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100th Anniversary - Sponsors are Called to be Prophets and Reformers

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Almost a quarter of a century ago, *Health Progress* published several articles on questions of Catholic identity and Cath-olic institutions by respected leaders in the ministry. Fr. J. Bryan Hehir wrote the first one in which he raised questions about institutional identity and described its three historical stages of institutional identity. Lawrence Singer and Sr. Helen Amos, RSM, echoed some of his concerns and raised questions of their own. We have learned a great deal since 1995, but we are still struggling with many of the questions Fr. Hehir, Singer and Sr. Amos raised. As *Health Progress* marks its 100th volume as a publication, I would like to recall some of their observations and suggest that we are now moving into a fourth stage of thinking about institutional identity and sponsorship.

Fr. Hehir acknowledged a concern at the time that Catholic health care had lost its identity. He said he did not believe that it had, but he did say that our identity would have to be refashioned in a new context of "the rational demands, the secular settings, the pluralistic context and the scientific requirements of the world of health care."[1] That much, at least, has not changed. Today, we face all of the challenges Fr. Hehir cited and then some.

In terms that are now familiar to many of us, he described three stages of development of our ministry: the immigrant stage, which began in the Ellis Island days, lasted until at least 1960. It was a time when great numbers of immigrants, most of them devoutly religious (not just Catholics, but Methodists, Lutherans, Orthodox Christians and Jews) came to the United States from Western Europe, Ireland, Russia, Central and Eastern Europe and elsewhere. Most of our Catholic institutions — schools, hospitals and social service agencies — were founded during that time to educate and care for Catholic immigrants. These institutions not only provided care but a supportive community during the difficult transition from immigrant to established citizen.

A second stage began in 1965 at the end of the Second Vatican Council, when the church was maturing into respectability and acceptance in a land that had initially been suspicious, sometimes even hostile, to Catholics as immigrants. The church in the U.S. began to understand itself as part of a pluralistic world and to wrestle with the challenges of health care financing (especially the vast sums of money injected into health care by Medicare and Medicaid) and increasing government oversight and regulation. Catholic health care became professionalized as the founding members acquired advanced credentials in clinical areas and health administration. It was no longer just charitable work and a safe harbor for struggling immigrants but part of a vast network of health care services — Catholic, other-than-Catholic and public. As Fr. Hehir said in his article, "The result of the Council's vision — in the world, for the person, in dialogue with the world — is a church that is more open to the secular, is universal in its conception of service and defines itself as a servant."[2]

The impact of Vatican II was evident in so many ways. Catholic laity were given some responsibility for governance in the church through parish councils, and some were

admitted to certain limited liturgical roles or held advisory roles to bishops. The permanent diaconate was inaugurated. In health care and education, religious sisters were still a strong presence, but they were joined by growing numbers of new lay executives. These were small steps, but they pointed to much bigger changes to come.

In 1995, Fr. Hehir saw yet another stage of development marked by rapidly evolving technology, increasingly complicated funding and the failure of the sixth attempt at national health care reform in 1992. In an "Exhortation to Sponsors," written about the same time as Fr. Hehir's article, health care attorney Singer identified the time as a critical period. "Catholic healthcare is at a crossroads," he wrote in the September-October 1997 issue of *Health Progress*. "At a time when its mission – providing high-quality, spiritually based care, particularly to the poor, is needed more than ever, it finds itself threatened. Managed care, together with the refusal of sophisticated purchasers to pay for inefficiency, has radically altered the health care landscape. Sharp competition is forcing venerable Catholic organizations with 'blue-blood' pedigrees to reexamine their place in the market, and some are deciding to substantially alter their institutional presence, if not to leave the market altogether."[3]

These events raised new questions about the role of the state in delivering and funding health care as well as the growing influence of the market as systems jockeyed for prominence and sometimes survival in an increasingly competitive world (sadly, some Catholic hospitals even competed with one another). As the presence of religious women began to diminish, individual hospitals became part of systems and systems began to collaborate (the era of "co-sponsorship") and then to merge (the era of ministerial juridic persons).[4] The first public juridic person — Catholic Health Care Federation — was formed in 1991. Others followed steadily in the years that followed. Today there are 30 ministerial juridic persons worldwide, more than half of which are in the United States.[5]

The time after 1995 was marked by new corporate structures and new models of sponsorship, but also by an increased emphasis on diversity and inclusion. This was a worthy goal, but it led to a self-consciousness and flattening of Catholic identity.

