Steady Air

Steady Air:
Exploring Catholicism at Work

Edited by

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FOREWORD

The seeds for this project were sown while I was on a retreat in Lismullin Conference Centre two years ago. I have since resolved to treat all such inspirations with a healthy reserve and doubtless none would agree with me more heartily than the other contributors, who have been pursued relentlessly for the past twenty-four months. This lengthy gestation period owes as much to my inexperience as an editor as it does to their very demanding professional obligations. For their great patience and willing cooperation with the endeavour, I am inexpressibly grateful.

Contributors were given what I now realise must have been a rather vague brief: to discuss the relationship between their Catholic faith and their professions. Readers may at first glance consider the results both disparate and eclectic, but I hope that on closer inspection they will see that the essays actually have one thing in common: the conviction that, in an authentic social democracy, Catholics who know what they believe and why they believe it are completely at home.

Orla Halpenny

Dublin, September 2012.

“I caught this morning morning’s minion, king-
dom of daylight’s dauphin, dapple dawn-drawn Falcon, in
his riding
Of the rolling level underneath him steady air, and striding
High there, how he rung upon the rein of a wimpling wing
In his ecstacy!...”

The Windhover, Gerard Manley Hopkins.

1

THE PLACE OF FAITH AND RELIGION IN HEALTHCARE

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There are clear and pragmatic reasons why insights into religion and faith are important in healthcare. This was illustrated when the largest teaching hospital in Dublin removed the Christmas crib from its atrium a few years ago: the response to the resulting public outcry suggested a timorous confusion about the difference between pluralism and secularism that is not uncommon in medicine. As artists are ever to the fore in illuminating societal dilemmas, *South Park*[1] (not as yet figuring in many medical school curricula) provides an amusing if scabrous insight into what we can lose by failing to recognize socially-evolved traditions which are deeply embedded in our society.

An awareness of religious beliefs, practice and sensitivities should form a part of the fabric of health care, regardless of the personal beliefs of practitioners. At a pragmatic level, this is needed for a range of issues from blood transfusion through diet to burial customs. Decision-making at the end of life can also be affected by religious belief[2]. Good medicine also promotes an understanding of what motivates and consoles many of our patients. In ethics, we are mindful of the role that the 'methodological atheist' Habermas discerned in the great religions as sources of virtuous thinking[3].

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[1] American animated sitcom.

[2] Clarfield AM, Gordon M, Markwell H, Alibhai SM. Ethical issues in end-of-life geriatric care: the approach of three monotheistic religions-Judaism, Catholicism and Islam. *Journal of the American Geriatrics Society* 2003;51(8):1149-54.

[3] Habermas J, Cronin C. *An awareness of what is missing: faith and reason in a post-secular age*. Cambridge, U.K.; Malden, Mass.: Polity Press, 2010.

But most elusive to an outwardly scientific medical system is an understanding of the role of ritual and traditions, particularly in modern urban society. From Gadamer's concept of our shaping by 'historically effected consciousness'[4] to Bruno Bettelheim's exploration of the role of fairy tales in *The Uses of Enchantment*[5] - whereby children can use these dark and often grim tales to understand their fears and the multiple contradictions of life when growing up - an appreciation of these deep under-currents is important.

The makers of *South Park* (a programme of stupefying poverty of taste), both declared agnostics, picked up on how rigid political correctness can blind us to the bigger picture. In this episode, the Jewish Kyle is forbidden by his mother to take the part of Joseph in the Nativity play: she also asks for all religious elements to be removed from the school. Mayor McDaniels then decides to take anything 'offensive' from Christmas celebrations, including Santa Claus, mistletoe, wreaths and candy canes. The Christmas pageant becomes a bizarre minimalist production with music by Philip Glass!

All the while, Kyle has developed his own Christmas ritual with all-singing, all-dancing Mr Hankey, the Christmas Poo, who, in a demented allegory to *A Christmas Carol*, appears in person and spreads havoc (and mess) across South Park. All is eventually resolved, with the townspeople singing Christmas carols and watching Mr Hankey flying off with Santa Claus: in a gesture to the season of goodwill, it also is the first episode where Kenny avoids death!

While not for the faint-hearted or easily-offended, there is much food for thought (and a roller-coaster of entertainment) in this episode, and an impetus to ensure that we work out how to celebrate (and make due space for) tradition in our lives, as well as those of our patients and their families, in the practice of good medicine.

