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RESEARCH ARTICLE/ARTICLE DE RECHERCHE

Canadian Catholic Health Care at the Nexus of Multiple Legal Regimes*

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Abstract

What does it mean to be a public Catholic institution in Canada? How does this Catholic identity evolve with the secularisation and diversification of society, and with the rising awareness of the complicated legacy of Catholicism and colonisation in Canada? This article explores those questions drawing on document analysis and interviews with staff working in Catholic health care. Taking a legal pluralist approach, it documents how Catholic health-care institutions navigate between transnational canon laws and ethics, and human rights law. Catholic health care is situated in a web of national and transnational legal regimes. We argue that this navigation takes different forms to adapt to societal changes, such as the authorization of Medical Assistance in Dying (MAiD). This article speaks directly to how Christianity continues to play a subtle, but still constant presence in Canadian Catholic hospitals, and debunks tropes that construct relationships between state and religion as one of clear separation.

Keywords: religion; law; Catholicism; health care; secularism; politics; medical assistance in dying

Résumé

Qu'est-ce qu'une institution catholique publique au Canada ? Comment cette identité catholique évolue-t-elle dans un contexte marqué à la fois par la sécularisation et la diversification de la société ainsi que par une prise de conscience croissante de l'héritage

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complexe du catholicisme et de la colonisation au Canada ? Cet article explore ces questions à partir d'une analyse documentaire et d'entretiens menés auprès du personnel œuvrant au sein d'institutions de santé catholiques. Adoptant une approche pluraliste du droit, il examine la manière dont les institutions de santé catholiques naviguent entre le droit canon transnational, l'éthique ainsi que les droits humains or ainsi que les droits de la personne. Les institutions de santé catholiques s'enracinent dans un réseau de régimes juridiques nationaux et transnationaux. Nous soutenons que cette navigation prend différentes formes afin de s'adapter aux changements sociaux tel qu'illustrer par l'autorisation récente de l'aide médicale à mourir (AMM). Cet article traite de la façon dont le christianisme continue de jouer un rôle discret, mais constant dans les institutions de santé catholiques canadiennes, et démystifie les idées reçues relatives à l'existence d'une séparation claire entre l'État et la religion.

Mots clés: religion; droit; catholicisme; soins de santé; sécularisme; politique; aide médicale à mourir

Introduction

In Canada, there are approximately 129 publicly funded hospitals and long-term care homes that are accountable to the Catholic Church. While this corresponds to just over 5 percent of all health-care institutions (Hoskins 2017), this figure varies from province to province. In Ontario, for instance, 15 percent of health services are affiliated with the Catholic Church, while in Alberta 12 percent of acute-care beds and 27 percent of palliative-care beds are managed by Catholic institutions (Glauser 2022). In British Columbia, more than 50 percent of hospice beds in Metro Vancouver are located in publicly funded religious institutions (DeRosa 2023). The influence of Catholicism on health care is a historical legacy. Orders of nuns spearheaded the establishment of the first hospitals and health-care facilities throughout Canada. In fact, religious congregations controlled more than 35 percent of health care until the introduction of public health care in the 1960s (Glauser 2022). At that time, provincial governments, who were focused on efficiency, took over several religious institutions, while the Quebec government, as part of the *Révolution Tranquille*, closed or took over the administration of Catholic-run hospitals.

Despite an overall decrease in the number of Catholic-led health-care facilities over the past forty years, these institutions still remain deeply embedded in the texture of Canadian society. They play a role in the lives and experiences of care of many Canadians, who often enter the doors of these facilities because they are the closest to their homes (and sometimes the only health-care institution in town). The fact that these publicly funded institutions are governed at the same time by Canadian law and Catholic canon law remains largely unknown by both scholars and the broader public. The scarcity of social science research on the topic (aside from some theological research, e.g. MacLellan 2017; Morrisey 2011; Pijnenburg et al. 2008; Self 2022) is illustrative of this reality, so shedding light on the ethics and governance structures of these institutions is essential. Indeed, with the legalization of Medical Assistance in Dying (MAiD) in Canada in 2016—and the fact that Catholic facilities uniformly do not offer this procedure—the "Catholic" identity of these institutions has suddenly become

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more visible. Thus, better understanding these institutions and how they are embedded in Canadian institutions can help us shed light on the complexity of contemporary debates about the role of religious actors and institutions in public life.

Drawing on interviews with doctors, health-care practitioners, managers and Catholic sisters, as well as policy and archival analysis, this paper explores what it means exactly for hospitals today to identify as Catholic, in terms of their governance structures, the services they provide and how they deliver them. In other words, we examine to what extent there is something distinct about this Catholic institutional identity and how this distinctiveness evolves with social change. Theoretically, this paper contributes to contemporary efforts to complicate our understanding of Canada as a secular society and refine our appreciation for the role of religion in institutions and policies, (e.g. Berger 2015; Pavolini et al. 2017)—including the deep-seated privilege of Catholicism and Christianity more broadly, in Canadian institutions (e.g. Beaman 2021; Kaell 2017; Bramadat and Seljak 2008). The paper also provides original empirical data on the ways in which Catholic health care shapes approaches to care, access to care and understandings of health-care equity.

The paper begins by locating Catholic hospitals in Canada within the broader theoretical context of critiques of Canadian secularism, then introduces the study's legal pluralist framework. The first analytical section includes an overview of how different sponsorship models contribute to the governance of Catholic hospitals. The second analytical discussion illustrates how Catholic identity is embedded within everyday hospital practices. We illustrate this with two examples: a discussion of the role of mission and values offices in maintaining Catholic identity in hospitals and an analysis of how Catholic hospitals navigate debates about MAiD. We conclude by arguing that our analysis of Catholic hospitals helps to make visible the entanglements—and privilege—of Christianity in Canada's public life.

