SPECIAL  SECTION

SPONSORSHIP AT THE CROSSROADS

Religious Institutes Must Consider the Direction in Which They Will Go

BY REV. DANIEL C. CONLIN, JCD

Finding a discussion of Catholic health care in which the word *sponsorship* is not used is nowadays almost impossible. Unfortunately, the term has evolved over the last 30 years into a catchall phrase that too often tries to catch too much. As a result, sponsorship is sometimes understood to mean something that it actually does not.

Some promoters of sponsorship in Catholic health care understand it to mean *ownership.* Others understand it to mean, not ownership, but rather an influence, whether vestigial or extensive, on the health care institution in question. A recent solid, practical definition says:

> Sponsorship is a reservation of canonical control by the juridic person that founded and/or sustains an incorporated apostolate that remains canonically a part of the church entity. This retention of control need not be such as to create civil law liability on the part of the sponsor for corporate acts or omissions but should be enough for the canonical stewards of the sponsoring organization to meet their canonical obligations of faith and administration regarding the activities of the incorporated apostolate.[1]

Canon law defines ecclesiastical goods as being those goods belonging to public juridic persons.

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Civil law is inclined to use words such as "owner," "ownership," and "shareholder." How did sponsorship become such a common part of the U.S. Catholic vocabulary concerning health care? What are the canonical implications?

Sponsorship is neither a canonical nor a civil legal term in regard to the ownership of the temporal assets of a Catholic health care facility. No category of canonical temporal goods called sponsorship exists; and in the canons on baptism and confirmation, the word "sponsor" does not transfer well by analogy to Book Five of the 1983 Code of Canon Law, which covers the temporal goods of the church. To accept sponsorship responsibility for a person entering the Catholic faith is not the same reality as to claim ownership or sponsorship of a Catholic health care facility.

History of the Term

Rev. John J. McGrath's controversial 1968 work, *Catholic Institutions in the United States: Canonical and Civil Law Status,* used the phrase "sponsoring body."[2] Fr. McGrath believed that a Catholic hospital became a public trust when the religious institute reorganized the board of trustees of the hospital from an all-religious board to a predominantly lay board. For Fr. McGrath, this reorganization changed the religious institute from canonical owner to canonical sponsor, a move akin to surrendering parental status in favor of godparent status. What came to be known as the "McGrath thesis" had wide canonical and civil legal influence in Catholic health care and educational circles.[3]

Cardinal Adam Maida, who in 1974 was legal counsel for the Diocese of Pittsburgh, used the phrase "sponsoring body" in a *Hospital Progress* article in February of that year. Without specifically mentioning the McGrath thesis, Cardinal Maida disagreed with it, arguing that even lay

trustees must recognize that "the hospital apostolate is an exercise of ministry within the Church, an exercise of religion."[4] Cardinal Maida's reaction to the McGrath thesis formed in the 1970s an interesting canonical debate, whose effects are still with us today. (The sale in 1997 of Saint Louis University Hospital to a for-profit corporation provoked a debate along the lines of the McGrath-Maida model.)

The Catholic Health Association's first official use of the term "sponsorship" occurred in a 1969 booklet called *Study of the Future Role of Health Care Facilities under Catholic Auspices in the United States.* The first appearance in *Hospital Progress* of "sponsorship" (as opposed to Cardinal Maida's phrase, "sponsoring body") appears to have been in January, 1975.[5]

Because sponsorship is neither a canonically nor civilly recognized category in regard to the ownership of public juridical or civilly corporate assets, its definition in Catholic health care has tended to be somewhat nebulous. (The phrase *ex nihilo* would seem to apply to the fluid way "sponsorship" is sometimes used in religious institutes, dioceses, and boardrooms.) Because sponsorship is not a technical legal word in the sense of having a precise meaning, it has become an umbrella word with multiple amorphous meanings.

What is noteworthy in the definition of sponsorship by Rev. Jordan Hite, TOR, JD, that I quoted earlier is the phrase "a reservation of canonical control by the juridic person." Notice that nowhere in this definition does the word "ownership" appear. As I will presently show, sponsorship does not and need not imply any canonical control at all. Without canonical control, there can be no ownership. Sponsorship, then, must mean something different than ownership.