Defining the place of faith, and in particular of Christian faith, in healthcare is of significant importance in many countries of Europe where there has been a significant change in the centrality of Christian belief in public life, allied with patterns of immigration with consequent infusion of other

[4] Gadamer H-G, Barden G, Cumming J. *Truth and method*. Rev. ed. New York: Crossroad, 1988.
[5] Bettelheim B. *The uses of enchantment: the meaning and importance of fairy tales*. New York: Knopf: distributed by Random House, 1976.

major religions into what once was an apparently a more homogeneous environment.

Nostalgie de la boue

A balanced perspective on the past is also important, as there is little as undermining of critical thinking as rosy-hued nostalgia. While the role of the Christian churches in developing healthcare and education were of enormous importance in societies prior to significant state involvement in the sector, they were also often marked by rigid hierarchies, dirigiste managerial styles and a sometimes tunnel vision of Christian teachings. Particularly in Ireland, a focus on teachings relating to sexuality and the end of life may have detracted from wider Christian teachings such as social justice, humility and charity.

The engagement with private medicine has also been controversial. Astute commentary, such as Barrington's *Health, Medicine and Politics*, paint an unappetising picture of private medicine allying itself with certain moral attitudes in a way that served poorly the credibility of the role of religious life in the provision of healthcare[6].

This distortion of vision was not exclusively a Catholic one: historically, the appointment of doctors to the lucrative positions of consultants in Protestant hospitals was often on the basis of religion and nepotism[7], and as outlined in Peter Gatenby's history of the Meath Hospital, showing that these practices crossed faith boundaries in Ireland[8]. Even in recent times, the (albeit limited) practice of appointing consultants without outside advertisement and open interview has only recently ended in Tallaght Hospital in Dublin, a hospital whose charter positioned it as the focus for Protestant participation in healthcare in Ireland.

In addition, many retain vivid impressions of opportunists playing the religion card in denominational hospitals to consolidate either positions of power or promote the development of their own units. That such distortions should occur should not surprise students of Illich's concept that the goals of organizations eventually transform from their original

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[6] Barrington R. *Health, medicine and politics 1900-1970.* Dublin: IPA, 1987

[7] Geary LM. *Medicine and charity in Ireland, 1718-1851.* Dublin: University College Dublin Press, 2004

[8] Gatenby P. *History of the Meath Hospital*. Dublin: Town House, 1996

purpose to increasingly occupy themselves in the survival and growth of the organization[9]. In turn, in the context of this book, such experiences should motivate those with faith in the Christian message to redouble their efforts that the governance and practices of their hospital should be fair, inclusive and collegial.

Spirituality and religious belief

One of the most interesting challenges in defining the role and faith and religion in healthcare arises from the burgeoning literature in spirituality in healthcare, particularly in the literature on end of life care. Spirituality is internationally recognized as an important aspect of health care: the majority of US medical schools include a module on spirituality in the medical curriculum, and the General Medical Council in the UK has helpful guidance on personal beliefs and spirituality for patients and doctors alike.

Yet outside of palliative care, there is virtually nothing in the Irish medical literature, or that of the Irish Medical Council, on spirituality, possibly as a counter-reaction to the unhealthy dominance of the Catholic Church on Irish intellectual life until recent times, the atrocious mishandling of the child abuse scandals by senior churchmen and the frequently rancorous tenor of media discourse (some commentators remind me of the food critic in a TC Boyle story who has lost all her tastebuds and consequently gives every restaurant a drubbing[10]). What little literature there is seems to confuse good interpersonal care with spiritual care[11], and in general this is an area of medical practice defined by silence and absence of discussion.

A victim of this is the understanding that spirituality is a broad concept applicable to those of all faiths and none, and that regardless of our own personal beliefs we need to develop ways to support expression of this aspect of our shared humanity in healthcare settings.

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[9] Illich, I. Medical Nemesis. *Lancet* 1974; 1(7863):918-21.
[10] Boyle TC. *If the river was whiskey : stories*. New York, N.Y., USA.: Viking, 1989.
[11] McBrien B. Nurses' provision of spiritual care in the emergency setting—an Irish perspective. *International emergency nursing* 2010; 18(3):119-26.

As pointed out by Speck and Higginson[12], spiritual belief may or may not be based on religious belief but presumably most of those with religious beliefs will be spiritual. Within the medical literature, spirituality and spiritual care have acquired a bewilderingly large range of definitions, and a helpful approach has been to define spiritual care as not just the facilitation of an appropriate ritual but engaging with an individual's search for existential meaning, and in particular a belief in a power greater than the self (such as God, higher power or forces of nature), as reflected for example in the existential domain of the McGill quality of life questionnaire[13]. It is clear that the long traditions of religious pastoral care have much to offer in terms of providing a language and systems for attending to the spiritual and/or religious needs of those using health care from all denominations and none[14].

