Bioethics Outlook

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'Accomplish justice in peace, and let truth prevail.'

What attitude should a pluralist and democratic society take to healthcare institutions which do not perform legal but controversial practices such as abortion, assisted suicide and euthanasia?

One hundred and fifty years ago, and in very different social circumstances, Mary Aikenhead said '*Accomplish justice in peace and let truth prevail.'*[1] Her words are a reminder of the importance, in healthcare as well as in education, not only of the need for justice in institutional practices but also for truth in the ideas which inform those practices.

Secular ideas about healthcare are increasingly associated with intolerance towards institutions which do not perform abortion or assist at euthanasia. That intolerance can motivate arguments which, if politically effective, would deny tax-payer funding for Catholic public hospitals, hospitals which provide 'free' treatment and care to everyone in need. I shall argue that the canons of thought that inspired the work of Mary Aikenhead both inform and act as a healthy contrast to some of the ideas about healthcare which dominate in the public square, and that they themselves should be recognized as aspects of the intellectual processes of a healthy, pluralist society. [2]

In this issue

We offer the two talks which together comprise the Inaugural Mary Aikenhead Oration given in May, 2023, by Bernadette Tobin and Xavier Symons.

[1] https://maryaikenheadministries.com.au/wp-content/uploads/2023/07/Inaugural-Venerable-Mary-Aikenhead-Oration-transcripts-1.pdf

[2] See also Fisher, Anthony, OP. The west: post- or -pre-Christian? *First Things,* February 2023.

First, two preliminaries, one from Socrates, the other from John Stuart Mill.

Euthyphro was on his way to the temple to obey a command of the gods, to prosecute his own faither for murder, when Socrates ran into him.[3] Socrates asked Euthyphro how he could be so sure that obeying a religious injunction – today we might call it a 'faith based' injunction - was in fact a good thing to do. When, to clarify his question to Euthyphro, Socrates asked '*Is that which is morally good, good just because God commands it?'* or *'Does God command it because it is morally good?'* Euthyphro did not understand the distinction. Catholics, though perhaps not all Christians, should be clear on this distinction. When Jesus tells the story of the Good Samaritan, his 'go and do likewise' recommends a way of living *as morally good.* In fact, you do not need to be a Christian to understand the status of the elements of a sound morality, specifically that they are based on reasons intelligible to, discoverable by, anyone, even if there is reasonable debate about their implications.

John Stuart Mill's famous defence of free speech is instructive about the value of a contest of ideas in a pluralist society. True, he was talking about the value to the individual, but what he says can profitably be applied to the value of the spoken words - the mission and values - of institutions themselves. He says: "*He who knows only his own side of the case knows little of that. His reasons may be good, and no one may have been able to refute them. But if he is equally unable to refute the reasons on the opposite side, if he does not so much as know what they are, he has no ground for preferring either opinion... Nor is it enough that he should hear the opinions of adversaries from his own teachers, presented as they state them, and accompanied by what they offer as refutations. He must be able to hear them from persons who actually believe them...he must know them in their most plausible and persuasive form."*[4]

Mill gives four reasons for the value of this contest of ideas: first, a silenced opinion may be true; second, even if it is false, it might contain a part of the truth; third, even if a received opinion is wholly true, unless it is vigorously contested it will be held in the manner of a prejudice, and fourth, its meaning will be in danger of being lost or enfeebled or deprived of its vital effect on character and conduct.

That, in short, is why it is a good thing for a pluralist society to have some public hospitals which differ in their conception of healthcare from the rest. Without that 'enacted' competition of ideas between institutions, without that contrast of institutional ethics, the community's ideas about authentic health care risk being mistaken, partly mistaken, held as prejudices, or deprived of their meaning.

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[3] Plato. *Euthyphro.*
[4] J S Mill. *On Liberty,* chapter 2.

Let me give three illustrations to show where Christian ideas of healthcare both inform and contest dominant secular ideas, and thus that the former both fortify as well as challenge the latter.

The first comes from Daniel Sulmasy's introduction to Xavier Symons' book *Why Conscience Matters: A defence of conscientious objection in healthcare.*[5] Sulmasy thinks that the current debate about the proper scope and legitimate limits of respect for conscientious objection in medicine is not about conscience: after all, as he says, don't we all want doctors to act conscientiously? The debate is really about deciding what attitude a healthy, pluralist, liberal, democratic society should take to individual healthcare practitioners who will not perform socially-controversial but legally-permissible practices.[6] Though his question is about individual doctors and my question is about institutions such as hospitals, the two questions have much in common. He says that to answer the question with respect to individual doctors, we need to start with a sound conception of the relationship which is at the heart of medicine, the relationship between doctor and patient. That is also true with respect to institutions. For even today when medicine is practiced in multi-disciplinary teams of doctors, nurses, allied professionals, administrators, all with access to advanced technology, the one-to-one relationship between doctor and patient remains at the heart of medicine.

