



CHA STUDY GUIDE for the Second Edition of
*The Pastoral Role of the Diocesan Bishop in
Catholic Health Care Ministry*

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ABOUT CHA

The mission of Catholic Health Association of the United States (CHA) is to advance the Catholic health ministry of the United States in caring for people and communities.

Catholic health care is a ministry of the Catholic Church continuing Jesus' mission of love and healing in the world today. Composed of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation.

At the national level, these organizations join together in the Catholic Health Association of the United States.

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FOREWORD

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*



We are pleased to provide our members with the CHA Study Guide for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*, the newly revised document of the United

States Conference of Catholic Bishops (USCCB). Given the evolution of sponsorship and the growth of new sponsorship models inclusive of laity, this revised document and study guide provide a clearer understanding of the important relationships and roles of those who are responsible for the Catholic health ministries within the United States. This work is the result of the ongoing dialogue and collaboration between the USCCB and CHA.

In 2017, the USCCB Subcommittee on Health Care Issues was entrusted with the task of preparing an updated version of the 1997 document *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*. At that time, CHA was asked by the subcommittee to provide input on the document. A process was initiated with sponsors, executive leaders and canon lawyers to elicit their feedback. CHA continued to assist with the ongoing review of the document and worked with representatives of the USCCB to prepare this study guide. I extend

my gratitude to those who helped throughout this process, especially Father Charles Bouchard, OP, S.T.D., CHA senior director, theology and sponsorship, and Lori Ashmore-Ruppel, director, sponsor services, for their efforts in leading the development of this valuable new resource.

As the complexities of health care in the United States continue to evolve and we strive to care for those who are poor and vulnerable, it is vitally important to ensure collaboration between the diocesan bishop and Catholic health leaders. The CHA Study Guide for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry* is a valuable resource for bishops and health care leaders to reflect on the mutual responsibility for our health ministries and explore ways to foster greater collaboration. The strength and viability of our health ministries depend on it.



SR. MARY HADDAD, RSM

*President and Chief Executive Officer
Catholic Health Association of the United States*



LEFT:
USCCB TEXT
(second edition)

RIGHT:
SIDEBAR
COMMENTARY
& DISCUSSION
QUESTIONS
(from CHA)

STUDY GUIDE

This document is a study guide for the 2020 revision of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*. The first edition appeared in 1997.

THE STUDY GUIDE INCLUDES:

- ✦ Exact text of the document itself, which is also available on the USCCB website (<https://www.usccb.org/committees/doctrine/publications>);
- ✦ Discussion questions to facilitate group study;
- ✦ Sidebar commentary; and
- ✦ Extended endnotes and references to CHA resources that pertain to various parts of the document. (The notes for the document itself are footnotes and are numbered in Arabic numerals; the notes on CHA's commentary are endnotes and are numbered with Roman numerals.)

The commentary and questions were created by members of CHA's Sponsor and Canon Law Committee with the assistance of CHA staff from the Department of Sponsorship and Mission Services.

The study guide and support materials are available at chausa.org/sponsorship and chausa.org/store.

We hope this study guide provides individual readers with the context for various parts of the document and provides background on the concepts and terms used throughout. We also hope it helps you apply the document to your particular situation and to create an opportunity for more dialogue with your bishop(s).

INTRODUCTION

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*



I am very grateful to write these words of introduction to this very important Study Guide from the Catholic Health Association for the Second Edition of *The Pastoral Role of the Diocesan Bishop in*

Catholic Health Care Ministry. As I write these words, we have also heard in the Liturgy the words of the Lord Himself when He says, “This is the time of fulfillment. The Kingdom of God is at hand,” and when He calls the first apostles and says, “Come after Me,” and they left their nets and followed him.

This dialogue of call and response is integral to the life of those involved in Catholic health care ministry, especially in our increasingly complex age. I am very blessed to have ministered in a Catholic health care system as a medical technologist (MT ASCP) earlier in my life, where I witnessed this call and response lived out personally.

Having been involved in the writing of this document, it is my hope and prayer that that same experience of the “Gospel Context of Health Care” is conveyed to you here as an Encounter with the Lord as you study the *Ethical and Religious Directives* and the critical role of the diocesan bishop in Catholic health care. I see in these pages the lives and witness of all who were involved in the health care ministries I have known. As a diocesan bishop now for 15 years, I certainly affirm the conclusion of this work, which says, “*This call for the exercise of the bishop’s pastoral office in overseeing health care ministry is issued in an atmosphere of mutual understanding, fruitful collaboration, and ecclesial communion. In performing such a ministry, they [Catholic health care institutions]; are imitating Christ, when “he saw the vast crowd, his heart was moved with pity for them and he cured their sick (Matt 14:14).*”

A handwritten signature in blue ink that reads "Kevin W. Vann". The signature is written in a cursive style with a large initial 'K'.

MOST REV. KEVIN W. VANN JCD, DD
Bishop of Orange in California

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan
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The Gospel Context of Health Care

1. The Gospels are filled with examples of Jesus curing many kinds of ailment and illness. In one account, our Lord's mission is described as the fulfillment of the prophecy of Isaiah, "He took away our infirmities and bore our diseases" (Mt. 8:17; see Is. 53:4). Jesus instructed his apostles to heal the sick (Mt 10:8). **The care of the sick, therefore, is an important part of the mandate that Christ gave to his disciples.**
2. Since the principal work of Christ was our redemption from sin and death, the healing that he brought us went beyond caring only for physical afflictions. His compassion for the poor, the sick, and the needy fit within his larger mission of redemption and salvation. Christ touched people at the deepest level of their being. As the source of physical, mental, and spiritual healing and well-being, he described his work as bringing life in abundance (John 10:10).
3. To understand the significant role of the Catholic Church in health care throughout the centuries, one needs to look at the faith of those who have attempted to imitate the love, compassion, and healing of Jesus. It is nothing less than Christian love that animates health care within the Church. **The work of healing and the acts of compassion that envelop it are seen as a continuation of Christ's mission that is enabled by his life-giving grace.** It is out of this context of faith, hope, and love that the Catholic health care ministry came into existence.