Some feared that we could not claim our Catholic identity and at the same time be diverse and inclusive. In addition, many sisters who had at one time been active participants in institutional ministries began to opt for hands-on service to the poor, which they saw as a more powerful direct witness to the ministry of Jesus. Some Catholics began to draw an unfavorable comparison between the "institutional" church and some other kind of church, one which was presumably less bureaucratic, more authentic and more spiritual.[6] The problem with this view is that the church, warts and all, is part of our incarnational understanding of the Body of Christ. To be sure, there is a transcendent church, "the spotless Bride of Christ" beyond time and history, but we see that church imperfectly through our human institutions. To deny the reality of this incarnate church is to fall into some kind of dualism. We need to believe in the transcendent church and also its earthly, institutional expression.

Fr. Hehir understood this and emphasized the importance of the church's institutional mission. "Fashioning an identity always requires institutional strategy," he said, adding that we need to be more "aware of the value of institutional presence. Today our institutional instinct is a social asset; in this society, institutions will not do everything, but they will fundamentally shape the quality and character of life. How we keep alive that institutional presence is an ecclesial theme, a social challenge and a human necessity."[7] These were prophetic words.

Sr. Amos, at the time president and CEO of Mercy Medical Center in Baltimore, also was thinking institutionally. Although she was speaking specifically of sponsorship as an institution, Sr. Amos noted ambivalence about institutions that existed in the 1990s.[8] "We vacillate between seeing ourselves as part of the problem, and seeing ourselves as, potentially at least, as part of the solution … We worry that our resultant power may be more attuned to maintaining the institutions themselves than to serving the medically underserved."[9] She also noted the desire of many women religious to serve the needs of the poor more directly. In other words, was the power of institutional ministry a contradiction in terms? Was it possible to be a committed follower of Jesus and part of a large ministerial corporation, or would institutional power co-opt us from the start? Still, she insisted that the institution of sponsorship remained an "essential bearer of our ideals and meanings" even if it was imperfect.[10]

SACRAMENTALITY

When they affirmed the value of institutions, Sr. Amos and Fr. Hehir implicitly

acknowledged the sacramental dimension of these institutions and the importance of sacramentality to Catholic life generally. In every aspect of Catholic life — liturgy, devotions, religious life, institutional ministries — we use real, tangible things as mediating symbols of grace. On a personal level, we use bread, water, wine, and words of human commitment to signify Christ's presence; socially, we use organizations, institutions and structures to do the same thing. This sacramental character is the key to renewal of our ministries and of the church itself if they are to remain effective signs of God's presence in the world. This is true even when they fail or cause scandal, as most things human eventually do. Despite human sin, we believe that human persons — and the things they create — remain suitable vehicles for grace. Our founders may not have used this language, but this is the reason they founded these ministries in the first place. They believed that human beings and their endeavors could, to some small extent, foreshadow the reign of God. Today, in a world dominated by huge corporations, institutional ministries provide a counterweight to other organizations that are not primarily concerned with human well-being, the common good or the transcendent possibility of life. Can our ministries model a different kind of financial accountability, a different kind of leadership, a different way of doing business that impacts other businesses?

WHAT IS THE NEXT STAGE?

So where are we today? If in 1995, Fr. Hehir left us subject to the "catalyst of social forces," is our path any clearer in 2019? What is the next stage of development of Catholic health care and the other ministries of the church?

I believe that we are in a time when the promise of Vatican II is just beginning to be realized. The Council documents used previously unimaginable language to describe the church as the "people of God" and to restore Baptism to its place as the primary sacrament of vocation, giving it precedence over Holy Orders and priesthood.

The promise of those words has been realized very slowly, and not without setbacks and resistance, but there have been important advances. It gave rise to permanent deacons, who are ordained diocesan ministers not bound by celibacy (as a sign of our inadequate understanding of ordination, they are still often referred to as "lay

deacons"). Ministry expanded to include both ordained and lay ministers, the latter being employees of parishes and schools who began to do things formerly done only by priests or sisters. In some rural dioceses, they even became "lay parish coordinators," and functioned much like pastors, except that they could not celebrate the sacraments. Even though many of these lay ministers were arbitrarily employed, poorly paid and lacked the ecclesial status and recognition that priests, deacons and sisters enjoyed, they still represented an important realization of Vatican II theology.