Sulmasy argues that the ideal way to conceive of this relationship is that the patient and the doctor are undertaking a joint enterprise aimed at a common goal – making or keeping the patient well. Hippocrates agrees.[7] True, this is a shorthand way of characterizing the relationship. It needs both unpacking and contextualizing. The very general goal of making or keeping the patient well encompasses a wide variety of more specific objectives depending on the patient's circumstances. These include educating the patient about her health ('doctor' means 'teacher'), diagnosing what is wrong, determining what is the specific objective to be pursued (be it cure, stabilization of the patient in a reasonable condition, relief of symptoms, doing what can be done to ensure that the patient dies in comfort and with dignity, etc) and deciding what treatment will best suit the pursuit of that objective in the circumstances of an individual patient.

[5] Symons, X. *Why Conscience Matters: A defence of conscientious objection in healthcare,* Routledge, 2022. Sulmasy's introduction to this excellent book is a valuable source of insight in its own right.

[6] The question addressed in this talk is an adaptation of this question.

[7] Hippocrates. 'I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them. I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.' https://www.nlm.nih.gov/hmd/greek/greek_oath.html, accessed 22 June 2023

The wider context also matters. What can best be done for a sick person when resources are abundantly available may be different from what can be offered to a patient when, as in a pandemic, that patient may be an unwitting competitor with another patient for the available healthcare resources.

However, in current discussions of healthcare, there are some very different views of the doctor-patient relationship. Provider to consumer, agent of the state to citizen, to name just two. It is instructive to see what is wrong with these ways of conceiving the relationship as well as what they get right. Or, to put the point another way, that ideal way of characterizing the relationship – two people engaged in a joint enterprise of making or keeping the patient well - both challenges mis-descriptions of the relationship at that same time as it informs them.

A provider of services such as a shoe salesman will sell a customer shoes even if they are ugly and ill-fitting, so long as the customer likes them[8]: however doctors are obliged to refrain from providing what they think will not make or keep the patient well.[9] This contrast invites reflection on the role of 'cosmetic' surgery today, the vast majority of which has little to do with reconstruction after injury and much to do with the perpetuation of rigid gender norms.

Agents of the state might be expected to do whatever state authorities ask of them, for example, using a chemical restraint on a detained person solely for a non-medical purpose: doctors by contrast are obliged to refrain from using the knowledge and skills entrusted to them by the community for purposes which fall outside of making or keeping the patient well.[10]

But each of these mischaracterizations of the doctor-patient relationship gets something right. 'Provider to consumer' represents an attempt to recover the idea, central to the Christian tradition, of recognizing the patient - receiver of the gift of life - as the person responsible for taking care of that gift, and thus for decisions about his or her own healthcare. That idea had been threatened in the early 20thCentury when medicine began to acquire the ability, for the first time, to keep patients alive. Sometimes the patient would be kept alive in circumstances in which he or she had neither the desire nor the obligation to accept life-prolonging treatment.

[8] This is Sulmasy's illustration. But most will recognize the experience of being pressured to buy an item of clothing against better judgment.

[9] 'The idea that [medical care] can be reduced to money — that doctors are just "providers" selling services to health care "consumers" — is, well, sickening. And the prevalence of this kind of language is a sign that something has gone very wrong not just with this discussion, but with our society's values.' Paul Krugman. Patients are not consumers. *New York Times*, 21 April 2011

[10] Australian Medical Association, *Code of Ethics*, 2017. 8.1

Thus, an over-correction: at its best, the description of the patient as 'consumer' or 'customer' belongs to a well-meaning effort to rebalance the relationship as a partnership and so to treat the patient as the person who is responsible for decisions about his or her own healthcare.

As for agent of the state. Sometimes, there is a good reason for a doctor to collaborate with state authorities. Every general practitioner of a certain age will know how near-to-impossible it was to refuse the elderly patient whose driving was no longer safe the certificate she needed to renew her driving license. Thus it made sense for the state to require the GP to assess the patient's health in general and eyesight in particular against criteria which served to protect not only her own safety but also the safety of others on the road. That said, when the state requires doctors to 'follow the science' in circumstances in which the science is debated, it encroaches on matters of professional judgment. [11]

These misconceptions of the doctor-patient relationship dominate secular discussions about healthcare. Appreciating the true nature of that relationship is the starting point for understanding why Catholic hospitals do not perform some legally-permissible practices: they do not belong to a conception of medicine as oriented to the making or keeping the patient well. It also helps to clarify what parts of the truth – though through a glass darkly – the mischaracterizations of the relationship get right.

A second illustration. At a recent academic discussion of the implementation in NSW of the service called euphemistically 'voluntary assisted dying' (VAD) in Australia, it was said, '*There seems to be a significant difference between this new service and traditional end of life care, but it's very hard to know how to spell out the difference.'* That reflects the commonsense intuition that there is a difference, recognizable whether you support or oppose doctors implementing VAD.

Drawing on the intellectual elements in a sound ethics, the difference can be clarified.   First, a sound ethics takes into consideration not only likely consequences but also all the other morally salient features of action such as the agent's intention, her motivation, what she actually does, the wider context, etc. Such careful ('complex') judgment goes against the grain of contemporary evaluative thinking, which is often undermined by the thought that the *only* thing that matters in the ethical evaluation of an act is its likely consequences (or 'outcomes'). Consequences do matter, but they are not the only thing that matters. So the first step is to attend to everything that is ethically-salient, in particula*r what the doctor is actually doing in two very different scenarios*, one which accepts the end

[11] Thakur, R. Health disgrace: bureaucrats in bid to silence our doctors, *The Australian*, 27 October 2022

of life and one which brings about the end of life. This begins to spell out the difference in answer to the puzzle that was raised.

