

‘Tolerance’ as a Moral Concept for Catholic Health Care Ministry in a Pluralist World

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Introduction

“Healthcare in the United States is marked by extraordinary change.” This is the opening sentence of the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)* as revised in the early 1990s. It is a statement that has not needed to be modified in the subsequent editions of the *ERDs* as extraordinary structural change seems to have increased in velocity.

In the last 50 years, stand-alone hospitals developed into health care systems to survive, and small systems often joined together. Moral theologians responded to the wave of hospital mergers and acquisitions by use of the long-standing analytic framework of cooperation with evil. Cooperation review had been present, of course, in clinical practice and was modified from its original application for individual persons and events to the hospital structures themselves in Catholic health care ministry.

At present, merger activity continues, but a more fundamental re-imagining of the structure of health care is underway. Perhaps there is a shift from a “component” view (i.e., acute care facility,

medical group, rehabilitation services, home health and hospice services) of the health care system to a continuum of care. In the component model, the “health care system” usually owned all the pieces, whereas, the continuum model will probably be too big and too complex for system ownership.

A continuum will often be assembled by an entity, such as a governmental agency or insurance company that holds health care contracts for segments of an area’s population. Many Catholic health care systems have contracts with insurers to provide elements of medical care to persons who are insured by health plans. A continuum of care is not built with brick and mortar but by contracts.

One moral question that emerges with the developing paradigm is the way Catholic health care ministries might be able to structure significant parts of the continuum of care. How will the ministry view and engage a range of potential partners who may share with us common values in a vision of health care, but are neither formed by the Gospel vision of service nor adhere to Catholic moral teaching and the *ERDs*?

Of course, cooperation analysis will continue to be used in future discernment. This article proposes that “toleration” is an equally well-established theological way of responding to real life situations and understanding aspects of responsibility

and action. The article will examine the term based on its use in the writings of St. Thomas Aquinas in the *Summa Theologiae* and its application to health care, particularly in light of participation in the emerging continuum.

In *Evangelii Gaudium / The Joy of the Gospel*, Pope Francis writes, “When we read the Gospel we find a clear indication: not so much our friends and wealthy neighbors, but above all the poor and the sick, those who are usually despised and overlooked” are to be the first attention of the Church.¹ This call from the poor and the sick is ever-present to Catholic hospitals in the United States from their immigrant roots. Increasingly, service to the poor and the sick will be found in 21st century contracts for “population medicine” and in the continuum of care. It seems that this is a path the health care ministry must take.

Catholic Health Care’s Foundation

Service is a demand of Christian discipleship, a Gospel call transmitted by the Church, expressed in the “mission” of Catholic health care. We respond to the Gospel call to “go and do likewise” (*Lk.* 10) to the persons of our time, whom we understand as our sisters and brothers in the Lord, persons beloved by God-Trinity.

In his important inaugural encyclical, *Deus Caritas Est*, Pope Benedict XVI turns to the “great parable of the Last Judgment (cf. *Mt* 25:31-46), in which love becomes the criterion for the definitive decision” of a person. The Pope concludes the section

stating that “love of God and love of neighbor have become one: in the least of the brethren we find Jesus himself, and in Jesus we find God.”²

In *Deus Caritas Est*, Pope Benedict wrote that “two essential facts emerged” in the course of his teaching. The first is the presence of the ministry of charity in the heart of the Church: “The Church’s deepest nature is expressed in her three-fold responsibility of proclaiming the word of God (*kerygma-martyria*), celebrating the sacraments (*leitourgia*), and exercising the ministry of charity (*diakonia*). These duties presuppose each other and are inseparable. For the Church, charity is not a kind of welfare activity which could equally well be left to others, but is a part of her nature, an indispensable expression of her very being.”³

Pope Benedict does not isolate the three elements, but shows they are dynamically related: “Faith, worship and *ethos* are interwoven as a single reality which takes place in our encounter with God’s *agape*.” The Pope writes in stark terms: “Here the usual contraposition between worship and ethics simply falls apart. ‘Worship’ itself, Eucharistic communion, includes the reality both of being loved and loving others in turn. A Eucharist which does not pass over into the concrete practice of love is intrinsically fragmented.”⁴

The second half of the encyclical makes explicit application to care of the sick, and finds it an abiding and essential element of the life of the Church, an application of *diakonia*.

