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for
Pastoral Assistance to
Health Care Workers

Church and Health in the World
Expectations and Hopes on the Threshold of the Year 2000

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Editorial and Business Offices: VATICAN CITY;
Tel. 6988-3138, 6988-4720, 6988-4799,
Fax: 6988-3139. E-MAIL: opersanit@hlthwork.va

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ARCHBISHOP JAVIER LOZANO'S GREETING TO THE HOLY FATHER

Most Holy Father:

The Pontifical Council for Pastoral Assistance to Health Care Workers has held its twelfth international conference, which has been dedicated to the subject of "Church and Health in the World: Expectations and Hopes on the Threshold of the Year 2000—Gratia Eius Salvati Estis (Eph 2:8)."

This international conference has also sought to be a grateful recognition of the major endeavors and efforts of my predecessor, Cardinal Fiorenzo Angelini, thanks to whom the conferences of the last eleven years were a great success.

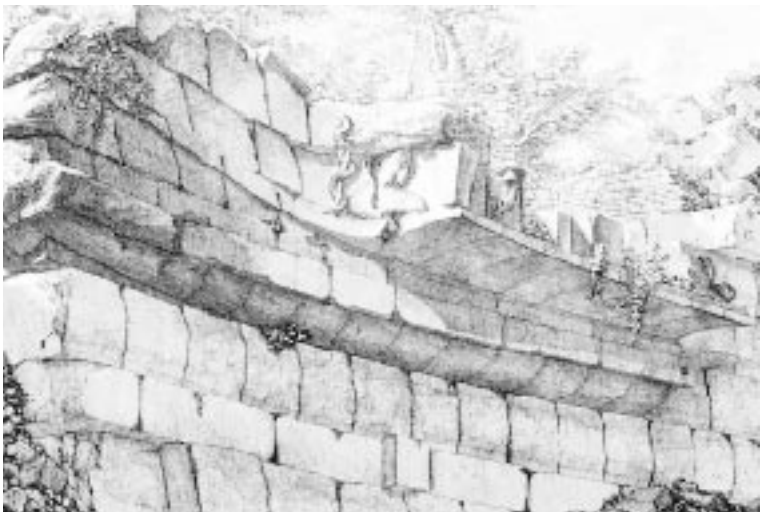
In this year of preparation for the Great Jubilee of the Year 2000, and in line with the indications made by Your Holiness, we have dedicated our work to Jesus Christ, Word of God made Flesh, the source of health for everyone. Our conference began with faith in Jesus Christ, in the Church, and addressed itself to the reality of health in today's world from many standpoints. It concluded by establishing pastoral orientations for this very important field of the Christian life which Your Holiness has entrusted to us.

Thus it is that after reflection on Jesus Christ we dwelt upon the anthropological dimension of health, which with all its modern questions and aspects requires a present-day response from the Church. We spoke about the Church as a healing community, and of medical science and Christian faith, which offer valuable answers during this preparation for the Great Jubilee. We did not neglect the relationship between our subject and the great religions of the world, and in dwelling upon the *semina Verbi* we also studied the contributions which in particular are offered by Buddhism, Hinduism, Judaism, and Islam. We also examined the practical answers which are offered in the field of science and technology and then concluded by addressing the serious contemporary problem of medicine and economics.

We now await Your Holiness's Word so that you can point out to us the ways which we should follow in this very complex area of pastoral assistance to health care workers at the end of the second millennium.

With religious respect we listen to Your Holiness,

Most Rev. JAVIER LOZANO
President of the Pontifical Council for Pastoral Assistance to Health Care Workers



ADDRESS BY THE HOLY FATHER

To Promote Health Development Based on Equity, Solidarity, and Charity

Venerable Brothers in the Episcopate and the Priesthood,

Dear Brothers and Sisters,

1. I am pleased to extend a cordial welcome to each one of you attending the 12th International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers on the theme: *"Church and Health in the World: Expectations and Hopes on the Threshold of the Year 2000."* I wish to express particular gratitude to Archbishop Javier Lozano Barragán for his many efforts in organizing this Symposium and for the courteous words he addressed to me on behalf of all those present. With him I greet and thank all his co-workers.

During these concentrated days of study and discussion, the various papers emphasized how complex health problems are, calling for joint, coordinated action for effectively involving not only health care workers, called to offer increasingly "skilled" therapy and assistance, but also those engaged in the field of education, in the world of work, in protecting the environment and in the economic and political spheres.

"To safeguard, recover and better the state of health means serving life in its totality," states the *Charter For Health Care Workers,* drawn up by your Pontifical Council. In this perspective the lofty dignity of medical and health care work takes the form of a collaboration with that God who in Scripture is presented as a "lover of life" (Wis 11:26). The Church commends you and encourages you in the work you undertake with generous readiness in the service of vulnerable, weak and sick life, at times leaving your homeland and even risking your lives in fulfilling your duty.

2. There are *many signs of hope present in the last part of this century.* One need only recall the "scientific, technological and especially medical progress in the service of human life, a greater awareness of our responsibility for the environment, efforts to restore peace and justice wherever they have been violated, a desire for reconciliation and solidarity among different people..." *(Tertio Millennio Adveniente,* no. 46).

Health care must be imbued with solidarity and charity

The Church rejoices over these important achievements, which have increased hopes for life in the world. However, she cannot be silent about the 800 million people reduced to surviving in conditions of poverty, malnutrition, starvation and precarious health. Too many people, especially in poor countries, still contract illnesses that can be prevented and cured. With regard to these serious situations, world organizations are making a considerable effort to promote health care development based on equity. They are convinced that "the struggle against inequality is both an ethical imperative and a practical necessity, and on this will depend the achivement of a health system for everyone in the whole world" (World Health Organization, *Projet de document de consultation pour l'actualisation de la strategie mondiale de la santé pour tous,* 1996, p. 8). While I express my sincere appreciation of this worthy action on behalf of our poorer brothers and sisters, I wish to address an urgent invitation to be vigilant so that human, economic and technological resources will always be fairly distributed in the various parts of the world.

I likewise urge the responsible international bodies to commit themselves to drawing up effective legal guarantees to ensure that the health of those who do not have a voice will also be promoted in its entirety and that the world of health care will be imbued with the logic of solidarity and charity rather than with the dynamics of profit. In preparation for the Jubilee of the Year 2000, *the year of the Lord's favor,* the Church repeats that riches must be considered a

common good for all humanity (cf. *Tertio Millennio Adveniente,* n. 13), to be used in a way that fosters, without any discrimination of persons, a healthy and dignified life.

3. Health is a precious good that even today is compromised by the sin of many and is at risk from behaviour lacking proper moral standards. The Christian knows that death entered the world with sin (cf. Rom 5:12) and that vulnerability has marked human history from its very beginnings. However, sickness and pain, which accompany the journey of life, often become occasions for fraternal solidarity and of heartfelt supplication to God that he show his consoling and loving presence.

"In bringing about the Redemption through suffering, Christ *has* also *raised human suffering to the level of the Redemption.* Thus each man, in his suffering, can become a sharer in the redemptive suffering of Christ" *(Salvifici Doloris,* no. 19). Pain lived in faith leads the sick person to discover, like Job, the true face of God: "I had heard of you by the hearing of the ear, but now my eye sees you" (Jb 42:5). That is not all: through his patient witness, the sick person can help even those who are caring for him to see themselves as images of Jesus who went about doing good and healing.

In this regard I would like to emphasize, as the *Charter for Health Care Workers,* recalls, that medical-health-care service is both a "therapeutic ministry" (no. 5) and "service to life." Consider yourselves collaborators with God, who, in Jesus, is shown as the "physician of souls and bodies," so that you may really proclaim the Gospel of life.

Sickness is an opportunity to discover God's presence

4. Jesus Christ, the one Savior of the world, is the ultimate Word of salvation. The love of the Father, which he gave to us, heals the deepest wounds of the human heart and calms its anxietes. For believers involved in health care Jesus' example is the motivation and model for daily commitment in the service of those who are wounded in body and spirit, to help them regain their health and be healed, in expectation of their final salvation.

Looking at the mystery of the Trinity, the health care worker, by making decisions that respect the ontological status of the person created in the image of God, his dignity and the rules inscribed in creation, continues to tell the story of God's love for humanity. Likewise the believing scholar, by obeying the divine plan in his research, gradually brings out all the potentiality with which God has enriched creation. Study, research and technology applied to life and health must, in fact, be factors of growth for all humanity, in solidarity with and respect for the dignity of every human person, especially the weak and defenseless (cf. *Evangelium Vitae,* no. 81). In no way can they become an expression of the creature's desire to replace the Creator.

5. The care of physical health must not disregard the constitutive and life-giving relationship with the interior life. It is necessary therefore *to cultivate a contemplative outlook* that "does not give in to discouragement when confronted by those who are sick, suffering, outcast or at death's door. Instead, in all these situations it feels challenged to find meaning, and precisely in these circumstances it is open to perceiving in the face of every person a call to encounter, dialogue and solidarity" *(Evangelium Vitae,* no. 83). In the Church's history contemplation of God's presence in weak and sick human beings has always inspired persons and works that, with enterprising inventiveness, have expressed the infinite resources of love, as Mother Teresa of Calcutta has witnessed to in our time. She became a *good Samaritan* to every suffering and despised person, and as I noted on the occasion of her departure from this world, "she leaves us the witness of contemplation which becomes love, of love which becomes contemplation" *(Angelus,* 7 September 1997, no. 2; *L'Osservatore Romano* English edition, 10 September 1997, p. 1).

6. The Virgin Mary, Mother of Health and Icon of Salvation, who in faith opened herself to the fullness of Love, is the highest example of the contemplation and acceptance of Life. The Church, which "by preaching and Baptism... brings forth children, who are conceived of the Holy Spirit and born of God," looks to her as her model and mother *(Lumen Gentium,* nos. 63-64). To her, *Salus infirmorum,* the sick turn to receive assistance as they flock to her shrines.

May Mary, the *welcoming womb of Life,* make you ready to understand, in the requests of so many sick and suffering people, the need for solidarity and the "plea for help to keep on hoping when all human hopes fail" *(Evangelium Vitae,* no. 67): May she be near you to make every treatment a "sign" of the kingdom.

With these wishes, I impart a special Apostolic Blessing to you, to your co-workers and to the sick for whom you lovingly care.

Church and Health in the World

Expectations and Hopes on the Threshold of the Year 2000

thursday
november
6

JAVIER LOZANO

A Greeting and an Introduction

With the holding of the twelfth international conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers, the project expressed and promoted by these conferences, which bega15n twelve years ago, is carried forward and developed.

We cannot forget to mention, in a grateful spirit, His Eminence Cardinal Fiorenzo Angelini, the previous President of the Pontifical Council for Pastoral Assistance to Health Care Workers. His dedication and his constant commitment made the perfect success of all these previous initiatives possible. This ministry, which was founded by the Holy Father, John Paul II, arose and then developed under his direction. To Cardinal Angelini goes our affectionate gratitude and our prayer, in the hope that the Lord will provide an abundant reward for his work in favor of the Church, which has been carried out with effective action at the service of this Pontifical Council.

We return to the Synod Hall where our conferences began and which has witnessed so much work and so much study. We believe that a reduced number of specialists will enable us to engage in a deeper exploration of the directions to be taken by this ministry, and will also foster a greater ease of communication among those who are taking part in our deliberations in this place.

Our international conference has a general importance and worth which is rooted in the subjects it has chosen. It is concerned with the Church and health in the world, and it is to be placed within the context of preparations for the Jubilee in the year 2000, in the light of Jesus Christ and of faith in Jesus Christ our Lord. Aware of being saved by His Grace, it is from this point of departure that we immerse ourselves in the hopes and the expectations to be found in this very involving and extensive field. We believe that health is something which is integral in character and which is made up of physical, mental and social well-being. It is also something which extends to the furthest boundaries of spirituality.

Our Pontifical Council numbers among its objectives that of acting within the field of health and health care in line with Christian perspectives, and this is exactly what we intend to achieve through this twelfth international conference, which is dedicated to the Church and health in the world. We have chosen a method which seemed to us to be, because of its multidisciplinary character, appropriate. By this method we want to get to the heart of things and find illuminations which will guide us concerning the pastoral task of the Church in the field of health in our world. It is a method which begins with reflection to complement what has been obtained at a practical level, and concludes with action by which to improve what has already been achieved.

Such is the background to the organization of our conference, which begins with a central principle which must, of necessity, be Christological in character, because Jesus Christ is the practical paradigm for all health—Jesus, the Word made Flesh, health and salvation for man. All the other subjects which will be considered will be valid because they all start from this first principle.

At a practical level, given reality as it now is, we encounter such subjects as the anthropological dimension to health and its historical evolution; the human person and his fundamental right to life; Christian morality and health; the preventive role of healthcare education and instruction; healthcare workers at the service of life and health; health and healthcare problems and the industrialized countries; aging and health; the questions and problems relating to health in developing countries; the connections between poverty and vulnerability; the organization of healthcare systems; the ethical models by which to approach and govern health; and the distribution of economic resources and health.

These realities require an explicit response from the Church in the field of pastoral assistance and health. Thus it is that within the framework of the perspective of Christ and health, the subject of our deliberations will be the Church, a healing community, and the practical forms which are needed to meet this ecclesial requirement. We will thus speak about medical science and Christian faith, the contribution of pastoral action in the field of health on the part of consecrated life, the role of Catholic hospitals, the world of health and the new evangelization, the ways by which death and suffering can be experienced in a healthy way, the sacraments—a source of health and salvation—and the Great Jubilee, the year of grace, of health and of salvation.

In searching for the seeds of the Word in the subject of the Church and health, we will also direct our inquiry towards observing health, illness, and healing in the great religions, especially Buddhism, Hinduism, Judaism, and Islam.

Striving at all times to find suitable forms of action in the field of pastoral care and treatment, we will then study the subjects of science and technology at the service of the person; technology or the use of technique for health in the third millennium; the new treatments and therapies in medicine; the potentials and the limits of scientific and technological progress; the impact of the environment on health; ecology; the creation and health; the protection of

health in the world of work; the impact of emigration on health; the excesses of consumer society; and our responsibilities towards the future.

We will conclude by discussing a practical question which is now becoming very important and which has modified the traditional approaches to health in many countries—the question of the economy. We will thus study health and the global allocation of goods and will discuss, from many points of view, the subject of international cooperation and its role in securing solidarity.

These are very separate subjects but they are unified by the central topic of our conference—the Church and health; or, if we want to go even more deeply into the question, Christ and health today. We hope in this way to cooperate to the full in the run-up to the Jubilee celebrations and in the subject of pastoral assistance in the field of health and health care, hoping to participate thereby in the highest possible celebration of the Year of Jesus Christ as a preparation for the third millennium.

Arcbishop JAVIER LOZANO
President of the Pontifical Council for Pastoral Assistance to Health Care Workers

OPENING ADDRESS

PIO LAGHI

Jesus: The Word Made Flesh, the Health and Salvation of Man

It seems to me that it would be most appropriate to open this Twelfth International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers, entitled "Church and Health in the World: Expectations and Hopes on the Threshold of the Year 2000," with the words of a Preface—the prayer with which the priest begins the rite of consecration. It is a hymn of praise and of gratitude addressed to God, the Creator and Lord of the universe.

"*It is truly right and just to praise you and thank you, Holy Father, omnipotent and eternal God, in every moment of our lives, in health and in sickness, in suffering and in joy, through Christ, your servant and our redeemer.*

"*During his mortal life He passed by, blessing and healing all those who were prisoners of evil; today, too, like the Good Samaritan, he draws near to every man afflicted in spirit and in flesh and pours on his wounds the oil of consolation and the wine of hope.*

"*Through this gift of your grace, even the night of pain opens to the Easter light of your Son crucified and risen again. And we, together with the angels and the saints, sing with one voice the hymn of your praise (Common Preface* VIII)."

This beautiful liturgical prayer, in addition to helping us raise our blessing and imploring thoughts to all-powerful and merciful God, well captures the specific subject about which I have been asked to talk—"Jesus: The Word Made Flesh, the Health and Salvation of Man."

[In the Romance languages] the words signifying 'health' and 'salvation' come from the same Latin root—*salus*. They are closely connected and evoke certain mutual meanings. This is especially true when we come to discuss Jesus Christ, the Word made flesh: He is *salus*—the health and at the same time the salvation of man.

1. The salvific mission of Jesus, the Word made Flesh
2. Salvation from illness
3. Salvation from sin
4. The breadth of Christian salvation
5. The salvific action of the Church

1. The Salvific Mission of Jesus, the Word Made Flesh

In order to place in context what is stated in this paper, it is necessary to begin with the plan of salvation conceived for us by the Father throughout eternity. This design—the decree *Ad Gentes* makes clear—derives from the "fountain of love"—that is, the charity of God the Father, who "decided to enter in a new and definitive way into the history of men by sending the Son with a body like ours to free men, through him, from the power of darkness and of Satan, and to reconcile the world to himself in him" (no.2). In this way, "the Word became flesh and came to live among us" (Jn 1:14). "His nature is, from the outset, divine, and yet he did not see, in the rank of Godhead, a prize to be coveted; he dispossessed himself and took the nature of a slave, fashioned in the likeness of men" (Ph 2:6-8).

The Son of God, in the Incarnation, completely entered into human and earthly reality and linked himself to it indissolubly in a real, not apparent way. He did not brush humanity with the tip of a finger without passing through its dark mirror of misery and pain. On the contrary, he profoundly shared its reality: "He worked with the hands of a man; he thought with the mind of a man; he acted with the will of a man; he loved with the heart of a man" (GS, 22). He took up life and death, joy and suffering, holidays and work, the sweat of the brow and food, sleep and being awake. He preferred to be in the state of the poorest and the most disinherited. He accepted unjust torments and an ignominious death. Coming

into the world, therefore, the Word of God took on our total human nature as it exists in both rich and poor, without, however, taking on sin (cf Heb 4:15). And he saved this nature through his redemptive death. The Holy Father repeated this point almost in a refrain: "He took on everything for me to give me salvation so that what he did not take on has not been saved." And the Roman liturgy has expressed the same idea in song: *Id quod fuit remansit et quod non fuit assumpsit*—"He remained what he was, God, and took on that which he was not, the nature of man."

Christ took on the whole of man and all men, and for this reason all men find salvation in him. We can with good reason proclaim with the words of the rite of the benediction of the Easter wax: "Christ yesterday and today. He is the beginning and the end, the alpha and the omega, to Him belong time and the centuries." With good reason we can say He is the "savior" of the world.

The title "savior" is only present in the later parts of the New Testament—those that express their contact with the Hellenistic world, such as the last letters of Paul (Tt 1:4; 2:13; 3:6; 2 Tim 1:10) or the first letter of John (1 Jn 4:14). But its contents pervade the whole of Holy Scripture and in particular the Gospels. It is no matter of chance that the name of Jesus is given to the child who is to be born to Mary: "You will call him Jesus," the angel says to Joseph in a dream. "He will save your people from its sins" (Mt 1:21).

This is the message which we are called upon to announce with *parresia* at the dawn of the third Christian millennium. Many peoples in the world have still to hear the Good News of their salvation. There are many who have lost it by the wayside. We must feel responsible and ensure that this message continues to be heard with strength to the furthest frontiers of the earth. But we must give this message all the breadth, height, and depth which belong to it.

In order to do this we must first understand what slavery the Word made flesh came to free us from. If He had come merely to liberate us from ignorance, a philosopher Christ would have been enough. If He had come to free us from poverty, an economist Christ would have been enough. If He had come to liberate us from oppression, a politician Christ would have been enough. If He had come to raise us up out of despair and anxiety, a psychoanalyst Christ would have been enough (cf. B. Mondin, *Gesù Cristo Salvatore dell'Uomo*, Bologna, 1993, p. 267).

It seems to me that here is to be found the weak point of certain contemporary forms of Christology. They have concentrated their attention solely on men's needs for salvation, and have at times converted Christ into a philosopher, an economist, a politician, or a psychoanalyst. They have certainly revealed the exceptional nature of his person, but they have not understood to the full the singularity of his mystery. As a result, the salvation provided by Christ has also been wounded, placed within social and cultural dimensions, and deprived of its spiritual, transcendent, and eternal importance. Such, indeed, is the dangerous reductionism which was stigmatized by the Instruction *Libertatis Nuntius*, the work issued by the Congregation for the Doctrine of the Faith.

This document observes, "To some people it even seems that the necessary struggle for the justice and liberty of man—understood in their economic and political meanings—constitutes the essential and exclusive aspect of salvation. For such people the Gospel becomes reduced to a purely earthly Gospel" (VI,4). This position cannot be accepted because it leads to the "kingdom of God and its fulfillment being identified with the movement for human liberation and makes history itself the subject of its development, seeing it as a process involving the self-redemption of man" (*ibidem*, IX, 3) through both the class struggle and scientific, medical, and technological advance and progress. This Instruction, issued by the Congregation for the Doctrine of the Faith, thus concludes: "This identification is in opposition to the faith of the Church as expounded by the Second Vatican Council."

Christian salvation is very special. It does not exclude physical health and does not ignore the importance of various kinds of human (social, political, and economic) liberation. In his work *Crossing the Threshold of Hope*, John Paul II emphasizes the following with great clarity: "To save means to liberate from evil. This does not refer only to social evils, such as injustice, coercion, and exploitation. Nor does it refer only to disease, catastrophes, natural cataclysms, and everything that has been considered as a disaster in the history of humanity. To save means to liberate from *radical, ultimate evil*. Death itself is no longer that kind of evil.... An even more radical evil is God's rejection of man—that is, *eternal damnation* as the consequence of man's rejection of God *(Crossing the Threshold of Hope,* p. 70).

With this made clear, I believe that all of us ask ourselves what the relationship is between earthly liberation (in our case, from illness) and Christian salvation. An answer will be given to this question by analyzing how Jesus approached the matter, first in relation to illness and secondly in relation to sin. A contrast and comparison between the two forms of salvation will then enable us to fully understand the breadth of Christian salvation.

2. Salvation from Illness

Matthew the evangelist summarizes what Jesus did when he writes: "So Jesus went about the whole of Galilee, teaching in their synagogues, preaching the gospel of the kingdom, and curing every kind of disease and infirmity among the people" (Mt 4:23). One deduces from what Matthew says—but also from what the other evangelists write—that the healings worked by Jesus were not merely chance events. They involved a constant approach and attitude which was closely intertwined with the proclaiming of the gospel. Indeed, Jesus was constantly surrounded by ill people of all kinds—the deformed, the lame, the blind, the paralyzed, and lepers. The list of illnesses which He cured is thus a kind of litany.

In the expressions and the pleas which the sick directed towards Je-

sus one can unfailingly perceive anxiety and the strong wish to be healed. Thus the leper draws near to Him and declares, "Lord, if you want to, you have the power to make me clean" (Mt 8:1-4). And Bartimeus, the blind man of Jericho, felt Him pass by and cried out, "Jesus, son of David, have pity on me" (Mk 10:46-52). And then there was the poor woman who for twelve years had had an emission of blood and thought that if she could only touch the cloak of the Master she would be healed (Mk 5:25-34).

In the face of so much suffering which he finds on his way, Jesus shows feelings of pity, compassion, concern, and strong emotion. He is moved deeply and even comes to weep, as happens in the case of the death of Lazarus (cf Jn 11:33-35). When confronted with the cry of those who ask for His help with trust and insistence, He does not remain idle, but acts with a generosity which is without reserve.

But it should be noticed that during his public life Jesus works miracles for many people, but not for everybody. For example, when he heals the palsied man at the pool there are many other sick people who are waiting to be healed, but instead remain sick. But this is not all! All the healings which Jesus carries out are only temporary. The healed or resurrected people did not live forever, but at a certain point fell ill again or (undoubtedly) died.

Furthermore, in the gospels there are other statements which tell us that Jesus did not believe that physical well-being was an absolute: "If your right eye is the occasion of your falling into sin, pluck it out and cast it away from thee; better to lose one part of your body than to have the whole cast into hell" (Mt 5:29; cf 18:9).

Another element which should command our attention is that many healings carried out by Jesus were to the benefit of those possessed by evil spirits or sick people whose illness was thought at the time to be the work of the devil. An emblematic example is that of the healing of the woman bent double. Luke tells us that for eighteen years she was kept infirm by a spirit and could not straighten up to the least degree. "Woman, you are free from your infirmity" (Lk 13:12). The received wisdom of the contemporaries of Jesus held that there was an explicit relationship between the devil and illness. It seems to me difficult to believe that Jesus did not take such a belief into account when working this miracle.

All of this leads us to ask what the deepest meaning of the miracles of healing really was.

Jesus himself helps us to understand the nature of this meaning. These miracles are not an end in themselves, but the "sign" of a far greater event—the sign of the arrival of the Kingdom of God among men. As Jesus says to the disciples of John the Baptist, "Go and tell John what your own ears and eyes have witnessed; how the blind see, and the lame walk, how the lepers are made clean, and the deaf hear, how the dead are raised to life, and the poor have the gospel preached to them. Blessed is the man who does not lose confidence in me." (Mt 11:4-6). If the signs predicted by Isaiah have arrived, then this means that the Messiah is in your midst!

But why does Jesus employ above all *these* actions of healing in order to proclaim the arrival of the Kingdom? To answer this question we need to start from the anthropological perspective of the Bible, a vision which sees man as a "living totality." In this perspective, illness is the symbol of man in a state of sin, of the man who is spiritually blind, deaf, paralyzed, and suffering from leprosy. In contrary fashion, the healing of the body is the symbol of a broader healing, the healing of the deepest "self" of man, the healing of his soul. This is the meaning which Jesus gives to the miracles which he performs. Through these miracles He wants to tell us that He has come to heal the most radical illness of man—his drawing away from God.

In this perspective the man born blind who recovers his sight is the man who opens himself to Jesus, "the light of the world" (Jn 9:1-41). The deaf man who hears is a sign of the man who listens to the Word who saves (Mk 9:25). And the palsied man who rises up and walks is the image of the man given life by Christ (Jn 5:1-18).

In Jesus, therefore, the healing of physical ills is a sign and demonstration of liberation from spiritual evil. And here we come to the central feature of the analysis presented in this paper.

3. Salvation from Sin

Jesus is fully aware that his fundamental mission involves saving man from sin. To the scribes who murmur to each other because they see him eat with sinners and publicans he answers, "It is not those who are healthy who have need of the physician; it is those who are sick. I have come to call sinners, not the just" (Mk 2:17). He sees himself, therefore, as the physician of sinners who has come to take upon himself their infirmity and their illnesses (cf Mt 8:17).

J. Leclercq has written that "the healing of the sick and the banishment of devils are two forms of the same victory over sin." They are two forms which declare that Satan has now been defeated and that the Kingdom of God has already begun upon the earth. Indeed, as Jesus himself observes, "Which command is more likely given, to say, Thy sins are forgiven thee, or to say, Rise up and walk? And now, to convince you that the Son of Man has power to forgive sins while he is on earth (here he spoke to the palsied man), I tell thee, rise up, take they bed with thee and go home" (Lk 5:23-24).

The essential purpose of Jesus is the spiritual liberation of humanity and liberation from its sins. This is expressed with extreme clarity at the solemn moment of the Last Supper. The blood shed for the multitudes is "for the remission of sins" (Mt 26:28).

This is what many of our contemporaries find difficulty in understanding and this is because they have lost the sense of sin. There are various factors which have brought this about. There is certainly the very high level of material prosperity, which has led to a decline in sensitivity to sin. There is also a certain abuse of the principles of psychology, which has led to a taming and weakening of the

concept of sin. But, above all, there has been a debilitation of faith and of reference to God, and this is a development which has obscured the truth about man and his vocation, leading as a result to a decline in knowledge about sin.

When faced with this cultural climate, our preaching must help our contemporaries to be aware of the abyss of death and loneliness in which we find ourselves, and to open ourselves with trust to the salvation of God.

But let us return to the argument of the analysis. It has been observed that the salvation brought by Christ is in fundamental terms salvation from sin. But let us be careful here! This does not mean a spiritualistic and disembodied salvation which is unconcerned with the realities of this world. Indeed, redeemed man, rendered a son of God, makes material things participate in his destiny. The whole of the universe is made one with him so that it can have a certain participation in the new life which is granted. This "new creation" will achieve its fulfillment in the final resurrection of mankind. However, while waiting for this ultimate transformation, the universe has already begun—like the body of man—to take part in spiritual liberation.

The work of the Church takes place during this "meantime." The Church is called to spread the spiritual liberation of Christ through the Word and the Sacraments and to embody it ever more in the transfiguration of suffering and commitment to the defense and promotion of health.

4. The Breadth of Christian Salvation

The teaching and work of Christ establishes that the deepest essence of salvation lies in liberation from sin and death, and in participation in eternal life and the infinite joy of the Trinity.

This salvation is spiritual in character, but at the same time temporal. It is not opposed to forms of human liberation (from injustice and suffering), nor does it identify with them. Its peculiarity is to be, in fundamental terms, salvation from sin and only subsequently to be salvation from the fruits of sin—although on a horizon which crosses the threshold of present life.

Here we encounter the second dimension of Christian salvation—it is at the same time historical and eschatological. Although it is real, it is present only in hope—it will manifest itself to the full at the Second Coming, when our mortal body will be transformed into the glorious body of the Risen and the whole creation will be freed from the slavery of corruption.

This reflection on the final outcome of history helps us to understand a third dimension of Christian salvation—it is both personal and community-based. It is salvation which saves the person by making him come out of the drama of his loneliness and by placing him in the circle of trinitarian and fraternal communion.

Christian salvation, therefore, is an integral salvation which saves the whole of man in all his dimensions, within the horizon of eternal life.

It should be stressed that the horizon of Christian salvation is eternal life. This horizon does not remove implicit meaning from a commitment to earthly liberation, but gives this latter a quality and new and extraordinary meanings which are eternal in character.

It is within this horizon that the commitment of the Church to the salvation and the health of man should be situated. Over the next few days this is something which will be much debated and discussed. Here I would like to offer only some general observations.

5. The Salvific Action of the Church

As a sacrament of Christ, the Church must "save" man by fighting the evils which afflict man at their root, and she must do this by giving him new life. It follows from this that her salvific action must take the form of evangelization and the celebration of the sacraments.

But such an undertaking cannot but have consequences for history. This is because the fragment of the world which is already "saved" by its very nature tends to spread itself and to extend the dynamism of the Incarnation which energizes it to the whole of the creation. The salvific action of the Church also spreads out, then, in the offering of a meaning to suffering and in a commitment to the defense and promotion of health. If this were not to take place, we would fall into a dualism which would place history and faith on two different levels that would never meet each other.

However, there are points of encounter, and they are very precise in character. At the wide level of human progress, they involve a thousand facets of Christian charity—from social and political commitment to scientific research, from donation to welcoming and sharing, and from voluntary work to physical and spiritual works of mercy.

With regard to the realm of health, the first undertaking of the Church is that of being a companion to those who are in pain, and this involves helping them to give a new meaning and significance to their suffering and to transfigure that suffering into love.

In addition, the Church is called to continue the ministry of healing of Christ. From the very beginnings of her history, she has been involved in the safeguarding of health, in medical research, in the building of hospices and hospitals, in caring for the sick, and in aiding the handicapped. She has always been very sensitive towards new and unexpected social needs. The creation of the diaconias to begin with, followed by the rise of a very large number of religious orders dedicated to the sick and thee suffering, make up a splendid chapter in the history of humanity.

Today the Church continues her ministry of healing through the work of members of religious orders, voluntary workers, and Christians active in healthcare facilities and organizations. All of these groups wish to bear witness to a style of service centered around the sacred values of life and the human person, and to demonstrate the favored treatment which the Church bestows upon those categories which within the world of health

are the most forgotten—the elderly, the handicapped, the terminally ill, and the dying.

In this sense, I would like to refer to a very fine text written by Paul VI. With lucidity and gratitude it brings out the commitment which the Church feels towards the sick and the suffering. I would like to give you a copy of this text, in part as an expression of admiration for that great Pope one hundred years after his birth. To a General Audience held some twenty years ago Paul VI said: "The Church displays an intelligence of human needs as no other social organism has been able to do, even though today civilization has achieved marvelous advances. An intelligence which has meant the rise of so many benevolent institutions from the heart of the Church, and this at a time when society did not think of bringing help! The Church perceives the pain of man, in every situation, at every age, in every country, where she is allowed to exercise her humanitarian mission… There is no example of human misery which has not had in the Church its own institution to which members of religious orders, and especially female members of religious orders, have not consecrated their lives, with infinite patience, with silent love. Even today examples of evangelical witness, such as that—to cite the most famous examples—of Padre Damian, the leper with the lepers of the Maluccas, of Mother Theresa, with the numberless poor of Calcutta, or of the Petits Frères and Petites Soeurs of Charles de Foucauld, now to be found throughout the world, and of the many, many daughters of innumerable religious families, and of many benevolent works—all these declare with the heroism of their immolation what the Church does in the world. The same is manifested, throughout the great cities and on the outskirts of urban life, and with admirable perseverance, by the ranks of women, companies, conferences, and groups which draw inspiration from St. Vincent de Paul, and by members of the laity and young people as well, who bearing that name, and the names of other saints, both male and female, and by numberless good Christians throughout the world, when they search for the Poor, wherever they are to be found… It is Christ who inspires, guides, sustains, transfigures, and sanctifies this program, in its most demanding and expressive part of his Church. Because this is her program; such is her genius. Loving and serving God-Christ in suffering man" (*L'Osservatore Romano*, September 22, 1977, p. 2).

Conclusion

This is where Christian salvation reaches! It reaches where nothing else reaches. It reaches the last, to their souls, to eternity!

Christian salvation is imbued with "meaning"—the meaning of life, the meaning of existence, the meaning of history. Where so many men recklessly strive for what can endanger their individual and collective destiny—and many give up and give over to despair—Christianity proposes a light and a direction. To say, as Christianity does, that there is salvation means, in reality, to say that life does not move towards the absurd or towards nothingness. But Christian salvation is not only a question of meaning and of a journey. In fundamental terms, it is a question of life—it is the overcoming of death and loneliness and participation in the life and love of God.

We, therefore, are not lost because we have life. We are not deceived because we have truth. We are not dead because we have life. Christ is our life; truth is life. He, the Word made flesh, is our salvation and our health.

As the Apostle declares, "*Gratia eius salvati sumus*" (cf. Eph. 2:8).

His Eminence PIO Cardinal LAGHI
The Holy See

CORRADO VIAFORA

The Anthropological Dimension of Health: A Philosophical Approach Based Upon the "Crisis of the Individual"

Introduction

The question as to what a healthy man really is gives rise to questions whose answers involve different perspectives and different forms and kinds of methodology. There is the perspective of medicine, which may be deemed "scientific" in the usual sense of that term, that of psychology, that of sociology, and that of history. But if one wants to bring out the human experience of health in its true singularity, then the most suitable kind of perspective which should be used is that of an anthropological/philosophical character. The term "anthropology" often refers to "cultural anthropology." It is also employed to describe the human sciences in general. By the term "philosophical anthropology" we mean that department of the discipline of philosophy which is concerned with man and all his constitutive dimensions. Unlike other disciplines which bear the name of "anthropology" and which study man in terms of his different and separate aspects, philosophical anthropology studies man as a personal subject considered and examined in his entirety and seen in overall terms. Such is the approach employed in this paper.

The aim of this paper is to provide certain guidelines by which to formulate an overall and complete concept of health at a time when we are face to face with challenges and forms of provocation which come to us from our cultural context. The underlying phenomenon which links the different approaches to an overall and complete concept of health is a critical approach to any concept which seeks to reduce the health of man to a merely naturalistic/biological reality. It should be added, however, that this condemnation is not applied so much to what such concepts say as to what they do not say. The burying or concealment of the human dimension to the workings of health and illness which arises from such perspectives is on the whole the outcome of an arbitrary shift from a reduction of health and illness provoked by methodological needs and requirements to a reduction which is carried out at the essential level of what man is. This process should be exposed and revealed for what it is even though it is promoted within the orbits of disciplines which continue to claim that they are fully scientific in their theory and practice.[1]

Where the burying or concealment of the human dimension of the workings of health and illness produces its most negative consequences is in the context of health policy and care—an approach in this area which is unable to promote and sustain a systematic "anthropological intention" is inevitably destined to transform a healing approach into an approach which in reality does the opposite.

The picture which emerges from the developments in the world of epidemiology only confirms the importance of the need for renewed attention to be paid to the anthropological dimension of the way things are in the workings of health and illness. A good example of all this—precisely because of what they mean for the way in which health is conceived and thought about—is to be found in the health needs which arise from the aging of the population and the consequent increasing incidence of chronic and degenerative pathologies; the appearance of new and aggressive forms of infectious disease which are connected with certain kinds of lifestyle; and the spread of new kinds of social maladies such as drug-addiction, alcoholism, tobacco-addiction, and the new disorders arising from interpersonal problems such as anorexia, depression, and bulimia. If there is one thing which really links these pathological conditions it is the presence of the specifically human aspect of health and illness.

1. A Culture Which is Obsessed with Health?

The point of departure of the analysis presented in this paper is a phenomenon which is increasingly emerging as the hinge on which individual and collective attention and concern turns as this century comes to a close—the growing and intensifying interest which people have in their own health. But here it is necessary to be clear about who one is referring to, as, indeed, an eminent observer of contemporary trends has rightly pointed out. The people who display this phenomenon are those who belong to the industrialized countries of the globe and more precisely those "integrated two-thirds" of the populations which exist within such societies. When this distinction has been made, it becomes more than evident that this phenomenon is now widely and commonly recognized by all observers of the contemporary scene.[2]

Rather than focusing upon the forms of behavior which lie behind

this kind of emphasis and attention, it is more interesting to dwell upon what is written and argued by those who do not hesitate to perceive the signs of a very real cultural transformation when examining the present-day social expression and manifestations of health. I am referring here, for example, to the conclusions at which François Laplantine arrived after completing his research into the different ways in which the men and women of our societies express themselves when it comes to matters of health and illness.[3]

In the view of this French anthropologist, what characterizes our culture is not so much the search for security—given that this pursuit in Laplantine's view is no more intense and keenly-felt now than it was elsewhere in the past—but, rather, the way in which this search expresses itself in new health terms within our respective societies. Worry about health is now considered of such great moment and importance that health itself even becomes the objective, goal, and value of existence itself. This worry and concern is pervasive and to be found everywhere. There is a very great risk that it will become a real and authentic obsession. Laplantine perceives two other principal factors in this general picture and framework of how the search for security comes to express itself in the pursuit of health—the growing "medicalization" of life and the tendency to construct a new morality based upon medical considerations and criteria. The latter takes place within a context where a large gap or void has been left by a general lack of interest in the religious view of the world and by the discrediting of various kinds of political ideology.

The function of today's medicine is not only that of treating illness, but of distancing (as much as this is possible) our worry about our self-preservation. This function is no longer a part, albeit very important, of our culture, but the dominant element, to the point of becoming almost the complete expression of our culture and our way of life. Laplantine observes that "in every society various kinds of mental configurations are brought into play to give an overall explanation of the individual and the social world, but whereas most of the time such explanations are religious, or often political or economic in character, for the first time in the history of humanity they now tend to become health-related and more specifically biomedical."[4]

By this route medicine has come to appear as knowledge *par excellence*, and it has a hypertrophic tendency to extend its range of dominion well beyond the narrowly biological and to end up by becoming a new form of morality or ethics. The traces of this development are to be found in the image that we have of medicine at the present time: it is medicine which orders, prescribes, and notifies; it is medicine which threatens and creates anxiety in all those who are aware that they do not conform to the laws of health; and it is medicine which manages the terror which is felt in the face of cancer—that scourge which overwhelms and besets the imagination of contemporary man.

The conclusion which Diego Gracia arrives at is even more dramatic and striking when seen in terms of the history of medicine. For this authority "twentieth-century man has assimilated the medical norm to such an extreme extent that he lives out his health in an obsessive fashion and comes to the paradox of living for the sake of his own health."[5] How should we interpret this growing concern and worry about health? And, more specifically, how should we approach the health matrix which is imposed in an overall way on culture, meaning by this term the horizon of understanding within which we comprehend and perceive our own existences?

There are some people who reflect upon the importance and weight of the phenomenon and invite us to realize that we are face to face with a real milestone in the development and evolution of our civilization. Whereas the nineteenth century gave special importance and significance to the right to work, our own time is characterized by insistence upon the right to health. As a result of this development, although this century began under the banner of "more industrial development and growth," it now seems to be coming to an end rooted in the wish and request for "more guarantees for people's health," not least through rather tardy steps taken to remedy the damage caused by industrial development itself.[6]

A drastic and negative evaluation of all this is offered by those who see this new worry and concern with health as an expression of mediocrity, as a somewhat seductive mask for the impoverishment of man—that mask which Nietzsche attributed to the "last man": "a longing for the day, a longing for the night, as long as there is health." A very critical judgment on this craving for health is given by Francis Fukuyama in his much-discussed work *The End of History and the Last Man*.[7] In this book he refers directly to the figure of the last man to be found in the works of Nietzsche. When talking about the Americans (who are taken to represent Western man), Fukuyama observes that "for the Americans the health of their own bodies—that is, what they should eat and drink, what physical exercise they should do, and the means by which to keep fit—has become an obsession which is of far greater importance than that which their ancestors felt for moral questions."

There are those, however, who express a positive judgment of this emphasis and concern with health, even though they are aware of the consumeristic pressure to which this growing interest in health is subjected in a market-oriented economy. They perceive in this emphasis and concern with health an expression of a search for a new relationship with the body and believe that this approach will involve a long-lasting anthropological change if it manages to achieve substantial influence and impact. Far from being a sign of the impoverishment of man, this attempt to "regain control" over the body should, rather, be understood, it is asserted, as the harbinger of a new kind of humanism.[8]

The interpretations which tend to be given to this new kind of health culture are, as we have seen, numerous and varied. I am personally inclined to place it within the

logic of a "sign of the times," in the logic, that is, of statistics to which special attention should be paid because of their ability to bring out the horizons of meaning within which a certain culture strives to understand itself. The analyses which have been discussed and outlined so far in this paper clearly suggest that the system of symbols adopted by our culture is strongly modelled on reference to health. It is certainly true that this reference is not immune to ambiguities, limits, and distortions. And for this reason an approach which is in line with emphasis on the signs of the times requires perspicacity. This is what I will attempt to do, and I will employ two lines of analysis. On the one hand, there will be an examination of the ambiguities with which this new culture of health is imbued, and, on the other, light will be thrown on ways of promoting the positive aspects which are present within that culture.

2. Health or Happiness? The First Ambiguity to Be Discussed

This ambiguity springs from the fact that in this new culture of health the good which is health does not coincide with a state where there is an absence of illness, but is identified, rather, with a condition of complete well-being—in essential terms it is synonymous with happiness. But, however legitimate it might be to strive for an overall concept of health, should we really identify health with happiness? Is this something which should really be done?

These questions go back to the debate which was begun in 1948 at the time of the adoption of the definition embraced by the World Health Organization (WHO)—the health of man was defined by this organization as being a condition of complete physical, mental, and social well-being and was not taken to mean merely the absence of illness. Despite the very great and detailed discussions which have taken place since that time, this definition continues to hold sway. The reason for this is to be found in the fact that this definition includes the ideas of mental well-being and social well-being in addition to that of physical well-being, and this means that there is no rigid distinction between body, mind, and society. However, criticisms of this World Health Organization definition of what health is have not been lacking and at the present time are not absent. This is because this concept of health is open to all kinds of dangerous forms of mystification.

Among the most important criticisms of this definition are the following.

