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Drawing on thorough research, the best of human insight and the strengths of Catholic teaching, we offer an ethical vision to inform modern health care. We strive to guide our readers to greater knowledge and deeper understanding about issues in health care, and to assist all people in their search for insight and wisdom.

In this issue

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Welcome again to the new look *Chisholm Health Ethics Bulletin*. This is the second issue of our Bulletin in this refreshed, contemporary format. This issue of the Bulletin contains articles by each of our researchers:

Dr Dilinie Herbert writes about the delivery of healthcare in prison. Without taking away from the trauma caused to victims of crime, and without condoning the negative actions of those who have committed crimes, she notes that the prison population is made up largely of people who have experienced significant social and economic disadvantage, and who often have a diagnosed mental health condition. Alongside the provision of primary care, healthcare in prisons must focus on the social and psychological issues and behaviours of prisoners in order to reduce recidivism and to foster genuine rehabilitation.

Carol Ong RSM makes a valuable contribution to the debate in Australia about euthanasia and assisted suicide (EAS) by carefully presenting the traditional morality which has guided many societies for millennia, and which is still expressed in the teaching of the Catholic Church. This traditional morality does not require us to do everything possible to preserve life. Instead, it permits us to withhold or withdraw any treatment which is overly burdensome. It also permits pain relief even if this might cause semi-consciousness and reduced lucidity. However, because it holds that all human life is inviolable, this traditional morality does not support the deliberate killing either of oneself or another person. Carol asks us to consider whether this traditional morality still has something to teach us about what it means to be human and how we should live together in community.

The Aged Mental Health service at St Vincent's Hospital, Melbourne has developed an innovative model of care in which pastoral care practitioners delivering spiritual care are full members of the multidisciplinary team which plans and delivers care. This integrated model for pastoral care in aged mental health is well described in *A Voice at the Table*, written by Rosemary Kelleher with Olga Yastrubetskaya. Our researcher Emanuel Nicolas Cortes Simonet offers a concise review of this most valuable resource.

I contributed the last of three articles about Pope Francis's *Evangelii Gaudium (The Joy of the Gospel).* This article considers the fourth chapter of the Apostolic Exhortation. Francis believes passionately that the desire of Christians to share the Good News calls them into social engagement particularly with those who are most disadvantaged. "None of us," the pope says, "can think we are exempt from concern for the poor and for social justice." He asks us therefore "to seek, as a community, creative ways of accepting this call." (*Evangelii Gaudium*, #201)

Kevin McGovern ✠

About the Caroline Chisholm Centre for Health Ethics

The Caroline Chisholm Centre for Health Ethics is a Catholic bioethics centre:

- We research and publish about health care issues.
- We provide education and training about health ethics to health professionals and the general community.
- Over the phone or face to face, we assist without discrimination any person who seeks help in making decisions about health care.
- We contribute to community discussion and debate by making public comments about important matters related to health care.
- We also assist health care institutions in the development of policies, protocols and procedures, particular in areas which might be ethically contentious.

Catholic bioethics is based upon both faith and reason. "Faith and reason," Pope John Paul II once wrote, "are like two wings on which the human spirit rises to the contemplation of truth." (John Paul II, *Fides et Ratio*) Thus, the long Catholic tradition contains much reasoned reflection on human experience – reflection which has discerned a natural ethic which is sometimes called the natural law. However, the Catholic tradition also contains much reflection on the wisdom which is found in what the Church recognises as divine revelation. This includes the Bible and above all the example of Jesus Christ. Noting that Jesus healed the sick, for example, many Catholic health and aged care services proudly proclaim that they are continuing the healing mission of Jesus.

Above all, faith and reason reveal the inherent dignity of each and every human being, no matter how sick, aged, frail or disabled we may be. In the Bible, the book of Genesis records that God created human beings "in the image of God." (Gen 1:27) In the Catholic tradition, it is this *imago Dei* – the image of God which is present in every human being – which is the ultimate foundation of human dignity.

From this starting point, Catholic bioethics contributes to moral discourse in every stage of the life continuum from conception to natural death. This Catholic perspective strives to be holistic and to take into consideration all the needs of the individual – physical, emotional, psychological, social, and spiritual. The Catholic approach to care is marked by great emphasis on the importance of pastoral and spiritual care.

Catholic bioethics makes a significant contribution to the moral debates in our society that are critical in this age of advancing technology. It reminds us of our meaning and purpose in life, and guides us towards its fulfilment, not just as individuals but as people in community.

Breaking the Stranglehold of Prison Life

The lived experiences of prisoners and the delivery of healthcare into this population raise important ethical issues. The prison population is made up largely of people who have experienced social and economic disadvantage, and who often have a diagnosed mental health condition. International and national authorities recognise that the health needs of prisoners are complex but that slow progress is being made to reform and improve existing practices. This article will demonstrate that alongside the provision of primary care, healthcare in prisons must also focus on the social and psychological issues and behaviours of prisoners in order to prevent recidivism

Prison – an institutional facility for people convicted of a criminal offence – can aggravate the already volatile social and economic environment of the vulnerable people who are highly represented in prison populations. A vicious circle of family violence, youth unemployment, drug and alcohol abuse, and mental illness is contributing to the growing population of incarcerated men and women in Australia. Even as spending on prisons and prisoner resources continue to increase, these underlying and ever-present social and cultural issues persist. The reform of prisoners and their assimilation back into the community require more than money.[1] They require insight into the underlying psychological and behavioural influences that first elicited criminal activity. Better understanding of these psychosocial factors can provide insight into appropriate health and social services to improve rehabilitation programs in prison and in the community setting.[2] This article seeks to explore the social dimensions of the life experience of prisoners and the underlying health implications of life behind bars.

Social Disadvantage, Imprisonment, and Health

The criminal justice system is a path few travel, and despite their efforts to make a better life for themselves, those few frequently re-offend. Intentionally (or sometimes unintentionally) causing grief or harm to another is widely recognised as unethical behaviour. People who do this in ways that break the law are disciplined by various means, including imprisonment. The number of men and women incarcerated each year continues to escalate at a rate beyond both population growth[3] and reported criminal activity. In an attempt to make sense of this, we need therefore to turn our attention to the underlying social and economic factors within our most vulnerable communities that shape those who constitute the majority of people in the prison population. Some of these influences include negative childhood experiences, extant economic disadvantage, adverse life events[4] and experiences of victimisation which may in turn be associated with mental health issues that can manifest as either self-harm or aggression. A combination of these factors and other environmental influences can eventually lead to anti-social behaviour and thence to imprisonment. Oftentimes, these negative experiences are augmented by periods of homelessness, unemployment and engaging in highly risky behaviours.[5]

When compared to the health of the general population, prisoners are overwhelmingly worse off. Socio-economic disadvantage is a significant predictor of both risk taking behaviour and poorer health outcomes. By virtue of the experiences of prison, the incidence of morbidity is further concentrated within this population. Overcrowding, insurgent violence, widespread illicit drug use, limited purposeful activity, estranged family networks and emotional deprivation are just some examples of the health-harming factors that afflict prisoners every day.[6]

Healthcare in Prisons

In Australia, correctional facilities fall under the jurisdiction of the state and territory governments.[7] Prison health services are outsourced to private health networks. Depending on the size of the prison, there may be a team of on-site clinical staff or a single nurse to care for the entire prison population. This is a huge task which involves addressing a multitude of health complaints such as communicable diseases, mental health issues, and chronic and acute illness. Older prisoners, women prisoners, and those with existing medical conditions require particular care.[8] Services should also extend beyond treatment to disease screening, and prevention.

Ensuring a healthy environment in a correctional facility is fraught with many challenges. Both negative public sentiment and excessive regulation make prisons less healthy places. The World Health Organization recognised the inequality of health outcomes and the growing health concerns in prisoners in Europe and as a consequence developed the *Health in Prisons Project (HIPP)*. Its primary functions are to improve health resources in prison, and to facilitate coordination between prison healthcare and the wider public health systems.[9] This latter function was of particular importance because in many European countries prison health was significantly isolated from the rest of the country's health services. HIPP also sought to establish 'consensus recommendations based on best practice.' The European countries participating in HIPP have implemented some of its strategies. However, progress has been slow due to both political and public attitudes towards crime and punishment, and the fast pace of prison growth.[10] There is also another flaw in HIPP's model, for it fails to consider the communities that are in dire need of health resources so as to avoid people being sent into detention and prison in the first place. This is a much more complex issue that still needs to be addressed.