Theoretical framing and methodology

Canada is often imagined as a "secular" country (Selby et al. 2018). This image enables the telling and retelling of a secular myth in which religion and politics are thought to be neatly separated.[1] More specifically, in this myth, religion is located in a private realm (preferably one's private conscience) and does not influence the realm of public affairs and policy decisions. Of course, as scholars have discussed over the years (Beaman 2021; Bramadat and Seljak 2013; Lefebvre and Beaman 2014; Selby et al. 2018), this trope does not reflect empirical reality.

[1] Of course, there are differences in how secularism is imagined and shapes policies in Canada. In Quebec, secularism has over the past decade become a political ideology culminating in the passing of Law 21 in 2019. Thus in that province the concept does not only convey an implicit idea that religion and politics ought to be separated in a modern state, but this is accompanied by a more explicit discourse where secularism has become an ideology mobilized by the Quebec government to give shape to the Quebec nation, and delimit the boundaries of the proper Quebec citizen (see Béland et al. 2021; Taher et al. 2024).

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Religion, and Christianity especially in North-Atlantic societies, remains stitched into the fabric of societies and institutions, influencing time (e.g. calendar and official days off); space (e.g. names of streets, buildings, art and religious paraphernalia in the public domain); sound (e.g. ringing of church bells) and service provisions (e.g. education, health). In Canada, as elsewhere in the North-Atlantic, this is a product of history, where Christianity has informed and shaped the politics and development of modern society, including colonial politics. And yet, this myth continues to be very powerful and shapes the everyday experiences of individuals. Indeed, as Oliphant (2021) has elegantly theorized, the presence of religion—particularly Christianity—in public life appears unremarkable, unseen, or "banal." It is so ingrained in the texture of society that it is not understood as disturbing the secular myth; it does not even, one could argue, actually qualify as "religion."[2]

This paper is inspired by Oliphant's (2021) theorization of the banal in her work on Catholicism in France. The notion of the banal gestures towards the implications of the privileged position given to Christianity and, in our specific study, to that of Catholicism in the Canadian context. While several scholars of secularism have identified the Christian bias of secular arrangements, especially in North America and Europe (whereby Christianity appears invisible), this bias has generally been understood mainly in terms of a Protestant bias (e.g. Sullivan 2005). This paper, not unlike Oliphant's work, is an invitation to complexify what we mean by Christian bias and think about it as well in terms of the privileges given to Catholicism in Canadian society. Thus, it is an invitation to think beyond the "secular myth" and to pay careful attention to the textured arrangements between religion (and Catholicism in our case) and politics and how those can impact policies and the everyday life of communities and individuals.

This paper is also in conversation with scholarship on legal pluralism (e.g. Tamanaha 2021; Engle Merry 1988; Macdonald and McMorrow 2007; Vanderlinden 2005). Rather than understanding Catholic publicly funded hospitals as only accountable to provincial law, we analyze these institutions through a legal pluralist lens. Indeed, because of their Catholic identity, these institutions are required to navigate between multiple norms, including provincial health-care acts, human rights law and norms, and transnational canon law. Of course, this plurality, and the importance of transnational canon law, remains unseen if the "secular myth" is not questioned. In fact, one could argue that the "secular myth" in many ways supports the idea of a sovereign nation-state under one state-controlled legal regime (and therefore not vulnerable to transnational norms). Questioning the "secular myth" is thus essential to grasp the extent to which transnational legal plurality shapes the governance structures and policies of Catholic hospitals, the ethics promoted by these institutions and the everyday decision-making of health-care practitioners. Our analysis situates Canada in a

[2] Beaman (2021) and others (Oliphant 2021) have discussed how the presence of Christianity is actually framed and experienced as being part of culture.

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web of national and transnational legal pluralist arrangements that shape institutional modes of health governance.[3]

Because there is little research on Catholic hospitals (with the noteworthy exceptions of Reimer-Kirkham et al. 2020; Glauser 2022; Self 2022; MacLellan 2017) and none that has discussed the governance structure of these hospitals from a social science perspective,[4] we had to gather basic information on the ways in which the governance structures of hospitals are related to the Catholic hierarchy, as well as on how this informs the culture of these institutions. To do so, we conducted sixty semi-structured interviews from January 2023 to February 2024 on Zoom with doctors, health-care practitioners, bioethicists, managers, lay members of Catholic organizations overseeing hospitals and Catholic sisters who formerly led these hospitals throughout Canada. In addition to these interviews, we also draw on jurisprudential, policy, media and archival analysis, and on online and in-person observation of conferences and trainings organized by different Catholic organizations involved in Catholic health care. This multifaceted methodology allowed us to get a better sense of the choices that informed the models of governance that these hospitals put in place when congregations running these institutions decided to hand them over to lay-people, as well as the ways in which Catholic identity has been upheld, navigated and challenged in those institutions.

The governance of Catholic hospitals through sponsorship models

In 2019, a controversy erupted at Bruyère Hospital in Ottawa, where a physician who also happened to be a MAiD activist was given privileges to work in its palliative-care unit. His appointment was criticized in some Catholic circles (see Gyapong 2019) because of the worry that it would infringe on the Catholic identity of the institution and in particular the Catholic moral injunction to protect life from conception until death. More interestingly, his nomination had to be approved by Ottawa's archbishop. At first glance, this story might appear puzzling, especially if we are prone to the secular myth mentioned above. Why is an archbishop involved in the appointment of a doctor in a publicly funded hospital? Why is this member of the Catholic hierarchy interfering in provincial health-care affairs? The key to understanding this intervention is to consider the complex governance structures of Catholic hospitals today that are accountable to not only health-care legislation, but also to the Catholic Church.