(a) Some people believe that this definition gives rise to mystification because it does not make a sufficient distinction between the medical sphere ("medical goals") and the health field ("health goals"). A definition of health which is so broad in scope, it is asserted, means that it is very difficult to determine which aspects of health are strictly medical in character, and it is thus also very difficult to decide on what the tasks and goals of healthcare policy should be. If the purpose of healthcare institutions is to maintain and restore all aspects of our natural well-being__as, indeed, is suggested by the definition of health proposed in idealized fashion by the World Health Organization—then, it is argued, too much is asked from medicine and too much emphasis is being placed on the right to health.[9]

(b) Others criticize this definition by beginning with a condemnation of "obsession" and "exaggeration." They argue that this emphasis on complete well-being has very serious consequences which involve a legitimation of erroneous attitudes and approaches towards those human conditions and situations which do not display such well-being and which are therefore inevitably seen in pathological terms. Old age is said to be a very good example of this. With such a definition, it is observed, old age could not be seen or assessed as being "healthy." Similarly, a way of life which is conditioned and shaped by a situation of handicap or disability could not be defined as being "healthy."[10]

(c) Still others—and this paper belongs to that category—employ the more relevant and incisive anthropological perspective. This line of thought argues that an approach which sees health as complete well-being and which thus sees health as both a means by which to achieve other ends and as the synthesis of these very ends leads to health's being wrongly identified with happiness. This confusion cannot be left behind if a distinction is not made in relation to the specific level at which health is to be located in relation to the horizon of meaning in its entirety. This is only possible if there is a perception of the relationship between health and happiness which at one and the same time maintains a distinction and detects the mutual interaction.[11]

3. Health and Medicine: Mutual Seductions in the Doctor-Patient Relationship

There is a second ambiguity which must be laid bare and discussed: Is it medicine which tends to treat the needs of the health of the individual in total terms, or do individuals delegate the management of their health needs to medical institutions and structures?

This question brings us back to the provocative theses advanced by Ivan Illich and to the wave of controversy which his views provoked in the mid-1970s.[12] Illich was clearly a supporter of the first thesis: it is medicine, he thought, which tends to take over the health of individuals and to deprive people of the potential ability to face up to, and to deal with, their own health needs at a personal level. In Illich's view, professionally organized medicine had taken on the role of a despotic moral undertaking directed towards planning an expansion of its range of action in the name of a fight against each and every form of suffering. In this authority's opinion, in reality this initiative, despite its humanitarian declarations of intent, had only undermined the ability of individuals to deal with their own health needs and their capacity to integrate into their lives the inevitable wounding, decay, and death which take place within human existence.

Despite the provocative tones

and the set of prejudices which support the thesis that medicine involves a kind of expropriation of health, there is an aspect of this point of view which deserves to be considered very seriously. I am referring here to the strong appeal to consider health as a "virtue," as a personal task which should be shouldered with responsibility, more than as something to be expected from medical doctors and their drugs and medicines. This is the constructive contribution which is to be found in Illich's condemnation, but it is precisely this element which makes clear that his two propositions in relation to "medical power" are no longer sustainable. Indeed, both historical analyses[13] and psychological investigations[14] have made it increasingly clear that resistance to the idea that health should be something placed exclusively in the hands of the individual has not been promoted by medical doctors alone. The opposition to the idea on the part of doctors is only one part of the story. We should also recognize the fact that patients themselves go to their doctors to free themselves of the symptoms of their maladies and do not go to the root of the matter. They refuse to accept part of the responsibility for the process which has led to their illness and thereby do not accept the role of being protagonists of their health. For this reason, although it is true that, on the one hand, as some people have pointed out, an inability to integrate the personal dimension into the clinical relationship has weakened the healing hand of the medical doctor, it is also true, on the other, that such impersonality is very attractive for the patient, for whom a more personal relationship with his doctor—which involves an invitation to become responsible for his own illness—can lead to very difficult questions being asked about the way in which he leads and manages his own life.

4. Health and the Right to Health: the Limits to Institutionalized Solidarity

There is yet another ambiguity in this whole controversy which must be discussed and debated: Should the needs of health be discussed solely in the language of rights, or should it be recognized that there are certain health needs which by their very nature cannot be expressed through such language?

An initial examination of the relationship between health and law must, of course, concentrate on all those cases where the right to health is denied. This is true of all those individuals in a weakened condition who do not have the strength or power to uphold their claims and rights. A very good example of this is to be found in the instance of elderly people who are not independent and who have their right to health denied. Such denials of these rights as do actually take place should be condemned most severely. And yet it has to be recognized that it is not in this area that the greatest difficulty is to be found in relation to the whole question of the relationship between health and human rights.

It may well happen, for example, that institutional solidarity is achieved to the full and that new health or social institutions come into being to care for elderly people who are not independent and who can no longer look after themselves, but that these new institutions—which are perfectly effective from the organizational and healthcare point of view—fail to breach the wall of indifference which separates people and which marginalizes categories which are seen as a burden—categories, for example, such as the bedridden elderly. It is here, in radical form, that this perspective creates difficulties as regards the basic strategy which modern man employs in relation to his health—that is, where health is seen as a right which should be upheld and enforced.[15]

Of great relevance here is the distinction made by the Canadian sociologist Michel Ignatieff in his history of human needs, a work which bears the highly significant title *Other People's Needs. An Essay on the Art of Being Men Between Individualism and Solidarity*.[16] In his analysis Ignatieff makes a distinction between needs which are expressed in the language of rights (political rights or social rights) and other needs which cannot be expressed in the language of rights. Employing this distinction, this author comes to the following interpretation: modernity has produced a concept of the person which is modelled in large part on the idea of individuality and has developed answers which are based upon needs which are rooted in the independence of the individual. It has forgotten, however, those needs which cannot be found in the language of rights and has done so to such a degree as often to abolish them altogether. Although this language is, on the one hand, very well suited to the expression of those claims which an individual can make in relation to, or in contrast to, society as a whole, on the other, it is rather weak as an instrument by which to express the needs of society as a whole in relation to the individual.

This is an interpretation of modernity which is so incisive that it deserves further and deeper analysis in the future. But we should recognize that in relation to the whole process of seeing health as merely a question of the upholding of personal rights it is certainly very convincing. When we consider the increase in demands for care and treatment which are strongly based on the practice of solidarity (such as, for example, assistance to the terminally ill, patients suffering from AIDS in its final stages, and the elderly who can no longer look after themselves), and given the contradiction which exists between these claims which are made on health professionals and staff and the "apathy" which dominates within the society from which these claims are made, the wisdom of Ignatieff's insight is more than evident.

5. The Anthropological Dimensions of Health: An Approach Based upon the "Crisis of the Individual"

If what has been observed hitherto is correct, we are led naturally to understand that the characteristics of this new culture of health, in addition to the contradictions which mark it, should all be seen with reference to a single matrix:

the crisis in which contemporary man presently finds himself. For this reason, it is within the events and developments of the self-construction, self-deconstruction, and self-reconstruction of the individual that we should detect the points at which we should intervene to give substance to a culture of health which is not transient and ephemeral in character. The proposition which I will advance in this paper will become clearer if a more detailed analysis is achieved of the interrelationship which exists between the question of health and the most important features and aspects of the crisis in which we now find ourselves.

5.1. The Growing Belief That Health Is a Task and the Moral Uncertainty of the Individual

The more the belief grows that health, rather than being a natural fact or a mere product of medicine and its application, is in reality a task which each and every individual is called to carry out in a responsible spirit, the more the individual is thus placed at the center of the whole question of health. But what happens to this task if the individual does not want to accept his responsibilities in relation to health or cannot shoulder such responsibilities? It is at this point that in all honesty the real reasons for the failure of so many projects and programs which have arisen in the field of prevention become apparent. For this reason we must achieve a very clear idea of the origins of this weakened ability on the part of the individual.

Of direct and central importance in this area is the ethical competence of the individual. I am referring here not so much to a knowledge of, and respect for, rules and norms, but to the most basic dynamic which is at the root of an authentic ethical competence: a commitment to manage and to be responsible for one's own life. This is the dynamic which expresses and directs the ethical dimension of the individual and opens up the horizon of meaning which can lead to an attitude of responsibility towards personal health. From being an absolute good and thus an inevitable source of obsession (as, indeed, is borne out by its various forms of expression in social life), health comes to be seen as a means by which to achieve the realization of various life projects. In this way of thinking health is certainly a fundamental good, but it is not an absolute good.

Seen in this light, the difficulties which are encountered in perceiving health as a personal task may be understood as a special feature of a more general critical situation, namely, what may be termed "the ethical crisis of modern man." Zygmunt Bauman, one of the most perceptive observers of this crisis, describes it in the following terms: "At the end of the path which modern society has taken in search of a code of ethical rules which are universally valid along the lines of Law, the modern individual is bombarded by requests, options, and desires of a moral nature which are in conflict with one another, and upon his shoulders falls the responsibility for the actions in which he engages."[17]

Ambiguity and fragmentation—such is the direction taken, in Bauman's opinion, in the shift from the modern to the post-modern. "Ours is an age characterized by a deeply-felt moral ambiguity. An age which offers us a freedom of choice which has never before been experienced, but which also throws us into an uncertainty which has never before been so anxiety-inducing."[18] Is it that the rules are not there? No, not at all. Indeed, there are too many such rules for us to be calm and serene. And this is not a matter of mere coincidence or chance. Here we are dealing with phenomena which are intrinsically linked to the modern condition—on the one hand, there is an increasing complexity in criteria of evaluation, and, on the other, there is a fragmentation of roles. The dimensions of evaluation have developed in directions which are ever more distant from each other, and for this reason what was once widely recognized by people as constituting the "right way" has become fragmented into what is seen as "economically reasonable," "aesthetically pleasing," and "morally appropriate." In this way actions can be seen as being right from one point of view, but wrong from another. When one adds to all this the "fragmentation of a form of life which is increasingly divided into a multiplicity of objectives and functions which are weakly bound together, each of which can be pursued in a different context and in a different practical way"[19], one can easily understand how the construction of goals and ends by the individual is undermined and weakened, not least those concerning his ability and capacity to take personal responsibility for his own health.

5.2. The Increase in Health Needs Which Must be Dealt with Collectively by Government and the Difficulties Which Exist in Achieving a Harmony Between the Professional Pole and the Personal Pole

The more the belief grows that there are health needs which cannot be expressed with the language of rights, the more attention is paid to the individual and to what he must do. In this instance, what has to be addressed is the hope which is very much a feature of modern man of being able to manage his health exclusively within and through the language of rights. This aspiration is increasingly being shown to be an illusion, and this happens not so much because of economic restrictions, but because that good which it is thought can be expressed entirely in the language of rights and contract is in reality an inter-individual good which cannot be identified completely with the narrowly individual sphere.[20] An attempt to engage in such an identification is an illusion. This is because as long as there is an individualistic conception of society which sees society as an atomistic construction, the modern idea of the contract will be nothing more than the false idea that what has been found is a suture between severed limbs.

Every attempt of a contract-inspired character will be merely a fragile suture if the interpersonal dimension is not placed at the very center of the individual and seen as a moment of expansion and fulfillment of his personal life.[21] If the "post-modern" perspective involves first and foremost the ripping off of the mask of illusions

and the recognition that certain aspirations and hopes of modernity are false and certainly not objectives to be striven for, then there is perhaps no other situation in which such an interpretation should be applied with greater force.

The illusion in question, which is to be understood in relation to the specific field of health needs, lies in the fact that it is impossible to build relationships based on solidarity as long as the individualistic and atomistic conception of the person continues to hold sway. It is impossible to believe that within a society where the only relationships which are legitimized and recognized are those of a utilitarian and functional character there can also arise healthcare institutions where there is room for more human and humanizing relationships, where, that is, there are healthcare workers who do not see their work as a mere "supplying of a service" and where sick people have not been reduced to "users" and "customers." What is needed—and this point should be greatly stressed—is not a moralistic kind of initiative destined to have no future. What needs to be done, rather, is to become aware of the limits to the atomistic and functional concept of the modern individual. In the health field this concept tends to bestow real dignity on the technical competence and skill of the profession alone, and this reinforces the creation of a therapeutic relationship which is based exclusively on the management of a role. What is the healing value of such a relationship, given new health needs which, rather than forms of medical treatment, in reality require a human presence that is shared?

5.3. The Tendency to Convert Health into a Total Horizon of Meaning and the Weakened Capacity of the Individual to Create and Interpret Symbols

The more within present-day culture there is a tendency to turn health into a total horizon of meaning, the more attention is paid to the individual and what he must do. It is his symbolic capacity which is of direct relevance. But what happens to this symbolic capacity within a social context and a framework of communication which encourage a state of perpetual stimulation and excitement? There is a very real risk that the individual will become blocked in this capacity by an obsessive search for ever more novel forms of stimulus. In the end, this dimension of narcissistic stimulation to which the individual is consigned does not expand his capacity for feeling and enjoyment, but merely creates new forms of dependence or addiction. "Over the last decades it seems that a sociocultural context has been created and developed where every opportunity for excitement and pleasure is seized with greed and speed. It thus becomes a source of dissatisfaction which leads to greater and more intensive exposure to the same kind of stimulation. All the attention of the individual and his social environment is directed towards attractive forms of stimulus which soon become worn out and insufficient."[22]

From a sociological point of view the words of Marco Ingrosso give a very good idea of the significance of the dimension of narcissistic stimulation which modern man risks being sucked into. This interpretation seeks to account for a specific choice which brings about illness—that is, the origins of every form of dependence or addiction. When understood with reference to the point of view adopted by this paper, namely, the crisis of the individual, this interpretation of the social reproduction of dependence or addiction brings out a very important aspect of the crisis of the individual: his weakened ability to create and deal with symbols.

What is the relevance here of the attempt to turn health into a total horizon of meaning? What this aspiration really needs is a strong capacity for symbolizing which enables the individual to rise above the merely physical and draw upon a dimension of higher meaning. Only by this route can reference to health become a symbol which can embrace and express the human horizon in its entirety, capable, that is, of expressing a healthy way of life, a healthy way of coping with suffering, a healthy way of thinking about death, and a healthy way of living, even where there is a condition of handicap and disability. Without such an approach and perspective there is the risk that the emphasis placed upon health, in addition to reducing the horizon of meaning within which the individual conceives and projects himself, will lead to a legitimation of a new concept of "social normality" which is seriously discriminatory in its impact and character. All this is not said in order to ostracize the totalizing importance and influence of health within our culture but to give sound and incisive answers to the question posed by this paper.

Conclusion: From an Anaesthetic Concept of Health to an Aesthetic Concept of Health

If, on the one hand, the contradictions which mark the new demand for health can all be traced back to the "crisis of the individual," on the other, a suitable response to such a demand should necessarily take place within a real empowerment of the individual himself which can strengthen him at those points where evidence shows that he is most exposed and at his weakest. Reference to an aesthetic concept seems, however, not to imply something which is "strong." The aesthetic approach goes beyond a narrowly ethical approach and is generally seen as conforming to the most characteristic feature of post-modern thought, that is, "weak" thought. It is for this reason that we must be very clear about the steps which are being proposed.[23]

The aesthetic concept which is suggested here is understood as constituting at both an individual and an interpersonal level an overcoming of the anaesthetic concept of health, a concept which sees health as that state the individual is in when he runs no risk of being exposed to suffering. In an aesthetic conception of health, in contrary fashion, the specifically human dimension to health lies in a readiness to listen to the language of the body and to decode that language in its double meaning of "means" and "limit"; in a readiness to open

oneself to what is new and to that which has not yet happened, overcoming thereby the fear of losing control; and, finally, in a readiness to learn even during hard times of defeat, disability, and the narrowing of physical space. From the development of this readiness the individual finds a new way of constructing himself, and this readiness is deemed aesthetic in a general way because it promotes an expansion of feeling. In particular, the discriminatory contrasting of health and illness at a merely physical level gives way to a similar opposing relationship between an attitude which is authentically productive and an attitude which is irremediably sterile.

The final meaning of the shift from an anaesthetic conception of health to an aesthetic conception of health is to be found at an interpersonal level. The alternative between aesthetic and anaesthetic, at this level, operates along the lines of the opposition between "empathy" and "apathy." Apathy indicates a lack of readiness to feel and to receive the signals of the suffering of other people. It is something which must be neutralized at any cost. Empathy, in contrary fashion, involves an ability "to put oneself in other people's shoes" and thereby to feel and experience the world as they do.

The implications which this approach has for the practical world of health are more than evident. A new way of thinking and behaving in relation to the therapeutic relationship is opened up by the development of this empathetic readiness. To listen more than to speak, to be present more than to do, to feel more than to act__in short, these are the conditions which at a human level render the healthcare relationship authentically healing. And not only for the patient. From being a subjective good, health becomes an interpersonal good. Not only the good we share most, but also the good which most binds us together.

CORRADO VIAFORA
Professor of Bioethics
at the University of Padua,
Coordinator of the Ethics
and Medicine Project,
The Lanza Foundation, Padua

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Notes

[1] On the methodological principles of the anthropological perspective on health and illness see: P. LAIN-ENTRALGO, *Antropologia Medica* (Paoline, Milan, 1988) and D. GRACIA, *"La Estractura de la Antropologia Medica,"* in Realitas, Trabajos del Seminario Xavier Zubiri 1 (1972-3), Madrid, 1974, pp. 293-397, for the work of two leading exponents of the Spanish tradition of "Humanidades Médicas," and see also H. VAN DER BRUGGEN, *Il Malato. Protagonista Sconosciuto* (Armando, Rome, 1977), a representative and popularizer of the "Nordic branch" of the anthropological perspective, to which belong such important names as Buytendijk and V. von Weiszacker.

[2] For commentary on the "new demand for health," see A. ARDIGO, *"Salute e Diritto alla Salute nella Società in Trasformazione,"* in L'Arco di Giano 4 (1994), pp. 111-125.

[3] F. LAPLANTINE, *Antropologia della Malattia* (Sansoni, Florence, 1988).

[4] *Idem,* p. 229.

[5] D. GRACIA, *"La Medicina nella Storia della Civiltà,"* in *Dolentium Hominum* 1 (1988), pp. 67.74.

[6] A. ARDIGÒ, *art. cit.,* p. 111.

[7] F. FUKUYAMA, *La Fine della Storia e l'Ultimo Uomo* (Rizzoli, Milan, 1992).

[8] See S. SPINSANTI, *Il Corpo nella Cultura Contemporanea* (Queriniana, Brescia, 1982).

[9] For criticisms along these lines, see D. CALLAHAN, *"The WHO Definition of Health,"* in The Hastings Center Studies 1 (1973), pp. 77-87.

[10] For criticisms, see F. ANSCHUTZ, *Medicina Umanistica. Scienza ed Etica per Gurarire* (Città Nuova, Rome, 1991).

[11] Such is the attempt of R. MORDACCI, *"Health as an Analgical Concept,"* in The Journal of Medicine and Philosophy 5 (1995), pp. 475-497.

[12] I. ILLICH, *Nemesi Medica. L'Espropriazione della Salute* (Mondadori, Milan, 1976).

[13] See E. SHORTER, *La Tormentata Storia del Rapporto Medico-Paziente* (Feltrinelli, Milan, 1996).

[14] See S. SPINSANTI, *Guarire tutto l'Uomo. La Medicina Antropologica di V.von Weiszacker* (Paoline, Milan, 1988).

[15] One would not want in the least to question "modern" advances as regards the "right to health." For a detailed discussion of the bases and the development of this right, see P. BENCIOLINI and A. APRILE, *"Il Diritto alla Salute,"* in A. MARTIN and R. NACCARATO, *Diritto alla Salute e Coscienza Sanitaria* (Cedam, Padua, 1989), pp. 1-12 and, more recently, *"La Salute: Diritti e Responsibilità,"* dossier of L'Arco di Giano 4 (1994). See in particular D. GRACIA, *I Diritti in Sanità nella Prospettiva della Bioetica,* pp. 29-44; F. D'AGOSTINO and L. PALAZZANI, *La Dimensione Internazionale del Diritto alla Salute,* pp. 45-53; and A. SANTOSUOSSO, *Gli Sviluppi del Diritto alla Salute in Italia,* pp. 53-75.

[16] M. IGNATIEFF, *I Bisogni degli Altri. Saggio sull'Essere Uomini tra Individualismo e Solidarietà* (Il Mulino).

[17] Z. BAUMANN, *Le Sfide dell'Etica* (Feltrinelli, Milan, 1996), p. 37.

[18] Z. BAUMANN, *op. cit.,* p. 27.

[19] Z. BAUMANN, *op. cit.,* p. 12.

[20] See the comments and observations of A. Autiero.

[21] I am referring here to the communitarian personalism of E. Mournier.

[22] M. INGROSSO, *"La Nostra Salute verso l'Anno 2000,"* in AA.VV., *Salute. Malattia* (Cittadella, Assisi, 1996), p. 37.

[23] I am following on here from M. INGROSSO, *op. cit.,* pp. 63-70.

DIEGO GRACIA GUILLÉN

The History of the Concept of Health

Introduction

The concept of health is so inseparable from the concept of illness that it cannot be defined without reference to the latter. Human beings become aware of health through their experience of illness. It is for this reason that health is usually defined in negative terms, as the absence of illness, the silence of the organs, etc. Popular wisdom observes that you appreciate health more when you do not have it. We have before us a paradox: a negative value, illness, bestows a positive connotation on health.

Furthermore, the values of health and illness have gradually changed their meaning, or have been defined in different ways over the course of history. We can distinguish at least three separate phases in the history of civilization in this respect. The first, that of primitive cultures, sees illness in terms of "ill-fortune" and health in terms of "good fortune." In a second phase health is seen as "order," and illness is seen as "disorder." The third phase perceives health as "happiness" and illness as "ill fortune." My paper will examine these three stages in the definition of health and illness. In the conclusion I will seek to reflect upon the meaning that these two concepts of health and illness have in our present-day situation—that is, here and now.

1. Primitive Cultures: Health as Good Fortune and Pain as Ill Fortune

The etiological texts of the great Mediterranean religions, and in particular those to be found in Judaism, usually attribute pain to sin.[1] The Book of Genesis may be cited as an example. Yahweh creates man in his image and likeness and places him in an earthly paradise. But man commits sin and as a punishment begins to experience pain, illness, and death. The Lord God says to the woman, "I will greatly multiply your pain in childbearing; in pain you shall bring forth children."[2] And to the man the Lord God declares the following.

> Cursed is the ground because
> of you;
> in toil you shall eat of it
> all the days of your life;
> thorns and thistles it shall bring
> forth to you;
> and you shall eat the plants
> of the field.
> In the sweat of your face
> you shall eat bread
> till you return to the ground,
> for out of it you were taken;
> you are dust,
> and to dust you shall return.[3]

When placed in their rightful context, these texts well demonstrate that for the author there are two situations or basic states in the life of man: the "state of grace," which was enjoyed by Adam and Eve in the earthly paradise, and the "state of disgrace." The first is accompanied by health, beauty, immortality, material prosperity, and so forth. The second, on the other hand, is characterized by the exact opposite: pain, illness, death, poverty, etc.

The primary religious experience is always that of the freely given, or of grace, which by definition is something which is not gained by merit. Here we encounter the fundamental difference between religious experience and moral experience—the latter is the experience of that which is gained by merit. What is freely given is not won by merit. That which is won by merit is not freely given, but we can deserve a gift which is not won by merit. This means that in religious thinking the religious dimension is always deeper than the moral dimension and its basis. This is the meaning of the term "sin"—a negative moral response to a gift which has been received. For primitive peoples this is the root of all forms of "ill fortune," including physical ills, pain, hunger, disease, and death. Thus it is that negative physical elements, such as pain, are seen as the outcome of a moral failing: sin.[4]

The critique of this theology of grace and disgrace is not formulated clearly until the moment of Job's poem. In this text we encounter the story of a just man who—there can be no doubt—feels destroyed by suffering. Job falls ill, but cannot find a sin within his own life to which he can attribute this condition of disgrace:

> Like a slave who longs
> for the shadow,
> and like a hireling who looks
> for his wages,
> so I am allotted months of
> emptiness,
> and nights of misery are
> apportioned to me,
> When I lie down I say,
> "When shall I arise?"
> But the night is long,
> and I am full of tossing till
> the dawn.

My flesh is clothed with worms
and dirt;
my skin hardens, then breaks out
afresh.[5]

The author of the Book of Job is an innovative theologian who comes into conflict with the traditional thesis that pain and ill fortune are the consequence of sins which have been committed by the sufferer. It is for this reason that the protagonist of his poem, namely Job, does not see sin as the cause of so much evil. Job's three friends, Bildad, Eliphaz, and Zophar, represent traditional theology and thus present a contrary view. They go on recriminating Job for his lack of piety and for not accepting the traditional doctrine of justification.

The last draft of the Book of Job is very late and comes approximately from the third century BC. For this reason we might propound the view that the idea that pain and illness are the results of sin had at that time entered into a state of crisis. The way in which another Mediterranean culture, namely ancient Greek culture, had already addressed itself to this whole question, was not unknown to the Judaism of this period.

2. Ancient Culture: Health as "Order" and Pain as "Disorder"

The originality of Greek culture was to be found in its interpretation of reality in terms of "nature" *(physis)*. Things were not to be understood with reference to the "grace/disgrace" schema, but in terms of the "natural/anti-natural" frame of reference. As a result, health is not seen—at least in such an immediate way as in other Mediterranean cultures—as a "gift" or "grace," but as something which is "natural." Thus illness and pain are not interpreted as being, as they were before, "guilt," "disgrace," or "sin." They are seen, instead, as being "anti-natural" realities.

On the basis of these fundamental principles established by the pre-Socratic thinkers, it was indeed in ancient Greece that Western medicine was born. Hippocratic medicine was different from the medicine of the other peoples of the Mediterranean area in that it saw health and illness in terms of "nature." Nature was "order" (cosmos), and illness and pain were "disorder" (chaos). Alcmeón of Croton declared the following in the text which initiated modern science.

> The maintenance of health is due to the "balance" (*isonomia*) of the forces: dampness, dryness, cold, heat, bitterness, sweetness, etc. The contrary is also true, and the "domination" (*monarchia*) of only one of these produces illness.[6]

Health, like happiness, is to be found in natural order, and illness and pain are to be found in anti-natural disorder. A text by Aestobeus tells us that Democritus

> "gave other names to happiness (*eudaimonia*) such as: *euthymia* (good spirit), *euestos* (well-being), *harmonia* (good temperament), *symmetria* (proportion, balance), and *ataraxia*.[7]

The physiological order (*harmonia, isonomia*)—that is, what the Hippocratic physicians defined as being health—was also intimately bound up with *ataraxia* and with happiness. It was said that health, balance, *ataraxia*, and happiness were "natural" or "physiological" phenomena, in the same way as illness, imbalance, passion, and pain were "anti-natural" or "pathological" phenomena. A passage from the Hippocratic tract entitled "On the Nature of Man" is very revealing about this line of approach. It reads as follows.

> The human body contains blood, catarrh, yellow bile, and black bile. These are the basic constituent parts of human nature and the cause of illnesses and health. A person has good health when these elements are suitably balanced in their mixture, force, and quantity, and when their proportion is right. Vice versa, pain is felt when an element is in excess or lacking, or when one of them becomes separate and is not in the right proportion to the others. This is because if one of them becomes separated and manifests itself in a pure form, not only does this cause pain and disturbance in the part of the body from which it has separated, but also in that part of the body where it has become localized in its pure form and where it has spread because of the excess of secretion.[8]

This piece is interesting because it seeks to provide a physiological explanation of the phenomenon of pain. Natural or balanced things do not give rise to pain. This occurs when there is a disproportion, caused either by excess or by a deficiency—when, that is, a "disorder" is produced, which always involves, in some way or another, an "unnaturalness." Another Hippocratic text declares that

> "pains always occur when there is a transformation and corruption of nature. Pains are cured by their opposites."[9]

Galenus adds the following.

> All of us need health in order to conserve the functions of life, which are attacked, impeded, and terminated by illnesses. In addition, we have equal need of liberation from that which bothers us, for we are gradually weakened by pains. The healthy constitution is one where pains are not felt and where the functions of the living being are not impeded in their workings.[10]

The consequence of this was that pain could not have a "natural" or "positive" meaning in medicine or in ancient Greek culture. Pain was always negative. For this reason, the fight against it had an almost religious significance. The Latin saying *Divinum opus sedare dolorem*, which clearly has a Hippocratic origin, is fully in line with this approach. And in the work *On Art* we read that

> "the aim of medicine is to eliminate the suffering of the infirm."[11]

The Hippocratic crusade against pain had deep theological roots. The ancient Greeks defined God as perfect nature and thus as the fullness of order, unity, goodness, beauty, and, obviously enough, health. The manifestations of

speech, happiness, and thus health are consubstantial with the God of the ancient Greeks. In God, therefore, pain, illness, and death are not possible. If he is God, he cannot suffer, and if he suffers, he is not God. The Stoics established the principle that by definition God must be *apathés*, or "impassive." *Pathos* always implies imperfection. God cannot be a being who is "patient" in relation to something because this would be to admit that he needs something external to himself, and this, of course, implies imperfection. To suffer is to be imperfect. God cannot be defined through the category of passiveness, but through its opposite—that of action. As a result, he is seen and defined as being "pure action."

The "apathetic" God does not have affections precisely because he cannot be interested in something which is outside him. Stoic theology praises, in particular, two features of the human psyche in approaching God, intelligence and will, but not affections and feelings. God can neither feel nor suffer. It is for this reason that we never hear of God suffering. And because, at the same time, the wise man must imitate God (this is what the term "philo-sopher," imitator of wisdom—that is, of God—refers to), this means that the wise man, too, must free himself of every feeling, whether positive (a feeling of pleasure) or negative (a feeling of pain). This is the "purifying stage" of his spiritual life. As a consequence of this procedure, intelligence understands the dictates of the *logos* (the "enlightening stage") much better, and the will becomes united to this latter ("unitive stage"). At a certain point, Stoicism and Neoplatonism came together in the search for this ideal of detachment from the feelings and the affections, and in the pursuit of "pure" and "perfect" wisdom. The result was *ataraxia* or "imperturbability," which Sextus Empiricus defined as "serenity and the calm of the soul."[11] Seneca, for his part, called it *tranquillitas animi*. The man who could remain impassive even when the whole world collapsed around him was seen as wise. Here there was no place for "pain," which, indeed, was seen as an "impure" and "imperfect" sentiment.

The appearance of Christianity in part brought a change and in part brought continuity. It represented a fracture with the past in that the Christian God, Jesus, is not an "apathetic" God, but, on the contrary, a "pathetic" God. The passion of Jesus in this sense is a theological paradox, almost an example of blasphemy. One can thus well understand why it was that when St. Paul referred in the Areopagus to a God who suffered his passion and death, the Stoics and Epicureans who were listening to him made fun of him and engaged in mockery. This is an event described to us in the Acts of the Apostles.[13] For the Stoics and Epicureans, to speak of the death of a God was to proclaim oneself an atheist. One can thus more readily understand why it was that the early Christians were often accused of being atheistic. In his *Apologia*, Justine says that

> "for this reason as well we were described as being Atheists, and if it was a matter of such gods as these, then we were indeed without gods."[14]

And he continues,

> "Given that we are not atheists—an atheist being someone who in the fullness of his capacities does not profess belief—when we worship the God of this universe who, as we have been taught, has no need of blood, sacrifices, or incense, who are we really glorifying—according to the strength we have—with words of praise and actions which render thanks quite beyond the offerings we make...? And then we demonstrate that we also rightly honor Jesus Christ, who was our teacher in these things and was born from Him, the very same who was crucified under Pontius Pilate, procurator of Jude at the time of Tiberius Caesar, who we learnt was the son of the same true God and whom we place in the second place, like the prophetic Spirit, whom we place in the third. Here, in very real terms, we are accused of madness when we say that we give the second place after the immutable God, who always is and who created the universe, to a crucified man; they ignore the mystery which is in him.[15]

These quotations from the apologist Justine clearly demonstrate how new—at the beginning of the second century after Christ—was the message of a "pathetic" God who had suffered passion and death. There could be no greater fracture with the Stoic tradition. Despite this fact, speculative theology continued on its way until it found a "natural" or "physiological"—that is, "Greek"—explanation for the great newness of the Christian vision. The route discovered lay in a distinction between the two "natures" of Christ, the divine nature and the human nature. Only the second was vulnerable and mortal. For the first nature the whole of the inheritance of Greek apathetic theology continued to be used to the full. Furthermore, it was also possible to affirm that there were two natures in Christ, an apathetic nature and a pathetic nature. And, to the question as to why God was made flesh in the pathetic nature, it was possible to answer, following the tradition espoused by the people of Israel, that after the first sin man had fallen into "disgrace" and needed a redeemer who could remedy this condition.

Jesus suffered his passion and his death, thereby "de-naturalizing" himself, in order to restore the "state of grace" to man. The result was what the medieval theologians called *status naturae lapsae et reparatae*. When the state of nature falls, man continues to experience pain, illness, and death, despite the redemption. But when nature is repaired, man will be removed from sin and called to divine filiation. The redemption which Christ obtains through his passion and death bestows a new dimension on pain which is strictly positive in character, the salvific dimension. There is no reason why this should only be the consequence of sin. It should also be, and principally be, a positive ingredient of following and identifying with Christ along the path which leads to the Kingdom. For this reason, in pain as well,

"this is why there were manifested in him the works of God."[16]

If Christian speculative theology during the medieval period was to a large extent Greek, this is all the more the case with practical theology. The Neoplatonic ideal of detachment from the body through the negation of the affections was at the root of all ascetic theology. Only after the achievement of a state of nonvulnerability was it possible to advance in spiritual life through the enlightening stage which in turn culminated in mystic union. The ideal of the holy Christian conserved the principal features of the Greek ideal of the wise man. Thus one explains, for example, why St. Augustine defined peace as *tranquillitas animi*, with exactly the same meaning as Seneca and the Stoics. Only in figures who were very remote from the Greek tradition, such as Francis of Assisi, was it possible to detect something which was really outside these approaches, and it was these latter which shaped, for example, the Benedictine and monastic ideals.

3. Modern Culture: Health as "Good Fortune" and Pain as "Ill Fortune"

With the appearance of modernity there emerged the beginning of a new framework of interpretation in relation to the reality of pain. Modern men, beginning in large part in the eighteenth century, began to become aware of the fact that pain and illness could not be interpreted in terms of "disorder."

It began to be thought that pain was as much a "natural" fact as good fortune. It was thought to be mere theory, and a false theory, to think, as the ancient Greeks did, that nature was in itself ordered and that every disorder was antinatural. In the preface to his book *Medical Observations on the History and Treatment of Chronic Illnesses*, Thomas Sydenham made the following observations.

> Hitherto there has been no complete history of illnesses, chiefly because many people thought that they were the confused and disordered outcome of nature, badly treated by itself and deviating from its natural state and were thus persuaded that it would be a waste of time to write a history of illnesses in an incomplete fashion.[17]

Not even the natural history of illness was studied, because maladies were always seen as deviations from the natural state of nature and understood as abnormal, disordered, and confused alterations—that is, as unnatural realities. It was only from the moment when illness began to be seen as being as natural as health that it was possible to apply the methods of natural sciences to the study of illness. It was only then that pain and illness could be seen as being something which was "natural."

If pain is "natural," then it cannot be interpreted as something which arises from "disorder." But at the same time it is not easy to define it in conceptual terms as a "disgrace." Modern man has slowly gained an awareness of his own independence and has learnt how to distinguish, differently from the Medieval schools, immediate causes from remote causes.

To interpret pain as a disgrace is to see it from the medieval perspective—that is, with reference to its remote causes. In the perspective of immediate causes—or, to use other terms, with reference to daily or earthly elements—pain cannot be seen as a disgrace but as something very different, as "ill fortune." In this way of thinking, there can be no doubt that pain is something which is negative in human existence, but this negativity is not primarily a matter of disgrace or disorder, but of good or ill fortune. What pain does is to endanger the well-being and happiness of earthly man. From the standpoint of disorder, illness comes to be conceptually defined as a "fact." From the standpoint of ill fortune, it is seen as a "value." This, perhaps, is one of the great modern developments, involving as it does the opposition between the idea of a value and the idea of a fact.

Already present in the work of Hume, this element subsequently had a fundamental importance in the whole of the history of Western culture. Health is no longer primarily a question of fact, but a matter of values.

As has already been observed, by good fortune we mean the world of value. Good fortune is a positive value, and ill fortune is a negative value. Naturally enough, these values come to be defined with reference to individual, social, and historical frameworks. Thus it is that in the final analysis the definition of good fortune must be personal, and there are many different definitions of this term, involving, as they do, life projects, ideas of happiness, and value choices.

All these different value choices can be categorized according to very separate methods. One of these is to make a distinction between those who see in good fortune merely an enjoyment of life and those who perceive good fortune—and its opposite, ill fortune—as being something which goes deeper and touches upon the meaning of life itself. The first approach may be termed "immanent" in relation to good fortune (or to this value), and the second may be seen as being "transcendent." In general, the first has been more keenly adhered to in the popular mind and very much bound up with earthly considerations. The second has usually been seen as a characteristic of chosen spirits. In Spanish literature the first is represented in paradigmatic fashion by Sancho Panza, and the second, by Don Quixote.

These two kinds of mentality see pain in radically different ways. For those who subscribe to the approach which we have described as transcendent, pain is seen as a formal constituent element of human nature. Man must learn to rely upon pain. Man without pain is not a man. In contrary fashion, those who absolutize the concept of good fortune adhere to a diametrically opposed point of view: pain is the only thing which disturbs our good fortune, and for this reason a ceaseless and unremitting struggle must be waged against it. It should be pointed out that this approach gradually became established within Western culture through a gradual process whereby the progress of modern science was followed by the belief that scientif-

ic discoveries would enable us to abolish pain and thereby to construct a world without misfortune. I will now investigate in greater detail the characteristics of these two separate approaches to pain and suffering.

The approach which absolutizes the concept of fortune sees happiness as the result of the highest level of well-being and the achievement of a total absence of pain. Authentically scientific medicine must therefore dedicate itself to these outcomes. During the sixteenth century Descartes wrote his *Project for a Universal Science which Elevates our Nature to the Highest Level of Perfection*, a work which was later published under the title *Discourse on Method*. In this volume Descartes teaches that scientific medicine must make us "masters and owners of nature." He goes on to say that "this is much to be desired, not only because of the infinite number of instruments which would enable us to enjoy the fruits of the earth and all the benefits that it offers us without any kind of work at all, but also, and principally, because of the maintenance of health, which is, without doubt, the first and fundamental good of the other goods of this life, because the spirit itself depends on both the temperament and the disposition of the organs of the body. If it is possible to find some means to ensure that men are generally wiser and more able than they have been hitherto, I believe that this is to be looked for in medicine."[18]

In the view of this philosopher, medicine was the fundamental science of the art of avoiding pain and achieving perfection and good fortune in this life. Descartes was well aware of how little medicine was able to do in this direction during his times, and dreamed of dedicating himself to the establishment of a new medical science. The passage by Descartes quoted above continues as follows.

> "It is certainly true that the medicine practiced at the present time has very few useful things. But without thereby wishing to devalue it, I am certain that there is nobody who has made of it their profession who does not know that in this science there is to be found nothing which is to be compared to what one wants to discover, and that we could free ourselves from an infinity of illnesses, both of the body and of the spirit, and perhaps also of the weakness brought to us by old age, if we gained sufficient knowledge of their causes and all their remedies, which nature has supplied us with."[19]

There thus was born the belief in the infinite progress of mankind through the work of science, and more specifically the idea that medicine, within a short period of time, could deal with pain and defeat. A century after Descartes the ideology of progress overturned all previous certainties. "The time seemed to be drawing near," writes Paul Hazard, "when Ormuz, the god of good, was about to finally triumph over Ariman, the god of evil." At the end of the century, in 1794, Antoine de Condorcet, in his *Text of a Historical Picture of the Progress of the Human Spirit*, wrote that "nature has placed no limit on our hopes" and that for this reason there were few things that man would not achieve in time. "Without doubt man will not become immortal; but the distance between the moment when he begins to live and that in which, naturally, without illnesses, without misfortunes, he begins to experience the difficulty of being—could this not grow greater without end?"

John Bury writes that "between 1870 and 1880 the idea of progress became transformed into a thesis of faith for mankind."[20] One of its most evident expressions was Compte's law of three stages. And when Compte fell out of fashion—and we are referring here to this century—the belief that medicine would manage to provide us with complete and perfect good fortune never ceased to grow in importance. Indeed, in 1946 the World Health Organization was able to define health, at its foundation, as "a state of perfect physical, mental, and social well-being, and not merely the absence of illness." The dystopia of a happy world along the lines described by Aldous Huxley seems to be possible. We have arrived at a "well-being society," or "welfare state," and we are very close to a "perfect welfare."

Similarly, we continue to favor the consumption of health, understood in terms of good fortune. In this way health has become the only and ultimate moral criterion—that which produces health and welfare is good (that is, good fortune) and that which does the opposite is bad.

This explains why since the middle of the nineteenth century medicine has seen the "unremitting struggle against pain" as a moral imperative. Pain is an evil because it means ill-being and defeat, and thus must be exterminated. The whole of the "culture of well-being" is based upon this attitude. It is probably not possible to understood the complicated cultural and human fact of drug-addiction without an awareness of these structural characteristics of our environment. In a society which absolutizes well-being, and which defines it as the absence of every kind of physical, mental, and social pain, drugs are probably the only suitable instrument by which to obtain happiness. They are also a paradigmatic example of the paradoxes brought about by our concepts of happiness and well-being. When good fortune becomes an obsession, people suffer the misfortune of good fortune. In the same way, an obsessive search for health is in itself an illness, an illness of health. Years ago Ivan Illich described this phenomenon with the phrase "medical nemesis." Health and good fortune have become an aberration, and in this way medicine has begun to constitute a serious danger for the health of men.

The phenomenon of drugs itself demonstrates that this way of thinking is full of inconsistencies and paradoxes. This explains the fact that throughout the modern world there are accusing voices which maintain that pain has a highly positive aspect—namely, to remind man that his condition is finite and transient. Pain, in this line of approach, is what opens up the horizon of the infinite and the transcendent. The general thesis is that pain spiritualizes, elevates, and makes us better men. Well-being makes us live in everyday reality, just as ill-being leads us to relativize it, to touch the depths, and to place ourselves within the horizons

of ultimate things__that is, the transcendent. For this reason, Karl Jaspers affirms, suffering is a "limit-situation" which makes us touch the bottom of existence and opens up the horizons of the transcendent. Pain does not always dishearten—indeed, it can make us more noble. Nietzsche wrote that "only great pain is the ultimate liberator of the spirit." Rilke, for his part, in one of his writings analyzed the "bad" character of pain and observed that in German the word *schwer* has the double meaning of being both "bad" and "the center of gravity." Pain provides us with our center of gravity. In a way this echoes St.Augustine's *pondus meum, amor meus*.

In Spanish poetry we can encounter very many similar sentiments and observations. Lines written by Valle Inclán read as follows.

Sadness is a divine inheritance,
sad heart, good heart.
Only pains make aware,
pain is the science of Solomon.

And Antonio Machado wrote the following very striking poem.

Yesterday they were my pains
like worms of silk
which wove weaves.
Today they are black butterflies.

From how many bitter flowers
have I drawn white wax!
Oh, the time in which my pains
worked like bees!

Today they are maddened
bagpipes,
or sown discord,
like blight on ears of corn,
like a worm in wood.

Oh, the time in which my pains
had good tears,
and were like water from
the well
which irrigates an orchard!
Today they are waterfall water
which takes lime from the land.

Pains which yesterday made
my heart a hive
today treat my heart
like an old wall:
they want to demolish it,
and right away,
with the blows of a pickaxe.