Mental Health

As an institution which punishes through the deprivation of liberty, prison is meant to reform and to deter

recidivism. Allocating health resources to prisons is part of this: it is seen as a meaningful way to support prisoners to lead healthy lives when they are released. However, many challenges arise for the health service provider in prisons. One example is mental illness. Mental health issues are ubiquitous in the prison population. William Glaser has recognised that disproportionately more people with mental illness end up serving time behind bars.[11] After studying prisoners admitted to a prison psychiatric unit, he also concluded that this group of prisoners with mental illness is quite heterogeneous. He identified a lower-functioning sub-group for whom a secure psychiatric unit seemed more appropriate than prison. He also identified a higher-functioning sub-group who needed psychiatric treatment, but who were not always well served by psychiatric care in prison.[12] Public policy which refers convicted criminals with mental illness not to prisons but to secure psychiatric facilities outside prisons has always been contentious. What is more, in recent years throughout Australia there has been a dramatic decline in public psychiatric services and public psychiatric beds. At the same time, alternative arrangements for the patients served by these services were not investigated. Sadly, as a result, the deinstitutionalisation of psychiatric care in Australia simply became 'transmigration' of these vulnerable persons from psychiatric facility to prison.[13]

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Issued by the Australian Institute of Health and Welfare, the *Health of Australia's Prisoners 2012* report published quantitative data on prisoner health upon arriving in, during, and after release from prison. One chapter provides data on the mental health of Australian prisoners. It highlighted that the incidence of mental health issues is significantly higher in prisoners than in the general population. Concerningly, 38% of people entering prisons were medically diagnosed with a mental illness, whereas 46% had such a diagnosis upon release. To account for this difference, the report suggested that health services inside prisons frequently diagnosed mental illnesses which may have been ignored outside the prison.[14] However it failed to report on how the experience in prison itself may contribute to the development of mental health issues. Furthermore, it reported only limited improvements in the management of psychiatric symptoms in prison inmates at the point of release. All this supports Glaser's argument that the experience of imprisonment exacerbates mental illness.

With regard to the growing evidence that prison is contributing to the issues faced by those imprisoned, Nick De Viggiani states:

> Emotional and psychological survival partly depends upon an individual's ability to tolerate the deprivations of prison. Most prisoners, however, come from the poorest or most socially excluded tiers of society and often have the greatest health needs. Prison may therefore be the worst place to send them given that, in the main, they are likely to be highly vulnerable or susceptible to poor health.[15]

A fragile mental state can compromise both personal responsibility and responsibility to the community. In the treatment of mental illness, there is often uncertainty in diagnosis, particularly in the absence of organic cause. Further, there is rarely a cure. Even so, significant improvement can be achieved through medication, psychiatric health care, and inpatient facilities. Sometimes due to varying severity and the episodic expression of mental illness, lucid states of wellness can be compromised by social indifference and stigma. Sadly, the trajectory of mental illness can be complicated by many challenges related to the prison environment. The prison environment can perpetuate the symptoms of mental illness through deprivation, isolation and feelings of powerlessness. These experiences may be not uncommon to most prisoners outside the prison walls. Even so, due to the regimentation and customs of prison life they may become even more withdrawn and removed from society – thus making reintegration back into the community after prison even more difficult.

Health Services in Prison

The provision of healthcare services in prisons is a necessary step in the quest for better health for prisoners. Primary health care is integral to the services provided, whereas specialist consultation is less frequent and sometimes outside the scope of what can realistically be offered given the resources available to prisons. In general, prisoners make extensive use of their healthcare services. However, this use can be highly variable. Those prisoners who seek to retain some control over their lives are more likely to see the prison doctor. On the other hand, the control which health professionals often have over inmates' lives can create distrust, which limits the use of health services in prison.[16] The care of prisoner health is not limited to their time in prison but should also extend to support for healthy behaviour within a healthy community when they are released. Successful rehabilitation of prisoners requires that they become independent and responsible for their own health and wellbeing. They must therefore learn about risk factors, learn to manage these risks, and learn to make use of preventive interventions including screening and follow up. To better themselves and re-establish their relationships with others, they must also learn to negotiate and manage the fear, anxieties and loneliness that have often plagued their lives.[17]

The medical model is a valuable stepping stone in prison health care. Even so, there also needs to be an emphasis

on the social determinants of health which are most critical in this demographic. Working with prisoners to develop interpersonal and vocational skills can sustain a positive mental state, which then translates into greater productivity. As the *Health of Australia's Prisoners* report recommends, these skills need to be introduced, established and practised throughout the time in prison. This is not always possible. Because of personal circumstance and criminal history, some prisoners are not eligible for these 'correctional programs'. Only a third of prisoners in one survey reported they had participated in correctional programs. Most commonly, these were drug and alcohol programs. Successful integration back into the community is determined by incorporating these learned behaviours when negotiating everyday activity from the time of release. Another hurdle at the time of release is continuity of care, complicated by the number of agencies involved at discharge, which are not connected and which need to be identified and sourced, making access yet another key issue in this area. More cohesive and streamlined services are required around release from prison to ensure that released prisoners are not neglected or overlooked.[18]

The life course from a disadvantaged upbringing, delinquency and imprisonment is complex. This article does not dismiss the trauma caused to victims of crime, nor does it condone violence and the negative behaviours of some members in our community. It does however highlight the plight of those who are imprisoned and the health disparities they experienced before, during and after imprisonment. For those trapped in this vicious circle of disadvantage and anti-social behaviour, punishment alone is not sufficient. Something more must be offered. Forensic and correctional research disciplines, including qualitative and quantitative methodologies, are focused on articulating these social and cultural nuances and the sensitivities therein. What is needed above all are targeted health responses and social services appropriate to the needs of this cohort, that do not further vilify their lived experiences, and which can hopefully offer a positive turn towards not reoffending and a better life.

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Many of these issues were addressed in the Social Justice Statement 2011–2012 issued by the Australian Catholic Bishops Conference. Entitled *Building Bridges, Not Walls: Prisons and the Justice System*, this statement explores many issues related to prisons, prisoners and judicial processes. It argues punitive views and a lack of rehabilitative services are contributing to the growing problems Australia is facing in this area. Prison chaplains are often at the front line offering support to all within the prisons. This Social Justice Statement argues that the community response to prisoners should not be contempt and prejudice, but rather respect and dignity and solidarity.[19] By building bridges across social exclusion, we can ensure that walls don't barricade the most vulnerable within our community.

ENDNOTES

[1] Jane Lee Cameron Houston, "Beds in the Cell Block to Balloon to Almost 7000," *The Age* May 7, 2014.
[2] Australian Catholic Bishops Conference (ACBA) *Building Bridges, Not Walls: Prisons and the Justice System,* Social Justice Statement 2011–2012 (Canberra: ACBA, 2011)
[3] Australian Bureau of Statistics (ABS), "4517.0- Prisoners in Australia, 2014," ABS, http://www.abs.gov.au/ausstats/abs@.nsf/mf/4517.0.
[4] Rosalyn D. Lee, Xiangming Fang, and Feijun Lou, "The Impact of Parental Incarceration on the Physical and Mental Health of Young Adults," *Pediatrics* 131, no. 4 (Aoril 2013): e1188–e1195.
[5] Emma J Palmer and Asia Begum, "The Relationship between Moral Reasoning, Provictim Attitudes, and Interpersonal Aggression among Imprisoned Young Offenders," *International Journal Offender Therapy Comparative Criminology* 50, no. 4 (August 2006): 446–457.
[6] Lauren Brinkley-Rubinstein, "Incarceration as a Catalyst for Worsening Health," *Health & Justice* 1, no. 1 (2013): 3–20.
[7] Australian Institute of Health and Welfare (AIHW), *The Health of Australia's prisoners 2012*, Cat. No. PHE 170 (Canberra: AIHW, 2013), 2.
[8] Francesca Harris, Gill Hek, and Louise Condon, "Health Needs of Prisoners in England and Wales: The Implications for Prison Healthcare of Gender, Age and Ethnicity," *Health & Social Care in the Community* 15, no. 1 (2007): 56–66; Roger Watson, Anne Stimpson, and Tony Hostick, "Prison Healthcare: A Review of the Literature," *International Journal of Nursing Studies* 41 (2004): 119–128.
[9] World Health Organization (WHO), "Who Health in Prisons Programme (HIPP)," WHO, http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp.
[10] Alex Gatherer, Lars Moller, and Paul Hayton, "The World Health Organization European Health in Prisons Project after 10 Years: Persistent Barriers and Achievements," *American Journal of Public Health* 95, no. 10 (October 2005): 1696–1700.
[11] William F. Glaser, "Admissions to a Prison Psychiatric Unit," *Australian and New Zealand Journal of Psychiatry* 19, no. 1 (1985): 45–52.
[12] Ibid., 45.
[13] M. J. Huxter, "Prisons: The Psychiatric Institution of Last Resort?," *Journal of Psychiatric and Mental Health Nursing* 20 (2013): 735–743.
[14] AIHW, The Health of Australia's Prisoners, 35.
[15] Nick de Viggiani, "Unhealthy Prisons: Exploring Structural Determinants of Prison Health," *Sociology of Health & Illness* 29, no 1 (2007): 115–135 at 115.
[16] Jean-Mac Fernon et al., "High and Variable Use of Primary Care in Prison. A Qualitative Study to Understand Help-Seeking Behaviour " *International Journal of Prisoner Health* 4, no. 3 (2008): 146–155.
[17] Micheal J. Merton, Alex J. Bishop, and Amanda L. Williams, "Prisoner Health and Valuation of Life, Loneliness and Depressed Mood," *American Journal of Health Behavior* 36, no. 2 (2012): 275–288.
[18] Wendy Dyer and Paul Biddle, "Prison Health Discharge Planning - Evidence of an Integrated Care Pathway or the End of the Road?," *Social Policy and Society* 12, no. 4 (2013): 521–532.
[19] ACBC, *Building Bridges, Not Walls*.

