Christianity at the Crossroads of Post-Modernity

Missional Leadership into the Future

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Introduction

Leadership for Mission today, and in to the future, requires a level of theological thinking that is often new and always demanding. As our culture becomes ever more complex and diverse, many once taken for granted ‘truths’ no longer hold sway. In an attempt to engage with this post-modern reality of identity confusion, Pope Francis is determined to drive church reform. In this brief paper I want to concentrate on four theological concepts that are at the forefront of Pope Francis’ determination to engage the church with contemporary culture. They are:

- Accompaniment
- Discernment
- Inclusivity
- Transcendence

These four Mission orientated concepts are of course deeply rooted in an Incarnational Spirituality: “The incarnation is both a human and a divine reality.” In the context of Catholic health care in Australia, an Incarnational Spirituality seeks to recognise the presence of Christ in our work place, in our colleagues, and in a special way, to recognise the presence of Christ in those who seek physical, emotional and spiritual care in our Catholic hospitals.

Objectives of this paper:

- To locate Catholic health care within the wider context of our history, secular culture and a contemporary understanding of the Australian church;
- To explore contemporary notions of Mission and church – for example, ‘The Mission as a church’;
- To centre Mission Leadership at the heart of Catholic health care in Australia;
- To emphasise the importance of formation for mission within the demands of 21st Century hospital culture and the threat of an ever increasing neo-liberal agenda of excessive profit or Armageddon.

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1 This paper is dedicated to all the inspirational people who work in Catholic health care and who personify, through their work of service, a sacramental vision of reality.

2 Vincent Cardinal Nichols, Archbishop of Westminster, in the Tablet, 18 February 2017, 4/5. Here the Cardinal highlights two characteristics, accompaniment and discernment, I add a further two from the writing of Pope Francis, inclusivity and transcendence.


Discerning Mission in Chaotic Times

In the stress and strain of modern hospital culture, challenges to the Mission of Incarnation I have just described, include: time short, high demand, secular culture, one increasingly dominated by a science and business focused ideology. Business professionals make endless deals with modern science, business acumen understands well that science and technology are a means to maximise profit. Science in turn needs business to invest in scientific and medical research. Bill Clinton famously declared in an election campaign, ‘it’s the economy stupid’, his intention was to emphasise the significance of good economic management. One can imagine business executives in all industries repeating a form of this mantra, ‘...it’s economics stupid’.

A neo-liberal culture, incidentally, that last week suffered a setback in its attempts to demolish the so-called Obama health care. Health provision aimed at the care of 30 million vulnerable and needy people. Whilst beyond the scope of this brief paper, I think it is important to name neo-liberalism of the Trump variety as an existential threat to the founding story of Catholic health care. Our mission leaders are called to be ‘guardians’ of Gospel values and to be advocates opposed to the prevailing tide of economic rationalism, which breaks daily on the shores of all Catholic institutions. One of the challenges before all Catholic institutions in health care and education is to explore who else in the institution are mission leaders? It simply cannot be the Director of Mission, Mission fails if it is not driven by the whole executive team.

In such economically drive “catholic” environments, one might hear: ‘If only we didn’t have this “Catholic” brand, we could make serious money from these health care businesses’. After all, ‘people always get sick’. Then, perhaps another view might determine that a nuanced business narrative would articulate that the “Catholic” brand is good for profits. We suddenly hear: ‘let’s invest in the Catholic brand’. Such thinking which is more common then we might like to admit, represents an aspect of the neo-liberal commodification of health care relationships, one that understands people as “units” to generate ever increasing profit.

The Reason for Being in Catholic Health Care

This reason for being in health care from the perspective of Mission has two interrelated dimensions – the personal and the institutional. The personal ‘being’ might include human flourishing and wellbeing, along with personal discernment around vocation. The institutional ‘being’ might include, growing out from the Catholic intellectual tradition, how do we strive to enhance the common good of all members of society?

Such discernment with regard to complex existential questions requires far more time to depth than we have today. Such questions - and of course answers - are mission critical to the future of Catholic health care in Australia.