✦ *It is hard to imagine the ministry of Jesus Christ without healing of the body. The founders of various Catholic health ministries all took seriously the command of Christ "to proclaim the reign of God and heal the afflicted" (Luke 9:2); "to expel unclean spirits and to cure sickness and disease of every kind" (Matthew 10:1); and "to raise the dead and heal the leprous..." (Matthew 10:8). They took to heart Jesus' teaching that whatsoever we do to the least of his brothers and sisters, we do to him (Matthew 25:40). They believed and taught that if we truly love him, then we must feed the hungry, welcome the stranger, clothe the naked, comfort the sick, and visit the imprisoned. These became known as the "corporal works of mercy."*

The 3rd century (215) Didascalia Apostolorum obligated bishops to seek out the sick and care for them in their own homes. Although the text was not written by the twelve apostles, it does demonstrate historically how important care for the sick was considered by the middle of the third century.ⁱ

By the 4th century, the Church began to institutionalize health care as a ministry. The "basilead" founded by St. Basil in the 4th century was one of the earliest monastery "hospitals" providing care for people who were poor and sick.

✦ *U.S. Catholic health care is the nation's largest group of not-for-profit health care providers, with more than 660 hospitals and 1,660 continuing care facilities across the country. Every day, more than 1 in 7 patients are cared for in a Catholic hospital.*

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

4. Historically, religious institutes and societies of apostolic life of women have taken the lead in the development of Catholic health care ministry in the United States. While a number of health care initiatives have been established by individual dioceses, religious institutes of men, and associations of the Christian faithful, the vast majority of Catholic health institutions have been sponsored¹ and directed by religious institutes of women for whom this ministry is an integral part of their religious charism and apostolate. Their efforts have resulted in an extraordinary array of health care organizations that reflect and embody the care of the Church and the love of Christ for the sick. Their dedication to work on behalf of the sick has served as a way of announcing the Good News of Christ through their example.

5. As the numbers of religious have been decreasing, lay men and women have increasingly been taking leadership and sponsorship roles in many of our Catholic health care institutions, while striving to maintain the charism and spirit of the founding religious institutes and societies of apostolic life.

✦ *The Ursuline Sisters were the first to establish health care in the United States, arriving in New Orleans from France in 1727. By 1900, religious congregations had founded over 500 hospitals in the United States. For a brief and entertaining summary, see “Three Hundred Years of Sister History (in 5 Minutes),” produced by America Magazine and narrated by Cokie Roberts.*

✦ *The ministries of health care are part of the Church’s evangelization effort. The ministry serves human need and the common good, but does so in imitation of Jesus and for the sake of the Reign of God.*

✦ *The growing involvement of the laity in the ministries is not just a concession to necessity. It is the activity of the Spirit, as the documents of Vatican II suggest.ⁱⁱ*

The formation of juridic persons is more than just a juridical or organizational construct. It is an unprecedented new opportunity for all sponsor members to deepen their own spiritual lives and for Catholics to realize their baptismal call in a vocation of leadership.

✦ *The evolution of Catholic health care includes collaborations and mergers of ministries founded by many different religious institutes. For many new public juridic persons, the focus has shifted from charisms of individual founders to a Gospel or ecclesial charism.*

Discussion Questions on the Gospel Context of Health Care

- How is the Gospel mandate reflected in your mission statements?
- How is the charism or the spirit of the founders lived out in Catholic health care ministries?
- How does that charism or spirit contribute to the life of the local Church?

1 “Sponsorship of an apostolate or ministry is a formal relationship between a recognized Catholic organization and a legally formed entity, entered into for the sake of promoting and sustaining the Church’s mission in the world.” This is the common definition of sponsorship agreed upon by the participants in a Canon Law Society of America symposium on the subject; see Rosemary Smith, S.C., Warren Brown, O.M.I., and Nancy Reynolds, S.P., eds., *Sponsorship in the United States Context: Theory and Praxis* (Washington, D.C.: Canon Law Society of America, 2006), ii.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

Challenges and Opportunities

6. Today, Catholic health care ministry in the United States is facing formidable economic, demographic, cultural, and ministerial challenges.

These include the following:

- the unsustainable growth in health care spending, which is burdening federal and state budgets, businesses, families, and the poor and vulnerable;
- an aging population, many of whom suffer from multiple chronic conditions that are difficult and expensive to treat; the accelerating shift of risk from public and private insurers to providers through new payment methods;
- the growth of competition from non-traditional providers of health care, such as chain drug and retail stores;
- downward pressure on provider net revenues;
- the pressure on Catholic health care systems to gain economies of scale through mergers and acquisitions, sometimes involving non-Catholic systems and facilities;
- ever fewer women and men religious;
- and cultural pressures that have led some politically influential groups to claim that elements of Catholic teaching are incompatible with emerging standards of medical care.

+ These challenges differ significantly from those cited in the 1997 version of this document. At that time, the bishops cited the shift to outpatient (non-hospital) care, networks, risk shifting through managed care, partnerships and reductions in force that resulted from economic pressure. The effect of economic pressure is the only one that is explicitly mentioned in this document.

+ This is not intended to be an exhaustive list. There are other challenges not mentioned, such as technological and medical advancements that have ethical ramifications, as well as health disparities that arise from bias and systemic racism.

+ There are many new opportunities as well, including the expanded use of telehealth and home care and new approaches to senior care. Awareness of socioeconomic disparities is leading us to a greater focus on population health and prevention.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

7. In addition, there is what Pope Francis has called the “spiritual poverty of our time,”² and what Pope Benedict XVI labeled as the “dictatorship of relativism.”³ This spiritual poverty can be seen in the numerous moral and ethical issues that place Catholic teaching against popular culture – such as in contraceptive, transgender, and end of life issues. “Service to life,” however, “is performed only in *fidelity to the moral law*, which expresses its values and duties.”⁴ How Catholic health care organizations might effectively respond to these multiple developments is the challenge of the moment. These pressures are driving Catholic health sponsors and other leaders to reassess and restructure their organizations in an effort to remain a viable part of today’s health care delivery, and a valuable expression of the Church’s mission in the world.

✦ See the discussion of “service to life” found in *The New Charter for Health Care Workers*.ⁱⁱⁱ

✦ Our ministries do regular “community needs assessments” to identify problems in their community that they can address. The “Community Benefit” programs that result are varied and innovative.^{iv}

Discussion Questions on Challenges and Opportunities

- What are the most pressing challenges in your ministry?
- How can the bishops support the health care ministry today?
- What are the opportunities amid these challenges?
- What role do community needs assessments play in identifying and meeting these pressing challenges?