[3] It is important to note that this article does not engage in an in-depth discussion of canon law and how it applies to health-related questions. This would be outside our area of expertise and the scope of this article. Our focus is limited to unravelling how canon law is entwined with the governance of Catholic hospitals, revealing certain ways in which these hospitals navigate legal plural regimes.

[4] The thesis of Sr. Bonnie MacLellan, (2017) and the work of Fr. Morrisey (2011) discuss these structures from a theological standpoint. Thus, they are more interested in thinking about how these structures of governance fit within canon law than about the place of these structures within the broader Canadian sociolegal landscape.

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The specificity of governance models put in place by Catholic hospitals vary with specific hospitals and the province and diocese in which they are located, as well as the congregation of nuns who used to run these hospitals. In fact, these models started to emerge in the late 1980s/early 90s across Canada with the exception of Quebec, which had secularized its health-care system three decades earlier (Bélanger and Lepage 1989). The reason for their emergence is in part related to the fact that the Catholic sisters running these institutions were declining in number and ageing: "We ran hospitals as CEOs, but when it got to the point where we didn't have any more sisters that could really do a good job as CEOs, we felt it was time for us [...] to move out and look for other ways to do our mission and values" (Sister Karen, interview with researchers, May 2023).[5] It was also related to calls coming out of Vatican II to give a greater role to the laity (MacLellan 2017, 19, 20; Editor 1961).

Some of these new governance structures have taken the form of sponsorship models, whereby sisters chose to entrust the responsibility for keeping the "Catholic identity" of hospitals to a body (a "sponsorship" organization) that is constituted principally of lay individuals. In other words, these lay individuals become the "keepers of the flame" (Dr Cooper, interview with researchers, January 2024).[6] Francis Morrisey, discussing the role of sponsors, clearly explains that: "Sponsors must be able to articulate what they consider to be the non-negotiable for the Catholic ministry yet be flexible enough to choose between total control and having some presence with the power to influence" (Morrisey 2013). Sponsors are identified by canon law specialists as Public Juridic Persons (PJP) that are responsible for ensuring that Catholic identity is preserved and perpetuated through time (for more on this see MacLellan 2017).

In other words, a sponsor organization can be responsible for ensuring that the organizations it sponsors follows Catholic values and the mission of the Church, while not necessarily owning these institutions. On this distinction between ownership and sponsorship, Conlin (2001) reminds us that: "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." In fact, this involvement is part of what is understood to be the "reserved powers" that are the prerogative of the sponsor[7] (see also Morrisey 2001; MacLellan 2017). Reserved powers typically include: "the three Ps—paper, persons, property" (Morrisey 2013); that is: "The powers now focused on documents (corporate documents, bylaws, mission statements), on persons (CEO and board) and on property (alienation, mortgages, bond issues)" (ibid.). The "person" dimension is an important one. It explains the involvement of the sponsor organization in the nomination and approval of Board Members of particular institutions and in

[5] All interviewees have been given pseudonyms to protect their identity.

[6] MacLellan explains that sponsors should be understood as "godparents," "guarantors of the faith" and "as a person who assumes personal responsibility for the development of the faith of the individual" (2017, 38).

[7] In some cases, these "reserved powers" are still retained by congregation members that sit on the boards of sponsorship organizations, and in some other cases they are retained by the sponsorship organization itself (see Morrisey 2001 on this).

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some cases—as we saw with the example of Bruyère Hospital at the beginning of this section—it might shed some light on why members of the Catholic hierarchy weigh in on more specific appointments. More generally, sponsors are responsible for ensuring that the mission and values of the institutions they sponsor meet canonical principles and are in harmony with those of the founding congregations (see McGowan 2005 for more information).

Because sponsorship models are not defined in canon law, these models are living experiments that change with society (see Morrisey 2013). Today, in Canada two models dominate the landscape. The first one is called a Public Juridic Person of Pontifical Right (PJPP). In this model, the sponsor organization reports directly to the Holy See. For instance, the sponsor, Catholic Health International, which oversees more than thirty health-care institutions in Canada (principally New Brunswick) and the United States, is a PJPP. In outlining its role and responsibilities, this sponsorship organization notes that it has to: (1) submit an annual report on the activities of its institutions to the Vatican, (2) "maintain strong relationships [...] with the Founding sisters," (3) "integrat[e] the essence of a mission founded on 670 years of collective service by our Founding Sisters, into the facilities and operations which we have been entrusted to guide," (4) provide "leadership development focused on the spiritual and ethical foundations of Catholic social teachings" and (5) "support our Sponsored Corporations in governance by involvement in the appointment of individuals to their Board of Directors/Trustees and Advisory Committee" (Catholic Health International 2001).

The second model is a Public Juridic Person of Diocesan Right (PJPD). In this model, the sponsor organization reports to the diocesan bishop (McGowan 2005, 6). The St Joseph's Health Care Society in London, Ontario is an example of this sponsorship model. This society was established in 1993, with the objective "of ensur[ing] that the mission of Catholic health and the treasure of the Sisters' health care ministry continues to be animated and celebrated, now and into the future" (St Joseph Health Care Society, "Orientation," n.d.). It oversees four institutions: St Joseph's Health Care, St Joseph's Hospice, St Joseph Hospice-Sarnia/Lambton and Hospice of Elgin (ibid., 8). One of the responsibilities of a PJPD sponsor, because it answers directly to the diocesan bishop, is precisely to "ensure positive relationships with the Bishop" (St Joseph Health Care Society, "Unique Role of Sponsor," n.d., 3).