These changes were a start, but the biggest change in our understanding of lay leadership from Vatican II is occurring now, in the shift from religious sponsorship to new juridic persons that are largely lay. Singer and Sr. Amos both understood the import of this development. Though largely unnoticed, it is the new ministerial juridic persons, consisting largely of lay persons that are the most definitive and important realization of the new role of the laity. The new generation of lay sponsors are not just deacons, religious educators or even parish directors. They are groups that are authorized by the Holy See to "sponsor" or guide the mission and identity of a ministry.

Sponsors, the members of sponsoring bodies like Catholic Health Care Federation (now sponsors of Catholic Health Initiatives and Dignity Health, known together as CommonSpirit Health), Ascension Sponsor, Bon Secours Mercy Ministries, and more than a dozen others, are mostly public juridic persons of *pontifical right*. This means that canonically they have a certain equivalence to a diocese or a religious order. They have official ecclesial status and have real authority over a ministry of the church. Their authority, like that of a sponsoring religious community, is under the vigilance of the bishops in whose dioceses their ministries operate, but it transcends any one diocese. This is a truly remarkable development. In fact, as far as I can tell, it is unprecedented in the history of the church.

Few Catholics are aware of the existence or theological significance of these new canonical entities; many bishops know little about them and do not fully understand their significance. Even sponsors themselves are wrestling with their identity, their role and emerging responsibility.

In his "Exhortation to Sponsors," Singer mentioned the various pressures that sponsors were subject to in 1995. "Sponsorship is in flux," he said. Investor-owned

health care, takeover offers, partnerships with physicians, confusion (or conflict) with boards are just a few of the pressures they faced. Still, he says, "These pressures are not entirely negative. Sponsors can in fact use the pressures as an impetus to provide strong, innovative leadership for Catholic health care. Now is the time for sponsors to exercise such leadership."[11] Partly because they are above the fray of day-to-day management and governance," he said, "they have an obligation to develop innovative solutions," beginning with the way in which church authority is exercised. This flows from the prophetic nature of sponsorship. Although the prophetic charism is present throughout the church — even in traditional church structures — the foundation of new religious orders was understood as a prophetic impulse. I believe the same is true of new sponsors. We did not expect, or even imagine, the sudden decline in the numbers of women religious, yet their willingness to explore new options for the ministries they sponsored opened the door for these new juridic persons. Born of the Sisters of Mercy, the Daughters of Charity, the Franciscan Sisters, the Sisters of Bon Secours and many others, these new entities in the church have been nurtured by the prophetic charisms of those communities. Those charisms are being superseded by new charisms, the nature of which we are only beginning to understand. The new gifts will certainly reflect the historic charism of the founding communities, but they will gradually take on a life of their own in a new world with new demands.[12]

It is important to describe what the prophetic charism is and is not, because in my opinion the word is overused when applied to any new or unconventional thought someone might have. True prophecy is essential to the pilgrim church which is always on a journey and passes through many different times and cultures. Given the various pressures cited by Fr. Hehir, Sr. Amos and others, we must count on a prophetic charism to help us make necessary adaptations. "Prophecy as a permanent charism in the church has many aspects," says Cardinal Yves Congar, one of the principal theologians behind the documents of Vatican II.[13] The prophetic charism exists both in the hierarchy and in the church at large, but there must be a "complementarity between a principle of continuity or form coming from the hierarchy, on the one hand, a principle of movement or unexpectedness, coming from those inspired to act on the frontiers," on the other. Most of the time, he notes, "initiatives do not come from the center, but from the periphery, from below rather than from above."[14]

The evolution of sponsorship is an expression of the church's prophetic charism. The new models came not from the Vatican or the bishops, but from the periphery in the

form of an initiative of health care systems that were seeking a way to preserve the ministries that had been founded and led by religious women for generations. They conceived this new canonical structure and submitted it to the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life for approval, exactly in the way the founding orders had been conceived and approved. Both were an example of Congar's theory of innovations coming from below and seeking approval from above. Furthermore, Congar says, even if such changes come from the periphery, "they can only lead to a reform *of the church* and reform *in the church*, rather than a break, if they are taken up and incorporated by the church into its unity."[15]