Pope Francis, in a recent visit with bishops of Zambia, pointed to Catholic schools and hospitals as fruits of the rootedness of the faith in that nation. The Pope called out the “plentiful spiritual harvest evident in the many Catholic-run clinics, hospitals and schools and parishes throughout Zambia, a wide diversity of lay ministries, and substantial numbers of vocations to the priesthood in a society that has been transformed by Christian values.”⁵ In this list, the Pope gave a very early recognition to Catholic clinics and hospitals and celebrates them as part of a “plentiful spiritual harvest,” rather than as an organizational structure. A vision of Church ministries as a fruit of the life of faith is an opportunity for moral analysis, a foundation for discernment of pathways and engagement.

Pope John Paul II gave ongoing support and guidance to Catholic health care ministries and Catholic physicians and nurses in the course of his pontificate. Among other topics, he repeatedly called for a “humanization of medicine” so naturally arising from his personalist philosophy. The Pope saw this humanization as a pressing contemporary need because despite progress in curative medicine, the reality of sickness and mortality remains. There is a great risk, the Pope told a religious institute devoted to hospital ministry, that the sick could be “marginalized” and clinicians see their work as “becoming a job.” The people of Catholic health care “are called to “humanize” treatment of the sick, and to see the sick person as a creature of God, a brother in Christ.”⁶

Tolerare, Toleration in the Catholic Tradition

As care for the sick is a Gospel mandate, Catholicism has a long and impressive tradition of engaging with the clinical situations of persons who are the reason for this ministry in the context of the political and social realities of the time. A range of styles of theological reflection for engagement has developed in theologies of *praxis*. Theological *praxis* looks for ways Gospel ministries can continue to respond to God’s call in the needs of our brothers and sisters. Theological *praxis* has significantly expanded from clinical response to ministry structure.

“Cooperation with evil” analysis, often referred to as “cooperation analysis” has been an essential resource for engagement by Catholic moral philosophers and theologians. While first and classically used to address cases of individual moral actors, cooperation has been heavily used in the analogous application to institutional arrangements of various kinds.

As “cooperation” is a resource that has been retrieved from well-established use in theological analysis, this article proposes recovery of an ancient term in Catholic theology, that of toleration (*tolerare*) of evil. The two, cooperation and toleration, can accompany each other as resources for analysis.

Perhaps we should first address the word ‘tolerate’ in current English language usage to address any barriers in our language that could impede a recovery of

‘tolerate’ in theological usage. A significant barrier to understanding theological toleration would be primarily equating the term with a philosophy of relativism or nihilism, in which the absence of meaning demands an equal status for all points of view that are not offensive to public attitudes. This use of toleration is present in philosophy in recent centuries, and so it is important to air this concern. However, such usage is neither the classical nor leading contemporary meaning. In fact, while it is necessary to recognize the relativist use of toleration, it would be a mistake to lose a classical term in our ecclesial lexicon.

Turning to the multi-volume *The Oxford English Dictionary (OED)* is like a visit with the history of the language. *OED* finds “tolerate” coming into English use from 15th century French, and from the Latin *tolerare*, which it translates as “to bear, endure.”⁷ The underlying Latin meaning of bearing with or enduring something remains the common and current use of “tolerate.”

The first meaning *OED* gives to tolerate is “to endure, sustain (pain or hardship)” which was first found in 16th century English use⁸ and is also applied in the 19th century to “endure with impunity or comparative impunity the action of (a poison or strong drug).” The second meaning is also found in 16th century use: “To allow to exist or to be done or practiced without administrative interference or molestation...to allow, permit.” When toleration was used by rulers it did not signify approval of a range of social phenomena (heretics, usury and

prostitution are longstanding examples), but the relative inability to control them with resources available, and was utilized in situations by Catholic monarchs and the Papal States. The third meaning is “to bear without repugnance; to allow intellectually, or in taste, sentiment; to put up with.”