In addition, deliberately ending life means creating a new (lethal) condition with the intention of making the patient dead. In VAD, this is what the patient does to herself, with the aid of doctors. That is why, in the US, both those who support, and those who oppose, the legalization of this service call it 'physician assisted suicide'. On the other hand, withdrawing or withholding a life-prolonging treatment means deciding against an intervention which might thwart the progression of a pre-existing (lethal) condition, such as cancer, and accepting death. [12]

Indeed, the doctor's accepting (without precipitating) death may be undertaken for good reasons: the doctor herself may recognize that a treatment has proven or will likely prove an *ineffective* means to a therapeutic objective; or the patient himself may find that the treatment just too onerous. Judgments of futility and burdensomeness: these are two key aspects of the joint enterprise in which, in that circumstance, the doctor and the patient are engaged.

Identifying the difference between, on the one hand, a doctor's assisting in a suicide and, on the other, a doctor's withdrawing or withholding therapeutically-ineffective or overly-burdensome treatment can help to explain why some healthcare institutions, as well as some individuals, do not offer this practice. It can also help individuals to think about what to hope for at the end of life, for themselves or for others. Clarifying the difference might go some way to assisting the Australian community to appreciate that, in a pluralist society, there is reason to value public hospitals which will not deviate from a commitment to making and keeping the patient well, whatever the circumstances, and even as the patient dies.

A third illustration of how Christian ideas fortify as well as challenge secular assumptions arises in the context of healthcare and its connection to human reproduction. In this context a host of decisions – about being pregnant, having children, spacing one's children, and about the means to these ends - have to be made by couples in their own circumstances. They have a range of resources to assist their thinking and their decision-making, from (on the one hand) the prevailing social norms (according to which access to elective terminations is claimed to be an essential part of women's reproductive healthcare) to (on the other) advice offered by the Church. All such resources are apt for reflection,

[12] Sulmasy, D, Finlay, I, Fitzgerald, F, Foley, K. Siegler, M. Physician-Assisted Suicide: Why neutrality by organized medicine is neither neutral nor appropriate, *J Gen Intern Med,* 2018, 33(8), 1394-1399

discussion, debate. Indeed, in this domain, as in others, the Church's authentic role is that of teacher not policeman, a teacher who has 'accumulated a store of moral experience, know-how and wisdom' without claiming to 'know the answer to every one of the thousand questions that a morally serious person faces'.[13]

Consider a claim made in a recent program by a public broadcaster. In that program, it was implied if not directly said that, in a Catholic hospital, a doctor caring for a pregnant woman whose life or health was at grave risk must wait until she was close to death before providing emergency treatment that would protect her life but would risk or foreseeably cause the death of her unborn child.[14]

At one level, the falsity of this claim is easy to show. The *Code of Ethics for Catholic Health and Aged Care Services in Australia* is unambiguous: '*In some cases a woman may develop a life- or health-threatening condition for which the only effective and available treatment is one that would endanger the life or health of her unborn child. Such treatment is permissible provided that the risks to the woman's life or health posed by her condition are at least comparable to the risks the treatment would pose for the life or health of her child, and provided any harm to the unborn child is neither the intended goal nor a means to the treatment goal.'*[15]

But at a deeper level, the challenge is more complex. In a related article on the broadcaster's website, headed 'Catholic hospitals denying women healthcare', reference was made to women with very limited social and financial support, often parenting completely on their own, women in disadvantaged areas, migrant women, refugee women. The implication was that justice requires relieving them of the burdens pregnancy imposes on them. As Ross Douthat says, there is a truth in that view. [16]

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[13] 'The Church has been empowered by God to *teach the truth* in matters of faith and morals. The Second Vatican Council says that it is "as, by the word of Christ, the Teacher of Truth" that the Church addresses the individual Catholic conscience. Jesus said that he would send His Spirit "to lead you into all truth". Gently, generation by generation, He has been doing that and the Church has been accumulating a store of moral experience, know-how and wisdom. This does not mean that she knows the answer to every one of the thousand questions that a morally serious person faces. She is constantly adding to and articulating this accumulated wisdom and seeking better ways to teach it to us and to motivate us to keep it: rather as medical science is constantly learning and teaching and motivating. The "model" of the Church's relationship to the individual Catholic conscience is, therefore, not that of a legitimate government whose laws are to be obeyed; but rather, that of the greatest living authority on a specific subject, from whom every serious student will want to learn.' Australian Catholic Bishops Conference, 1983. *Bases of moral truth.*

[14] In good faith. How a Catholic code of ethics is influencing women's healthcare at Australian public hospitals - *ABC News,* 14.12.22 https://www.abc.net.au/news/2022-12-03/catholic-hospitals-denying-womens-healthcare-australia-hospitals/101712558

[15] Catholic Health Australia, *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, 2001, 2.28

[16] Douthat, R. The case against abortion, *New York Times*, 30 November 2021

Some women need stronger financial and social support. Some need more flexible working conditions, or better paid part-time jobs. Some need the men in their lives to accept responsibility for the children they father, and in general, social conditions that are better adapted to the realities of child-bearing and motherhood. But it would be an inhumane society which relied on access to abortion as its sole or even chief response to those realities. That said, Catholic hospitals should do what they can, in conjunction with Catholic social services, to offer alternative forms of support for women who struggle with the burdens of pregnancy and motherhood.

