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## Female Genital Mutilation/Cutting (FGM/C)

*This article reports on the experiences of Female Genital Mutilation/Cutting (FGM/C) for women living in countries where it is widespread and for those who migrate to Western countries. It explores the attitudes that shape the ongoing practice of FGM/C and the role of female hierarchy in sustaining these customs in practising communities. In particular, it investigates the dialogue between health professionals in Western countries like Australia and women presenting for antenatal care. This includes conversations around de-infibulation.*

Female circumcision dates back to ancient Egypt. Today, the practice of female genital mutilation/cutting (FGM/C) is endemic in twenty-eight countries in Africa, but also extends as far as some regions in Asia and the Arabian Peninsula. Increasingly, cases of FGM/C are recorded in Western countries due to migration.

The World Health Organisation (WHO) first issued a statement and was responsible for raising awareness about issues arising from FGM/C in the 1960's. According to its recently updated definition, FGM/C "comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons."<sup>1</sup>

Since then, FGM/C has received attention in the medical literature, and amongst governing health authorities. The discussion surrounding FGM/C is multi-faceted and includes, but is not limited to: meaning around traditional practice, social identity, culture and sexuality. It also explores aspects of female reproductive health, and clinical complications specifically related to pregnancy, and postpartum care. The aim of this article is to report on the experiences of FGM/C in developing countries, explore broadly the attitudes of women seeking antenatal care in Western countries and more specifically how health professionals are responding to the ethical challenges of providing obstetric care in this setting.

There are four distinctive types of FGM/C namely: clitoridectomy (Type I); excision (partial or total removal) of the labia minora and clitoris (Type II); infibulation (Type III), and an unclassified type that includes all other harmful piercing, pricking of the female genitalia and narrowing of the vaginal wall (Type IV).<sup>2</sup> The type of FGM/C practised and the age at which it is performed is based on the region and the cultural traditions in a given community.

FGM/C is sometimes preceded by ceremony and celebration, and concludes with the young girl being taken by her mother and other women from the community to a secluded area. The almost always fearful girl is held down by several women as using a sharp instrument one woman ceremonially cuts and/or stitches her genitalia. To promote healing, the girl's legs are tied together, and she is left alone for several days or weeks. The practice is emotionally distressing for the girl. It is also physically traumatic, often leading to

haemorrhage, infection, broken bones, and sometimes death.

Despite the concerted efforts of UNICEF and other international organisations to abolish the practice, it estimates that over 125 million women worldwide are living with FGM/C, and thirty million young girls are at risk each year.<sup>3</sup> Some reports suggest the incidence of FGM/C is decreasing in some regions, but remains unchanged in other regions due to community attitudes towards FGM/C practice, and education.<sup>4</sup> There are strong social and cultural factors, and to a lesser extent religious beliefs,<sup>5</sup> that withstand the political and international opposition of FGM/C in practising communities.

Social and cultural discourse predominantly influences the widespread practice of FGM/C. The Republic of Djibouti in the Horn of Africa has one of the highest incidences of FGM/C in Africa. Women in these communities commonly cite aesthetics, tradition and religion in support of FGM/C, though some also note its role in controlling female sexuality. While men in these communities are reluctant to discuss FGM/C, they generally support the practice.<sup>6</sup> Elsewhere, it is sometimes performed as an initiation into womanhood, to maintain abstinence, to protect against infant death, or to promote hygiene.<sup>7</sup> Community attitudes and support in favour of FGM/C are therefore complex, and often involve a combination of various factors.

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Drawing on social convention theory, Shell-Duncan and her colleagues argue that an 'intergenerational peer convention' predominately explains this widespread custom. With limited resources girls and younger women must rely on extensive networks for support. In this context, girls and young women undergo FGM/C to signal both their subordinate position and their willingness to accept the hierarchy of power in women's networks. This gains them access to a supportive network while at the same time reinforcing the power and standing of the elders in these networks.<sup>8</sup>

In communities where aspects of female initiation may serve to preserve FGM/C among the female population, the practice is therefore further strengthened by the expectation that to be accepted in the community, girls and women will: conform to community expectations; respect authority and their elders; and be disciplined in their social network. For many women growing up in these communities, the social harms of "not-cutting" are inescapable despite the obvious physical and psychological harms. Understanding these forces facilitates better awareness and constructive intervention programs in the future.

Apart from the immediate health risks and mortality associated with performing FGM/C, there are other long-term health complications. The effect of HIV/AIDS is devastating across the African sub-continent, though to date there is limited evidence to show a direct link between FGM/C and HIV transmission. However, the potential risk of transmission is apparent through the use of unsterilized "cutting" instruments where cross-contamination can potentially occur.<sup>9</sup> Other infections that have been reported in women who have undergone FGM/C are Trichomonas, Candidal vulvovaginitis, bacterial vaginosis, and urinary tract infections. However, the literature in this area has its own limitations such as reporting bias, inaccurate serological results and incomplete medical records, issues that need to be negotiated within the health systems and what are often the sub-standard health practices in these regions.<sup>10</sup>

A woman's reproductive health is an important issue raised by living with FGM/C. Provisions for safe obstetric management and postpartum care are vital for the health of both mother and child. The implications of FGM/C can be differentiated based broadly on Type and more specifically on the health care facilities, and medical assistance at the time of delivery. The narrow vaginal opening caused by infibulation (Type III) can obstruct child-birth. According to the WHO study group on FGM/C, there are six significant complications: caesarean sections, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death.<sup>11</sup> These complications are more frequently associated with the more extensive and severe forms of FGM/C.

Health professionals working in obstetric care can inform the ways in which pregnancy is managed for women with FGM/C. Seeking antenatal care in a Western country for the first time is fraught with many challenges. These often include: initially finding a health provider; then negotiating the language barrier; then making informed decisions about care; leading eventually to the health experiences and outcomes for mother and child. In circumstances where a

health professional is unfamiliar with FGM/C, women can readily feel disempowered<sup>12</sup> and embarrassed.<sup>13</sup> The pain associated with physical examinations and during labour itself, often provokes memories of the FGM/C experience which can make some women fearful, anxious<sup>14</sup> and reluctant to actively cooperate in making decisions about their care.