This passage from Antonio Machado well demonstrates that not all pains are bad. There are pains which make us more noble and there are pains which abase, pains which can be borne and pains which cannot. For this reason, when we tackle the subject of pain, we should employ a certain "discrimination" of understanding. The old idea of a "discriminating mind" emerges here with a new significance. In this line of thinking aesthetics and ethics also take on a new meaning. We encounter aesthetics of pain which cannot be based upon the old Stoic doctrine of *sustine et abstine*, but upon the principle that pain is a constituent element of life without which it is impossible to be fully aware of what it means to be a man.

This new approach to pain also involves a new ethical attitude. The ethics of modern culture are based upon concepts of "independence" and "right" in the same way that ancient culture was rooted in concepts of "natural order" and "virtue." This enables us to understand why it is that in the new ethics of pain the fundamental principle we encounter is that of respect, within suitable limits, for the wishes of the patient. Only the individual himself can decide about his own pain because only he can give it meaning. Today this is not a mere *pim desiderium*, but a fundamental human right which the whole world is obliged to respect.

Finally, we should recognize that this new approach to pain also involves a specific theology. During the medieval period pain was always interpreted in terms of the theology of the "remission" of punishment. Through his suffering Jesus paid our punishment, and when we suffer we do something similar. Suffering in this world redeems the punishments of the hereafter. There is a "commerce" of pain and an "economy of pain". In his work *Ecce Homo*, Nietzsche observes how Christianity has been interpreted by many people as being something which is purely commercial—everything is done with a selfish end in view. Given this situation, one can well understand why contemporary theology has made great efforts to overcome these traditional approaches. Some theologians have sought to do this through the elaboration of a new *pathetica*. Such is the case with Kazoh Kitamori and Jürgen Moltmann. Others, and in my opinion with greater success, have striven to produce what we can describe as a new form of "neoethics" of the problem of evil. These approaches well demonstrate that the question of the theology of pain can be placed in categories which are very different from those employed by the ancient Greeks and the citizens of the medieval period. Pain is not seen in relation to the category of order, but with reference to the finite. Employing this point of departure, it will be possible to elaborate a new theology of redemption.

Dr. DIEGO GRACIA GUILLÉN
Professor of the History of Medicine at the Complutense University, Spain

Notes

[1] See P. RICOEUR, *Finitude et Culpabilité* (Paris, Seuil, 1960).
[2] Gen 3:16.
[3] Gen 3:17ss.
[4] PEDRO LAIN ENTRALGO, *Enfermadad y Pecado* (Barcelona, Toray, 1961).
[5] Job 7:2-5.
[6] H. DIELS and W. KRANZ, *Die Fragmente der Vorsokratiker* (Berlin, Weidmann, 1972), vol. 1, pp. 215ss: 24 B 4.
[7] H. DIELS and W. KRANZ, *Die Fragmente der Vorsokratiker*, vol. 2, p. 129: 68 A 167. Cf. J. MARIAS, "Ataraxia y Alcionismo," in J. Marías, *Obras Completas* (Madrid, Revista di Occidente, 1969), vol. VI, p. 442.
[8] HIPPOCRATES, "Nature of Man", 4, in W.H.S. Jones (ed.), *Hippocrates* (Cambridge, Mass., Harvard University Press, 1979), vol. 4, pp. 11-13.
[9] HIPPOCRATES, "De Locis in Homine," 42, in E. Littre (ed.), *Oeuvres Complètes d'Hippocrate* (Amsterdam, Adolf M. Hakkert, 1962), vol. 6, p. 335.
[10] GELNUS, "De Sanitate Tuenda," I, 5, in C.G. Kühn, *Claudii Galeni Opera Omnia* (Hildesheim, Georg Olms, 1965), vol. 6, p. 18. Cf. R.M. MORENO and L. GARCIA BALLESTER, "El Dolor en la Teoría Práctica Médicas de Galeno," in *Dynamis*, 2, 1982, 18.
[11] HIPPOCRATES, "The Art," in E.T. Wittington (ed.), *Hippocrates* (Cambridge, Mass, Harvard University Press, 1968), vol. 2, p. 193.
[12] J. MARIAS, *Obras Completas*, vol. 6, p. 439.
[13] Acts 17:16-32.
[14] ST. JUSTINE, *Apologia*, in D. RUIZ BUENO (ed.), *Padres Apologistas* (Madrid, BAC, 1979), p. 187.
[15] ST. JUSTINE, 1979, pp. 193-4.
[16] John 9:3.
[17] T. SYDENHAM, "Observationes Medicae Circa Morborum Acutorum Historian et Curationem," in P.L. ENTRALGO (ed.), *Sydenham* (Madrid, CSIC, 1956), p. 74.
[18] DESCARTES, *Discorso sul Metodo* (Buenos Aires, 1938), p. 87.
[19] DESCARTES, *ibid*.
[20] J. BURY, *La Idea de Progreso* (Madrid, Alianza, 1971), p. 309.

FRANCESCO D'AGOSTINO

The Person and the Right to Health

1. That *the right to health* now has its place among fundamental rights is not only a question of fact which can be demonstrated empirically through a consideration of the large number of "charters of rights" which include it, but it is also, and much more, a *principle of interpretation* of the times in which we live, a "statistic" (to use Jaspers' phrase) which allows us to achieve a better focus by which to understand the juridical-social dynamics of the modern age, but also, and at a more general level, to comprehend the way we understand ourselves. As is well known, this is a sociological-cultural development (or perhaps even a spiritual one) which is relatively recent, but which by now is absolutely rooted in the consciousness of modernity.

2. What is the basis for this "right to health"? A question of this kind is not ingenuous, nor should it be seen as a mere appeal to common sense which puts "being well" at the top of any possible or conceivable hierarchy of "values." We are dealing here with an essential question, if only because it is posed before the elaboration of any kind of analysis of this right carried out in juridical terms (if, for example, this right is individual or collective, promotional or repressive, if it is "implementable," etc.) or from a sociological perspective (that is, how much the defense and/or promotion of this right has a real effective character at the present historical time and in what geopolitical contexts). Furthermore, it is noticeable how the same scientific approach by legal experts to the category "the right to health" is often lacking in a full awareness of what its specific epistemological context really is. This is a context which is by its *constitutional nature relational* (an expression where the emphasis must fall on the expression "constitutional nature"). This context could at first glance appear to be banal and self-evident, and could for this reason give rise to possible and unwelcome misunderstandings.

It is indeed clear that an immediate (and superficial) examination produces the view that the manifestation of illness—at least at certain levels of importance—opens up *obvious* relational dynamics (between those people who need treatment and those who are responsible for supplying such treatment, between those who cause harm to health and those who receive such an injury, etc.) which themselves have *obvious* juridical consequences. But they are not by their *constitutional nature* relational dynamics—indeed, they appear to be in a certain way secondary and derivative. They seem to lay stress, notwithstanding the appearances, on an elusive self-referential *a priori*—"being well" and "being not well" appears, on rigorous analysis, as absolutely personal and subjective states whose very interpersonal communicability, if seen from the perspective of objectivity, appears to be very arduous and problematic.

In other words, there is no common yardstick by which to measure the well-being produced by "health" or the ill-being produced by "illness." What comes to be defined is not the "well-being" or "ill-being" in itself but the well-being or ill-being *induced* by relational dynamics which appear to be, for whatever reason, *sanctionable.* When a judge is called upon to establish the compensation due to someone for damage caused to that person's health by an act which is considered wrong committed by a third party, he must—as is well known—refer to absolutely *extrinsic* criteria (the length of the hospital stay, the level of the loss of organic functions, etc). Obviously enough, he cannot do otherwise. When during a dispute he is called upon to establish (although such cases are rare) the correct fee which the medical doctor can ask from the patient he is treating, the judge adopts criteria which are fundamentally sociological and economic in character. In practice, such criteria do not have any specific connection with the diagnosis carried out by the doctor or with the *existential* relevance of the therapy suggested to the patient and then implemented by the physician.

Thus, for example, a correct diagnosis of pneumonia and the application of a correct treatment—which involves, for example, a limited number of visits by the doctor to the patient's home—on the one hand, can at the level of the "historical" evolution of events objectively save the life of the patient but, on the other, do not seem at a strictly juridical-social level to entitle the doctor to receive extremely high fees—that is, it is as if being well and not being well involved in themselves and *per se* an experience of the person which was absolutely *private.* At a social level what acquires significance is not the intrinsic nature of these phenomena, but their expression in relational dynamics. Or to be even more precise: it is as if being well or not being well were strictly *nat-*

uralistic and therefore *pre-juridical* and *pre-social* dynamics, and as if they acquired juridical and social relevance only when they involved effective contents of *ex contractu* or *ex delicto* interpersonal experiences. This is the paradigm which underlies one of the most widely held bioethical models of our times—that elaborated and proposed by H.T. Engelhardt Jr.[1]

3. Today this paradigm is no longer sustainable. The relational character of the right to health has a deeper and at the same time more radical connotation. And it is this connotation which explains the entry of this right to health into the list of fundamental human rights and its universal diffusion. To paraphrase Rawls[2], we could say that the fact that some people enjoy good health and that others have bad health (whatever the reasons for these respective states of affairs may be) cannot be defined as being either right or wrong. They are dynamics which should be understood with reference to fortune, or to employ the phrase chosen by Rawls, seen as a kind of "natural lottery." What, on the other hand, can be seen as being right or wrong is the way in which these facts are treated and dealt with within the global system of social relations. Indeed, independently of who or what the *ill-being* of a person might possibly be attributable to, it is the fact itself of the existence of this ill-being which has acquired in the consciousness of our time a new absolute relevance—that of being a *question of justice.*

The *relational* perspective on the character of the being of man—which seems increasingly to be a basic feature of contemporary anthropology—means that illness, like health itself, cannot be seen according to the case in hand as acts of ill-fortune or as "private" benefits to which individuals are subjected by the work of some blind or obtusely active "nature." Health and illness define our being in the world as persons in relation to each other or are indices not of the opportunities we have to relate to the world (elevated to the case of health, poor health, or, as in the case of illness, to absent health), but of the general constitutive character of the world. In other words, illness and health are not refracted in the personal sphere of individuals, but are reflected in the possibility that in general *there are individuals,* and individuals who only beginning with rationality (and the effective level of such rationality) manage to construct a world of meanings. This means that health and illness do not precede a relation, but compose it. Or, if it may be put another way, it is possible to refer to illness and health solely because they in exist in relation to one another.[3]

In this way the right to health comes to acquire a new significance. This is something which by now has entered definitively into the collective consciousness, even though it is not always seen as such. This significance is bound up with the identity itself of the human person. In seeing health as a *right,* in the final analysis the individual claims the right to be recognized in his own identity, and this is a right which is based not upon nature but upon relationality. In recognizing health as a *fundamental human right,* the juridical system (beginning with the international juridical system) recognizes and *takes seriously* the shared and equal subjectivity of each and every human being.

The new paradigm of subjectivity which is here perceived through reference to the right to health does not have a primary ethical value, nor does it have a political-pragmatic value. It has an epistemological value. What is of immediate importance is not the "humanization" of medicine—that is, withdrawing or reducing its *cold* image of abstract scientific knowledge in order to lead it back in paranetical fashion to that much *warmer* environment of a *culture of welcome*[4]. This objective and many others are obviously to be striven for and must be striven for, but they will be much more realizable if they are based upon an image of man which is epistemologically adequate. The paradigm of the right to health, seen as a *fundamental human right,* helps us to construct this image in the right way. The fundamental right to health should not be seen in terms of compassion or more generally with reference to fraternal solidarity—to compassion and solidarity vast spaces of implementation are given which do not, however, completely coincide with the anthropological context of the juridical and the social. This context is the only one where the idea of *rights* has a meaning and appears to be feasible and is that of our identity as a relational identity—that identity which each one of us acquires in referring himself or herself to another person, through the other person and with the other person, and through which our personal physical-biological history takes on all its value.

Professor FRANCESCO D'AGOSTINO
Ordinary Professor of the Philosophy of Law, Tor Vergata University, Rome

Notes

[1] See his well-known textbook, *Manuale di Bioetica* (Italian edition, Milan, 1991).

[2] J.RAWLS, *Una Teoria della Giustizia* (Italian edition, Milan, 1982), p. 99.

[3] This means that the very categories of "health" and "illness" are *anthropological* categories which only *by analogy* can be extended to living creatures that are not humans. The assertion that animals in the proper sense of the term *do not fall sick* just as they *do not die* does not imply a devaluation of the life and dignity of animals. This is because not only do they not have the opportunity to conceive as a future experience the state of "no longer being" but more in general because they are not aware of the *pathological* character (in the sense of what is *unnatural)* of their possible "not being well." And given that for animals it is not appropriate to speak about *rationality* in the true sense of the term, so in the same way is it not possible to attribute to them experiences or connotations which require, *a priori,* a relation.

[4] On this question see the important observations of F. Rotturi, "La Medicina come Prassi della Cultura dell'Accoglienza," in P. Cattorini and R. Mordacci (eds.), *Modelli de Medicina. Crisi e Attualità della Professione* (Milan, 1993), pp. 105-112.

BONIFACIO HONINGS

Christian Morality and Complete Health

A moral discussion of health involves certain limits because it requires research by the human mind into what God has wanted to tell us about the whole question. As a result, this discussion cannot be based upon interdisciplinary research because the sources of divine revelation are not concerned with the subjects of science and technology. However, it is precisely Christian moral discussion about the health of man which requires increasingly deep exploration and investigation. Indeed, those who seek to understand the divine project as it applies to the health of man must first know the will of the Creator, then go on to the intention of the Redeemer, and lastly inquire into the mission of the Sanctifying Spirit. Only then does it become clear that God—the Father, the Son and the Holy Spirit—has never sought the suffering or the death of man but has wanted only his complete health. This line of argument reveals that the Divine Creator conceived of man in a state of complete health. When suffering and death became a heritage of the sin committed by the first parents, the eternal Son of God became flesh in order to heal man of this inheritance. And when the Son of God, made man, after taking upon himself all things, asked the Father to send the Holy Spirit, this latter came to restore life to all men who had died because of sin and in order one day to resurrect their mortal bodies in Christ.[1]

I would like to point out immediately, in the same way as St. Paul wished to observe, that such an approach discerns the wisdom of God which was hidden and prepared by God from the beginning of time for our glory.[2] Of this glory it is written: "Things no eye has seen, no ear has heard, no human heart conceived, the welcome God has prepared for those who love him."[3] We are referring here to things that require words that do not come from human wisdom but from the teaching of the Spirit, and this teaching applies spiritual words to spiritual things. The Apostle himself explains that: "Mere man with his natural gifts cannot take in the thoughts of God's Spirit; they seem mere folly to him, and he cannot grasp them, because they demand a scrutiny which is spiritual."[4] All this constitutes the background to my decision to divide this paper into three parts: 1. Complete health in the project of God the Father for creation; 2. The health which must be restored in the redemptive project of the Word made Flesh; and 3. Restored health in the mission of the Holy Spirit.[5]

Those who wish to enter right away into debate about the creation must first of all be aware that the project for creation is "the foundation of 'all God's saving plans,' the 'beginning of the history of salvation' that culminates in Christ," but, above all, that "the mystery of Christ casts conclusive light on the mystery of creation and reveals the end for which 'in the beginning God created the heavens and the earth'(Gen. 1:1): from the beginning, God envisaged the glory of the new creation."[6] This fundamental project, conceived in the decisive light of the glory of a new heaven and a new earth, is characterized by "the hierarchy of creatures...expressed by the order of the 'six days,' from the less perfect to the more perfect."[7] This account places man at the summit of the work of the creation, as is borne out by the creative act itself of God: "Then the Lord God formed man of dust from the ground, and breathed into his nostrils the breath of life; and man became a living being" (Gn 2:7).

But—and here an irrefutable approach to the subject under consideration imposes itself—it is precisely from these "material" origins of the body that there derives the fact that man is by his very nature a transitory and vulnerable creature who is destined to die. Despite the fact that we must understand the account of the origins of man in *symbolic* terms, it remains true that he is connaturally a creature-being who is destined to suffer and to die—that is, return to dust. Not even the deep unity of the soul and the body, as emerges from the perception of the soul as a *form* of the body—and thus not even the fact that we are not face to face with two natures, but one single nature—changes the reality that we are faced with a vulnerable and mortal nature.

However, the fact is—and here God reveals his project of *complete health for man*—that this living being who is a unity of soul and body was not meant to suffer or die. In order to avoid every possible misunderstanding I would like to repeat that this does not mean that man as projected by the Divine Creator had become by his nature invulnerable and immortal. God wanted to render even more evident that He wanted to create a man in his image and likeness. Indeed, the first man not only was created good, but was also established, as the *Catechism of the*

Catholic Church teaches, "in friendship with his Creator and in harmony with himself and with the creation around him, in a state that would be surpassed only by the glory of the new creation in Christ."[8] It is in this sense that the Church gives an authentic interpretation of the symbolism of biblical language.

In the light of the New Testament and of tradition she "teaches that our first parents, Adam and Eve, were constituted in an original 'state of holiness and justice.'"[9] This means that the rays of original holiness—or, rather, of participation in divine life—pervaded all the dimensions of the life of man. But—and here we come to the most convincing proof that man *created by God* is connaturally vulnerable and mortal—"as long as he remained in the divine intimacy, man would not have to suffer or to die. The inner harmony of the human person, the harmony between the first couple and all creation, comprised the state called 'original justice.'"[10] Thus "the first man was unimpaired and ordered in his whole being because he was free from the triple concupiscence that subjugates him to the pleasures of the senses, covetousness for earthly goods, and self-assertion, contrary to the dictates of reason."[11] For this reason, the complete health of man in paradise was made up of a triple harmony: radical or, rather, religious harmony, and its two consequences—that is, intrapersonal and interpersonal harmony and cosmic harmony.

But let it be observed this was the only case so long as man remained in religious harmony—that is, in intimacy with the divine. Now, it is known that "this entire harmony of original justice, foreseen for man in God's plan, will be lost by the sin of our first parents."[12] And, indeed, the "preternatural" gift of not having to suffer or to die came to be lost, as God himself had clearly established and ordained: "And the Lord God commanded the man, saying, 'You may freely eat of every tree of the garden, but of the tree of the knowledge of good and evil you shall not eat, for in the day that you eat of it *you shall die.*'"[13]

At this point we should now turn our attention to the reaction of God the Creator to the action which disintegrated religious, personal, social and cosmic health.

2. The Greater Reintegration of Health in the Redemptive Plan of God the Son

The divine reaction is surprising. After his talk with the protagonists of this disintegration—the serpent, the woman, and the man—the Creator promises a Christic reintegration. To the first parents who felt the reality of their self-punishment,[14] God declares, when turning to the serpent, "I will put enmity between you and the woman, and between your seed and her seed; he shall bruise your head, and you shall bruise his heel."[15] This passage from Genesis, which is called the "Proto-Gospel," pre-announces the redemptive Messiah or, rather, the descendant of the Woman who will achieve final victory in her struggle with the serpent.[16] This is a victory, we should be very clear, which reintegrates the health of man in an unsuspected way through the ineffable grace of Christ.

As St. Leo the Great observes, "The ineffable grace of Christ has given us better goods than those which the envy of the devil took away from us."[17] And St. Thomas writes, "Nothing contradicts the fact that human nature is destined for a higher end after sin. Indeed, God permits that there are evils in order that from them a greater good is produced. Hence St. Paul's statement—"Where sin abounded, grace abounded all the more" (Rom 5:20)—and the song of the Exultet: "Oh happy blame which deserved such and so great a Redeemer."[18] We can assert without fear of contradiction that "Christians believe that 'the world has been established and kept in being by the Creator's love, has fallen into slavery to sin, but has been set free by Christ, crucified and risen to break the power of the evil one....'"[19]

This is very true: "the name of 'Jesus' signifies that the very name of God is present in the person of his Son, made man for the universal and definitive redemption from sins."[20] Indeed, if, on the one hand, the evil spirits fear his name, it is also true that the disciples of Christ perform miracles in his name.[21] In other words, the Father sent the Son to save—that is, to heal—the sick, fallen, and dead world. As a Greek Father wrote, "Sick, our nature demanded to be healed; fallen, to be raised up; dead, to rise again. We had lost the possession of the good; it was necessary for it to be given back to us." And he went on in rhetorical fashion: "These things—did they not move God to descend to a human nature and visit it, since humanity was in so miserable and unhappy a state?"[22] Here we have clearly stated why it was that "The Word was made flesh" (Jn 1:14)—to reintegrate the health which had been lost because of the action of sin.

At this point it should be stressed that this reintegration began with the Son of God's taking on our human nature. Being the perfect man, the Son of God, in uniting himself to each and every man, gave back to the sons of Adam the likeness of God. "Because in him human nature was taken on, without being destroyed, it was in us, too, raised to a sublime dignity."[23] Freely shedding his blood, He "made us worthy of life, and in him God reconciled us to God and with each other and brought us out of the slavery of the devil and sin. In this way each one of us can say with the apostle that the Son of God "loved me, and gave himself for me" (Gal 2:20).[24] Here it is evident how in the redemptive plan of the Son of God the primary intention is that of reintegrating religious health—that is, the harmony between God and man. As a result, the aim is also social reintegration, or interpersonal harmony. This is a reintegration whose ineffability, we grasp, took place at the level of the hypostatic union between divine nature and human nature.

However, we still have before us the question of personal reintegration or rather interpersonal harmony and, as a consequence, the subject of the propensity towards suffering and death. The following is the answer to this question. Now rendered in the image of the Son the firstborn among all brothers, man receives "the spiritual harvest" by which he becomes able to carry out the new law of love.[25] Indeed,

because of this Spirit, which is the "pledge of the inheritance" (Eph 1:14), the whole of man becomes internally remade to the point of the goal of the "redemption of the body" (Rom 8:23). The answer is clear, but lies in this goal. This means that in the meantime the reintegration of nonvulnerability and nonmorality has not yet come, and cannot come. Indeed, man, even though Christian, "remains locked up in the necessity and the duty of having to combat evil through many tribulations, and to endure death."[26] However, by now things are radically and totally changed because for "Christ and in Christ the enigma of pain and death are illuminated, an enigma which outside the Gospel oppresses us. Christ has risen, destroying death by his death, and he has given us life so that as children of the Son we exclaim in the Spirit: 'Abba, Padre!'"[27]

However much it may be true that the paradisiacal harmony of nonsuffering and nondeath has been replaced by a much greater harmony, I believe that the Son of God wanted to give proof of this harmony each time that he restored health to the sick and gave back life to the dead. One needs only to think of the many miracles which he performed to understand this point. They bear witness to the fact that Jesus not only possessed the power to heal but also had the power to forgive sins.[28] He came to heal the whole man, in both soul and body. He was the physician of whom the sick had need.[29] The sick people sought him out and were convinced that they only needed to touch him in order to be healed: "All the multitude was eager to touch him, because power went out from him, and healed them all."[30] St.Mark tells us that "he did many works of healing, so that all those who were visited with suffering thrust themselves upon him, to touch him. The unclean spirits, too, whenever they saw him, used to fall at his feet and cry out, 'Thou art the Son of God.'"[31] The same evangelist, who was himself a physician, also writes, "When they had crossed, they came to shore at Genesareth and moored there. As soon as they had disembarked, he was recognized, and they ran off into all the country round, and began bringing the sick after him, beds and all, wherever they heard he was. And wherever he entered villages, or farmsteads, or towns, they used to lay the sick down in the open streets, and beg him to let them touch even the hem of his cloak; and all those who touched him recovered."[32]

St. Mark makes clear that Jesus came not only to save sinners—that is, those who were sick in their souls—but also to heal those who were sick in their bodies. Jesus sent his disciples to preach the Gospel and commanded them to place their hands on the sick in his name in order to heal them.[33] As St. Mark writes, "So they went out and preached, bidding men repent; they cast out many devils, and many who were sick they anointed with oil, and healed them."[34] I would like to emphasize that the Church has always followed the commandment "Heal the sick" and has tried "to carry it out by taking care of the sick as well as by accompanying them with her prayer of intercession. She believes in the life-giving presence of Christ, the physician of souls and bodies."[35] Indeed, the Church believes and confesses that among the seven sacraments "there is one especially intended to strengthen those who are being tried by illness, the Anointing of the Sick",[36] of which St. James speaks: "Is one of you sick? Let him send for the presbyters of the church, and let them pray over him, anointing him with oil in the Lord's name. Prayer offered in faith will restore the sick man, and the Lord will give him relief; if he is guilty of sins, they will be pardoned."[37]

Jesus also wanted to demonstrate that He came to conquer death. On more than one occasion, he made a dead person return to the land of the living. One thinks of Lazarus, the daughter of Jairus, and the son of the widow of Naim.[38] However, his definitive victory over death was that of the Resurrection because the return to life of Lazarus, of the daughter of Jairus, and of the son of the widow of Naim, involved only a temporary return, a return which was destined to die once again. The Resurrection is a completely different event, as, indeed, is revealed by the mission of the Holy Spirit.

3. The Definitive Reintegration of Health in the Sanctifying Mission of God the Holy Spirit

"And this is the message that we preach to you; there was a promise made to our forefathers, and this promise God has redeemed for our posterity, by raising Jesus to life."[39] The importance of this reintegration of the physical death of each man through the resurrection of Jesus emerges from what is taught by the *Catechism of the Catholic Church:* "The Resurrection of Jesus is the crowing truth of our faith in Christ, a faith believed and lived as the central truth by the first Christian community; handed on as fundamental by Tradition; established by the documents of the New Testament; and preached as an essential part of the Paschal mystery along with the cross: Christ is risen from the dead! Dying, he conquered death; to the dead, he has given life."[40]

Jesus, "the author of life" (Acts 3:15), "destroyed 'him who has the power of death'—that is, the devil" and delivered "all those who through fear of death were subject to lifelong bondage'"(Heb 2: 14-15). "Henceforth the risen Christ holds 'the keys of death and Hades'" (Rev 1:18).[41] An ancient homily for Holy Saturday declares, "God and his Son go to free Adam and Eve from suffering, and they are in prison: 'I am your God, who for you became your son. Wake up, you that are sleeping! I did not create you for you to remain a prisoner in hell. Rise up from the dead! I am the Life of the dead.'"[42]

It is true that so far in this paper the Holy Spirit has not been discussed in detail, but the ineffable task of reintegration is entrusted to Him. As the Fathers of Vatican II write, "What the Lord preached or took place in him for the salvation of mankind must be proclaimed and spread to the ends of the earth, beginning with Jerusalem, so that what was done at one time for the salvation of all is fully achieved down the centuries."[43] "In order for this to be achieved, Christ sent the Holy Spirit from the Father so that he could carry out from within his work of salvation and encourage the Church to grow."[44] The Apostle comments on this in the following

way, "It is only through the Holy Spirit that anyone can say, 'Jesus is the Lord'" (1 Cor 12:3).[45] "To be in touch with Christ, we must first have been touched by the Holy Spirit. He comes to meet us and kindles faith in us. By virtue of our Baptism, the first sacrament of faith, the Holy Spirit in the Church communicates to us, intimately and personally, the life that originates in the Father and is offered to us in the Son."[46] This is what in all clarity the Church teaches. Therefore, even if every work *ad extra* is the work of all the Trinity, nonetheless in the divine economy of salvation the Holy Spirit is sent to unite everybody *to Christ* and make everybody live *in Christ.*

For this reason, He is really the Spirit of the promise. "Disfigured by sin and death, man remains 'in the image if God,'" but is "deprived 'of the glory of God'(Rom 3:23), of his 'likeness'. The promise made to Abraham inaugurates the economy of salvation, at the culmination of which the Son himself will assume that 'image' and restore it in the Father's 'likeness' by giving it again its Glory, **the Spirit who is 'the giver of life**.'"[47] The promised descendant of Abraham is Christ, in whom "the outpouring of the Holy Spirit will 'gather into one the children of God who are scattered abroad' (Jn 11:52). God commits himself by his own solemn oath to giving his beloved Son and 'the promised Holy Spirit..., **the guarantee of our inheritance** until we acquire possession of it'" (Eph 1:13-14).[48]

The fullness of the reintegration, the work of the Holy Spirit, consists therefore of restoring, *with Christ and in Christ,* the full *divine likeness* to man. And this reintegration will take place fully and definitively with the participation of bodies in the resurrection of Christ. This brings me to my conclusion.

Conclusion

After losing his complete health because of the sin of his first parents, man was once again placed—by the work of the Holy Spirit—in the grace of God, or the intimacy of life with Him. This is because just as Christ rose from the dead through the glory of the Father, so, too, we can walk in a new life. This is a life which is victory over the death of sin and new participation in the grace—or, rather, in the Offspring—of Christ, and thus in the inheritance of Christ. As the *Catechism of the Catholic Church* observes, "Christ, 'the firstborn from the dead'(Col 1:18), is the principle of our own resurrection, even now by the **justification** of our souls, and one day by the **new life he will impart to our bodies**."[49] These are the best goods among those goods which sin removed from us. The loss of the holiness and original justice of Adamic man in paradise was abundantly compensated for by participation in the Holiness and Justice of God the Son, made man.

In sacrificing Himself, the Son of God made us share in his Intratrinitarian Life, and in rising from the dead He made us heirs of His Glory as the Resurrected One. As proof of these better goods, attention should be paid to the fact that this grace of being adopted sons has so much luminosity as to render the resurrected human body eternally *immortal through grace, through pneumatic irradiation.* As the Apostle himself writes: "What is sown corruptible rises incorruptible; what is sown unhonored rises in glory; what is sown in weakness is raised in power; what is sown a natural body rises a spiritual body. If there is such a thing as a natural body, there must be a spiritual body, too. *Mankind begins with the Adam who became, as Scripture tells us, a living soul; it is fulfilled in the Adam who has become a life-giving spirit."*[50]

To summarize, therefore. original justice did not make the human body, by its nature mortal, immortal; rather, God ensured merely that it did not die. Paradisiacal man could die, but by God's intervention he **was not** to suffer or die. The man of "redemptive and sanctifying" reintegration, in contrary fashion, became the man who **could not** suffer or die. This is the "celestial" man of the reintegrating project of God produced in reaction to the action which led to the loss of the complete health of "earthly" man. "Celestial" man, therefore, reveals that the "original" plan of God envisaged neither illness nor death, but only complete physical, psychic, and pneumatic health. What the earthly Adam lost the celestial Adam gavein superabundance. After being lost, paradisiacal harmony was restored in an ineffable way by the glory of the new creation in Christ,through the work of the Holy Spirit.[51]

From what has been argued hitherto, the primary and principle needs of Christian morality as regards complete health will be evident: if God the Redeemer-Creator and Sanctifier-Creator **envisaged** a man who was not to suffer or die, and **re-envisaged** (for all eternity) a human being who cannot suffer or die, then it is clear that man is obliged to take very great care of his own health. And given that "pneumatic" health, or that health which comes from grace, radiates into physical and psychic health, we must recognize that the first and principle task in relation to complete health lies in special attention being paid to "spiritual" health. And the ineffable reintegration of the lost harmony of earthly paradise obliges each man of good sense and good will to aim for the high goal of harmony or "religious" health. This is because from this latter health there also springs intrapersonal, interpersonal, and cosmic health—to an extent which much greater than is usually imagined.

Naturally enough, this moral-religious analysis of health does not seek to evade or to minimize the many questions relating to illness, suffering, and death. Indeed, I want to stress that "by his Passion and his death on the cross Christ has given a new meaning to suffering: it can henceforth configure us to Him and unite us with his redemptive Passion."[52] Christian morality argues that suffering and death can become sources which work for the reintegration of health in the same way as the suffering and the death of the Redeemer. Although they are consequences of sin which disintegrated complete health, suffering and death became participants in the salvific work of Jesus, and as a result they are sources of greater participation in His Glorification. I will conclude this paper with the words of St. Paul: "No, we do not play the coward; though the out-

ward part of our nature is being worn down, our inner life is refreshed from day to day. This light and momentary affliction brings with it a reward multiplied every way, loading us with everlasting glory.... Once this earthly dwelling of ours has come to an end, God, we are sure, has a solid building waiting for us, a dwelling not made with hands, that will last eternally in heaven.... For this, nothing else, God was preparing us, when he gave us the foretaste of his Spirit."[53]

Rev. BONIFACIO HONINGS, O.C.D.
Consultor to the Congregation for the Doctrine of the Faith, and Consultor to the Pontifical Council for Pastoral Assistance to Health Care Workers, the Holy See

Notes

[1] Cf Rom. 8:10-11.
[2] 1 Cor. 2:6-7.
[3] 1 Cor. 2:9; cf Is. 64:1-3.
[4] 1 Cor. 2:14.
[5] To avoid any misunderstanding I would like to observe that every work of God *ad extra* is common to the Most Holy Trinity, to the Father, to the Son, and to the Holy Spirit, but by *appropriation* the creation is attributed to the Father, redemption to the Son, and sanctification to the Holy Spirit. The *Catechism of the Catholic Church* (henceforth in these footnotes CCC) teaches that "though the work of creation is attributed to the Father in particular, it is equally a truth of faith that the Father, Son, and Holy Spirit together are the one, indivisible principle of creation" (CCC, 316).
[6] CCC, 280.
[7] Cf CCC, 342.
[8] CCC, 374.
[9] CCC, 375.
[10] CCC, 376.
[11] CCC, 377. The italics are mine.
[12] CCC, 379.
[13] Jn 2:16-17. The italics are mine. But in practical terms what happened? The CCC answers this question as follows: "The harmony in which they had found themselves, thanks to original justice, is now destroyed: the control of the soul's spiritual faculties over the body is shattered; the union of man and woman becomes subject to tensions, their relations henceforth marked by lust and domination. Harmony with creation is broken: visible creation has become alien and hostile to man. Because of man, creation is now subject 'to its bondage to decay' (Rom 8:20). Finally, the consequence explicitly foretold for this disobedience will come true: man will return to the ground, for out of it he was taken. *Death makes its entrance into history* (CCC, 400).
[14] Cf Jn 3:9-24.
[15] Jn 3:15.
[16] Cf CCC, 410-411.
[17] ST. LEO THE GREAT, *Sermones*, 73, 4: PL 54, 396.
[18] ST. THOMAS, *Summa Theologiae*, III, 1, 3, ad 3.
[19] CCC, 421.
[20] CCC, 432.
[21] Cf Acts 16:16-18; 19 13:16; Mk 16:17.
[22] ST. GREGORY OF NYSSA, *Oratio Catechetica*, 15: PG 45, 48 B.
[23] *Gaudium et Spes* (henceforth GS), 22.
[24] *Ibidem.*
[25] Cf Rom 8:1-11.
[26] GS, 22.
[27] *Ibidem.*
[28] Cf Mk 2:5-12.
[29] Cf Mk 2:17.
[30] Lk 6:19. Cf. the account of the healing of the leper in Mk 1:40-42.
[31] Mk 3:10-11.
[32] Mk 6:53-56. It is interesting to observe that at that time the cloak was a symbol of power and thus for the sick people it was enough to touch the hem.
[33] Cf Mk 16:17-18.
[34] Mk 6:12-13.
[35] CCC, 1509.
[36] CCC, 1511.
[37] James 5:14-15.
[38] Cf Jn 11:44 and 8:49; Lk 7:11-15.
[39] Acts 13:32-33.
[40] CCC, 638.
[41] CCC, 635.
[42] See *Liturgy of the Hours*, II, *Office of the Readings for Holy Saturday*.
[43] *Decreto sull'Attività Missionaria della Chiesa* (henceforth AG), 3.
[44] AG, 4.
[45] 1 Cor 12:3.
[46] CCC, 683.
[47] CCC, 705. The bold type is mine.
[48] CCC, 706.
[49] CCC, 658. The bold type is mine.
[50] 1 Cor 15: 42-45.
[51] I would like here to quote what the *Catechism of the Catholic Church* teaches about the glorious body of Christ. This authentic and real body because it still bears the marks of the Passion: "possesses the new properties of a glorious body: not limited by space and time but able to be present how and when he wills; for Christ's humanity can no longer be confined to earth, and belongs henceforth only to the Father's divine realm. For this reason too the risen Jesus enjoys the sovereign freedom of appearing as he wishes: in the guise of a gardener or in other forms familiar to his disciples, precisely to awaken their faith"(CCC, 645).
[52] CCC, 1505.
[53] 2 Cor 4:16-18; 5:1-2, 5.

ACHILLE ARDIGÒ

The Preventive Role of Education: Self-Training in Health to Meet Hopes and Expectations in Caring for the Sick

The hopes and expectations which exist in relation to the whole subject of "Church and health" on the threshold of the third millennium center around two principal orientations (or approaches), and these orientations constitute the subject of this paper.

The first orientation is to be placed in an ethical-rational context or framework and involves a redressing of the balance in health care towards prevention and promotion/self-promotion and away from urgent in-house forms of treatment; towards an overall medical/healthcare approach to the patient which involves both his soul and his body and away from the physicalistic/scientistic approach which has hitherto dominated the world of medical science.

The second orientation is of a religious character and involves a return—within the Church herself—towards the early teaching of Jesus Christ in favor of an evangelization which is always associated with the healing of the sick (and the driving away of evil spirits). This is something which is taught and described by all four of the evangelists of the New Testament beginning with Luke 9:1-6 who writes: "And he called the twelve apostles to him, and gave them power and authority over all devils, and to cure diseases, sending them out to proclaim the kingdom of God, and to heal the sick.... So they set out and passed through the villages, preaching the gospel and healing the sick wherever they went."

For a believer, these two orientations are a specific aspect of the human ambivalence which exists in life of having to engage in the concurrent development of two polarities which are in logical terms divergent but which at the same time are also fused in relation to human health (understood in its full sense). The ambivalence of the two orientations is to be found in the expectation and hope that it is possible for humanity to overcome the materialistic limits to care for the sick without at the same time ignoring the enormous benefits of medical science. Over three centuries of hegemony of the scientistic/physicalistic model based upon the Cartesian separation between res cogitans and res extensa have led to the study of causality being based exclusively upon the connection between individual illnesses and individual pathological events within the human organism and/or which originate in external nature.[1]

As D. von Engelhardt has critically observed when discussing the natural sciences, the scientistic approach to medicine "with the erroneous concept which derives from that model" excludes that which belongs to the noncorporeal dimension of existence[2]. In this process, where infirmity is reduced to illness, observes F. Capra, the attention of medical doctors "has moved away from the patient as a total person..., although infirmity is a condition of the total human being."[3] "Rather than asking themselves why an illness takes place and trying to remove the conditions which have brought it about, medical researchers strive to understand the biological mechanisms by which the illness operates."[4]

And the patient as a total person should be observed—here we are dealing with the philosophy which opposes that of the medical-social model which has already been cited in this paper—in his environment, with reference to the social organization in which he lives, in the context of the burden (which emergent industrial society has increased while also producing economic prosperity) of unjust social inequalities, the exploitation of workers, and the marginalization of the essential needs of the family.

From such basic principles, the criticisms of the model here subjected to examination descend to the level of the practical/operative aspects. They involve first and foremost criticism of the sacrifice of prevention, rehabilitation, and diet in favor of an alternative concentration of greater human and mechanical resources on more spectacular medical processes, especially of a surgical character, and which often involve rapid intervention. As D. von Engelhardt observes, "Dietetics, prevention, and rehabilitation are pushed into the background." The loss of dietary considerations is

the result of a reduction of nutrition to a merely physical dimension, involving as it does the sacrifice of religious, sacral, and ritual elements to eating, drinking, sleeping, and making love.[5]

The first of the two orientations cited above must be seen as a countertendency, as an action which even goes against the facts as regards the various forms of scientistic hegemony which are associated with social injustice. The prevention of illness and the promotion of a sustainable development of nonalienating ageing should be seen as involving the raising of awareness about the body, which is also a moral responsibility, and goes well beyond the increasingly less valid impact of psychoanalysis or even worse of psychological determinism. There cannot be, therefore, prevention of illness from a subjective and interpersonal profile which does involve a search for the meaning of life—that is, in line with the phenomenological approach introduced by E. Husserl and his pupil E. Stein. In this direction—and however important the contribution of medical/healthcare knowledge to educating people in relation to health—the education provided by teachers must also bring into play the participation of the user. Education, then, cannot fail to include self-education. The reader is here referred to A. Ardigò, Società e Salute[6] for discussion of this point.

It is certainly true that we should not underestimate the fact that among the primary tasks in the prevention of illness and disability there are those which involve environmental prevention, in addition to the accompanying causes connected with the organization of society, and these concern collective responsibilities such as those borne by governments, civil society, and the bio-healthcare professions. In this context it is no accident that the principal causes of illness and death in contemporary society are connected with pollution, road accidents, accidents at work and in the home, and the stress caused by the convulsive and competitive organization of contemporary society.

They are, however, also related to forms of social injustice which aggravate conditions of poverty, marginalization, and chronic want. And there are so many examples of unjust disharmonies and inequalities that they are to be found both within the field of primary prevention and in national government. However, in the opinion of experts, as in the participation of users—and in their spokesmen—the role of raising consciousness and a sense of responsibility in both a personal and interpersonal dimensions in relation to safeguarding health is growing, beginning with the correction of unhealthy lifestyles of consumption and ways of living, most notably in the form of the struggle against smoking, alcoholism, drug-addiction, and sexual excess.

One could assert that in recent years prevention and the promotion of health through education and self-education in health care have been among the most cited objectives of European government programs. However, actual practice often does not correspond to the intentions of these programs in that such intentions imply—as has been observed—a certain exaggerated emphasis on an area which requires a great deal of funding, namely hospitals. And the urgent demand for hospitalization is too great in a context of a lack of public resources to encourage a radical change in approach which would transfer resources to prevention, education, and self-education in health care.

The field of prevention is, however, vast and very important, and there are at least three directions taken by specific forms of action.

For all three such directions education and self-education in health care have a specific role to play. These three directions are as follows.

a)Vaccinations and mass screening, and forms of environmental prevention.

b) Dealing with the most important damage caused to health by forms of personal and group behavior (smoking, alcohol, drugs, and AIDS).

c) The promotion of education and self-education in helth care and preventive and promotional measures—in favor of categories of handicapped people.

It should also be pointed out that the European Union has recently engaged in initiatives which involve a policy of coordination of the activity of the member states—in this context programs have already been set in motion against cancer and AIDS.

To conclude this section on the first orientation, we can say that such an orientation is by its very nature concerned with the following questions.

* The organization of society in general and the reform of health services and social services in particular (that is, community medicine). This is essentially a political question, but it is also linked to the following points.

* Collective and personal prevention, public hygiene, education and self-education in health care, and especially in relation to the iatrogenic effects of exposure to social situations and collective structures, not least those of a healthcare character (especially as regards public hygiene and healthcare education).

* the humanization and personalization of medical and healthcare treatment, with especial emphasis here on the relationships which connect the sick person with his immediate and familial context.

Preventive and promotional measures cannot be confined to the world of healthcare goods and services. The impact of environmental pollution and food substances and the effects of stress for people—where forms of social organization are at their most modern and intense in character—are areas of increasing relevance where prevention and promotion must be put into

practice beyond realms which are of a strictly healthcare nature.

In order to be effective, prevention and promotion must deal with the whole network of healthcare relationships between the local area and its hospitals and require constant changes in the roles played by basic healthcare structures, especially where there is an absence of close ties with residential processes of care and assistance.

As is always the case when objectives are involved which require major changes in the ways things are done and organized, certain early steps by innovators must be taken. If it becomes possible to set in motion relevant initiatives of prevention and promotion, then these will have positive effects as regards the reduction of an inappropriate use of hospitals—it will be possible to avoid an excessive use of diagnostic tests and of surgical operations which are not really necessary. The more prevention and promotion become important, the more the life expectancy of people will become greater even though they will have to face up to a broad variety of chronic-degenerative forms of illness. In conclusion, prevention and promotion in the field of health and health care through the employment of education and self-education in relation to lifestyles must rely increasingly upon greater information and upon making people far more aware of their own bodies, in addition to collective policies and initiatives relating to the field of health care and other sectors as well.