A further question goes to matters of trust. Here there are two questions. First, do Catholic hospitals have the trust of the community? Second, are Catholic hospitals *trustworthy?* That is, do they warrant the community's trust?

Whether Catholic hospital have the trust of the community depends largely on the political climate of the day with respect to Catholic institutions in general. No doubt much of that trust has been forfeited by revelations of past clerical child abuse.

Trustworthiness in a healthcare institution is partly a matter of competence, competence in medicine and the other forms of knowledge and experience that make up allied healthcare. It is partly a matter of commitment to the defining characteristics of the healthcare institution itself.[17] In the case of a Catholic hospital, its defining characteristic is that it is a community of practitioners dedicated to a Hippocratic and Judeo-Christian conception of healthcare. While eschewing the provision of abortion and euthanasia (and assisted suicide), a Catholic hospital makes a public promise always to act to help the pregnant woman, the sick person, the person in pain, the person who is dying, the person who is physically disabled or cognitively impaired, etc. In addition, a Catholic hospital promises to be honest ('transparent') as to what services it does and does not provide.

Today, Catholic institutions are staffed by well-motivated people, the range of whose beliefs about abortion and euthanasia can be assumed to reflect the range of those of the wider community. It is in these circumstances that the institutional leaders have the responsibility to ensure that its clinicians both understand and are committed to acting in accordance with the institution's conception of healthcare, and are thus well-equipped to make conscientious decisions in difficult circumstances.

[17] Adapted from Edmund Pellegrino's account of the trustworthiness of an individual doctor. Pellegrino, E. Professionalism, Profession and the Virtues of the Good Physician, *The Mount Sinai Journal of Medicine,* 2022: 69,6; 378-384

This is a more onerous responsibility today, when abortion and euthanasia are often portrayed as 'essential' healthcare, than it might have been in the past. It requires much more than the mere defence of pluralism as a matter of 'political theory' as offered here. Much harder is the challenge of devising workable institutional policies.

Catholic hospitals remain an important part of the social fabric of a pluralist Australian society and of healthcare provision for the community. Centralized control of a uniform hospital system, informed by the secular conceptions of healthcare that dominate in the public debate, may serve the important value of efficiency, but efficiency is only one value. So too, in a pluralist society, is institutional instantiation of a conception of healthcare – one committed to making or keeping the patient well without offering abortion or facilitating euthanasia - that stands in healthy contrast to at least some elements of the conceptions of healthcare which dominate in today's secular discussions: for that is needed if truth is to prevail.

Catholic hospitals can no longer rely on their past contributions to care of the sick and the poor to justify public funding. [18] Indeed, some will argue that, with the advent of the welfare state, the community no longer needs healthcare institutions with a religious ethos. Articulating the ideas which inform a Catholic ethic of care, one which promises second-to-none emergency treatment for pregnant women and second-to-none end of life care, without providing abortion or euthanasia, does not replace emphasizing origins and enduring motivations: it stands alongside them.

Jonathan Sumption argues that, for its survival, democracy needs two things. First, an effective institutional framework for discovering the values and desires of the *majority* of citizens – thus parliaments, elections, free media, respect for the rule of law.[19] Second, a culture of genuine pluralism, because censuring 'incorrect opinions' marks the narrowing of the community's shared intellectual world. Peter Singer and Robert George, who both teach at Princeton and who have opposing views of the ethics of abortion and euthanasia, regularly invite each other to lecture to their own students, thus acknowledging the value of Mill's advice that one needs to hear a contrary opinion from someone who actually believes it! Florence Nightingale, when asked whether she thought the Sisters of Mercy or

[18] Two days before the delivery of this talk, and less than a month after a government-controlled parliamentary committee criticized Calvary Public Hospital in Canberra for not providing terminations and other 'reproductive health services', the government of the Australian Capital Territory announced that it would compulsorily acquire the hospital.

[19] Jonathan Sumption: Death of democracy is now a real threat, *The Australian,* 7 October 2022.

the non-religious women who worked with her made better nurses, is reputed to have said: *'The best is when you have both together. For they keep each other up to the mark.'*

Finding effective ways of publicly defending the key ideas which inform healthcare (and, no doubt, education) in the Catholic tradition is not easy. To be avoided is the temptation to cast the other side of any debate as ignorant or ill-willed: there is always common ground in debates about justice and truth. One thing, however, is for sure. It is the mark of the false prophet that everyone admires him.[20] So it will take courage.

Bernadette Tobin

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[20] Luke 6, 26

‘Do pray that justice may be accomplished in peace and that truth may prevail’.