De-infibulation (reversal of Type III FGM/C) can be an accepted medical intervention for women preparing for child birth.<sup>15</sup> For many women in these communities, vaginal delivery is preferable to caesarean section,<sup>16</sup> and vaginal delivery is facilitated by timely de-infibulation. Perhaps due to misinformation, many women with FGM/C believe that obstetric surgeries and instrumental delivery cause both pain, and maternal and neonatal death. It is therefore remarkable that in many Western countries, women who have had FGM/C are more likely to have a caesarean section because health professionals are unable to accurately monitor the progression of labour.<sup>17</sup> Significantly, women who have sought antenatal de-infibulation are less likely to have a caesarean section.<sup>18</sup>

De-infibulation has been recognised as an important protective measure to avoid possible obstetric complications since 1995. With the increased number of immigrants from FGM/C regions into Western countries, health professionals are likely to treat more women with FGM/C in the future. Generally, health professionals are familiar with what FGM/C is, but lack the knowledge to differentiate between the Types of FGM/C. They are also less likely to be aware of the risk of complications, and to be able to identify when to perform de-infibulation. Shortcomings in knowledge such as these are connected with a doctor's origin, his or her medical education and seniority in the profession.<sup>19</sup> For example, a recent Norwegian study highlighted some of the misconceptions around FGM/C held by health professionals in that country. The study documented that Norwegian health professionals attending to the birth involving a woman with infibulation would often avoid conversations around FGM/C, believing that it could be interpreted as insensitive and would draw unwanted attention to the labouring woman. This silence can potentially lead to women having otherwise unnecessary caesarean sections, not being offered antenatal de-infibulation<sup>20</sup> and perhaps even being re-infibulated postpartum without prior consultation.<sup>21</sup>

Studies specifically exploring re-infibulation practices amongst doctors in Western countries showed that health professionals are still performing this surgery postpartum on women who were previously infibulated. Health professionals claim that re-infibulation (also referred to as re-suturing) is a common procedure to avoid infection, and that there is a lack of clear guidelines about what constitutes re-infibulation.<sup>22, 23</sup> In contrast, women living in Western countries who were once infibulated, are opposed to re-infibulation, and unlikely to allow their daughter to have FGM/C.<sup>24</sup> Antenatal de-infibulation is commonly performed in the second trimester. Educating health professionals about this and about FGM/C in general is a significant way to acknowledge the presence of FGM/C in the community. It also supports women and their families living in Western countries to denounce the practice.

Ethical challenges are inherent in clinical decision-making. Particularly in connection with FGM/C, these challenges are closely aligned with the cultural nuances and experiences of doctors and patients. Health professionals negotiating such challenges require education, cultural competence and interpersonal skills. Furthermore, patients need to feel empowered and confident to speak openly about their experiences of FGM/C. The Royal Women's Hospital in Melbourne has specialist clinics<sup>25</sup> that employ doctors and allied health staff specialising in medical and social aspects of FGM/C. Mercy Hospital for Women at Heidelberg in Melbourne has employed an African Liaison Worker to consult with women who present during pregnancy to discuss health care options, to facilitate conversations about FGM/C and to offer social support services for women and their families. This initiative is showing positive results.<sup>26</sup> At a national level, the Australian government hosted a National Female Genital Mutilation Summit, to raise awareness and support FGM/C initiatives.<sup>27</sup> This knowledge will hopefully permeate into permanent health policy and hospital practices. Local initiatives that pursue close liaison with community groups and health sectors in collaboration with national campaigns can provoke change in community attitudes that will eventually abolish the practice of FGM/C internationally.

## Acknowledgements

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## ENDNOTES

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Dilinie Herbert ✉

# Consumer-Directed Care: Who Will Pay for Mission and Ethics?

*This article is a slightly edited version of a speech given by Martin Laverty to the 2013 Annual General Meeting of the Caroline Chisholm Centre for Health Ethics. It views the movement towards consumer-directed care in Australia not as a threat to Catholic health and aged care, but as an opportunity to deepen our understanding of our mission and to develop services which are distinctive in their commitment to providing excellent care in response to the changing needs of the community. It explores consumer-directed care, highlights limitations in our current understanding of mission and ethics, and challenges us to be prophetic as the founders of our institutions were in responding to community need.*

The topic that I'm going to address is 'Consumer-Purchased Care: Who Will Pay for Mission and Ethics in the Years Ahead?' I'm going to do so by presenting three different propositions or questions to you. I don't necessarily have answers to these questions, but through the thinking process that we at Catholic Health Australia (CHA) are pursuing, I want to give you at least some guidance as to where this consumer-directed environment is taking us.

Proposition one: human services are moving rapidly in Australia and other western countries to this notion of voucher-purchased care. Rather than the care provider determining what happens to the patient or residents, the individual - the consumer - is being empowered to determine themselves the type of health care or aged care that they receive. That has a set of dynamics that we in the Church need to consider.

The second question is whether or not our current approach in Australia to understanding and thinking about mission and ethics within our organisations is sustainable in this new consumer-purchase world.

The third proposition is to explore what we can do now in the early stages of this direction towards consumer-purchased care to rethink our approach to mission and ethics - not just to ensure our place in this new consumer-driven marketplace, but more so to ensure that we are continuing the work of prophetic leaders that has been a part of our Church for the last two thousand years. It rests to all of us who are leaders of Church in this country to meet these challenges in these interesting times.

So with those three frames, I hope at the end of this discussion that you might help me - as I hope I might help you - to plot where it is we are today, and where it is we need to be in this new consumer-directed environment.

## Consumer-Directed Care

To move into this coming notion of consumer-purchased care: on 1 August 2013, all Commonwealth-funded home care services embraced the new framework of consumer-directed care so that any new Commonwealth-funded **aged care packages** delivered in a person's home are going to be under this banner of consumer direction. That means that the individual will be able to choose who their actual caregiver is. They will receive their entitlement: it will be invoiced on a regular, monthly basis. They will understand where all of their public entitlement is going: a hundred percent of their financial entitlement will be broken down on their invoice so that the home care recipient for the first time will be able to correlate the dollar cost against what

they are receiving.

Now the dynamics that this is going to drive as it slowly unfolds over the next few years is that the consumer or their advocate is going to become more attentive to which organisation delivers the most efficient service - which organisation tailors their service most to the interests of the individual. This is going to drive new cost competition: the provider that provides the most cost efficient service is going to find very quickly that they have an expanded place in the market. Those who are more expensive or indeed who cannot explain their costs or cannot demonstrate value or who don't have a strong brand to be able to communicate to that potential customer base, are going to find themselves increasingly challenged in years ahead to actually secure consumers willing to purchase from them.

Now for the time being, this principle in Commonwealth-funded aged care is operative in home care services only where there is no bricks and mortar for the service provider. But the Living Longer, Living Better legislation<sup>1</sup> that passed Parliament just before the Federal election, sets a five year horizon in which the Commonwealth will review the applicability of this consumer-directed care to **residential aged care**. Within five years, we have to go through a formal review on the application of a free market in residential aged care. At the moment as an aged care provider, you have certainty - you have aged care licenses for your beds and for your community packages. Shift forward a few years, and that certainty of business planning might be taken away as we move into this free market of the consumer determining where they go to receive their care.