In both sponsorship models, the PJP effectively does the same thing. It "delegates power to the leaders of the organizations that it is sponsoring (e.g., a specific health-care institution)" so that they can function on an everyday basis, while at the same time ensuring that the organizations and its leaders "carry out their mission" (Catholic Health Alliance of Canada 2009, 27). There appear to be different factors informing the choice of a diocesan or Pontifical PJP, including geographical (that is, if all the institutions sponsored are in the same diocese) and overall relationships with the bishop overseeing the diocese. One of the sisters we interviewed, recalling the process of choosing the PJP that would best fit the needs of their congregation, noted: "We had a wonderful relationship with a bishop and a history of always consulting him" (Sister Mary, interview with researchers, May 2023). In fact, it is this relationship that partly shaped their choice of a diocesan model.

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Some congregations, like those in Newfoundland and Nova Scotia, chose another route instead of the PJP sponsorship model. They made the decision to sell their hospitals to the provincial health-care authority with the caveat that the hospital would keep its "Catholic" identity.[8] For example, St Clare's Mercy Hospital in Newfoundland entered in an agreement with the health authority of that province in 1995. The 1995 agreement stipulated that the congregation of the Sisters of Mercy, who were the owners' of St Clare's hospital, would transfer ownership of that hospital to the province and that the province would in exchange: "agree to appoint to the St. John's Hospital Board not less than (2) persons to be nominated by the Sisters of Mercy for the duration of this Agreement."[9] In turn, the province would also ensure that St Clare's would continue to respect the principles of Catholic health-care ethics, including the refusal to perform direct abortions (Agreement 1995).

The interesting common element about all these agreements developed in the 1990s and that are often still enforced today is that they directly speak to the complex ties that exist between Catholic communities and public health care in Canada. The different arrangements show that several Catholic hospitals are effectively governed by Canadian health-care legislation but also by canon law. The way these latter systems of governance unfold can differ with the arrangements crafted by founding congregations, but often involves the presence of congregation members on boards, a requirement to be accountable and in direct communication with bishops or the Holy See with regard to the activity of the health-care institutions and—most importantly—sustained efforts to ensure that the mission and values of the founding sisters (and of Catholicism more generally) continue to be kept alive in those health-care institutions. The example of St Clare's Mercy Hospital is particularly fascinating as, even though ownership of the hospital was transferred to the province, this commitment to Catholic values remained. For most of the hospitals who are accountable to sponsorship organizations, the ownership of the land still belongs to founding congregations, even though these are public institutions that rely on public funds. Thus, these governance structures reveal the ways in which state politics and Catholicism continue to be deeply entangled in the Canadian context. These entanglements affect not only governance structures, but also everyday life in hospitals. It shapes the experiences and the navigations that some hospital staff undertake when they work in those institutions. We turn to this in the next section.

Catholic identity in everyday hospital practices

The discussion above described the various sponsorship models that ensure that hospitals integrate Catholic canon law into their governance structures. But it is

[8] Decisions around the model that a congregation should adopt vary greatly with the congregation's location, priorities and politics. It could be argued, however, that in areas where the population was relatively homogenous in terms of religion, it was easier for a provincial government to agree to preserve the Catholic identity of an institution in comparison to an area that would be more diverse. Several of our interviews with congregation members point to this.

[9] This was changed to one person in 2005 when the agreement was renegotiated.

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one thing to preserve Catholic identity through formal structures of leadership and governance. It is another matter to embed and operationalize Catholic identity and values within the everyday practices of health care. What exactly —if anything—makes a hospital a *Catholic* hospital in the context of service delivery? The next two sections describe how Catholic hospitals embed this identity in their everyday practices through two examples. The first example focuses on how mission and values offices, which are present in most Catholic hospitals, are established with the specific purpose to promote and advance the Catholic identity of their institutions. The second example examines how Catholic hospitals navigate debates and practices related to MAiD. Both examples illustrate how religious identity influences the everyday life of Catholic hospitals in Canada.

Missions and values offices and the operationalization of Catholic identity

Prior to the establishment of new models of governance through sponsorship organizations, Catholic sisters maintained a visible and influential presence within hospitals. This is because they occupied positions throughout the hospital at every level of leadership, from nursing stations up to the level of CEO. In such a context, there was no need to intentionally promote Catholic mission and values: the very presence of the sisters "set the tone" (Olivia (spiritual care provider), interview with researchers, November 2022) and ensured the maintenance of an institution's Catholic identity. All of this started to change, though, after the transfer of leadership to the sponsorship organizations. An intentional strategy was needed to ensure the continuation of Catholic identity and values.

The establishment of "mission and values" offices in Catholic hospitals across the country was a part of this strategy. The main responsibility of these offices is to build an organizational culture that protects and promotes Catholic values and identity, and to liaise between the hospital, sponsorship organizations and Catholic leadership. Our interview participants also cited the need to preserve the legacy left by the sisters. For instance, Emma, who works for a sponsorship organization, described her job in the following terms: "My role [is to] build and maintain cultures that are consistent with the spirit of the work that the sisters did as the initiators of all these organizations [...] Not to try to recreate a bunch of sisters or have people live in the same way. But are you working in the same spirit that the sisters would be coming, in a spirit of service?" (interview with researchers, February 2023). These mission and values offices are typically staffed by laypeople who have personal and/or professional affiliations with the Catholic Church, sponsorship organizations and/or other Catholic organizations—although not all of our research participants identified as Catholic. Additionally, staff members often have advanced degrees in theology and some training or familiarity with canon law. Most importantly, they are the cheerleaders of Catholic health care within their institutions, which they describe as being distinct from non-faith-based care.