It's an honour to deliver this response to the first annual Mary Aikenhead Oration and I’d like to thank the trustees of Mary Aiken Ministries for the invitation. I’ve had the great privilege of working closely with Bernadette Tobin at the Plunkett Centre for Ethics for the past three years and I’m blessed to count her as a mentor and friend. Her contribution to Catholic bioethics in Australia has been invaluable.

I would like to acknowledge the rich legacy of Mary Aikenhead. Penny Wright provided a beautiful summary of Mary Aikenhead’s life early today, and I think the vibrant corporate works of the Sisters of Charity in Australia are a testament to her vision, holiness, and perseverance. I was particularly amazed to read of how Mary Aikenhead coordinated the work of the Sisters and navigated the complexities of Church and State politics for decades while bed-bound with a debilitating autoimmune condition.

Now to my response. Bernadette has presented an argument grounded in principles of liberal democracy that religious-affiliated healthcare institutions ought to be able to refuse services that are legal albeit socially controversial. We should seek to preserve the pluralistic character of our society, and this entails respect for faith-based perspectives and a recognition of the epistemic benefit of allowing rival conceptions of the good to be enacted in education, healthcare, and social services.

Bernadette’s reflections are timely. We are at a juncture in the life of our nation where many are asking questions about the relationship between religious institutions and the State: *‘Why do faith-based schools receive public funding?’*; *‘Why are faith-based organisations eligible for charitable status?’*; *‘Why aren’t Catholic hospitals required to provide a full suite of options for patients seeking reproductive or end of life care?’*. Recent events in the ACT testify to the

immediacy of these questions.[21] An increasingly secular Australian public is seeking clarity on why faith-based institutions seek state support on the one hand and yet claim exemptions from state-endorsed social policy on the other.

In my short response, I would like to focus on the fundamental orientation of Catholic institutions – in particular, Catholic hospitals and Catholic schools – toward the *common good*. We live in a time where many are searching for an alternative socio-political paradigm to the dominant liberalism of the late 20th century.[22] One senses a desire for a politics that promotes a shared vision of the good and that builds up rather than hollows out civil society. Catholic social ethics presents a blueprint for a different way of thinking about the relationship between the individual and society than ossified forms of liberalism – one in which life in common is constitutive of human flourishing rather than just an instrument for the growth of capital and the satisfaction of individual preferences and desires. The very fact that Catholic institutions speak to the longings of our post-liberal moment ought to be given due consideration in the context of contentious debates about the relationship between Church institutions and the State.

The Common Good

So, what is the *common good*? We can start with what it is *not*. The common good is not aggregative. That is to say, the common good is not the sum total of the individual wellbeing of each member of society, nor is the good of the majority to the exclusion of a suffering minority. We are not concerned here with the English philosopher Jeremy Bentham's *"greatest happiness of the greatest number"*. On the contrary, the common good is a good that is attributed to a community and is participated in by those who participate in the community.

[21] Georgia Roberts. 'ACT government to take over Calvary Public Hospital to make way for new $1b northside hospital'. *ABC News* 9th May 2023.

[22] Cf. Patrick Daneen. *Why Liberalism Failed.* New Haven: Yale University Press, 2018.

The common good is often described as the sum total of conditions necessary for individual members of society to flourish. In *Gaudium et Spes*, Vatican II's Pastoral Constitution on the Church in the Modern World, the common good is defined as "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily" (26 §1). The *Catechism of the Catholic Church* (1906-1909) explicates this account of the common good in terms of three conditions: respect for the person; social wellbeing and development; and peace and social order.

But we can say more than this. In addition to creating the conditions for harmonious social life, the common good, insofar as it provides the context for the cultivation of virtue, is, in fact, constitutive of the flourishing of human beings. Virtues like kindness, generosity, hospitality and fidelity have a social character and are cultivated in community contexts. The philosopher Alistair MacIntyre makes this general observation in his *Dependent Rational Animals*, where he speaks of the virtues of acknowledged dependence as a vital complement to the virtues of independent rational agency.[23] Intellectual virtues such as self-knowledge and prudence, for that matter, are cultivated in part by interaction with those around us – in particular, our parents and teachers. It is in the context of families, neighbourhoods, clubs and societies, and religious and cultural communities, that we acquire the virtues that perfect our rational and social nature.

This has an important upshot. The common good is not just a necessary or instrumental condition of human flourishing, as if it were equivalent to the classical liberal conception of the State providing peace and order for individuals to pursue their own conception of the good. Nor are social institutions ancillary to the activity of markets and the endless growth of capital. The common good, rather, is constitutive of our flourishing and felicity as we live lives of shared virtue and mutual concern.[24]

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[23] Alistair MacIntyre. *Dependent Rational Animals: Why Human Beings Need the Virtues*. Chicago: Open Court, 1999: Ch.1.

[24] Cf. John Goyette. "On the transcendence of the political common good: Aquinas versus the new natural law theory". *National Catholic Bioethics Quarterly* 13;1 (2013): 133-155.

Faith-based institutions and the common good

In what way do faith-based institutions contribute to the common good? This is perhaps the point where I would be expected to refer to the social outreach of Catholic schools or the role of Catholic healthcare institutions in providing medical care for people experiencing homelessness, drug addiction or imprisonment.