All online documents accessed 13 October 2014.

Dilinie Herbert ✠

When Life is Ending….

In the debate about euthanasia, it is important that we consider all views, including those which might not at first seem attractive to us. Whether we believe in God or not, the views of the Catholic Church make a significant contribution to this debate. The Church does not support the deliberate killing either of oneself or another person. It

also emphasises our moral obligation to respect life and to uphold the dignity of each person.

Despite decades of debate and innumerable books, articles, blogs and every conceivable form of media discussing aspects of euthanasia and assisted suicide (EAS), societies continue to grapple with its moral and ethical implications. Varied definitions of both assisted suicide and euthanasia, together with imprecise and emotive language, have not helped the debate. Ultimately, our views on this matter, as with most ethical decisions, depend on our worldview, values, culture, belief system and much else. Over time, societal attitudes in many Western countries including Australia have changed so that the prime focus has shifted from the community to the individual alone. Also changing is the once strongly held societal belief that all human life is inviolable and worthy of respect. While some may view this as progress, for many others it is destructive and isolating.

When the Catholic Church and other faith-based institutions contribute to the euthanasia debate, secular voices often simply discount their views. They may for example claim that religion is becoming more and more irrelevant, and therefore so should its voice. Even so, the major religions have existed for millennia, which suggests that they must hold some truths to inform us of what it means to be a human being and how we should live in community. This article will explore Catholic teaching about EAS drawing primarily on the *Declaration on Euthanasia* issued by the Congregation for the Doctrine of the Faith (CDF). (This document is also known by a Latin name, *Jura et bona*, which means "rights and values.") It is hoped that this presentation will inform personal discernment about EAS.

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The Declaration begins by stating: "Human life is the basis of all goods…and…the necessary source…of human activity and of all society."[1] There is no argument here—without life we do not exist, and we cannot take action.

Life is seen as "a gift of God's love…to preserve and make fruitful,"[2] a gift for ourselves and for society. In *Evangelium vitae*, Pope John Paul II added: "Life on earth is not an 'ultimate' but a 'penultimate' reality; …entrusted to us, to be preserved with a sense of responsibility and brought to perfection in love and in the gift of ourselves to God and to our brothers and sisters."[3] Catholics believe that the ultimate meaning and purpose of life is union with God achieved fully only in eternal life.[4] Whilst others may not share this belief, there is in most people a need to belong and a need for union and intimacy, that is, a need to be loved and to love. Awareness of this deep need is perhaps most acute when life is ending.

For those who believe in the ultimate union with God after death, the dying experience may instead be one of coping with and finding meaning in diminishment and loss. For those who believe in life after death, apprehension of an unknown journey after death can be very daunting. Anxieties about this may be eased however by the loving support, both of those close to them and the medical team who care for them. For those who believe that all is ended with the last breath, the knowledge that they will be loved and can continue to love till they die, may be all that is needed for a good and peace-filled death.

For Catholic Christians, the ethics of gospel love facilitates fulfilment as life is ending by reminding us that our lives are not lived in isolation, and that we are all gifted and essential members of the Body of Christ. Each of us has a responsibility to engender the sense of community and interdependence, and the sense of belonging and being loved for who each one truly is as a human being. Christians believe that each person is made in the image and likeness of God. Each one of us is a vital whole within the greater wholeness of God. Whatever happens to one person affects everyone else. From this perspective, caring for another is not burdensome, either for the carer or the person receiving the care, but rather a living out of the essential truth of our interdependence.

The invitation is therefore to live a full life until natural death occurs, but not necessarily to try to prolong that life with extraordinary or overly burdensome means. The Declaration is very clear that respect for life must always remain. Death should never be intended nor sought.[5]

The CDF supports "the use of medicines" for "alleviating or suppressing pain." It accepts this intervention even in cases where it may cause "semi-consciousness and reduced lucidity."[6] The Declaration also invites us to see the many separations or 'letting gos' as preparation for the final separation of death, and, for some Christians, as opportunity for communion with Christ's suffering.[7]

The CDF identifies a number of considerations to bear in mind when making ethical decisions in end-of-life care. It suggests:

> … studying the type of treatment to be used, its degree of *complexity* or *risk*, its *cost* and the possibilities of using it, and comparing these elements with the result that can be expected, *taking into account the state of the sick person and his or her physical and moral resources* [emphasis added].[8]

This highlights an ethical process that considers each individual and their unique circumstances. The Declaration also recognises each individual as the person most qualified to make these end-of-life treatment decisions. Ultimately, "it pertains to the conscience either of the sick person, or of those qualified to speak in the

sick person's name, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case,"[9] the right course of action to take. The document continues: "One cannot impose on anyone the obligation to have recourse to a technique… which carries a risk or is burdensome."[10] Withdrawing or withholding burdensome treatment, the Declaration emphasises is not suicide but "an acceptance of the human condition."[11] For Christians, end-of-life is about still living life to the full to the end, respecting life as a gift, and when the end comes having the courage to let go in the hope and belief of achieving the ultimate good of union with God.

When a gravely ill person requests aid in dying, the Declaration suggests that this might not imply a true desire for euthanasia: "it is almost always… an anguished plea for help and love. What a sick person needs, besides medical care, is love, the human and supernatural warmth…"[12] of loved ones and the medical team. Given that in recent times the reasons for requesting EAS are usually socio-psycho-spiritual in nature,[13] there is much truth in this observation.

Healing the whole person is the core purpose of medicine. Even in the final stages of life when cure is not possible, healing can enable a deep peace in one's relationship with self, loved ones and God. To claim that the killing of another should be a medical service as has happened in Quebec,[14] and now in the *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* before the Australian Senate,[15] goes against the very foundation of medicine. To relieve the suffering of another is core to medicine. To comfort is also core. However, to kill another is to cross the line between healing and destroying, and, albeit controversially, outside the scope of medicine.

It is very upsetting to watch loved ones suffer. Apart from possible pain, there is also associated restlessness, lack of control, being trapped in a body that is failing, dependence on others, loss of modesty, the sense of loss of identity, and the inability to do what one could once do (including caring for another and fulfilling one's obligations to society). Fear of the unknown along with associated feelings of powerlessness, loss of control and prolonged dying may also be very confronting, despite assurances from palliative care professionals that pain can usually be controlled or at least made bearable, and psycho-socio-spiritual suffering can be alleviated with the help of a multidisciplinary team. These experts—and many stories—speak of the preciousness of this time as death approaches when relationships can be healed and deepened by simple presence. Many stories are told of people who, despite being incapacitated, lived life to the full till they died, primarily because of loving relationships.[16] In the face of death, with all of our façades stripped away, we are forced to face our true selves. As we do, we often realise that we are respected and unconditionally loved not for what we do, but simply for who we are.