Of all of our research participants, staff from mission and values offices spoke the most eloquently and with the greatest amount of detail about the distinct features of Catholic health care. Gabrielle, who trained in spiritual care prior to

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her role as missions and values leader in an urban hospital, explains what sets Catholic health care apart from non-faith-based care:

> What I think makes Catholic health care distinct for me is that intentional focus on missions and values integration [...] What I see as spiritual traditions of reflection, formation, or discernment are all kinds of spiritual words, but how to operationalise those in the delivery of health care or care giving? We talk a lot about creating healing communities. That sense of healing versus delivery of a health service [...] it has just a bit of that broader, holistic approach to health services. (Interview with researchers, July 2023)

Here we see that health-care delivery is imbued with spiritual meaning: it is more than the delivery of a service. Many of our research participants from mission and values offices expressed this idea that health-care delivery is connected to a sense of higher purpose. They understood one of their primary responsibilities as cultivating this sense of higher purpose to staff throughout the organization. For instance, Karen describes the role of Catholic health-care explicitly using metaphors that are commonly applied to Christian ministry beyond hospitals: "That's really the essence of Catholic health care, is being that light and shining that light in darkness, turbulence and uncertainty." For the staff in mission and values offices, Catholic health care is part and parcel of the broader ministry of the Catholic Church.

In the context of the Canadian public health-care system, the challenge is to communicate and promote Catholic mission and values in terms that are acceptable and meaningful to a diverse range of staff members and the broader public, only a minority of whom might personally identify as Catholic and some of whom might be actively hostile to Catholicism. In order to do this, mission and values staff are required to translate Catholic identity and values into terms that resonate for a diverse set of stakeholders using a more generic *lingua franca* that is centred on universal values such as compassion, human dignity and social justice. Along these lines, Ryan, who previously worked for a non-Catholic institution before joining a Catholic network in the 2000s, explained:

> You don't have to hang compassion and dignity and all of those things on the hooks of the parable of the Good Samaritan and Catholic values. What are the existing hooks in your own life on which you can hang those principles? [...] People feel more comfortable practicing Catholic values if they are attached to something individual and personal. In theology, it's called "dynamic equivalence." (Interview with researchers, November 2022)

In a similar way, Alex, who has been a mission and values leader for several hospitals across the country, observed that stories about the Good Samaritan, Jesus and the founding sisters "don't inspire in the same way" as hospital staff and patients become more diverse (i.e. less homogenously Christian), so his responsibility is to translate these stories into concrete organizational behaviours that nevertheless embody the same values.

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One of the challenges for mission and values staff is to maintain a balance between communicating a vision of value-based care in a way that will resonate with all staff regardless of their faith affiliation while nevertheless claiming these values as a distinct feature of Catholic health care. Wendy, who has spent most of her career working with different Catholic institutions, describes this tension:

> I would say a lot of our staff have a personal resonance to our values and are living them. But they don't necessarily have the language to speak about it in a mission and values-based language. So, they would talk about it in patient experience language or equity language [...] And all of those are really linked to social doctrine of the Church and our values [...] No matter what background or identity you come from, hopefully you resonate with these human values. If you don't, this is probably not a good fit for you. And even if you don't resonate with the word Catholic, hopefully you still resonate with these values [...] But I would say, we're always walking that tight rope. We don't want to hide our Catholic identity, because we are Catholic health care. Yet, there is a lot of tension there for a lot of people and we want to honor that. (Interview with researchers, January 2023)

Wendy's observations illustrate how mission and values offices must grapple with two competing pressures. On the one hand, if values like compassion or equity resonate across all contexts, what makes them uniquely Catholic—and by extension, what makes a Catholic hospital distinct by virtue of the promotion of these values? On the other hand, insisting on a Catholic interpretation of these values could risk alienating staff and patients—and by extension risk undermining support for the continuation of Catholic health care. Mission and values offices constantly try to navigate the balance between preserving a unique Catholic identity at the same time as crafting the message that Catholic health care can be—and is—accessible to all.

There are a number of concrete practices through which mission and values offices cultivate and, one could argue, ritualize Catholic identity and values at all levels of their institutions—from the highest levels of executive leadership all the way down to frontline staff. First, mission and values are embedded into daily routines. For example, Wendy explained how her institution incorporates "mission moments" at the beginning of all corporate meetings, which are opening reflections that invite attendees to share how they integrate the hospital's mission and values into everyday life. Catholic hospitals also keep the memory of the founding sisters alive by combining the feast day of the hospital's patron saint with staff recognition events. For instance, an interviewee described how, on the annual feast day of their major urban hospital, senior leaders greet staff early in the morning as they arrive with coffee and snacks and distribute small tokens of appreciation such as pens and lanyards. The day is also marked by a special mass in the hospital chapel. Another example of this is giving staff awards that recognize individuals who exemplify the hospital's mission and values. For instance, one institution offers Mission Awards that are linked specifically to the institution's six official values, including a Compassion Award and a Respect

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Award. In this way, staff appreciation is explicitly linked to the institution's Catholic identity and is expressed in terms that amplify mission and values.

Moreover, the Catholic identity of a hospital is maintained and reinforced in the materiality of the hospital space. The hallways often feature photographs of founding sisters. It is common to encounter Catholic iconography, including statues of Jesus, the Virgin Mary or the hospital's patron saint on the hospital grounds. Karen notes how patients and staff in her institution leave flowers at the feet of the statue of the hospital's patron saint as an offering of prayer or gratitude (interview with researchers, March 2023). Often there are crosses and crucifixes placed in prominent locations, or in individual patient rooms. The hallways also feature photographs that represent the hospital's Catholic history, or special exhibits with images curated to represent the institution's mission and values in action. We encountered one such exhibit in the main hallway of St Michael's Hospital in downtown Toronto, which consisted of a photo collage combining black and white images of Catholic sisters and priests juxtaposed with contemporary photos of staff members engaged in their daily work (see Figure 1). These material artifacts serve as physical reminders to staff and patients about the hospital's Catholic identity, mission and values.