From this point of view, reference should be made—with the two objectives indicated at the outset in mind—to recent positive developments within the world of health care which are of a more social character.

a) The formation of associations made up of people already afflicted by illnesses marked by personal behavioral disorders (alcoholism, drug addiction, serious lack or excess of food intake, etc.) and other categories of sick people. These associations promote groups for self-therapy and shared education.

b) The employment of telecommunications, ranging from "tele-assistance" to "tele-medicine" in order to combat involuntary isolation, especially that of the elderly and the handicapped who can still be looked after at home. Such new developments, which have had positive results in our country as well, allow the direction of information and forms of communication through private/social channels which build bridges between families and residential social/healthcare institutions.

c) Education in relation to health through mixed and voluntary participation within hospital structures, and in other kinds of social/healthcare facilities, through consultative committees which can provide information to users and varieties of informal care. This can help such people to reach informed agreement in relation to choices as regards treatment which bears certain risks. There can also be promotion of personalization and humanization of forms of care with the cooperation of internal healthcare workers, such as doctors, nurses, laboratory technicians, and support personnel. Since 1992 Italy has taken important steps in this direction as regards both law and its actual implementation. The Rizzoli Orthopaedic Institute, in Bologna, an internationally-recognized center for research and treatment, has since 1992 been engaged in a pioneering system of a mixed consultative committees by which patients themselves exercise a monitoring of the treatment and forms of care which they receive.

To pass on now to the second orientation which was introduced at the outset—namely, the religious aspect—I will confine myself here to a brief reference to a pioneering initiative promoted by the Rizzoli Orthopaedic Institute. In 1995 an agreement between this institute and the diocese of Bologna led to the opening of a new center of an explicitly religious character since the Rizzoli Institute has for a very long time had within its walls one of the most important churches in Bologna—San Michele in Bosco. With the approval of Cardinal Biffi, the bishop of the diocese of Bologna, this agreement formalized the introduction of a new religious institution, the chaplaincy of San Michele in Bosco. The explicit aim on the part of the Camillian Fathers, who have looked after the parish since 1995, when they replaced the Olivetan monks who had been there for centuries, has been to provide religious assistance to the patients in line with a rediscovery of the early Gospel message—an evangelization which takes place in conjunction with the healing of the sick.

Professor ACHILLE ARDIGO
Professor of the Sociology of Health Care,
The University of Bologna

Notes

[1] See A. ARDIGÒ, Società e Salute. Lineamenti di Sociologia Sanitaria (F. Angeli, Milan, 1997), especially chap. 2, "I Modelli del Sapere Bio-Medico, etc."

[2] D. VON ENGELHARDT, "La Medicina di Fronte alla Sfida Antropologica,," in L'Arco di Giano, no. 1, 1993, p. 127.

[3] F. CAPRA, Il Punto di Svolta. Scienza, Società e Cultura Emergente (Feltrinelli, Milan, 1984), cf chap. 4, "Il Modello Biomedico," pp. 104-136, quotation, p. 104.

[4] D. VON ENGELHARDT, La Medicina di Fronte alla Sfida Antropologica, p. 126.

[5] Ibid., p. 30.

[6] A. ARDIGÒ, Società e Salute. Lineamenti di Sociologia Sanitaria (F. Angeli, 1997), see especially chap. 7.

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J.P.M. LELKENS

The Health Worker at the Service of Life and Health

There may come a time when recovery lies in the hands of physicians, for they, too, pray to the Lord that he grant them success in diagnosis and in healing, for the sake of preserving life.
Jesus Sirach 38, 13-14

With reference to these words of Jesus Sirach* in the book Ecclesiasticus (OT) I would like to discuss the aim and the task of health workers such as nurses, laboratory personnel, secretaries etc.

They, too, are involved in the service of the patient, be it sometimes at a distance or to a lesser degree.

The aim of the health worker is as the *Charter for Health Care Workers* says[1]: to guarantee, to restore and to improve the state of health, which means to serve life in its totality.

What do we understand by health?

From a purely biological point of view we can say that a healthy person is a coordinated entity with an intact blood circulation, respiratory system and central nervous system. But this is not man in his totality.

Health as defined by the World Health Organization (WHO) is a state of physical, mental and social well-being, and not merely the absence of disease or infirmity. But this definition is incomplete and vague because 'well-being' is a rather subjective factor which cannot be specified exactly.

Incomplete, because it does not take into account the fact that being man means to exist in the world as a spiritual-physical entity.[2] The first pole is the individual human being; the other contains the various situations in which man lives:

– the material situation: living under physical, chemical, and environmental influences and meeting their requirements to hold one's own;

– the personal situation: living in various personal relations;

– the socioeconomic situation;

– the spiritual and religious situation: living according to a philosophy of life and a religious conviction.

It appears that we have to conceive the notion 'healthy' in such a broad perspective because medicine has to deal with all these situations which can make a man ill or affect his health.

Not being able to cope with them, causes suffering. We may say that only a man who is adapted to all these aspects harmoniously is healthy.

This leads us to the following description of the aim of the health worker: to maintain, restore, or foster a condition of optimal adaptation of a patient to the totality of his situation in existence by applying the methods which are known to him from medical science. The consequence but at the same time the advantage of using the notion 'adaptation' is that a person may be ill in the restricted sense of the word, but nevertheless 'healthy', as is the case in a number of saints who showed a very healthy attitude with respect to their somatic suffering. Apart from that, striving for adaptation does not relieve the doctor from his task to remove an abnormality if this can be trated therapeutically without harming the person.

Health is thus one of the most fundamental notions which play a role in human existence. Therefore, it is not coincidental that in every culture, however primitive it may be, a special person was looked for and appointed for the service of health, whether a witch doctor, a temple priest, a barber or a physician.

We know that medical treatment was probably already used by the earliest humans.[3] The best information about health care in ancient times stems from the writings of Hippocrates *(Corpus Hippocraticum)*, who lived from 460 BC till 370 BC in Greece. He formulated his famous oath, which is relevant for any physician with regard to his duties to his patients to this very day. He was a humanist with a pagan religiosity which linked the art of medicine to his gods.

As for the practice of medicine, it is not irrelevant whether the physician has a particular philosophy of life or not. A physician is a special minister of health, and health contains, as we have seen, a normative element and thus becomes a philosophical matter. A Catholic doctor aims for something else than a doctor with a positivistic-materialistic attitude because he has a different view on the hierarchy of values at the various levels of existence.

He knows that the patient, like himself, has the task to live his life in a certain way, even when his body puts him into a state of being ill. At the same time—and this is important nowadays—he also knows that a patient has to live out his life and that it is his task as a doctor to lend succour to a dying person, but never to take his life, for life itself is holy and therefore healthy, and all that is healthy does not need a doctor.

The first one who connected the aim and the task of a physician with God was Jesus Sirach, already cited in the beginning of this paper.

If we look at the Old Testament,

and notably at the discourse by Jesus Sirach in *Ecclesiasticus*, we will find in chapter 38, verse 1-15,[4] a rather detailed description of the doctor and his patients. The author presents himself as Jesus, the son of Eleazar, the son of Sirach. He is also called Ben Sira; he wrote the book around 190 BC, and around 130 BC a grandson translated it from Hebrew into Greek. In the Greek text this book is entitled 'The Wisdom of Jesus Sirach[5].'

It is an interesting text because it brings up an important religious element, namely the relationship between the physician and God: "...for the Lord created them; for their gift of healing comes from the Most High" and in verse 14: "...for they, too, pray to the Lord..." (see addendum).

Thus Sirach has in mind a religious and faithful Jewish doctor who is able to serve health by making use of medicines which "the Lord created out of the earth" (verse 4) so that "from Him health spreads over all the earth" (verse 8).

God gave skill not only to physicians, but also to other human beings ...that. He might be glorified in His marvellous works (verse 6). This means that every man has the task to utilize creation in an optimal way and because... "God's works will never be finished" (verse 8), he should not leave creation fallow. Thus Sirach developed a new daring vision[6] on man in general and on the doctor in particular seeing him not as a competitor with God but as a co-creator in the sense of finishing and, if necessary, restoring His works, His creation, by the skills and wisdom given to him. Both sources, faith and science, must be used by the doctor if it is his intention to fulfill this task.

"Finishing His works" means that God wants His creation to be complete, whole, and especially man, the crown of His creation. To reach this aim He uses the service of the doctor.

Among other things, 'to serve' stands for helping, being useful to another person. In health care the concept of 'serving' also contains the concept of love, of charity: the fundamental law of the community. In its essence Christian charity: to will the other, to want the other to exist, preferably in a complete way. A human being is complete if he is healthy, whole, or whole again. Thus the doctor contributes to a healed, wholesome world as wanted by God[7]. Therefore there probably is a liguistic affinity between the words 'whole,' 'holy', and 'health', at least in Dutch there is.

By serving the existence of someone else the doctor becomes a real fellow man like the Good Samaritan. Like all other men he takes care of the development of the abilities of his fellow men by specializing in care for a certain facet in particular. He is no longer someone who provides only medical treatment as some of his colleagues do nowadays, in an era in which less and less attention is paid to the human person.

Every doctor knows that the diagnosis is the beginning of his treatment. We have to learn to understand the content, the original meaning of the Greek word 'diagnosis': seeing through the things, the symptoms, the process of an illness and through this process a human being who undergoes a crisis[8].

It is for this reason that the doctor, according to Sirach, prays to the Lord ... that He grant him success in diagnosis and in healing, for the sake of preserving life (verse 14), and, we may add, not only for success in a medical diagnosis, but, above all, that he may help the patient on the basis of a human diagnosis. In this way, the writing of Sirach builds a bridge, so to speak, between the Hellenistic view of medicine and the Christian anthropology of the New Testament.

Addendum

The wisdom of Sirach 38; 1-15:

38.1) Honor physicians for their services, for the Lord created them;

2) for their gift of healing comes from the Most High, and they are rewarded by the king.

3) The skill of physicians makes them distinguished, and in the presence of the great they are admired.

4) The Lord created medicines out of the earth, and the sensible will not despise them.

5) Was not water made sweet with a tree in order that its power might be known?

6) And he gave skill to human beings that the might be glorified in his marvelous works.

7) By them the physician heals and takes away pain.

8) The pharmacist makes a mixture from them. God's works will never be finished; and from him health spreads over all the earth.

9) My child, when you are ill, do not delay, but pray to the Lord, and he will heal you.

10) Give up your faults and direct your hands rightly, and cleanse your heart from all sin.

11) Offer a sweet-smelling sacrifice, and a memorial portion of choice flour, and pour oil on your offering, as much as you can afford.

12) Then give the physician his place, for the Lord created him; do not let him leave you, for you need him.

13) There may come a time when recovery lies in the hands of physicians,

14) for they too pray to the Lord that he grant them success in diagnosis and in healing, for the sake of preserving life.

15) He who sins against his Maker will be defiant toward the physician.

* I owe many thanks to Professor J. Liesen of the Mayor Seminary of Rolduc, (Kerkrade, the Netherlands), who drew my attention to the writings of Jesus Sirach.

Professor J.P.M. LELKENS,
Emeritus Professor of Anesthesiology
at the Faculty of Medicine
Maastricht University, Netherlands

Notes

[1] *Carta degli operatori sanitari* (1994), Introduction nr. 3, published by the Pontificio Consiglio della pastorale per gli Operatori Sanitari, Vatican City (Translated into Dutch by W.J. Eijk en H.M.G. Kretzers, *Handvest van de werkers in de gewondheidszorg*, 1995, Colomba, Oegstgeest, Nederland, Inleiding nr. 3, p. 13).

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[4] De Heilige Schrift, *Apologetische Vereniging 'Petrus Canisius'* (1973), Het Spectrum N.V., Utrecht, p. 803.

[5] ibid. p. 762.

[6] BEENTJES P., *Een gedurfde visie op de genneskunst* (1979) *Schrift, Katholieke Bijbelstichting*, Nijmegen 65:5, pp. 178-183.

[7] ibid. p. 183.

[8] KORTBEEK L.H.TH.S. op. cit. p. 245.

AFTERNOON SESSION

ANGELO SCOLA

Introductory Remarks

More than any other question which impinges in an essential way on human existence, the question of health possesses in structural terms a social dimension and thus an economic dimension as well. As Archbishop Lozano observed during the press conference held to introduce this international conference, we should not think that the social and economic aspects of health—aspects which are usually placed under the general heading of health care—are independent of the profound anthropological—and, in the final analysis, Christological—meaning which the need for health serves to reveal within man.

Indeed, man, in the self-understanding of which he is capable, perceives within himself the existence of a dramatic dimension. This drama is the impossibility of avoiding the limit by which he is constituted. He is capable of the Infinite, but he is not capable in the final analysis of originating it, and he is therefore limited. In the light of the magisterium of John Paul II, it can be said that this condition of man emerges from his own elementary experience. He is one, but he has a dual unity. There are within him constitutive polarities—soul/body, man/woman, individual/community.

When we speak about something which is "constitutive," we speak about something which is "necessary" because the freedom of man must be aware of it in every act he performs and at every moment. Nobody can decide for him. The awareness of this drama, however, does not mean that man, as Sartre would have us believe, is a "useless passion." On the contrary, man with his freedom is able to perceive the real dimensions of the drama of which he is made up and constituted, although it must be made clear that nothing and nobody can decide beforehand the drama which will befall each man.

This dramatic character of the existence of man is brought out and emphasized with especial acuteness in the experience of illness and the consequent need for health which arises from that condition. When man is wounded in his physical integrity, he does not halt at the question *What treatment is suitable for my condition?* Indeed, he goes on to ask another question, and this is something especially true when the illness is serious: *Why am I ill?* In this sense, the experience of the lack of health reveals the intrinsic need for salvation which characterizes the heart of man, and therefore brings out the dramatic character of human existence—the fact that in a certain sense he finds himself in the condition of being "wounded." Every request for care also involves a request for salvation. In this way the unity of the self is recognized, in opposition to every exclusion of the individual—something which applies to the practical expression and implementation of medicine as well.

I have dwelt upon this anthropological dimension to health because reflection upon the social and economic problems and questions which are connected with health cannot involve methodic neglect (on the basis that such an element is taken for granted) of the need for salvation to which reference has been made. The answers which society can offer to the question of health care (compulsory insurance, public services, and so forth), with all their resultant economic consequences (the resources of the state dedicated to the national health service), must take all the factors into account. Controversial questions such as, for example, the respective roles of the public and the private in the healthcare sector, should be addressed with reference both to the principle of support (the clear application of a suitable anthropology which sees the person in terms of his original social component in his relationship with the state) and to practical needs, especially as regards the poorest sections of the population (that is, the policy of solidarity).

The papers by the participants in this session will address themselves, firstly, to the sociopolitical and economic aspects of health care within the context of reflections on the condition, difficulties, and relevant features of care in industrialized countries and in developing countries. Attention will also be paid to questions relating to the organization, management, and ethical models of healthcare systems.

It is my hope and wish that the debate which will be conducted this afternoon will contribute to the achievement of a unitary vision of health care which has as its interlocutor man *anima et corpore unus*.

Most Rev. ANGELO SCOLA
Rector of the Pontifical Lateran University, Rome

MARIA DE BELEM ROSEIRA

Sociopolitical and Economic Aspects of Health

1. Introduction

On the threshold of the third millennium man and the dignity which springs from his nature are emerging ever more as the primary values of global society.

We have witnessed with satisfaction the growing consecration of new expressions of the rights of man, and the recognition of such rights in the international context by means of a whole variety of mechanisms.

I have wanted to place my paper within the framework of values which spring from the dignity of the human being. This paper bears the title "the sociopolitical and economic aspects of health," and in response to an invitation extended to me by the Pontifical Council for Pastoral Assistance to Health Care Workers I would like to share this paper with you.

With regard to the title, it is right and proper to affirm that in the field of health and health care the meaning of human dignity acquires a very special weight, and to that dignity must be directed political, economic, and social questions. This is something which was very fittingly observed by *Gaudium et Spes:* "Man is the author, the center, and the end of the whole of social-economic life" (GS, 63).

2. The Right to Health

Within the framework of its project for health for all in the year 2000, the World Health Organization has drawn attention to the importance of healthcare systems which seek to achieve equity through a reduction of the inequalities which exist in the health levels of different countries, regions, and populations. Equity, here, has three principal aspects:

* geographical equity between different countries;

* socioeconomic equity between different social groups;

* the equity which should exist between different groups at risk.

The right to health is recognized by most of the fundamental texts of the developed countries. It is not, however, possible to exercise this right if the state does not guarantee access to it equally for all citizens, irrespective of their economic condition, their education, their geographical situation, and so forth.

We are equally aware of the fact that the elements which determine health levels in a community are numerous: there are those which have a direct relationship to health (technical and human resources) and there are those which contribute to providing the conditions which allow the inhabitants of a country to enjoy higher levels of health (education, development, and social and economic integration).

If these resources are not distributed fairly, access to the right to health is denied. It is for this reason that we believe that a healthcare system is fair only if it allows the same access to care and offers the same resources to people equally. In order for this system to be fair, it should provide different treatment for those who find themselves in different conditions. To put it succinctly, equal treatment for the same kinds of people and different treatment for different people.

As the World Health Organization has observed, "The new policy of health for everyone bears witness to the need to build a world where there is a real `culture of health' and where health is placed at the center of human development. The policies and the strategies which guide this transition must be defined and accepted rapidly so that the efforts of the next decades can be cohesive and coherent" (WHO, p. 6).

3. Principles for a Reform

In July 1996 I had the great pleasure, as the Portuguese Minister of Health, to take part in the approval of a document of notable importance which conforms to this spirit—*The Ljibljana Charter*. This *Charter* establishes a set of fundamental principles which we have sought to implement in our reform of the National Health Service of Portugal.

We would like to submit for the consideration of those taking part in this conference the following concepts, which were upheld on that occasion and which we believe to be of very great value.

1. "The reform of healthcare systems must be based upon the fundamental values of human dignity, equity, solidarity, and professional ethics."

2. "Each reform which aims to be important must have as its final objective the improvement of forms of health care and treatment. The prevention and promotion of health must be the fundamental concerns of society and its citizens."

3. "The reforms of healthcare systems must correspond to the needs of the citizens and their hopes and aspirations in the field of health and health care, within a democratic framework. The opinions and the choices of the citizens must exercise a decisive influence on the way in which healthcare systems are conceived and how they function and operate. The citizens must be jointly responsible in matters relating to health and health care."

4. "Each reform must take into account the continuous and constant improvement of healthcare treatment and assistance, without, however, neglecting the importance of the relationship between cost and effectiveness."

5. "The funding of healthcare systems must allow the treatment and assistance which are provided to be made available to everybody in an effective and real way. This means the right, for each individual, to payment for services and to fairness in questions relating to access to treatment and assistance, and for this reason there must be a rational use of the resources which are available. Governments, therefore, must be able to guarantee solidarity and actively participate in the regulation of the funding of healthcare systems."

4. The Challenges of the Future

The healthcare systems of modern, complex, and pluralistic societies have developed in line with a large number of influences, and these have expressed themselves in a process of reform which has taken place over a period of time.

The social transformations which are currently under way, and which are taking place at an accelerating pace, require a permanent adaptation of all systems which provide help, in addition to a constant response to the various and different problems which are raised by the emergencies of such new situations as the progressive aging of the population, new forms of social exclusion, and new illnesses associated with lifestyles which are brought about by economic development.

The reappearance of certain infectious diseases which we thought had gone forever, and the rise of new and unknown pathologies, both in the field of infectious diseases and in that of immunology, constitute very serious challenges, not to mention certain problems which we recognize as being of equal importance and significance—those connected with the quality and safety of the products of the food chain and other problems of a similar nature, in particular those relating to the condition of the air and water.

These questions and those connected with the conservation of the environment must go to make up a clear message for the generations to come, and the essential vehicle for this message must be education.

Scientific and clinical research, with all the moral, political, and religious implications that are associated with it, also constitutes a challenge for us which is at one and the same time both promising and disturbing.

All these factors work to augment the costs of health care. And at the same time the financial resources which are available, because of the very size of the task that we have to face, are clearly inadequate. Such resources, therefore, must be managed and directed in such a way that all citizens can benefit from them to the utmost.

5. Portugal and its Healthcare System

When we come to consider the Portuguese national health service, it should be pointed out that reform has been set in motion by the present government, which has given a clear definition of the lines to be followed in the growth and development of the system. The citizen has been placed at the center of the decision-making process, and this has given forceful energy to a strategy for change. It is also something which is indispensable to any reform which gets to the heart of the matter.

The essential principles of this process have been defined, and I would like to set out what they are here. These principles are as follows.

1. *The First Principle:* to invest in the potentiality of the National Health Service and guarantee respect for the principle of universality of access. This should involve an improvement in the size and breadth of the network of infrastructures of the healthcare and hospital facilities which cover the whole of the country; the appreciation and promotion of the professional aspects of this network; and the best possible use of the opportunities offered by the statute of this network to introduce changes and reforms in an organized and detailed way in relation to the funding of the system, the carrying out of the functions of public health, and the disposition of the services which provide various forms of health care.

2. *The Second Principle:* to make sure that the reform of the health system takes place on the basis of a rigorous analysis of the factors which have influenced its development, on the one hand, and deep and broad reflection on the possible scenarios of its future evolution, on the other.

3. *The Third Principle:* to go beyond the mechanical, one-dimensional, and voluntary work methods, include reference to changes in social systems, and adopt a dynamic and interactive idea of how things should be organized.

4. *The Fourth Principle:* to embrace the principle that change in the system must be based upon the citizen, and to guarantee a real commitment on the part of the various people who are involved in its practical implementation.

5. *The Fifth Principle:* to adopt balanced forms of the work carried out by the system which seek to maximize efforts towards concentration, thereby preparing and creating a framework for a gradual development in the medium and long terms—without, however, neglecting the needs for rigor and opportunities for action in the short term.

Following the process of the participation of civil society which has been promoted by the action of the Council for the Programming of Health, an organism which was set up to ensure the successful outcome of a specific task, in the near future there will emerge reform proposals which will be debated and discussed at a political level by parliament.

We are, however, convinced that the question of funding remains of cardinal importance for the healthcare system. We must assess whether public funding will be sufficient to ensure and sustain the provision of health care in relatively fair terms or whether we should also seek to draw upon private sources of funding.

As a European people which is attached to the values of solidarity, we are not prepared to turn our backs on the principle that access to health care must be guaranteed to each and every citizen.

In the same way, we also hope and wish that the technical quality of the care and assistance which is provided by the health system will not be different for rich and poor.

In the international context of attempts which are made to contain public expenditure, we must from now on be able to find the right point

of balance for ourselves as a country and a society.

6. Conclusion

In a world which is involved in a process of the progressive aging of populations, where healthcare methods are more effective, and where the number of people who are socially disadvantaged or openly incapable of upholding their rights is on the increase, solidarity emerges as an operative principle of life in society.

The enormous pressure exercised by these factors in the healthcare system requires a philosophy which is totally innovative. We need management of this whole area which has a strong ethical dimension.

"The ethical questions which are raised in relation to the distribution and use of resources destined to health concern every society and all citizens. They also concern the state and its different institutions, and all the professional groups which are involved in health care—in particular, medical doctors and nurses. From the united action of these social actors there can emerge a more universal and more equitable employment of the resources which are destined to health care" (CNEV, p. 81).

Technological and scientific advance and development in the healthcare sector must be understood from two points of view. On the one hand, new forms of technology allow healthcare workers to act more rapidly and with greater effectiveness in the treatment and curing of illness. But, on the other hand, they involve the danger that the *doctor/patient* relationship may come to be forgotten.

For this reason, if the enormous diversity which exists in means and resources "is not supported by a moral intention and by an orientation towards the real good of the human person, it will easily spring back on him and oppress him" (SRS, 28).

The reforms of the National Health Service, for this reason, are based upon a "new culture of health" where development inevitably involves an economic dimension which is directed towards ensuring that the human person has a suitable quality of life and prosperity. But it also involves, above all, another dimension which goes much deeper than this and which allows such development to be more consonant with the essence of man himself, where "having" is limited to serving the truth of "being."

Indeed, it is in this way that *Salvifici Doloris* sees the question when this publication observes that "the world of human suffering invokes, so to speak, another world unceasingly: that of human love; and this disinterested love, which he feels in his heart and his works, man owes in a certain sense to suffering" (SD, 29).

To conclude, I would like to say that in the face of the depth of man and the essence of the concept of humanity I feel absolutely small in size when faced with the ancestral value of the lesson and the practice of the two-thousand-year-old institution, which quite rightly can be defined as being "**expert in humanity**."

But in approaching the new century the Church must adopt in an ever more evident and active way the role of the shaker of consciences, a role which obliges the political powers which make decisions to be in line with the heights of the nobility of the objectives which are in view.

Dr. MARIA DE BELEM ROSEIRA
Portuguese Minister of Health

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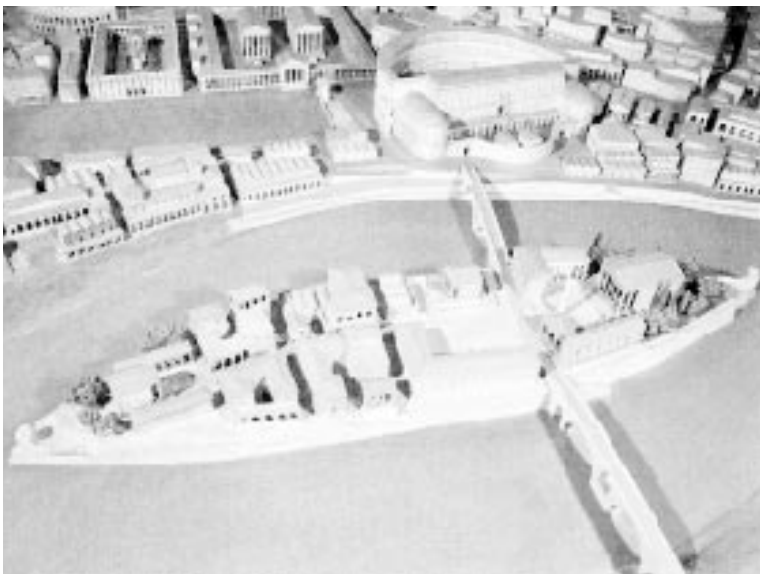


PIERLUIGI MARCHESI

Health and Health Care in the Industrialized Countries

In the variety and range of the expertise which is represented at this round table, one can perceive the complexity of the problems which concern the whole world of health care. During my brief paper, I have sought to present to the eminent experts here present the view that the time has perhaps come when, in dealing with health care, we should eliminate detailed analyses.

By now we all know everything about the high costs of health care, about its impact on the welfare state, and its relationship to the trials of the citizens of the whole world. What we need to do now is to get an overall vision and produce local strategies in order to move from abstract analytical theories to practical initiatives and policies which improve health care to the benefit of sick people.

In the tandem "health and health care" is to be found, it seems to me, exactly that nexus which links the practical needs of sick people with the structural problems of health services. Indeed, during our discussions there must be a marked and detailed reference to that need for health which is at the basis of, and underpins, the decision to turn to healthcare services and facilities.

From every quarter we hear it said that the various health services—and not only in the industrialized countries—have begun to come up against the requirements and imperatives of existing social and economic systems. In particular, there has been the need to think about the whole organization and system of provision of health care because of pressures to contain the costs of the welfare state and to increase its effectiveness and efficiency.

From the north to the south of the planet there is one order of the day: "rationalize welfare expenditure." To put it bluntly, this means a radical change in how things are managed, in how services are organized and provided, and in the distribution of human and financial resources.

Here certain problems arise which I will very rapidly submit to your attention:

1. The measurement of costs and respect for justice.
2. The rethinking of the concept of quality of life as a bioethical criterion.
3. The guaranteeing of access to services for all citizens.

1. The Measurement of Costs and Respect for Justice

I hope it will not appear to you to be exaggerated, during this round table meeting, to refer to John Paul II's teachings on economic questions. In the encyclical *Centesimus Annus*, which was published in 1991, the Holy Father reaffirms the relevance of the international context in which market economies operate. Through their access to the international market, it is possible for all national economies to achieve growth and development, first and foremost through the understanding and appreciation of their own human and natural resources.

The fact that the market economy is seen as the most efficient way of bringing resources together and of responding to people's needs is not something which the Pope sees as being contrary to the traditional teachings of the Church. When we apply this approach to the questions that we are considering here today, we can see that the entrance of the market into the world of health care can indeed be a useful way of avoiding waste and organizing expenditure. But for the world of health care separate observations must also be made which combine control of expenditure with respect for the needs and requirements of all sick people.

Indeed, and with great incisiveness, the Holy Father makes clear that the free market has different roles according to the nature of these needs: "This, however, is valid only for those needs which are *resolvable*, which involve a power of purchase, and for those resources which are *saleable* and able to obtain a suitable price. But there are very many human needs which do not have access to the market. It is a strict duty of justice and truth to keep fundamental human needs from remaining unsatisfied and the people who are oppressed by them from dying" (C.A. 34).

The need for health which appears in the constitutions of certain countries in the form of an ambiguous right to health is clearly a need which cannot be expressed in money. For this reason, the time has come to divide the real cost of the service from the plus-value of care for the sick person. This last should be measured and valued in terms of overall quality and—why not?—also assessed and paid as a surplus. Indeed, a healthcare system cannot be reduced to the level of a mere

profit-making company, even though such profits indicate and bear witness to the economic success of a healthcare company.

In this case, the Pope argues, profit cannot be the only yardstick by which to assess the effectiveness of a company: "The aim of a company is not merely the production of profit, but also the existence itself of the company as a *community of men* which in a different role pursues the satisfaction of their fundamental needs and constitutes a specific group at the service of society as a whole" (C.A. 35). In other words, the keeping of accounts must include the cost of that immeasurable good—the dedication of professionals. This—and I repeat the point—must be paid for as a quality service which would not be such without the dedication of healthcare workers, regardless of their religious loyalties, which in themselves act as a force for the achievement of improvement.

2. The Rethinking of the Concept of Quality of Life as a Bioethical Criterion

In all the countries of the world healthcare problems center around the question of the measurability of the quality of life. Indeed, for economists healthcare costs must obey those criteria of efficiency and effectiveness which characterize the system of industrial production. This assumes that there can be men whose life is worth more than that of other men, and that the lives of some men are worth less than those of others. For this reason it is argued that some people should be treated, but others should be abandoned.

For Christians, this line of argument is not acceptable. This is because for us the basis of ethics lies in the idea that all men are equally important and that their lives and needs must be dealt with equally without any kind of distinction. We might think here of the disastrous consequences we would encounter if we came to consider—as, indeed, some legislators propose—the quality of life of an elderly person or of a mentally handicapped person to be of less importance, or if we were to lower ourselves to employing utilitarian considerations as a basis for the provision of aid to developing peoples.

Thus, the following decision-making criteria cannot be excluded solely on economic grounds: the value of life, the principle of equity in treatment, and respect for civil rights.

In applying A. Sen's concept of quality of life to health care, we can only refer here to the complexity of the concepts which this perceptive economist of Indian origin brings into play when discussing the policy which governments should adopt in relation to the well-being and quality of life to which their citizens aspire. In seeking to understand to the full the reasons which allow a person to be satisfied with his own condition, A. Sen declares: "There are many fundamentally different ways of perceiving the quality of life and a certain number of these have a certain immediate plausibility. One could be well-off without being well. One could be well-off without being able to live a life that one would like to live. One could live the life one would like to live without being happy. One could be happy without having much freedom. One could have a great deal of freedom without possessing much. And so the list goes on" (A. Sen, *Il tenore di vita tra benessere e libertà*, Venice, 1993).

We can see that from this perspective a much more fruitful approach can be set against naive utilitarianism. In this approach individual self-determination which takes place through a process of *preferences* also becomes a path marked by obstacles. This path becomes an intricate cultural fact with which a whole series of disabling conditions can interfere (for example serious illness, physical and mental handicaps, and old age).

In opposition to the utilitarian approach—according to which man is as he is—is placed a disturbing idea: "Man is what he is allowed to be."

The ethical problem of social justice as it bears upon bioethics is not only that of having to ensure that all men have sufficient resources with which to satisfy their own *given* preferences and aspirations. It is, rather, *to ensure that all men have those sufficient opportunities by which to accomplish a full and complete project of the development of their aspirations and potential.*

The resource which is really scarce is that which could be defined as *opportunity for human development.* It is a lack of respect for the development of man which creates the material preconditions for injustice.

The injustice of the individual who has to suffer the deprivation of goods or health is not for bioethics a reason why that person should be deprived of the treatment which is necessary to obtain his *opportunity* to live.

The Human Development Indicator produced by the development program of the UN does not in this light seem to be very helpful. This is because the values which it takes into account do not seem to be sufficient to guarantee respect for the human person in his various existential situations and conditions of life.

For the United Nations the development of a population is to be judged in relation to four factors—gross domestic product *per capita*, literacy levels, average educations levels, and life expectancy.

The term "life expectancy" is not synonymous with quality of life, but introduces a certain material/measurable dependence between life expectations, health conditions, and a permanent dependence on external factors. In this approach those disabled people who are unable to generate income would come to be considered a weight.

From a personalistic point of view, overall care for the human person does not embrace the partiality of economic calculation based upon the relationship between costs and effectiveness as a value. It proposes, instead, a new emphasis on the role of the biomedical researcher, the medical doctor, and the nurse as defenders of the life of every human person and as guarantors of the rights of every human person.

3. The Guaranteeing of Access to Services to all Citizens: Information and the New Role of Voluntary Workers

I would not like my words to be taken as constituting an attack on the health services of the industrialized world. I must, however, say with frankness that the world's health service in its present reduced terms is in itself a problem. Above all, this is because it is becoming increasingly isolated from the rest of society in its propensity to rely for its success upon the spectacular work of certain eminent doctors and to shut itself up within a sort of labyrinth which is open only to the initiated. In order to resist this closure a new humanizing culture of medicine and a new kind of training for professionals must be brought into play.

The healthcare service must make itself credible in the eyes of all people and should no longer be a service made up of *healthcare workers,* but a decisive instrument in the promotion of health. This should take place through programs of healthcare education and prevention, improvements in the quality of services, and concern and care for the weakest members of society.

All this requires a new model of providing information which will commit healthcare institutions to drawing nearer to people and to all potential users. We need to bring our health services nearer to people and to use an accessible language to explain to them what they can expect and what they can obtain from the health service of their country.

Access to health services is not only a question of architectonic barriers and obstacles. It involves first and foremost the culture of health care. If people are not helped to recognize what health institutions are and how they function, then they cannot know how to direct their requests or obtain suitable answers.

The Catholic voluntary workers active in hospitals can and must participate in this sensitive operation by performing a new role. The timidity which has characterized the first steps of this movement must be placed to one side and be replaced by a programmed initiative involving a two-way drawing together of citizens and healthcare institutions.

Voluntary work must abandon the role of ancillary activity which it has hitherto embraced and direct its steps towards the construction of a fairer and more solidarity-inspired society. Such a society must guarantee its citizens the opportunity of being able to meet their needs as though they were securing the honoring of their rights.

Healthcare workers and Catholic voluntary workers in hospitals must brace themselves to the task of redesigning a world made up of the exercise of solidarity between institutions and citizens. This must be done if we do not want to risk the disintegration of the very unity of human civic coexistence in each continent of the globe.

In conclusion, I cannot but refer to what in the near future should be the role of the Catholic hospitals.

In being Catholic—that is, in being universal in their vocation—our healthcare institutions should find a way of expressing the uniqueness and the originality of their mission.

A Catholic hospital which is really inspired by God's charity towards men searches for and imprints a *style based on communion* which in caring for men's bodies is also concerned with the salvation of those persons who constitute the community of the saved. This is a sign of hope and a promise of salvation for a world wounded by illness.

Hence the attempt to find guidelines for action which I would like to summarize as follows, expounding at the same time certain points of view which I have expressed elsewhere in other contexts.

a) The quality of the medical care provided in Catholic facilities may not be inferior to that offered by corresponding non-Catholic or secular institutions. However, a Catholic institution cares for the whole person—his body, his mind, and his spirit. This kind of overall health care requires that attention be paid not only to the scientific quality of the medical care which is provided, but also to the way in which it is provided.

Although there is nothing exclusively Catholic in such a concern for quality, a widespread opinion makes a net distinction between Christian healthcare facilities and others precisely because of this personal aspect.

b) The credibility of the preaching of the Gospel by the Church is undermined when her internal life—which includes her healthcare institutions—does not reflect the justice which she preaches. Catholic institutions must be responsive to calls for social justice when they make decisions about the services they offer and the allocation of resources. These decisions should be made in the light of the real healthcare needs of the communities which such Catholic institutions serve, rather than with reference to merely financial considerations. The social teaching of the Church must also leave its mark on the relationships between employers and workers which exist within such institutions.

c) In the near future market pressures may prevent Catholic healthcare institutions from being able to increase the care they are able to offer to their poor patients. Nevertheless, they can respect the dignity of the poor patients whom they treat and care for by providing them with the same quality of assistance and the same personal attention as they give to their rich patients. They can also call for public policies which provide fairness for poor people in gaining access to health care, something which is in line with the pressing appeals of the Holy Father. Decisions regarding the location of institutions, the kinds of service which should be provided or ended, and the kinds of equipment which should be purchased, should be made while bearing in mind their impact upon the poor (cf. J. Beal, "Ospedali Cattolici," in *Concilium,* no. 5/1994, pp. 115-129).

Perhaps this is not so much a program as a way of addressing the question of moral coherence which the Gospel demands of all healthcare workers.

Fra PIERLUIGI MARCHESI
Member of the Pontifical Council for Pastoral Assistance to Health Care Workers

FERNANDO MORALES MARTINEZ

Aging and Health

The phenomenon of the aging of the population in Latin America is a new experience which is taking place at an accelerated pace and for which we are preparing only very slowly. What we have to do, and what is most urgent, is to adopt a culture which respects the dignity, the rights, and the complete integrity of elderly people.

In this part of the world there is a constant and explosive expansion in the size of this part of the population—that is, the sector which comprises people who are sixty years of age and over.

The aging of the population involves an ever-greater increase in percentage terms of the number of elderly people within the population as a whole.

This process is caused first and foremost by the birth rate and secondly by the death rate, and this is because populations with a high birth rate tend to have a lower proportion of elderly people, and vice versa. The term "demographic transition" refers to a gradual process whereby a society passes from a situation of a high birth rate and a high death rate to a situation involving a low birth rate and a low death rate. This transition is chiefly characterized by a reduction in levels of infant and child mortality, which are gradually lowered with the decline of the incidence and effects of contagious diseases and illnesses caused by parasites.

The best results concerning life expectancy occur when birth rates tend to grow constantly, thereby leading to many births and a high number of children in relation to the adult population as a whole.

When the birth rate falls and the death rate continues to improve, the population begins to age.

Table 1 - Age of the Population of Latin America and the Caribbean - 1950-2020

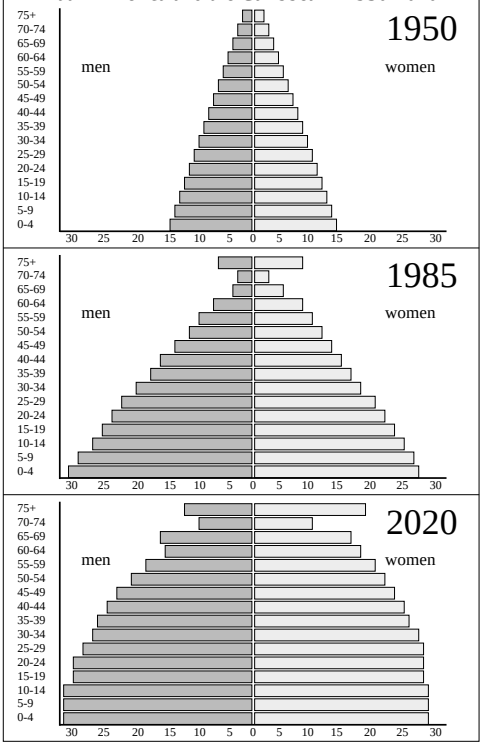


Table 1. These statistics demonstrate the recent historical transformation of, and the projections for, the age structure of the population of Latin America and the Caribbean.

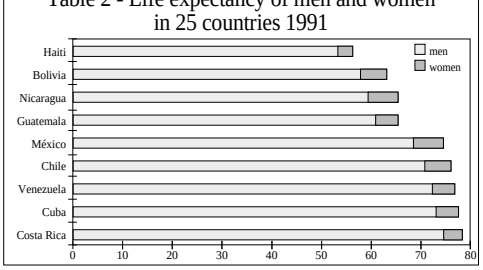
In 1950 the general situation was characterized by a reduction in the death rate of the youngest members of the population at a time when the birth rate was high (on the average, each woman had six children). This gave rise to a great expansion at the base of the population pyramid. This pyramid had lost its triangular form, and the percentage of elderly people as a proportion of the population as a whole had increased slightly. In the year 2020 the base of the pyramid will be rectangular and the number of people in their thirties will be the same as the number of people in middle age. It is predicted that in the year 2020 the elderly part of the population will constitute from 12% to 13% of the total, as opposed to the 5.5% of the year 1950 for the same grouping.

There is a wide variety in the figures relating to Latin America and the Caribbean, and this reflects the demographic and socioeconomic differences to be found between these countries. There are elderly people in difficult living conditions who have very little welfare support and very low levels of purchasing power.

Some nations, such as Costa Rica (the leading country in Latin America in terms of life expectancy levels at birth), Uruguay, Cuba, and Argentina have experienced a rise in aging levels within their populations, in contrast to such other countries in the region as Haiti, Guatemala, and Nicaragua, which still have high birth rates.

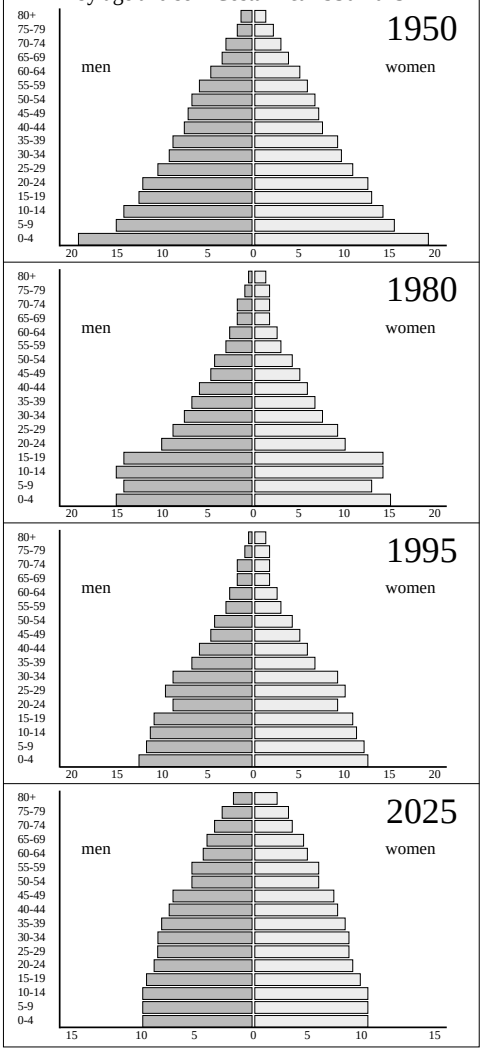
The following table clearly demonstrates levels of life expectancy in Latin America.

Table 2 - Life expectancy of men and women in 25 countries 1991



Because it is a small country located in Latin America, Costa Rica has the following historical population structure.

Table 3 - Structure of the population by age and sex- Costa Rica 1950-2025



In a study carried out in June 1994 in Costa Rica by the Institute of Research on Multiple Subjects it was clearly demonstrated that those over seventy within the population represented 8% of the whole. Projections envisaged a decisive increase in this group which would be sustained and explosive, and which in the year 2020 would reach 14% of the general population, whereas in many countries in the region the proportion of people over 75 years of age would have tripled over the same period.