Sponsorship Needs More Explication

Rev. Michael D. Place, STD, has pointed out that religious communities and health care professionals "have not been able to find a suitable theological explanation or description of sponsorship."[6] The absent theological explanation has been a problem. In recent years some religious institutes have turned their sponsorship responsibilities over to lay groups—unfortunately, in some cases, without first reaching a clear mutual understanding of what sponsorship means. However, Fr. Place also suggests a possible solution to this dilemma. "With this change in sponsorship," he writes, "the theological foundation will come from the theology of baptism, not the theology of religious life."[7]

Pressures from the external marketplace also complicate the sponsorship question. Frequent mergers and acquisitions often make it difficult for sponsors to solidify their Catholic identity.

I would argue that sponsoring an entity that you do not own is difficult. On the other hand, if you *do* own a health care facility, that fact need not necessarily imply the conclusion that you also sponsor the ministry conducted within your facility. Put differently, sponsorship is certainly not the same as ownership, and ownership need not imply sponsorship.

One can always own a health care facility and yet have no sponsorship role within it. By the same token, sponsorship need not imply ownership. A facility sponsored by one religious institute may be owned by another, or by a group of institutes, or by the diocese, or by a health care system. Any of these possible owners might have agreed to entrust the ministry of the facility to the sponsorship of the religious institute. An owner owns and a sponsor sponsors. In these examples, the owner and sponsor are distinct entities.

Today some religious institutes prefer to sponsor a health care apostolate without owning it. Owning such an organization necessitates a huge investment of economic resources; trained, experienced, and highly motivated personnel; and a large long-term commitment of the institute's time and energy to a single ministry. Sponsorship can remove such limitations. A religious community can create a "win-win" situation by selling its health care organization, on one hand, while continuing to sponsor it, on the other—meanwhile investing the proceeds of the sale. Such an institute is now free to prayerfully determine where it might invest its personnel and resources in fidelity to its founding charism and its tradition as a religious community.

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Ownership versus Sponsorship

The conflict between ownership and sponsorship is similar to the decision facing automobile drivers: Will I buy or will I lease? Although I can eventually buy the car I currently lease, I cannot, by the same token, lease from myself a car I own. Many religious institutes face a similar question: Should we own or sponsor our health care organization? Can we do both? In my judgement, institutes have, in the replies they have made to these questions over the last 30 years, been too cool to ownership and too friendly about sponsorship.

One clear distinction between ownership and sponsorship is that concerning an organization's administration. Owners may or may not be involved in administration. Sponsors are always involved in it, although the extent of the involvement may be great or small. For example,

I may, like many thousands of other people, own stock in the Microsoft corporation; but the chances are miniscule that I will be involved at all in administering and managing Microsoft. Even my right to be involved in administration and management via a shareholder's meeting can be delegated to a proxy. A religious institute as sponsor could never take such a lackadaisical approach to administering an apostolate. Granted, one might simultaneously be an owner of stock in, and an administrator of, the same corporation. However, ownership need not imply administration. On the other hand, sponsorship, which need not imply ownership, *does* by definition imply at least some aspects of administration.

Sponsorship and ownership differ in other ways. A sponsor, for example, may well provide its sponsored organization with funds or a public-relations presence. In fact, a sponsor will want the various constituencies of its health care facility to know that the sponsor is involved in the facility's mission. An owner, on the other hand, may choose to be quite hidden and behind the scenes, a kind of anonymous presence. Indeed, an owner might have strategic reasons for camouflaging its ownership interests. For example, a for-profit pharmaceutical corporation that had purchased a not-for-profit hospital might want to avoid publicizing that fact, lest it raise civic eyebrows. If, on the other hand, such a company were to sponsor a hospital without owning it, that could be a godsend for both the hospital and the civic community.

Ownership implies control, whether the control is total or undertaken by a majority or large minority of stockholders. Sponsorship suggests administration or contributed human and financial resources or a kind of public seal of endorsement. Ownership ends with an organization's sale, merger with another, or simple closing. Sponsorship, on the other hand, ends with the conclusion or termination of the sponsor's contract with the sponsored organization.