One of the most important functions of mission and values offices is to provide training to staff around the hospital's Catholic identity. Although all staff receive a brief orientation to the Catholic identity of their institution during onboarding, we consistently heard from interviewees around the country that mission and values offices focus their efforts on providing extended mission and values training to individuals in leadership roles. The rationale is that commitment to Catholic mission and values will permeate through an organization from the top-down. The trainings are also costly, so this is a strategic choice to focus extended trainings on individuals in decision-making roles (Jamie, interview with researchers, March 2023). The trainings are meant as well to ensure that leaders are committed to protecting an institution's Catholic identity, especially during negotiations with regional or provincial health authorities.

Figure 1. St Michael's Hospital Mural, 2023. Photo taken by authors.

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Many interviewees referred to extended leadership training opportunities that are available for health-care leaders from across Canada through national Catholic health-care organizations or sponsorship organizations. For instance, the Catholic Health Sponsors of Ontario (CHSO) offers the Mission Leadership Program, a nine-day training delivered in three modules over the span of nine months. Here, participants learn about the history and mission of the Catholic Church in health care, Catholic social teachings and canon law. The training also includes content about compassionate leadership, truth and reconciliation in relation to Indigenous peoples in Canada, cultural safety and equity and inclusion, all through the lens of Catholic teachings. As described on the CHSO website:

> [b]y the end of the Program, participants will better understand the history and legacy of Catholic health care in Canada, and how it is now their responsibility to continue the legacy. As part of this responsibility, participants will also recognize that they are mission leaders and will represent the Church in today's modern world. (CHSO 2024)

This highlights the close entanglements between Christian mission and health care within Canada's Catholic hospitals. From the perspective of Catholic health-care leaders, hospitals are an important branch of Catholic ministry. Bringing leaders together from different institutions serves the purpose of ensuring that there is consistency in leadership formation for hospital leaders from around the country—that is, creating a common culture of Catholic health-care leadership.

Finally, the mission and values office plays an important role in liaising and communicating with sponsorship organizations and the local diocese at the level of the bishop or archbishop. Regardless of whether a Catholic hospital is sponsored through a PJPP or PJPD model, hospitals are required to engage regularly with diocesan stakeholders. Alex notes:

> [The] local ordinary actually has the power to determine whether or not an organization is a Catholic health care ministry [...] Basically, a bishop can remove Catholic identity from a Catholic organization because it is the bishop's interpretation that ultimately matters [...] So, part of the relationship that's possible from a highly effective health-care organization is to ensure that the right conversations are happening with the local ordinary, because we would never expect an ordinary to understand how to run, you know, a health-care organization like ours [...] That's another part of my role, which is to build the relationship that allows the CEO, with the cardinal or the archbishop, to have those conversations. (Interview with researchers, January 2023)

In other words, the mission and values office acts as a bridge between the hospital leadership team (composed of laypersons) and the clerical Catholic hierarchy. Jamie, who has regularly been meeting with the archbishop as part of his role, provides us with more insights on their relationship:

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> I go to the archbishop every six weeks, and we have a meeting together for about an hour. In that role, I'm advising him in terms of health issues, because often, we know them as a health care provider, but the church—that's not how they think. So my role is kind of to bridge those two worlds, helping them understand why is it that we do things like why we do, what we do. And for them to ask, "Well, why can't you do it this way?" and then just negotiating back and forth. (Interview with researchers, March 2023)

At a time when Catholic hospitals are engaged in difficult conversations about, for instance, the provision of MAiD, it is especially important for them to maintain good lines of communication with the Catholic clergy to whom they are ultimately accountable. In the next section, we discuss this complex navigation in the context of MAiD and Catholic health care.

Conflicting ethics and MAiD

Several physicians we interviewed told us that they were not aware of the influence of the Catholic identity of the institution they were working in until it interfered with how they provided care to their patients or until they integrated hospital higher management. Most were aware that the hospital they worked for had Catholic origins and/or a Catholic name, but few of them understood that it could shape the care and the decisions they could make as providers. It was only when Catholic ethics collided with the care they wanted to provide that this identity became visible and more tangible.

The experience of physicians providing MAiD is a case in point. Several physicians we spoke to who were practising in palliative care prior to the legalization of MAiD had not had to navigate the ethics of the hospital, but when MAiD was legalized, the hospital's official ethics policy directly affected their ability to provide MAiD. It also required them to creatively navigate how to provide adequate support to their patients without violating the hospital's ethics given that such infringement could jeopardize their hospital privileges.[10] The experience of Dr Brown, a palliative-care doctor and MAiD advocate, is illustrative:

> Initially when MAID was legalized, there was kind of a blanket policy that it's not supported within Catholic health affiliated centres. If a patient requested MAiD, we would always be very transparent and open about the legal aspects of MAID and have an open and frank conversation with them. Then what I would do is I would put them in a wheelchair, and I would wheel them across the street [to] a church next door that is not related to our institution. And we would do a MAiD assessment in the church grounds and then bring them back. They would resume their care, then we would

[10] It is important to note that in contrast with other hospital staff, physicians in Canada are given privileges to work in a particular hospital but they are not employed by the hospitals. This, our participants noted, gave physician greater leeway to navigate some of the hospital rules related to Catholic ethics than hospital staff.