In the context of a Catholic hospital, good economic management, the advancement of science and technology is for a purpose, that purpose is to support the Mission and Identity of the Church. Mission thinking lives in tension with business and science KPI’s. Such tension can be useful and good, so long as we have robust, dedicated and theologically literate missional leaders.
Such leaders who never lose sight of our founding story taught by Jesus of Nazareth 2000 years ago, narrated in the Gospels, and illustrated in paradigmatic parables such as the Good Samaritan. Such a founding story has the potential, with theologically literate leadership, to shape hospital Mission and Culture into the future.

Mission leadership seeks to ‘enflesh Christ’, that is to incarnate Christ into our hospitals. Such leadership awakens a Trinitarian understanding of reality (Father, Son and Spirit), a recognition of ‘God in all things.’ Seeing God in all peoples is a concept deeply embedded in the spirituality of Pope Francis, it is, I suggest, the essential modus operandi of Catholic Health Care. St. Mary Mackillop, Australia’s first saint, would I believe expect no less from Catholic health care. Her famous maxim applies inspirationally to the mission of Catholic health care in an Australian context:

‘See a need and do something about it’

Vatican II to Pope Francis

Two generations of theologians have asked: What did Vatican II say? One thing we can be sure, the thousands of bishops at Vatican II agreed that the Church should reform in order to live meaningfully in the modern world. This reform is being led by the laity, mostly it is a silent passivity - walking out of churches and not returning. I urge each person in this room to stay theologically engaged with catholicity, it is one of the great challenges of our time, to reform the church so it can model Jesus and play a true servant leadership role in society. The culture of palaces, thrones and church princes has gone. In a manner similar to Saint John XXIII, Pope Francis has clearly indicated that he wants the church to radically engage with contemporary secular culture.

It is difficult to imagine that Francis has been Pope for only four years. He has achieved an incredible amount - fundamentally - he is attempting to change a 1700 year old Church culture. Pope Francis is clearly a Vatican II Pope. For Catholic health care to have a Catholic future it must be a Vatican II inspired institution critically in the area of leadership and mission. I would suggest each person in this room should know what Vatican II means for Catholic health care in Australia, and indeed how Vatican II, through Pope Francis, is moving the church into the future. Pope Francis is a conduit for the reform agenda of Vatican II. If you do not know the significance of Vatican II, then you will find it virtually impossible to contribute to the future mission and direction of Catholic health.

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Inspired by Vatican II, Pope Francis asks us to study with discernment 'the signs of the times', and to work collaboratively as we strive to build a reformed church in our hospitals, to build God’s kingdom here on earth.

Lumen Gentium, a central pillar of Vatican II, described the church as the "People of God". First and foremost then we recognise that we are church; the word Church derives from the Greek, ecclesia meaning group or an assembly of people. So this assembly of people, gathered in this place, working in Catholic Health Care, are a dynamic manifestation of church, the church in action (orthopraxis) in daily life. A church striving to build the kingdom (of God) ‘Your kingdom come, your will be done, on earth as it is in heaven’.

Three Models of Leadership for Mission

From the perspective of Leading for Mission, Jim and Therese D’Orsa, colleagues at BBI-TAITE, identify three types of leadership that is relevant to our context:

- Operational Leadership
- Strategic Leadership
- Missional Leadership

1. In the 1970’s most leadership thinking in faith-based organisations such as health care was operational. The focus was on day-to-day operations. In this period leadership training for mission was practically non-existent. You learned on the job. Leaders could manage solely on operationally thinking because faith-based groups operated in a stable cultural environment. In this environment expectations were tightly defined by a centralised religious leadership. The presence of priests or religious was the guarantor of Mission and Catholic Identity.

2. As this world began to collapse in the 1980s, it became necessary to think in new ways and make provision for a future in which the guardians of the Mission would not be present, or present in much reduced numbers. So, by the 1990s leaders of faith-based organisations had to learn to think strategically. This development took about a decade to land in Catholic institutions

When the presence of priests and religious provided the guarantee of Catholic identity, mission was simply taken for granted. The congregations sponsoring hospitals provided a generic response to “What is our basic purpose?” Members of these two leadership groups (operational & strategic) were given intensive initial training that wound them up like little clocks after which they were set in career-long motion. As long as the Catholic cultural world remained stable this seemed to work.