Owners, moreover, have full control of what they own, subject, of course, to civil, canonical, and ethical codes. Sponsors have control only to the extent that such control has been delegated by the owner. Sponsors help carry out and maintain the mission of the owner, but the sponsor need not *be* the owner. A sponsor may be, rather than an organization's owner, the mediator, facilitator, or translator of its charism, tradition, and mission.

In the United States over the last three decades, ownership of Catholic health care institutions has frequently been reduced to sponsorship of those institutions. As a result, sponsorship itself has been institutionalized as the preferred way of speaking about the church's presence in the health care marketplace.

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Reserved Powers, Ownership, and Sponsorship

The term "reserved powers" is the current way of describing, protecting, and even camouflaging church ownership/canonical control of its institutional apostolates. Under this arrangement, a public juridic person—usually represented by a board—exercises a sponsored organization's reserved powers, while another board—the board of trustees—exercises the organization's ordinary administrative powers. Such a structure may sound unwieldy. In fact, the same people usually occupy seats on both the public juridic person's board and the board of trustees.

Over the years, the sponsors of Catholic health care facilities and educational institutions have essentially honed their reserved powers down to five. According to a CHA booklet entitled *The Search for Identity: Canonical Sponsorship of Catholic Health Care*, sponsors typically reserve for themselves the right "1.) to establish the philosophy according to which the corporation operates, 2.) to amend the corporate charter and bylaws, 3.) to appoint or to approve the appointment of the board of trustees, 4.) to lease, sell, or encumber corporate real estate in excess of the approved sum, and 5.) to merge or dissolve the corporation."[8] One should note that the five commonly recognized reserved powers appear to have clear roots in canon law.[9]

Sponsorship indicates ownership when it refers to canonical control as such control is expressed in certain reserved powers. Put differently, canonical control must be clearly manifested in at least some of the reserved powers if sponsorship is to be understood as ownership.

An understanding of sponsorship based on reserved powers does not mean that women or men religious must serve in the sponsored organization's administration or on its staff. It does not mean that an institute must make a financial contribution to the organization it sponsors. Rather, sponsorship means that the institute (or any other public juridic person) carries out its governance responsibilities through the reservation of some powers that give the sponsor exclusive canonical control over certain key areas of the organization sponsored.

This kind of power ought to be explicit and clear, and this canonical control ought to be recognized in civil law. But the absence of such recognition in civil law does not change the fact that, in canon law, a public juridic person does

canonically own its apostolate. The reserved powers fix and focus the ownership of the health care institution in the canonical juridic person.

The Great Challenge

When Catholic hospitals were founded, there was a *fusion* between the hospitals and their founders. Then, in the 1960s and 1970s, a *distinction* was made between the founders and their hospitals, largely because of the "McGrath thesis." In the 1980s and 1990s the dominant trend was the *separation* of the hospitals from their founders. Catholic hospitals, most of which were a phenomenon brought into existence by institutes of women religious, are today witnessing the evaporation of such congregations from institutional Catholic health care.

Thus the great canonical challenge and question is: Who will become the next generation of Catholic health care owners? Sponsorship is now slowly shifting from religious institutes to lay groups. How will the eventual ownership change be managed?

The future of the Catholic health care ministry in the United States appears bright. Now is the time to ensure that the bright promise becomes reality. □

NOTES

1. Jordan Hite, *A Primer on Public and Private Juridic Persons: Applications to the Catholic Health Care Ministry*, Catholic Health Association, St. Louis, 2000, p. 37.
2. John J. McGrath, *Catholic Institutions in the United States: Canonical and Civil Law Status*, Catholic University Press, Washington, DC, 1968.
3. See Paul C. Reinert, "The Role of Religious in Management," *Hospital Progress*, September 1967, pp. 59-61, 96-100. Fr. Reinert, a Jesuit, was then the president of Saint Louis University. In this article, adapted from a speech he had given two months earlier to the annual CHA assembly, Fr. Reinert essentially endorsed Fr. McGrath's position in the debate. Fr. McGrath himself addressed the 1968 CHA assembly. (*Hospital Progress* was *Health Progress*'s previous name; CHA was then the Catholic Hospital Association.)