Our English language sense of toleration as enduring or bearing with the difficult is quite the same as the 13th century theological use of the term by St. Thomas. Yet, the classical Christian “world view” of St. Thomas available to us, of course, was shaped by God’s active self-giving (grace) for human response in time for the sake of consummation in the eternal communion of Trinitarian love. In the matter of human actions, Thomas readily saw us moved by some sense of the good, but one that could be flawed or misbegotten. However, the presence of humanity’s failings does not thwart God’s healing and elevating work. Thus, Thomas could be very realistic about flawed individual or social actions and yet would expect the Church to continue its proper work and witness in the midst of it all. St. Thomas’ use of toleration arises from his reception of it from earlier Christian theologians, in a manner so typical of the Catholic theologian—to first be a listener in the theological conversation that has preceded us and to sustain and perhaps develop it, in reliance on the gifts of the Holy Spirit.

Tolerare appears eleven times in the *Summa Theologiae* and on numerous other occasions in different verb tenses. *Tolerare* itself demonstrates the manner in which St. Thomas uses it for purposes of this

essay. In the 1947 Benziger (1920, Blackfriars) edition, *tolerare* is primarily translated as “bear with” and “endure.” It appears four times each and accords with the *OED* usage. “We ought to suffer them with equanimity” appears once, “suffer” being a quaint or archaic manner of stating “bear with” or “endure.”⁹

St. Thomas quotes *tolerare* in citing St. Augustine and St. Gregory the Great, further establishing and validating the ongoing use of *tolerare* from very early Christian theological usage. Beneath it all, *tolerantiam* appears as “endure” at 2 Cor. 6 in the Vulgate: “...if we are being consoled, it is for your consolation, which you experience when you patiently endure the same sufferings that we are also suffering.”¹⁰

An important modern sighting of *tolerare* is in the encyclical of Pope Paul VI, *Humanae Vitae* (1968). In section 14, several contrary arguments to the encyclical are presented and dismissed, including that of overall totality of marital intercourse that is open to conception. In the midst of this discussion is this classical moral statement: “Though it is true that sometimes it is lawful to tolerate a lesser moral evil in order to avoid a greater evil or in order to promote a greater good, it is never lawful, even for the gravest reasons, to do evil that good may come of it.”¹¹ Its use by Pope Paul VI suggests the continued availability of this term for moral discourse in our time, following the example of early Christian writers through St. Thomas to us.

Theological Analysis

A recovery of moral toleration may be particularly helpful in the present stage of health care transformation in the United States as the continuum of care, which can include many distinct health care organizations, is being developed.

Toleration’s new usefulness is timely as the word “collaboration” gains prominence in Catholic moral discourse: collaboration to find opportunities to offer needed health care services in the continuum of care while addressing the moral risks to the Catholic health care ministry. New attention was rightly given to collaboration with the release of a February 17, 2014 letter and document from the Congregation for the Doctrine of the Faith (CDF) to Archbishop Joseph Kurtz, president of the United States Conference of Catholic Bishops (USCCB).

The CDF letter from Cardinal Gerhard Muller, Prefect of the Congregation, states that the question presented to the CDF by the USCCB in 2013 was specifically regarding a particular arrangement, but the CDF thought it best to provide a series of principles to guide arrangements between Catholic and other-than-Catholic health care organizations. *Some Principles for Collaboration with Non-Catholic Entities in the Provision of Healthcare Services (Principles)* begins with a significant theological location of care for the sick as a “prophetic witness to the Faith” and an “evangelical spirit.” It notes that while care of the sick always presented clinical moral questions, new

issues regarding the structure of health care services itself require response.

Health care organizational structures exist to fulfill the Gospel mandate. Thus, they are neither ends in themselves nor can they be understood outside of the context of Gospel response. The prologue of *Principles* quickly states its understanding of the present health care environment: “In today’s world...effective engagement in healthcare often calls for collaboration with non-Catholic healthcare institutions, even establishing joint working arrangements in which the Catholic and non-Catholic entities are full partners.”

An important and very traditional point follows: “In itself, collaboration in good works is, of course, a good thing...” The remainder of the sentence draws attention, as is required in a vigilant spirit, to the danger of potential involvement with various degrees of “institutional connections with activities that conflict with the natural law and Church teaching.” Collaborative relationships require that Catholic health care governance must “ensure that the witness of the Church is not adversely affected” and that these relationships do “not give scandal.”

Seventeen principles that apply the Principle of Cooperation to various types of arrangements with non-Catholic health care entities follow the prologue. These principles both restate existing principles of licit and illicit cooperation with non-Catholic health care entities and specify applications of these norms to the recent phenomenon of system mergers.