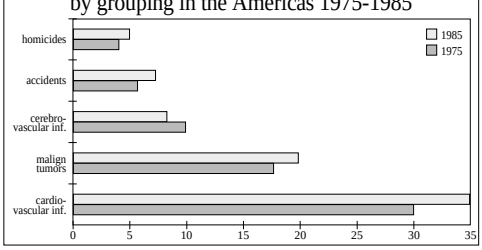
Projections indicate that women will make up the majority of elderly people in all regions of the world where there are developing countries. If the existing gap between female and male survival rates in Latin America continues to increase with the passage of time—as is happening in Europe and North America—it is predicted that there will be an even greater gap in future years than is presently envisaged, especially as regards the oldest segments of the population.

In the studies carried out in Latin America on the composition of the family it is found that the majority of people over the age of seventy live in extended and elaborate families made up of members belonging to a number of marriage units (for example, with an elderly couple and with a married grandson and grandchildren). About 25% of elderly people live in nuclear family units made up of a married couple or of a single person who lives with his or her unmarried children, and about 7-16% of elderly people live alone. This fact confirms the belief that traditionally the family (in its various forms) has been, and remains, one of the principal sources of the social and economic support which is provided to elderly people.

In Latin America there is a strong tendency towards participation in the female workforce, and this is something which has been brought about by the processes of industrialization. For this reason, the possibilities for care being offered by women are reduced, and the result of this is a possible “abandoning of the elderly.” All these phenomena lead to a strengthening of the family structure and to an improvement of the quality of life enjoyed by elderly people as regards their primary and imperative needs.

As can be observed, cardiovascular diseases occupy the first place in the causes of death in Latin America, something which is also true of the industrialized countries. The same may be said of the presence of a number of other pathologies.

Table 4 - Percentage causes of death by grouping in the Americas 1975-1985



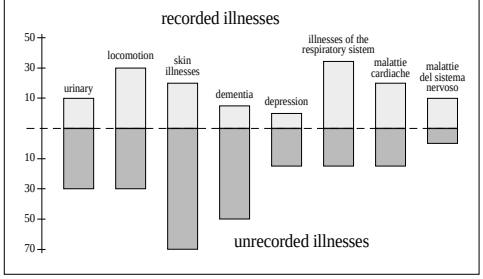
The epidemiological transition is rooted in a change on a large scale from previous types of illness to those of a chronic and degenerative character. In general, the epidemiological transition accompanies the demographic transition, even though the effects of the first appear later than the effects of the second.

The present-day or future economic situation diminishes the benefits which elderly people need, and which they deservedly and rightly hope for. The increasing number of elderly people who come to receive a pension has led to there being a serious economic deficit, and this has had serious consequences for the standard of living of many elderly people.

Without doubt, the real test of the social programs of Latin America is to be found in the healthcare sector.

An additional phenomenon is now to be found in the world of healthcare services, namely, the lack of suitable training on the part of the healthcare teams which look after elderly people. This emerges clearly from a study carried out in Scotland in 1964 which lays out the number of illnesses which were not detected by healthcare teams looking after the elderly.

Table 5 - Non-recorded illnesses



In the face of this situation great efforts have been made in Latin America to teach geriatrics and gerontology. In countries such as Costa Rica, Cuba, Mexico, Argentina, Uruguay, Chile, and Brazil, energetic attempts are being made to increase people’s knowledge about these areas and to apply such knowledge in the provision of services which work to the benefit of elderly people.

In Costa Rica major advances have been achieved in the field of formal and informal education.

The Dr. Raúl Blanco Cervantes National Hospital for Geriatrics and Gerontology of the National Fund for Social Insurance, which is the only such institute at a university level of its kind in Latin America, provides a specialization course which lasts four years within the framework of the System of Higher Studies of the University of Costa Rica. In addition, this National Fund for Social Insurance also offers an overall approach to elderly people through programs of prevention and recreation. There are also a large number of state and private institutions which look after elderly people and which seek to achieve for them a good quality of life.

Before finishing this paper, I would like to reflect briefly upon what growing old and aging means.

We are indeed dealing with growing old and aging in a world where, luckily enough, science and technology have made enormous advances, but at the same time in this world morality, principles, and spirituality grow worse every day. This is something which is not worthy of a Christian society.

What are we doing? I believe that it is obvious. However great the advances of science and medicine may be, if *today* all of us do not commit ourselves to strengthening family ties and generally secure a substantial improvement in the quality of life of elderly people, it will be hard for us to experience an old age which is dignified.

In December 1996 the United Nations carried out a study in Central America which revealed that 81% of the population of Costa Rica professed themselves to be Catholic. Such figures are to be found not only in Central America, but in nearly all the countries of Latin America. Without doubt, and curiously enough, this great majority of practicing Catholics, who are often immersed in the pressures and strains of daily life, forget or tend to put off to another date their duties towards elderly people.

I believe that the opportunity for renewing and strengthening such a commitment is drawing near with the declaration by the United Nations of *The International Year of the Elderly* which will be held in 1998. For this reason, I would like to make a humble, but strong appeal to you to secure the authoritative and indispensable support of the Catholic Church in this arduous, but important task, namely, to bring about an awareness within our societies and to protect our elderly people through solidarity, respect, and love for one's neighbor, and at the same time, united in the Faith, to secure the proclamation of 1999 as the "International Year of the Elderly," preferably through an encyclical, an apostolic exhortation, or another document published by the Vatican.

This will be an act of homage to our much-loved elderly people, to whom we owe so much.

Dr. FERNANDO MORALES MARTINEZ
General Director of the National Hospital for Geriatrics and Gerontology, San José, Costa Rica

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FERNANDO S. ANTEZANA

Facing Poverty and Vulnerability

The world is at risk of losing the considerable health gains that have been achieved over the past 40 years. The main threats are increasing poverty and inequality.

Since the 1950s, average life expectancy in developing countries has risen from about 40 to 64 years, and the number of children dying before they reach the age of one year fell from about 10% to 62 per 1000 live births. In comparison, people in developed countries can expect to live until 75, and infant mortality is 7 times lower.

Since the mid 1980s, however, the number of people living in extreme poverty with income of less than $1 a day has risen, reaching an estimated 1.3 billion in 1993. There are several reasons. They include economic decline in developing countries during the 1980s—the "lost decade" for development—and in eastern Europe and countries of the former Soviet Union in the early 1990s; economic growth that lags behind population growth; and, especially, inequality in the distribution of income, which means that the benefits of accelerating growth accrue to a small portion of the population.

In all countries, there is a clear correlation between poverty and ill-health. Poor people bear a disproportionate share of the total burden of disease, which reflects the persisting inequity in access to resources, including health care. In developing countries, poverty is the underlying cause of the 11.2 million deaths each year among children under five years from malnutrition and such diseases as diarrhoea, dysentery and acute respiratory infections. In adults, it accounts for many of the annual around 5 million deaths from tuberculosis and malaria.

Although few people in industrialized countries exist at the same level of absolute poverty experienced by so many in less developed ones, substantial minorities do not have the material resources to participate fully in society. Their poverty is described as relative, that is, as compared to the living standards of their fellow citizens. Research indicates that even relative poverty is a leading cause of ill-health and premature mortality.

Poverty is widely perceived to mean low levels of income and consumption. Yet, as the United Nations Development Programme says in its latest report, "Poverty has many faces. It is much more than low income. It also reflects poor health and education, deprivation in knowledge and communication, inability to exercise human and political rights, and the absence of dignity, confidence and self-respect." Such factors as insanitary and overcrowded housing, unsafe work environment, poor diet, and damaging lifestyle habits affect health, destroy self-esteem, and reduce the opportunities of poor people in every sphere, hence their ability to live full and productive lives. Those most vulnerable include children and elderly people, households headed by single women, refugees and migrants, and people with a disability or who are chronically ill.

The narrow view of poverty has made it difficult to define the broad policies needed to reduce it, and has led to ineffective anti-poverty programmes. The inequities and increasing gaps between rich and poor in many countries and communities now threaten social cohesion and are strongly related to excess mortality, violence and psychological and social stress. It is being increasingly recognized that peace and security, the cornerstones of economic growth, are incompatible with the existence of gross equity gaps and huge numbers of people living in poverty.

For most countries, the political and economic trends of the past decade have had far-reaching effects on the health sector. Policies aimed at improving health have been undercut by economic adjustment measures, including reduction of public sector budgets. Increasingly, countries, including poor ones, are looking to households to shoulder a larger share of health care expenditure. The private provision and financing of care have become a reality, irrespective of health policy. The growing influence of free-market economics is enhanced by globalization, the growing integration of the world economy through the free flows of trade and finance.

In these circumstances, it is even more pressing to introduce poverty-reduction measures and set up social safety-nets so as to avoid further marginalization of the poor. Difficult questions will have to be faced. For example, how do we strike a balance between individual and social needs? How do we ensure that quality of care is reconciled with equity and not used as a pretext to serve the interests of the few? How do we ensure that the market-driven develop-

ment of technology takes account of the needs of the poor?

Our responses have to be both honest and humane. They must be applicable to people's circumstances and meaningful to them. They must be respectful of people's rights, dignity, and values, as lived within their own communities. In other words, they must be worked out with the people concerned.

The traditional response of the health professions—as of the Church over centuries—has been to offer care and compassion. "Care" means a wide range of services, both technical and humane, such as relief from pain and support for a dignified death. The work of nongovernmental organizations and family members in caring for terminally ill AIDS patients in Africa reminds us that care is not a luxury, but a basic and universal need. But the immensity of poverty and of health inequality begs the question, Is care and compassion enough?

On the eve of the twenty-first century, the challenge for health systems is to continue to improve health status, despite the prevailing context. This will depend on eliminating the health disadvantage of the poor. WHO is committed to equitable access to health services for everyone—its "health-for-all policy". The concept of equity refers to fairness and justice, but recognizes that people have different needs. Each person has the right, and should have the opportunity, to be healthy. This requires more than equal access to health care—health services have to take into account ways in which needs can differ between people and communities. WHO's commitment is based on the understanding that for all countries equity and social justice are not solely ethical imperatives, but form the basis for sustainable human development and economic growth.

What should be the basic characteristics of a health system able to cope with that challenge? First, it must be able to provide equitable access to care on the basis of need. It must address the main health problems of the community, through treatment, prevention and control of disease, immunization, provision of essential drugs, maternal and child care, supply of safe water and basic sanitation, promotion of proper nutrition, and health education.

In addition, health authorities must be able to lead partnerships with all providers of health care and to influence the policies and actions of other sectors. They must also be able to inspire, support and collaborate with community organizations, the media and business leaders in order to create an informed, supportive and healthy environment.

We have arrived at a crossroads at which we have to choose the best way to fulfil those tasks. We know where the different roads will lead, yet we hesitate over which one to follow. One route leads to health becoming increasingly subservient to short-term economic concerns, where much greater emphasis is placed on the role of market forces in the financing and production of health services.

A second route leads government to focus their efforts on the health needs of the poorest people while private care provides for the more affluent. But experience has shown that choice can lead to two systems of care with two levels of quality, which has to be offset by high levels of public expenditure to ensure access of the needy to appropriate care.

The third route leads the assurance of health services for everyone. It focuses on the health status of the entire population. It is based on a broad view of service financing and provision that brings together public and private sectors, nongovernmental organizations and informal care providers in a comprehensive national health system, in which resources are allocated on the basis of equity. This is the direction contained in WHO's policy for health for all.

WHO believes that the principles of health for all need to be translated into a new public health ethic, distinct from, but complementing, long standing medical ethics. This would provide a framework for analysing and responding to the social and economic determinants of ill-health, in which priority is given to the needs of poor and vulnerable groups.

However, values cannot be imposed from the outside; we need to find for convergence in the values which guide our health work and polices. To foster health development and international health action in a spirit of respect, solidarity and equity, WHO's first responsibility must be to promote genuinely open dialogue involving all peoples, cultures, and health-related entities.

Only clear political will can direct the health sector along the road to equity. WHO provides strong support and commitment, but we also need greater partnership and coordination among all bodies concerned with health and development: international agencies, nongovernmental organizations, associations of health professionals, and churches and religious groups. Only concerted efforts will help influence governments and major financing institutions to take effective action to reduce poverty and its health consequences and to achieve greater equity in health. We have to work together to this common goal, because, without substantial shifts in policy and practice, poverty will continue to exact a heavy toll on human health.

Dr FERNANDO S. ANTEZANA
Assistant Director
General /Deputy Director
General a.i., World Health Organization

FRANCO SPLENDORI

The Organization and Administration of Health Services

1. Introduction

In order to engage in a comparative analysis of the different models by which health services are managed and administered we must develop a methodology which brings out and employs comparative elements of reference which are homogeneous in character.

In such an undertaking we should take the following into consideration:

1. The population and its healthcare needs.
2. The overall supply of services.
3. The means and nature of funding.

The management models should be identified and listed with reference to the objective impact that they have upon these three elements, which should thus also be employed, in turn, as indicators of:

a) whether needs are being satisfied; the quantity of the resources which are used; and the fairness of the costs and benefits which characterize the system;

b) the correlation between the distribution of resources to the different functions and structures of the service and what those resources actually provide;

c) the juridical and administrative status of the institutional system.

2. The Purposes of the Model

The character of the model corresponds in an almost overall fashion to the fulfillment of three institutional tasks and roles.

a) Efficiency in the use of resources.

b) The achievement of effective levels in the defence and safeguarding of health.

c) The definition of the conditions of the usability of the resources in terms of fairness of access and equality in the provision of services.

2.1. Reference Points and Indicators

Overall healthcare expenditure consists of all the resources which are employed in the workings of the healthcare sector.

In order to engage in evaluations and comparisons, healthcare expenditure is defined with reference to:

a) expenditure *per capita;* and b) the relationship between that expenditure and gross national product.

Such statistics allow us to make observations and judgments in the context of a lack of administrative clarity about the workings of such services; about the various interrelated headings of social expenditure and healthcare expenditure; with reference to the hidden costs which are imposed upon citizens in terms of delays in receiving treatment and the similar costs of what it takes to obtain such treatment in reality—namely, appointemts, transport, and bureaucratic red tape; and about real costs whose calculation is made difficult by the presence of different national currencies.

The way in which resources are employed and the fairness of a system can be assessed by using the statistics of the above-mentioned indicators, and more specifically: 1) the relationship between healthcare expenditure and gross national product; 2) the structural quality of the system; and 3) the socioeconomic situation (demographic composition, income *per capita*) of the population which is under study.

The relationship between healthcare expenditure and gross national product can be analyzed by studying its different component parts. Attention should be paid to such key elements as the growth in expenditure, the growth in gross national product, levels of population growth, growth in the various reference factors of the component parts of healthcare expenditure, variations in the volume and intensity of technology (the growth rates of services *per capita*), and variations in the price of the healthcare sector in relation to inflation rates, more generally.

When analyzing the indicators of structural quality, attention should be paid to the total beds available and to the beds available for chronic cases; the number of medical doctors; and the employment of advanced technology. The indicators of the socioeconomic situation which are of special importance are the gross national product *per capita* and the elderly as a proportion of the total population.

2.2. Healthcare Effectiveness

It should be observed at the outset that the impact of a health service on the different levels of need cannot be directly assessed in an objective fashion because of a set of social, economic, cultural, demographic, and geographical factors. For this reason, elements which are not particularly reliable in the comparative evaluation of

healthcare systems are usually taken into account.

The most widely employed elements of this kind are infant mortality rates and life expectancy rates at birth. These, in turn, are complemented by post-natal mortality rates and levels of life expectancy at the age of eighty (these provide indirect information on the availability and employment of advanced forms of technology in the provision of treatment and the making of diagnoses).

2.3. Equity

This concept has a large number of definitions. It necessarily refers to the individual's relationship to the distribution of benefits and costs. The principal indicator, but at the same time also the least sophisticated indicator, is that which expresses the degree of social protection—that is, the proportion of the population which is covered by obligatory public services. This concept implicitly defines the opportunities which exist to gain access to essential services—at least as regards the weakest parts of the population__which are provided by structures financed by mechanisms of funding based upon the principle of compulsory contributions or contributions raised from taxes.

2.4. Resources

According to the methodology which is most widely used, resources are defined with reference to the services which they finance. This analysis breaks down healthcare expenditure into four major functional categories: hospital care, clinics, pharmaceuticals, and care for the bedridden (including such care carried out in the home of the patient).

3. The Models of Organization for Health Services

1) Governments are now chiefly concerned with finding solutions to the growing expansion of healthcare costs and expenditure in both the public and private sectors__a development which has an inflationary effect on the economy and also generates social tensions.

The initial models, which were based upon criteria relating to systems of funding or legal status, have been adopted over the years in response to specific national needs. The result has been a series of mixed or hybrid systems with features in common with other models.

3.1. Insurance-Based Systems of the Bismarckian Model

To begin with, these systems were based upon insurance funds for specific categories of workers or professions which provided help to their respective memberships. They have since been gradually transformed into systems which cover the whole population.

The state now acts to guarantee this public service. Insurance against illness is the principal means by which to provide financial resources which are used to pay for services offered by professional healthcare services. In practical terms, this kind of system now works in a number of different ways, which are as follows.

a) Rigid systems where the insured person belongs to a special insurance fund and is assigned to a medical doctor who is directly nominated by the national health service of that country (Germany).

b) Flexible systems where the insurance scheme pays after the service has been provided by the doctor and where the doctor is chosen by the insured person himself (France, Belgium, Luxembourg).

c) Mixed systems where health insurance is public and helps citizens beneath a certain level of income who are assigned a doctor within a healthcare relationship which is rather rigid in character. Above a certain annual income (equivalent to 54 million Italian lire) citizens take part in a private insurance scheme (Holland).

The large number of forms of health insurance and the notable variations which exist between them necessarily produce a very approximate kind of classification. However, it should be pointed out that they have the shared characteristic of giving an important role to trade unions and private employers.

3.2. Healthcare Systems Based on the Principles Enunciated by Lord Beveridge

In such systems access to health care is guaranteed by a system based upon taxes levied by a public authority of one kind or another. This model arose in the postwar period in England and was later adopted by countries with social-democratic governments (Denmark, Sweden, and Finland). Systems of this type involve national health services based upon different levels of national institutional organization and are both centralized and localized (regions, provinces, and municipalities) in character.

3.3. Mixed Systems

In these systems the recent creation of a national health service, with its founding principles of access to all and fairness for all, exists side by side with elements which remain from previous insurance-based systems which were created for ideological reasons at the end of the 1970s and during the mid-1980s. The present-day movement, however, is towards systems rooted in concepts of national solidarity (as, for example, is the case in Italy).

3.4. Individualistic Private Systems

The American model is the classic example. The objective which lay behind its creation and development was control over costs. The organizational and ideological basis of this system in the USA is

rooted in the principles of competition. There are a large number of healthcare workers, sources of funds (private insurance and public authorities), and structures, all of which compete with each other.

The citizen is responsible for the defence of his own health and freely decides upon the proportion of his income which he wishes to devote to health care. In addition, he also chooses his own doctor and the healthcare facilities which he wants to look after him.

For their part, the administrators and managers are responsible for the way in which health care is organized and provided, and for the programs of investment which are implemented.

The public system, for its part, upholds certain general rules and guarantees care for the elderly, the disabled, and protected categories (Medicare) and for the chronically ill (Medicaid).

Although the private system is efficient, it involves very high funding costs (14.5% of gross domestic product) and a large number of people who are excluded from insurance coverage (about 40 million citizens).

4. A Convergence of the Two Models

Leaving aside differences caused by local needs and local forms of health care, two models emerge which are differentiated by their forms of funding.

a) The *American* individualistic model, where there is a broad range of insuring bodies—for the most part private in character—which secure healthcare provision from independent institutions and organisms.

b) The *European* social model, where there is a sole body which strives to guarantee healthcare coverage for the whole of the population.

There are diverse variants of the European model. In the Bismarckian system specific contributions are raised by a system of compulsory insurance schemes. The Beveridge system involves the system being funded from general government revenues. The "mixed" Italian system is marked by a territory-based and company-based institutional system on the English model where, however, one half of the expenditure is covered by contributions from salaries and wages (45%). In this system there are hospitals which are in part independent and in part within the national health service where the patient pays for the service he receives.

The most consistent aim of these various systems is the containing of costs because within these systems there is no clear preference in favor of a single, ideal, model.

This is a conclusion which is in contrast with the traditional medical ethical view which calls on the medical doctor to strive to the full to restore the health of the patient. But constraints on resources means that there must be rationality in their employment.

The constant search for rationalization promotes policies aimed at efficiency which in turn encourage separation and competition among insured individuals, healthcare facilities, and the providers of funds, as, indeed, occurs in the world of advertising.

There is an attempt to unite the features of fairness and solidarity which characterize the European systems with the effectiveness and efficiency of the privately-based systems.

5. The Reformed British Social Model

The National Health Service (NHS) was for many years the cornerstone of the Welfare State and left a very deep mark on the Italian reforms of 1978.

The original character of this service, which was markedly social, was changed in 1990 with a view to achieving restraints on expenditure.

Great Britain is the country which spends the least on healthcare services (OCSE, 1996) (1,019 dollars *pro capita)* after Portugal ($594), Spain ($790), and Ireland ($912). Italy, however, spends more than Great Britain ($1,101).

Decision-making was decentralized to local health bodies under managers employed on specific contracts. Those who are responsible for the system can supply services directly or purchase them directly from the more efficient public or private hospitals.

Funding comes from general government taxation (82%), a small contribution from the citizen (15%), and the revenues from prescription and other charges (for medicines, dentistry, and the work of oculists).

The system is preponderantly public in character, and in 1990 a small program of privatization was introduced into certain areas.

The insurance sector covers 11% of the population, which must, however, continue to pay the usual taxes towards the maintenance of the national health service.

A payment is made to each family doctor for each of the patients on his roll. He is thus made responsible for how he manages the funds placed at his disposal, and he is also encouraged to provide only those services and forms of treatment which are strictly necessary.

6. The Reformed German Model

The German healthcare system comes from the insurance program introduced by Bismarck. Two-thirds of the funds for its expenditures (7.1% of GNP) come from social contributions paid by employers and workers (60%); 21% comes from taxation; 7% from private insurance companies; and 11% from the patients themselves.

Compulsory insurance against

illness covers 88% of the population. 10% of the population relies upon private insurance companies, and this group does not have to pay national health contributions. The mixed system of the German Federal Public, which contains both private and public elements, is slowly giving way to state intervention. Public hospitals make up 38% of the total; private hospitals integrated into the public system constitute 35%; and 27% of hospitals are exclusively in private hands.

7. The American Health System

This is the private system *per excellence* and is the most expensive in the world (healthcare expenditure per capita: $1559; total healthcare expenditure: 14.3% of gross national product. Total healthcare expenditure (both private and public) in the United States of America is so high that public expenditure in percentage terms is 42-50% greater than in Italy.

Furthermore, American public health expenditure (which is 44.3% of total American healthcare expenditure), although in percentage terms inferior to Italian public healthcare expenditure (70% of the total), is higher when calculated in absolute terms.

What happens is that the thirty million citizens helped by Medicare (public care for the elderly, the disabled, and those suffering from protected illnesses), the thirty million citizens covered by the programs sponsored by Medicaid (care for the poor), and the forty million citizens without any protection, whether public or private, *reduce private healthcare expenditure to only 56% of the total* (both public and private) within the most important private healthcare service in the world.

The reasons for the high costs of the American system are to be found in the high levels of expenditure on research, the high quality of the care and treatment provided, but also, above all. in the particular features of the workings of that system.

There are three factors which operate at a macroeconomic level to increase the allocation of resources to the health sector to the disadvantage of other social spheres.

The payment for services, a depleted capacity to engage in programming and to coordinate those health systems based upon insurance schemes, and the presence of a private health system which is managed like a private company—these are all elements which promote an increase in expenditure in the healthcare field.

8. Italy: A "Mixed" Public Model

In Italy there is a national health service which is public in character and based upon "an integrated public model." This service is subject to the important changes which have been promoted by laws 502 and 517.

8.1. The Changes Introduced by These Laws

* The adoption of a *per capita* quota system at a national level for the allocation of current funds to the regions of the national health fund.

* Making the regions responsible for expenditure levels.

* The creation of future additional health funds.

* The reform of the system of agreements with private facilities through the establishment of a system of competition between public and private sectors where the citizen has an absolute freedom of choice and where payments are made in return for specific services rendered.

* The transformation of the local health boards into public service companies.

* The systematic adoption of the classic instruments of economic regulation which are characteristic of private companies—that is, analytical accounting, budgeting, and reporting systems and making managers and directors responsible for the overall results of their actions through the introduction of contracts and managerial posts which are not permanent. This system is immediately operative in relation to general directors and medical and administrative directors, but in the future will be applied to all those responsible for management and direction within the national health service.

8.2. Healthcare Needs and Healthcare Consumption

The general program today is directed towards changing the orientation of the system of services away from an emphasis on legal-administrative and institutional dimensions towards questions relating to fairness in the distribution of technological and financial resources.

Analyses of the experience of this program have revealed a worrying delay in the establishment of links between data relating to the presence of illness, the needs which are expressed, and decisions regarding the proper responses to be adopted.

The reorientation which is now under way is rooted in a recognition based in scientific terms upon empirically significant data relating to the present level of discordance between satisfied demand (services provided) and healthcare needs (conditions of health), on the one hand, and a reformulation of hypotheses concerning the territorial distribution of services and directors.

9. Future Developments

From a general examination of the different kinds of ways in which public healthcare systems are organized, one readily grasps how there has been a progressive expansion of these systems in line with the spreading right of citizens to be defended in relation to their health and physical and mental well-being.

The extraordinary economic growth of the last fifty years which has taken place in Western countries has given rise to a new social—and thus political—fact: the mass demand for health care.

Healthcare coverage has now become an irreversible social conquest. Although, on the one hand, this development is welcomed by those who believe that emancipation from the physical and existential need to be defended against various forms of illness is a factor working for the advance of civi-

lization and the processes of modernization, on the other, it also opens up a series of unprecedented economic, ethical, and organizational problems which require very deep changes in people's lifestyles.

The costs of the working of the present-day healthcare apparatus, which is very extensive, with a marked social emphasis, have risen to such an extent as to challenge the financial stability of national budgets when these have to pay for national health services. They have also introduced major difficulties in relation to the personal payments to be made to mixed public and private systems which are based upon private or collective insurance schemes.

So far growing financial and organizational shortcomings have marked these systems as they try to grapple with an expansion of, and an intensification in, a demand for health care which still seeks equality in the provision of services, their availability to all, and their being free—all elements which characterized such health systems at their origin.

The selective mechanisms which were created in order to achieve free access—or least lower contributions from citizens, which were based upon such criteria as low income, age, illness, and family composition—will in the future become increasingly relevant. There will be a necessary redressing of the balance between equity and solidarity. Such a development will be essential for healthcare systems, which will necessarily want to remain (and must remain) public in character and funding. This is because such public services are now seen and experienced as a social, mass, and individual good which cannot be given up.

It is not too much to imagine that in the future social models of life and production will be created which will be used to establish certain sets of objectives and that such objectives will be used to draw up government health programs.

Indeed, the importance of health and of the quality of life is destined to be seen in the most economically advanced countries as a real and authentic consumer good, and this development will give rise to a neohumanism in the healthcare world which will express ideas about the value of the biological and physical, constituent parts of human life.

The increasing appreciation of health as a value will inevitably lead to a uniform convergence of the various present-day models of how to provide health care. This will come about principally because of the high costs of such services and because of a process of growing social and cultural uniformity in the world of health care.

The emancipation of the culture of health from the private enterprise ideology of the single individual or from the mystic ideology of production will come to have a great influence on governments and government policy. Social programs of organization in this sphere will be shaped by considerations relating to civic coexistence and the compatibility of various kinds of technology, and the guiding idea will be to achieve the highest levels possible of quality of life.

In political terms the right to health will not only be assessed in terms of the ethical content of an advancing democracy moving towards the realization of its principles, nor will it be limited to technical questions which are the sole concern of specialists and professionals in the field. Instead, it will be, above all, a social right, a legitimate aspiration affirmed by civilized communities.

In this context of ethical and civic principles, the limiting of the level of environmental pollution, the containing of the use of polluting technology, or the initiatives taken for prevention of certain widespread serious illnesses will be not only the policies of an up-to-date, enlightened, and modern intelligence, but a permanent and informed political program required by the citizen from his public authorities.

The rights which are upheld will have a cost which the citizen will be prepared to bear in order to be treated. The cost will be borne either indirectly, through general taxation, or directly in the form of insurance payments which will allow him access to a medical doctor or to private or public healthcare systems and institutions.

The present-day shift in the nature of the prescription charge or special ticket from being a deterrent to avoid abuse to constituting a special system of funding, on the one hand, and the call for a rationalization of the employment of resources which will no longer be variable elements within general programs, on the other, will become features of a civic struggle against waste and the demand for greater efficiency which will work against the increasing costs of a lunatic and far too powerful system of modern medicine.

These will be the signs of an authentic democratization of health care, which will finally be seen and understood as a social question.

The move towards partially freed market methods will lead to a reduction of the prerogatives of the medical doctor, and there will be growing extramedical control of scientific research and the application of its discoveries. And all this will promote a major transformation of needs and a radical change in social behavior and in the forms of political response to the new culture of health care.

We already have before us—in both the private enterprise American model and in the European "social" model—a process under way which involves a narrowing of public intervention to healthcare areas of special danger or social risk and burden.

This process has just begun, but it already demonstrates that the costs to be met are too high for conventional insurance schemes and bear too heavily upon the deficits of public systems, which are themselves weighed down by their bureaucratic processes of administration.

The limiting of healthcare policy to the programming, assessment, and judgment of results will push public healthcare systems to concentrate upon areas and sectors of action which are concerned with the quality and importance of the services they provide, but which will always be of great political significance.

Professor FRANCO SPLENDORI
Professor of Health Programming and Organization at Tor Vergata University, Rome

W.J. EIJK

Ethical Models for Health Management

Health management concerns the organization, the financing and the policies of health care. The various themes directly falling under these topics, such as the social organization of health care according to the free enterprise model or the centralized model and the allocation of resources, are the subjects of the other lectures of this afternoon session. The aim of this article is to bring about a connection between health care management and one's fundamental ethical beliefs. The choices made in organizing and financing medical care depend in the end on the fundamental view one has of health care, which for its part is subject to one's view of man, the basis for one's ethical convictions. From this perspective I would like to present three ethical models for health management.

1. Health care as 'technical service'

Contemporary health care manifests a strong tendency to develop into a 'technical service' not only to the ill, but also to healthy people who are not satisfied with their bodies. Plastic surgery, body building with hormones, transsexual reassignment and diets are available to 'perfect' the otherwise healthy human body. And procreation, even if uncomplicated in itself, is not left to 'chance.'

The Dutch author Renate Dorrestein strikingly expresses this in her novel *Dit is mijn lichaam (This is My Body)*. While preparing breakfast for his pregnant wife Xandra on her birthday, Cas, one of the leading characters, is daydreaming about the child to be born in due course. It would be

> "a hundred percent certainly a boy, so the gender clinic had assured at the start of the very expensive treatment. Afterwards they intended to have a girl, and then new breasts for Xandra ..."[1]

The birthday present turns out to be a new nose for Xandra. While he, aware that he is facing another long day without food, is watching with unmistakably covetous eyes how she is eating her croissants, she encourages him:

> "This evening you may have six hundred calories... His mother had fattened him up as a child and made a glutton of him, with her pancakes and her puddings... In her kitchen smelling of bacon fat nothing had prepared him for the fact that in the real world everything revolves around physical perfection."[2]

This is a consequence of considering the body as a prestige object and the most important means of making an impression on fellow human beings. According to the prevailing neo-kantian view of man, in the end based on Cartesian dualism, the body is seen as a manipulable object, as it were opposite to the human person. Kant defined the person as a being that can say 'I,' possesses self-awareness and has a moral conscience.[3] Starting from this definition, the neo-kantians reduce the essence of being a person to the manifestation of specifically human functions of the brain: rational activity and the capacity of social communication.[4] According to this view of man, human foetuses and infants[5] as well as patients with irreversible cortical brain damage,[6] would qualify only as 'human beings,' but no longer as human persons with the right to autonomy and the right to life. Those who qualify as human persons could practice their autonomy even to the extent of disposing of their bodies and their lives, because biological nature is viewed as extrinsic to the human person and hence a merely instrumental good.

Health care has thus become a 'technical service' not only offering facilities for curing diseases, but also for 'perfecting' the healthy body or even uncomplicated procreation. Expectations are that this trend will intensify in the near future. By means of genetic screening and diagnostics lack of perfection, so-called defects, can be discovered before being manifest. Prenatal diagnostics paving the way for selective abortion already prevents the birth of fellow human beings deemed 'imperfect.'

> Because health care, conceived as a 'technical service', gives the impression that the body and hence future life are 'makable' through reassignment and the technical reproduction of human beings, those who are ill not rarely foster illusions about what modern medicine and surgery might achieve. The answer 'No, I cannot accomplish anything for you anymore' will hardly be accepted by many patients. Job Olson, the grandfather of Cas in the novel just quoted, finds his prostrate enlargement "a downright ridicule of human dignity. Still, while washing his pale thin hands that half-baked baboon of a specialist had said without batting an eyelid: 'You just have to learn to live with it ... He had expected an opera-

tion, something with laser, or else at least an effective treatment with pills. They could separate Siamese twins, transplant hearts, make big breasts smaller and small breasts bigger, they froze sperm and fertilized ova outside the womb. Every scrap and snippet of man could be revised, repaired, perfected; new or much improved parts were available for the whole kit; only Job Olson missed the boat."[7]

These expectations, pitched too high, can lead, on the one hand, to attempts to prolong life with futile treatment and, on the other, to regarding euthanasia as the ultimate 'technical' solution for all suffering. Both imply the same attitude of not accepting life as a gift and of refusing to give oneself up into the hands of God, the Creator of life.

Due to this development, health care facilities in the Western countries have become highly technicalized institutes managed like industries. The high demands of patients and the costs of new technologies together with the scarcity of resources force health care managers to organize their services in a bureaucratic way. Protocols, drawn up by governmental agencies and often by health care insurers, too, prescribe the calculated duration of the contacts between physicians and patients, the duration of hospitalization for various medical treatments, and the precise way in which to proceed in various cases. This concept of 'managed care' has its origin in the United States of America, but now finds increasing support in Western Europe as well.[8]

The protocols are mostly based on the calculation of the possible outcome of medical and surgical intervention in certain categories of patients, according to age, success rate, and the quality of life to be expected after treatment. An important criterion in this cost-effectiveness analysis is the number of 'Quality-Adjusted Life Years,' abbreviated as 'QALY's.' In deciding to apply, for instance, a life saving treatment like an organ transplantation to patient A or to patient B, the QALY theory offers a chance to calculate the number of life years gained in connection to an appropriate rate of discount for periods in which the quality of life would be poor because of illness or disability. Suppose that patients A and B would both presumably live for another 2 years after the operation and that A would have normal health, but B would remain bedridden. Moreover, suppose that the quality of two years of normal health could be equated with that of 1 year of life bedridden, then the rate of discount would be 0,5 for patient B. The QALY approach may serve to allocate health care resources on the micro as well as on the macro level. To this end, it has been used for the first time on a large scale by the state of Oregon in order to draw up a priority list of health services.[9]

Though seemingly very rational, the theory begs the questions as how to avoid subjectivism and find objective criteria in order to compare normal health life years with ill health or disability life years. Against a group of defenders of the QALY theory, among whom is Peter Singer,[10] Harris argues, in my view rightly so, that it implies a "double jeopardy" for those who are already suffering from diseases. The first risk would be their ill health, because of which, as a second risk, they would be 'punished' by not being admitted to a necessary medical treatment in favour of somebody else who is already in better health as a starting point and hence has a higher number of Quality-Adjusted Life Years.[11] This will, of course, be a disadvantage especially for the elderly and imply that the expenditure for palliative care of the terminally ill will automatically be quasi zero.

Thus, health care policies often disregard particular, especially human needs of patients, rendering it difficult for them to support and integrate their suffering emotionally and spiritually. Taken together with the view that bodily life has only an extrinsic value, and the dissatisfaction in case illusory expectations cannot be met, this puts pressure on those who are responsible for health care in the western world to allow life terminating acts in the form of euthanasia or assisted suicide as the ultimate technical answer to suffering, in case no curative treatment is available any more.

2. Health Care without Medical Technology

The opposite position is a refusal of modern medical technology. For religious reasons, some members of orthodox-protestant denominations in Holland are opposed to immunization. In Matthew 9:12 "those who are well have no need of a physician, but those who are sick," and in the definition of Divine Providence according to Sunday 10 of the *Catechism of Heidelberg* they read a prohibition of vaccination. When healthy, man should not take precautionary measures against possible future diseases, because this would imply that he did not recognize God, Who has all things in His hands, including the poliomyelitis virus. Man would therefore not be allowed to arm himself with 'non-ordinary' means, such as vaccination, against God's judgements, though he might do so with medicines against diseases, which are regarded as the blows dealt to us by His judgements, according to the text quoted from Matthew. At most, it would be permitted to use 'ordinary' (natural) means, like sanitary measures, against future diseases. This point of view was vehemently criticized during the poliomyelitis epidemic in some Dutch villages in 1971 and 1978. During the latter, 110 people, all orthodox-protestant, were affected; one of them died, while only a few suffered from protracted or lifelong paralysis.[12]

A comparable belief exists among members of the Church of Christ Scientist, founded by Mary Baker Eddy in the second half of the last century. They not only refuse preventive measures like vaccination, but also medical and surgical treatments, even in peril of death. In their view, disease is an illusion which will disappear as soon as the patient does not believe in his disease any more. He can achieve such a 'healing' by placing himself on one plane with the 'Divine Mind' through prayer so as to get rid of the illusion of material reality. Apart from isolation in case of contagious diseases, it is difficult to force patients to undergo vaccination or medical-surgical treatment. However, problems arise when it concerns their children. For instance, in the United States, several

times state courts have ruled in favour of children whose parents or guardians refused to permit medical-surgical treatment, applying the doctrine of *parens patriae*, the right of the state to intervene on behalf of children in case the acts or decisions of their parents or guardians threatened their health.[13]

During the last few decades, there has been a remarkable resurgence of interest in 'alternative therapies.' In contrast to conventional medicine, they do not merely focus on the body from a rather mechanistic point of view, applying high technology, but "tend to regard individuals in holistic terms. Individuals are seen as singular wholes and as constituent parts of some larger reality."[14] Hence, they are somewhat vaguely referred to as 'holistic medicine.' The 'holistic healing movement,' showing much interest in treating patients as whole persons, in educating people with regard to their responsibility for their physical and mental health, and in applying 'natural' or alternative therapies, has gained much influence. These therapies, also termed unorthodox, complementary, or unconventional, include various categories, such as a spiritual category (faith healing and paranormal healings), a psychological category (mental imaging, hypnosis, and laughter therapy), a nutritional category (herbal, vitamin, and mineral dietary supplements and macrobiotic diets), a drug category (serums, homeopathy, injection of live cells from fetuses and animals), and a category involving physical forces (chiropractic, massage, touch therapy, acupuncture, and electrotherapies). An alternative method of diagnosing internal diseases is iridology,[15] in which the iris of the eye is examined.

In 1981, the professional bodies of those practising some kind of alternative medicine in Great Britain had over 11.000 members in total, that is, 41% of the number of general practitioners. Fulder speaks of an increase of 10% a year since then. 8% of the general practitioners in Great Britain belonged to complementary medical professional bodies.[16] In the same year 7% of the Dutch population consulted a practitioner of unconventional medicine each year.[17] A framework law, whose details still have to be specified, the 'Wet op de beroepen in de individuele gezondheidszorg' (professions in individual health care act), promulgated in November 1993, lays down that, apart from the so-called reserved acts, these who are not medical doctors are formally allowed to perform acts in the field of individual health care. This will give more possibilities to alternative therapists.[18] An inquiry in the United States in 1990 showed that 34% of the respondents had used at least one unconventional therapy in the past year and that one third of these visited providers for this kind of treatment.[19] In general, they were well educated and had higher incomes.

Medical doctors are often unaware of the widespread use of alternative therapies. 72% of the respondents in the United States inquiry seeking help from them refrained from informing their physicians that they did so.

Though especially in New Age circles the use of crystals, therapeutic touch, and psychic healing based on certain metaphysical explanations of man has become quite popular, most adherents of this current still make use of 'orthodox' western medicine. Only 4% of the respondents reporting a major medical condition consulted an alternative therapist without also seeing a medical doctor.[20] This may be dangerous. From my own experience, I know of a housekeeper of a parish priest who suffered from an influenza-like disease three times in succession, for which she consulted a general practitioner using homeopathic medicine without positive results. After having finally been admitted to hospital she was found to suffer from Wegener's granulomatosis, a rare disease characterized by vasculitis of the upper and lower respiratory tract together with glomerulonephritis. Soon after, renal failure caused her death, though the prognosis of the disease would have been good, if therapy with cyclophosphamide (together with prednisone in the beginning) had been started in time. Other cases of this kind have been reported, like fatal doctor's delay in cancer patients because alternative treatment was tried first, and deafness after long-term treatment of inflammation of the middle ear with Weleda grains.[21]

The key question here is why so many people nowadays increasingly make use of unconventional medicine. Apart from other reasons, such as disappointments with the result of conventional treatment or New Age beliefs, an important factor turns out to be that modern technicalized medicine is not directed at the person as a whole.[22] According to Frohock,

> "Medicine seems to occupy a position somewhere between science and those spiritual and sometimes mystical discourses from which modern medicine historically derives. An increasing reliance on clinical theory and data makes medicine more like science than folk healing; for medical practice today is strongly influenced by the Cartesian separation between mind and body, and the dazzling technological advances of modern scientific inquiry. Spiritual reasoning, by contrast, views humans in a holistic perspective that includes spirit as well as body and often accepts realities not accessible to scientific inquiry."[23]

To a certain extent, rejecting all medical technology and taking one's refuge in homeopathy and other alternative forms of medicine might be an understandable reaction to the excessively technicalized and impersonal character of conventional health care. Because they focus on the human person as a whole, they exert a great attraction on a considerable number of patients, not only on those who are disappointed in what conventional health care can achieve for them.

The cause of the attraction of alternative practices should be a challenge for those responsible for health care management: more attention should be paid to patients as persons in all their aspects with regard to their specifically human needs than bureaucratic and technicalized medicine can offer. On the other hand, accepting alternative treatments in itself raises problems, too. In allocating limited resources governmental agencies, health care facilities, and insurance companies have to weigh the efficacy of these treatments against their possible harmful side effects and compare both factors with those of standard therapies. This is,

however, difficult, because the pro's and con's of most alternative therapies have not been experimentally assessed, at least not in trials meeting the scientific criteria of conventional medicine. This makes it especially difficult to distinguish genuine alternative therapy from quackery and deceit.[24] Without expressing an opinion with regard to alternative treatments, one may fear that in certain cases using only alternative treatments implies the risk of abandoning the proportionate means of preserving life available in conventional health care facilities.[25]

3. Health care based on prudential personalism

A middle course is health care based on prudential personalism, a term which I borrow from Ashley and O'Rourke.[26] The personalist view of man underlying this form of health care sees the body as an intrinsic part of the human person, participating in his dignity as an end in itself, thus refusing any dualism between some spiritual functions of the brain constituting personhood, on the one hand, and man's biological nature, on the other. This is confirmed by the Encyclical Letter *Veritatis Splendor*:

> "The spiritual and immortal soul is the principle of unity of the human being, whereby it exists as a whole—*corpore et anima unus* (*Gaudium et Spes* no. 14)—as a person. These definitions not only point out that the body, which has been promised the resurrection, will also share in glory. They also remind us that reason and free will are linked with all the bodily and sense faculties. *The person, including the body, is completely entrusted to himself, and it is in the unity of body and soul that the person is the subject of his own moral acts* (no. 48) ... *A doctrine which dissociates the moral act from the bodily dimensions of its exercise is contrary to the teaching of Scripture and Tradition*. Such a doctrine revives, in new forms, certain ancient errors which have always been opposed by the Church, inasmuch as they reduce the human person to a 'spiritual' and purely formal freedom. This reduction misunderstands the moral meaning of the body and of kinds of behaviour involving it (cf. 1 Cor. 6, 19)" (no. 49).[27]

This personalism does not admit manipulating the body, because this is equivalent to manipulating the person. Instead, the body is considered that part of the suffering person in which he or she is met. What is often seen as the ultimate technical solution for all suffering, the active termination of bodily life in its various forms, is no answer to the suffering of man, but merely the elimination of the suffering subject. The only fruitful answer to the suffering of the human person as an end in himself is human affection and love to which professional medical and nursing expertise is added.