An example of this is provided by the example of the pastoral care team in Tallaght Hospital in Dublin. Although formal linkages with clinical services are few, an interdenominational team is providing a remarkable service which deserves wider recognition.

No longer does one 'call for the chaplain' in Tallaght Hospital when patients are *in extremis*: the pastoral care team, lay and religious, pro-actively visit the wards and make contact with patients in the context of a listening and sympathetic ear, and on the basis of consent. This welcome sense of access to all is consistent with a holistic vision of care, one which has a broader reach than predominantly for those who are near death.

From this first level of pastoral care, patients can then access the sacramental aspects as they wish. For example, for Catholics, a thrice-weekly round by 70 volunteer ministers of the Eucharist is available to those who desire it, with a take-up of approximately two-thirds of the patients over the course of the year.

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[12] Speck P, Higginson I, Addington-Hall J. Spiritual needs in health care. *BMJ* 2004; 329(7458):123-4.

[13] Cohen SR, Mount BM, Bruera E, Provost M, Rowe J, Tong K. Validity of the McGill Quality of Life Questionnaire in the palliative care setting: a multi-centre Canadian study demonstrating the importance of the existential domain. *Palliative medicine* 1997; 11(1):3-20.

[14] Byrne M. Spirituality in palliative care: what language do we need? Learning from pastoral care. *International journal of palliative nursing* 2007; 13(3):118-24.

This two-stage approach – spiritual support for all and access to sacramental support for those who wish for it - provides a matrix within which healthcare workers can negotiate, particularly for those working in settings without the good fortune of having formal pastoral care, such as general practice.

In some ways, this synergy between religious faith in terms of facilitating exploration and discussion is paralleled in the field of ethics where much of the discourse in a secular/pluralist society has its origins in Judaeo-Christian thought.

The many narratives of health care

Rita Charon's model of the multiple narratives inherent in the physician-patient interaction is a helpful framework for reflecting on religion and our role as clinicians[15]. That between the patient and the doctor, requiring empathic engagement, is obvious. Less apparent is that between the doctor and his peers – standards, audit, conscious and unconscious rationing – requiring the development of due professionalism. The third discourse is the doctor with him/her self –beliefs, fears, prejudices, uncertainties, past experiences – mandating reflective practice. Finally, there is the dialogue with society – stigma, rationing, ethics, support/lack of support – an awareness of which is critical to the development of trust.

In terms of the first narrative, that between the healthcare worker and the patient, any definition of patient needs must be mindful of their spritual needs, and also of any possible interaction between the faiths of both actors in the dyad. In general, much of this process is effectively diffused among the health care team with pastoral care taking a lead and often autonomous role. The determination of values is increasingly seen as a central part of the assessment of the patient: patient values have been described by Sackett as the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient[16]. However, despite

[15] Charon R. The patient-physician relationship. Narrative medicine: a model for empathy, reflection, profession, and trust. *JAMA*: *the journal of the American Medical Association* 2001;286(15):1897-902.
[16] Sackett DL. *Evidence-based medicine : how to practise and teach EBM.* 2nd ed. Edinburgh; New York: Churchill Livingstone, 2000.

significant research in this area, particularly in psychiatry[17], it is likely that much of the assessment of values is informal until the point of significant decision-making or potential conflict of decision between doctor and patient.

The role of faith and religion is nuanced in this encounter in that while there must be no diminution of equality of assessment and treatment of any patient on the basis of faith and religion, clearly we have to make due allowance for values based on faith and religion within the context of practice, whether that means no blood transfusions for a Jehovah's witness or dietary issues for those observant in the Jewish faith – to be discriminating in the best sense of the word. Equally, physicians need to be accorded due allowance for matters of conscience which may (or may not) arise from their faith, and ideally this is something which they will have made clear to the profession, employers and potential patients, and for which guidelines will have been drawn up to ensure that patients do not lack for appropriate healthcare.

Indeed it is important that we do not allow moral decisions to suffer by artificially dichotomizing them as non-religious and religious in origin. In the case of euthanasia, for example, this does a disservice not only to the many humanists, atheists and agnostics who understand the dangers that euthanasia poses for individual and societal wellbeing, but also caricatures those with religious beliefs as uncritical and doctrinaire thinkers.

Physician and self

The narrative with self is also the subject of increasing interest, with the presence, teachings and examples of Christ and the Christian message undoubtedly important source of intellectual, emotional and spiritual support in the complex practice of medicine. Attendant on these core beliefs and values is the imperative to live a professional life infused with these principles, to lead by example, and to do so with due sensitivity to patients and colleagues of all faiths and none.