For a small proportion of people, suffering, or the fear of suffering, or whatever else it is, can be experienced as so unbearable that ending their life prematurely seems the only recourse. Unless we step into their shoes, it would be arrogant to presume to know what they should do. We make what we call conscious choices based on a complex array of intuitive knowing, experiences, knowledge, understandings, values and (for some of us) faith, all of which inform our worldview, and determine our identity, and our meaning and purpose in life. If we are affiliated with a faith tradition, we pay attention to our religious beliefs and their sources—for Catholic Christians, the Bible, tradition, theology, the *sensus fidei* and our prophets. We also call on the experiences, knowledge and expertise of those who have had the privilege of sharing similar end-of-life journeys with others, including palliative care professionals.

If we are considering EAS, we must ask ourselves what the true underlying issue leading us to this point is. We do this by determining all the facts (including our medical diagnosis, treatment options and likely prognosis), listening with the heart to our intuition, and pondering all these things deeply. People of various faiths will also bring all this before and into conversation with God. There can be many questions: If dignity is the issue, then what are the reasons I feel that my dignity is being undermined or not respected? If it is a sense of having completed my life and lacking any reason to go on living, what am I saying about my attitude to my life, and to its meaning and purpose? If suffering is the issue, what are the elements contributing to this? What might be changed? Are there experiences I am now rejecting that I may be able to perhaps grudgingly adapt to or accept? Is there need for greater access to palliative care? Must palliative care expertise improve even more? Is it about attempting to control the uncontrollable, to bring order in the midst of chaos? Might I learn to live with chaos and accept not being in control? Is there anything I must do to come into loving relationship with myself, with my loved ones and (if I believe) with God? What do I need in order to come to the healing place of letting go, and so accept peacefully the approaching end of my life? If honest reflection unearths issues like these, EAS may not be the answer. Perhaps a better solution might be ensuring access to various forms of expertise about the dying process—that is, holistic end-of-life care. Even if palliative care cannot currently relieve all suffering, might the legislating of EAS eventually result in greater threats to older persons, and people with disability, mental illnesses and other vulnerabilities? Despite the so-called legislated safeguards, this is already happening in Belgium.[17]

> ….In the dying process, the role of medicine is not to increase the burden of suffering, nor to pointlessly prolong dying, but also not to end life prematurely….

The contribution that the Catholic Church makes to the euthanasia debate gives us a lot to ponder. The Catholic *Declaration on Euthanasia* speaks of the inviolability of

life, a moral norm upheld for millennia in countless societies. It also reminds us that dying is part of life, and that there is no imperative to prolong dying if treatment will be overly burdensome and cause excessive suffering. The dignity of the individual is interwoven with respect for life. It is upheld and honoured when the person experiences a true sense of belonging, of loving and being loved unconditionally, regardless of their capacity or incapacity.

The purpose of medical technology is to assist the individual in making the most of life, to cure disease where possible, to ease if not eliminate suffering, and to comfort always.[18] In the dying process, the role of medicine is not to increase the burden of suffering, nor to pointlessly prolong dying, but also not to end life prematurely. Further, the role of medicine is to facilitate healing in the individual, by easing their pain and enabling space for the person's 'letting gos'. This in turn can facilitate the 'letting comes' of graces and deeper awareness of the individual's life, narrative and legacy. (It might also mean handing over to others to write for the individual the final paragraph in their life's narrative when they are no longer physically able to do so.) Thus, medicine can help provide, through the easing of pain and other sufferings, the liminal space of knowing more fully one's primary loving relationships with self, with loved ones, and (if we believe) with God, enabling life to end naturally and peacefully.

ENDNOTES

[1] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia - Jura et bona*, chap. 3, Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

[2] Ibid., chap. 1.

[3] John Paul II, *Evangelium Vitae - The Gospel of Life,* n. 2, Holy See, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html.

[4] *Declaration on Euthanasia*, chap. 1. See also *Evangelium Vitae*, n.2: "Man is called to a fullness of life which far exceeds the dimensions of his earthly existence, because it consists in sharing the very life of God."

[5] *Declaration on Euthanasia,* chap. 2.

[6] Ibid., chap. 3.

[7] Ibid., chap. 3. For Christians, the desire for total communion with Christ includes a desire to experience all that Jesus Christ experienced, including his suffering. Thus, St Paul wrote: "I want to know Christ and the power of his resurrection and the sharing of his sufferings by becoming like him in his death, if somehow I may attain the resurrection from the dead." (Phil 3:10–11).

[8] Ibid., chap. 4.

[9] Ibid., chap. 4. The moral obligation is to care for the sick "conscientiously and administer the remedies that seem necessary or useful." (Chap. 4) Treatment may be withdrawn if "the results fall short of expectations." (Chap. 4) "The medical profession… ought to neglect no means of making all their skill available to the sick and the dying; but they should also remember how much more necessary it is to provide them with the comfort of boundless kindness and heartfelt charity." (Conclusion).

[10] Ibid., chap. 4.

[11] Ibid., chap. 4. The definition of euthanasia in *Evangelium Vitae*, n. 65 is: "Euthanasia in the strict sense is understood to be an action or omission which of itself *and* by intention causes death, with the purpose of eliminating all suffering" [my emphasis]. This improved the definition in the *Declaration on Euthanasia*: "which of itself *or* by intention causes death…" [my emphasis], chap. 2. For an action to be euthanasia, both criteria must be satisfied: there must be both an intention to cause death and the use of lethal means.

[12] Ibid., chap. 2.

[13] Christine Monforte-Royo et al., "What Lies behind the Wish to Hasten Death? A Systematic Review and Meta-Ethnography from the Perspective of Patients," *PLoS ONE* 14 May 2012, http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0037117.

[14] *An Act respecting end-of-life care*, Assemblée Nationale Québec, http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-52-40-1.html.

[15] *Medical Services (Dying with Dignity) Exposure Draft Bill 2014 (Cth)*, Parliament of the Commonwealth of Australia, http://www.aph.gov.au/~/media/Committees/Senate/committee/legcon_ctte/dying_with_dignity/Exposure%20draft%20dying%20with%20dignity.pdf.

[16] I know a man with end-stage motor neuron disease, whose only form of communication is through a computer, which he activates by moving his eyes. The love of his new bride gives him reason enough to want to continue to live.

[17] Caroline Ong, "Legalising Euthanasia for Children: Dying with 'Dignity' or Killing the Vulnerable?" *Chisholm Health Ethics Bulletin* 20, no. 1 (Spring 2014): 5–9. See also European Institute of Bioethics, "Euthanasia in Belgium: 10 Years On," *Dossier of the European Institute of Bioethics* (2012); and Raphael Cohen-Almagor, "Euthanasia Policy and Practice in Belgium: Critical Observations and Suggestions for Improvement," *Issues in Law and Medicine* 24, no.3 (2009): 187–218.

[18] A well-known maxim states that the goal of health care is "to cure sometimes, to relieve often, to care always." This quote has been attributed both to Ambroise Pare (physician to King Francois I) and to Edward Livingston Trudeau (the physician who established the Adirondack Cottage Sanitarium at Saranac Lake in New York).

All online documents accessed 19 November 2014.

Caroline Ong RSM ✠

Pastoral Care in Aged Mental Health: A Voice at the Table

A Voice at the Table: An Integrated Model for Pastoral Care in Aged Mental Health, written by Rosemary Kelleher with Olga Yastrubetskaya, describes a practical model for integrating pastoral care practitioners into multidisciplinary teams within aged mental health services. While highlighting the importance of spiritual care within healthcare, the book also emphasises the need for pastoral care practitioners to have the essential skills and knowledge vital to being significant members of the multidisciplinary team. This article offers a concise review of a most valuable resource.

Both social worker Rosemary Kelleher and Associate Professor Olga Yastrubetskaya have had many years of experience in aged mental health. This includes many years at the Aged Mental Health service at St Vincent's Hospital, Melbourne. They are both currently Honorary Fellows at the Academic Unit for Psychiatry of Old Age at the University of Melbourne. They co-authored *A Voice at the Table: An Integrated Model for Pastoral Care in Aged Mental Health*[1] in 2011 in collaboration and consultation with other experts in the area of aged mental health. The book aims to highlight the skillset and knowledge required by pastoral care practitioners working in aged mental health settings. The authors propose a practical

model of integrating pastoral care into the multidisciplinary team. This model was developed at the Aged Mental Health service at St Vincent's Hospital between 2009 and 2011.