2 Francis, *Address to the Diplomatic Corps to the Holy See*, 22 March 2013.

3 Joseph Cardinal Ratzinger, *Homily for the Mass “Pro Eligendo Romano Pontifice,”* 18 April 2005.

4 Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, no. 5.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

Responsibility to the Diocesan Bishop

8. Catholic health care, as an expression of the healing ministry of Jesus Christ, participates in the apostolic mission of the Church in the same way that other ministries do. The varied and complex structures that are required to deliver health care are the particular responsibility of the sponsoring entity, boards, and other leaders who conduct this corporate ministry. At the same time, this ministry also necessarily involves the diocesan bishop. The bishop has the responsibility and right to exercise his authority over all apostolates in his diocese, including that of health care, in accordance with the *Code of Canon Law*, c. 678, and any other universal or particular law that may be enacted. The diocesan bishop should also seek the aid of legal consultants in understanding any applicable local and state secular laws. Sponsors of apostolates, including health care facilities, must give due recognition to the lawful authority and role of the bishop. This is the teaching of the Second Vatican Council and the universal law of the Church.⁵

9. There are a variety of ways in which the role of the diocesan bishop can be expressed in health care ministry. The bishop, as principal teacher, invites openness and receptivity to the splendor of truth by proclaiming the Church's teaching and by safeguarding the moral and doctrinal integrity

+ In the past, "ministry" was understood to be the individual work of a priest or deacon. The understanding of health care as a corporate ministry of the Church led by the laity and not simply a corporal work of mercy, or an apostolate, is a relatively new development. We are still discovering exactly what this means and how Catholic health care can collaborate with other ministries, such as parishes, Catholic social services and Catholic education."

+ Canon 678 discusses the relationship between bishops and religious who traditionally served as sponsors. It notes the bishop's authority over religious institutes in matters concerning the care of souls, public worship and other works of the apostolate, and, with reference to "organizing the works of the apostolate of religious," states that "diocesan bishops and religious superiors must proceed through mutual consultation."^{vi} The general oversight of the diocesan bishop for works of the apostolate applies to new public juridic persons that are not religious institutes, as well (see, for example, canon 394).

5 See, for example, *Lumen Gentium*, no. 20; *Christus Dominus*, no. 11; *Code of Canon Law (CIC)*, cc. 394 §1; 216; 223 §2; 375; 381 §1; 391 §1; 392; 678; 680.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

of Catholic health care.⁶ As sanctifier, the bishop exercises his ministry by ensuring the celebration of the sacraments and by providing for the overall pastoral care for the sick, their families, and the medical professionals in health care settings throughout the diocese, for example, through his appointment and supervision of priests as chaplains.⁷ The bishop, as pastor, governs the particular church in ways that seek appropriately to coordinate the healing ministries in the interest of the common good.⁸

10. In the area of pastoral governance, the bishop's authority and responsibilities vary according to the canonical status of the health care organization, the canonical status of the sponsor, and the canonical issues involved. It is the bishop's obligation to ensure doctrinal and moral integrity in the witness and practice of all Catholic institutions within the diocese. It is therefore the responsibility of the diocesan bishop, in cooperation with religious institutes and other sponsors, along with all those involved in the ministry of health care, to ensure that the Catholic identity of all health care organizations is maintained and strengthened. To aid in this responsibility, the bishop may find it useful to promulgate the current edition of the *Ethical and Religious Directives for Catholic Health Care Services* as particular law in his diocese. While the *Ethical and Religious Directives for Catholic Health Care Services* contain essential moral truths that are always binding upon the Catholic faithful, the Directives' adoption as particular law can further assist in their implementation as legislative directives within the local church.⁹

⊕ A fuller description of the various aspects of the diocesan bishop's role in health care is found in *Lumen Gentium*, no. 23, as well as in the *General Introduction of the Ethical and Religious Directives for Catholic Health Care Services*.^{vii}

⊕ Since these structures differ in the way they are accountable to the diocesan bishop, it is important that each health care ministry understands its own canonical structure and develops a plan with the local ordinary to operate in a way consistent with this structure. For instance, health care ministries that are sponsored by a diocese or that are sponsored by a diocesan juridic person, rather than a pontifical juridic person, will have a different relationship to the bishop that entails different obligations.

⊕ This suggests an opportunity for the local bishop to help foster active collaboration between Catholic health care and other Catholic institutions in his diocese.

⊕ "Particular laws" are those promulgated for a specific group of people (e.g., a religious institute) or a particular territory (e.g., a diocese). The ERDs are directives until they are promulgated by a bishop as particular law. Promulgation as particular law gives them legal force and helps ensure consistency.^{viii}

6 See *Lumen Gentium*, no. 23; CIC, cc. 753, 756; see also *Veritatis Splendor*, no.

7 See *Sacrosanctum Concilium*, no. 22; CIC, cc. 835, 564, 566.

8 CIC, cc. 394 §1; 223 §2.

9 Appendix A offers a sample decree establishing the *Ethical and Religious Directives for Catholic Health Care Services* particular law that a bishop can adopt for use in his diocese.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

11. The bishop may also find it helpful to appoint an ethicist as health care vicar or delegate, and/or to appoint a diocesan medical ethics board. The bishop and his delegate or ethics board can and should work in collaboration with the ethicists of the Health Care systems. It is also the diocesan bishop's responsibility to coordinate all apostolic activity within the diocese,¹⁰ while respecting always the particular character of each apostolate,¹¹ thereby fostering and promoting that unity in diversity which characterizes true ecclesial communion.

12. Recent developments in health care delivery, particularly those that involve substantial modifications in the canonical or corporate status of a Catholic health care organization, often give rise to questions concerning the applicability of Church laws governing the acquisition and administration of temporal goods; the alienation of Church property; the fulfillment of the intentions of founders, benefactors, and donors; and effective control of a Catholic health care organization. The diocesan bishop, along with the leaders of Catholic health care institutions, must assess the applicability of such laws and evaluate proposed arrangements in the light of Catholic identity and the Church's doctrinal, moral, and canonical requirements. They are guided in this assessment by the directives found in Part VI of the *Ethical and Religious Directives for Catholic Health Care Services*. As noted there, the ultimate responsibility for the interpretation and application of the *Ethical and Religious Directives for Catholic Health Care Services* rests with the diocesan bishop.¹²

+ Diocesan ethicists should have at least a master's degree in health care ethics and some clinical or pastoral experience in health care.

+ This is already the practice in large dioceses that have many Catholic hospitals. If it is not possible in a smaller diocese, the bishop might want to create a medical advisory board, consisting of physicians or other health care providers, to advise and keep him abreast of current medical and ethical issues.