Principles closes with a final positive use of the word “collaborate” to call Catholic health care systems to collaborate with the bishops of all the dioceses in which their facilities serve persons.

Principles creates a timely recognition of the positive meaning of “collaboration in good works.” It prompts a fresh reading of the Introduction to the *ERDs* Part Six—Forming New Partnerships with Health Care Organizations and Providers—with its notice and support of collaborative efforts for prophetic Catholic witness to its dedication to the health care ministry and health care professionals; to “implement the Church’s social teaching”; “to realign the local delivery system in order to provide a continuum of health care; to manifest “a responsible stewardship of limited health care resources”, and to develop “a more equitable access to health care” for poor and vulnerable persons.

Collaboration also receives support and encouragement from Pope Francis who writes of the importance of “feeling close to” and respectful of engagement with “those who do not consider themselves part of any religious tradition” and strive toward truth and goodness. This spirit has specific application to hopeful engagement with a pluralist continuum. “We consider them as precious allies in the commitment to defending human dignity, in building peaceful coexistence between peoples and in protecting creation.”¹²

As used by Pope Francis, “coexistence” can even be applied to rightly understood

participation in the pluralist health care continuum of care. Coexistence evokes our understanding of toleration and can be a significant term for moral theology. Looking to the future, coexistence can be based on the lived pastoral experience of “*tolerare*” as its platform for further development.

Coexistence in the writings of Pope Francis is also a prompt for common efforts for justice and peace. When disparate individuals and groups work together, opportunities for Church witness to the Lord and the life of faith can arise. Coexistence should call us to a more intense Christian ministry rather than a reduction to the lowest common denominator.

In those health care system relationships in which illicit cooperation is not an issue, collaboration in the good is freely available. When the potential partner in the continuum of care or in a joint venture is a non-Catholic entity, toleration can be an effective and principled response. Toleration is a way to live with the moral otherness of a partner that has common moral goals and practices. Toleration does not mean endorsement of practices taught as immoral by the Church. Coexistence is the recognition of pluralism and the freedom for the Church partner to witness to our faith.

A contemporary Catholic understanding of toleration and moral growth is found in philosopher Martin Rhonheimer, who states that only in the light of faith can the fulfillment of the person and

understanding of moral life appear in an integral manner. “This leads us to an attitude of understanding and tolerance, not of sin, but of the persons who feel unable to fully meet the requirements set forth in the Church’s moral teaching.”¹³ Rhonheimer continues, “Without relativizing or unduly adjusting the “ought” to the “can” or graduating the moral norm, all pastoral work nevertheless has to try to gradually lead each person to fulfill all the good toward which their human nature, redeemed by Christ, aims.”

Of course, St. Thomas did not live in an era characterized by our pluralism. But Thomas paid great attention to the meaning of good actions done in a collaborative spirit and the need for virtuous practice (prudence, justice, temperance and fortitude) to sustain the good envisioned. How would he see toleration employed in a continuum of care to effect greater health of a community with a range of Catholic and non-Catholic entities who share a general moral vision, but hold a range of specific moral positions at variance with one another?

St. Thomas is likely to affirm pursuit of the good if the consciences of the member organizations are protected in structure and practice. Toleration could be used when there are no demands for the Catholic ministry to either do evil or partner for the performance of specific evil actions. Membership in the continuum in which evil acts are present but without any involvement of the Catholic party should not be seen as cooperation in those acts.

My proposal that presence in a continuum of care with illicit procedures present in it does not in itself constitute material or formal cooperation may be somewhat controversial to some moral theologians or moral philosophers in the United States. I do not believe the proposal would be a surprising one to theologians who studied or practiced in Rome in the mid-twentieth century. Two reasons come to mind: first, they would likely be aware of St. Thomas' use of *tolerare* and, second, the Roman perspective was one in which observation of manifold new applications of secularity in post World War II Europe was tolerated.