A Voice at the Table has 142 pages, and is divided into 10 chapters and 8 appendices. Chapters 1 and 2 provide a literature review and background into the importance of spirituality and pastoral care in healthcare settings, particularly in aged mental health. These are followed by three chapters familiarising the reader with the basic structures and functioning of the brain, and the cognitive disorders which may occur in old age. This includes helpful, brief discussions about dementia, delirium and other mental illnesses including psychosis. Following these are four more chapters that relate to the model itself, the continuum of care, the importance of clinical information, and the skills and knowledge required in pastoral care, all of which provide the basis for successful integration of pastoral care practitioners into the multidisciplinary team.

….A pilot study found that 82% of persons with mental illness would have liked their psychiatrist to be aware of their spiritual beliefs and concerns. Pastoral care practitioners can provide this service….

The last chapter provides 16 case studies illustrating the role and skills that pastoral care practitioners must have in providing spiritual support to older persons with mental illness and their families. These case studies also exemplify how the model can be brought into practice in acute aged mental health settings. The appendices provide further explanation of mental illnesses in old age, and also summarise the FICA Spiritual Assessment Tool which was used in the case studies. This relatively simple tool allows clinicians to take a spiritual history of their patients, and thereby to understand them better so that the multidisciplinary team can provide the most appropriate and helpful care.

Spirituality and healthcare

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[2] This view of health includes its physical dimension but also acknowledges the social and psychological domains of health. Often referred to as the biopsychosocial understanding of health, it gives more emphasis to care of the whole person rather than just focussing on illness.[3] This is of particular importance in mental illness, which does not necessarily include physical signs of disease. One psychosocial aspect of health which is of particular importance is spirituality.

The concept of spirituality is often too complex to define simply, as its meaning is highly dependent upon the context in which it is used. Even so, it is widely acknowledged that the mind, body and spirit are interconnected.[4] The benefits of spiritual care in healthcare are well documented in the literature,[5] and these are of particular importance to older people who suffer from mental illness. Research shows that spiritual beliefs have predictable positive outcomes for psychological wellbeing in older people,[6] and result in fewer depressive symptoms in older people who are hospitalised.[7] In addition, spirituality provides a means of coping with the negative aspects of mental illness, above all by strengthening the intimate relationship between an older person and a Higher Power, leading to a sense of hope, personal meaning and purpose in life.[8]

Prior to the 1990s, mental health services in Victoria had dedicated chaplaincy services coming from religious organisations which provided spiritual support to patients.[9] The subsequent de-institutionalisation of Victorian mental health services resulted in the establishment of specialised multidisciplinary teams to care for people with mental illness in the community.[10] Whilst this approach modernised mental healthcare, it resulted in a lack of adequate spiritual support for those who suffered mental illness.

A pilot study conducted by Russell D'Souza[11] found that 82% of persons with mental illness aged between 17 and 71 would have liked their psychiatrist to be aware of their spiritual beliefs and concerns. Although a majority of clinicians are aware of the importance of spirituality in older persons with mental health needs,[12] some may lack the specialised skills necessary to provide effective spiritual support. Pastoral care practitioners can provide this service.

The role of pastoral care practitioners is to empower and nurture a patient's spiritual self,[13] to support a sense of meaning and purpose in life, and to give assistance to the spiritual needs of family members and/or friends.[14] This enriches the individual and social wellbeing of the patient, and is central to providing a holistic[15] approach to healthcare.[16] In an aged care setting, the pastoral care practitioner assists the patient in responding to the unwelcome life changes that may result when an older person is diagnosed with a mental illness. These include issues related to grief.[17]

Knowledge and skills of the pastoral care practitioner

The model proposed by Kelleher and Yastrubetskaya emphasises the need for pastoral care practitioners to gain appropriate knowledge and skills in caring for older people with mental illness and their families. These include understanding the mental healthcare system and familiarisation both with mental health legislation and with health laws in general. So that effective integration within the aged mental health service is possible, pastoral care practitioners also need to have communication skills to work alongside the other members of the multidisciplinary team.

Being admitted to an aged mental health facility may result in distress and/or confusion for the older person

and/or their family. This may in part be due to the experience of interfamilial grief as the result of mental illness diagnosis of a loved one. It may also be due to the nature of mental health laws in general, and how they operate in acute aged care settings.

Mental health laws often restrict a person's human rights and liberty through, for example, the imposition of treatment which may be against the person's wishes. This restriction may cause concern to the older person and/or their families, especially if the mental illness impacts upon the older person's cognitive capacity and their ability to give informed consent.[18] Understanding how these laws operate will enable the pastoral care practitioner to provide reassurance to the family that the laws are being applied appropriately, that the least restrictive alternative is provided, and that the care and treatment provided are in the best interests of the older person.[19]

Working as part of the multidisciplinary team involves collaboration and communication with other team members. In chapters 7 and 8, the authors make the point that clinical information needs to be transparent and shared with all those in the team including pastoral care practitioners. As pastoral care practitioners have access to patient records and are required to update clinical information accordingly, it is important that they develop an understanding of the clinical terms and acronyms used so that the information shared is understood by all team members.[20] Clinical supervision by the consultant psychiatrist as well as an external supervisor can provide a sense of direction, guidance and support for the pastoral care practitioner's professional wellbeing.

It is also important for pastoral care practitioners to be aware of clinical symptoms which may impact upon communication with the older person. These include any type of sensory, vision and/or hearing impairments as well as psychosis and/or concentration difficulties that may result from old age.[21] Having this knowledge aids pastoral care practitioners to seek alternative strategies in communication (such as speaking more slowly and more clearly, and the use of hearing/vision aids). Additionally, awareness of any transcultural issues and the use of interpreters if language barriers exist will help greatly in providing quality pastoral care.

The integrated model

The authors note that there are numerous pastoral care models currently being used to cater to the spiritual needs of older people with mental illness and their families.[22] Chapter 6 of *A Voice at the Table* describes the integrated model of pastoral care in the multidisciplinary aged care team. In this model, the pastoral care practitioner delivering spiritual support to the patient is a full member of the multidisciplinary team. The authors argue that this integrated approach is innovative in Australia.

The process of providing holistic mental health care begins with an initial consultation with the patient and his or her family by members of the multidisciplinary team, who may include the pastoral care practitioner. During this time, responses relating to any kind of spiritual need or belief system are noted. Spiritual concerns are then raised and discussed in team meetings, with referral onto the pastoral care practitioner if team members feel that this would benefit the older person and/or their family.

….In this model, the pastoral care practitioner delivering spiritual support to the patient is a full member of the multidisciplinary team. This integrated approach is innovative in Australia….

The pastoral care practitioner then conducts a spiritual assessment of the patient, asking relevant open-ended questions regarding the patient's spirituality. The framework behind these questions assists the pastoral care practitioner in determining appropriate clinical responses as well as identifying any spiritual concerns.[23] The primary spiritual assessment tool used in the book incorporates the spiritual domains of Faith, its Importance, Community, and how to Address spiritual needs (FICA).[24] The FICA tool aids the pastoral care practitioner in gathering a spiritual history of the spiritual beliefs and needs of the patient.[25] It is used in all the case studies to illustrate how the integrated model can provide spiritual support. Whilst the rationale of using this particular tool is not expressed directly in the book, elsewhere its use has been shown to be feasible in the clinical assessment of spirituality.[26]

With this information, a pastoral care plan and any desired outcomes that the older person and/or their family may have are made, and any relevant intervention(s) conducted. This plan is reviewed and shared with other members of the multidisciplinary team in team meetings, making collaboration, feedback and discharge planning more efficacious. Interventions may include providing empathetic emotional support, facilitating spiritual group sessions, or enabling external clergy visitation.[27] By having a 'voice at the table,' the pastoral care practitioner can give spiritual or religious opinions and insights into what the older person's needs are, usually by reporting in patient files and discussions in team meetings.[28] These in turn strengthen the approach of providing holistic care for those in aged mental health services.

Strengths and limitations of the book

The model proposed of integrating skilled and knowledgeable pastoral care practitioners into the multidisciplinary team, is significant for the provision of spiritual support – and hence holistic health care – for older persons in acute aged mental care settings.