Congar also notes that there are two ways in which these innovations come about through the power of the Spirit. One is what he calls the *via juris* (way of the law). These kinds of innovations come about through changes in the law (for example, the creation of the permanent diaconate). The other way is the *via facti* (by way of fact, or de facto, as we might say). These innovations arise from practice, so that action of the Spirit is discovered inductively. In the case of public juridic persons, there is a little bit of both involved. The idea for the ministerial juridic person arose from need, but it was endorsed by canon law as the public juridic persons were established. The law, Congar says, "often lags behind circumstances and changes in the law occur as a result of catching up with what is already going on." It is a beautiful example of the Spirit working on two different levels to effect change, or reform, in the church.[16]

Today's sponsors are called to exercise that charism with confidence and boldness in the rebuilding of these essential ministries in a new time. Sponsors today are rooted in the venerable charisms of their founders, but they are also claiming new charisms. They have the chance not only to innovate, but to disrupt business as usual and establish some new approaches to faith-based health care. Concretely, this involves at least three things.

First, sponsors must recover the sacramental character of our institutional ministries. While collaboration, partnerships and joint ventures are clearly the order of the day, we must enter into them carefully, making sure that we preserve our own faith commitments and our commits to human dignity, justice and the common good.

Second, sponsors must find ways to integrate Catholic health care with our other institutional ministries so that together we have greater impact. Fr. Hehir noted that

Catholic health care is the largest nonprofit health care system in the United States, Catholic Charities is the largest social service agency, and Catholic schools constitute the largest private educational system in the country. This is still true today. "Size never proved anything," he says, "but there is something to presence. If one seeks to influence, shape, direct, heal, elevate and enrich a complex industrial democracy, it cannot be done simply by the integrity of individual witness. It is done by institutions ..."[17] This is a powerful call to increase our influence not as a kind of ecclesial imperialism but as a way of protecting human dignity and revealing the grace of God in social and political life. Our voice and our values, especially Catholic social teaching, have a place in the public debate.

There is a downside to institutional life. Sociologists have noted the influence of "accumulated expectations of other actors in an organizational field" that make it difficult for a single organization to deviate in a significant way.[18] These expectations can be a good thing, such as when they lead to evidence-based standards of care and higher quality, but they also can lead to "institutional isomorphism" where every health care institution begins to resemble every other one. We must be careful so that we don't sacrifice our identity and purposes in imitation of "the best" hospitals that may eschew faith and spirituality in favor of scientific rigor, or as a way of emphasizing diversity and inclusion. This has been the undoing of many faith-based colleges and universities that abandoned religious affiliation in favor of academic freedom.[19] For us as Catholics, these are not competing values. We value faith and scientific rigor, we can also have a clear identity and be inclusive and diverse. This is the Catholic genius. It is not "either/or" but "both/and."

We also must take care that we do not compromise our identity in order to avoid negative pressure from advocacy groups that criticize us because we do not provide certain reproductive procedures, physician- assisted suicide, or euthanasia.[20] A *New York Times* article in 2018 suggested that we were hiding our Catholic identity to get more people through our doors. The article said, "Over the past decade or so, a number of Catholic hospitals have changed their names to something less obviously Catholic. In 2012, for example, Catholic Healthcare West became Dignity Health." And

"At the end of the day, it appears that Catholic systems want to diminish their Catholic identity to be more marketable," one person interviewed for the article said. [21]

The issue was raised again in March of 2019, when the *Journal of the American Medical Association* published a study of Catholic hospital websites. It reported that less than a quarter of Catholic hospitals directly described themselves as "Catholic," and that many failed to use words such as saint, holy, or Jesus or to mention or provide a link to the *Ethical and Religious Directives for Catholic Health Care Services*.[22] We must reclaim with pride a heritage rooted in quality, compassionate and inclusive care that is inherently spiritual. We want to be the best, but we also want to be different. We need to ask ourselves whether we should be more explicit about our Catholic identity. It is possible that some patients may be put off by more explicit identifiers, but the values we hold are human values and we have no reason to be ashamed of them. We should also remember that investor-owned systems that have purchased Catholic hospitals usually want to keep the Catholic name because they see it as a market advantage. There may be things that we do not do, but we cannot allow ourselves to be defined by such things.