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> discharge them home, and I would meet them at home and provide MAiD for them in their house. This was me as an individual trying to support equitable access. I think at a systemic level patients were disadvantaged because employees weren't sure that they could have open and frank conversations about it. So I worked with our ethicist who's excellent, very progressive and is able to walk that line between being very respectful of the hospital policies, but also trying to support access and equity and recognizing access and equity as being important to Catholic institutions as well [...] What it has evolved to now is that if I'm a physician in this hospital, providing care to a patient admitted to this hospital, I can't participate in assessments. However, we can speak openly about it, and we can also facilitate in getting external assessors [to come do the assessment in the hospital]. (Interview with researchers, January 2023)

Dr Brown's account is revealing on two fronts. First, one can see how his personal ethics came into conflict with the ethics of the institution he worked in when MAiD was introduced. For him, access to MAiD is a question of equitable access to health care. This appears to be particularly important for a number of our participants because, according to section 241.2 (2) of the Criminal Code, patients who are eligible for MAiD are suffering intolerably from a grievous and irremediable medical condition, and are therefore particularly vulnerable, do not necessarily choose where they seek health care or might not be aware of the ways in which the culture of the institution shapes the services it provides. To resolve this ethical dilemma, Dr Brown took it upon himself to find a creative workaround. The second important element is that Dr Brown explains that MAiD policies in Catholic institutions are evolving. He recalls how he was able with the help of the ethicist to allow for MAiD assessments to happen onsite, but that they had to be done by a physician who did not have privileges in that hospital. Thus, he and the ethicist[11] were able to find a compromise within the boundaries of the institution's professed Catholic ethics. This compromise had to be discussed and accepted by senior management in the hospital and discussed as well with the sponsorship organization and bishop overseeing the hospital.

While MAiD assessments are allowed onsite in the majority of Catholic facilities today, the procedure of MAiD is not. Patients who request MAiD are therefore required to transfer to a different facility. Doctors, like Dr Brown above, have expressed concerns with that requirement grounded in a number of arguments. Dr Brown stresses that:

> Patients develop a relationship with their care providers. They're sick, they're vulnerable, they're approaching the end of their life and you're saying you are eligible for this treatment, but you need to be sent to a place where you're surrounded by strangers so that you can receive this treatment. I think we provide palliative care quite well, here. The thought of

[11] Although it is beyond the scope of this paper to fully examine this phenomenon, we found that ethicists play a significant role in helping physicians to navigate complicated situations related to MAiD and other contentious issues.

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> going to the unknown is understandably very scary. So, in that regard, it is an internal deterrent to accessing a treatment. (Interview with researchers, January 2023)

Moving vulnerable patients is a central concern for Dr Brown and others. In fact, recently this question of transfer made the news in British Columbia, where Sam O'Neil, a young cancer patient who had been approved for MAiD, lost consciousness during her transfer from St Paul hospital to a non-faith-based hospice and was not able to say goodbye to her family.

While transfers are possible in urban areas (Paterson 2023), in more rural settings requesting a transfer might be more complicated. Dr Patel, a family doctor working in rural Canada, recalls how difficult it has been to transfer patients, as the Catholic hospital where she worked was the only hospital for kilometers:

> We had one patient go south to a hospital an hour or hour and a half south of us. Some people chose not to have MAiD because they couldn't face leaving the hospital or the hospice especially. So we had patients who had what we called MAiD tickets, but they chose not to use it because the thought of getting back in an ambulance with the pain they had, especially with bone fractures and stuff from metastatic cancer, it was just too painful even to get to the hospital the first time. So they could not envision doing that again and they gave up on MAiD. (Interview with researchers, September 2023)

For this physician, navigating the question of space (e.g. where to do MAiD) was very difficult and took an extra emotional toll. In her interview she explains that because several of her patients were homeless, undergoing MAiD in their home was not an option. Instead, she had to find "adequate" facilities to do it, which included doing it in an empty boardroom of a nursing complex and a funeral home.

Doctors are not the only ones tiptoeing around Catholic ethics and figuring out the limits of what they can and cannot do. Indeed, hospital administrators including sponsors, are also navigating this complex terrain. This is partly due to the rise in media coverage of MAiD cases, such as that of Sam O'Neill at St Paul's Hospital in Vancouver, having an impact on the reputation of Catholic hospitals. The frustration could ultimately lead to a court challenge that would mandate these public facilities to offer MAiD. The dilemma for these institutions is a substantial one: how to avoid a court decision that would mandate them to do something that would potentially challenge their *raison d'être*, that is contradict the "mission and ethics" entrusted to them by founding congregations, while also adapting to social change in a manner consistent with their philosophy of health care and service?

One solution that was identified by St Martha's Regional Hospital in Nova Scotia was for MAiD to be administered by nonhospital staff in an adjacent facility that is not considered to be "officially" part of the hospital—and therefore not subject to the same Catholic mission and values as the institution itself (see Lowthers 2019). The Sisters of St Martha opted for a similar governance structure as the one chosen by St Clare's Mercy Hospital discussed above. That is, they transferred ownership of their hospital to the Provincial Health Authority in 1996, with the proviso that the Catholic mission and values of St Martha's

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would be respected (see Canadian Press 2019). It is interesting to note that the compromise of administering MAiD in an adjacent facility was negotiated between the Nova Scotia Health Authority and the Mission Assurance Committee, the body trusted with upholding the mission of the hospital. In a media statement on this question, the congregation leader of St Martha stressed:

> The Sisters of St. Martha were informed that the Nova Scotia Health Authority continues to uphold our *Mission Assurance Agreement*, while providing access in Antigonish for individuals who request Medical Assistance in Dying (MAiD). The Nova Scotia Health Authority has assured us that Medical Assistance in Dying (MAiD) will not take place in St. Martha's Regional Hospital. We do not own St. Martha's Regional Hospital, or the building called *Antigonish Health and Wellness Centre.* We continue to uphold the Mission and Values of St. Martha's Regional Hospital for quality compassionate health care. (Sister Brendalee Boisvert in Dryden 2019)