One example in the mid-twentieth century would be the rise of comprehensive social welfare programs in Western Europe in which Church ministries had to find new roles and often accepted public funding for their ministry. Another would be the problem of Church persecution in Communist regimes. The Roman observer would see clearly what local churches had to endure, tolerate and bear. Their struggles were seen as acts of fidelity and witness. Particular churches used their opportunities to do the good they could do in a range of settings and to accept the social realities for what they were.¹⁴

Toleration in the evolving health care continuum in this nation would have the following elements: appreciate the members of the continuum for the good they do; welcome progress in the good envisioned; prioritize care of the poor and marginalized; learn from other members

how to improve the care given by the ministry; mourn the lack of moral vision by all members; effectively separate the ministry from planning, contracting, performance of or receipt of funding related to immoral procedures; educate patients about the scope of Catholic ministry; and develop ministry colleagues for ministry vitality and integrity.

Toleration would welcome doing good, respect of partners, and the ongoing and dedicated work of external information and internal education. Presence in a pluralist continuum of care would require, in a word, hope of the good and "bearing with" the specific new work required of the Catholic entity for collaborative participation in the pluralist continuum.

Participation in a continuum of care does not in itself signify cooperation with evil, and thus it is essential that the Catholic entity is effectively separated from immoral actions and identified as such. Collaboration, with a tolerance, cooperation and scandal review process, can be a framework for envisioning a good work together.

A "statement of common values" can be helpful for the internal culture of collaborative partners to state the common ground and goals they share. Catholic health care parties can take a lead in this conversation if the ministry has a mission-based culture and naturally pays heed to its culture and values.

Collaborative processes require that partners maintain their own identity. Such is critically important for the

Catholic health care entity, as it should be a good partner in meeting the needs of a population of persons and also maintain its own Gospel response and identity. Thus, internally and externally, persons know where the Catholic partner “begins and ends” in the continuum, while making its own contribution to a vibrant response to provide community medicine (covered populations) and community health (affirmative measures to support the health and wellness of communities).

At every stage of history, the Gospel call remains clear to those who have found discipleship and a transformed life in the Church: those we serve are our sisters and brothers and are neither “cases” of disease nor anonymous “populations.” The Lord has identified himself with the most marginalized we serve (Mt 25:36) who are at the core of our prophetic witness. Thus, if collaboration is needed to meet the needs of the poor and underserved, it does not seem morally optional.

In *Deus Caritas Est*, Pope Benedict wrote that “*caritas-agape*” to meet the necessities of life is essential for the inner life of the Church and that it also “extends beyond the frontiers of the Church.” The Pope follows this with a particular way of looking at persons, the second “essential fact” of *diakonia*: “The parable of the Good Samaritan remains as a standard which imposes universal love towards the needy whom we encounter “by chance” (cf. *Lk* 10:31), whoever they may be.”¹⁵

“By chance” leads to reflection on experience and on the future. Persons who work in acute care facilities experience as

normative that we never know who will come through the door for care. In the same way, the Catholic health care ministry can be drawn close to those who “by chance” appear within future populations for care, and strive to carry Jesus’ great command of love to unique persons within population groups.

Engagement with other health care entities can be difficult for health care leadership in the United States. A competitive experience and anti-trust laws and regulations inhibit an instinct of collaboration. However, three factors are signs of a new hope for meaningful collaboration: 1) the development of the continuum of care to provide “population medicine”; 2) recent federal government approval for health care institutions to pursue community health activities (providing no anti-trust standards are violated); and 3) the rising expectation of health and wellness measures by a wide range (beyond health care entities) of community leaders to initiate community health initiatives.

Conclusion

In conclusion, it was the modest hope of this paper to re-introduce the use of toleration. Collaboration may require toleration of other entities and expects that they would tolerate us as well. The health care environment today is highly stressed for persons at every level of the ministry. Health care structures and their financing are being rebuilt around us. It is a time of trial to build the future while caring for persons (and each other) in the present and while heeding the discipleship

call that is ancient and renewed in the moment of encounter.

Collaboration in the good is the work of peace, reconciliation and development. Catholic ministries should enter into this willingly, but in a humble manner as we may be learning much from other entities who are already present in this field.

Our present cultural environment is often one of a profound “horizontalism” and loss of the transcendent nature of each person.¹⁶ Committed engagement in building the new structures of health care can be an opportunity for the inner renewal of the Catholic health care ministry and a renewal of our interwoven love of God and neighbor. In a 2009 talk to Argentine bishops, Pope Francis stated that “the Holy Spirit leads us and guides us in two different directions: *inwardly*, as we enter into the mystery, and *outwardly*, to give us the strength to witness.”¹⁷

Pope Francis encourages hope in dedication to the needs of the poor and that the Church witness to conversion from a culture of waste and indifference to a culture of encounter and accompaniment. Committed to God and continuing our tradition of service, we can continue to find new ways to serve persons in their health care and human needs (which includes our human transcendent reality) and confidently participate with persons of goodwill in our time.