The book is insightful and valuable in offering a breadth of knowledge to the reader, illustrating complex mental health conditions with clarity. The information presented in the earlier chapters as well as appendices 4 and 5,

attempts to simplify the complicated nature of cognitive diseases affecting older persons with mental illness. Even so, this presentation is somewhat limited, and only provides a basic background for the reader. The appendices relating to socio-legal and clinical terms used in aged mental health are also helpful in offering a quick reference point for the pastoral care practitioner. While these resources provide a good beginning, a pastoral care practitioner working in aged mental health would benefit from drawing on other sources for a more complete understanding of both mental illness and mental health law.

Victoria's old *Mental Health Act 1986* has now been superseded by the *Mental Health Act 2014 (VIC)*. Because this book was written in 2011, it references the older Act. Nowadays, pastoral care practitioners in Victoria must be familiar with the new legislation.[29]

The case studies in Chapter 10 offer excellent examples of how the information provided in previous chapters is beneficial in everyday pastoral care practice. The listed examples range from older persons who are deeply affected by their mental illness and lacking in social support to those who are ready for discharge. The authors rightly reiterate that effective communication and sharing of clinical information is crucial in providing quality pastoral care.

Conclusion

A Voice at the Table provides a valuable resource for pastoral care practitioners who are interested in providing a holistic approach to healthcare in the context of an acute mental aged care setting. Its application can also be very relevant to residential aged care, where mental health issues in older persons are not uncommon.

The book effectively describes a practical model of integrating pastoral care into the multidisciplinary team, and thereby addressing the spiritual concerns of older persons perhaps at a time of great vulnerability. In order for effective integration to occur, the authors note that clinical and legal knowledge as well as awareness of the continuum of care in aged care settings is essential for the pastoral care practitioners. Clear and transparent sharing of clinical information within the multidisciplinary team is vital. All this enables the pastoral care practitioner to attune to the individual spiritual concerns that older people may have in a communicative style which is effective and appropriate. It also informs the rest of the team of the spiritual wellbeing of the patient, enabling them to adjust their management accordingly.

The role of pastoral care and the importance of spirituality in aged healthcare are regarded favourably both by older people and the multidisciplinary teams who care for them. It helps the therapeutic rapport between patients and their carers, as well as improving the wellbeing of older persons. Historically, Catholic hospitals have recognised the important role that spirituality plays in wellbeing and in coping with illness. This is now supported by scientific literature.[30] Providing pastoral care to cater for spiritual concerns may indeed be beneficial particularly for those patients who value this facet of life. It should be integral to the provision of holistic care in all healthcare settings.

ENDNOTES

[1] Rosemary Kelleher and Olga Yastrubetskaya, *A Voice at the Table: An Integrated Model for Pastoral Care in Aged Mental Health* (Mulgrave, VIC: John Garratt Publishing, 2011).
[2] World Health Organization, *Constitution of the World Health Organization*, 2006, 1–18 at 1, http://www.who.int/governance/eb/who_constitution_en.pdf.
[3] Bruce Rumbold, "A review of spiritual assessment in health care practice," *Medical Journal of Australia* 186, no. 10 (2007): 60–62 at 60.
[4] Russell D'Souza and Kuruvilla George, "Spirituality, religion and psychiatry: its application to clinical practice," *Australasian Psychiatry* 14, no. 4 (2006): 408–412 at 408.
[5] Ibid., 409.
[6] Sarah Kirby, Peter Coleman, and Dave Daley, "Spirituality and well-being in frail and nonfrail older adults," *Journal of Gerontology: Psychological Sciences* 59B, no. 3 (2004): 123–129 at 123.
[7] Harold Koenig, Linda George, and Patricia Titus, "Religion, spirituality, and health in medically ill hospitalized older patients," *Journal of the American Geriatrics Society* 52, no.4 (2004): 554–562 at 554.
[8] Walter Larimore, Michael Parker, and Martha Crowther, "Should clinicians incorporate positive spirituality into their practice? What does the evidence say?" *Annals of Behavioural Medicine* 24, no. 1(2002): 69–73 at 71.
[9] *A Voice at the Table*, 2.
[10] Ibid., 3.
[11] Russell D'Souza, "Do patients expect psychiatrists to be interested in spiritual issues?" *Australasian Psychiatry* 10, no. 1 (2002): 44–47 at 44.
[12] Robert Lawrence et al., "Clinicians' attitudes to spirituality in old age psychiatry," *International Psychogeriatrics* 19, no. 5 (2007): 962–973 at 971.
[13] *A Voice at the Table*, xv.
[14] Anita Goh et al., "Pastoral care in old age psychiatry: Addressing the spiritual needs of inpatients in an acute aged mental health unit," *Asia-Pacific Psychiatry* 6 (2014): 127–134 at 128.
[15] Whilst differences in the definition of 'wholistic' and 'holistic' exist, for the purposes of this article these terms are used interchangeably.
[16] Anita Goh et al., 127.
[17] Rosemary Kelleher et al., "Providing pastoral care service in aged mental health settings: A literature review," *Asia-Pacific Psychiatry* 3 (2011): 5–9 at 5.
[18] *A Voice at the Table,* 61.
[19] Please note information later in this article about a recent change in Victoria's mental health law.
[20] Ibid., 56.
[21] Ibid., 64–66.
[22] Ibid., 42.
[23] Ibid., 48.
[24] Ibid., 48.
[25] Ibid., 129.
[26] Tami Borneman, Betty Ferrell, and Christina Puchalski, "Evaluation of the FICA tool for Spiritual Assessment," *Journal of Pain and Symptom Management* 40, no. 2 (2010): 163–173 at 163.
[27] *A Voice at the Table,* 49.
[28] Ibid., 40.
[29] For my overview of the new Act, see Emanuel Nicolas Cortes Simonet, "Victoria's Mental Health Act 2014: The Human Rights of Persons with Mental Illness," Chisholm Health Ethics Bulletin 20, no. 1 (Spring 2014): 3–5. A very useful resource is the *Mental Health Act 2014 Handbook*, which is designed specifically for clinicians. For this, see Victorian Department of Health and Human Services, https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook.
[30] Larimore, Parker and Crowther, 70.

All online documents accessed 19 February 2015.

Emanuel Nicolas Cortes Simonet ✠

Evangelii Gaudium and Social Engagement

This article explores what is said in the fourth chapter of Pope Francis's Evangelii Gaudium about social engagement particularly with the poor. Francis sees practical engagement with the poor as an essential component of the Christian faith. This engagement begins with loving attentiveness to them. It seeks their integral development, and their full inclusion in the life of society. Such social engagement also calls us to care for the environment, to participate in the quest for peace, and to engage in dialogue with all people to seek consensus on ways of building a better world.

This is the last of three articles in the *Chisholm Health Ethics Bulletin* about Pope Francis's *Evangelii Gaudium (The Joy of the Gospel)*.[1] The first of these[2] revealed that the Apostolic Exhortation calls us to both service and silence. It also set out the dynamic between these two experiences, as we reflect on our service in silence, and as our silence in turn calls us back into wiser and more generous service. The second article[3] was an overview which noted the many different and important topics which *Evangelii Gaudium* addresses. This final article explores in more detail the fourth chapter of the Apostolic Exhortation. While *Evangelii Gaudium* is generally about evangelisation, its fourth chapter is specifically about the social dimension of evangelisation. In other words, this chapter explores how the desire of Christians to share the Good News leads them into social engagement particularly with those who are most disadvantaged. This article has six sections. The first explores why Pope Francis writes and speaks with such passion about social engagement particularly with the poor, and indeed why he lives this out in his own life with such commitment. The next four sections consider in turn the four parts of the fourth chapter of *Evangelii Gaudium*. A final section reflects briefly on the implications of all this for Catholic health, aged and community care in Australia.