3. However, this paradigm began to fail in the 1990s as people realised that the mission of faith-based institutions such as hospitals could no longer be taken for granted. Catholics no longer accepted old answers to their new questions.

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9 Gaudium et spes, n.11. 
11 Cf. Lumen Gentium, Chapter 2. 
Centralised control by clergy and religious began to break down as lay people began to take over mission and identity, previously the province of the religious. Lay leaders began to think for themselves. Faith-based institutions like Catholic hospitals had to learn to think in a new way, one that set directions consistent with what members now understood as the demands of the Gospel.

Catholics had to come to grips with the fact that these demands often ran counter to those of the evolving institutional culture in which they lived and the state funding upon which they relied. Two options emerged:

The first was to secularise - which happened with some health ministries, theologically informed leadership dissolved into business school leadership.

The second option was to do some fundamental re-thinking about why health institutions existed in the first place (ressourcement) and what their future might look like.

The response from the second option, lead to the development of mission leadership in many faith-based institutions. An early result was the creation of “mission statements”. Remnants of this period still survive in many hospitals. Mission statements do not equate to mission leadership, but were a by-product of early efforts to go down this path.

The emergence of mission leadership was helped by new theological developments growing out from Vatican II and the growing recognition of the role of laity in leadership roles for Mission and Identity. By the early 1990s “mission” was understood as “knowing your basic purpose” and leadership as “knowing how to mobilise people to achieve that purpose”.

This change in emphasis was the result of business orientated research into “excellence”. It was found that excellent organisations valued employees, seeing them not just as “units of production”, but as members of teams with a vested interest in achieving the mission of the institution.

Strategic thinking and Mission thinking have emerged as responses to changing cultural outlooks and historical circumstances. They are a cultural development formulated by leaders of excellent organisations in response to change.

Some circumstances require operational thinking, some strategic thinking and some missional thinking. The task of the leader is to know which requires what and you cannot do this if you do not understand the options. In the context of Missional Leadership, theological formation is essential.\(^\text{13}\)

**The Split between the Gospel and Culture**

A close personal friend and mentor Gerry Arbuckle, a cultural anthropologist, who has dedicated his life to the service of Catholic health care in Australia and the United States reminds us that, ‘The split between the Gospel and culture is without doubt the drama of our

time’. This is no less the case in our Catholic hospitals which are, and rightly so, a microcosm of contemporary culture. Gerry Arbuckle calls for a: ‘refounding [which] is the process of retelling the original story of a culture or organisation and reinterpreting it in creative ways in view of the changing needs of the contemporary world.’

Arbuckle argues passionately that what is needed ‘is a quantum-leap in thinking and action, not modifications of existing structures’. We need the right people, missional leaders, ‘people of above average imagination and creativity, with drive to take the risks necessary to build new cultures of healthcare’. The right people who can resist the temptations that neoliberalism offers to leaders in health care.

Catholic health care requires leaders who hear the foundational call of the Gospel in their heart, leaders who live their calling in countless non-commodified relationships in daily life. These ‘above average people’, as described by Arbuckle, are also described rightly by Jim and Therese D’Orsa, as ‘Missional Leaders’, those people ‘who understand the political tensions involved in issues of justice and inequality, and the allocation or rationing of scarce resources’.

Inclusivity Driving Church Reform

A third dimension at the forefront of Pope Francis’ drive to reform the church along with discernment and accompaniment is inclusivity. In the context of Catholic health care, inclusivity is a non-proselytising, welcoming of peoples of all faiths and none. Inclusive Mission leadership is not about ‘right-thinking faith’. A Christian community seeking to be incarnational is not self-selective, rather a Christian healthcare community will be Trinitarian minded in the sense that the Holy Spirit draws all peoples into health care communities. Our role then as Mission leaders in Catholic healthcare, as articulated by Maryanne Confoy, is to offer welcome to all peoples, to be inclusive and to practice inclusive attentive presence.