Pope Francis writes “...Our dream soars higher. We are not simply talking about ensuring nourishment or a ‘dignified

subsistence’ for all people, but also their “general temporal welfare and prosperity. This means education, access to health care, and above all employment....”¹⁸

As health care is restructured in the nation, we have our work ahead: responding to the call of Jesus in unique vulnerable persons, particularly in the poor, and stewardship of the ministry in transition. Ministry founders have taught and witnessed that our work is sustained by personal encounter with Jesus and the gift of the Holy Spirit. The particular steps ahead for health care are not fully known or clear, but we can have a common heart with the sisters and other religious founders of health care ministries that our generation is called to continue.

¹ Pope Francis, *The Joy of the Gospel / Evangelii Gaudium*, 2013. Sec. 48.

² *Deus Caritas Est*, 2005. Section 15.

³ Op. cit. Section 25.

⁴ Op. cit. Section 14

⁵ Pope Francis, “To the bishops of Zambia: evangelize cultures to inculturate the Gospel.” Vatican Information Service, 17 November 2014, Year XXII, Num. 202.

⁶ Pope John Paul II, “Discorso di Giovanni Paolo II ai Partecipanti al 61 Capitolo Generale dell’ordine Ospedaliero di San Giovanni di Dio.” 17 December 1982.

⁷ *The Oxford English Dictionary, Volume XVIII*. Oxford: Clarendon Press, 1989.

⁸ Ibid., 1531, Elyot, “To tollerate those things whiche do seme bytter or greuou (whereof there be many in the lyfe of man).”

⁹ The more recent (1960s-1970s) Blackfriars translation (ed. Thomas Gilby, OP) has a similar usage pattern: endure (four times); variations on “bear with” (three times); accept; tolerate and suffer (each once).

¹⁰ New Revised Standard Version.

¹¹ The Latin text is: “*Verum enimvero, si malum morale tolerare, quod minus grave sit interdum licet, ut aliquod maius vitetur malum vel aliquod praestantius promoveatur, numquam tamen licet, ne ob gravissimas quidem causas, facere mala ut eveniat bona.*” The Italian, similarly: “...*tollerare un minor male morale...*” Pope Paul’s statement is very close to the toleration St. Thomas states as reasonable for government: “So, too, in human government, the authorities rightly tolerate certain evils lest certain goods be impeded or greater evils be incurred.” *Summa Theologiae*, II-II, 10, a. 11, resp. (trans. Thomas Gilby, OP).

¹² *Evangelii Gaudium*. Section 257. This openness to others in themselves and for common action can occasion the important “reciprocity of conscience” described by Bernard Haring in *Free and Faithful in Christ*, Vol. 1, 264-270.

¹³ Martin Rhonheimer, *The Perspective of the Acting Person: Essays in the Renewal of Thomistic Moral Theology*. Washington, DC: The Catholic University of America Press, 2008, 17.

¹⁴ As Archbishop of Buenos Aires, Pope Francis spoke at a 2012 catechist encounter: “One must not take a selective attitude toward life as it comes to us, unlike the Scribes and Pharisees who murmured against Jesus: “This man receives sinners and eats with them” (Lk 15:2). Jesus received life as it was, not wrapped up in luxury packaging. “This is life, and I receive it,” Jesus would say. It’s the same with soccer: You have to accept penalty kicks wherever they come; you don’t get to choose where anybody is going to kick them. Life comes at us like that; you have to receive it even if you don’t like it.” Pope Francis, *Encountering Christ: Homilies, Letters, and Addresses of Cardinal Jorge Bergoglio*. New Rochelle, NY: Scepter Press, 2013, 16.

¹⁵ *Deus Caritas Est*. Section 25.

¹⁶ Karl Rahner, “The Church’s Commission to Bring Salvation and the Humanization of the World,” in *Theological Investigations, XIV*. Trans. David Bourke. New York: Seabury Press, 1976.

¹⁷ Pope Francis, *Encountering Christ*, 115.

¹⁸ *Evangelii Gaudium*. Section 192.