+ Public juridic persons are bound by the canons in the Code of Canon Law that govern the acquisition, administration, and alienation of property, since their goods are regarded as Church goods (see canon 1257 §1). In addition, the assets of most systems have been designated as part of their canonical "stable patrimony." Each system should be aware of what stable patrimony requires permission for sale or encumbrance (see canon 1291). Canonical requirements must be carefully coordinated with civil law.^{ix}

+ See also previous comment about the Ethical and Religious Directives for Catholic Health Care Services as "particular law."

10 CIC, c. 678.

11 CIC, c. 394 §1.

12 See *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), Part VI.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

Dialogue in such matters is essential and should occur on a regular basis, especially in the early stages of considering any venture, affiliation, or relationship that has the potential to affect substantially the mission, Catholic identity, or canonical status of a Catholic health care organization.

✦ *This highlights the importance of regular communication with the bishop or his liaison so that major changes in ownership, control or partnership do not occur so abruptly that they cannot be properly assessed.^x*

Discussion Questions on the Responsibility of the Diocesan Bishop

- In what ways does a bishop exercise his role as teacher, sanctifier and pastor in the ministry?
- What are opportunities for the bishop to be more active in the ministry?
- How does the Catholic health care ministry evaluate Catholic identity and share learnings with the bishop?
- Is there a bishop-delegated ethicist or diocesan medical ethics board? If so, how are they in communication with the ministry?
- Has the bishop appointed a health care vicar? If so, what is that person's role and authority?

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

Fostering Collaboration

13. The diocesan bishop collaborates with the leaders of Catholic health care institutions and systems, who have devoted their energies to the health care ministry with exemplary consistency and vigor and who, together with the bishop, seek to foster the continuance of this vital ministry in a rapidly changing environment.

14. The bishop also promotes collaboration among all the various actors involved in the Catholic health care ministry, from sponsors to hospital administrators to Catholic hospices to Catholic social agencies, such as Catholic Charities. Collaboration between Catholic health care institutions and Catholic social service agencies is especially important in an era in which health care systems are beginning to reach beyond their acute care settings to address the social determinants of health, such as adequate nutrition, housing, and employment.

15. Such collaboration is essential because these actors all approach the ministry from complementary perspectives, which result from their differing levels of involvement in the ministry and their differing responsibilities for the apostolates in the local Church. The diocesan bishop is in a unique position to foster this collaboration and has a duty to do so.¹³ In exercising their pastoral role in the Catholic health care ministry, diocesan bishops are encouraged

✦ For examples of this type of collaboration, see stories from Catholic Health World.^{xi}

✦ The Catholic health ministry addresses social determinants of health through community health needs assessments that identify specific issues in the community and create programs to answer the identified needs. The federal government requires that the Catholic health ministry and other not-for-profit organizations document efforts to address these needs.^{xii}

13 See Congregation for the Doctrine of the Faith, "Some Principles for Collaboration with Non-Catholic Entities in the Provision of Health Care Services" (27 February 2014), no. 17.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

to invite those who govern and manage these ministries to join in the effort to support and stimulate initiatives that will preserve and extend the health care ministry and ensure its Catholic identity.

16. One particularly helpful initiative has been the **development of programs for in-depth doctrinal and pastoral formation grounded in Catholic identity and in the tradition of the founders of the health care system.** These programs are designed to form faithful individuals and to create a community of leaders within each health care system, facility, and service area who articulate and integrate a Catholic understanding of the ministry of healing.

17. This marks an area of potential collaboration with the diocesan bishop, who has an interest in helping to ensure that the staff, particularly those in leadership positions, have a formation sufficient for them to do their part to sustain the mission of the Catholic health care service. The bishop may collaborate in various ways, perhaps by offering diocesan assistance or by facilitating cooperation among Catholic health care providers and Catholic educational institutions.

18. The diocesan bishop should also foster other initiatives that encourage Catholic health care institutions in their **outreach to the local communities.** In fact, one of the major changes occurring in health care today is the fact that health care systems are no longer comprised of only hospitals, but also include clinics, community care centers, physician care sites, and offices. In considering how the diocesan bishop and a Catholic health care system collaborate, this expanded notion of health care must be kept in mind.

✦ *The emergence of formation programs for boards, sponsors, executives and other associates is perhaps the most important development in the role of the laity since Vatican II. These programs are designed to deepen faith and spirituality so that a new generation of lay leaders can be spiritual as well as business leaders.^{xiii}*

✦ *This is a very important aspect of the “pastoral” role of the bishop.*

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

19. Another area of critical importance is the urgent need to address the growing number of people who die with serious health-related suffering associated with life-limiting and life-threatening conditions. Palliative care and hospice care help relieve serious health-related suffering by providing physical, psychosocial, and spiritual care to patients and their families. The diocesan bishop could foster dialogue with Catholic health care institutions about how they can develop effective palliative care programs. This dialogue should center around a document developed by the Pontifical Academy of Life that contains forty-three recommendations for improving global palliative care.¹⁴

+ *The recent document from the Congregation for the Doctrine of the Faith, Samaritanus bonus (September 22, 2020), was issued to stress that the last interval before death is an opportunity to become more closely configured to Christ.^{xiv}*

+ *The White Book for Global Palliative Care Advocacy is available online.^{xv}*

Discussion Questions on Fostering Collaboration

- How do bishops facilitate collaboration between Catholic health care and other Catholic institutions?
- On what current initiatives/programs could Catholic health and other Catholic agencies collaborate?
- Are there ways the diocesan bishop can contribute to the formation of lay leaders and sponsor or board members?
- Are there ways the formation resources developed by the Catholic health organization can be shared and adapted for other Catholic agencies and ministries in the diocese?
- Does your ministry know of the palliative care recommendations mentioned in the text? How could the systems/ministry implement some of these recommendations?

14 *White Book for Global Palliative Care Advocacy: Recommendations from a PAL-LIFE Expert Advisory Group of the Pontifical Academy for Life, Vatican City* (<http://www.academyforlife.va/content/dam/pav/documenti%20pdf/2019/White%20Book/WHITE%20BOOK%20English02%2025Apr19.pdf>).

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

Practical Issues Affecting Catholic Health Care Systems

20. Given the complexity of the new developments in the health care field that need to be addressed and the intersecting competencies that need to be respected, the effective exercise of the diocesan bishop's pastoral responsibility in the health care ministry presupposes communication and dialogue among all those involved in the ministry. Such an approach will both strengthen the Catholic presence in health care and contribute to the ecclesial communion of the local church.