This viewpoint may usefully inform one of the most significant debates in teaching health care or life-science ethics, i.e., whether it is a means of

[17] Fulford KW. The value of evidence and evidence of values: bringing together values-based and evidence-based practice in policy and service development in mental health. *Journal of evaluation in clinical practice* 2011;17(5):976-87.

creating virtuous physicians or of providing physicians with a skill set for analyzing and resolving ethical dilemmas[18]. The pragmatic answer is that both aspects should be addressed[19]. A key to ensuring that ethical reasoning is incorporated into personal practice, is to ensure that the curriculum is relevant to the present and future experience of the students, ideally by ensuring co-working between ethicists and attuned clinicians/ scientists[20], and relating the teaching to issues which they encounter[21]. It should imbue a sense of moral agency at even the earliest stages of their career, as evidenced by an interesting paper on the imperative for physicians to speak out if they encounter unethical practice, and the challenge of adding *primum non tacere* (first do not be silent) to the venerable Hippocratic principle of *primum non nocere* (first do no harm)[22].

This places a particular importance on the development of articulacy about ethics. The development of formal ethics courses is a relatively new phenomenon in Ireland. There was not a single lecture on ethics during my medical course in Trinity College Dublin during the early 1980's. It was not that I did not learn good ethical practice: through the apprenticeship model of medical training I was exposed to mostly very high standards of ethical care in doctor-patient relationships.

What was missing, however, was the opportunity to develop an articulacy about that which was good in medical practice, and the vocabulary and debating skills to defend life at its most vulnerable, particularly at the extremes of life. Equally, the experience did not clarify the understanding that Christian thought on ethics needs to be fought on intellectual and moral grounds, without recourse to dogma, in a pluralistic society.

In addition, the apprentice model does not foster the important ethical imperative of standing back and interrogating ethical issues such as social

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[18] Eckles RE, Meslin EM, Gaffney M, Helft PR. Medical ethics education: where are we? Where should we be going? A review. *Acad Med* 2005:80(12):1143-52.
[19] Pellegrino ED, Thomasma DC. *The virtues in medical practice.* New York: Oxford University Press, 1993.
[20] Russell C, O'Neill D. Ethicists and clinicians: the case for collaboration in the teaching of medical ethics. *Irish Medical Journal* 2006;99(1):25-7.
[21] Kushner TK, Thomasma DC. *Ward ethics : dilemmas for medical students and doctors in training.* Cambridge: Cambridge University Press, 2001.
[22] Dwyer J. Primum non tacere. An ethics of speaking up. *Hastings Cent Rep* 1994;24(1):13-8.

justice, particularly in a mixed public/private healthcare system, and one in which involvement of the Catholic Church in private healthcare raises complex issues in its own right.

This broad spectrum is also needed in a Christian approach to ethical practice, with due attention given to 'upstream ethics' [23] rather than a disproportionate focus on beginning of life and end of life issues, important as they undoubtedly are. For example, are we looking after our prisoner patients with unconditional positive regard[24]? Do we make the effort to see and support personhood in our patients with dementia[25]? A helpful check-list to ensure that our ethics are consistent with both professionalism and the Christian message is whether they satisfy the triad of care, communication and competence (both ethical and technical).

Physician and patient

It is telling that the ethical and professional guidelines of the General Medical Council in the United Kingdom include an extensive section on Personal Beliefs and Medical Practice, while those of the Irish Medical Council contain not a scintilla on this important subject. The UK guidelines are helpful and contain three important messages. The first is an attentiveness to the spiritual and religious beliefs of patients; the second is the importance of ensuring that patients are not denied appropriate care should the practitioner find that certain aspects of their care are in conflict with his/her conscience; and third, that the doctor's surgery or clinic is not a pulpit, as per

> "You should not normally discuss your personal beliefs with patients unless those beliefs are directly relevant to the patient's care. You must not impose your beliefs on patients, or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views. Equally, you must not put pressure on patients to discuss or justify their beliefs (or the absence of them)."

This is indeed a delicate balancing act, but one that most healthcare professionals seem to manage, although one UK GP was disciplined for

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[23] Russell C, O'Neill D. Developing an ethics of competence, care and communication. *Irish Medical Journal* 2009;102(3):69-70.
[24] Tuite H, Browne K, O'Neill D. Prisoners in general hospitals: doctors' attitudes and practice. *BMJ* 2006;332(7540):548-9.
[25] O'Neill D. Cogito ergo sum?—refocusing dementia ethics in a hypercognitive society. *Irish journal of psychological medicine* 1997;14(4):121-3.

undue presentation of his Christian beliefs with a patient. While this action sparked some outrage in the conservative press, having worked with uncomfortably overt evangelical Christian doctors in the UK, my sympathies lie with the GMC on the basis of the facts presented.