Pope Francis's Passion for Social Engagement

In the second of these articles, we noted that *Evangelii Gaudium* drew upon two traditions of thought within the Church – international teaching about evangelisation, and the teaching of the Latin American bishops. While these are clearly important to Francis, the deepest inspiration for his passion for social engagement lies elsewhere. Ultimately, Pope Francis's passion for social engagement arises from his own life experience. In the twenty-one years when he was bishop or archbishop in Buenos Aires, Francis frequently visited the slums. He met the people of the slums; he connected with them; and above all he listened to them and learnt about them. He learnt how they lived. He learnt about their faith in God. He saw goodness and great generosity even in the midst of great poverty. Above all, it is these sorts of experiences which have given Pope Francis such passion for social engagement particularly with the poor.[4]

One of the first people to recognise the extent to which Pope Francis based his insights on experience was Archbishop Blase Cupich of Chicago. He called this Francis's "hermeneutic of experience." Archbishop Cupich noted that some people dismiss what the Pope says about economics or politics because Francis argues not from some grand theory but from "real-life experience." Against this view, the archbishop suggested instead that Francis "is calling people to a more authentic way of knowing and learning." Cupich continued:

> And, in fact, herein lies what I believe is how we should understand his unique contribution to the tradition of Catholic Social Teaching. Instead of approaching life from the 30,000 feet level of ideas, he challenges policy-makers and elected officials – indeed all of us – to experience the life of everyday and real people.[5]

….Christianity calls each and every believer to find practical ways of contributing to human advancement and to caring for this planet which is our common home….

Pope Francis also writes about this perspective in the fourth chapter of *Evangelii Gaudium*. He warns of the dangers of "ideas disconnected from realities." He cautions that "it is dangerous to dwell in the realm of words alone, of images and rhetoric." He insists therefore that "realities are more important than ideas." He calls this "the principle of reality." (*Evangelii Gaudium*, #231-233)

Francis has returned to this insight on numerous occasions. In a video message sent in September 2015 to a theology conference in Argentina, he insisted that the "Ecclesial Tradition" must be in dialogue with the "reality" of people's lives, for "the questions of our people, their anxieties, their quarrels, their dreams, their struggles, their worries have a hermeneutical value that we cannot ignore."[6] Similarly, when he spoke on 24 September 2015 to the US Congress about migrants and refugees, he stated, "We must not be taken aback by their numbers, but rather view them as persons, seeing their faces and listening to their stories, trying to respond as best we can to their situation."[7] Again, when he spoke on 25 September 2015 to the UN General Assembly about armed conflicts in the world, he argued that "real human beings take precedence over partisan interests… In wars and conflicts there are individual persons, our brothers and sisters, men and women, young and old, boys and girls who weep, suffer and die. Human beings who are easily discarded when our response is to draw up a list of problems, strategies and disagreements."[8] And finally, in his concluding address at the 2015 Synod of Bishops,

Francis stated that "the true defenders of doctrine are not those who uphold its letter, but its spirit; not ideas but people; not formulae but the gratuitousness of God's love and forgiveness."[9]

Pope Francis's understanding of social engagement both invites us and challenges us. He is telling us that we can only understand really and fully if we truly engage with other people. If we do not engage, we cannot really understand. This is both a powerful invitation and a powerful challenge to social engagement.

From this perspective, let us now look at what Francis says about social engagement in the four parts of the fourth chapter of *Evangelii Gaudium*:

I. Christianity and Social Engagement

In the first part of this chapter, Pope Francis insists that Christianity necessarily calls each and every Christian believer to social engagement and to a commitment both to "human advancement" and to care of this planet which is our "common home." (*Evangelii Gaudium*, #178 & 183) Christians believe that God is at work in the world repairing what is damaged and renewing all things. What is more, Christians believe that they are called to cooperate with God in God's great work in the world. Christianity therefore calls each and every believer to find practical ways of contributing to human advancement and to caring for this planet which is our common home.

What Francis rejects is a view that "religion should be restricted to the private sphere and that it exists only to prepare souls for heaven." (*Evangelii Gaudium*, #182) To the contrary, Francis insists strongly that "the Church cannot and must not remain on the sidelines in the fight for justice. All Christians, their pastors included, are called to show concern for the building of a better world." (*Evangelii Gaudium*, #183)

There are at least two challenges here. If we are Christian, we are asked to reflect whether we have grasped the social dimensions of our faith. We are also asked to reflect on what we are currently doing, and what more we might possibly do. On the other hand, some of us are not Christian but we are involved in various ways in the struggle for justice in the world. If we are in this situation, our challenge is to reflect on this theological vision and to see if there is anything in it which makes sense to us and which can empower us in our own work for justice.

II. Solidarity with the Poor

In the Old Testament, God constantly called the Chosen People to have a particular concern for the poor. Christ himself "was always close to the poor and the outcast." (*Evangelii Gaudium*, #186) Throughout its long history, the Church has served the poor in many different ways. Indeed, Catholic health, aged and community care arose from the Church's commitment to the poor. Francis concludes that the Church is called to make a "preferential option for the poor," and indeed that "the whole tradition of the Church bears witness" to this. (*Evangelii Gaudium*, #200, 198)

Francis identifies many dimensions of an integral concern for the poor. The first and most important of these is "loving attentiveness" to the poor. This enables us to know them, to understand them, to appreciate their goodness, and to value them. (*Evangelii Gaudium*, #199) It also enables Christians to "recognise the suffering Christ" in the poor, and therefore to esteem and care for them as Christians would esteem and care for Christ. (*Evangelii Gaudium*, #210)

An integral concern for the poor involves giving "assistance" to them. (*Evangelii Gaudium*, #199) This could be material help, or it could be help with other difficulties. It also involves recognising where they have been deprived, and therefore what is needed for their "integral development" which in turn will enable them to participate fully in the life of society. (*Evangelii Gaudium*, #186-188) In this regard, Francis wisely suggests that they may need "education, access to health care and above all employment" and a "just wage." (*Evangelii Gaudium*, #192)

An integral concern for the poor also involves identifying and then "working to eliminate the structural causes of poverty." (*Evangelii Gaudium*, #188, cf #202) For example, there are clearly some places in Australia where there are real deficiencies in such things as pregnancy care, early childhood care, health care, housing, education, and access to decent employment. Seeking to remedy these situations leads us into advocacy and engagement in both the economic and political processes of our country. (*Evangelii Gaudium*, #202-205)

Because damage to the environment often also harms the poor, an integral concern for the poor also includes caring for this planet which is our common home. (*Evangelii Gaudium*, #206, cf #216) Finally, Francis counsels us not to neglect the spiritual care of the poor. This could be explicitly religious care, or it could also be support in finding meaning and purpose in their lives. "The worst discrimination which the poor suffer," Francis suggests, "is the lack of spiritual care." For this reason, our preferential option for the poor must include "a privileged and preferential religious care." (*Evangelii Gaudium*, #200)

It is most worthwhile to reflect on the many dimensions of care which Francis has identified. These are the insights of someone who has himself been involved in the care of the poor. His insights help us to celebrate what we are already doing, and they challenge us to consider what more we should do.

Francis also tells us that as we care for the poor, we should know that they also have something to teach us. He writes:

> [The poor] have much to teach us…. We need to let ourselves be evangelised by them…. We are called to find Christ in them, to lend our voice to their causes, but also to be their friends, to listen to them, to speak for them and to embrace the mysterious wisdom which God

wishes to share with us through them. (*Evangelii Gaudium*, #198)

….Francis also tells us that as we care for the poor, we should know that they also have something to teach us….

This is not an insight which has previously been articulated in international Catholic teaching. However, it is an insight that the Latin American bishops have expressed. For example, in their *Aparecida Document*, they state:

> We also encounter [Jesus Christ] in a special way in the poor, the afflicted, and the sick (cf. Mt 25:37-40), who reclaim our commitment and give us testimony of faith, patience in suffering, and constant struggle to go on living. How many times do the poor and those who suffer actually evangelise us!.... The encounter with Jesus Christ in the poor is a constitutive dimension of our faith in Jesus Christ.[10]

As we have noted, Francis – then Cardinal Jorge Mario Bergoglio of Buenos Aires – led the final editing of the *Aparecida Document*. He is therefore drawing on the teaching of the Latin American bishops when he shares this insight with us. I would suggest, however, that he is drawing even more on his own experience as he himself has been evangelised by the poor.