Third, sponsors must take an active role in working with and for the bishops, some of whom may see Catholic health care as irrelevant, or worse. This means always working to reveal that Catholic health care is not just a business but a ministry, rooted in and serving the local church. It also means educating bishops about the complex clinical situations encountered in health care and the challenges in applying the concise language of the ERDs to these complex questions. Even though our primary purpose is health care, we should certainly take every opportunity to collaborate with and enrich the local church in which we find ourselves. This means finding new ways to connect with local dioceses and parishes.

Finally, there is perhaps nothing more important than to recognize the emergence of new charisms and gifts in the church, and to carefully form them for the church. Sponsors must establish profiles and identify potential sponsors and then initiate, sustain and assess formation programs at all levels of the ministry. Using the language of sociologist Max Weber, Sr. Patricia Wittberg, SC, describes in her book the age of "religious virtuosos" (religious men and women in Catholicism, deaconesses in several Protestant denominations) who devoted their lives to seeking spiritual perfection and helping others do the same. They prepared for this by years of religious formation,

distinctive garb and vowed life in community. They did the heavy lifting of identity and culture, and at least in the United States they created the Catholic Church and most of the Catholic institutional ministries as we know them today. How will we continue this momentum without them? This is the challenge for tomorrow. The future of our institutions can only be assured with solid theological and spiritual formation, and only sponsors can mandate this from their ministry's Board of Directors on down.

CONCLUSION

The emergence of public juridic persons as corporate sponsors of the ministry of health care is an ecclesial earthquake. It is radically reshaping the way we understand and govern our institutional commitments. Sponsors are not just caretakers, holding these ministries in trust until some future day when vowed religious emerge to reclaim their historical role. Lay people are now in this for the long haul, and it will require a new understanding of their baptisms, a full appreciation of their share in the priestly, prophetic and kingly role bestowed by Baptism, and a commitment to the personal formation required by this new vocation.

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NOTES

1. Fr. J. Bryan Hehir, "Identity and Institutions: Catholic Healthcare Providers Must Refashion Their Identity as Actors and Advocates in the World," *Health Progress* (November-December 1995): 17-23.
2. Hehir, "Identity and Institutions," 21.
3. Lawrence Singer, "Exhortation to Sponsors," *Health Progress* (September-October 1997): 54-56.
4. There is some confusion about terminology. The generic canonical term is "public juridic person"(PJP), but when we apply that to ministerial entities, we often refer to it as a "ministerial juridic person" (MJP) or a "ministerial public juridic person" (MPJP) to distinguish it from other kinds of PJPs, such as dioceses or religious orders.
5. The shift from religious to lay CEOs was dramatic at Catholic hospitals. In 1988, there were still 196 religious serving as hospital CEOs and 420 lay CEOs; by

1996, the number of religious had dropped to 45 hospital CEOS, with 525 lay CEOs. In 2019, there are no sister CEOs of Catholic hospitals. This was not an intentional, strategic change, yet it had an enormous effect on the nature of this ministry. A list prepared by Fr. Elias Ayuban, CMF, in May of 2018, cites 17 ministerial juridic persons in the United States, seven in Australia, four in Canada and two in Ireland. Some of these are only health care, but others include education and social services.

