The Evolving Nature Of Sponsorship

Recent Decades Have Brought Changes Both in Theory and Practice

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One can, by following the evolution of the concept of "sponsorship," trace the changing relationship between the Church and Catholic healthcare organizations in the United States.

Until after the Second Vatican Council, that relationship was rather straightforward: Religious institutes of men and women, dioceses, or groups of Catholic laity operated hospitals, homes for the elderly, and other social service agencies. These organizations were typically managed by personnel from religious institutes, usually at minimal salaries, or none at all. The institute often owned the organization's property and assets, and also provided it with access to capital.

Lay Administrators

Things began to change in the late 1960s and early 1970s, when lay men were appointed as administrators in religious institutes' hospitals. This occurred not so much because of a reduction in the number of religious as because of institutes' insistence that administrators be educated and professionally qualified for such positions.

In doing so, the institutes were continuing their tradition of educating their members. In the early years of this century, sisters pursued nursing education not only for themselves; they also opened many schools of nursing for lay women, thus ensuring that their hospitals always had a pool of qualified recruits.

Thirty years ago, hospital administrators often came from the ranks of sister nursing supervisors. But as the demand grew for specially educated hospital administrators, the number of sisters with such educations could not keep pace. Thus more and more lay men took on the role of administrator. By the 1980s, lay women had begun to move into these positions. At the same time, the number of women religious available for hospital work was diminishing.

Legal Challenges

Another factor that changed the relationship was the law concerning institutions of charity. Until the 1940s such institutions enjoyed immunity from lawsuits.[1] Since then, however, courts have held them liable for malpractice. Many religious institutes incorporated their hospitals to protect themselves from such suits. Some institutes appointed nonmembers to seats on their hospitals' boards of directors. As a result, some people began to ask serious questions about the role of religious institutes in Catholic hospitals.

Clarification of Sponsorship

Civil Law Perspective W. A. Regan, writing in *Hospital Progress* in 1970, presented one of the first analyses of sponsorship from a civil law perspective:

> Commitment to apostolic service by a religious institution is called sponsorship. In the U.S.'s pluralistic society, the concept of Catholic sponsorship of voluntary nonprofit hospitals is traditional and is recognized by both the federal government and state governments. Further, nothing in the civil law concept of separate hospital incorporation and the consequential concept of local trustee ownership and control of these hospitals militates against the fundamental concept of sponsorship by a religious order, congregation, or institute.[2]

Regan recommended that religious institutes determine the kinds of power they wanted to reserve to themselves and the types of corporate structure they wanted to use and then formulate

their legal documents accordingly.

Canon Law Perspective Two years before Regan's article appeared, J. J. McGrath had addressed the issue of institutional organization in terms of canon law. McGrath postulated that, in many cases, civil incorporation removed a Catholic institution from the realm of Church property and direct control. He argued that religious institutes should maintain their relationships and roles in these civilly incorporated—but now, in his opinion, non-Catholic institutions—through provisions in the legal documents and congregational membership on the boards of directors.[3]

> A. J. Maida argued that Catholic institutions must follow both civil and canon law.

Reserved Powers To counter McGrath's argument, A. J. Maida (today the cardinal archbishop of Detroit) wrote *Ownership, Control and Sponsorship of Catholic Institutions.*[4] He argued that Catholic institutions must follow both civil and canon law. Incorporation, he wrote, protected the property and assets of a Catholic institution under civil law, and did not affect its canonical status: A Catholic hospital remained Catholic after civil incorporation.

Although the issue was much debated, everyone agreed that, to protect an institution's Catholicity, a sponsoring institute should control both the institution's civil documents and its governance functions, through the reservation of certain powers to the sponsor.

Shift to Mission Concerns

During the 1980s, Catholic sponsors shifted their focus to mission concerns. They realized that unless a healthcare organization was thoroughly imbued with the spirit of Jesus' healing mission, neither ownership nor control of governance could ensure its Catholic identity. This led sponsors to make concerted efforts to clarify the fundamental values of Catholic healthcare.[5] Most Catholic healthcare facilities also developed mission integration programs to ensure that their personnel and practices stayed focused on mission.