Now this is similarly happening at the moment as the **National Disability Insurance Scheme (NDIS)** is being deployed. As a member of the NDIS Board, I am obligated to say the thoughts that I express tonight are my own, and that they do not necessarily represent those of the Board. But what the NDIS represents is a full financial voucher that can be cashed out for the individual with a disability to literally do whatever they like with that entitlement providing that it fits within an agreement that they've worked out with their planner. So whereas today a disability service provider might be providing accommodation or rehabilitation services or day care services for people with disabilities, in the future the individual, their family or their advocate might say that I want to cash that entitlement out and I want to spend it in the local gymnasium. The certainty that the disability provider has had in the past or still has today, is going to move to this consumer-directed environment. Through the 0.5 percent increase in our

Medicare levy that all of us as tax payers are now contributing to fund this scheme, when the NDIS is fully operative in five years, it will cost the nation \$19 billion per annum. All of that funding is going to flow through this consumer-directed environment.

Within that, how do the traditional organisations that have had security about their business planning respond? Those that provide the most efficient service - those that can demonstrate a strong brand in the market place - they're the types of providers in years ahead who are going to succeed in this consumer-directed world.

If we turn to the **health care**, we see a similar dynamic happening. The arrival of the National Efficient Price (NEP)<sup>2</sup> gives the opportunity for Commonwealth and State governments today - but more increasingly in years ahead - to say that we will direct our purchasing power to those service providers that are able to demonstrate the lowest price. Within the NEP, we will be able to break down all of the cost of the delivery of a hospital bundle. We know that the average hospital admission at the moment costs about \$4600. With the National Efficient Price being able to scrutinise what makes up those cost drivers, purchasers - governments and private health insurance funds - will be able to scrutinise where costs are being triggered.

In this consumer-directed environment where efficiency in health care, aged care and disability care is now shifting from the decisions that the providers make to the expectations of the consumer, where is the place for valuing mission? At the moment, organisations might have some idea what pastoral care or the overhead of mission costs. However, in that consumer-directed package that will be delivered through the residential aged care service in the future, are we yet ready to cost that - to put it on an invoice - and to say to the care recipient that you value this service so much that you will pay for it, and to pay for it over and above something else? Are we able to say to the care recipient that you value the role of pastoral care - of mission - within our hospitals such that you will pay for it when you see it broken down on the invoice? In order to answer this question of whether the consumer of the future (when the sophistication of this system is in place) will be willing to purchase mission and ethics, we need to be able to articulate what mission and ethics actually are, and to communicate this effectively to the resident, the patient, and the consumer.

## Renewing our Understanding of Mission and Ethics

This leads into my second proposition: is our current approach as Catholic health and aged care services in Australia to our shared understanding of mission and ethics sufficient today, to sustain us into this new consumer-directed environment where we will have to become much more transparent about valuing - both in the monetary but in the delivery sense - that which is so dear to the origins of Catholic health? To help us understand how we see mission and ethics today, I'll take the easy route, not drawing on an Australian experience but going instead to the United States to a paper by Dr Ron Hamel, Senior Director of Ethics at the Catholic Health Association of the United States of

America (CHAUSA). This paper, titled 'Catholic Identity, Ethics Needs Focus in New Era',<sup>3</sup> was published in June 2013. In it, Dr Hamel asked, "Do we have a common understanding of what [our mission] is? What happens if we don't?" Some seem to reduce Catholic identity to the mere observance of a couple of the Church's Ethical and Religious Directives - particularly the prohibitions on sterilisation, prohibited reproductive services, direct abortions, and physician assisted suicide. The reasoning seems to be that if a Catholic organisation does not perform these prohibited procedures, it can be considered Catholic. Others go further and seem to see Catholic identity as not performing prohibited procedures, having religious symbols in the lobbies, supporting a pastoral care team, and having formal recognition by the local bishop. Whilst these practices are not unimportant, and they are indeed part of Catholic identity, they miss a deeper reality.<sup>4</sup>

To consider what might be happening in the Australian context, we can look at some recent occurrences in the Australian environment over the last decade or so or in one case going back further. As we think about participating in this new consumer-directed environment of the future, these raise some questions about the robustness of our shared understanding of our current approach to mission and ethics:

Three and a half years ago, we at Catholic Health Australia raised with the Catholic Bishops Conference the growing scarcity of priests able to administer sacraments within our hospitals. If you accept that the presence of the sacraments within our hospitals is one of the tenets of our Catholic identity, it raises a concern when three and a half years later we are still debating with the Bishops Conference meaningful and practical solutions to the availability of clergy for the delivery of those sacraments that only clergy are able to deliver within our organisations.

We had a seven year debate - Catholic Health Australia, Catholic maternity hospitals and the Catholic Bishops Conference - on the role of prenatal testing. Before I started at CHA six years ago, debate had already begun about new technologies coming to check the health of the unborn child to ensure that they might safely come to this world. That debate involving ethicists, clinicians, bishops and Catholic Health Australia took seven years to bring to an eventual comfortable conclusion - seven years when energies could have been directed to other aspects of our mission and identity.

Some many years ago now, there was an extraordinary debate when the Sisters of Charity in Sydney wanted to operate a safe injecting room in Kings Cross - a safe injecting room that has operated now for more than a dozen years with the support of other Churches. Great energy went into that debate then, and that energy still exists around this debate today.

I've plucked these three incidents out of recent events; there are others that continue today and will continue to confront us in the future. Such events suggest that our current approach to debate about mission and ethics in Australia perhaps hasn't yet embraced Hamel's deeper reality that calls us to think these things through.

So what do we have in Australia to help us unpack an

understanding of this deeper reality? The infrastructure that serves us well is the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*. There are also different histories, cultures and charisms within our health and aged care organisations. As someone said to me recently, there is still blood yet to be wrung in charisms to ensure the continued presence of Catholic identity within our organisations. As well, we have the now very mature place of Directors of Mission within our hospitals, and a greater awareness of the distinction between the role of pastoral care and mission. Our social outreach programmes - some substantial, others seeking to be so - are demonstrating aspects of mission. We have terrific engagement in Australia with our local bishops. When we reflect on the experience of bishops, religious and Catholic hospitals in the United States, we should regularly celebrate the terrific relationship that we have with our bishops here in this country. We are also grateful that so many Catholic hospitals, bishops, religious and Catholic Religious Australia (CRA) engage so freely and easily with Catholic Health Australia.

Catholic Health Australia itself was set up in response to a perceived threat: the threat in the 1970s that was Medicare. I put it to you that now a new threat is emerging and that new threat is consumerism. It won't actually be secularism that challenges Catholic hospitals - it will in fact be consumerism and how we respond to that in the years ahead.