Institutions Sponsored by Religious Institutes or Societies of Apostolic Life

21. The apostolic activity of religious institutes or societies of apostolic life, whether they be of diocesan or pontifical right, reflects an important element of collaboration with the diocesan bishop.¹⁵ The *Code of Canon Law* provides direction for the relation between the diocesan bishop and religious superiors in the coordination of such apostolic activity.¹⁶ At the same time, “[i]n exercising an external apostolate, religious are also subject to their proper superiors and must remain faithful to the discipline of the institute. The bishops themselves are not to fail to urge this

✦ *Bishops typically have responsibility for a geographical area such as a diocese. They oversee all ministries in that territory. Religious institutes or other pontifical public juridic persons (PJPs) are committed to specific kinds of ministry — education, health care, social service — and may serve within multiple dioceses. Religious institutes and bishops have developed protocols and practices over many centuries that enable them to work together for the good of the Church. We must now find intentional ways to ensure the same collaboration between bishops and new PJPs.*

15 See *Lumen Gentium*, no. 44; *Christus Dominus*, no. 35; CIC, cc. 675, 681 §1; see also *Vita Consecrata*, nos. 48-49.

16 CIC, c. 678 §1. For societies of apostolic life, see c. 738 §2.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

obligation if the case warrants it.”¹⁷ For this reason, “[in] organizing the works of the apostolate of religious, diocesan bishops and religious superiors must proceed through mutual consultation.”¹⁸

Health Care Institutions of Pontifical Right

22. As noted, more and more Catholic health care institutions are being administered by lay professionals. Often this occurs through the establishment, by the concession of a competent authority, of a juridic person. A juridic person is a group of persons or things “ordered for a purpose which is in keeping with the mission of the Church and which transcends the purpose of the individuals.”¹⁹ Those institutions established as public juridic persons provide health care in the name of the Church, usually by carrying on the charisms of the religious institutes or societies of apostolic life that originally founded the institutions.

23. Although many of the juridic persons established for health care are, like many religious institutes, under the direct jurisdiction of the Holy See, they do exist in communion with the local church and its bishop. The diocesan bishop aids the juridic person in helping to safeguard its rights and overseeing the fulfillment of its obligations. The obligations of a juridic person in health care include adherence to Catholic teaching in all aspects of the institution’s life and ministry, the disciplinary requirements of correct usage of financial and temporal goods, as well

✦ *Juridic persons may be public (in which case their goods are regarded as “Church goods” and are governed by the Code of Canon Law and their own canonical and civil statutes) or private (in which case the assets are owned by the juridic person but are at the service of the ministry and are governed only by their canonical and civil statutes). In the United States, the term “ministerial juridic person” (MJP) is commonly used to distinguish these entities from more traditional religious institutes or societies of apostolic life. Ministerial juridic person is not a canonical term. For more information about juridic persons, go to CHA’s Guide to Understanding Public Juridic Persons.*

✦ *Health care and educational institutions are generally “a group of things”; that is, physical assets, assembled for the purpose of carrying out a ministry. Associations of persons do not necessarily have any physical assets; they exist for a spiritual purpose, such as prayer or public witness.*

✦ *There are more than 30 ministerial public juridic persons in the world. Most are of pontifical right (i.e., established by the Holy See through the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life [CICLSAL]), but some are diocesan. Outside of the United States, juridic persons have also been established by the local conference of Catholic bishops. Australia has an Association of Ministerial Juridic Persons that includes groups of like ministries, or ministries founded in the same historic charism.^{xvi}*

17 CIC, c. 678 §2.

18 CIC, c. 678 §3.

19 CIC, c. 114 §1.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

as other specified laws, and, where applicable, the maintenance of the original charism of the institution.

24. The diocesan bishop should foster the kind of collaboration among these apostolates that will strengthen the health care ministry overall and ensure that they are conducted in accord with the teaching and discipline of the Church. In this way the diocesan bishop will fulfill his responsibility to be vigilant about the Catholic identity of any individual or group operating within his diocese.

25. In order to provide a common basis for collaboration and dialogue, the diocesan bishop and his staff should strive to become informed about the complexities of the current health care environment. At the same time, sponsors, administrators, and board members need to develop a fundamental grasp of the doctrinal, pastoral, and canonical principles that have a bearing on Catholic health care delivery.

✦ *Sponsors must ensure the regular assessment of the Catholic identity of the ministry. Results of the assessments should be shared with the local bishop to acknowledge the strengths and opportunities for growth in the ministry.*

Discussion Questions on Practical Issues Affecting Catholic Health Care Systems

- What are your usual means of communication between the ministry and the bishops?
- If your system is sponsored by a religious order, how are the religious superiors and diocesan bishops in relationship?
- If your system is sponsored by a public juridic person, how is the public juridic person in relationship with diocesan bishops? What is the system of communication? How could it be improved?
- How can the ministry and bishops mutually contribute to greater understanding of the current health care environment, doctrine, pastoral principles and canonical issues?
- How are ministry identity and formation connected in a way that helps sponsors, board members and senior leaders understand the connection of identity to integrity? How is the integration of formation and identity assessment communicated to the bishop?

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

Collaborative Arrangements

26. The diocesan bishop, sponsors, and other leaders of Catholic health care should give careful attention to proposed and existing ventures, alliances, mergers, or other associations among Catholic health ministry organizations within the diocese or in conjunction with other dioceses. Such collaboration could serve to protect and strengthen the individual and collective well-being of the ministry as well as contribute to the fuller realization of ecclesial communion. When collaboration with other than Catholic providers is considered necessary or opportune for sustaining and enhancing the ministry, the bishop is to be consulted, and the appropriate approval is to be obtained.

27. The *Ethical and Religious Directives for Catholic Health Care Services* state: “When there is a possibility that a prospective collaborative arrangement may lead to serious adverse consequences for the identity or reputation of Catholic health care services or entail a high risk of scandal, the diocesan bishop is to be consulted in a timely manner.”²⁰ Sponsors and other leaders make an important contribution to the diocesan bishop’s exercise of this responsibility by providing adequate and timely information about developing partnerships.