It is once more to the parable of the Good Samaritan that we are drawn in to Catholic health care. The Samaritan himself was an ‘outsider’, reaching out in compassion to the suffering ‘outsider’, the outcast, or in today’s Australian context, the refugee we lock up on Manus Island or Nauru. The Good Samaritan as an “outsider” reaching out to another “outsider”, contains a further message for us in Catholic health care. Conceivably we need to be ever mindful that we don’t become too comfortable in the ebb and flow of secular culture, too at home on our side of the river that we can no longer feel empathy for the homeless, those on the “other” side of the river, on the margins of society. As Confoy says, ‘Pope Francis challenges all Christians to exercise a ‘Samaritan praxis of justice and love’, showing

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16 Arbuckle, Healthcare, xxi.
17 Arbuckle, Healthcare, xxi.
18 Maryanne Confoy, Welcome, Inclusion, Attentive Presence: The Central Role of Pastoral Care in Catholic Health Care and Aged Care, Catholic Health Australia (Canberra: Catholic Health Australia, 2015).
the importance of ‘compassionate action on behalf of justice, particularly for those who have no voice or who have become invisible.’ 19

Awareness of Transcendence and Dialogue with Culture

The final dimension I invite you to consider from Pope Francis’ call to reform the church, is the call to be transcendent in our outlook. Transcendence above some of the more dominant cultural movements, including utilitarian thinking, materialism and relativism. A call to transcendence in Catholic health care includes recognising some of the more excessive aspects of contemporary culture. Such leadership is radical indeed and work for exceptional people. Those individuals who can swim against the current of ‘populist-thinking’, those people who can detect truth from what Donald Trump defends as justified truthful hyperbole.

Pope Francis calls us to missional leadership that has three defining transcendent aspects:

- To transcend the material to promote a profound relationship with God
- To transcend the individual to promote a profound relationship with other human beings
- To transcend the individual elements of our world to understand them as parts of the whole of God’s creation

Christianity at the Crossroads of Post-Modernity

To conclude, we can be in no doubt that many secular forces oppose a sacramental vision of reality. A sacramental vision in the words of Pope Francis that is based upon discernment, one that accompanies those in need, is inclusive and ultimately capable of transcendence. Leaders for Mission in Catholic health care are required to be a prophetic voice of conscience. Jesuit Frank Brennan insists that we must discern the place for the prophetic voice in our institutions. 20 What is the place for the prophetic voice in Catholic health care? Can we all hear that voice and engage in mutually enriching dialogue to build the future? And who leads this call to Mission? I suggest it is all of us. But we must learn to be reasonable in our thinking and theologically informed in our outlook. A prophetic voice, Brennan continues, has a better chance of being heard when it resonates with the world of the audience, with the experience of reality and the values and cultural identity of the local people. Finally, without trust between those whose conscience differ, Brennan insists, we will not incarnate the mystery of the Godhead.

Vatican II fundamentally reoriented Catholic theology and Catholic institutions. This theological call to reform continues today in the life of Pope Francis and is signposted by the four missional concepts I have sketched this morning: to accompany; to be discerning; to be inclusive; and to be transcendent. The church is at a major crossroads in its 2000 year history. In those 2000 years, I would suggest the Church has experienced four major crossroads.


Today coming to terms with the complexity of post-modern culture is perhaps the most such crossroads and probably the most difficult to negotiate.

Vatican II described the Church as a sacrament, a sign and symbol of God’s kingdom on earth. Throughout history, Catholic health care has been a pastoral endeavour of the church. Its purpose is to bring Jesus’s healing to those in need, ‘to see a need and do something about it’. In this sense, Catholic health care in Australia is a sacramental vision of reality. An incarnated vision of Christ in the world. Let us strive together to ensure that Catholic health care remains a beacon of the incarnation at the cultural crossroads of post-modernity.

Questions for Reflection

1. How do we measure success beyond the balance sheet, how do we measure success with regard to our historical reason for being?
2. What are the challenges to the future Mission of Catholic health care in Australia?
3. What should we safeguard in Catholic health care for future generations, what works well today?
4. Describe a Mission Leader in Catholic health care, what skills and training do we require from our leadership in faith-based organisations?
5. What will be distinctive about Catholic Health Care in the Future, how might we recognise a Catholic hospital in the future?