontario and elsewhere in Canada. Perhaps someday these programs will be unified.

To support this ministry will require a significant investment by Church leaders, sponsors, trustees and senior Catholic health care leaders, in the process of ongoing formation and the development of communication strategies to educate new staff and the public we serve, about the value-added of Catholic health care inserted into a secular world and funded by public tax dollars. Sponsor collaboration and preferably consolidation into a One-Sponsor model, was noted as one model which might help to dispel confusion created by multiple sponsors with multiple venues of care delivery.

Given the current structure of the Ontario health care system which is coordinated by 14 regional Local Health Integration Networks whose objective is to integrate health services to meet different health needs throughout the province,[1049] developing a single voice for Catholic health care was noted to have its own challenges. However, sponsor-failure to develop a mechanism or organizational structure to speak with one voice, could lead to a weakening of the distinctive "brand" of Catholic health care[1050] that shares a Gospel foundation and a common story of founding by dedicated members of religious institutes. Catholic health care exists for one purpose only: to continue the healing mission of Jesus in the name of the Catholic Church.

Finally, this study examined external pressures which could be anticipated as the Church continues the healing mission of Jesus in a changing secular and pluralistic world. Issues of government transfer payments for Catholic health care and associated political and legal pressures to offer all government-approved health care services, including those which are contrary to Catholic doctrine (abortion and euthanasia) were noted. A shared sponsorship voice for Catholic health care values was identified as critical to the continuation of Catholic health care in Ontario. As public health care dollars are reduced, the need for collaboration and consolidation among those organizations with shared values

[1049] See GOVERNMENT OF ONTARIO, Ontario's LHINs, http://www.lhins.on.ca/ (29 January 2017).

[1050] See ST. JOSEPH'S HEALTH CARE LONDON, Branding and Identity Guidelines, 18 November 2016, https://www.sjhc.london.on.ca/sites/default/files/pdf/branding.pdf (29 January 2017).

and a shared mission to continue the healing mission of Jesus, creating a unified voice and sponsorship model for Catholic health care in Ontario, will be an ever more important consideration into the future.

Future research examining the impact of shared sponsorship models with other Catholic sponsored health care systems, as well as the impact of mergers and consolidations of Catholic and other-than-Catholic health care organizations on Catholic health care's capacity to maintain a unique Catholic identity, will offer important research opportunities for the future. The question of whether such mergers or consolidations have enhanced or limited Catholic health care's capacity to seek out the poor and vulnerable in our midst, to respond like the Good Samaritan, will help both the Church and sponsors continue to respond to the needs of our time in creative ways, fulfilling our mission of the Church "in the world,"[1051] now and into the future.

[1051] See *GS*, no. 4, 1070.

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Curriculum Vitae

Sister Bonnie MacLellan entered The Sisters of St. Joseph of Sault Ste. Marie in 1972. During her novitiate, she served in various areas of nursing and hospital administration in hospitals owned and operated by her congregation throughout northern Ontario. In 1985, she completed a Master of Public Health with a specialty in hospital administration from the University of Minnesota. In 1996, she completed a Masters Degree in Human and Organizational Development from the Fielding Institute in Santa Barbara, CA, and in 1998, successfully defended her doctoral thesis in Human and Organizational Systems.

After completing four years as a General Councillor on the leadership team of her congregation from 1998-2002, she was elected General Superior, a position in which she served from 2002-2010. In 2011, she began her study of Canon Law at Saint Paul University, and completed her JCL in 2013. She was re-elected to the position of General Superior in 2014, and in which she completed her JCD.