## The Catholic Identity Matrix

The Veritas Institute out of the University of St Thomas in Minneapolis has developed one of several Catholic matrixes to assess the presence of mission and identity within Catholic hospitals.<sup>5</sup> I think the Veritas Institute's matrix is particularly instructive. It sets out a list of very simple points drawn from Catholic teaching. First and foremost is that the Catholic hospital must have solidarity with those who live in poverty. It should ensure that it commits to holistic care. It should guarantee a respect for human life. It should have a participatory community of work and mutual respect. It needs to commit to the principles of stewardship, and it must also act within the communion of the Church.

The benefit of the Veritas Institute's matrix is that it provides a detailed framework to look at mission and ethics within the Catholic health care environment. It moves beyond the language that we all use and understand that we are committed to the healing ministry of Jesus. While certainly true, this latter statement needs unpacking in this time when we recognise that leaders of our Catholic hospitals in many cases today are not Catholic and increasingly in the future are not going to be and in fact do not need to be.

Each Catholic institution needs to commit itself anew to its Catholic identity. Understanding Catholic mission and ethics through solidarity with those who live in poverty, through holistic care, through respect for human life, through being a participatory community of work and mutual respect, managed with regard to sound stewardship, and acting in communion with the Church gives us a framework for testing whether or not our mission and identity is in fact reflecting the purposes for which our

organisations were established.

## What can we do now?

Let us turn now to the third and final proposition: what is it that we could do now to ensure that our practice of mission and ethics while serving us today can continue to serve the needs of our organisations into the future? I put it to you that our challenge is to affirm that Catholic health care is distinctive and different from both state-provided care and private- and commercially-provided care. Our distinctiveness that makes us Catholic must be subject to continual renewal and refreshing. We must be defined not just through the services that we don't offer but rather through our distinctiveness. If we are honest, the care that is provided in state-run government hospitals in many cases is of good quality and high standard, just as it is within for profit and commercially-operated hospitals. In that environment, how do we ensure the distinctiveness of a Catholic hospital genuinely is both different and founded in those principles of our call to the Gospel?

I commend to you as both recent and instructive Hamel's paper about mission and ethics, and I return to it again. Hamel said that in a market where there is an increasing consumer demand for health services and that demand is increasingly being met by for profit service providers, the unique place for Catholic health is to move to become Accountable Care Organisations (ACOs). In Hamel's view, Accountable Care Organisations deliver services as has been the practice in the past, but they take on a greater responsibility for the overall health of a defined population within a geographic region. They are not assessed on throughput or head count or delivery of procedures, but rather they are assessed on a defined population health outcome.

DeVore and Champion in their 2011 paper explored this notion of the Accountable Care Organisation (ACO).<sup>6</sup> They said that an ACO empowers people to take charge of their health and to engage in shared decision-making processes with providers of care. Both the consumer and providers jointly seek to eliminate waste and unnecessary spending. Patients' choices are respected. There is increased preventive health and other strategies to keep people well and to avoid reliance on primary and acute care cost expenditure. The ACO framework draws much from cost efficiency, but it also puts at the centre a "people-centric perspective"<sup>7</sup> that we in Catholic health care would connect to the dignity of the human person.

Is there a role for this principle of the Accountable Care Organisation in Australia? Is it possible for a Catholic health organisation to take on responsibility for population health within a defined geographic area? Would governments allow it? Is it logistically possible? I put it to you that one of the distinct communities to which Catholic health already has significant presence and infrastructure is the care of the aged. As many of our hospitals have aged care services as part of their operating footprints, we can therefore think about the opportunity to pursue this notion of an Accountable Care Organisation not in relation to a geography but more so into relation to a defined population. In other words, we are thinking about an integration of the needs of older people as they move through community

care, home care, residential aged care and hospital care as a model which provides an opportunity for this notion of the Accountable Care Organisation to be tested in the Australian Catholic health environment.

## Improving Aged Care through Greater Integration of Services

If we thought for just a moment that we might want to focus our lens on this principle of the ACO and the care of the aged in the Australian context, we could turn to the *Australasian Journal on Ageing* which has reported a significant body of work on how to better the care of the aged. I am going to cite three different studies that are illustrative of the evidence around how the care of the aged could be improved by greater integration between hospital, residential, and community aged care.

The first is a study by Arendts et al titled ‘Can transfers from residential aged care facilities to the Emergency Department be avoided?’ This study was principally undertaken in Western Australia. It found that 31% of admissions from residential aged care services to the Emergency Department could have been avoided if a simple, consistent standard of primary care had been delivered in residential aged care services. Let me stress again what the study found: it found not that there needed to be more primary care, but rather just that the standard of primary care that was accessible in some aged care services should be more accessible in all aged care services for 31% of residential aged care admissions to Emergency Departments to be avoided.<sup>8</sup>

The Jones et al study titled ‘A randomised controlled trial of an exercise intervention to reduce functional decline and health service utilisation in the hospitalised elderly’ found that a twice daily allied health-led exercising program for older people with functional decline improved functional outcomes and reduced length of stay for an extraordinary 60% of study participants. A simple exercise program like this could even be implemented by unpaid volunteers.<sup>9</sup>

The Kruger et al study titled ‘The oral health and treatment needs of community-dwelling older people in a rural town in Western Australia’ found that over three quarters of hospitalised old people were professionally assessed as being in need of immediate dental care. The average age of dentures in this study was found to be eighteen years.<sup>10</sup>

Now I have cited these three studies, but I could have picked any number of others. Within your own organisations, you will be aware of other illustrations of how the care of the aged could be vastly improved. Why have I cited these studies when our topic is mission and ethics? I’m putting to you that we spend a lot of time talking about the things that we don’t do within our hospitals, and we put a lot of energy in the public square defending the fact that we do not provide these services. However, the opportunity in the period ahead where the consumer is looking for the value that they receive from the service, is to provide the value that they really want, which is excellence in care and above all holistic care. In our language, that is the work of the Gospel.

If we are to be ready for this new consumer-directed environment where the individual, the family member, and

the consumer ultimately has the power to purchase, to choose, and to direct the types of services that they want, there is an extraordinary amount of work that we need to do on business systems, on costing our services, on cost competition, on branding, and on ensuring that we are competitive. But above all and indeed more importantly and before we even think about those aspects, we need to re-engage in the definition of mission and ethics within our organisations as we move into this new consumer-directed environment. We need to draw down once again on the charisma of the brave religious, of the clergy, of the bishops who have come before us, who were willing to challenge, who were willing to test boundaries, and to prioritise where the changing need of community was.

I hope that these thoughts give you some insight into the public policy pressures that are ahead of us that are coming to a consumer discussion near you one day very soon. As that time approaches, to cope with this changed world, a Centre like the Chisholm Centre and those of us who are leaders in Catholic health care have the opportunity to engage anew within this redefinition of mission and ethics. Our task is not to change the foundational purposes of our organisations, but to re-articulate how we engage with this changing environment.