⊕ *For much of history, Catholic hospitals were relatively free-standing. In the 1960s and 1970s, however, they began to collaborate and even merge to achieve greater efficiency and to strengthen identity. This process started with religious institutes that brought their individual hospitals under one umbrella (e.g., Mercy Health), and expanded so that different religious institutes collaborated to create systems sponsored by several religious institutes.*

⊕ *The language regarding consultation with the bishop found here and in #68 of the Ethical and Religious Directives for Catholic Health Care Services is slightly different. The text of this document states that consultation should take place when collaboration with other-than-Catholic providers is “considered necessary or opportune”; the ERD text is more specific, requiring consultation when collaboration may lead to “serious adverse consequences for the identity or reputation of Catholic health care services or entail a high risk of scandal.” Therefore, it is important that the ministry and the bishop(s) come to a common understanding as to when and under what circumstances such consultation is required.*

⊕ *Specialization, efficiency and the trend toward “population health” and preventive care call for greater coordination of health care resources, whether they are faith based, investor owned or government sponsored. Although engaging in effective collaboration while maintaining Catholic identity can be a difficult but important task, these partnerships can also help us to pool scarce resources to extend our mission and address emerging needs, particularly to poor and vulnerable persons.*

²⁰ Directive no. 68.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

28. The nature of a bishop's authorization of a collaborative arrangement varies. The *Ethical and Religious Directives for Catholic Health Care Services* go on to explain, "the diocesan bishop's approval is required for collaborative arrangements involving institutions subject to his governing authority; when they involve institutions not subject to his governing authority but operating in his diocese, such as those involving a juridic person erected by the Holy See, the diocesan bishop's *nihil obstat* is to be obtained."²¹

Interdiocesan Cooperation and Coordination

29. In today's health care environment, where regional and national collaboration is often seen as essential to vitality and survival, collaborative arrangements often span multiple dioceses. In such cases, there will need to be a dialogue that brings together bishops, sponsors, and other leaders from across diocesan and state boundaries. The *Ethical and Religious Directives for Catholic Health Care Services* stipulate that in evaluating prospective collaborative arrangements involving Catholic health care services, "the bishop should consider not only the circumstances in his local diocese but also the regional and national implications of his decision (no. 67)." To assist the local bishop and Catholic health care systems, Directive 69 states:

In cases involving health care systems that extend across multiple diocesan jurisdictions, it remains the responsibility of the diocesan bishop of each diocese in which the system's affiliated institutions are

✦ *The nihil obstat is not the definitive vote, but rather the diocesan bishop's expressed opinion offered to the Holy See as it determines the liceity of a particular collaborative agreement.*

The bishop's nihil obstat does not imply his approval of the arrangement; rather, it only means that in his opinion, "nothing stands in the way" of it moving forward; that is, there is nothing in the arrangement that is contrary to faith and morals. In a recent merger, a bishop was criticized for "approving" a restructuring and had to point out this careful distinction.

Discussion Questions on Collaborative Arrangements

- What, if any, are the current collaborative arrangements in your system?
- What lessons were learned in the process of creating these collaborative arrangements that might be helpful to note in the future?
- When are bishops normally informed about possible collaborative arrangements?
- Have you had a conversation regarding Part VI of the *Ethical and Religious Directives for Catholic Health Care Services* to ensure that both bishops and the ministry leaders share a common understanding about the expectations of Part VI?

21 Directive no. 68.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

located to approve locally the prospective collaborative arrangement or to grant the requisite nihil obstat, as the situation may require. At the same time, with such a proposed arrangement, it is the duty of the diocesan bishop of the diocese in which the system's headquarters is located to initiate a collaboration with the diocesan bishops of the dioceses affected by the collaborative arrangement. The bishops involved in this collaboration should make every effort to reach a consensus.

30. In pursuit of the **common good**, it is desirable for diocesan bishops, in consultation with sponsors and other leaders, especially where local health care organizations belong to systems that cross diocesan boundaries, to strive to cooperate with each other in fostering consistent diocesan policies in their supervision of the health care apostolates of their dioceses, insofar as this is possible. Consultation and collaboration among the diocesan bishops in whose dioceses the health care system operates will improve the chances for success among new ventures in the apostolate and help promote their Catholic identity. **Contrary or contradictory policies among bishops** can mislead people and do a disservice to the ministry of the whole Church. On the other hand, when two or more particular churches unite in a common effort, they witness to the catholicity of the whole Church.²²

✦ *The bishops can join the Catholic health ministry not only working within the community, but also advocating for policies at the state and federal level that promote the common good.*

✦ *The sponsors and health care leaders can assist in communication between bishops across diocesan boundaries. This greater communication can allow for enhanced input and consensus between diocesan bishops, especially when a nihil obstat is needed.*

Discussion Questions on Interdiocesan Cooperation and Coordination

- What are any “consistent diocesan policies”?
- What mechanisms exist for bishops to collaborate with one another during new ventures?
- How can ministry leaders assist when “contrary or contradictory policies among bishops” mislead people?

²² See *Lumen Gentium*, no. 23; *Christus Dominus*, no. 37.

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

Diocesan Guidelines and Procedures

31. Particular diocesan guidelines or procedures, often called diocesan protocols, developed in dialogue with sponsors, other health care leaders, and consultants possessing the requisite legal, canonical, and theological expertise, can be helpful for evaluating new forms of health ministry.

Procedures should be in place to ensure that there will be a consistent approach to the challenges and opportunities posed by the current health care environment. The form such procedures or guidelines take will vary depending on several factors, among them the size of the diocese, the diversity of sponsoring bodies, the level of the Church's involvement in health care delivery in the local area, and the extent to which multistate and multi-diocesan interests converge in the provision of this health care. Normally, such procedures would provide guidance for a generally consistent approach to the variety of circumstances that might arise as new collaborative arrangements affecting the Catholic identity of the providers in question are pursued and developed.

32. Such guidelines or procedures - designed to meet local circumstances and respect legitimate local competencies and interests - may be seen as further specifying the general direction provided by Part VI of the *Ethical and Religious Directives for Catholic Health Care Services* in this area. In this way bishops, sponsors, and other leaders can pursue together their common objective of promoting the integrity of the Catholic health

CHA STUDY GUIDE

for the Second Edition of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*

care ministry by fostering the thorough review of affiliations, partnerships, mergers, ventures, and any other relationships that affect the Catholic identity of the health care provider as well as the Catholic presence in the health care field.

Conclusion

33. This call for the exercise of the bishop's pastoral office in overseeing health care ministry is issued to create an atmosphere of mutual understanding, fruitful collaboration, and ecclesial communion. Out of such collaboration, and with the pastoral direction of the diocesan bishop, Catholic health care organizations will continue to manifest the teaching and love of Christ through their caring ministry. In performing such a ministry, they are imitating Christ who, when he "saw the vast crowd, his heart was moved with pity for them, and he cured their sick" (Matt 14:14).

Discussion Questions on Diocesan Guidelines and Procedures

- What are the current "diocesan protocols" applicable to your ministry? How are they communicated and lived out?
- How should these guidelines be established? Who needs to be a part of this process?
- Do these guidelines carry over when a new bishop is installed into the diocese? How and who raises this question to the new bishop?