6. Desire for a less institutional church is not new. Theologian Yves Congar cites a German column written in 1934 by "a Roman Catholic Priest" which called for "more Christ and less church," more gospel and less church," and "more love and less church," as if all of these things were opposites. "Gedanken zur Erneuerung der Römisch-Katholischen Kirche," in *Eine Heilige Kirche* (Jan 1934) 50-57. This dichotomous view is still around. Tom Smith, a former priest and diocesan pastoral life director, wrote, "I Can't Get the Institutional Church Out of My System," (*National Catholic Reporter* blog, May 30, 2017). His point was that he likes some aspects of this institutional church, but it did not always meet his criteria for authentic religion.
7. Hehir, "Identity and Institutions," 23.
8. Confidence in institutions generally has declined steadily over more than 40 years. The annual Gallup poll of confidence in institutions reports that in 1975, 68 percent of respondents had "a great deal or quite a lot" of confidence in the church and organized religion. In 1998, it had fallen to 59 percent. It dropped steadily to 38 percent in 2018. The medical system fared even worse, going from 80 percent high confidence in 1975 to 40 percent in 1998 to 36 percent in 2018. See their annual survey at https://news.gallup.com/poll/1597/confidence-institutions.aspx.
9. Sr. Helen Amos, "A Moral Quandary for Sponsors," *Health Progress* (January-February 1996): 20-22, 42.
10. Amos, "A Moral Quandary," 22.
11. Singer, 56.
12. New understandings of sponsorship and the role of public juridic persons and ministerial juridic persons were explored in the May-June 2017 issue of *Health Progress*.
13. Yves Congar, T*rue and False Reform in the Church*, trans. Paul Philibert (Collegeville, MN: Liturgical Press/A Michael Glazier Book, 2011). Originally

written in 1950, its publication and translation were initially prohibited. Congar revised it in 1968, and this translation is based on the 1968 version.

14. Congar, *True and False Reform*, 184, 238-40. He notes that even in a church as hierarchical as ours, "not one single religious order has ever been created by the central power. All such initiatives come from the periphery."
15. Congar, *True and False Reform*, 244.
16. Congar, *True and False Reform*, 277. It is important to qualify the word "reform" here, especially in a time when we are thinking about reforms that will prevent child abuse or financial mismanagement. We might distinguish *reparative* reform, which is concerned with remedying causes of corruption or scandal, and *adaptive* reform, which is primarily what Congar was talking about. It is this second kind of reform, not the result of scandal or corruption, but because of changed circumstances that requires new theology, new structures or new ways of relating to the world.
17. Hehir, "Identity and Institution," 18.
18. Patricia Wittberg, *From Piety to Professionalism and Back: Transformations of Organized Religious Virtuosity* (Lanham, MD: Lexington/Rowman and Littlefield, 2006), 14. She cites "coercive pressures" that result from government mandates and tax laws, or requirements of accrediting agencies; "normative pressures," embodied in training courses and professional schools and standards, and "mimetic pressures," which arise in times of uncertainty when each organization tends to model itself, consciously or unconsciously, on what its competitors are doing.
19. James Tunstead Burtchaell makes this point (controversially) in his book *The Dying of the Light: The Disengagement of Colleges and Universities from Their Christian Churches* (Grand Rapids, MI: Eerdmanns, 1998). Melanie Morey and John Piderit, SJ, raise similar questions in their study of Catholic higher education, *Catholic Higher Education: A Culture in Crisis* (New York: Oxford University Press, 2006).
20. Katie Hafner, "As Catholic Hospitals Expand, So Do Limits on Some Procedures," *New York Times*, Aug. 10, 2018.
21. Hafner, "As Catholic Hospitals Expand," quoting Lori Freedman, a medical sociologist at the University of California, San Francisco.
22. Joelle Takahashi et al., "Disclosures of Religious Identity and Health Care Practices on Catholic Hospital Websites," *The Journal of American Medical Association* 321:11 (March 19, 2019): 1103-4.

QUESTIONS FOR DISCUSSION

Fr. Bouchard notes that Catholic health care has been wrestling with its institutional identity from its early days in the U.S. and continues in the ongoing evolution of sponsored ministries.

1. Describe your ministry's model of sponsorship. Has it been this way from its founding, or has it evolved through other forms? What aspects and activities of your ministry are most guided by the evolving charism of your sponsors?

2. Fr. Bouchard compares new models of sponsorship to the origins of religious congregations: they were born of a need or a hope for reform rather than being created by the hierarchy. How do you think the sponsors of your ministry are responding to change — especially in mergers and acquisitions, population health, health informatics and technological discoveries with ethical implications?

3. Catholic health care alternately has been accused of watering itself down for marketing purposes and pumping itself up to merit nonprofit tax status. Discuss Fr. Bouchard's argument that we can value both faith and scientific rigor, that we can embrace Catholic identity and be genuinely inclusive and diverse. In what ways does your ministry fulfill that both/and? In what ways does it fall into an either/or?