The 1990s have brought great changes in healthcare, including the creation of integrated delivery systems and the formation of new partnerships. Many of these arrangements are too large and complex to be sponsored by a single congregation. Some may require sponsorship by several congregations; some, indeed, may involve non-Catholic sponsors. In this changing environment, sponsorship is again shifting its focus, moving now to the fundamental issues of Catholic identity, especially service to the poor and disadvantaged.

Mission and Communion

Catholic identity has two main components, *mission* and *communion*. Catholic institutions exist to participate in the salvific mission of Jesus, while, at the same time, maintaining some sort of structural communion to the whole Church. The *Ethical and Religious Directives for Catholic Health Care Services* provide one way healthcare institutions can address issues involving mission.[6] Communion comes through an institution's structural relationship with the Church or through a bishop's recognition of it as Catholic. An institution can relate itself to the Church through integration with a formally established entity, such as a religious institute or diocese. In the past, nearly all Catholic institutions were related to the Church in this manner.

Today, however, healthcare institutions and systems are forging new types of relationships with the Church. They can, for example, be integrated into formally established associations of lay Catholics. They can also be established in their own right as juridic persons, the Church's counterpart to civil corporations. There are two kinds of juridic persons:

- *Public juridic persons,* which have the closer relationship to the Church. They participate in the mission of Jesus in the name of the Church and are more obligated to follow canon law. Their assets are Church property.
- *Private juridic persons,* which have the more

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IMPROVING QUALITY

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One of the more developed ongoing projects is high-risk maternity management. This team has developed a prenatal screen to identify women at risk for early deliveries or other problems. The team has also redesigned staffing for labor and delivery and implemented case management for high-risk pregnant patients. This group is collecting and analyzing the risk screens, assessing outcomes such as cesarean birth rate, low birth weights, and frequency of prenatal care. After this analysis, the project team will continue its quality improvement efforts.

The low back pain team is the only one that has officially "finished" its project. It consisted of an observational study of low back pain treatments in a large primary care clinic, with the goal of proposing a treatment guideline. The limited study enrollment, lack of unmet needs or opportunities for improvement among study enrollees, and pressures from other projects led to the primary care group's decision not to develop a formal guideline. Instead, the group's members are awaiting the GEAR project's quality recommendations, which will span the continuum of care to address primary and specialty care treatment and specific interventions such as physical therapy and surgery.

The high-utilization Medicare and Medicaid projects started with the fewest and least-defined available resources. Both have developed evidence-based risk screens, with the goal of proactively identifying people at risk for poor health and high healthcare costs. These risk screens are now administered to newly enrolled members of the health maintenance organization. □

The authors gratefully acknowledge David J. Lansky, PhD; Nancy L. Erckenbrack; and Deborah M. Gannon for their contributions.

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SPONSORSHIP

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distant relationship to the Church. They act in their own name, and their assets are not Church property.

Juridic person status can be granted by either the diocesan bishop, the U.S. Conference of Catholic Bishops, or the Vatican.

In addition, there are healthcare organizations that, although they do not seek institutional ties to the Church, are formally recognized as Catholic by the bishop.

CHANGE IN THEORY AND FORM

Sponsorship has changed both in theory and in form over recent decades. It will most likely continue to change as healthcare changes, because it serves the Church as a useful way to maintain its focus on the essential components of the Catholic mission in healthcare. □

NOTES

1. A. Joachim, "Legal Aspects of Charitable Institutions," *Thought*, no. 15, 1940, pp. 237-244.
2. W. A. Regan, "A Legal Analysis of the Ownership and Corporate Control of Catholic Hospitals," *Hospital Progress*, October 1970, pp. 93.
3. J. J. McGrath, *Catholic Institutions in the United States: Canonical and Civil Law Status*, Catholic University of America, Washington, DC, 1968.
4. A. J. Maida, *Ownership, Control and Sponsorship of Catholic Institutions*, Pennsylvania Catholic Conference, Harrisburg, 1975.
5. For example, see Catholic Health Association, *The Dynamics of Catholic Identity in Healthcare: A Working Document*, St. Louis, 1987.
6. National Council of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, U.S. Catholic Conference, Washington, DC, 1995.