### ENDNOTES

<sup>1</sup> *Aged Care (Living Longer Living Better) Act 2013*, Australian Government, <http://www.comlaw.gov.au/Details/C2013A00076>

<sup>2</sup> Independent Hospital Pricing Authority (IHPA), “National Efficient Price Determination”, IHPA, <http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/content/national-efficient-price-determination-lp>

<sup>3</sup> Ron Hamel, “Catholic Identity, Ethics Needs Focus in New Era,” *Health Progress* 94, no. 3 (May-June 2013):

85-87; online at Catholic Health Association of the United States of America (CHAUSA), <http://www.chausa.org/docs/default-source/health-progress/ethics---catholic-identity-ethics-need-focus-in-new-era.pdf?sfvrsn=2>

<sup>4</sup> *Ibid*, 86.

<sup>5</sup> Veritas Institute, “About the Catholic Identity Matrix,” University of St Thomas, <http://www.stthomas.edu/centers/veritas/assessments/about-the-catholic-identity-matrix-cim/>

<sup>6</sup> Susan DeVore and R. Wesley Champion, “Driving Population Health Through Accountable Care Organizations,” *Health Affairs* 30, no. 1 (January 2011): 41-50; online at <http://content.healthaffairs.org/content/30/1/41.full.pdf+html>

<sup>7</sup> *Ibid*, 43.

<sup>8</sup> Glenn Arendts et al, “Can transfers from residential aged care facilities to the Emergency Department be avoided through improved primary care services? Data from qualitative interviews,” *Australasian Journal on Ageing* 29, no. 2 (June 2010): 61-65.

<sup>9</sup> Catherine T. Jones et al, “A randomised controlled trial of an exercise intervention to reduce functional decline and health service utilisation in the hospitalised elderly,” *Australasian Journal on Ageing* 25, no. 3 (September 2006): 126-133.

<sup>10</sup> Estie Kruger et al, “The oral health and treatment needs of community-dwelling older people in a rural town in Western Australia,” *Australasian Journal on Ageing* 26, no.1 (March 2007): 15-20.

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## *Evangelii Gaudium* and Catholic Health and Aged Care

*Pope Francis's Evangelii Gaudium (The Joy of the Gospel) calls us to both service and silence. This article explores the theological underpinning of this call, and considers its implications for Catholic health, aged and community care services in Australia*

*Evangelii Gaudium (The Joy of the Gospel)*<sup>1</sup> is a fifty thousand word Apostolic Exhortation issued by Pope Francis on 24 November 2013. This is the first of three articles about it which will appear in the *Chisholm Health Ethics Bulletin*. Subsequent articles will overview the content of the Exhortation, and explore in detail its fourth chapter which focuses on social teaching and social engagement. This article details the key message of *Evangelii Gaudium* – its big vision – and considers the implications of this for Catholic health, aged and community care services in Australia.

### What is Evangelisation?

In the first paragraph of the Exhortation, Pope Francis states, "I wish to encourage... a new chapter of evangelisation." *Evangelii Gaudium* is therefore about evangelisation. But what does that mean? Many of us are familiar with the model of evangelisation which comes from what are sometimes called the Evangelical Christian Churches. This model focuses almost exclusively on the confession of Christian belief. In this model, evangelisers question other people, "Have you confessed Jesus Christ as your personal Lord and Saviour? Are you saved?" A concern about spirituality and personal faith is not absent from the Catholic model of evangelisation. However, it is only one element of the Catholic model. It surely has its own proper place, and it cannot be dismissed, ignored or downplayed. But even so, it must also be kept in harmony with every other element of the Catholic vision. This is why *Evangelii Gaudium* is important. It is a comprehensive account of the Catholic model of evangelisation. It helps us to identify the many elements of this Catholic vision, and to appreciate the proper place of each one. It also allows us to compare our current practice against this model, and therefore to identify areas where we are falling short and where we need to improve. I submit that many people will find this Catholic vision of evangelisation both more appealing and more challenging than the narrowly focussed Evangelical model.

This is where it does get a bit complicated. To understand the Catholic model of evangelisation, we must first understand the Catholic view of reality – that is, the Catholic worldview or the perspective from which Catholicism makes sense of reality. This Catholic worldview is a narrative, a story. Like the Shakespearean plays, this story has five acts. In the Christian story, these five acts are Creation, Fall, Incarnation, Redemption, and Resurrection Destiny.<sup>2</sup> Let us look in more detail at these

five acts of the Christian story, considering several of them together:

### Creation and Fall

Christians believe that everything is created by God. This means that everything which exists is essentially good. The Fall, however, indicates that Creation is damaged and that it is no longer exactly as the Creator had originally intended. Human wrongdoing – human sin – is at least one cause of this damage.

To better understand this worldview, we can contrast its understanding of Creation with a dualistic worldview. Dualism holds that there are two First Principles – in other words, a good god and a bad god. It then divides reality into the good products of the good god, and the bad products of the bad god. Almost invariably, spiritual things such as soul and mind are seen as good, whereas physical things – sex especially – are seen as bad. The task of the enlightened soul, therefore, is to shun physical pleasures and especially sex so as to flee the physical realm and to return to the disembodied world of the spirit.

It cannot be denied that some Christians do subscribe to a dualistic worldview. Christianity itself, however, should affirm the essential goodness of all created things, including physical pleasure, sexual attraction, and sexual intercourse.

Christianity also believes that the Creator God continues to be at work in Creation. Its vision of God is not like that of a clockmaker who makes a clock, winds it up, and then leaves it by itself to keep the time. Christianity holds instead that God is always at work in the world. God can – and, indeed, sometimes does – intervene in a miraculous way. Mostly, however, in this world God works in and through natural processes. For this reason, a Christian who contemplates a beautiful sunset might thank God for God's marvellous handiwork. Or a married couple whose loving sexual embrace has created new life might recognise in this the mysterious presence and action of God. Or again, Christians believe that God is also present and active whenever "hatred is overcome by love, revenge gives way to forgiveness, and discord is changed to mutual respect."<sup>3</sup>

The Fall reminds us that everything in this world is not quite as it should be. Both the great English Christian apologist G. K. Chesterton and the great American theologian Reinhold Niebuhr have observed that the only Christian doctrine for which there is empirical evidence is the doctrine of sin.<sup>4</sup> While many good and inspiring things

are done, human history is also a long record of human wrongdoing, and all the damage and suffering which this has caused. Even when damage is caused by natural disasters, our collective failure to come to the aid of those affected has added greatly to the suffering.

In the Bible, Creation and the Fall are presented as stories in the first three chapters of the Book of Genesis. These simple but compelling stories do indeed grab our attention. Even so, we should recognise that these stories are not a literal historical record. Their purpose is not historical but ontological – that is, they teach us about the nature of reality. Created by God, all things are essentially good. Damaged by the Fall, this world is not exactly as the Creator intended.