Challenges can also arise when religious practice and societal values, particularly those based on interpretations of human rights, come into conflict.

Physician, peers and society

The role of faith and religion in promoting virtuous thought and action (although holding no monopoly in this role) are clearly highly relevant, and generally seem implicit rather than explicit. In terms of our dealings with our colleagues, justice and honesty are important. Doctors' treatment of one another other has had a balanced score-card over the years, and moral distress over the behaviour of colleagues is increasingly recognized in the international literature[26].

Medical history texts which seem to eulogize the golden age of Irish medicine [27] may not be sufficiently aware of other historical aspects which showed the Dublin voluntary hospitals to be ridden with sectarianism, nepotism and divisive politics. Alongside the official narratives of collegiality, we can divine a more variegated pattern. The eminent Irish physician Dominic Corrigan was dismissive of the needs of colleagues working with Famine victims (although the complaints about his conduct may also have been motivated by sectarianism), the treatment of junior consultants by senior consultants in terms of the 'pool' system which existed prior to the common contract in Ireland was often lamentable, and resistance to access to new entrants to the Medical Card scheme seemed to relate more to Shaw's description of a profession as 'a group of people who band together to hide their short-comings' than that of the Hippocratic oath. In my own area of practice, the possibility of philanthropic funding prompted uncollegial and secretive behaviour among some in the profession with a resultant erosion of trust and moral credibility[28].

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[26] Forde R, Aasland OG. Moral distress among Norwegian doctors. *Journal of medical ethics* 2008;34(7):521-5.

[27] Coakley D. *The Irish school of medicine : outstanding practitioners of the 19th century*. Dublin: Town House, 1988.

[28] O'Neill D. For better ageing philosophies, vote for Berlin. *Irish Times*, 24th January 2012.

We could do better here: when developing an ethics module with a focus on everyday ethics, such as confidentiality for prisoners patients, students' own experiences, I was struck by how little space was dedicated in text-books and Medline to the potential for ethical dissonance from our personal vested interests, whether through income or payment systems, or among groups of doctors by maintenance of hierarchies of power, esteem, influence and convenience through public advocacy.

These issues are important. The few available Irish studies show markedly different prescribing habits for private and public patients in Irish general practice [29] [30]. Some helpful debate arose from the introduction of managed care in the USA, where incomes and untrammelled clinical freedom were circumscribed in a manner akin to much European medicine. One perceptive (and pilloried) commentary highlighted the degree to which the many who opposed managed care failed to give due recognition that 'best care for my patient' was also a proxy for 'optimal reimbursement for my practice' [31].

In addition, we also have little debate and discussion on public advocacy for certain diseases and disentangling the potential for conflict of ethical interests. A 2012 campaign by a large children's hospital in Dublin neatly illustrates this[32], as does the ongoing relationship between a major teaching hospital in Dublin and an alcohol company in raising charitable funds[33].

Sources outside of medicine provide the most helpful literature on professional vested interest and public advocacy. A paper from the wildlife sector provides this insightful quote: 'knowledge and expertise are

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[29] Murphy M, Byrne S, Bradley CP. Influence of patient payment on antibiotic prescribing in Irish general practice: a cohort study. *The British journal of general practice : the journal of the Royal College of General Practitioners* 2011;61(590):549-55.

[30] Usher C, Bennett K, Feely J. Prescription patterns in the elderly population—"new" versus "old" medical card holders. *Irish medical journal* 2004;97(8):234-6.

[31] Hall MA, Berenson RA. Ethical practice in managed care: a dose of realism. *Annals of internal medicine* 1998;128(5):395-402.

[32] O'Neill D. The Ethics of Advocacy. In: Dobson J, editor. *BMJ Group blogs*. London: BMJ, 2012.

[33] O'Neill D. Aiming to Lose. In: Dobson J, editor. *BMJ Group blogs*. London:BMJ, 2012.

not the neutral scientific elements emphasized by traditional theory but political resources in the battle for power and status'[34]. An equally helpful reflection from the social sciences[35] points out how advocacy directed by professionals can become divorced from the palette of needs of the vulnerable and marginalized.