I do not doubt that faith-based institutions have and continue to contribute extensively to improving the wellbeing of society's most vulnerable members. We might, for example, consider Ward 17 South at St Vincent's Hospital Sydney, which was the first dedicated HIV/AIDS unit in Australia and became the healthcare epicentre for patients suffering from the disease throughout the 1980s and 1990s.[25] This came about through the leadership of the Sisters of Charity and the Board of St Vincent's.

My concern is that these considerations are increasingly falling on deaf ears – a concern that Bernadette raised in her talk and which she has convinced me of. Appeals to the social justice mandate of religious organisations no longer seem to cut muster with more strident secular critics who would argue that we can achieve all of this and more without religion. That is to say, many believe that we can do away with the controversial dogmas of religious belief and the problematic transparency of religious institutions and replace it with a secular, independent, open and data-driven approaches to health, welfare and social justice.

Ironically, effective altruism, a philanthropic humanitarian movement inspired by utilitarian philosophy and modern welfare economics, was marketed as a superior alternative to religious charitable initiatives. It now stands in serious need of reputational repair after a string of scandals, not in the least of which was the spectacular collapse of the effective altruist-aligned crypto-currency bank FTX.[26]

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[25] Paul Van Reyk. Life during wartime: nursing on the frontline at Ward 17 South at St Vincent's Hospital. *HIV Aust* 2014; 12: 38–42.

[26] Nicholas Kulish. FTX collapse casts a pall on a philanthropy movement. *New York Times* 13th November 2022.

But it seems that the question at the centre of the social debates surrounding our ministries is a fundamental one – ‘is religion a force for evil or a force for good?’ or ‘is religion harmful or helpful to individuals and communities?’. It seems that many people have been convinced, often through misinformation or half-truths from bad-faith actors, that religion is not essential for the wellbeing of communities and in fact may be harmful to it.

I would challenge this contention. Religiously-affiliated institutions are, in fact, uniquely oriented to the common good and community flourishing in a way that liberal state institutions are not, but, more to the point, *cannot be*.

My claim is not that secular schools or healthcare facilities fail to contribute to the common good. On the contrary, there are many ways in which the Australian public school system prepares students for being good citizens with a social conscience and a concern for justice. And our robust, public healthcare system was what allowed this country to weather the pandemic in a way that most other nations were unable to.

In fact, it’s sometimes a difficult task to try to draw practical distinctions between the social justice mandate that Catholic schools prosecute and that of state schools, or the care received in St Vincent’s Public versus the care received at Royal Prince Alfred or Royal North Shore.

But this is why my claim is more fundamental. My claim is that the focus on social justice in secular public schools or hospitals is contingent rather than a necessary feature of liberal praxis. A classical liberal creed is one that sees the State and State institutions as playing a minimal role in facilitating the realisation of the common good. Strictly speaking, the role of the State is restricted to the enforcement of contracts and the maintenance of law and order. The defining mark of liberalism is, perhaps, the rule of law and various regulatory constraints on different arms of government – particularly the executive. Classical liberalism may presuppose a robust civil society but it provides very limited support for it. One of the great contemporary defenders of the classical liberal creed, political scientist Francis Fukuyama, appears to concede this when he writes in *Liberalism and Its Discontents* that liberalism “has a tendency to weaken other forms of communal engagement and in particular turns people away from virtues like public-

spiritedness that are needed to sustain a liberal polity overall".[27] Later in the book he acknowledges the "legitimate criticism" that liberal societies "don't provide a strong sense of community or common purpose".[28]

The expectation in classical liberal political theory appears to be that citizens will naturally form the sorts of intermediary institutions that define the liminal space between the individual and the State. But this is a gratuitous expectation and the collapse of civil society in recent decades illustrates this. Fewer people are joining clubs and societies; fewer are getting involved in community interest groups; fewer people are actively participating in religious communities.[29] This regrettable trend points up the need for the State to actively support diverse social initiatives (some secular, some religious) that each in their own way build up civil society – a point that Bernadette eloquently made. As Bernadette said:

"…it's a good thing in a pluralist society to have some publicly-funded hospitals which differ in their conception of healthcare from the majority of hospitals. Without that 'enacted' debate of ideas between institutions, the society itself risks stagnation".

Granted, more contemporary forms of liberalism are more acutely preoccupied with equality and non-discrimination. At its most radical, contemporary liberalism sees social institutions as playing an active role in helping individuals redefine their identities in accord with their "own concept of existence, of meaning, of the universe, and of the mystery of human life".[30] Indeed, this shift in liberal thinking about the role of social institutions is at least part of the explanation for the proliferation of healthcare 'rights' that has led to the positing of 'a right to die' in some jurisdictions and restrictions on institutional conscientious objection.[31]

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[27] Francis Fukuyama. *Liberalism and Its Discontents*. New York: Farrar, Straus and Giroux, 2022: 62.

[28] Ibid., 115.

[29] Cf. Robert Putnam. *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon and Schuster, 2000.