What would human beings have been like before the Fall? Being material beings, we would still have died, but perhaps we would not have feared death so much. I suspect that we would have been more resistant to both physical and mental disease, and more resilient and able to heal. We would have recognised much more readily that human happiness comes not from having great material possessions but from our relationships with one another. One of our greatest ethical challenges has always been to extend our moral sense beyond our own tribe to embrace all peoples.<sup>5</sup> I suspect that pre-Fall human beings would have had a much greater sense of solidarity with all people from every tribe and nation. I think they would have had a more immediate sense of the presence of God, and a deeper appreciation of the importance of their relationship with the Divine. They would also have had a different relationship with all created things. They would have had a greater sense of wonder and gratitude for the bounty and the beauty of creation. The creation would have reminded them more readily of the Creator. And while they would surely have made use of created things, I am sure that they would have had a much greater sense of responsibility to care for creation and to preserve it for future generations. While never completely lost, all these things have been damaged by the Fall.

## Incarnation and Redemption

While Christian beliefs about sin make some sense to those who do not have Christian faith, Christian beliefs about Jesus Christ make sense only to those who share the Christian faith. Christians believe that Jesus Christ is the Word of God Made Flesh, God who has become Human. Christians believe that what was lost through the Fall was definitively restored through the Life, Death and Resurrection of Christ. Christians therefore believe that the Life, Death and Resurrection of Christ is the turning point of history, the most important event in the history of the world.

At the end of the previous section, we noted some of the things which were lost through the Fall. At the beginning of his public ministry, Jesus announced that he had come to restore these things:

*The Spirit of the Lord has been given to me,  
for he has anointed me.  
He has sent me to bring the good news to the poor,  
to proclaim liberty to captives  
and to the blind new sight,*

*to set the downtrodden free,  
to proclaim the Lord's year of favour.* (Luke 3:18)

Jesus did this in two ways. He did it firstly through his active ministry, which involved both his preaching and his miraculous healings. In his preaching, Jesus announced that the Kingdom or Reign of God was once again establishing itself in this sin-damaged world. In this Kingdom, those who are sick will be healed – and Jesus' miraculous healings were therefore one more sign of the coming of the Kingdom. In this Kingdom, people will live in solidarity like sisters and brothers, and really care for one another. In this Kingdom, all people will know God – God who is loving and forgiving, God who is like the father in the Parable of the Prodigal Son. (Luke 15:11-32) And while Jesus did not directly address caring for the environment, his attention to creation does indeed call us to ecological conversion. For if we recognise as Jesus did God's care for the lilies of the field and the bird of the air (Luke 12:22-34), we recognise too our own responsibility to care for creation.

Jesus also restored what was lost by the Fall through his Passion, Death and Resurrection. In the context of the five act Christian story, the arrest, torture and execution of Jesus seemed like a disaster: the one who would restore what was lost was killed. But something mysterious happened. Jesus restored what was lost above all through his Death. In this, the Word of God Made Flesh was totally obedient to the will of God the Father. This radical obedience by the Word Made Flesh changed everything. At the same time, through the Incarnation, the Word Made Flesh was radically connected to all humankind and all of creation, so these changes extended to embrace all of reality.<sup>6</sup> Through his Life, Death and Resurrection - but particularly through his Death - Jesus restored what was lost by the Fall.

While this Christian belief ultimately makes sense only to those who share the Christian faith, an analogy might help to clarify what Christians believe in this matter. Think of the divine action of restoring what was lost by the Fall as a war. And think of the death of Jesus as analogous to the Japanese surrender at the end of the Second World War on 15 August 1945. At that time, the war was over and for the Allies the war was won. But at that time there was still a great deal yet to do. The news that the war was over had to be circulated across the Pacific. Vast changes were yet to be made. It took time. It is said that many years later there were still some isolated Japanese soldiers on isolated islands who had not yet learnt that the war was over. So it is for Christianity. The war against the damage of the Fall was definitively won through the Life, Death and Resurrection of Christ. But there is still a great deal to do.

## Resurrection Destiny

As we noted above, the victory is won, but there is still a lot to do. In this time, the divine mission of healing, sanctifying and perfecting everyone and everything in creation continues. Because this is God's work, contemporary missiologists refer to this mission as *Missio Dei*.<sup>7</sup> This is Latin for the Mission of God.

The church exists to contribute to the *Missio Dei*. In the way we live within the Church, we are meant to be a *sign* of how things will be in the Kingdom of God. We are also

called to be an *instrument* of the Kingdom in all the things we do to make this world a better place. To capture the idea that the Mission existed before the Church, contemporary missiologists suggest not that the Church has a Mission, but that the Mission has a Church.<sup>8</sup> And according to Darrell Gruder, this *Missio Dei* is “more radical, more inclusive, [and] more transforming” than we can even imagine.<sup>9</sup>

## So, What is Evangelisation?

But let us return to Pope Francis and *Evangelii Gaudium*. And let us once again ask the question: what is the Catholic understanding of evangelisation? Quite simply, it is everything we do as we contribute to the *Missio Dei*, everything we do which builds up the Kingdom of God. It is caring for people’s material needs and particularly the needs of the poor: “human advancement... must necessarily find expression and develop in every work of evangelisation... evangelisation would not be complete if it did not take account of the unceasing interplay of the Gospel and man’s concrete life, both personal and social.” (*Evangelii Gaudium*, #178 & 181) It also involves asking hard questions about the causes of poverty: “it means working to eliminate the structural causes of poverty and to promote the integral development of the poor.” (*Evangelii Gaudium*, #188) It also means caring for people’s spiritual needs: “the worst discrimination which the poor suffer is the lack of spiritual care... they need God and we must not fail to offer them his friendship, his blessing, his word, the celebration of the sacraments and a journey of growth and maturity in the faith.” (*Evangelii Gaudium*, #200) It is also caring for the environment: “all of us, as Christians, are called to watch over and protect the fragile world in which we live...” (*Evangelii Gaudium*, #216) Evangelisation means literally ‘proclaiming good news.’ It follows that everything we do which is good news is part of evangelisation.