   For further discussion of the "McGrath thesis," see Alice Gallin, *Independence and the New Partnership in Catholic Higher Education*, Notre Dame University Press, South Bend, IN, 1996, and *Negotiating Identity: Catholic Higher Education since 1960*, Notre Dame University Press, South Bend, IN, 2000; William W. Bassett, "The American Civil Corporation, the 'Incorporation Movement,' and the Canon Law of the Catholic Church," *Journal of College and University Law*, Spring 1999, pp. 721-750; and Robert T. Kennedy, "McGrath, Maida, Michiels: Introduction to a Study of the Canonical and Civil Law Status of Church-Related Institutions in the United States," *Jurist*, vol. 50, pp. 351-401, especially 351-368.
4. Adam Maida, "Identity of the Catholic Health Facility," *Hospital Progress*, February 1974, p. 65.
5. Paul Boyle, "Sponsorship: Canonical and Social Obligations," *Hospital Progress*, January 1975, pp. 54-56.
6. Michael Place, "Elements of Theological Foundations of Sponsorship," *Health Progress*, November-December 2000, p. 9.
7. Place, p. 10.
8. Catholic Health Association, *The Search for Identity: Canonical Sponsorship of Catholic Health Care*, St. Louis, 1993, p. 81.
9. Canon 298, sec. 1, could serve as a root for the first reserved power ("establish the philosophy"). Canon 94 would anchor the second ("amend the charter"). The canons concerning administrators (e.g., cc. 492-494; 532; 562; 636; 638; 1232, sec. 2; 1279, and 1282-1289) appear to anchor the third ("approve the board"). Reserved powers four ("sell real estate") and five ("dissolve the corporation") seem to be rooted in canons 1290-1298 and canons 121-123 and 320 respectively.

   Rev. Francis Morrisey, OMI, JCD, PhD, a well-known canonist (see his article, pp. 28-31, 51 of this issue), lists eight reserved powers, including those to establish subsidiary corporations, designate the sponsored organization's the chief executive officer and some or all of its board of trustees, and appoint its auditor. See Francis Morrisey, "Basic Concepts and Principles," in Lawrence DiNardo, Kevin E. McKenna, and Joseph W. Pokusa, eds., *Church Finance Handbook*, Canon Law Society of America, Washington, DC, 1999, pp. 3-15, especially p. 14. Fr. Morrisey holds that "the notion of reservation is found in canon 87, sec. 1, and in other canons throughout the code." However, canons 94 and 1279, sec. 1, would seem to provide a firmer grounding in issues concerning the ecclesiastical goods of civilly incorporated apostolates.

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ship and mission services at CHA (the senior staff person responsible for this project), asked her colleagues to draw three concentric circles. She asked them to write *action* on the inside circle, *infrastructure* in the second circle, and *culture* in the outside circle (see illustration on p. 7). She then pointed out that both the data gathering and the external research associated with this study had shown that the establishment of an organizational vision of promoting the dignity of the workforce through, for example, promoting satisfaction with its involvement in decision making, could not be achieved without creating specific and measurable strategies. Over time the successful implementation of such strategies is what creates the desired culture of worker satisfaction. The important part of the study, then, is in what each of our organizations can learn from the drivers that surfaced. Some organizations may find that some drivers have no particular relevance for them; no organization should simply adopt a driver without first adapting to its needs. In general, though, an organization that has no successful strategies will have a weak or low level of worker satisfaction. Although the good news of our study is that Catholic health care is long on vision, the bad news is that, in general, it is short on effective strategies for promoting worker satisfaction.

As I write this, I do so acutely aware of the very real impediments to our achieving what we would like to accomplish. My own experience, however, has taught me that the critical difference is in the amount of time dedicated to establishing, implementing, and evaluating potential strategies. As one wise colleague told me, "if you [CEO and senior executives] put as much energy into staff issues as product issues, you could change an organization's culture." Another colleague put this belief a bit differently by suggesting that we have a responsibility to minister not just to our patients, but also to our coworkers. Our colleagues are the subjects of a ministry that will be only words, not a reality, without effective mediating structures. □

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