[30] Justice Anthony Kennedy in the O'Connor, Kennedy, and Souter plurality opinion in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

[31] Xavier Symons. *The Principle of Autonomy: Does it Support the Legalisation of Euthanasia and Assisted Suicide?*. Oxford: Anscombe Bioethics Centre, 2022.

But whether we concern ourselves with the classical or more contemporary forms of liberalism is immaterial. The fundamental point remains that social institutions, on a liberal conception, have a primarily instrumental role and are ancillary to an individual's personal conception of the good, whatever that may be. The fundamental *raison d'etre* of institutions is the realisation of the private good of the individual.

This is not the case for Catholic institutions that authentically seek to enact Catholic social teaching. For Catholic institutions, the common good, understood as both an instrumental and intrinsic good, is an essential feature – a *sine qua non* – without which these institutions become unintelligible and purposeless. Catholic schools, for example, do not just exist to provide structures that allow students to pursue and realise their own conceptions of the good, whatever these may be. Catholic schools exist to promote the common good of communities through providing excellent education and moral formation for students informed by the teachings of the Church. This is the proper impetus for the social outreach of our schools and also ought to motivate these schools to educate students in the Church's teaching on the family, human sexuality and the dignity of human life. Catholic schools educate students in a particular tradition of thinking about the common good, but one that presents the common good in its full integrity.

The temptation for Catholic schools and healthcare providers is to make concessions to a society that is increasingly hostile to the Church's teachings on bioethics and anthropology. But this would be a mistake. It is the fact that Catholic schools teach the faith in its integrity that allows them to stand aloof from the problematic individualism of a late-modern liberal and atomistic culture. It is the fact that Catholic schools present a comprehensive vision of the good life – according to which civic participation, a concern for the most vulnerable, and active religious participation are all part of community flourishing – that allows them to continue to promote the common good. Without a substantive creed, the common good loses its content.[32]

[32] At the same time, one also must bear in mind Pope Francis's concern expressed in *Evangelii Gaudium* (n.34): "...the message we preach runs a greater risk of being distorted or reduced to some of its secondary aspects. In this way, certain issues which are part of the Church's moral teaching are taken out of the context which gives them their meaning. The biggest problem is when the message we preach then seems identified with those secondary aspects which, important as they are, do not in and of themselves convey the heart of Christ's message".

Justice, for that matter, loses its content. Contra John Rawls, justice is not just procedural in character.[33] Justice is not just about fairness. It is not just concerned with equality of opportunity or equality before the law. Nor is it reducible to some principle of non-discrimination. Justice is fundamentally about seeing our fellow human beings as beloved creatures made in the image and likeness of God. Justice is not just a way of structuring society but a stable disposition of the will whereby we show due love for all members of the human community.[34]

Religion, wellbeing, and Gen-Z

So far I have presented a philosophical argument in favour of public support for Catholic schools and hospitals. But I'd also like to talk briefly about the contribution that Catholic schools in particular can make to the wellbeing of young people.

We can start with a regrettably incontrovertible fact, namely, that young people are struggling. The sobering statistics of the COVID-19 pandemic are not limited to mortality rates from COVID itself. We should also remember the impact that the pandemic had on youth mental health. One in four young Australian adults between the ages of 16 - 24 contemplated suicide in the period 2020-2021.[35] One in four.

This data is sadly unsurprising when one considers a recent study conducted by the Human Flourishing Program at Harvard University on flourishing across age groups. This particular study considered six domains of wellbeing: happiness and life satisfaction; mental and physical health; meaning and purpose; character and virtue; close social relationships; and financial stability. Gen Z (age 18-25) scored worse than every other generation on all these metrics of wellbeing.[36]

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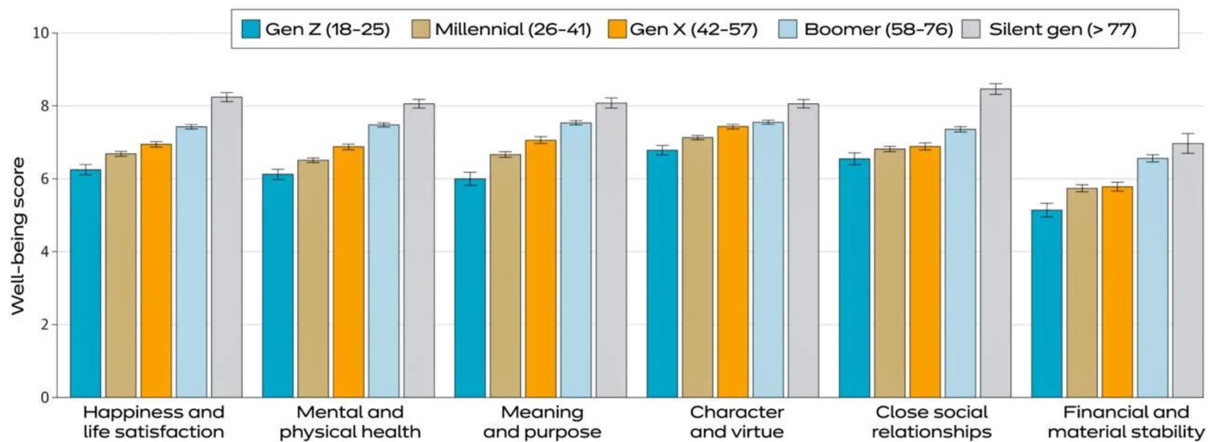
[33] John Rawls. *A Theory of Justice*. Cambridge, MA: Belknap Press, 1971.