A number of perceptive commentators have already noted this in different ways. Archbishop Mark Coleridge of Brisbane wrote, “At the heart of all this talk about evangelisation and new evangelisation is a very simple question: how can we, you and I, in practical ways reach out particularly to those who are on the margin, who are wounded, who are broken, who are poor.” In like vein, Frank Brennan said, “Get out there. Do something to help your neighbour. Do it joyfully. Do it with passion.” Lay Catholic Bill Donaghy reported when he was involved in mission work at a Haitian sugar workers’ town, one man observed, “Some people want to come and just tell us things, but I can tell that you just want to be with us.” Bill added, “That’s what the New Evangelisation is supposed to be: it is more listening than talking.” Cardinal Reinhard Marx of Munich said, “What impresses me above all is how strongly the Pope combines the social dimension of the Option for the Poor with the mandate to evangelise.” The Tablet editorial made the same point: “[Pope Francis] dissolves the boundaries between evangelisation and work for social justice, so that they become two aspects of the same thing.” This same point was also made by Archbishop Denis Hart of Melbourne who bemoaned that “too often evangelisation and working for social justice are presented as separate, or even opposing, missions.” Archbishop Hart noted that the Archdiocese of Melbourne has “offices for evangelisation, for youth, for life, marriage and family, for

justice and peace, for social services, for migrants and refugees, for ecumenical and interfaith relations, for Aboriginal ministry, AIDS ministry, prison and hospital ministry, local and international charity, and many educational agencies.” He insisted that all these agencies are involved in “the evangelising mission of the Church.” Dr John Borelli observed, “Pope Francis broadens the New Evangelisation, beyond efforts at restoration of Christian faith where it has lapsed, to a renewal and reform of the Church from top to bottom for a recommitment to a more authentic living of the Gospel and for sharing the joy and hope of the Gospel with all people.”<sup>10</sup>

## Implications for Catholic Health and Aged Care

Pope Francis has one more surprise. Even though there is so much to do, he calls us first to a “renewed personal encounter” with God. (*Evangelii Gaudium*, #3) As he explains, “Thanks solely to this encounter... we are liberated from our narrowness and self-absorption... Here we find the source and inspiration for all our efforts at evangelisation. For if we have received the love which restores meaning to our lives, how can we fail to share that love with others?” (*Evangelii Gaudium*, #8)

Pope Francis therefore directs us to two different experiences. He calls us to service. But he also calls us to what we might call silence.<sup>11</sup> Let us consider what silence and service might mean for those of us who are involved in Catholic health and aged care in Australia. Before doing so, however, let us note the Catholic Law of Gradualness which Pope John Paul II once called “step-by-step advance.”<sup>12</sup> This principle reminds us that we should never try to do everything all at once, and particularly that we should not attempt anything which is not yet possible for us. Instead, we should work out what is possible, and take those steps now, hoping that in the future as we move forward we might be able to do even more. This principle therefore reminds us that the following discussion is not intended to overwhelm us with everything that we could be doing, but instead simply to help us identify what is the next possible step for us to take:

## Service

Catholic public and private hospitals, Catholic aged care and community services all serve in different ways. For example, Catholic public hospitals often serve the most disadvantaged, whereas Catholic private hospitals often serve more advantaged people, but use the profits from this to provide services to those on the margins. All of these various strategies are legitimate. We should not forget that our service of people who are relatively advantaged is also very much part of our contribution to the *Missio Dei*. From the perspective of everything which God wants for our world, almost everything good which we do is part of our mission.

Within this total mission, the Catholic principle of the Preferential Option for the Poor gives a certain priority to services for the most disadvantaged. There are many ways we can develop this aspect of our service. One fine way is to recognise our strengths and then to find ways to use these strengths in the service of the most disadvantaged. One

hospital, for example, might initiate a programme whereby its health professionals provide flu shots for homeless people. Or another organisation might use its catering department to provide the homeless with hot meals. Yet another organisation might use its laundry service to provide employment and training for disadvantaged people. Drawing on our strengths to serve the poor is a very useful strategy.

Another strategy is to partner with another agency which does provide services to the poor. Thus, a Catholic hospital or aged care facility might alert its staff that a local shelter for victims of domestic abuse either needs certain material goods such as new blankets, or certain services such as help with their budget and accounting.

Catholic Social Teaching reminds us of the Gold Standard in services to the poor. As Pope Benedict XVI reminded us, in the very best programmes “the people who benefit from them ought to be directly involved in their planning and implementation.” Indeed, such programmes work best “with poor people playing the central role” and the contribution of those not in poverty being ultimately not to replace but to support the initiatives of the poor.<sup>13</sup> The challenge is surely for our services to have more programmes developed and implemented in this way.

We also contribute to the *Missio Dei* by reducing waste and caring for the environment. It is pleasing when Catholic organisations receive awards for excellence in this area.<sup>14</sup>

In my opinion, however, our greatest challenge in the area of service is doing more to meet the spiritual needs of everyone who is involved in our services. Pope Francis has asked us to look at all we do from the perspective of evangelisation. From this perspective, we cannot claim that we only provide health care or residential aged care or community services. Instead, we are challenged to consider how we might better respond to the spiritual needs both of those who receive our services and those who provide them.<sup>15</sup> One strategy might be to develop relationships with local Catholic parishes and retreat centres who offer programmes which respond to spiritual need. It would be tragic if we ignored this area of need and the challenges it presents to us.

## Silence

As we have noted, Pope Francis calls us to silence as well as service. Silence can mean different things for different people. Some of us either do not believe in God or are uncertain about God. For these folk, silence will simply be silence. They will still find that silence enriches both their professional and personal lives. And even if they do not recognise God, Christians will believe that God still speaks to them in the silence. Others of us do have some sense of God. We will try at least sometimes to listen to God in the silence and to respond to him in prayer. Whether we are believers or not, our common challenge is to find time and space in our lives for silence.

For our organisations, a key challenge is to be concerned about our employees’ work-life balance. We cannot expect them to have time for silence if their lives are full of work.

For each one of us, the challenge is to structure our lives so that there is time for silence. This requires discipline. It

sometimes requires that we let go even of relatively important commitments so that we have time and space for silence.

At this time in history, it particularly requires that we are disciplined in our use of social media. Social media can rewire our brains so that we receive a squirt of dopamine (the ‘feel-good’ hormone) every time we receive a tweet or a text or check Facebook. This can be highly addictive. What is more, it can make us “increasingly emotionally disconnected, spiritually malnourished and petrified of being alone.”

Silence on the other hand “can improve mood, creativity and memory, and lower stress and agitation.” It can increase our self-knowledge, deepen our appreciation of nature and our sense of God, and enrich both our creativity and our sense of meaning and purpose in life.<sup>16</sup>

If we persevere in both service and silence, we will find that they flow into one another. Our service calls us into silence as we reflect on what we have seen and experienced. But then our silence calls us into wiser and more generous service. Service feeds into silence, and silence feeds into service. In my opinion, the invitation to enter into this dynamic of service and silence is the key message of Pope Francis’s *Evangelii Gaudium*.