III. The Quest for Peace

Having reflected on the integral development of the poor, Francis turns his attention to the quest for peace. This is obviously very important, because armed conflict and war are great scourges in this world. We might think that peace has been achieved if there is currently no actual conflict. However, Francis calls us beyond this superficial view. If there is systemic injustice – if sectors of society or even different nation-states are being treated unfairly – conflict will inevitably follow. The only sure foundation for peace is true justice. This in turn requires the integral development of all people particularly the poor. (cf. *Evangelii Gaudium*, #218)

Francis offers four insights about this quest for true peace:

The first is that we must take a long-term view. Peace depends ultimately on the integral development of all people. This of course takes time. Indeed, it takes a long time. Even so, in the quest for peace, we must keep our focus on these slow "processes of people-building." They are far more important than superficial "immediate results." (*Evangelii Gaudium*, #222-224)

Francis's second insight is that we cannot allow disagreement and conflict to stymie the quest for peace. Instead, he suggests that we should "face this conflict head on" – that is, that we must acknowledge the reality of conflict, seek to understand this conflict from all perspectives, and then seek a way forward which is just and acceptable to all. In this way, conflict effectively managed becomes not an obstacle to peace, but rather a "link in the chain" of the process towards true peace. (*Evangelii Gaudium*, #227)

We have already discussed Francis's third insight in the first section of this article. In the quest for peace, Francis insists that we must focus not on abstract ideas or ideologies, but rather on real people, particularly those real people who will be hurt by ongoing conflict.

Finally, Francis proposes what we might call global multiculturalism as an alternative to globalisation. One of the problems in the current process of globalisation is that it is imposing the same, materialist and consumerist culture on all peoples. While we must seek greater international cooperation for its many benefits, Francis suggests that we must also maintain a local perspective which recognises all the unique and valuable aspects of a local culture which must not be lost. Francis's vision of global multiculturalism allows for greater international cooperation while at the same time respecting, valuing and preserving local cultures.

IV The Importance of Dialogue

The final part of the fourth chapter of *Evangelii Gaudium* highlights dialogue as a way forward for achieving important social goals. Dialogue occurs between people who have different forms of expertise, or who possess different types of authority, or who hold different viewpoints, or who come from different cultures or religious traditions. Dialogue does not ask anyone to abandon his or her own perspective. It is instead "a means for building consensus and agreement while seeking the goal of a just, responsive and inclusive society." (*Evangelii Gaudium*, #239)

Without trying to be exhaustive, Francis identifies a number of significant dialogues. One of these is the dialogue between different levels of the Church and different levels of various governments. The goal of this dialogue is safeguarding and promoting the universal common good. Yet another form of dialogue occurs between faith, reason and science. Francis insists that "faith is not fearful of reason." Indeed, he believes that "the light of reason and the light of faith both come from God," and therefore that faith and reason can work together for the good of all. (*Evangelii Gaudium*, #242) Francis also writes about the necessity for ecumenical dialogue within a divided Christianity. In this dialogue, we can learn from other ecclesial traditions, "reaping what the Spirit has sown in them, which is also meant to be a gift for us." (*Evangelii Gaudium*, #246) He also discusses Christian relations with Judaism and Islam, interreligious dialogue, dialogue with people who are not part of any religious tradition, and dialogue to preserve religious freedom in the world. He notes that "interreligious

dialogue is a necessary condition for peace in the world," and therefore "a duty for Christians as well as other religious communities." (*Evangelii Gaudium*, #250)

….Our hospitals, community and aged care services employ a truly multicultural workforce. We are challenged to move outside our own cultural groups and our own comfort zones, and to become involved in the sort of dialogue which Francis encourages….

Francis's reflections on dialogue therefore give us much to ponder and reflect upon.

Implications for Catholic Health, Aged and Community Care

Let me once again conclude with some brief reflections on the significance of all this for Catholic health, aged and community care in Australia, and for all of us who work in these organisations. Let me make four points. Firstly, we can indeed feel great satisfaction at all we do to serve so many people. In particular, we can feel great satisfaction about our service of the poor and our social engagement with those on the margins. We make a difference for many people. What we do gives many people hope. Secondly, of course, we are also challenged to consider what else we might be able to do, both within our organisations and as individuals. Francis's observations recorded in this article should guide us in this discernment. Thirdly, as I have already noted, we are all invited to reflect on the religious vision which has been articulated here. If we are Christian, we are called to connect our social engagement and our faith. Or if we are not Christian, we are invited to reflect whether there is anything in this religious vision which makes sense to us and which can inspire us in our own work for justice. Finally, we should recognise how well placed our organisations are for the sort of dialogue which Pope Francis wrote about. Our hospitals, community and aged care services employ a truly multicultural workforce. In our private lives, it is possible to remain only within our own cultural group and our own comfort zone. But in the multicultural workforce of our organisations, we are challenged to move outside our own cultural groups and our own comfort zones, and to become involved in the sort of dialogue which Francis encourages.[11] This dialogue among people who are different from one another is not always easy. But, as Pope Francis said, it can indeed "build consensus and agreement while seeking the goal of a just, responsive and inclusive society."

It is an inspiring, exciting and challenging vision which Francis places before us. It is the dynamic of service and silence. It is a religious vision which nonetheless speaks to people who are not believers. It is a vision which calls us to social engagement particularly with the poor. It is a movement to build a better world. It must be said that there are many people who will reject this vision. Such rejection, however, is not the greatest threat. The greatest threat is apathy. The greatest threat is that we who are inspired by this vision do not follow through and ultimately do not do anything. If this vision speaks to you – if it inspires you – please follow through and do what you can to live this vision in practical ways.

ENDNOTES

[1] Pope Francis, *Evangelii Gaudium,* 24 November 2013, Holy See, http://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html.
[2] Kevin McGovern, "*Evangelii Gaudium* and Catholic Health and Aged Care," *Chisholm Health Ethics Bulletin* 19, no. 3 (Autumn 2014): 8–12.
[3] Kevin McGovern, "An Overview of *Evangelii Gaudium*," *Chisholm Health Ethics Bulletin* 20, no. 1 (Spring 2014): 12–15.
[4] See, for example, Inés San Martín, "For Pope Francis, people are more important than ideas," *Crux*, http://www.cruxnow.com/church/2015/09/18/for-pope-francis-people-are-more-important-than-ideas/.
[5] Michael Sean Winters, "Archbishop Blase Cupich: Pastor of the people," *The Tablet* 268, no. 9075 (15 November 2014): 10–11 at 10. In like vein, David Brooks has written, "Francis has consistently criticized abstract intellectual systems [which are] so abstract, you can't smell the sweat of real life…. Francis's great gift, by contrast, is learning through intimacy…. Francis's whole approach is personal, intimate and situation-specific." For this, see David Brooks, "Pope Francis, the Prince of the Personal," *New York Times*, 22 September 2015, http://www.nytimes.com /2015 /09/22/opinion/pope-francis-the-princeof-the-personal.html?hpw&rref=opinion&action=click&pgtype=Homepage&module=wellregion&region=bottom-well&WT.nav=bottom-well&_r=2.
[6] "Pope's Video Message to Theology Conference in Argentina," *Zenit*, 7 September 2015, http://www.zenit.org/en/articles/pope-s-video-message-to-theology-conference-in-argentina.
[7] "Address of Pope Francis to a Joint Session of the United States Congress," 24 September 2015, *Holy See*, http://w2.vatican.va/content/francesco/en/speeches/2015/september/documents/papa-francesco_20150924_usa-us-congress.html.
[8] "Address of Pope Francis to the General Assembly of the United Nations Organization," 25 September 2015, *Holy See*, http://w2.vatican.va/content/francesco/en/speeches/2015/september/documents/papa-francesco_20150925_onu-visita.html.
[9] "Address of Pope Francis at the Conclusion of the Synod of Bishops," 24 October 2015, *Holy See*, http://w2.vatican.va/content/francesco/en/speeches/2015/october/documents/papa-francesco_20151024_sinodo-conclusione-lavori.html.
[10] Fifth General Conference of the Bishops of Latin America and the Caribbean, *Concluding Document: Aparecida, 13–31 May 2007* (Washington, D.C., United States Conference of Catholic Bishops, 2008), #257.
[11] I have written previously about this aspect of Catholic health, aged and community care in Australia. For this, see Kevin McGovern, "Ethical Challenges for Catholic Health and Aged Care," *Chisholm Health Ethics Bulletin* 17, no. 1 (Spring 2011): 6–12 at 7. Note too that in his message for the 2016 *World Day of the Sick*, Francis again called for "an encounter with Judaism and Islam and other noble religious traditions… so that we might know and understand one another better." He also noted that "every hospital and nursing home can be a visible sign and setting in which to promote [this] culture of encounter and peace." For this, see "Message of Pope Francis for 2016 World Day of the Sick," *Holy See*, http://w2.vatican.va/content/francesco/en/messages/sick/documents /papa-francesco_20150915_giornata-malato.html.

All online documents accessed 1 November 2015.

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