Personalism thus described does not reject technology, but fully accepts it, thus showing all openness to plastic surgery if necessary for humane reasons, genetic engineering insofar as it concerns somatic gene therapy, or assisted procreation insofar as the conjugal act is not being replaced by a technique. However, it excludes man being controlled by the technique. It is man who has to control the technique. The *auriga virtutum* (wagoner of the virtues), prudence will show him what is proportionate to preserve health and life or—if this is not possible any more—to alleviate suffering by palliative care. Thus, health care is not only ruled by the virtue of the discipline (*ars* in Latin), teaching how to *make* or *produce things well* (*recta ratio factibilum),* but also and even in the first place by the virtue of prudence, enabling him to *act morally well* in taking concrete decisions *(recta ratio agibilium).*[28] Prudential personalism leading to a harmony between cure and care guarantees good technical an at the same time really humane health care.

Health management meeting high technological demands joined to those of a personalist approach implies that health care will become expensive. One should be aware of the fact that health care facilities cannot be staffed with few employees, like modern factories, in which a single person is able to operate a whole set of computer-controlled machines. Exactly because of the human needs underlying every disorder, physical and mental alike, most health care activities cannot be automatized, and this problem will not be remedied by protocolling the time allotted to patients personally. If economic resources to employ a sufficient staff are lacking, well educated and organized volunteers as well as family members of patients could be involved in caring for the sick.

This does not rule out that protocols may be useful and necessary for an appropriate allocation of health care resources. They are most certainly effective means to render medical decisions more objective and goal-oriented. The point is, however, that the QALY approach, apart from the objections listed above, can easily lead to a serious ethical problem. When the intrinsic value of the life of the human person is denied, the notion 'quality of life' is easily conceived to be a judgment of the reasons for the further existence of a concrete person or a category of persons. Thus, Perrett writes:

> "...The sanctity of life doctrine is usually restricted to cover only human lives, and insofar as the concept of a human being is defined in terms of membership of the biological species *Homo sapiens*, the doctrine is unsatisfactorily speciesist in the way it discounts the value of some beings simply on the morally irrelevant basis of species membership. Moreover it is just implausible to suppose that merely being alive is intrinsically valuable. Faced with the prospects of extinction or irreversible coma, most of us are indifferent between them ... Personally, I attach no intrinsic value to merely being alive, but rather to those things that being alive enables me to experience. (That is why I am indifferent between the prospects of extinction and irreversible coma.) My life seems only valuable for the valuable qualities of experience it makes accessible and it is those qualities that are intrinsically valuable."[29]

In applying the QALY approach, the person's life should be valued, according to Perrett, by taking into account two extrinsic components:

> "Firstly there is its *personal value*, i.e. its value for the person whose life it is. But there is also its *social value*, i.e. its value for others. Thus the *total value* of a person's life is the sum of its personal and social values."[30]

That a 'poor quality of life,' taken as an extrinsic good, may be conceived as an argument to justify euthanasia and other intentional life terminating acts, is shown in a report of the *Commissie Aanvaardbaarheid Levensbeëindigend handelen* (Commission on the Acceptability of Life-Terminating Actions, abbreviated CAL) of the *Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst* (Royal Dutch Society for the Promotion of Medicine, abbreviated KNMG). It argues as follows: if the human quality of the lives of long-term comatose patients has come "under an (un)certain minimum," intercurrent disorders should not be treated and life-prolonging treatment abandoned; because death is thereby accepted, it is allowed to administer medicaments in a lethal dose with the aim of terminating their lives.[31]

Because the expression 'quality of life,' though not necessarily, nonetheless implies this risk, it should be avoided. The term 'condition of the patient' is perhaps preferable in cost, benefit and cost, effectiveness analyses. This term which is generally used in medicine, is neutral and does not suggest in itself that it would concern the most 'fundamental' quality of life.

In case protocols are unavoidable, health care authorities should prevent a stifling bureaucracy by leaving room to medical doctors for taking personal prudential decisions deviating from the letter of the protocol in concrete situations, according to the principle of subsidiarity.

Conclusion

Many employees in health care facilities, thinking they only need to consult an ethicist in difficult cases, are generally little interested in fundamental ethical questions. Hopefully, this article, brief as it may be, will make it clear that the view of man and the ethical convictions derived from this ultimately determine the options made in health care management.

W.J. EIJK, M.D., Ph.D., STL
Professor of Moral Theology in the Theological Faculty of Lugano (Switzerland) and the Major-Seminary of the Diocese of Roermond (Netherlands)

Notes

[1] R. DORRESTEIN, *Want dit is mijn lichaam*, Uitgeverij Contact/Stichting Collectieve Propaganda van het Nederlandse Boek, 1997, p. 27.

[2] Ibid., p. 30.

[3] I. KANT, *Die Metaphysik der Sitten*, Einleitung IV, in: I. KANT, *Schriften zur Ethik und Religionsphilosophie*, ed. W. Weischedel, Darmstadt: Wissenschaftliche Buchgesellschaft, 1975, vol. IV, pp. 329-330, and I. KANT, *Anthropologie in pragmatischer Hinsicht*, I.Teil, I.Buch, Paragraph 1, in: I. KANT, *Schriften zur Anthropologie. Geschichtsphilosophie. Politik und Pädagogik*, Darmstadt: Wissenschaftliche Buchgesellschaft, 1975, Vol. VI, p. 407.

[4] H.T. ENGELHARDT, *The Foundations of Bioethics*, New York/Oxford: Oxford University Press, 1986, pp. 104-109.

[5] Ibid. pp. 228-236.

[6] R.M. VEATCH, "The Impending Collapse of the Whole-Brain Definition of Death," *Hastings Center Report* 23 (1993), nr. 4, pp. 18-24.

[7] R. DORRESTEIN, *Want dit is mijn lichaam*, op. cit., pp. 51-52.

[8] W. VAN DER WERF, "Managed care. Een nadere nuancering vanuit zorgaanbiedersperspectief," *Medisch Contact* 52 (1997), nr. 16, pp. 511-513.

[9] D.C. HADORN, "The Oregon priority-setting exercise: quality of life and public policy," *Hastings Center Report* 21 (1991), nr. 3/Supplement, pp.11-16.

[10] P. SINGER, J. MCKIE, H. KUHSE, J. RICHARDSON, "Double jeopardy and the use of QALYs in health care allocation," *Journal of Medical Ethics* 21 (1995), pp. 144-150; idem, "Double jeopardy, the equal value of lives and the veil of ignorance: a rejoinder to Harris," *Journal of Medical Ethics* 22 (1996), pp. 204-208.

[11] J. HARRIS, "Double jeopardy and the veil of ignorance—a reply," *Journal of Medical Ethics* 21 (1995), pp. 151-157; idem, "Would Aristotle have played Russian Roulette?," *Journal of Medical Ethics* 22 (1996), pp. 209-215.

[12] J. DOUMA, W.H. VELEMA, *Polio. Afwachten of afweren?*, Amsterdam: Ton Bolland, 1979 (=Ethisch Kommentaar 5), p. 9; the ethical arguments contra vaccination are discussed on pp. 43-62; the authors do not agree with these, but rebut them very prudently on pp. 63-80.

[13] N. GEVITZ, "Christian Science healing and the health care of children," *Perspectives in Biology and Medicine* 34 (1991), pp. 421-438.

[14] F.M. FROHOCK, *Healing powers. Alternative medicine, spiritual communities, and the State*, Chicago/London: The University of Chicago Press, 1992, pp. 173-174.

[15] R.H. MURRAY, A.J. RUBEL, "Physicians and healers—unwitting partners in health care," *The New England Journal of Medicine* 326 (1992), p. 61.

[16] S. FULDER, "Alternative therapists in Britain," in: M. Saks (ed.), *Alternative medicine in Britain*, Oxford: Clarendon Press, 1992, pp. 167-169.

[17] *Alternative medicine in the Netherlands: summary of the report of the Commission for Alternative Systems of Medicine*, Leidschendam: Ministry of Health and Environmental Protection of the Netherlands, 1981.

[18] P. LENS, "Regulier en alternatief, een LAT-relatie," *Medisch Contact* 52 (1997), nr. 39, p. 1221). Some fear that the new law makes it more difficult to institute proceedings against malafide alternative therapists, because this will only be possible in case harm or a chance of harm can be proved, which is not always easy; cf. Wet op de beroepen in de individuele gezondheidszorg art. 96-98, *Wetgeving Gezondheidszorg* (1994), februari, Supplement 132, pp. 112-113.

[19] D.M. EISENBERG, R.C. KESSLER, C. FOSTER, F.E. NORLOCK, D.R. CALKINS, TH.L. DELBANCO, "Unconventional medicine in the United States. Prevalence, costs, and patterns of use," *The New England Journal of Medicine* 328 (1993), pp. 246-252.

[20] Ibid., p. 249.

[21] The (anthroposophic) general practitioner who had prescribed the Weleda grains was censured by the Central Medical Disciplinary Tribunal in The Hague, because he had deviated from the general standard of conventional medicine without serious reasons (1997/38, *Tijdschrift voor gezondheidsrecht* (1997), nr. 5, pp. 294-297).

[22] R.H. MURRAY, A.J. RUBEL, "Physicians and healers—unwitting partners in health care," op. cit., p. 62.

[23] F.M. FROHOCK, *Healing powers ...*, op. cit., pp. 5-6.

[24] J.F. DRANE, "Alternative therapies: ethical and legal issues," in: *Encyclopedia of Bioethics*, W.T. Reich (ed.), New York: Simon & Schuster Macmillan, 1995 (revised ed.), pp. 141-142; E. Ernst, "The ethics of complementary medicine," *Journal of Medical Ethics* 22 (1996), pp. 197-198.

[25] In the past, the Catholic moralists used to speak of the distinction between 'ordinary' and 'extraordinary' means. The terms 'proportioned' and 'non-proportioned' better express the fact that this distinction concerns the ratio between the advantages and disadvantages of treatment. Cfr. S. Congregatio pro Doctrina Fidei, "Declaratio de euthanasia," *AAS* 72 (1980), p. 549-550; Pontificio Consiglio della pastorale per gli Operatori Sanitari, *Carta degli operatori sanitari*, Città del Vaticano: Libreria Editrice Vaticana, 1995 (4e ed.), nr. 120.

[26] B.M. ASHLEY, K.D. O'ROURKE, *Healthcare ethics. A theological analysis*, St. Louis: The Catholic Health Association of the United States, 1989 (3e ed.), pp. 159-172.

[27] Quoted from JOHN PAUL II, Encyclical Letter *Veritatis splendor*, Vatican City: Libreria Editrice Vaticana, 1993.

[28] S.THOMAS VAN AQUINO, *Summa Theologica* II-II, 47, 5.

[29] R.W. PERRETT, "Valuing lives," *Bioethics* 6 (1992), p. 186 and 198.

[30] Ibid., p. 187.

[31] CAL, *Discussienota inzake levensbeëindigend handelen bij wilsonbekwame patiënten. Deel II: Langdurig comateuze patiënten*, Utrecht: KNMG, 1991, pp. 30-35; cfr. *Doen of laten? Grenzen aan het medisch handelen in de neonatologie*, Utrecht: Nederlandse Vereniging voor Kindergeneeskunde, 1992: the active termination of the life of a neonate with genetic or congenital defects would be acceptable, if its quality of life has become too poor and hence its life would not be 'livable' any more.

JOSEPH JOBLIN

Health and the Distribution of Resources

Some epochs, like our own, are a break with those which go before them. This is especially evident in certain fields, and this is the case today with regard to the world of health and health-care. The movement for equality, which began during the eighteenth century in the United States of America and was spread far and wide by the French Revolution, can no longer tolerate inequality in this field. Health has always been seen as a good to which all people should be able to gain access in an equitable way. But the distribution of economic resources between the different nations of the world, and within societies themselves, is so unequal that health-care is the privilege of the few. The situation condemned by *Gaudium et Spes* (9, 88.1) of the contrast between the "opulence" of a privileged few and the acute poverty of entire populations is also present when we consider the status of health in all societies. Faced with this "scandal," the Christian must ask himself how the resources of the earth can be put at the service of everybody. My paper aspires to be a contribution to this question.

1. The Present-Day Relevance of This Question

Christian moralists have always taught that the mother who steals bread to feed her children and to keep them alive does not commit a crime if she does not deprive somebody else of something which is actually necessary to that person. This is because the goods of the earth have been given for the benefit and well-being of everybody, and their use is a means by which to achieve this end: "The whole creation is for man.... Each man has, therefore, the right to find in it what is necessary to him.... Nobody is authorized to reserve for his own exclusive use that which goes beyond his needs."[1]

Although it has certain connections with the case which has just been mentioned, the question which concerns us is really of another nature. Here we encounter the break between our epoch and the epochs which have preceded it. We are no longer dealing with the mother who takes bread to feed her children. Here our attention falls upon marginal or minority populations whose physical or mental capacities are reduced because of lack of care and protection. The question arises as to whether they have the right to ask those who have sizeable economic resources to engage in a more equitable distribution of the goods of the earth—something which would enable such people to "grow in their humanity"[2] and more generally to contribute to the growth and development of the planet. Health is no longer seen as the absence of illness but as a good in itself which it is legitimate, and profoundly right, to benefit from through a utilization of the economic resources which are available, wherever they may be found.

The change in outlook which has taken place during our epoch constitutes the first challenge which we must face up to and deal with: Does a "social mortgage"[3] weigh upon the goods of the earth when it comes, in particular, to ensuring the health of all of its inhabitants? If this is the case, what do we mean by health? And how should this need be located within reality? Is there a connection between the right to health and the right to development? How can economic resources be allocated to this end in a fair way? It is more than evident that at any specific moment economic resources are limited and that as a result certain choices must be made as to their use and allocation. These are only some of the questions which are raised by the upholding of the right to health—this right cannot be separated from the idea of development or from the idea of the just and equitable distribution of the resources of the earth, resources which, although they are destined for everybody's use, are nonetheless inadequate when it comes to what people's actual needs are.[4]

2. The Right to Health and the Solidarity-Inspired Development of Humanity

The phrase "the right to health" seems nowadays to be in common use. Indeed, it is of recent creation. Its content has become clearer and more fixed over the last fifty years, and during this period it has been increasingly associated with the idea of development.

The first politicians to advance the doctrine of the rights of man wanted to direct the organization of society with a view to ensuring that everybody could satisfy their essential needs and requirements. But health was hardly mentioned among the list of such rights. Roosevelt seems to have seen health merely as a liberation from

illness. In his famous speech on the "four freedoms" made on January 6, 1941 he listed those freedoms which were to be guaranteed to all men at the conclusion of the war: freedom of speech, freedom of religion, freedom from want so that the inhabitants of every nation would enjoy a "healthy peacetime," and freedom from fear and war. At the same time, in his Christmas message of 1942, which was addressed to the internal reorganization of the various states of the world, Pope Pius XII called for a promotion of the dignity of the human person which included "the right to have and to develop physical, intellectual, and moral life, and in particular the right to religious instruction and education."

The *Universal Declaration of Human Rights* of 1948 did not make direct reference to health, but dedicated its clauses to the right to work, to fundamental freedoms, to nationality, and so forth. However, clause 25 of this declaration refers to health as being one of those elements which make up a standard of living to which everybody should be able to have access: "Each person has the right to a standard of living of a sufficient level to guarantee his health, his well-being and that of his family." These texts demonstrate that at the beginning of the second half of this century the most enlightened spirits, and *a fortiori* public opinion, saw health as a state of being which was certainly to be sought after, but which derived essentially from the absence of illness.

The first break in the traditional idea of health was made by those who created the bases for the World Health Organization. The constitution of this body, which was adopted in 1946 and made operative in 1948, advanced a positive vision of the character of health. It laid down that health should be seen as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infection." But it was only in 1948, during the Alma-Ata Conference, which was held in the Soviet Union, that a dynamic definition of health was adopted in which health was seen as a *sine qua non* of development. This approach was later officially adopted by the General Assembly of the United Nations in 1979.

a) Development ensures the improvement of health-care and the latter largely depends upon the former. The *Alma-Ata Decclaration* (1978), which was the work of the World Health Organization (WHO), has in this sense a clear importance. Three parts of that declaration may be discussed here:

* *Health must be the subject of a deliberate policy promoted by governments*. After proclaiming that health is "a fundamental right," the beginning of the declaration adds that "the attainment of the highest possible level of health is a worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." Thus it is that a healthcare policy is seen as no longer being the defense of the members of a community against illness, but the result of a deliberate policy involving the mobilization of economic and other resources by governments.

* *The upholding of the right to health depends on the achievement of a form of economic and social development which works to the benefit of all*. Such a policy ensures sustained economic and social growth and development and contributes to the achievement of a higher quality of life and the establishment of peace (principle II).

* *An acceptable level of health in the world cannot be achieved without a reorientation of the use and employment of economic resources*: "An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente, and disarmament could and should release additional resources than can well be devoted to development, of which human health is an essential part" (principle X).

The importance and significance of these principles should not escape us:

* They continue to see health as a good which in itself is good for the individual.

* They lay down that its achievement depends upon the outcome of a certain number of economic and social factors.

* In particular, its achievement depends upon an improved distribution of economic resources.

* They do not believe that growth and development are possible without an improvement in the health standards of the world's populations.

The conference held at Alma-Ata was only one stage on a long journey. The relationship which the declaration maintained existed between health and development is discussed in more detail later on in its clauses. Development was said to aim not only at a reorientation of resources in order to promote health (principle X), but also at securing the spread of health-care services which were themselves considered a precondition to balanced growth and development. So, we might ask, why should this latter policy be preferred to an unequal form of development and growth which obtains solely the happiness of a minority?

b) *The solidarity-inspired development of humanity which is postulated by Christian anthropology implies a recognition and satisfaction of the right to health on the part of everybody*. The United Nations, like the Catholic Church, speaks with insistence about the need for a more equitable distribution of the goods of the earth. This principle was one of the leitmotifs of *Gaudium et Spes* (1965): "While immense multitudes still lack bare necessities..., luxury exists side by side with acute poverty."[5] But while the documents of the United Nations dwell upon the reasons why this imbalance is not acceptable to society, the works of the Magisterium of the Catholic Church have a very different approach and point of departure. They are based upon a social anthropology which at a fundamental level sees man as the "agent of his own destiny"[6] or, as Leo XIII declared in *Rerum Novarum*, man must find on the earth, and thus in economic resources as well, the means by which to fulfill his own supernatural vocation.[7]

Christian anthropology lays emphasis upon the human person and not upon the individual along the

lines of the thought of the philosophers of the eighteenth century. This anthropology, taking its starting point from the principle of solidarity, holds society responsible for ensuring that the employment of its resources is directed towards guaranteeing that each and every person has the means available by which to achieve his own personal growth.

Christianity believes that the person is an autonomous subject capable of moral decision who constructs the social order through this capacity—this is what marks it out from Liberalism or Socialism.[8] On the one hand, Socialism sees the human being as a molecule or a "cog"[9] in the social body, and thus the well-being of the individual is attained through the action of the state without reference to the autonomous choice of the individual and his capacity for responsible decision. On the other hand, Liberalism considers social organization as the creation of man and not as something which is a fact of nature and therefore has its own constitutive laws.

The basis for the Christian vision is to be found in the "natural precept of mutual love and mutual compassion" which human beings owe to each other. This cannot be achieved without the existence of a "political and moral unity" among people, "irrespective of any category to which they might belong."[10] To put it succinctly, institutions are the elements which allow man to exercise his sociability and to place the resources of the earth at the service of everybody. This cannot take place when societal structures marginalize entire populations and deprive them of basic healthcare structures and amenities, among other things. As Paul VI observed, it is necessary to "share the resources which are available and thereby achieve authentic communion among the nations."[11]

For this reason, in the Christian way of thinking, the individual right to health has a collective dimension. It is directed towards the development and advance of the community and is based upon the presence of effective solidarity among men. Their commitment and role in the affairs of the state is a means of practicing charity towards others and of thereby freeing other people from an obstacle (in this case, the absence of health) which obstructs them.[12]

An unresolved question, however, remains: that of how a just distribution of economic resources should be achieved. How can the governors of a country really satisfy this right to health when the resources that are available to them are limited and at the same time when different ways of using them are also suggested?

3. The Realization of the Right to Health

The upholding of the right to health for individuals and peoples to be enjoyed every day comes up against the requirements which are involved in the realization of other essential rights: what principles can we employ to resolve these conflicts? What practical suggestions can be gleaned from the study of real-life examples?

1. The Principles for a Solution

a) The distribution of resources must take place in conformity with the principle of social justice. This has been the constant doctrine of the Catholic Church for nearly a century. The fact that economic resources are to be used by everybody in order to allow them to satisfy and meet their right to health is, for the Church, a question of justice. But, it might be observed, socialism and liberalism also invoke the concept of justice—in what ways, then, is the position of the Church different? What is the real meaning of the phrase "social justice," a phrase which is now so widely employed that there is no longer any serious attempt to understand what it really means?

As has already been observed in this paper, Christian anthropology is poles apart from liberal individualism. In the former outlook, a solidarity naturally exists between human beings, and this solidarity is the basis of mutual obligations. For the supporters of the liberal doctrine, the universal destination of goods does not exist. Instead, such goods are a *res nullius* freely available to all. It is thought that no natural solidarity exists which obliges individuals to meet the essential needs of other people. Only the conventions which men have established with each other, it is argued, can create the right to benefit in justice from such a service provided by society.

The Christian vision of social justice is in the same way incompatible with that held by certain expressions of socialism. These creeds argue that a natural solidarity exists between men, but that its promotion and achievement is the task of the state. Intermediate bodies do not engage in the direct management of public affairs, but are the instruments of higher structures of power. The horizon of this social justice, furthermore, is exclusively of this world.

In the Christian approach, the propensity of the spirit to live according to the needs of natural solidarity leads us to speak about social justice in two senses. In recognizing that there is an order of things wanted by the Creator, the human being feels that he is responsible for making sure that this order conforms to reality. The state certainly performs a necessary role, but it is only a subordinate role. The participation of individuals in intermediate bodies is a way for them to take an active part in this initiative and function, in union with others and with the state, in order to achieve this end.

b) The definition of the concept of social justice. Although the concept of social justice is the key guiding principle of social relationships, in a historical perspective it has only appeared recently. This is because before the industrial revolution such human action had no meaning or sense. We can certainly affirm that there has been a growing use of the term since the eighteenth century, but its nature and its binding role were undoubtedly expressed for the first time by Pius XI, and more specifically in *Quadragesimo Anno* (95) and *Divini Redemptoris* (51). In both these works we encounter the exposition of a directive principle which must permeate the whole of economic life.

We should remember first and foremost that we are not dealing here with a model or a "specific

technical system"[12] which we need only reproduce, but of a permanent orientation of the will which leads people to search for and choose—in every circumstance they come across—that which makes available to "the members of a community" "everything which is necessary to the performance of their social functions".[14]

Pius XI's teaching on social justice is at the center of the question of "health and the distribution of economic resources." It operates at two levels, one of which is sociological and one of which is doctrinal. This teaching is *sociological* because it compares social relationships to the relationships in an "immense living body where every organ performs a specific role which at the same time influences its own development and its relationship with the other organs".[15] (This assumes that all the members of society enjoy the best state of health possible). This teaching is also *doctrinal* because it believes that social justice is the "regulating principle" which effectively guarantees an "intense activity of the whole of economic life in a state of peace and in order."[16]

c) *The evolution of the teaching of the Church in relation to social doctrine*. The promotion of the right to health has never occupied a central position in the social teaching of the Catholic Church. However, it has acquired an important role as a result of the impact of the Pontifical Council for Pastoral Assistance to Health Care Workers. This body has not only asserted that sick people and the handicapped are members to the full of the human community, but has also emphasized their specific place in a Christian approach to the construction of a more human world. This Pontifical Council has not only drawn attention to the questions and problems of illness and health, but has also explored the issue of how health can be encouraged and secured through the activities of the twelve international conferences held in the Vatican and the deliberations of the Academy for Life.

Reflection on the concept of health has taken three directions: a) as a factor to be integrated into the theories of development; b) as a field of research which must mobilize all those scientific disciplines which bear on the whole subject of health; and c) as a human reality, and thus as a moral reality, because all forms of research must be directed towards the good of man, taking life, its origins, its development, and its end, as their guiding criterion.

These different aspects illuminate the relationships which exist between the use of economic resources and the realization of the right to health. This is an indispensable precondition for the participation of every individual or community in the development of society and the growth of every person in humanity.

Here we find ourselves in a new terrain. The right to health is no longer an individual right which confers upon a human being, of whatever community, people, race, or religion he belongs to, the right to have access to the economic resources of the earth in order to achieve the best physical and mental health possible (the World Health Organization). This right has also become a collective right in the sense that the diffusion of health to the benefit of everybody has an impact on the economic and social life of a community. Here health is not the residue of a policy of development, but one of the *sine qua non* preconditions of its success. From this point of view, the responsibility of the state changes. It can no longer be limited to a just distribution of health care but presupposes an active policy by which to assess the impact and role of all the factors which go to make up collective life and which have consequences for the state of health of society as a whole and each individual person. A sound management of healthcare policy must not only take into account the availability of health services in the most distant areas of the country, but should also consider the effects which other government policies, such as those concerning agriculture, schooling, commerce, and industry, can have on general levels of health.[17]

There are thus three principles which demonstrate the link between health, development, and economic resources:

* *Man is a social being who needs the cooperation of his fellows because of the narrowness of his capacities.*[18] He therefore has the right to create political communities with a view to "acquiring the resources which are necessary to their development" and we should observe that this principle has its counterpart that "men cannot serve their own interests at the price of injustice towards other people."[19]

* *Individuals and communities, therefore, must cooperate without any spirit of economic and political domination* in order to involve the largest possible number of individuals in the processes of development.

* This cooperation must be practical and should have as its objective the reform of "existing legal arrangements when these do not pay sufficient attention to the equal distribution of the advantages and obligations of social life."[20] John Paul II dwells upon this principle in *Sollicitudo Rei Socialis*, when he refers to the responsibilities of individuals and the community as regards "structures of sin."[21] There is, therefore, a dual aspect to the relationship between health and economic resources: on the one hand, the universal destination of goods requires that economic resources are managed by society in such a way that everybody can enjoy the best possible state of health with a view to participating in the human development of the community; on the other, this objective cannot be achieved without an active policy aimed at a reform of the structures of society which impede its attainment.

2. The Application of this Doctrine: the Examination of Practical Cases

There is a distance between the principles and the doctrine which have just been outlined, on the one hand, and reality, on the other. Indeed, all social agents do not share the same point of view about the priorities which should be adopted to reach the ideal of justice which has been determined. Certain examples taken from recent publications enable us to have an idea

about the practical difficulties which are encountered by those who want to put economic resources at the service of the equal right of everybody to health and which can also induce a state of discouragement.

* *The great differences in the healthcare budgets* of industrialized countries and so-called developing countries is the first element which should be considered. The wealthiest populations of Western countries enjoy an abundant use of highly sophisticated medicines while those of the poorest countries in the world are without elementary methods by which to render their water drinkable or to eliminate certain parasite-borne illnesses which afflict children, first of all. But where and how can we fix limits to medical care and research in the rich countries? One passes imperceptibly from expensive treatment to other kinds of therapy which seem to be merely extravagant. As Professor Salvatoire Rubino has observed,[22] from treatment necessary to improve mastication one easily passes to the demand for aesthetic corrections of the face at public expense on the grounds that such a condition provokes psychological harm. In concluding his observations on the increasing demand for treatment, Rubino goes on to stress that "we must also remember the waiting-lists in the hospitals for sex-change operations." Certainly, those in government must take public opinion into account and be aware of the fact that medical research, even though it is very expensive, is a necessary stage in providing simple and effective remedies for everyone. But at the same time such people should not forget that some of these remedies are superfluous when one comes to consider the state of acute poverty which is endured by many populations.

* *The rulers of some poor countries believe that the dignity of their peoples is upheld by the fact that they can obtain treatment of a comparable quality to that obtained in the United States or in Europe.* We know about the case of one man of government who, in order to be treated in his own country, allocated most of the healthcare budget of his government to a diabetes unit, to the obvious detriment of the development of healthcare clinics in the rural areas of that country.[23] In his opinion, he was doing nothing else but exercising his own right to health. He did not feel any compunction to share that right with other people. Perhaps he believed that his own person and the services which he rendered to his country justified this special kind of treatment. If this example is especially illustrative of differences which exist in access to health care between the poor sections of a country and its rulers, we should not be deceived as to the nature of the wider canvass. This situation is present in all those countries where urban populations who have access to power reserve to themselves opportunities for health care which are not available to the inhabitants of the more disadvantaged areas. In this case, too, we must pose the question, How can a correct balance be found?

* *Within industrialized countries there are problems relating to specific choices* concerning both the establishment, for example, of what the healthcare budget should be, and the management of hospital structures. Three situations can be cited here by way of example:

+ *A certain number of healthcare activities are questioned from a moral point of view.* In this category are to be found everything connected with abortion, but also a series of medical practices which are spreading in societies which no longer have religion: euthanasia, bioethical experiments, interference with what man is, the conservation and destruction of surplus embryos, etc. Here we become immersed in an atmosphere where the means to achieve what is defined as being healthy are placed beyond any kind of moral consideration. Thus we encounter the questions which pose themselves to a legislator or a Catholic in a pluralistic society when their professional activity involves these new practices.[24] For such people the right to health of individuals cannot go against the fundamental needs of life. They often come into conflict with what Pius XII called "questions of fact"[25] which must be resolved by the individual conscience in union with the Church.

+ *The costs of running* a clinic or a hospital have become so high that their managers have to deal with questions relating to expenditure: the purchase of new machinery and instruments could seem to be a luxury because paying for them would be difficult. On the other hand, not to buy them would involve reducing the status of the institution and consigning it to a slow death, because it would be abandoned since it would no longer be able to provide the forms of treatment requested by the society within which it operates.[26]

+ *The healthcare institutions run by the Catholic Church* experience very special problems all of their own. The role of the Church in healthcare activity comes from her wish to provide the poorest populations with forms of treatment and support that they lack. Often the technical qualifications which are nowadays required in hospital centers, as regards both machinery and the skills of trained personnel, go against the vocation to bear witness to the *love of Christ for the poorest among us.* The need for income, the use of economic resources, and the right to health are at the root of problems whose solutions should be examined from a large number of points of view.

Conclusion: Justice Through Dialogue and Negotiation

The conflicts between rights which have been discussed in this paper cannot be resolved to the full satisfaction of everybody. The ideal of social justice leads us to have greater respect for the aspirations of each and every individual, on a constant basis. Pius XI observed that this ideal is of both an individual and a collective character. It is *individual* in the sense that it assumes a determination of everybody to practice social justice. It is collective because it must be based upon institutions[27] which promote the drawing near of points of view and the "return of the distribution of resources" to a more equitable level.[28]

With such observations, Pius XI opened up the prospect of solving social problems through dialogue, a method which would be highly valued by Vatican Council II and the Popes which came after that Council. For these Pontiffs, man must allow himself to be guided by "a moral idea: social justice which must be established day after day, and by shared agreement" and progressively establish "new rules of social behavior which become norms based upon rights".[29] Only this path allows us to cancel out the injustices which exist in every society and which call out for revenge, and in particular in the field of the relationship between the right to health and the universal destination of economic resources. We have before us the absence of institutions which work in this direction and the lack of a commitment to solidarity on the part of the privileged. This is captured in the strong words of Paul VI: "We need to build a world in which every man, without reference to race, religion, or nationality, can live a life which is fully human... And therefore voluntary cooperation needs to be established, an effective sharing among people, in a climate of equal dignity, for the construction of a more human world"[30]

Rev. JOSEPH JOBLIN
Professor of the Social Doctrine of the Church, the Gregorian Pontifical University, Rome

Notes

[1] *Populorum Progressio* 22, 23. Cf PIUS XII, the Angelus, 24 November 1940: "Radiomessagio per la Pentecoste 1941"; *Mater et Magistra* 41; *Sollicitudo Rei Socialis* 27; *Centesimus Annus* chap. 4 "Private Property and the Universal Destination of Goods."

[2] *Populorum Progressio* 15.

[3] JOHN PAUL II, "Discorso ai Vescovi Latino-Americani," Puebla, 28 Jan 1979; *Sollicitudo Rei Socialis* 42.

[4] Pontifical Commission (Council) Justice and Peace, *A Proposito della Conferenza del Diritto del Mare. La Destinazione Universale dei Beni* (1972), p. 12.

[5] *Gaudium et Spes* 63.3.

[6] *Populorum Progressio* 15.

[7] *Rerum Novarum* 8; 32.3.

[8] *Centesimus Annus* 13.

[9] *Divini Redemptoris* 10.

[10] SUAREZ, *De Legibus* II 19.9.

[11] *Populorum Progressio* 43.

[12] PIUS XI "Allocuzione ai Dirigenti della FUCI (Federazione Universitaria Cattolica Italiana)," 8 December 1927, in *Discorsi*, Vol. 1 (SEI, Turin, 1960), p. 745.

[13] *Divini Redemptoris,* 34.

[14] *Divini Redemptoris,* 51.

[15] J.VILLAIN, *Interventi alla Settimana Sociale di Muhlouse* (1931), p. 269.

[16] *Divini Redemptoris,* 51.

[17] L.MUCHIRI, "Faire des Choix ou Liasser Mourir," in *Contact* (1997/1), p. 4.

[18] JOHN PAUL II, Angelus of 20 February 1991.

[19] *Pacem in Terris,* III.

[20] *Rerum Novarum,* 3.

[21] *Sollicitudo Rei Socialis,* 9, 36.

[22] S. RUBINO, "Salute: Definizione, Attuazioni, Contraddizioni, Lettura Politica, Politica Sanitaria," in *L'Operatore Sanitario* (ACOS), 1997/1, p. 10.

[23] *Contact, op. cit.,* p. 3, draws attention to the special treatment accorded to Heads of State and other African leaders (the same, however, happens in the West) and describes them as "exclusive privileges." "According to a report from Kenya, 40% of the national healthcare budget was allocated to the costs of equipping the National Kenyatta Hospital. The proportion of the same budget allocated to the clinics of the rural areas was just 1.4%" *(ibid.).*

[24] J. JOBLIN and R. TREMBLAY (eds.), *I Cattolici e la Società Pluralista. Il Caso delle Leggi Imperfette* (ESD, Bologna, 1996), p. 284.

[25] PIUS XII, "Allocuzione all'Unione dei Giuristi Cattolici Italiani," 6 December 1953.

[26] J. HUG, *Dimension of the Healing Ministry* (Catholic Health Association of the United States, St Louis, Missouri, and Center of Concern, Washington, 1989), p. 222.

[27] Social justice "can be observed by everybody only if everybody agrees to practice it together through institutions," *Divini Redemptoris,* 64.

[28] *Quadragesimo Anno,* 64.

[29] PAUL II, "Allocuzione in Occasione del Conquantenario dell'Organizzazione Internazionale del Lavoro," Gineva, 10 June 1969.

[30] *Populorum Progressio,* 37 and 54.

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LUCIANO SANDRIN

The Church: A Healing Community

1. The Example of Jesus and His Commandment

1.1. The Example of Jesus

The synoptic Gospels describe the healing of a leper by Jesus. Matthew writes as follows about the episode, "A great multitude followed him when he had come down from the mountain; and then a leper came and knelt before him, and said, *Lord, if you so will, you have the power to make me clean*. Jesus held out his hand and touched him, and said, *It is my will; be made clean*. Whereupon his leprosy was immediately cleansed" (Mt 8:1-3).

In a miniature painted by a monk some thousand years ago the figures which are depicted are in a scene containing movement. Jesus descends from the mountain, from on high, and behind Him there are two men who, on seeing Jesus perform a miracle of healing, look at their hands as if to ask themselves what they themselves might not be able to do. In the background there are other people who have different clothing from that of the biblical figures and are certainly contemporaries of the artist. In front of them there is a leper. The artist has represented the action of Jesus in an image. He has captured the way Christ responded to the leper and has thus expressed his practice—that is, his pastoral action.[1]

The leper is a sick person, but he is also a *marginalized* sick person who has been excluded from the community. He is isolated, *ex-communicated*, and in social terms already dead. Not only does he not have physical health, but he also lacks certain essential ingredients of a fully human health—most notably, the opportunity of growing as a person in interaction with other people. He lives like a foreigner in his own country. Within him there is still the strong hope that he will be healed, and he asks for help from Him (for such is his perception) who is able to help him.

Jesus is the *savior*. His encounter with the leper is *healing and health-inducing*. The leper is given back the place in life which he had lost—the relationship which makes him feel like a person. The *welcome* which Jesus gives to the leper is health-inducing. By this action Jesus breaks human law, but "complies with the law of God," according to the dictates of which the human person has absolute precedence. Jesus stretches out *his hand* and comes into contact with the leper, but this contact is united to an *effective word* which creates that which it proclaims. In healing the leper physically, Christ also restores to him his social life, or relational space. The leper passes from the domain of death to the realm of life—*he rises again*. The healing of the leper is an Easter story and narrates a return to the fullness of life in physical and social terms, but also, above all, it describes an encounter with God, who in Jesus expresses his definitive Word of salvation. The action of Jesus has its origins from on high, from the *mountain* as the synoptic evangelists tell us, and thus expresses the intentions of God and carries out his project of salvation, which is directed towards his people.

The two men in the miniature who are placed behind Jesus think about themselves in relation to Him. They look at their hands and ask themselves what they can do to ensure that *the way of acting of God*, which is *incarnated in the way of acting of Jesus*, becomes the criterion of their way of acting. In these direct witnesses we can perceive the first community of the followers of Jesus—that is, his Church, that asks herself what she must do to ensure that her pastoral action continues the action of God within history and gives credibility to his love. The question as to whether our practice *conforms to Jesus* and his action and, therefore, *conforms to the action of God*, is—as the point is expressed in pastoral theology—the most important of all criteriological questions. The practice of Jesus is the criterion of our practice, of the action of us Christians, of us as the Church of Christ, and the question is whether and how our pastoral action is in line with, and conforms to, the practice of Jesus.

In representing his contemporaries in the miniature as well, the artist seeks to emphasize the fact that the example of Jesus must not only involve his direct witnesses, but also reach out down the gradual path of history to ourselves at the present time.

1.2. Preach the Gospel and Heal!

In reality the disciples of Christ, as regards their endeavor in the field of health and healing, received from Him not only an example, but also a specific *mission*-commandment in which the preaching of the kingdom is strictly linked to healing action: "And preach as you go, telling them, 'The kingdom of heaven is at hand.' Heal the sick, raise the dead, cleanse the lepers, and cast out devils" (Mt 10:7). Luke, too, emphasizes that Jesus "called the twelve apostles to him and gave them power and authority over all devils, and to cure diseases, sending them out to proclaim the kingdom of God and to heal the sick," and in obedience to this command "they set out and passed

through the villages, preaching the gospel and healing the sick wherever they went" (Lk 9:1-2; 6). And the evangelist Mark informs us that the twelve who had been sent out in pairs by Jesus "went out and preached, telling men repent; they cast out devils, and many who were sick they anointed with oil, and healed them" (Mk 6:13). It is interesting to observe that this command, which described the mission entrusted by Jesus to his disciples, is referred to in the Gospel according to St. Matthew after a long account of the signs of the works of healing carried out by Christ. The disciples had been present at these miracles and had thus engaged in a kind of apprenticeship under the guidance of a master who was unique in his kind.

The Church has been aware of her *healing mission* from her very beginnings and early history. The account of the healing of the lame man by Peter which is described in the Acts of the Apostles is in this sense emblematic and representative: "Peter and Paul were going up to the temple at the ninth hour, which is an hour of prayer, when a man was carried by who had been lame from birth. Every day he was put down at what is called the Beautiful Gate of the city so that he could beg alms from the temple visitors. And he asked Peter and John, as he saw them on their way into the temple, if he might receive alms from them. Peter fastened his eyes on him, as John did, too, and said, *Turn towards us*; and he looked at them attentively, hoping that something would be given him. Then Peter said to him, *Silver and gold are not mine to give; I give you what I can. In the name of Jesus Christ of Nazareth,* rise up and walk. So, taking him by his right hand, he lifted him up, and with that, strength came to his feet and ankles; he sprang up and began walking and went into the temple with them, walking and leaping, and giving praise to God" (Acts 3:1-8).

Following the example of Jesus and obedient to the mandate which they had received from Him, the members of the apostolic community attached special importance to the sick and employed with them the same words and actions which had been used by Jesus. This was possible because of the strength of their communion with Him in faith. It is Easter which led the Church to carry out the actions of Jesus and to perform them in his name: "In healing the lame man at the Beautiful Gate the apostles do nothing else but obey the command of the Lord: "Preach the Good News and heal the sick." Their strong communion with the Risen Christ is translated into an active remembrance of his healing presence. Just as they celebrated the remembrance of his Easter in the Eucharistic mystery, so in the same way did they celebrate remembrance of him by performing his Messianic actions. In the declaration *Silver and gold are not mine to give. I give you what I can. In the name of Jesus Christ of Nazareth, rise up and walk!* Peter professes his faith in the Lord who is alive and present and who carries out the healing."[2]

The *example and the command of Jesus,* which Peter expresses and embodies, has passed into the history of the Church to arrive at our own times, and it has become a *question which involves us* and touches us forcefully: What kind of action, and therefore what kind of pastoral action, should we as the Church of Christ engage in *today* to respond in a healing way to the demand for health and healing which—whether explicitly or implicitly—comes to us from those who live in this society of ours?

2. The Plea for Health, the Longing for Salvation

2.1. Today's World and God's Invitations

There is a close relationship between the biblical *text* (the event-Word) and the *con-text* in which the Word is now to be heard and expresses Himself. The context, therefore, from a theological point of view, is the time in which God acts today in a special way through the Church. The Bible calls this salvific time *kairos.* In the thought and outlook of pastoral theology, therefore, the kairological function is to decipher—in the light of faith—the signs of the times with a view to understanding the promptings and the invitations of God (Lk 12:54-57). In *Gaudium et Spes* Vatican Council II reminds us that "the People of God, moved by faith, because of which they believe to be led by the Spirit of the Lord who fills the universe, strives to discern within the events, entreaties, and aspirations which they share with the other men of our time, what the real signs are of the presence or design of God" (no. 11).