## ENDNOTES

<sup>1</sup> Pope Francis, *Evangelii Gaudium*, Apostolic Exhortation, Holy See, [http://w2.vatican.va/content/francesco/en/apost\\_exhortations/documents/papa-francesco\\_esortazione-ap\\_20131124\\_evangelii-gaudium.html](http://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html)

<sup>2</sup> For more on this, see Charles E. Curran, “The Stance of Moral Theology,” in *New Perspectives in Moral Theology* (Notre Dame, Indiana: Fides, 1974), 47-86. Note too that the five-act Christian story follows the common pattern for five act drama. The first act is the Exposition, which introduces the principal themes and characters. The second act is the Complication, which threatens some desired outcome. The third act is the Climax or Turning Point, which promises to overcome the difficulties raised in the Complication. The fourth act is the Reversal, which threatens the successful outcome promised by the Climax. And the final act is the Dénouement or Resolution which ties up all the loose ends. For more on this five act structure, see Joshua Patrick, “Shakespeare’s Five Act Structure: Learn It, Live It, Love It,” Go For The Juggler, <http://goforthejuggler.hubpages.com/hub/Shakespeares-5-Act-Structure-Learn-It-Live-It-Love-It>; and Frank Deis, “Five Act Play,” Rutgers University, <http://www.rci.rutgers.edu/~deis/fiveact.html>.

<sup>3</sup> This is from the Preface of the Second Eucharistic Prayer for Reconciliation from the Catholic Mass. For this, see, for example, Catholic Resources for Bible, Liturgy, Art, and Theology, <http://catholic-resources.org/ChurchDocs/RM3-EPR1-2.htm>. From the Christian belief that God is involved in all things, it follows that God is also involved in some way even in the bad things that happen. Here, however, we should distinguish between God’s active will (i.e. what God wants to happen), and God’s permissive will (i.e. those things which God does not want but merely permits to happen).

<sup>4</sup> In the second chapter of *Orthodoxy*, G. K. Chesterton (1874-1936) wrote that original sin “is the only part of Christian theology which can really be proved.” Some sixty years later, quoting the *London Times Literary Supplement* with approval, Reinhold Niebuhr (1892-1971) stated, “The doctrine of original sin is the only empirically verifiable doctrine of the Christian faith.” Original sin is both our capacity and our propensity to sin. For these quotes, see G. K. Chesterton, *Orthodoxy* (London: William Clowes and Sons, 1908); and Reinhold Niebuhr, *Man’s Nature and His Communities: Essays on the Dynamics and Enigmas of Man’s Personal and Social Existence* (New York: Charles Scribner’s Sons, 1965), 24.

<sup>5</sup> For one account of this, see Paul Bloom, "The Moral Life of Babies," *The New York Times Magazine* 5 May 2010, [http://www.nytimes.com/2010/05/09/magazine/09babies-t.html?\\_r=0](http://www.nytimes.com/2010/05/09/magazine/09babies-t.html?_r=0).

<sup>6</sup> For more on this, see *Catechism of the Catholic Church*, #613-618, Holy See, [http://www.vatican.va/archive/ENG0015/\\_INDEX.HTM](http://www.vatican.va/archive/ENG0015/_INDEX.HTM).

<sup>7</sup> For an accessible account of this, see "Missio Dei," Wikipedia, [http://en.wikipedia.org/wiki/Missio\\_Dei](http://en.wikipedia.org/wiki/Missio_Dei).

<sup>8</sup> See, for example, Stephen Bevans SVD, "The Mission Has a Church: An Invitation to the Dance," *Australian eJournal of Theology* 14, no 1 (2009), [http://aejt.com.au/2009/issue\\_14/?article=197644](http://aejt.com.au/2009/issue_14/?article=197644).

<sup>9</sup> Darrell L. Gruder, ed., *Missional Church: A Vision for the Sending of the Church in North America* (Grand Rapids, MI: Eerdmans, 1998), 4-5.

<sup>10</sup> For these quotes, see Archbishop Mark Coleridge, "Pope gives direction with evangelisation," *The Catholic Leader* 2 February 2014, 9; Frank Brennan, "Pope's vision for a bruised and dirty Church," *Eureka Street*,

<http://www.eurekastreet.com.au/article.aspx?acid=38583>; Natasha Marsh, "Time Out With... Bill Donaghy," *Kairos Catholic Journal* 25, no. 21 (9 November 2014): 8-9 at 9; *The Tablet* 267, no. 9026 (30 November 2013): 27 and 2; Archbishop Denis Hart, "More than words: Engaging our society with the Gospel (*Evangelii Gaudium*)," *Kairos Catholic Journal* 25, no. 4 (16 March 2014): 4-5; and John Borelli, "Power to the People of God," *The Tablet* 267, no. 9027 (7 December 2014): 6-7 at 7.

<sup>11</sup> I noted these useful terms in an article about Pope Francis's message on the Feast of the Immaculate Conception on 8 December 2014. For this, see "Silence and Service," *The Catholic Leader* 14 December 2014, 9.

<sup>12</sup> Pope John Paul II, *Familiaris Consortio*, Apostolic Exhortation, #34, Holy See, <http://w2.vatican.va/content/john-paul-ii/en/>

[apost\\_exhortations/documents/hf\\_jp-ii\\_exh\\_19811122\\_familiaris-consortio.html](http://w2.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate.html).

<sup>13</sup> Pope Benedict XVI, *Caritas in Veritate*, Encyclical Letter, #47, Holy See, [http://w2.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf\\_ben-xvi\\_enc\\_20090629\\_caritas-in-veritate.html](http://w2.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate.html);

Australian Catholic Bishops' Conference, *A New Beginning: Eradicating Poverty in our World* Blackburn, VIC: Dove, 1996), 28.

<sup>14</sup> "SJOG health care recognised for environmental efforts," *Health Matters* 68 (Summer 2013): 44.

<sup>15</sup> Calvary Community Services assist "staff, partners and clients to connect with faith, hope and love in their spiritual journey." St John of God's Pinelodge Clinic has groups which assist patients to "explore their own spirituality and how their spirituality may impact on their recovery from psychiatric illness." Similar programmes are offered overseas. For more on this, see Kevin Meese, "Celebrating the Joy of Mission," *Kairos Catholic Journal* 25, no. 4 (16 March 2014): 16; Liz Huglin, "Pastoral care groups as spiritual intervention with psychiatric patients," *Health Matters* 71 (Spring 2014): 18-19; Carwyn Gravell, "A refuge in faith," *The Tablet* 267, no. 8992 (6 April 2013): 8-9.

<sup>16</sup> For more on social media and silence, see Scott Pape, "Devil's in the device," *The Herald Sun* 28 March 2015, 61; and Jill Stark, "So long solitude," *Sydney Morning Herald* 12 October 2014, <http://www.smh.com.au/national/why-being-alone-means-keeping-good-company-20141011-114mtf.html>.

All online resources accessed on 5 May 2015.

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