CHA ENDNOTES

- i The *Didascalía Apostolorum* is taken from the “Ordinances of the Holy Apostles Through Clement,” the largest collection of ecclesiastical law that has survived from early Christianity. Although the text is probably pseudo-canonical, it does demonstrate historically how central care for the sick was considered by the middle of the third century.
- ii “The laity, by their very vocation, seek the kingdom of God by engaging in temporal affairs and by ordering them according to the plan of God. They live in the world, that is, in each and in all of the secular professions and occupations. They live in the ordinary circumstances of family and social life, from which the very web of their existence is woven. They are called there by God that by exercising their proper function and led by the spirit of the Gospel they may work for the sanctification of the world from within as a leaven” (*Lumen Gentium*, no. 31). “The laity are gathered together in the People of God and make up the Body of Christ under one head. Whoever they are they are called upon, as living members, to expend all their energy for the growth of the Church and its continuous sanctification, since this very energy is a gift of the Creator and a blessing of the Redeemer” (no. 33). “The lay apostolate, however, is a participation in the salvific mission of the Church itself. Through their baptism and confirmation all are commissioned to that apostolate by the Lord Himself. Moreover, by the sacraments, especially holy Eucharist, that charity toward God and man which is the soul of the apostolate is communicated and nourished. Now the laity are called in a special way to make the Church present and operative in those places and circumstances where only through them can it become the salt of the earth” (no. 33).
- iii See *The New Charter for Health Care Workers*: “Service to life is performed only in fidelity to the moral law, which expresses its value and duties. Indeed, for the health care worker there are moral responsibilities too, the guidelines for which spring from bioethical reflection. In this field, with vigilant, zealous attention, the magisterium of the Church makes pronouncements in reference to the questions raised by biomedical progress and by the changeable cultural ethos. For the health care worker, this magisterium is a source of principles and norms of behavior, which enlightens his conscience and orients it — especially in the complexity of today’s biotechnological possibilities — toward decisions that always respect the human person and his dignity” (no. 5). The full resource can be found at <https://www.ncbcenter.org/free-scribd-texts/new-charter-for-health-care-workers>.
- iv Community benefit programs offer assistance to local communities in many different ways; e.g., addiction screening, food insecurity, senior care, grief support, housing, and even transportation. For a fuller description of what community benefit means, see <https://www.chausa.org/communitybenefit/community-benefit>.

CHA ENDNOTES

- v See Bouchard, “Health Care as Ministry: Common Usage, Confused Theology,” *Health Progress* (May-June 2008).
- vi The full text of canon 678 of the *Code of Canon Law* reads as follows:
- §1. Religious are subject to the power of bishops whom they are bound to follow with devoted submission and reverence in those matters which regard the care of souls, the public exercise of divine worship, and other works of the apostolate.
- §2. In exercising an external apostolate, religious are also subject to their proper superiors and must remain faithful to the discipline of the institute. The bishops themselves are not to fail to urge this obligation if the case warrants it.
- §3. In organizing the works of the apostolate of religious, diocesan bishops and religious superiors must proceed through mutual consultation.
- vii See *Lumen Gentium*, no. 23: “The individual bishops, who are placed in charge of particular churches, exercise their pastoral government over the portion of the People of God committed to their care, and not over other churches nor over the universal Church. But each of them, as a member of the episcopal college and legitimate successor of the apostles, is obliged by Christ’s institution and command to be solicitous for the whole Church, and this solicitude, though it is not exercised by an act of jurisdiction, contributes greatly to the advantage of the universal Church. For it is the duty of all bishops to promote and to safeguard the unity of faith and the discipline common to the whole Church, to instruct the faithful to love for the whole mystical body of Christ, especially for its poor and sorrowing members and for those who are suffering persecution for justice’s sake (no. 160), and finally to promote every activity that is of interest to the whole Church, especially that the faith may take increase and the light of full truth appear to all men. And this also is important, that by governing well their own church as a portion of the universal Church, they themselves are effectively contributing to the welfare of the whole Mystical Body, which is also the body of the churches.”

CHA ENDNOTES

The General Introduction of the *Ethical and Religious Directives of Catholic Health Care Services* describes the bishop's role in Catholic health care more specifically: "Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop exercises responsibilities that are rooted in his office as pastor, teacher, and priest. As the center of unity in the diocese and coordinator of ministries in the local church, the diocesan bishop fosters the mission of Catholic health care in a way that promotes collaboration among health care leaders, providers, medical professionals, theologians, and other specialists. As pastor, the diocesan bishop is in a unique position to encourage the faithful to greater responsibility in the healing ministry of the Church. As teacher, the diocesan bishop ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese. As priest, the diocesan bishop oversees the sacramental care of the sick. These responsibilities will require that Catholic health care providers and the diocesan bishop engage in ongoing communication on ethical and pastoral matters that require his attention."

viii The ERDs are directives, not formal law. The USCCB did not issue the ERDs in the form of legislation; however, the diocesan bishop can do so if he proclaims them to be "particular law" in his diocese. When promulgated, the ERDs become law and have more legal authority within the Church. In cases of dispute over the proper interpretation of the

ERDs, the USCCB Committee on Doctrine may be consulted, but the USCCB cannot arbitrate, as the USCCB only has collegial authority, not juridic authority over the local bishop. Of course, either party (the health care party or the local bishop), can appeal to the Holy See as a last resort when there is a dispute — which is one of the functions of Disputed Questions and Responsa (usually with the assistance of the National Conference as a way of demonstrating that the dispute has national and not only local significance).