In this statement, Sister Boisvert clearly outlines that the "Antigonish Health and Wellness Centre"—that is, the building adjacent to St Martha's hospital—is not covered by the Mission Assurance Agreement and thus that providing MAiD there would not violate the Catholic precepts of respecting life from conception to natural death. The other significant element is that, while she makes it clear that St Martha is not owned by the sisters anymore and that health care is managed by the province, its agreement with the Nova Scotia Health Authority still ensures that the Sisters of St Martha remain involved in providing care for the community. In other words, delving into these MAiD navigations reveals the deep ties between Catholicism and public health care, and more concretely the ways in which the agreement negotiated by the sisters in 1996 continues to shape health-care policies in Nova Scotia.[12] St Martha's appears to be the first hospital to develop such an arrangement in Canada, an arrangement that was perhaps facilitated by its remote geographical location (making transfers difficult) and by the fact that it was fully owned by the province (and thus not governed by a sponsorship organization). Nevertheless, other hospitals in the country, such as St Paul's in British Columbia, are today negotiating similar arrangements with provincial governments: "The province announced the construction of the new clinical space for MAiD, which will not be part of the existing St Paul's, but on adjacent property. It will be connected to the hospital with a corridor" (Paterson 2023).[13]

Conclusion

Lori Beaman and Winnifred Sullivan, borrowing from David Martin (2000), remind us that when we pay close attention to the Canadian model of religious

[12] It is relevant, for instance, to mention that Lowthers in his coverage of this story concludes his article by stressing that "the Nova Scotia Health Authority has no future plans on lifting the restrictions on abortion at St. Martha's" (Lowthers 2019).

[13] This solution has been criticized by MAiD activists as they do not think it tackles the structural question of Catholic ethics limiting access to health. They also raise the point that building these new facilities (that are not on hospital "grounds") are an extra expenditure for taxpayers (see Paterson 2023).

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governance, we become aware that it is closer to a shadow establishment model (where Christianity continues to play a role in the "shadows") than a model where religion would officially be separated from the state (Beaman and Sullivan 2016). This article provides evidence related to the specific workings of this shadow establishment in Canadian health care. We document how Catholicism continues to be deeply embedded in some health-care institutions. As seen, this embeddedness is not limited to the paraphernalia adorning the walls of hospitals; it also shapes the governance structure, the "mission" and "values," as well as the ways and types of care delivered by those institutions. What makes it a "shadow" establishment is that these relationships between public institutions and Christianity remain mostly invisible to the lay observer. And yet, as we document above, Catholicism continues to shape the contours of Canadian publicly funded health care.

These shadows, we argue, are also unremarkable because of the secular myth that informs the ways we imagine Canadian society to work. In this myth, religion is part of one's private life and, thus, the fact that religion can be entangled in the governance and legal structures of public institutions is hardly conceivable. Because of this myth, in many ways these complex relationships between religion and society remain out of sight. One of our article's objectives has been to reveal some of these relationships and in so doing to debunk secular assumptions.

It is important to note that we are not taking a position here on whether Catholic hospitals should be abolished or remain a part of the Canadian public health-care system. Indeed, a number of our research participants have stressed the unique social justice approach of these institutions that for them is informed, in part, by the social doctrine of the Church and the legacy of the sisters. Other research participants also emphasized that Catholic hospitals themselves reflect Canada's diversity through offering a distinct approach to health care. Although it is beyond the scope of this article, additional research is necessary to understand whether and how Catholic hospitals may take a unique approach to social justice. We are, nevertheless, arguing for the importance of rendering visible the position of Christianity in Canadian society as a whole, specifically here by documenting how this plays out in Catholic hospitals. Indeed, acknowledging this presence is an essential first step towards being able to construct a more equal society. If the privileged position of Christianity is obscured by the myth of Canadian secularism, the grounds for building such a society appear skewed from the onset.

Along these lines, the paper questions the claim that there is only one "secular" law in Canada. This claim limits our ability to see the role that canon law plays in the governance of public health-care institutions. Excavating the presence of canon law allows us to better understand the structure of the relationships that Catholic hospitals have with the Catholic hierarchy. In other words, it reveals the ways Catholic governance models can shape the organizational structure of public hospitals, as well as everyday decisions around the delivery of care. As researchers, we are much better equipped to make sense of these decisions when we understand the ways Catholic hospitals remain formally accountable to the Catholic hierarchy through legal arrangements. Likewise, this

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legal pluralist lens help us make better sense of individual navigations and institutional negotiations taking place around the provision of MAiD—and how such practices have evolved over time.

The legalization of MAiD in Canada and ongoing debates about its scope appear to be a particularly complex moment for Catholic institutions. It is a moment where the consequences and conundrums of working or seeking care in a Catholic hospital becomes visible for both physicians and patients—and for the broader public at large. It also makes clear how Catholic hospitals are located at the centre of a complex web of legal arrangements that include canon law, the *Canadian Charter of Rights and Freedoms*, the *Canada Health Act* and provincial health-care legislation. This makes them simultaneously accountable to the Catholic hierarchy in addition to federal and provincial lawmakers. Thus, it is in moments like this that the privileged place of Catholicism in Canada is cast into the spotlight and that important questions around the implications of this privilege start making their way into public conversations. It is also during such moments that secular claims around the separation of religion from public life start to visibly crumble. Recognizing and acknowledging these entanglements is an essential first step towards imagining and building a more inclusive society.

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