[34] St Thomas Aquinas. *Summa Theologiae* II-II, 57-1; 58-1.

[35] Jewel Topsfield and Sophie Aubrey. 'Urgent national priority': pandemic's staggering mental toll on young Australians. *Sydney Morning Herald* 27th March 2022. See also Mark E. Czeisler 'Mental health, substance use, and suicidal ideation during the COVID-19 pandemic — United States, June 24–30, 2020'. *Morbidity and Mortality Weekly Report* 69;32 (2020): 1049-1057.

[36] Ying Chen et al. 'National data on age gradients in well-being among US adults'. *JAMA Psychiatry* 79;10 (2022): 1046-1047.



Source: National Data on Age Gradients in Well-being Among US Adults

One might point out that this sort of study, reliant on a self-report survey, is highly subjective and not necessarily reflective of the objective circumstances of a respondent's life. But this actually seems to imply the situation is worse, not better. If true, young people are decidedly more pessimistic and negative than their generational seniors. Solutions to this kind of problem are even more difficult than, say, relieving student debt for cash-strapped young adults or solving the housing crisis.

But there is one social factor that is remarkably effective in decreasing suicidality, depression, anxiety and substance abuse among the general population: active participation in a religious community (religious community here means a Church or other community). People who are actively involved in a religious community experience, according to at least some literature, a five fold decrease in suicide risk.[37] They also experience statistically significant improvements in all-cause mortality; depression; substance abuse; anxiety; and life satisfaction.[38]

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[37] Tyler J. VanderWeele et al. Association Between Religious Service Attendance and Lower Suicide Rates Among US Women. *JAMA Psychiatry* 73;8 (2016): 845-851.

[38] Tracy Balboni et al. 'Spirituality in serious illness and health'. *JAMA* 328;2 (2022): 184-197. See also David. H. Rosmarin et al. 'Religious affiliation protects against alcohol/substance use initiation: A prospective study among healthy adolescents'. *Journal of Adolescence* 95;2 (2023): 372-381.

These benefits are particularly important given the skyrocketing mortality rates among young people on account of suicide, substance abuse, and homicide.[39]

Religiously affiliated schools could play a significant role in unlocking the potential of the social benefits of religious participation for young people. But this may require hiring teaching staff who are themselves active members of a religious community and who can encourage religious practice and engagement among the student population.

A liberal, individualistic approach to education, in contrast, is failing students. I suspect that part of the issue is that value-neutrality or an obsession with procedural fairness does not give people, particularly young people, a solution to their existential problems. Young people are also looking for substantive guidance on how to use their freedom. They are looking for guidance as they seek to form their identities and characters. The purging of values from educational institutions, or the enforcement of a narrow set of fashionable values, does no favours for young people looking for morally serious answers to life's big questions. A cavalier notion that students should be left to make their own minds up leaves them adrift and existentially confused. An authentic religious education, in contrast, has the capacity to provide existential orientation for young people at a crucial moment of their lives.

This is not to deny that people have had and will have bad experiences with religion. It is also not to deny the horrific failings of the Church to justly and transparently respond to the abuse of minors in its institutions in the second half of the 20th century.

But the idea that religion is an overwhelming negative force in society in general or education in particular is not born out by the data. On the contrary, young people seem to be struggling much more in our world of declining religious institutions and decreasing rates of religious practice. I also wouldn't mean to deny that some fringe, extreme forms of religious belief may provide an exception to the favourable picture of religion that I have presented in this response. But I would think that your average religious institution – far from being an oppressively dogmatic organisation – is, in fact, remarkably uninteresting and indistinctive.

[39] Steven Woolf et al. 'The new crisis of increasing all-cause mortality in US children and adolescents'. *JAMA* 329;12 (2023): 975–976.

The problem is not so much the intensity of belief to the exclusion of a respect for individual freedom, but rather an uncertainty concerning the overall aims of the institution.

Conclusion

The aim of this response has been to build on Bernadette's insights and to offer additional reasons for supporting the work of Catholic institutions in Australian society. In the end, this is not just about a liberal accommodation of diverse viewpoints but also a recognition of the unique orientation that Catholic institutions have toward the common good in education, healthcare, and social services.

Bernadette very thoughtfully positioned this discussion as one of a robust exchange of ideas in a healthy, liberal and pluralist democracy. I would emphatically endorse this contention and would draw attention to the way in which what we do differently matters, not just for us but also for enriching the moral imagination of the societies in which we live. For several decades many have tried to prosecute a case for Catholic education and healthcare in a manner that accepts the terms of debate bequeathed to us by a particular political philosophy – what I have called the late modern liberal consensus. I feel that we have reached the limits of arguments by internal critique, and ought instead to highlight not just our distinctive contribution to the flourishing of individuals but also the unique orientation of our institutions to the flourishing of societies. This, more than anything, seems to be the most distinctive offering that Catholic institutions can make in liberal democratic societies.

Xavier Symons