Just as with clinical practice, advocacy is not a pure process, and when raising funds there will always be pragmatic compromises between what is possible and what is desirable. As a profession however, we need to do better in terms of more formal reflection, discussion and research into how we undertake public advocacy, more reflection as to who is benefitting and whether our advocacy is unwittingly skewing the provision of healthcare and reinforcing existing gaps in attentiveness of the health services[36].

Equally, in a small country where the life sciences are a key part of our industrial strategy, it is not unsurprising that medical researchers should engage with the pharmaceutical industry, but all are protected by the international trend for routine transparent disclosure of conflict of interests, for example when giving lectures or undertaking advocacy for new and costly medications.

The Council on Stroke of the Irish Heart Foundation was the first body in Ireland to routinely use this approach, and this could serve as a useful template to reassure the public that the profession is doing the best it can in an imperfect world. Our credibility as a profession in the longer term, and the maintenance of the trust of the general public, mandates no less than this.

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[34] Gill RB. Professionalism, Advocacy and Credibility: A Futile Cycle? *Human Dimensions of Wildlife* 2001; 6(21-32).

[35] Samuel J. Public advocacy and people-centred advocacy: mobilising for social change. *Development in Practice* 2007;17:615-21.

[36] Pendlebury ST, Rothwell PM, Algra A, Ariesen MJ, Bakac G, Czlonkowska A, et al. Underfunding of stroke research: a Europe-wide problem. *Stroke; a journal of cerebral circulation* 2004;35(10):2368-71.

Conclusion

Few can seriously doubt the importance of recognizing faith and religion as playing an important role in the policies and practice of medicine in a pluralist society. However, believers from all faiths need to recognize the complexity of this environment, the importance of a balanced approach across the spectrum of human activity, the recognition of vested interest(s) that may influence each of us and the development of the ability to articulate important values and principles through debate rather than through dogma.

2

THE QUESTION OF LIBERAL THEORY IN IRISH LAW AND CIVIL SOCIETY

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Roman Catholicism and the collapse of civic responsibility

In October 2010, in the midst of the most serious economic crisis the Irish State has ever faced, Garret Fitzgerald published an article in the "Irish Times" newspaper attributing the political and economic turmoil to a collapse in civic morality in the latter part of the twentieth century.[1] Fitzgerald, a former Taoiseach and leader of Fine Gael and renowned as an insightful and highly influential social affairs commentator, saw in this collapse one main source worth specifically mentioning: the pernicious influence of the Catholic Church.

According to his narrative, Church-State stand-offs identifiable from as early as 1937 lost the Catholic Church the motivation to advocate and promote matters of civic justice and responsibility. Instead, "all its energies were concentrated on aspects of sexual morality – an area where ... it has lost credibility not only with the younger generation but with the older one as well." According to Fitzgerald, this focus permeated throughout society in general via an education system almost exclusively Catholic both in ethos and control, and led to a value system which "undervalued integrity in public life, to such a degree that it has seen tax evasion by a minister as grounds for repeatedly re-electing him to parliament."

[1] Garret Fitzgerald, "Apocalypse may yet spark the rebirth of civic morality", *Irish Times*, October 16th 2010.

It is precisely this lack of civic responsibility which led to the unethical and/or indifferent behaviour of bankers, politicians, property developers, regulators and civil servants, which in turn contributed so disastrously to Ireland's present economic and financial calamity. The only reason this collapse did not occur earlier was due to the benign influence on Irish civic life by the unselfish patriotism of Ireland's revolutionaries, some of whom remained politically active for over 40 years thereafter, well into the 1960s.

Fitzgerald's piece attracted a good deal of attention, almost universally positive, from both the letters pages of the Irish Times and from general discussion within civic society itself. It is a forthright thesis, but does it hold up under closer scrutiny? In order to answer this, a couple of preliminary clarifications are necessary. First, is Fitzgerald correct in describing our current problems as an "apocalypse"? Have there not always been cases of civic vice and failure within Irish society, either since the establishment of the Irish Free State in 1922 or the current State in 1937, not to mention in societies elsewhere? Certainly it is true that clientelism, general political corruption, cover-ups, tribunals of enquiry and of course terrorism were present in Irish society prior to the current economic crisis originating in the 2000s.[2] Yet there is something exceptional about an economic crisis that requires one of the largest bailouts in international financial history, triggers the beginnings of a sovereign debt crisis within the EU, results in EU/IMF imposed austerity measures necessitating the slashing of public expenditure and, for good measure, creates a crisis in consumer confidence and spending power leaving tens of thousands unemployed. Nonetheless, if we are serious about analysing an issue we should be sober in how we describe our subject matter – if our present financial crisis is an "apocalypse" then what word could we possibly use to describe the cases outlined in the 2009 Murphy and Ryan reports of religious-perpetrated child abuse, facilitated by Church and State indifference, incompetence and cover-up over a 55 year period from the late 1930s to the mid-1990s? If Fitzgerald's approach to his subject is guided by hyperbole then it would not surprise to see, in the final analysis, that it is also reductively simplistic.