To those who asked Him if he was the one who was to come or whether they had to wait for another, Jesus displayed his credentials in the form of the signs which marked Him out as the Messiah, the One sent by the Father, and among these signs were to be found healings and the preaching of the Good News to the poor (Mt 11:1-6). Today, the Church, too, must be able to display these credentials and to do this she must be able to answer certain decisive questions (her kairological function): Who is the leper of today, who are the sick people, the blind and the disabled of today? How should the Word entrusted to the Church be pronounced so as to really constitute a happy declaration of *shalom,* of overall salvation? What is the health Christians must respond to according to the example of Jesus? The way of acting adopted by Christ will in this sense be illuminating and authoritative (a Christological function), and from Him our practice will receive the right guidelines for the achievement of a suitable change in present conditions (praxeological function).[3]

Pastoral theology, in relation to the healthcare world as well, must therefore scrutinize the situation with the eyes of faith (kairology), gain a clear idea of goals to be pursued and the models of reference to be adopted (criteriology), and promote an ecclesial action—the pastoral action of the whole of the Church—which expresses in today's world the fullness of her guiding model (praxiology). In this endeavor it must be remembered that the ecclesial community is the subject of pastoral action just as the whole of the Church is the object of the thought and assertions of pastoral theology. As René Latourelle observes, "Within theology, therefore, there is a place for a methodical and scientific study of the Church as a contemporary phenomenon in the decisive moment of its current presence in the world. This study of the *Church-in-her-historical-situation* belongs to the intelligence of the Church.... In this way, while dogmatic theology deals with the Church in her essential being—

that is, as a mystery and an institution which is both human and divine, pastoral theology is a theological reflection upon the her *mutable* being—that is, upon the mystery of the building up of the Body of Christ which is the Church in its *present and practical* realization and upon the *conditions* of this realization, and upon the way in which the contemporary situation reacts to the achievement of the salvific mission of the Church. By the phrase "contemporary situation" we mean the cultural and social changes which characterize each epoch. In each new historical situation there is an indication by God, an invitation to engage in new tasks, or at least to practice a constant up-dating".[4] God has chosen a specific way by which to achieve the salvation of humanity—the economy of the Incarnation. And this way which He has chosen has precise consequences for the pastoral and salvific activity of the Church and for theological thought and reflection about what such action ought to be.

2.2. The Plea for Health and its Implications

The World Health Organization helps us to understand the current healthcare situation in the world. Its latest bulletins tell us that every year infectious diseases kill about seventeen million people and afflict another hundred million, and this is a special characteristic of developing countries. On the other hand, in the other countries chronic illnesses constitute the principal threat to health. But given that life expectancy levels are rising in developing countries as well and in such societies Western healthcare models are gaining the upper hand and becoming ever more dominant, these countries will be increasingly exposed to illnesses of a chronic character. The developing countries, therefore, are subject to a "double burden" because these new problems come to be added to the existing burden of the endemic infectious illnesses at exactly the moment when the gap between rich and poor countries in terms of the resources which are available is growing larger and larger. At a planetary level *life expectancy* is increasing, but this does not always find a corresponding expression in *health expectancy*—that is, "expectancy of a life spent in good health."[5]

In the planet's wealthiest countries the search for health is becoming the most important aspect of life. On the one hand, this search is becoming increasingly a life project which is seen in dynamic and relational terms and conceived as the achievement of harmony (or, rather, continual harmonization) between the different dimensions in which the life of each and every man comes to obtain fulfillment—namely, the physical, the psycho-social, and the spiritual.[6]

On the other hand, the search for health and thus the state of *being healthy* is often understood as *being fit*. It therefore becomes reduced to the merely physical dimension of an individual's life, and this involves a spasmodic tension produced by the desire to identify with socially ascendant models of how to live today. In our kind of society, which takes strong, healthy, young, and beautiful beings as its ideal model, illness is often a tragedy, and the same may be said of pain, disability, and old age—realities to which it is not possible to give a meaning and which are as a result *no longer bearable*. Health is increasingly becoming a value-symbol which at times is the only value to which people can attach themselves. "In times of crisis and the loss of a horizon of meaning it seems that the only value which remains in sight is that of taking refuge in the search for health, in the wish to *be well*, and thus within the context of a state of *good health* it is thought that it will be possible to solve all the other problems which still remain. When values no longer exist, there remains a sole half-value which is weak, without energy, without illusions—it is a poor ideal, but a sincere one. It is that of being able to live without tears, material difficulties, or physical ill-being and troubles, and without forms of psychological disturbance."[7]

The search for health in the form of a life-project, and the achievement of harmony between the different dimensions of the human person, where the spiritual dimension plays an important role—something which is also recognized today by medical science—must become increasingly the terrain of theological reflection and thought, and a realm in which the intelligence of the faith perceives and grasps the present-day appeals and invitations of God. While, on the one hand, the experience of illness has always been the subject of theological reflection and thought and the domain of loyalty to the evangelical mandate to heal and to preach, on the other hand, "health—however paradoxical this may seem—until recent times has not been seen as a *theological question* and still less as an essential realm of theology which is on a par with illness and suffering."

The new anthropological importance which is being attributed to the health experience opens the road to forms of deeper theological reflection and thought where attention is not reduced to observing and reflecting on what happens within man (health is not only an *event*), but also involves asking what human health is and what he is called to be (health as a vocation, as history, and as commitment). There is room for theological thought and reflection about health, and therefore for a *theology of health*, because the health experience involves an anthropological vision which the Christian deduces from the design which God has for the salvation of man and humanity.[8]

But to ensure that its action carries on from that of its Founder and is effective in pastoral terms, the ecclesial community must today be capable of perceiving in the search for the health of the sick not only a request for care and healing to which it *must* respond, but also a wish "for company, solidarity, and support during a moment of trial"—that is, as John Paul II points out in *Evangelium Vitae*, a "request for help in order to go on hoping when all human hopes burn low" (no. 67). But the Church must also know how to read and understand the desire for salvation which is implicit in the kind of search for health which is now socially ascendant (the desire to *be well*, to achieve *well-being*, and to *be fit*) and to perceive within this desire "the strange game of substitutes which enter the fray: health in the place of salvation and salvation as a mirror of health in the form of an endless *Carpe diem*. It is like a continuous game of ping-pong where, however, at the end of the game it is not possible to avoid the basic dilemma: is man not

perhaps directed towards a salvation which includes health and which moves towards a transcendental polarity which eludes human projects and which can only be invoked *de profundis*? In this context, therefore, there arises almost spontaneously a reflection upon health which has as its final end and its most authentic aspect the search for *salvation*".[9]

The healing mission of the Church, which is a mandate received from her Founder, certainly implies caring for the sick (being committed at all possible levels to their care and treatment) and being concerned with all those who in various ways share their experience and help them, but (above all, today) this mission must also express itself in the promotion of an overall (physical, relational, and spiritual) health of which *the gift of salvation* forms an integral and meaningful part. If the pastoral action of the Church in the field of health has the sick person as its focus of concern and, in addition, clearly has certain special areas of expression, then its healing (salvific/health-inducing) action must become ever more forcefully *the dimension which is present in all her ways of acting*.

3. The Healing Response of the Church

3.1. A Health-Inducing Salvation

In *Lumen Gentium*, Vatican II observed that "the Church is in Christ as a sacrament or sign and is the instrument of intimate union with God and of unity with the whole of mankind" (no. 1) The Church "by a not at all weak analogy is compared to the mystery of the Word made flesh. Indeed, just as nature is employed by the divine Word as a live organ of salvation which is to Him indissolubly united, so, similarly, the social organism of the Church is employed by the Spirit of Christ, who vivifies her to achieve the growth of her body (cf. Eph. 4:16)" (no. 18).

Sacramental ecclesiology offers "the right coordinates by which to approach the subject of health, the sick person, and the hope of being healed, from the unprejudiced perspective of Christian salvation." In Holy Scripture the idea of "sacrament of salvation" is often applied to Christ and is implicitly referred to the Church in all these passages which see her as the sacrament of communication of Christ, and with a structure which is similar to that of the Incarnation. The purpose of the Church is to lead men to the salvation given by the Father through Christ in the Spirit—that salvation which, at its deepest level, consists of liberation from sin and death and of participation in eternal life and the infinite joy of the Trinity.

It is at the same time personal salvation and the salvation of the community, spiritual salvation and temporal salvation, and historical and eschatological salvation—*it is an overall and complete salvation which, within the framework of the horizon of eternal life, saves the whole human person in all his dimensions*. As a radical sacrament, the Church is the root of innumerable sacramental expressions of salvation, and among these the most important are "the community of believers, which manifests and achieves Trinitarian communion within the world; the charisms and the ministries which offer the word of God to the community—that word which proclaims and involves salvation—and the sacraments which realize this proclaimed salvation"[10].

The sacramental actions of the Church manifest within themselves the character of the totality of the salvation of Christ, give reality to this salvation, and, within the real unity which exists between the order of created beings and the historical-salvific order, relate to the reality of *health* in a relationship of deep and mutual interaction with the reality of *salvation*. There exists a kind of void or vacuum of theological reflection and thought as regards the relationship between *health, salvation, and the sacraments* (whereas the relationship between *illness, salvation, and sacraments* has been quite well analyzed). However, as Carlo Rocchetta well expresses it, *health can be* "a *theological realm* of equal importance to that of illness for an overall conceptualization of the Christian event of salvation and the sacraments which give it reality during the time of the Church."

In Jesus salvation is offered as health and health as salvation, and the good news is the proclamation of a *saved health* and of a *health-inducing salvation* for man, for the whole man and for all men. In the sacramental events, which are placed at the central points of human existence, the relationship between health and salvation is realized in terms of real, historical, existential, and ecclesial correspondence. In these events "the believer is placed in a position where he is able to draw upon the highest meaning of life and to realize—through a gift—the expectation of that full salvation which he bears within him like a profound and irremovable longing." The event of healing/salvation is understood within the sacramental events as a new condition of existence which liberates man from sin and places him anew in the fullness of the gift of the Spirit, and transforms him by committing him to his complete fulfillment. "In this sense, one can speak about sacramental grace as a *grace of overall healing*." Pastoral action in the field health, therefore, belongs in an inseparable way to the salvific mission of the Church, and the sacraments give practical expression to this mission.[11]

In the celebration of the sacraments and in the preaching of the Word, the Church carries on the salvific work of Christ. *The Catechism of the Catholic Church* reminds us that "the Lord Jesus Christ, physician of our souls and bodies, who forgave the sins of the paralytic and restored him to bodily health, has willed that his Church continue, in the power of the Holy Spirit, his work of healing and salvation, even among her own members" (no. 1421). Just as the sacraments now express the salvation brought by Christ, so the evangelization promoted by the Church is an incarnation and prolongation of the evangelizing action of Christ and must find a basis and inspiration in his salvific action. "This loyalty to her Lord must lead the Church to offer and communicate the salvation of Jesus as a healing force which can be experienced right away, within the suffering and the weakness of the contemporary human condition as a foretaste and hope of eternal life"[12].

And, in order to do so, the Church must commit herself to ensuring that the salvific force of the Gospels penetrates the present-day culture of health. She should also be the critical voice of a culture which emphasizes the physical dimension

of health and forgets its spiritual and transcendental dimension. The evangelization of the culture of the healthcare field must involve the Christian community's bringing the Word which heals and bearing witness through action which stewards the profound meaning of life and the multidimensional aspects of health, thereby rendering more possible the encounter—that is, incarnation—between the divine and the human, in such a way that the human is ever more expressive of the divine and health is a sign of the Kingdom of God which is *already* among us, but *not yet* fully expressed.

3.2. To Evangelize Through Healing

The Church is a sacrament of salvation and expresses the salvific action which has been entrusted to her as a gift and a task through evangelization and the celebration of the sacraments. "However, the fragment of the world which is already *saved in the sacrament* by its very nature tends to spread, bringing the dynamism of the incarnation which energizes it to the whole of the creation. The salvific action of the Church, therefore, also expands into the promotion of human well-being"[13] through the commitment of all Christians to ensuring that within society the energies of salvation are active which the Church, guided by the Holy Spirit, receives from her Founder in order to save the human person in all his aspects (GS 3).

Christ came into the world so that men "may have life, and have it more abundantly" (Jn 10:10) and the Church, in all her actions, does nothing but continue his action of salvation. The life which the Church is called upon to preach "is the fullness of the gift of grace which fills the total life experience of man, taking on his vocation to health in order to transfigure it into a vocation to salvation and taking on his vocation to salvation in order to turn it into a service of love for man, the whole man and all men." Just as every sacramental theology is a theology of charity and hinges around charity (and thus service and care) as its proper form of manifestation and realization, so the preaching of the Gospel of salvation and its acceptance are inseparable—within the teaching of Jesus—from service towards the least, the sick, and the marginalized, even to the point of identification with these groups of people[14].

Jesus never separates his therapeutic action from the proclamation of the Kingdom. The acts of healing which He carries out are at the service of evangelization. These are the most evident sign of the salvation which He offers; they are the experience which allows men to understand or at least to sense the meaning of his evangelizing action. This means that the evangelization of the world of health by the ecclesial community should not be something added to the therapeutic action of its members, but must be an integral part of the actions of care and healing by health workers. This should take place in such a way that these very actions become *gospel*, the happy declaration that God is a present God, a God who loves, who heals, and who consoles, "sign of a God-Friend and savior, and an invitation to accept his salvation"[15].

Service to the sick, which is at times also expressed in actions of extraordinary healing, is an integral part of the mission of the Church, of her pastoral and evangelizing mission, and is a *high point in her ministry*. And the various kinds of healthcare workers are called to be the living image of Christ and his Church expressed in love towards the sick and the suffering. These health workers in various ways not only give modern expression to, reveal, and communicate to the sick "the healing love and consolation of Jesus Christ",[16] but also manifest in a constant and often silent way the miracles of healing which the Church has the power—received from Christ—to carry out. In their therapeutic actions, and in the credibility of their role and commitment, the Church's credibility in the healthcare field is put on the line, as Cardinal Tettamanzi well observes: "The Christians who labor in the health field work under an individual banner, but if they are Christians they also and inevitably work under an ecclesial banner. The credibility of the Church is sustained or not sustained by the individuals who go to make up the Church"[17].

Healthcare workers are called upon each day to write the parable of the Good Samaritan again, the figure who became a neighbor to those who suffer. In their actions for treatment and care they should give constant modern expression to the "therapeutic charity" of Christ towards the "christ" who is present in the sick person. In their professional lives, where they engage in service to life, they express a real and authentic *therapeutic ministry* because they become God's co-workers in "restoring health to the sick body and giving praise and glory to God in the loving acceptance of life, especially if that life is weak or sick".[18] The Christian vocation, on the one hand, and professional activity, on the other, are not in conflict. To be good Christians in the complicated world of health does not mean to dispense with (technical and relational) training of the highest quality—indeed, it requires such training: *only competent hands manage to provide the therapeutic love which the sick person needs*.

But only in working together (like the pieces of a successful and meaningful mosaic) can health professionals achieve that real therapy which stewards the richness of the dimensions in which health expresses itself and whose harmony within the sick person has entered a state of crisis. Illness, like health, is something which concerns the whole of the human person and thus involves a *great alliance* of factors. *Therapy*, too, is the outcome of a successful *mosaic of professional skills and expertise*. Only together can healthcare workers "rewrite the richness, the depth, and the wholeness of the therapeutic approach of the Good Samaritan, who, in offering care, preached the good news of the love of the Father"[19].

This is a task entrusted by Christ and by his Church in a special way to the various kinds of professional groups who work in the world of health, but it is also an "inescapable duty" for all those who, as members of the Church of Christ, participate in his healing mission—a *mission* for the whole of the people of God, for the community which has chosen Christ.

3.3. A Healed and Healing Community

It is precisely in her saved and healed community that the Church can express herself, both at a universal level and at a specific level, as a *healing community*. It is in her

being as a community that the Church expresses most fully her sacramental character—she reveals and communicates the salvation of the Trinity (of the loving Father, the beloved Son, and the Holy Spirit as Love) through new interpersonal relationships which are ever-more expressive signs of such salvation.

The model of service—that is, *diakonia*—which the Church is called upon to manifest today in the world of health, as a sign of the Kingdom, is the model of *ecclesial communion*. This model strives to achieve the full integration of the sick, the disabled, the weak, and the vulnerable into the community. This is a model which aspires to construct a community of new lives where the other person is welcomed not for what he has, but for what he is, in a process without barriers and prejudices, and in full appreciation of the contribution made by each individual. This is the *Trinitarian* model of reciprocity, where each person is a partner in a relationship where he gives and receives, where he heals and is healed. It is the model of Christ the Samaritan and Christ the sick person.

An important dimension of the healing role of the Church is to be located in this function of a community. The Church, which is made up of a people assembled by the Trinitarian God and is a place of communion among men with the Father, the Son, and the Holy Spirit, becomes a context in which health—experienced as the harmony of the individual with himself, with other people, and with God—finds an important place for care, prevention, and advancement and becomes the *already* of a salvation, of a *not yet*, which will have its complete fulfillment in the *eschaton* of God.

But the Church also has an important healing function as a *place of meaning*. As Cardinal Ratzinger writes, "A vision of the world which cannot give a meaning to pain and render it valuable is of no use at all. It fails precisely where the decisive question of existence makes its appearance. Those who have nothing to say about pain, but that it should be fought against, deceive us. Certainly everything should be done to alleviate the suffering of many innocent people and to limit suffering. But a human life without pain does not exist, and the person who is not able to accept pain withdraws himself from those purifications which alone make us become mature".[20] For the person who believes, nothing, not even the experience of pain, can bring about separation from Christ. Indeed, it is precisely the moment of suffering which can become, as for Job, an "experience" of the presence of God which is healing and redemptive, not only for the person concerned, but also—as St. Paul reminds us—for the whole of the Church (Col 1:24).[21]

In communion with Christ, who has died and risen, with Him who *lived through* pain and death meaningfully, the Church becomes a welcoming place of hospitality, "a place of hope" where every tired or ill pilgrim, a "searcher after the meaning" of what he is undergoing, can *live out*, in a health-inducing and salvific way, his suffering and his dying, and write a *meaningful* chapter in his history of alliance with other people and with God.[22]

In expressing herself as a healing community, the continuation of the Word which saves and the action which heals, and as a community in which the relationship between people is mutually healing and redemptive because of the work of the Spirit, the Church obeys the command of her Lord and fully realizes herself. Her *healing activity* thus rises above certain specific places and becomes a *healing dimension* which evokes and gives reality to her identity, and this is something which can be experienced in all of her pastoral action.

Rev. LUCIANO SANDRIN, M.I.
Dean of the Camillianum International Institute for the Pastoral Theology of Health Care, Rome

Notes

[1] P.M. ZULEHNER, *Teologia Pastorale. 1. Pastorale Fondamentale. La Chiesa fra Compito e Attesa* (Queriniana, Brescia, 1992; the German edition 1989-1990), pp. 13ss. This work is referred to in abbreviated form in subsequent footnotes. For the subject under consideration see volume 3, *Passaggi. Pastorale della Fasi della Vita.*

[2] E. BRESSANIN, "Unzione degli Infermi," in *Dizionario di Teologia Pastorale Sanitaria* (Cammilliane, Turin, 1987), p. 1344. See also R.A. LAMBOURNE, *Le Christ et la Santé. La Mission de l'Eglise pour les Guerisons et la Salut des Hommes* (Le Centurion, Paris, 1972).

[3] P.M. ZULEHNER, *Teologia Pastorale. Pastorale Fondamentale. 1. La Chiesa*, pp. 19-21.

[4] R. LATOURELLE, *La Teologia*, Scienza della Salvezza (Cittadella, Assisi, 1992), pp. 141-142.

[5] OMS, *Informe Sobre la Salud en el Mundo 1997. Vencer el Sufrimento, Enriquecer a la Humanidad.*

[6] See C. BRESCIANI, "Salute. Approccio Storico-Culturale," in Dizionario di Teologia, pp. 1073-1079.

[7] A.N. TERRIN, *Il Sacro Off Limits. L'Esperienza Religiosa e il suo Travaglio* (EDB, Bologna, 1995), p. 251.

[8] F. ALVAREZ, "Salute. Approccio Teologico," in *Dizionario di Teologia*, pp. 1079 and 1082.

[9] A.N. TERRIN, *Il Sacro*, p. 253.

[10] S. PANNIZZOLO, "Chiesa Sacramento di Salvezza," in *Dizionario di Teologia*, pp. 189ss. See also T.L. ALKIRE, *Healing as a Parish Ministry. Mending Body, Mind, Spirit* (Ave Maria Press, Notre Dame, Indiana, 1992).

[11] C. ROCCHETTA, "Sacramenti," in *Dizionario di Teologia*, pp. 1063-1073. C. ROCCHETTA, "Salute e Salvezza nei Gesti Sacramentali," in *Camillianum*, 4, 1993, pp. 9-27. See also J. CASTELLANO CERVERA, "I Sacramenti di Guarigione: la Dimensione Sanante della Penitenza e dell'Unzione degli Infermi alla Luce del Catechismo della Chiesa Cattolica," in *Camillianum*, 6, 1995, pp. 209-229.

[12] J.A. PAGOLA, "Evangelizzazione e Mondo della Salute," in *Dizionario della Teologia*, p. 427. J.A. PAGOLA, *Accion Pastoral para una Nueva Evangelization* (Sal Terrae, Santender), pp. 135ss. See also B. HARING, *Proclamare la Salvezza e Guarire i Malati. Verso una Visione più Chiara di una Sintesi fra Evangelizzazione e Diakonia Sanante* (Ospedale Miulli, Quaderni 1, Acquaviva delle Fonti, Bari, 1984, or the German edition 1984). Conferencia Epsicopal Española, Congreso Iglesia y Salud, 26-30 September 1994, (Editorial de la Conferencia Episcopal Española, Madrid, 1995).

[13] S. PANNIZOLO, "Chiesa Sacramento," p. 201.

[14] C. ROCCHETTA, "Sacramenti," in *Dizionario della Teologia*, pp. 1073 and 1070.

[15] J.A. PAGOLA, "Evangelizzazione," p. 428.

[16] JOHN PAUL II, *Christifideles Laici*, no. 53.

[17] D. TETTAMANZI, "Chiesa e Salute," in *Progettualità Ecclesiale nel Mondo della Salute, Proceedings of the Third Conference of the National Health Council of the Italian Bishops' Conference*, 23-25 April 1995, (Salcom, Brezzo di Bedero, VA), p. 87.

[18] The Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* (Vatican City, 1994), nos. 4 and 5.

[19] The National Health Council of the Italian Bishops' Conference, *Il Mosaico Terapeutico* (Camilliane, Turin, 1997), 13 and 14.

[20] J. RATZINGER, *La Chiesa. Una Comunità sempre in Cammino* (Paoline, Cinisello B., Milan, 1992), or the German edition of 1991, p. 111.

[21] For this question and debate see JOHN PAUL II, *Salvifici Doloris* (1984).

[22] For some interesting observations and comments see M.E. MOHRMANN, *Medicine as Ministry* (The Pilgrim Press, Cleveland, Ohio, 1995), pp. 75-88.

MARIE-ODILE RETHORE

Medical Science and Christian Faith

At the end of this century, on the threshold of the third millennium, scientific and technological advance and development are so rapid that the strongest of wishes and hopes come to dominate man and are soon transformed into needs which have to be satisfied by all means possible.

At the same time wisdom and virtue do not increase—they even diminish as the mass media adopt the role of "intellectual guides"; education enters into decay and the family breaks up, and faith and religion—when they are not actually directly attacked or ridiculed—are held up as being archaic values which are not fitted or suited to modern man.

It would certainly be a great achievement if medical doctors performed the duties which they are given in a spirit of loyalty to the Hippocratic Oath, by reducing suffering, healing wherever possible, always accompanying the sick, and bearing witness to compassion when faced with an adverse destiny. But in societies which we consider "advanced" they are called upon to do very different things.

For example, there is no longer the question of alleviating the problems caused by aging. Now youth has to be preserved, old age impeded, and the effects of growing old abolished. People want to remain—or to become again—young, beautiful, and active in sports. They want to do this without, however, accepting the least effort that this entails, but by using, instead, medical or surgical forms of treatment which are becoming ever more expensive and increasingly dangerous.

In the same way illness, suffering, and death are hidden and concealed in our society by "healthy" people. "If you do not know how to heal him, keep him for yourselves—that is, to say kill him. . . . But I do not want him!" And all of this, it should be made clear, takes place in the name of great principles and fine sentiments.

It is within this kind of philosophy that we should place the request for pre-implantation diagnosis in the case of in vitro fertilization, the demand for prenatal diagnosis, advice to abort if there is an anomaly, but also advice to abandon the child if born with a malformation or an illness which could not have been foreseen.

In order to debate and discuss this question, which is of such vital importance for the family, ethical committees have been established to study new laws which, once approved, will influence habits and customs within society, and these, in turn, will have an impact on what laws are subsequently passed. With a little "openness," and behind the screen of a "good conscience," good and evil will no longer be the cardinal points of reference for an upright and illuminated conscience. In their place there will be the silent consensus of state or government ethics.

Out of fear that the debate on abortion could be re-opened, the document issued by the government declared that "it was not possible to pronounce, in the law, on the status of the embryo." The Senate and Parliament then followed this line of thought in their deliberations.

And thus it is that parliamentary bills grow larger in number and ethical committees debate and discuss for a very long period of time.

The real reasons for these requests—so deaf is the realism involved that we venture an explanation with difficulty—is that the embryo of a chimpanzee and the breeding of rats are too expensive. Human life does not have a price! It has lost all value after certain nations, which have been civilized for a long time, turned their back by a vote on what all the masters of medicine had sworn to uphold for more than 2000 years.

The achievements of medicine exist, and they are marvelous! Research, real research, continues, and it has no intention of stopping in its tracks. But it can be carried out perfectly without the life of even one single person being put at risk. As Professor Lejeune liked to repeat, we will never stop going forward!

There exist many ways by which to act with effectiveness on the child thanks to prenatal diagnosis. I hope that they will continue to increase in number. As doctors and researchers it is our duty to do everything we possibly can to bring this about. In the case of sick children we are dealing with a matter of life or death. This is why prenatal diagnosis is increasingly asked for by people. Such diagnosis is becoming ever more precise and is being carried out increasingly early. Because of this we find that an anomaly—even if it is very small—is accepted less and less by the parents when it is discovered after the birth of the child.

The technical means that we have available by which to observe and follow the child while it is still in the womb are becoming ever more sophisticated. Echography (which provides an image of the child in bold outline and color) and amniocentesis allow people who are expert and experienced in this area to "see" the slightest form of malformation, but it should also be stressed that only what is being looked for is actually found. Some of these kinds of images are difficult to interpret. There are false negatives which provide a false sense of security, and

there are false positives which lead to the abortion of children who are perfectly well formed.

An examination of the chromosomes of the child can be carried out in the seventh week of intrauterine life through the vagina by using a biopsy of the placenta. It can also be done later, in the sixteenth week of life, with the removal of amniotic liquid which contains foetus cells. The analysis of the karyotype enables us to determine the sex of the child (something which is very important when it comes to illnesses connected with its sex) and whether it is the victim of an illness caused by chromosome malfunction.

Such illnesses are frequent—one unborn child in every hundred is afflicted by them. One of the most frequent such illnesses is trisomy 21, a condition which affects one child in every 650. In 98% of such cases this occurs in families where there are no particular precedents in this direction. The frequency of these kinds of illnesses increases with the age of the mother, and in the child they involve visceral malformations with various levels of seriousness. However, in the main they produce a delay in psychomotor development of varying degrees of intensity according to the nature of the chromosome anomaly or, in the case of the same anomaly, according to the condition of the child.

The technology of molecular biology is advancing very rapidly indeed. It enables us to analyze the genetic code of the child while it is still in the womb by representing it in a way which is very similar to the grids which are used for large surfaces. If one of the lines is missing, or if there are two such lines, then it is known that the child has a constitutional and innate genetic illness.

In such circumstances French law allows abortion without any reference to age.

You can well imagine that for families and medical doctors this is a terrible temptation. These illnesses are very serious. Most of them still do not have an effective treatment which is available. Everybody practices abortion in such cases and everybody advises it. Some people do not even consider abortion in these circumstances as constituting a professional shortcoming or error. Some families even go to court over an abortion not having been carried out when the child is born with one of these illnesses. Many doctors, as if they were trying to be forgiven for not having carried out a prenatal diagnosis, suggest and even advise the abandoning of the child. At the present time in Paris one in every four children born with trisomy 21 is abandoned immediately after birth.

The discovery during intrauterine life that the child has a serious and incurable illness means that it comes to receive the label of being "condemned to a death caused by the ignorance of medicine."

This deliberate and conscious form of abortion is seen as an "abominable crime" by the whole of the Christian tradition. As John Paul II recently observed in *Evangelium Vitae*, "The human being must be respected and treated as a person from conception. No reason, however serious and dramatic, can ever justify the deliberate suppression of an innocent human being... The practice of selective abortion to impede the birth of children affected by various types of anomaly is ignominious because it seeks to measure the value of a human life solely according to parameters of "normality" and physical well-being, thereby opening the way even to the legitimation of infanticide and euthanasia."

Recently, the government authorized the repayment by the National Health Service of the costs of chromosome tests carried out on the child while still in the womb, regardless of the age of the mother, if the levels of maternal serumal markers indicate a risk that the child is a carrier of trisomy 21 which is higher than that connected with the age of the mother. This measure will be followed and studied for a period of two years. It is estimated that the total cost of this operation will be 500 million French francs over a timespan of two years. One is no longer dealing with the request for an analysis made by a couple, but of collective action which seeks to systematically identify children suffering from trisomy 21 syndrome, with the evident intention of eliminating them. This strategy of negative eugenics leads to the killing of individuals who do not correspond to the criteria which are required to find a place in our society.

This tendency is very serious because in beginning with the case of trisomy 21 it then rapidly extends to other kinds of illness. Furthermore, this whole state of affairs becomes even worse where pre-implantation diagnoses or predictive genetics are concerned.

Pre-implantation diagnosis involves the set of techniques which seek to identify a genetic anomaly in an embryo which has been fertilized in vitro. One or two cells are removed by means of micromanipulation three days after the fertilization in vitro when the embryos are at the stage of having four or eight cells. The DNA is extracted and one then amplifies the specific sequences which correspond to the illness which is thought might be present. Alternatively, there is an examination of the chromosomes with specific probes using in situ hybridation. If the anomaly which is being looked for is found, the remaining cells of the embryo are not transferred to the womb of the mother, but are thrown away. Only those embryos which are seen as being unaffected by the illness are subsequently transferred to the mother.

Various questions, obviously enough, are immediately raised. First of all, might not the removal and subtraction of the one or two cells which go to make up the embryo be prejudicial for the subsequent development of the remaining cells which are then implanted in the uterus? Experimental embryology gives us a reassuring answer with regard to animals but can we conduct such an experiment on man? Malformations have not been observed in thirty-one children born after a pre-implantation diagnosis but the question still remains. Furthermore, can we reasonably achieve the diagnosis of an illness from the study of only one cell, and before cellular differentiation, knowing that one cannot renew the removal and thus the analysis?

Pre-implantation diagnosis is authorized by the law of July 1994 only in exceptional cases, and it can be carried out only in authorized centers. We can imagine the risks of a tendency which is aggravated by the absence of a definition of the status of the embryo and which runs the risk of promoting less protection for the embryo than for the foetus. A lowering of the significance of an action performed outside of the maternal organism can lead to its trivialization and thus to an extension of the practice towards predictive medicine, with only vague limits. There is the risk of demands arising which

are exclusively based on convenience and which have nothing whatsoever to do with the field of pathology—for example, the choice of sex or even social pressure.

The situation becomes even more complicated when we consider predictive medicine. The geneticist identifies new genes every week, and today he is able to recognize them very early on and to predict their future effects. He can also predict the future of each one of us and of our children!

We are dealing here with an extraordinary advance if the discovery of a damaging gene allows us, through careful control, to engage in rapid action at a suitable moment or even, better still, to establish effective preventive action which impedes the illness from making itself felt. Such is the case, for example, in the localization of the gene which promotes diabetes. Clinical control and a dietary regime can allow us to avoid the appearance of such a pathology. In the same way, one can readily grasp the importance of such an approach in professional life and training. The discovery in a young person of pigmentary retinitis which will make him or her blind at the age of about forty can allow that person to learn Braille and engage in professional training suitable to his or her future condition. But what happens when the only thing which can be done is to await one's inevitable destiny? What happens when there is a predisposition or susceptibility gene and when the risk envisaged can intrude into the freedom, or change the life, of the person involved when he or she takes on the burden of knowing what lies in his or her future? Do we have the right to say to a man aged thirty who is in perfect health that he has the Huntingdon's chorea gene, which has just been identified in his father, who died in a state of dementia? Can we tell him that there is a 50% possibility that he will transmit the gene to his children, that this illness cannot be cured, and that it will inevitably lead to dementia when he reaches the age of about fifty?

Each person has a burden to bear during his life which comes from his history and that of his family, but the role of the medical doctor involves communicating information which is not always desired and which is generally useless. Certain protocols of family diagnosis concerning cancer are very worrying, indeed, and lead us to ask ourselves how far we should go when medicine is tempted to irrupt into the life of the individual. This requires extreme vigilance as regards the rights of the person, the right of each one of us to decide whether to accept the test, and the wish of each one of us to know or not to know.

Each time an individual application of a medical character is made, it seems that predictive medicine can provide invaluable support. When one draws away from the medical field, this becomes an obstacle on the path of the freedom of man. It would be even worse if it became an instrument which was used for collective purposes and goals, by a group of insurance companies, government officials, or administrators, with a view to selecting men and women according to their respective genetic strengths and weaknesses. In such a case, genetics would once again have allowed our societies to be led along roads where they lose their humanity.

All medical doctors, and especially geneticists, sooner or later find themselves face to face with the following dilemma: how should the truth be told in a way which fully respects medical secrecy? Tell the truth always, but not always the whole truth at the same time? It seems to me that we should see things as they are, take as much time as we need, and explain the way things are in simple terms. We should say what we know and not hesitate to say that we do not know, and we should answer questions even when they have only just emerged, without, however, going beyond what has been asked. We should listen or encourage the patients themselves to use the words that they are afraid to employ. In this way the truth will not fall like a guillotine which cuts off every hope forever and will not be seen as a sentence. When stated at the right moment and with the right words, it will free the patient from the anxiety of uncertainty and from having to wait for the diagnosis to be communicated to him.

This kind of confidence in an individual conversation which is protected by the secrecy which must exist between doctor and patient becomes different if in front of the doctor there is not a single patient, but a couple, or perhaps an entire family. Their shared concern is their genetic inheritance. The diagnosis, the explanations, and their consequences clearly concern the two members of the couple, but they also involve the grandparents and the children. For this reason, is the revealing—even to the marriage partner—of possible weaknesses written into the deepest part of the genetic code something which conforms to the idea of the secrecy which is owed to each person out of respect for his intimacy?

After a diagnosis of Duchenne's myopia, and of the family status from the point of view of cellular genetics, it is explained that the mother is the carrier, that it is she who is the cause of the illness of the child, and that each pregnancy—regardless of who the partner may be—involves a 50% probability that she will transmit the pathological gene. Thus it is that the mother is made to feel responsible! She runs the risk of finding herself in a situation of fragility, of guilt, perhaps she will even be accused within the family itself. What will happen to the couple after this has been made clear? Will this woman ask her mother and her sisters to be tested because they, too, could become carriers? What should genetics do if this woman refuses to talk about the question to her sisters? Should secrecy be respected in relation to this woman and this couple, and should the truth be kept from the sisters, who, if they are carriers, have a 50% probability of handing on the gene to their children?

An identical situation exists in relation to other illnesses, whether they are dominant illnesses or illnesses connected with chromosome X. In the case of recessive illnesses the problem is of a different order, but it is nonetheless equally difficult. For example, after the birth of a child afflicted by mucoviscidosis it should be made clear that the gene responsible for the illness was handed on to the child by the mother and the father, and thus by the couple. The same man with a different woman and the same woman with a different man would have run hardly any risk at all of having a child with such an illness, but in the case of such a couple each pregnancy would involve one probability every four of bringing a sick child into the world.

Information of this kind is a trial

for the couple, and the geneticist is directly involved in their lives at a specific moment of importance.

Today genetics is directly engaged in medical assistance to procreation. Insemination with the sperm of a donor, for example, has opened up new opportunities for couples who are exposed to a genetic risk. Such is the case where there is a man afflicted by a dominant illness who refuses to transmit his illness on to his children. Such is also the case where couples have brought a child into the world who suffers from recessive illness—in changing her partner the woman runs practically no risk at all of having a child who has the same illness.

One can well detect the path which has been followed and the future destination of eugenics. This is all the more the case given that the geneticist is called upon to provide assurances about the genetic quality of potential donors. This orientation towards a role of qualitative selection, obviously enough, departs from the traditional forms of medical behavior and runs the risk of giving rise to a positive eugenics which selects the best parents and suggests the sterilization of those who are deemed less favorable.

As long as respect for the other person (even if different) is observed and the weakest are protected, the most advanced techniques in this area do not give rise to alarm. Only if the desire for power deforms the heart of man can the worst be feared.

To conclude this paper I would like to read two passages to you. The first is by Michel Serres and comes from the preface to the book by Testard entitled *L'Ouef Transparent*: "We must make an inventory of the garden of Voltaire or that of Adam, but these images lead us into deception. A thousand gardens are possible. Our protoparents called every animal and every plant by a name. We must codify the possibilities. We must create a kind of infinite inventory, that of possible worlds which sleep in the divine intention, as Leibnitz puts it. We now have the responsibility of managing the infinite cone of those which are possible. The inventory seems not to pose any kind of ethical problem. The choice, on the other hand, raises one which is very serious. Once something has been produced for a long time, we must choose what will pass from the possible to the actual. This action which Leibnitz reserved to God, for some time, and increasingly, we can do in His place."

The second text comes from a speech by the Holy Father on November 21, 1993 during an encounter which concluded a meeting of the Academy of the Sciences at the Vatican: "The permanent deepening of knowledge about the living being is in itself a good because search for truth forms a part of the primordial vocation of man and constitutes the principal praise that there is in the eyes of Him who created mankind and who is at the origins of everything. Science is seductive and fascinating, but it does not on its own know how to expound the ultimate truth and propose the happiness which man wishes to reach, nor does it know how to lay down the moral criteria by which good can be achieved. It is important, therefore, to grasp the size of moral problems which impinge not upon knowledge itself, but upon the means by which such knowledge is acquired, and its possible or predictable implementations. It is not for the Church to establish the scientific and technical criteria of medical research. Her duty is to observe, in the name of her mission and her centuries-long tradition, the limits within which every action which is undertaken can be seen as a good for man."

And I would like to add, "The moral criterion for research is always man in both his physical and his spiritual being."

Professor MARIE-ODILE RETHORE
Member of the Academy of Medicine

MIGUEL MARTIN RODRIGO

The Contribution of Consecrated Life to Health Care

Introduction

I am deeply convinced that the Church is not fully conscious of the great contribution that she has made over the ages in the different fields where she has carried out her mission. One of these fields, without doubt, is that of the world of health care. Despite our obvious limits, the injunction of Jesus has been obeyed: "Let your right hand not know what the left hand is doing."

In this context of partial ignorance we can observe, first of all, a lack of effective and precise data on the real presence of consecrated people whose mission is dedicated to the world of health. The *Index* produced and published by the Pontifical Council for Pastoral Assistance to Health Care Workers, in a first edition in 1986 and then in a second, revised and expanded edition in 1994, comments on the difficulties which are encountered in trying to measure this presence. These difficulties concern both Catholic healthcare institutions and, as a result, the actual presence of members of religious orders within them.

The 1994 edition refers to 21,757 healthcare facilities in the world owned by the Church or where the Church is present. The Secretary of this Ministry, however, warns that, according to one estimate, another 8,000 institutions have not been listed. 43.5% of these are to be found in Europe, 20% in America, 17% in Africa, and 1.5% in Oceania. Sister Teresa Beorlegui, the Superior General of the Hospital Sisters of the Sacred Heart, employs the data supplied by the *Index* to suggest that there are 350,139 female members of religious orders involved in health care,[1] to whom should be added those involved in the 8,000 facilities which are not mentioned. There are also a significant group of male members of religious orders involved in the healthcare world. Although they are much fewer in number than their female counterparts, they nonetheless constitute a group which is not to be ignored. All in all, we are dealing with a real army of members of religious orders who are involved in the world of health care.

1. A Bit of History

The relationship between the Church and the world of health, and more specifically the relationship between religious life and this sphere, is very long-standing and vast. The role of the monasteries in providing medical care and in teaching the medical sciences and nursing was quite significant. The birth of the great congregations whose mission was directed towards caring for the "poor and the marginalized" which took place in the sixteenth century and in particular in the nineteenth was a milestone in the history of the presence of the Church in this whole field. This presence was so important that the Church believed that it was right to delegate a specific task to such religious groups, an element, indeed, which determined their identity. For further references to this historical subject, readers may wish to consult the excellent article written by Jesús Conde Herranz[2] and the entire book by the same author dedicated to this topic.[3]

The history of our own days, of which many of us have certainly been protagonists as agents within the world of health over the last thirty years, is especially illuminating. This is because of the fact that although the phenomenon of the acceleration of the pace of history is tangible in many spheres, it is especially marked in this field, namely that of health.

We all remember the existence of large religious orders which were responsible for healthcare facilities in our cities which were managed and developed by such congregations. A small number of the laity worked with them, usually with simple domestic jobs.

In the same way we remember communities of women religious who worked at large public hospitals which had been established with the advance of medical progress. These were big communities which exerted a major influence on the dynamics of life at such facilities, because of both their large numbers and the tasks which many of them were responsible for.

Gradually, a series of factors came to change this scene. The large number of people who abandoned the religious life naturally enough had an impact on the congregations dedicated to the world of health. Slowly but surely, there was a fall in the number of women religious who worked in this field, and at the same time their average age increased. In the decade which ran from 1970 to 1980 there was a fall in the United States of America of 60% in the numbers of women religious involved in the world of health care, and the average age of women who now work in this sector is over sixty-five.[4] Fra Pierluigi

Marchesi does not offer greater hope for the future in his analysis of the situation: "From what statistical science tells us about the contemporary history of religious orders—leaving to the Lord the possibility of a miracle—the previsions for the future are not encouraging. In ten years many of these orders will no longer exist and in twenty years half of women's religious families will have disappeared."[5]

On the other hand, however, we have witnessed a general process of secularization which has in the same way affected all spheres of life and from which our mission could not but suffer the consequences. Hospitals, too, have come to acquire their own independence, and they have increasingly emerged as enterprises with their own laws in relation to economic management, organization, and so forth.

The increasing universalization of the right to health and its accompanying public promotion have had consequences for many facilities which belong to religious congregations.

The undeniable advance and development of medicine and its corresponding technology have required specific training which has taken those engaged in religious life by surprise, as has already been pointed out. This life has had to endure a decline in numbers and an increase in the age of its members. It is clear that this advance and development have caught us off balance.

Hitherto in this paper I have offered a brief survey of the overall picture. From now on I will engage in a personal discussion about the role that we must perform today if we want to be loyal to our charism—that is, to the Spirit—and to our time. This loyalty cannot take the form of false longing for the past—no loyalty can do this—but, rather, should involve a serious analysis of what the Lord asks us to do today in order to construct his Kingdom in this world and not in the world as we would like it to be.

2. A New Concept of Health

If by health we meant "the absence of illness," the mission of religious life in relation to health would gradually lose its meaning. The development of human rights—and among them the right to health—is something which, it is hoped, will be slowly recognized by states which describe themselves as being "social, democratic, and based on law." They should defend and promote the means which are necessary for the practical realization of the right to health. Members of religious orders will have a role to play in this sphere, both as individuals, to the extent that they exercise their profession in a correct way, and as communities, to the extent that they take part in a public system of care. At both an individual and collective level, a democratic society will not be able to prevent them from offering their service within a framework of private activity. I fear, however, that this is not the most suitable *locus* for our presence.

Now, if we mean by health "a state of physical, mental, and social well-being," and many of us believe that here "spiritual well-being" in the widest possible senses should also be included, the situation changes radically.