- ix During alienation from one sponsor to another, "stable patrimony" consists only of those items so identified in a list that the founding sponsor devises when alienating to another sponsor. If the item is not on the list, it is not considered stable patrimony. For example, medical office buildings are often not listed, but sometimes can be. For more information on temporal goods, see the CHA product *Temporal Goods at the Service of the Mission of Ministerial Juridic Persons*. <https://www.chausa.org/store/products/product?id=3490>
- x A number of church documents address this relationship. See for example, "Directives for the Mutual Relations between Bishops and Religious in the Church" (1978) and "Economy at the Service of the Charism and Mission" (2018).
- xi The following are a just few examples of collaboration between Catholic health ministries and other social service agencies

CHA ENDNOTES

- featured in *Catholic Health World*: CHA's leaders spotlight ministry's involvement in housing; Chicago hospitals unite to address socioeconomic needs of West Side residents; Catholic Charities pilots housing initiative in five cities; Our Lady of the Lake, Catholic Charities creating payday loan alternative.
- xii We are seeing the importance of these social determinants of health as we move toward a "public health" or population health model and away from acute care, disconnected therapeutic interventions and fee-for-service payment. We have learned that we can provide better health care by identifying and addressing the causes of illness rather than waiting until it requires treatment. The Catholic Church, with its wide network of health care and educational institutions, can be of great service. For a national perspective, see Donald Berwick, "The Moral Determinants of Health," *Journal of the American Medical Association* (Viewpoint, 324:3, July 21, 2020, 225-226). Berwick says as a country we have thousands of "vast expensive repair shops," but little prevention or care, especially for the homeless, poor or those affected by racism.
- xiii CHA has developed a Ministry Formation website that offers formation in six areas for a variety of roles. See <https://www.chausa.org/cha-ministry-formation>. Login is available to members.
- xiv Some Catholics turn to euthanasia and assisted suicide because they have lost the sense that death and dying are meant to be a participation in the suffering, death and resurrection of Christ. The document *Samaritanus bonus* highlights the importance of hospice, which provides care for the dying, and palliative care, which manages symptoms for those with chronic, incurable illnesses. Hospice and palliative care are both important alternatives to euthanasia and assisted suicide. Catholic health care can take advantage of these programs in an important way by integrating excellent clinical care with spiritual care. The full text of *Samaritanus bonus* can be found here: <https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2020/09/22/200922a.html>
- xv <http://www.academyforlife.va/content/dam/pav/documenti%20pdf/2019/White%20Book/WHITE%20BOOK%20English02%2025Apr19.pdf>
- xvi The Association of Ministerial Juridic Persons in Australia was founded in 2016 to "bring together the MPJPs of some of Australia's major Catholic health, aged and community care, and educational organizations. This umbrella body allows the canonical stewards of these MPJPs to interact formally with Bishops, Church agencies and, importantly, with one another." It is the most highly organized association of juridic persons in the world. A fuller description is available at <https://ampjp.org.au/about-us>.

APPENDIX A

Decree Establishing the Ethical and Religious Directives as Particular Law

[SAMPLE]

GENERAL DECREE ESTABLISHING THE _____ EDITION OF THE
*ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC
HEALTH CARE SERVICES* AS PARTICULAR LAW IN THE (ARCH)DIOCESE
OF _____

Mindful of the significant contribution Catholic Health Care Services offers as well as my responsibility as diocesan bishop to safeguard the integrity and unity of the works of the apostolate pertaining to health care in the (Arch)Diocese of _____ (cf. canons 392, 394, 678, and 747);

I, Most Reverend _____, by the grace of God and the Apostolic See (Arch)Bishop of _____, hereby issue this General Decree in accord with canon 29 establishing the _____ edition of the United States Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* as particular law in the (Arch)Diocese of _____.

The ___ edition of the *Ethical and Religious Directives for Catholic Health Care Services* is to be promulgated in accord with canon 8, §2 by publication of the text on the Internet Website for the (Arch)Diocese of _____ (www.nameofdiocese.org) and by delivering a copy of same and a copy of this decree to the chief executive officer and the sponsors of all Catholic health care institutions located in the (Arch)Diocese of _____. The provisions of the ___ edition of the *Ethical and Religious Directives for Catholic Health Care Services* shall become effective and binding within the (Arch)Diocese of _____ on (month, day, year), any particular legislation, directives, or instructions to the contrary notwithstanding.

Dated this ____ (day) of ____ (month), in the Year of Our Lord _____.

_____ (Arch)Bishop of _____

ADDITIONAL CHA RESOURCES

The following resources are available in the CHA store:

Guide for Sponsors in Catholic Health Care: An Explanation of Purpose, Qualifications, Structures and Competencies



A valuable and timely guide for new, current and prospective sponsor members about the distinctive role of sponsors and important role of the laity for the health ministry of the Catholic Church.

The guide highlights the vocation, personal qualifications and recruitment of individual sponsor members and the importance of their ongoing formation and spiritual development. In addition to explaining evolving models of sponsorship and the development of ministerial juridic persons (MJPs), the guide describes core competencies of the sponsor body and its role as a Gospel ministry.

A Guide to Understanding Public Juridic Persons in the Catholic Health Ministry



This updated and expanded guide addresses changes in sponsorship structures and assists sponsors and those in management to understand the canonical responsibility of sponsors for a ministry of the Catholic Church. Developed by noted canon lawyers Fr. Jordan Hite, TOR, JCL, JD, LL.M.; Sr. Sharon Holland, IHM, JCD; and Fr. Francis Morrissey, OMI, Ph.D., JCD, the new publication was created to be a resource for Catholic health care systems or institutions that are considering new forms of sponsorship and provide a contemporary overview of public juridic persons (PJP's).

A Passionate Voice for Compassionate Care: Celebrating 100 Years



This comprehensive history of the Catholic Health Association of the United States features vintage and contemporary photographs that illustrate the 100 years of the association since its founding in 1915. The book describes the significant moments, leaders, challenges and issues of CHA's history through the major themes of standardization, leadership transitions, Catholic identity, models of sponsorship, health reform and health care ethics.

Temporal Goods at the Service of the Mission of Ministerial Juridic Persons



CHA presents this new publication in support of persons with direct responsibility for the temporal goods of public juridic persons in the Catholic Church. Written by Fr. Frank Morrissey, OMI, Ph.D., JCD, and Sr. Peggy Martin, OP, JCL, the publication is part of a series of resources from CHA to assist sponsors of Catholic health care in the effective exercise of this important ministry of the church. It updates and builds upon the 1994 CHA document *Inventoring Church Property and Other Administrative Matters*. It provides a great deal more foundational canonical information and praxis in the administration of temporal goods.

Other resources are available on the USCCB website.



We still are in a learning curve, but the results are now becoming more and more tangible. Laypersons who are duly qualified not only can assume responsibility for extensive ministries but also are able to represent them competently when dealing with Church authorities and their representatives.

The role of the diocesan bishop has not changed. What has changed is the person to whom he turns if there are questions or concerns beyond the level of the administration of the local facility.

Any progress, when different entities are involved, calls for continued dialogue, consultation and hard work. The Church now has available an untapped wealth to be found in so many of its members who resolutely have taken the path of living their baptismal commitment in unforeseen ways.

We have to learn to trust them, their judgment and their practical experience. In this way, the Church will flourish, and Christ's saving message can be more readily available to all.

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