In order to proceed further, a second issue requires clarification: the meaning of civic society and civic morality. Fitzgerald leaves it undefined, but the clear presumption is that it involves ethical conduct pertaining to

[2] See for instance Elaine Byrne, *Political Corruption in Ireland 1922-2010: A Crooked Harp?*, Manchester University Press (2012).

matters of public life and importance where the common good is at stake. This seems reasonable. Civic morality involves political (in the broadest, original Greek sense of this term) engagement and participation, but not as an end in itself. The ultimate aim of civic morality is to work towards social justice and the common good – hence why so many civic society groups include social justice and community welfare as part of their mission statements. Hence there is a dual aspect to civic responsibility and as such this piece will analyse it as a composite involving both political engagement and social justice.

With these preliminary clarifications made, we are now in a position to examine Fitzgerald's claim that the Catholic Church paid far too little attention to civic responsibility during the course of the twentieth century. For a start, it is obviously implausible that "all" (as Fitzgerald puts it) the energies of the Catholic Church were concentrated on sexual morality. Presumably this claim is no more than a rhetorical device. Unquestionably, though, the Church did focus a lot of attention on sexual morality. Is this problematic? Not *per se*, as sexuality is an important part of human existence and has widespread and significant effects on society at large (family stability, children, personal well-being etc.).[3] Most critics who lament the Church's teaching and activity concerning sexual ethics take issue principally with its content rather than amount.

Prescinding from the substantive question of core content, the articulation and application of Catholic sexual ethics in Ireland in the twentieth century does have a troubled history. Catholic teaching was employed by various Church and State actors to support the unjust treatment of so-called "illegitimate" children and their mothers, the censoring of art (from D.H. Lawrence to the video for R.E.M.'s "Losing my Religion"), and the promotion of an ascetic view of sexuality more in keeping with Victorianism and Jansenism (a heresy) than authentic Christianity. Of course, just because the Church did focus attention on the issue of sexual ethics, whether coherently or otherwise, does not preclude the possibility that it also devoted considerable attention to other matters, such as civic morality. Is this in fact the case, and is Fitzgerald wrong in his basic assertion that the Church was inhibited from advocating civic responsibility and morality? To answer this as objectively as possible I

[3] Fitzgerald himself penned a piece in 2000 on the potentially disastrous consequences of extra-marital births and single parenthood for society, "So many births outside marriage endanger social cohesion", *Irish Times*, September 23rd 2000.

turn to two of the most popular histories of twentieth century Ireland: Diarmaid Ferriter's *The Transformation of Ireland: 1900-2000* and Tim Pat Coogan's *Ireland in the Twentieth Century*. What makes these two works especially helpful in the present context is that neither author makes any secret of his dissent from Catholic moral and social teaching on a variety of issues. Hence it would be a major surprise if either wrote anything resembling a Catholic apologetics.

Beginning with the political engagement aspect of civic responsibility, part of Fitzgerald's narrative is immediately exposed as incoherent. The reason why it took so long for civic responsibility to collapse in Ireland, he offers, was because of the virtuous influence of "the remarkably unselfish patriotism of our two sets of national revolutionaries … all deeply committed to personal integrity in public life" and who stayed in public life for decades after the formation of the Irish Free State. Yet Coogan quotes two sources[4] indicating the positive role Catholic education had in the personal and political development of these same revolutionaries. First, Dr. C.S. Andrews, who participated in the 1916 Rising and who later became one of Ireland's most senior civil servants,

> Without the groundwork of the Christian Brothers' schooling it is improbable that there would ever have been a 1916 Rising, and certain that the subsequent fight for independence would not have been successfully carried through. The leadership of the IRA came largely from those who got their education from the Brothers, and got it free.

Second, the historian F.X. Martin,

> The leaders who emerged in 1916 and the subsequent years were largely pupils of the Christian Brothers' Schools … Due recognition has not yet been given to the Irish Christian Brothers for their part in the nationalist struggle, particularly for their unqualified support of the Gaelic revival.

Fitzgerald argues that "a society whose education has been almost exclusively in the hands of the Catholic Church was left with virtually no training in civic morality or civic responsibility." The evidence suggests that the revolutionaries of 1916 would disagree, the very men who according to Fitzgerald "postponed" the collapse of civic responsibility brought about by supposed Catholic indifference. It is worth pointing out too that the Catholic provision of education to Irish citizens saved the State

[4] Tim Pat Coogan, *Ireland in the Twentieth Century*, Palgrave Macmillan (2003), at 15-16.

hundreds of millions in today's monetary terms (similarly with the provision of hospital services) – hardly an inconsequential affirmation of an ethos of civic responsibility.

As well as its educational role in the quest for independence, the Church played an important role in the attainment of peace during the War of Independence,[5] in ending the Civil War,[6] and, in the figure of Archbishop Walsh of Dublin, preparing both the Church and society for independence.[7] The role of the Church in overcoming violence was not confined to the origins of the Irish Free State in the early 1920s. Ferriter recounts how the Church self-consciously became the bulwark preventing paramilitary control of community associations in Belfast in the 1970s,[8] while Coogan details the crucially formative roles of Bishop (and later Archbishop and Cardinal) Cahal Daly, and especially of Redemptorist priest Fr. Alec Reid, in helping to bring peace to Northern Ireland in the 1980s and 1990s.[9]

In the 1930s and 1940s the Church also proposed a vision for democratic politics, one which critiqued centralised governance[10] and which via the Vocational Commission's report of 1943 advocated for less centralisation and greater vocationalism and interventionism.[11] Needless to say, the State was not impressed with a proposal to divest it of power while also investing it with a greater duty-of-care towards its citizens. Bearing in mind current debates on the abolition of the Seanad (originally intended as a vocational entity but now fallen into disrepute due to, *inter alia*, overtly partisan government appointments), and on excessive executive power relative to both parliament, local government and even the judiciary, it is somewhat a shame that the Commission's report was not taken more seriously. Ferriter quotes a contribution to a 1933 edition of the Jesuit journal *Studies* outlining a critique entirely relevant to present debates concerning governmental structures,

> Half a dozen cabinet ministers, the "strong" personalities of a given cabinet, and a dozen or so civil servants, heads of departments or experts, literally dominate all the social and a great deal of the economic activity of

[5] Ibid., at 88.
[6] Ibid, at 138-139.
[7] Diarmaid Ferriter, *The Transformation of Ireland: 1900-2000*, Profile Books (2005), at 332.
[8] Ibid, at 624.
[9] Coogan, at 649-650.
[10] Ferriter, at 366.
[11] Ibid, at 404-407; Coogan, at 364.

> the citizens of a country. Citizens, deprived of any scope for the social side of their nature, become virtual individualists, each intent on his own affairs.[12]

The aforementioned details should not come as a surprise. It was inevitable that there would be some kind of Catholic view of what constitutes optimum political and social organisation: a series of Papal encyclicals over the course of a century had exhorted Catholics to have concern for workers' welfare, the right to private ownership, poverty, the value of subsidiarity, peace, communitariansim, progressive development, human dignity and rights, equality, unemployment, social justice and world debt. From 1891 to 1991, nine encyclicals were published dealing with these issues (*Rerum Novarum*, 1891; *Quadragesimo Anno*, 1931; *Mater et Magistra*, 1961; *Pacem in Terris*, 1963; *Gaudium et Spes*, 1965; *Populorum Progressio*, 1967; *Laborem Exercens*, 1981; *Sollicitudo Rei Socialis*, 1987; and *Centesimus Annus*, 1991), while only one was published dealing principally with sexuality (*Humanae Vitae*, 1968).

Yet while there clearly was Church encouragement of civic responsibility in the sense of ethical and conscientious political (again understood in its broadest sense) engagement, it would be a mistake to claim that this encouragement was either always well expressed or a main concern of the Catholic Church. This last point is important: it is ironic that Fitzgerald, a politician noted for his stress on the separation of Church and State, should expect the Catholic Church to place political engagement so high on its list of priorities. Though the historical record testifies to the fact that the Church did give more prominence to political engagement than Fitzgerald acknowledges, the Church's main concern, by virtue of being the Church, is and ought to be with Jesus Christ, the theological virtues of faith, hope, and love, and the salvation of souls. That these theological concerns also entail civic responsibility, and especially that aspect of civic responsibility yet to be discussed (social justice), is an inevitable yet secondary concern of its core mission.

It seems that the Church is damned by its critics either way on this issue, such as when it was openly encouraged by the political establishment to voice its broadly positive view on the Lisbon Treaty referenda (which it did, in support of the democratic process), and then, a matter of months later, when it was openly criticised by the political establishment for

[12] Ferriter, at 405.