I would like here to quote Diego Gracia Guillén. In his paper for the conference on *Church and Health* which was held in Madrid in September 1994, he made the following incisive observations: "Our diagnosis is that health is not a fact, but a value, and that as a result it cannot ever be defined in an absolute and atemporal fashion. It must be defined within the system of values of each social grouping and with reference to each historical moment. This means that the cause of all our evils is to be looked for, in the final analysis, in the value system of our society."[7]

It is here that the Church as such and religious life in particular have their special field. What we are asked to engage in is not acts of service, but values, criteria, lights, and presence. Such is the most specific character of the Church and the most genuine aspect of religious life—to be witnesses, reference points, light, and salt.

I usually observe forcefully in the papers and speeches I present that in the first of these two cases we are offered a "contract as a substitute," but in the second we are dealing with an "unlimited contract."

3. Towards a New Approach to Presence

I will begin by allaying the fears of those who are listening to me. Unfortunately, we will always be engaged in "filling in." Modern society is very expert in creating new forms of marginalization which governments do not always strive to solve, and least of all when they first emerge. This is the result both of a lack of awareness and, in the view of some, because of a lack of means. Today there are terminally ill people suffering from AIDS, the infirm elderly, the chronically mentally ill, drug-addicts... Furthermore, the crisis which the state of well-being in the developed world seems to be undergoing suggests—God forbid!—that perhaps the Church will once again have to address herself to areas which, unfortunately, have already come to be covered by public systems of care based upon the right to health.

Here the Church will have to be present. If her choice in favor of the poor is inherent in her identity, she will never be able to stop taking care, according to the resources she has available, of those who are marginalized by the sophisticated mechanisms of modernity. Religious life is here called upon to play an important role, as, indeed, it has done during the course of history.

In the same way, the Church will not be able to withdraw from her role in that sphere where the new concept of health holds sway. This is a concept of health which must be outlined, investigated, and clarified. Today health is a primary value—for many of our fellow citizens the paramount value. And in realizing and upholding this right no means, efforts, or sacrifices are neglected. What is sad is that in practice health is conceived of as a pseudovalue. It is the muscular strength admired in the athlete, the aesthetic beauty of male and female fashion models, and the ideal weight which enables us to wear fashionable clothes; it is the "wholeness" of products which is

sought after in order to obtain the elixir of immortality. It is, in essential and selfish terms, an aesthetic, individualistic, and narcissistic health.

Somebody should develop a new practical concept of what being healthy means—or, rather, what being really healthy means. Somebody who is a witness to another form of strength, other aesthetic forms, and other forms of "wholeness" or morality. Somebody who within their own diet includes solidarity, inner peace, a clear conscience, the joy which is born of simplicity, the acceptance of oneself and one's own limitations. In the achievement of health we need specialists in dietetics, dermatology, surgery, and even aesthetics, but at the same time we need healthy men and women. And these receive their degrees, of necessity, only from the university of life.

We are dealing here with a concept of health which involves the management of huge budgets weighing heavily upon the resources of countries and their governments. How should they be distributed? What use should be made of them? To what purpose and to the benefit of whom should they be distributed? It often happens that people who are really in need do not take part in the banquet, where other interests come to occupy the best places. Somebody should speak about all this; someone should stand up in favor of those who are not admitted to this banquet; and someone should adopt a critical attitude.

This is a concept of health which constantly gives rise to serious and intricate ethical dilemmas. Science and technology are able and want, at the present time, to be "lords of life." For this presence the contemporary debate does not revolve around "what can be done," but mainly around "what ought to be done." New techniques of reproduction, genetic engineering, abortion, eugenics, and euthanasia—all these are features of the frequently difficult and problematic context in which man finds himself. And here there must be somebody who, together with other men of good will, offers light, criteria, and values in relation to life and the respect which life deserves. In essential terms what one is dealing with here is the need to generate thought and learning around the concept of health. Beginning with a Christian vision of man united in turn to a humanistic vision of man, we need to engage in a serious search for, and the actual creation of, practical answers to the difficulties we have before us. These should be the expressions of a culture of life in opposition to the frequently suffocating culture of death in which we are immersed. This is something which has been stressed by John Paul II and which was so well expounded in the Encyclical *Evangelium Vitae*.

4. "New Wineskins for New Wine"

I am convinced that the concept which holds that health is "a state of physical, mental, and social well-being" is the concept which is most suitable for the authentic mission of the Church, the "sacrament of salvation" for the world, in the words of Vatican II. This is not a conviction which is trivial or superficial in nature, but which, in my opinion, is based upon the very reality of Jesus.

Jesus of Nazareth did not come to heal illness, but to proclaim salvation. This ministry, in certain, even numerous, cases, involved the healing of the sick. But such healing was only a "sign," a precursory signal of the full cure of which He alone was the authentic physician—salvation.

It is certainly true that Jesus healed many sick people. If we leave the healings of Jesus to one side, we do exactly the same to a great deal of the Gospels. It is also certain, however, that He did not heal all the sick people who at that time were in Israel. A much greater number of people were not healed of their maladies.

Jesus proclaimed salvation: *health*. This was a health which involved release from the blind circle in which man moved and his being opened up to the possibility of coming to meet Love. It involved breaking with selfishness and the opportunity of overcoming egoism through love. This process involved a great work of healing which was able to act surgically on the innermost part of man—the heart. It is in the heart that there dwells the authentic virus which afflicts the truth of man, and it is there that the healing action must work.

As a result, the Church must go on proclaiming salvation, and this salvation must be of a practical character for practical men in practical situations. For this reason, it should be said clearly that all of the Church's action should be *healing*—preaching, the catechism, the liturgy, the work of the hierarchy, the giving of the sacraments...

Within this healing action, the Church's work of care must be of primary importance. Furthermore, religious life is called to be a prophetic sign of health in a world which is largely sick, in a health system which if often pathogenic, and in certain institutions which perhaps provide "healthcare bandages," but which are very far from offering authentic health.

Logically enough, this means that the members of religious orders who dedicate themselves to the world of health and the religious life to which they belong must be the first reference points for health. This health is something which should be placed within a framework of human needs, limits, and normal illnesses, but which should also be located within the framework of the healing (something which should not, however, be an obsession) of the body, through balanced rhythms where there is time for dialogue, rest, prayer, solidarity, emotional equilibrium, and the ability to be silent, to find oneself anew, and so forth.

In essential terms, the first requirement of the member of a religious order who lives and works in the world of health is that of *being a healthy person*. Where this does not occur, he will from the outset fall foul of an intrinsic inconsistency. To adapt a famous phrase, "I sell the health which I do not possess," or, if you prefer, the words spoken by Jesus in the synagogue: "Physician, heal yourself." (Lk 4). This prophetic requirement involves first and foremost his own identity and also affects those religious communities of consecrated people whose mission is concerned with the world of health—they

must be *healthy human groups* where a healthy form of community life is achieved, a real capacity for dialogue, a readiness to forgive. In essential terms, a member of a religious order and a religious community are called upon to become reference points of *health*.

5. The Mission of Consecrated People in the World of Health Care

After following the line of approach based upon the concept of health advanced by the World Health Organization, and after making a brief appeal in favor of the achievement of a *healthy* identity on the part of members of religious orders who dedicate themselves to that world, I would like now to attempt to outline the framework within which, in my opinion, their mission should take place.

I would like to lay emphasis on two guiding principles:

a) in theological terms I believe that the fundamental paradigm of every presence of consecrated life in the world of health must be that of being an enlightening presence, a presence which is encouraging, critical, and prophetic. Work involving care, which has always existed and which will always exist, must be understood as constituting part of a process which goes in this direction. I would like to outline, from a theological point of view, the framework within which this mission should take place. I believe that there can be no doubt that the great importance of the action of Jesus is not to be found in the fact that he healed ten lepers, or the woman who lost blood, or that he raised the son of the widow of Naim and his friend Lazarus from the dead. The important thing is that Jesus declared and offered *salvation*—that is, *overall and complete health*.

b) For this reason the way in which every member of a religious order locates himself within his own mission cannot but be the following: to proclaim salvation, to proclaim *authentic health* in opposition to the various other kinds of health which the world offers us.

After these premises, I will now proceed to set out the framework within which, in my opinion, we should place those consecrated people who work in the world of health.

5.1. Work Involving Care

As I have already observed, this is a field which we can never abandon. Unfortunately, "the poor will always be among you." Scientific, technological, political, and social progress means that in theory and practice the need for health on the part of citizens will be expected and required with greater force and greater demands.

But reality itself is also stubborn in showing us that there have always been and there will always be groups which are detached from this sought-after universalization of health care. We do not have to wrack our brains to discover a long list of such sick people in the first world: the mentally handicapped, the chronically mentally ill, elderly people in poverty, sick old people, cerebral paralytics, people suffering from AIDS, and the terminally ill. At times it is technology itself which generates many of these disinherited people—elderly people with serious neurological illnesses, illnesses which derive from the advanced age which science itself has brought about in spectacular fashion, etc. And, as has already been pointed out, the crisis of the state of prosperity which seems to be an authentic reality suggests that these "excluded" people will increase in number in marked fashion.

Here religious life has a special role to play because it knows how to stop on that motorway of life where everybody travels at an incredible speed and look after those who are excluded and neglected because they are not interesting, or do not provide a source of earning, or do not supply prestige.

We need a form of religious life which knows how to become involved in this field and offer a complete and overall form of attention, which humanizes and confers dignity. And thereby utters a prophetic cry in a society which marginalizes such people and in the face of certain public authorities who relegate such people to a low level when it comes to their concerns and their budgets.

The work of care in the first world will lack evangelical meaning if it does not display a real and committed form of prophecy—first of all, as regards the care it provides in defense of such marginalized groups. When we engage in the construction of a void in this "market" in order to live a calm and tranquil life, an ugly symptom is manifested. The same may be said when our mission involves providing an image of what should be done and not getting to the heart of what is really needed.

In this work of care, at every moment, a constantly proclaimed "option in favor of the poorest" must prevail. In the difficult times in which we live the temptation to engage in private forms of care for categories of people who can afford such treatment and where the religious life has obvious advantages is by no means small. The economic support for such care must be looked for through an involvement of the public networks of health care and social security and will be proportionate to the extent to which we have made public authorities conscious of their duties; in a struggle to obtain public grants and aid; in contributions, which at times will be very small, from those who are cared for; and—why not?—in the search for charity, the authentic evangelical exercise of charity.

We should never—and this is something which today would be more ridiculous than scandalous, and in a very serious way—continue the practice whereby one religious congregation fights with another to fill its own centers for health care with patients in order to make them more remunerative. If we turn our attention towards those who really need us, there will be room for everybody. Unfortunately, this is a point which I have to emphasize once again.

It may be of importance here to emphasize the features which must characterize the identity of Catholic hospitals which José Ant. Pagola drew attention to in his paper to the conference which has already been mentioned: "We should observe certain features which today should characterize the Catholic hospital: service to life from its conception until its natural conclusion; preferential attention to

the less favored classes and the exclusion of interests based solely on material gain; overall and complete care for the sick person in all his needs, without any form of discrimination; exemplary forms of professional skill and expertise; the humanization of conditions of work and the promotion of true cooperation between healthcare workers; the ethical training of staff and personnel; the effective creation of an ethics committee which seeks to defend the Catholic identity of the hospital and to study its ethical problems and difficulties."[8]

It is more than obvious that this work of care is of great importance in the third world. There, where there is nothing, we are called upon to do everything. This is an authentic work of "substitution" while waiting for "a new earth" where international solidarity allows all the peoples of the globe to take part in the conquests of progress in matters relating to the most elementary human rights.

It should, however, be made clear that the healthcare and church realities of our "investments" in the third world require us to refrain from transferring our European criteria for care to realities which are in truth very different. We should not seek to transfer hospitals which are more or less advanced to native populations, but, instead, we should try to carry out initiatives which begin with a small center of reference and branch out with force into work involving the prevention of illness, the promotion of health, and the development of training in matters relating to health care.

I would like here to summarize the words spoken by the FERS (the Spanish Federation of the Healthcare Religious) at the conference referred to above: "In the outskirts, where there is no health power; in the desert where nobody goes; at the frontier where the limits are marked."[9]

2. Prophetic Work

Obviously enough, I do not like this heading. This is because the work of care which has already been described is also prophetic in nature—and in what a way! It has certainly never found a higher expression.

I would like here to include religious life, at both an individual and a community level, in health facilities where such life is not necessary to the work that is carried out. All these places are, in today's world, the sphere of public care and are administered and run by a host of healthcare workers who are very well trained, accompanied by a large number of young people who are waiting for the opportunity to obtain a post. These places range from the summit of the World Health Organization to the simplest post occupied by a nurse or an auxiliary worker in any large hospital in our cities or any healthcare center situated in our suburbs or villages.

Here there is no need for us, but we can be very important and almost indispensable, depending, of course, on what we do and the role we play.

When we fight honestly for a humanization of care, promote values which work in favor of an overall and complete concept of health, humanize and evangelize the professional healthcare context—which so encourages demoralization, routine, and disappointment—seek to defend the rights of sick people, bring clear and incisive analyses to the ethical assessment of various bioethical conflicts which arise in the world of health, and all the rest, we engage in work which members of religious orders can honestly contribute to the world of care. This should not be done through a process which involves exclusion. The lay faithful who work in this whole area should also engage in such activity. The integration of members of the Christian lay faithful into our centers, with all their rights and in ways which are suitable for their respective forms of training, is in today's world one of the greatest challenges which religious life has to meet. Of no less importance is the integration of that great army of solidarity made up today of Christian volunteers, who can contribute great human qualities to the world of care. Perhaps we should already think of a hospital of a Catholic community which, supported by Christian healthcare workers, is animated by the charism of a founder and fostered by the members of the religious order which he has founded.

This obliges us to immerse ourselves in the vast and at times excessively intricate tapestry of the world of health, and, as a consequence, in politics in the broadest sense of the term, in the mass media, in the university world and the world of teaching, and so forth. This is difficult—indeed, very difficult. This is fully recognized by the observations made by the FERS at the conference which has already been referred to: "Healthcare activity in the historical reality of our daily life involves living with technological rationality, the needs of organization, criteria of effectiveness, workplaces which are enterprises where technical work is produced, etc. All this has immediate consequences for our religious life: the weakening of its pastoral dimension, certain forms of dichotomy or identity crises, the temptations of only limping forward, of dispersion, and of individualism, but also positive signs: the rethinking and renewal of brotherhood and community life, and a return to our origins; many members of religious orders have achieved a real choice in favor of the poor...."[10]

I honestly believe that the context of religious life dedicated to the world of care does not have more variables than that of every other form of religious life in the first world. A world, that is, where there is an inflation of almost everything, but where there is a lack of "reference points for the transcendent," of those who by their characteristics draw attention to a framework of values, ideals, and transcendence. In a world evermore ready to drown in the emptiness of its own approaches to life and the world, there is an absence of lighthouses and signals which from a weakness based solely on the strength of faith point out paths and horizons. A world in which there is an abundance of healthcare beds and perhaps healthcare workers as well, but where there is a scarcity of authentic values which act to direct men towards true health.

When seen from this point of view, members of religious orders have the full right to lay claim to the role which is due to them in health services, in both individual and collective terms—wherever

they are, and in whatever professional guise logically enough gives external legitimation to their presence. In the Ministry of Health, in the universities, and in the management of hospitals, attention should be directed towards the patient with reference to all his possibilities. All these situations will be none other than different forms by which to express the evangelization of the world of health, understood in its broadest sense.

I hope you will allow me to finish this paper with an image which our Superior General, Fra Pierluigi Marchesi, used in a document which was for the internal use of our institution—*L'Ospitalità dei Fatebenefratelli verso l'Anno 2000*. While thinking about this document within the new social and healthcare context, Pierluigi Marchesi gave an example based upon the history of the bell towers of the churches which are in every village. At a certain moment, he says, given that the building was the highest in the village, he thought of the clock, which, together with the chimes of the bells, told all the inhabitants of the village the exact hour of the day. Today things have changed. Every inhabitant has a wristwatch. And they pose the following question: "Should we, therefore, knock down the bell towers because today people have a wristwatch?" This is not the question which we should ask ourselves. We should ask ourselves, instead, what the authentic role of the bell tower really is, the reason why the man of faith built it beside the church—to be seen from afar rather than to be heard. The bell tower expresses the desire of man to unite the earth with the sky, man to God, nature to the Creator. For man it is the most radical call there is, which goes back to his origins, to his destiny, to Him who is in heaven. Even though the building is not the highest one there is, surpassed as it often is by proud skyscrapers, it remains and will always remain a symbol of a proclamation, of a presence which invokes the *Presence*.[11]

It is undoubtedly true that the danger is not in the fact that the inhabitants now have a wristwatch. This is a result. Nor is it to be found in the fact that proud skyscrapers have sprung up. One could debate about their integration into the urban landscape. The real danger is to be found in the fact that the reason why the bell towers were built can be forgotten.

The danger and also the challenge of religious life dedicated to the world of health is not to be found in that world. It is to be found, rather, within religious life itself.

Fra MIGUEL MARTIN RODRIGO, O.H.
The Hospital of St. John of God, Barcelona,
Editor of Labor Hospitalaria

Notes

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MICHAEL F. COLLINS

The Role of Catholic Hospitals in the New Millennium

As we face the new millennium, there should be great hope and expectation for the role the Catholic Church can play in promoting health in the world. It is a privilege to discuss the role that Catholic hospitals can play in this quest to promote human dignity through the provision of health care services.

While I am not as familiar with the role that Catholic hospitals play outside of the United States, I would like to apply my knowledge of Catholic health care in the United States to discuss the role that Catholic hospitals can play in defining hopes and expectations for the new millennium.

I would like to place in context the magnitude of the commitment that is the Catholic health care ministry in the United States: There are more than 1300 Catholic health institutions in 48 states; 625 Catholic hospitals in 95% of all Catholic dioceses and 713 long-term care facilities in 85% of all Catholic dioceses. Catholic health care institutions provide greater than 16% of U.S. hospital admissions and outpatient visits. Catholic hospitals have more than $44 billion in hospital revenues on an annual basis and have greater than $50 billion in assets. There is a tremendous commitment by the 242 Religious Institutes, Congregations of Women and Men Religious, and 42 Dioceses, which sponsor Catholic health care entities and are determined to care and advocate for the poor.[1] As one example of such commitment, the Daughters of Charity have built a vibrant health care ministry which promotes excellence in medical care while maintaining a determination to care for the poor.[2]

At the present time, there is great challenge in the American health care system. Resources are diminishing as our government moves toward reducing the federal deficit. Managed care, a concept in which third parties control the health care dollar and the utilization of health care resources, now controls approximately one quarter of the care paid for by health care insurance plans.[3] Hospitals throughout our country are coming together to form health care systems in order to maximize their efficiency, to assure continued care for their communities, and to rationalize the use of medical technology. Reengineering of the health care marketplace is underway actively.

Catholic hospitals face the same business challenges as all other not-for-profit entities.

As Catholic hospitals face these increased and intense pressures on the business aspects of our ministry, the not-for-profit tradition which has been the hallmark of hospitals in America is being challenged by large corporations which have decided to enter the "sickness" business. These investor-owned companies must maximize the return on their shareholders' investments and are driven by bottom-line performance. Their business perspective has been forcing not-for-profit institutions, including the Church-sponsored Catholic health care institutions, to place increased emphasis on the business aspects of our ministry. Thus, bringing together individual hospitals**,** Catholic health care systems have been forming across America.

In Boston, His Eminence Bernard Cardinal Law brought together the Catholic health care institutions sponsored by the Archdiocese in 1985, long before the trend to build health care systems became popular and necessary. Caritas Christi, our Archdiocesan health care system, is composed of 12 health care institutions: Five hospitals, a chronic health care facility, two nursing homes, two schools of nursing and allied health, a hospice for the care of those with terminal illnesses and a home for women who are victims of domestic violence, homelessness, or substance abuse and who are pregnant. While smaller in comparison to some of the health care systems that are forming nationally, Caritas Christi has a $500 million revenue base, employs 7,000 people and cares for more than 500,000 people on an annual basis.[4] All of our System's facilities are guided by the teachings of the Church and the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the Bishops of the United States[5].

I want to propose three basic points that are characteristic of Catholic health care in the United States and should be part of the identity of Catholic health care entities anywhere in the world:

– Catholic hospitals throughout the world are integral to the ministry of the Church.

– Catholic hospitals have an explicit role to be witnesses to the promotion of human dignity.

– Catholic hospitals must be principled in the conduct of their business affairs.

If these are true, I reach the conclusion that Catholic hospitals will serve as beacons of hope for the expectations which will accompany the new millennium.

Catholic Hospitals as Integral to the Ministry of the Catholic Church

Throughout the Gospels, there are many references to the healing ministry of Jesus. We are familiar with the accounts of Jesus giving sight to the blind, speech to the mute and hearing to the deaf; curing those with leprosy; caring for a woman who is hemorrhaging;[6] and reaching out to those who could not walk. Integral to Jesus' ministry on this earth was a profound caring for the ill. Despite the afflictions that were encountered, Jesus demonstrated that a ministry to the ill was integral to His daily life. His healing addressed illness. In the process of curing the illness, He cured the whole person; body, soul, and spirit. Jesus teaches us by example that we must seek to offer that same care to all those who turn to us in need.

Enriched by this teaching, the Catholic Church has continued its commitment to the ill throughout the last two millennia. History is replete with examples of the Church reaching out to the poor and disenfranchised who were ill, continuing Jesus' example into the modern day.

Religious women have a rich tradition of extending their ministry to the ill. There is no question that care for the ill has been integral to their ministry. The example of St. Catherine Labouré and the Daughters of Charity is only one of the many shining examples of this truth.[7]

Throughout this extensive history of caring, those involved in the Catholic health care ministry have been guided by the teachings of the Church and our clear moral tradition. The Catholic Church is not new to its commitment to the ill or to the development of its teachings. These teachings and moral tradition, which find their roots in Jesus' time, are principles that have built a sturdy foundation from which those who are involved in caring for the ill can minister. Catholic hospitals, and the actions of those who minister in these institutions, represent a modern day embodiment of Jesus' healing ministry.

As we approach the new millennium, we recognize the truly catholic way the Church fulfills her mission in the world. The Church, however, unites these energies with all the other ministries which make up the Church and responds to the needs of the people in every part of the world. Witness the example of Mother Teresa and how she affected the world. Think as well of the institutions of education, the many cultural initiatives, the care for the poor, and the many other ways that the Church is present in every society and in every culture for the good of all. This collaboration brings together our various unique ministries in a fashion that coalesces and harnesses the manifold activity of the Church for the benefit of those to whom we minister.

Catholic health care belongs as an integral part of this unity of effort. The example of Jesus, the constant witness of the Church and the experience of the past several hundred years, all demonstrate the fact that Catholic health care serves the gospel by serving the poor, the sick and those in need.

Yet, often health care is not viewed as a ministry which is integral to the Church. The resources of Catholic institutions may be vast but, in the health care setting, are often detached from the Church. Catholic health care facilities may not be supported by the faithful because unlike other ministries of the Church, they are not viewed as being inextricably linked to the Church. So often these efforts of truly caring individuals are not directly coordinated or supported by entities within dioceses. Equally, some Catholic health care entities may wish to operate in the Catholic tradition but not consistent with the teachings of the Church, because their business interests might be threatened by adherence to our moral principles. In these all too real instances,

Catholic health care is not viewed as integral to the ministry of the Church. The efforts of the ministry are marginalized and the resulting rupture causes harm to the Church and to those in need.

As we proceed to the third millennium, I contend that Catholic hospitals have been in the past**,** and are to be viewed today, as integral to the life and ministry of the Church. Catholic hospitals must willingly adhere to the teachings of the Church and embrace its moral principles. Those within the Church must recognize the distinctly Catholic attributes of these institutions and work with those involved in the health care ministry to collaborate effectively to serve the ill and marginalized. We are fortunate in the United States to be guided in our own practice of health care by the Ethical and Religious Directives as well as the statement at the United States Catholic Conference on Health and Health Care: A Pastoral Letter of the American Catholic Bishops.[8]

Catholic Hospitals as Witnesses to the Promotion of Human Dignity

In my earlier premise, I indicated that as Catholic institutions, Catholic hospitals operate in a manner which is consistent with the example of Jesus' healing ministry. By that example, Catholic hospitals are challenged to positions of advocacy consistent with the mission of the Church and informed by the Church's teachings. From this position, Catholic hospitals should recognize and accept a freedom and obligation to promote the human dignity of each individual, to advocate for the poor and to conduct its affairs with an unwavering commitment to justice. This truth is based on Catholic social teaching regarding the equal value and dignity of every human being created in the image of God and redeemed by Jesus Christ.

Catholic hospitals are known for their commitment to life from the moment of conception to the moment of natural death. Throughout each and every

Catholic hospital this commitment is the norm. This stance allows our institutions to compel those who care for patients in the Catholic health care setting to care first and foremost for the human dignity of each person with whom we come in contact. Our Church's teachings inspire those who care for patients to extend their healing hands and their caring touch in each and every encounter. Patients who seek care in our facilities have an expectation that they will encounter caring individuals in an environment which promotes life and preserves the dignity of the individual. That commitment to human dignity demands that we offer quality care. It also protects us from equating quality care solely with technological and scientific measures that look on the human person as an objective thing or even work against the dignity of the human person.

Thus, in moments of happiness and despair we minister to the medical, psychological, social and religious needs of our patients. Catholic hospitals are committed to the pastoral care of patients, regardless of the patient's faith, as being essential to the well being of patients and those they love. In Catholic health care settings, the sacraments are always available to the faithful and prayer is a vital part of the life of this caring community.

The poor have an equal claim on dignity**.** Catholic hospitals, in promoting human dignity, care and advocate for all who are in need regardless of their ability to pay. The resources of Catholic institutions, though limited, must be marshaled so that the poor and disenfranchised feel welcome at our door. Our advocacy for those in need extends beyond our caring resources into the communities we serve. We advocate for the needs of children, instigate community leaders to promote programs that deal with the needs of the less fortunate and insist on the development of programs and policies which make health care coverage and access universal in their application and practice.

To be honest, our country has far to go in this regard. Catholic health care can give witness in our American culture, in contrast to the individualism that is so rampant, by placing the value of the patient as the one primary consideration. Through caring for the whole person, we must use all of our resources to promote the true good of every person in our care.

Catholic hospitals and those who provide care in our facilities should accept the challenge to care for each and every patient as if that person were Jesus. What a marvelous result would occur if we accepted the notion that each patient, formed in the likeness of God, deserved the care and caring that we would provide if fortunate enough to minister to the health care needs of our Lord. The quality of the health care provided would be above reproach. Pastoral care would be a priority. We would provide care in a setting that was appropriate for our patient's dignity.

As we approach the promotion of each and every patient's human dignity in the Catholic health care setting, it is a privilege for us to care for our patients. In few other settings are fellow human beings allowed to know the intimate details and concerns of another person's life. Rarely is a person afforded the responsibility of providing diagnoses and prognoses which will determine the health and well being of another. If we take seriously our commitment to preserve the human dignity of each and every patient, we will invest each caring opportunity with an importance for the privilege that it represents.

Commitment to the promotion of human dignity includes the responsibilities that Catholic hospitals have to be centers of education and research. As vital centers of learning, it is appropriate that we continue to pursue opportunities to provide education for the next generation of health care providers. We should not underestimate the importance of this commitment to educational pursuits in our institutions. Immersed in our environments of caring, future professionals will have the opportunity to experience first-hand our commitment to each and every person by the way we teach and by the research we conduct.

At one of our institutions, for example, on this very day clinician-researchers are working to establish new methodologies to treat blockages of blood vessels which could revolutionize treatment and improve the human condition for patients with such illnesses. This first-in-the-world research is being conducted at a Catholic hospital.[9] Such scholarship will assure that we do not become marginalized by those who would claim that health care is solely a business and has little, if any, Mission imperative.

Our role in education and research in medical science should be tied to the study of morals and ethics. Our Church teachings and moral tradition provide us with the norms for judging medical/moral issues. In the most complex world of medicine, we will be challenged in the new millennium by ethical issues so complicated that they defy prediction at the present time.[10] Nevertheless, Catholic institutions will address these issues through methodical study and careful pedagogy, using the principles of Catholic moral theology. We should welcome this responsibility for which we are singularly prepared and to which we can bring so much light.

Catholic Hospitals as Principled Business Enterprises

Earlier I quantified the extensive assets which are held by Catholic hospitals in the United States. There is no question that Catholic hospitals represent formidable business enterprises that are important assets of the Church. Yet, despite these impressive financial attributes, there are many challenges which face the business of Catholic health care.

Catholic health care institutions approach the provision of health care as a good and not as a commodity to be bought and sold.[11] There is a fundamental difference in approach between the provision of a good and operating an entity to produce a commodity.

In providing health care, Catholic health care institutions must operate as prudent businesses**.** Sound business principles and

practices must be followed. If there is an excess of revenues over expenses, however, these funds are reinvested to provide care for patients and to ensure that Catholic health care has appropriate technology and infrastructure to continue to provide high quality health care services into the future.

By contrast, in an investor-owned business enterprise, a disinterested third party makes an investment in a business which happens to provide health care. This business must have the interests of patients as one factor, but not necessarily as the primary factor, which is the case with the not-for-profit entity. Investor-owned facilities have a prior obligation to the investor to demonstrate a return on investments for their shareholders. Thus, shareholders serve as the primary beneficiaries of such a business enterprise. Capitalism in this case takes the place of ministry.[12]

Catholic health care institutions will face challenges from the rise of investor-owned health care facilities. We must not forget that patients deserve the care they receive as the provision of a good which promotes their human dignity. We must not become induced to relegate the provision of health care to the status of a commodity in order to "succeed" at building business enterprises which serve corporate needs before the needs of the patients.

Equally, Catholic health care entities must continue to recognize the importance of those who are employed by these facilities. While corporate entities often quantify their assets in terms of cash and investments, Catholic health care entities must recognize that their employees are their most important asset. They must receive a just living wage and be true collaborators in the health care enterprise, consistent with the whole panoply of Catholic social principles. Employees must be treated fairly at all levels of the organization. Adequate employee benefits and pension plans must be present for all those who work in support of the Catholic health care ministry.

A special challenge arises when, because of increased business pressures, new partnerships are necessary. Catholic health care facilities should look first to partner with other Catholic entities when attempting to develop business partnerships. If Catholic entities are Catholic first, and businesses second, they will seek every opportunity for collaboration with other Catholic institutions in order to collectively increase the Church's reach to those with health care needs.

This is a serious and often difficult challenge to meet**.** Catholic entities have long traditions, supported by the different Charisms of Religious Institutes and governed by disparate structures, all of which are valid in the eyes of the Church. In our desire to continue to serve the health care needs of those who choose to come to our facilities for care, we will need to put aside some of our particular traditions and our perceived needs to respond to local market conditions in order to ensure a continued Catholic presence in the field.

In short, Catholic health care is a good, not a commodity. The ministry imperatives of Catholic health care should be more dominant than any perceived business imperatives.

Catholic Hospitals as Beacons of Hope for the New Millennium

As we approach the new millennium, there is bright promise for the role that Catholic hospitals can play to ensure the well-being of those who are ill.

Catholic hospitals have developed superb facilities, conducted world-class research and served as scholarship-filled environments. In addition, Catholic hospitals have a legacy of reaching out to serve the disenfranchised in their community and beyond. Homes for those who are infected with HIV, homeless shelters that feed the hungry, drug treatment facilities to serve those who are addicted, children's centers that provide care for the poor and facilities that care for women who are pregnant and homeless or addicted, all represent commitments made by Catholic hospitals to improve the health status of their community and to extend the ministry of caring which is Catholic health care.

This is values-based medicine. It can serve as a powerful beacon of hope into the new millennium.

The faith-based tradition of Catholic hospitals is our best known trait. Our resolve to promote life, to promote the needs of the family and the needs of the poor is known throughout the world. This faith-based dimension to our Catholic hospitals has always resulted in the establishment of pastoral care commitments which have served the spiritual needs of our patients.

The receipt of health care is an intensely religious experience. The fact that Catholic hospitals make such a commitment to the spiritual needs of patients brings comfort to the ill we serve. Imagine the reality if the strength and commitment of our pastoral care programs extended beyond the walls of our Catholic hospitals and into the homes of those who are ill. Parish-based health care ministry programs can unite the spiritual dimension of health care with the somatic needs of our patients.

In his message for the sixth world day of the sick to be celebrated February 11, 1998 at Loreto, Italy, Pope John Paul II has written:

"My thoughts turn particularly to health-care and pastoral workers, both professionals and volunteers, who continuously live in proximity to the needs of the sick. I want to urge them always to maintain a lofty conception of the task entrusted to them, without letting themselves be overcome by difficulties and incomprehension. To dedicate oneself to the world of health care does not mean only to combat evil, but, above all, to promote the quality of human life. Moreover, the Christian, in the awareness that 'the glory of God is the living man,' honors God in the human body, both under the exalting aspects of strength, vitality and beauty and under those of frailty and decline. He always proclaims the transcendent value of the human person, whose dignity remains intact even in the experience of pain, illness, and aging. Thanks to faith in Christ's victory

over death, he trustingly awaits the moment when the Lord 'will transfigure our mortal body to conform it to his glorious body, by virtue of the power he has to subject all things to himself' (Phil 3:21).

Unlike those who 'lack hope' (cf. 1 Thes 4:13), the believer knows that the time of suffering represents an occasion for new life, grace and resurrection. He expresses this certainty through therapeutic dedication, a capacity for accepting and accompanying, and sharing in the life of Christ communicated in prayer and the sacraments. To take care of the sick and dying, to help the outward man that is decaying so that the inward man may be renewed day by day (cf. 2 Cor 4:16)—is this not to cooperate in that process of resurrection which the Lord has introduced into human history with the paschal mystery and which will be fully consummated at the end of time? Is this not to account for the hope (cf. 1 Pt 3:15) which has been given to us? In every tear which is dried there is already an announcement of the last times, a foretaste of the final plentitude (cf. Rv 21:4 and Is 25:8)."[13]

As we approach the third millennium, imagine the reality if Catholic hospitals are viewed as integral to the ministry of the Church. Imagine the reality if Catholic hospitals stand proudly in witness to the promotion of human dignity for each and every patient regardless of their illness or their social standing. Imagine the reality if Catholic hospitals operate as principled businesses where justice motivates the workforce and the marketplace. Imagine the reality if Catholic hospitals continue our rich legacy and serve as beacons of hope which promote values-based medicine in a culture of caring which fosters collaboration within the Church and a heightened awareness of the spiritual needs of our patients.

When the millennium becomes a reality, these attributes of Catholic hospitals can be a reality. Together with the whole Church, Catholic hospitals can walk with Jesus as they minister to those in need.

MICHAEL F. COLLINS, M.D.
President and Chief Executive Officer
Caritas Christi Health Care System
Boston, Massachusetts, USA

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VITOR FEYTOR PINTO

Challenges for the New Evangelization in the World of Health

Introduction

1. For me it is a great honor to participate once again in this international conference, which is organized by the Vatican on the question of health. This eleventh conference has two key aspects which I cannot but comment upon. The first is the fact that it is presided over by Archbishop Javier Lozano in his capacity as President of the Pontifical Council for Pastoral Assistance to Health Care Workers. The second is that we find ourselves gathered together to reflect upon the responsibilities of pastoral action in the world of health, and thus of the Church as well with her various initiatives in relation to the health of the peoples of today—initiatives which express an ever-greater sensitivity to an improved quality of life.

2. In today's world, health has an extraordinary importance. In 1977 the World Health Organization unveiled a program entitled "Health for All by the Year 2000." In this program the WHO called for more years of life, more life in years, and a higher quality of life for everybody. Health occupies a primary position in the worries and concerns of citizens, within the political programs of nations, and in the organization of society. This is borne out by what has been constantly done by the World Health Organization at a very practical level in relation to both the primary needs of prevention and the harm that befalls people and the treatment that is required. It is no accident that health is defined as constituting "bio-psycho-social and cultural well-being"—that is, the overall fulfillment of the individual and of all individuals.

3. The Church cannot remain on the outer rings of this worldwide movement which strives to achieve the best health possible for the peoples of the planet.

Jesus Christ halted before the poorest. They brought all the sick people to him, and he "healed them all" (Mt 4:22). The first Christian communities paid special attention to the poor and the sick. To the man who asked for alms at the gates of the temple Peter and John were able to answer, "Silver and gold are not ours to give, but in the name of Jesus Christ rise up and walk" (cf. Acts 3).

Over the centuries the Church has concerned herself with the sick and especially with those who were despised and rejected by everyone. For this reason the Church established hospitals next to monasteries, supported religious orders which dedicated themselves to the sick, and developed programs by which to help those suffering from the most difficult of maladies. Everybody remembers John of God, a Portuguese saint, and St. Camillus de Lellis, both of whom became models for those within the Church who have dedicated themselves to the sick and especially to the poorest and the most abandoned.

At the end of this millennium, pastoral care in the world of health occupies a primary position in the Church's evangelizing action. Through pastoral care in the world of health "we give the Good News to the poor, freedom to the oppressed, and joy to those who suffer" (cf. Lk 4:16-19). For this reason we accept the challenges of this evangelization, challenges which take place, of course, within a very delicate and sensitive field. It is very important for us to know about such challenges and to deal with them.

1. Evangelizing Today

1. Evangelization is always characterized by the Good News. It is not a declaration of principles, of rules of behavior, or of liturgical precepts. We are dealing here with Good News for the poor, for the oppressed, for the sick, and for those who suffer. It is for this reason that the Lord Jesus told the seventy-five disciples that "in whatever home you enter give peace, heal the sick that are there, and tell everyone that the Kingdom of God is at hand" (Lk 10:7-11). We always announce the Risen Christ, Christ the Savior.

2. There are, however, many of our fellow-citizens who have lost their faith and, thirsting for God, look for him in a number of various ways. It is our duty to draw near to them and to "bear witness to the Risen Christ everywhere and to those who ask us to lay emphasis upon the hope of eternal life which is in us" (LG 10).

Such is our responsibility during the second evangelization, knowing as we do that the whole world is a land for missionary work and that in various ways everybody is searching for the Lord. Missionary work does pertain only to distant lands in Africa and Asia—Europe and the New World, too, need to be evangelized.

It is our duty to re-Christianize people and systems which have already been Christian and which have drawn away from Christ and the Church for reasons of culture or because of new ways of approaching life.

Each and every person must be evangelized—the sick and those who work in the field of health care, a child at the time of catechism and an elderly person well advanced in years, and the highly

educated and ordinary people who open their heart easily to God. Everybody can, and must, be evangelized.

And in the same way we are all evangelizers. St. Paul himself said, "Woe to me if I do not evangelize!" Through bearing witness, a timely word, and a constant presence, we are evangelizers of the word which converts and saves. We bear tidings of Jesus Christ.

3. It is more than obvious that at the present time and within the world of health the importance of evangelization is making itself increasingly felt. It is precisely for this reason that John Paul II has called for a New Evangelization.

The New Evangelization is not a re-evangelization, but bearing the news of the same Gospel with new commitment, new methods, and new forms of expression. But we need to dedicate special attention to new receivers of the message, new spaces within which to proclaim it, and new agents. It is at this point that we can perceive the originality of pastoral work in the sphere of health and health care. It is our duty to evangelize the world of human suffering and declare that "there is salvation in Jesus Christ only" (Acts 4:20). We must evangelize the world of science and technology to ensure that they are at the service of man and act as an instrument of salvation. We must evangelize the worlds of exclusion and marginalization, given that the Church expressly works in favor of the poorest and the most abandoned. We must evangelize and declare the Good News to the sick and the healthy in ways which provide instruction as to how to achieve health, support those who are afflicted by illness, and accompany people in an effective way during those situations in their lives which are most difficult.

Every Christian professional worker in the world of health-care and every Christian voluntary worker must be an agent in this New Evangelization. But in his relationship with other sick people or with healthcare workers each sick person must be an instrument of the Lord in the transmission of joy and peace. Illness is not a punishment or a trial. It is always a human limitation which appeals to and invokes the Lord, who gives life, and gives it in abundance.

2. The Great Challenges for Evangelization in Pastoral Care in the World of Health

We should list the challenges which we believe to be essential if we want to evangelize the present time, which is so difficult. Those challenges are humanization, ethics, organization, the most difficult situations which present themselves, pastoral action, effective presence, and the explicit good news of the risen Jesus Christ. These are the challenges which I would like to bring to the notice of everyone.

2.1. The Humanization of Health Care

Living as we do in a world which is profoundly dehumanized, where the value of success, power, and money dominate all human behavior, it is almost natural that the world of health is marked by this framework of values as well.

Pastoral action in the world of health accepts the challenge of humanizing it.

– Science and technology are not enough; research and efficiency are not sufficient. More is needed in order to serve the human person and save him.

– It is our duty today to welcome and be at the side of all sick people and their families. We are dealing here with an indispensable human relationship, of essential support for the cooperation which the sick person must give in relation to all the treatment which he receives.

– In addition, there must be the achievement of overall quality, which should be not only scientific and technological, but also human—that is, it must be aware that the human person has plans, a capacity to decide, practical forms of self-expression, and a need for answers.

– When we talk about humanization in health, we imply the humanization of forms of treatment, spaces, relationships, and buildings and machinery. Without such an operation the human person becomes fatally compromised.

– It is in this context that the Church through pastoral action within the world of health-care must condemn everything which attacks the human person and at the same time in clear and direct fashion propose new attitudes which contribute to the full recovery of the individual by directing attention to his real needs.

2.2. Ethics in Health Care

At the present time in the world there is a great deal of talk about ethics and of respect for the human being, and the aim in this debate is to go beyond simple norms, laws, and regulations in the relationships which exist between people within society at large.

But ethics does not amount to an empty word, something which is fashionable or which might be seen as a panacea to check certain forms of behavior and repress people. No! Ethics in reality is a constant challenge.

– A challenge to respect and promote the human person in all circumstances.

– A challenge to uphold and realize all human rights and go beyond the simple theoretical vision of the *Charter of the United Nations* and insist on its implementation in relation to the rights of sick people, the rights of professional healthcare workers, in guaranteeing care and assistance and as regards conditions of work, in equality of treatment and in securing that special attention be paid to each and every specific case.

– A challenge to create a just and fraternal society with healthcare systems which serve all people without any kind of exception, and with public and private institutions which direct their attention to the individual and not to the self-interest of a particular group.

– A challenge to promote forms of treatment which heal patients, which involve preventive methods which educate people in relation to health, which are effective in being able to help those who are in a state of crisis, which involve therapeutic assistance even when the diagnoses concerned offer no hope for the future, and which promote the quality of life in all circumstances.

Through pastoral action in the world of health care, the Church has the task of evangelization, and in this endeavor she must propose fundamental ethics which always defend and promote life, which accompany people in truth so that they are responsible in their approach, and which distribute equally to all, and with justice, the forms of help and aid to which they have a right. Such pastoral action must champion

justice, and the Church's own representatives and agents must practice this justice by welcoming and understanding everybody, being side-to-side with the poor, displaying tolerance, fraternal coexistence, dialogue, and solidarity towards all people, to achieve true membership in society, which should be made available to everybody.

2.3. Organized Evangelization

Today's world has lost the reference points of Christian culture, and the world of science and technology as it expresses itself in relation to health has completely forgotten about the presence of God within everybody and in all things. Many people think that the art of medicine is supreme and is unequalled in its power and possibilities.

The evangelization of the world of health is an urgent priority. Perhaps it will prove to be the greatest challenge of all.

– The action of the Church must not be based solely upon hospital chaplains who have a large number of good words to say and offer the usual sacraments. All those who declare themselves Christians have the duty to be evangelizers as well, whether they are professional workers or patients, whether members of the laity or priests or members of religious orders, and whether they are those who practice their religion regularly or those who only draw near to God and His Son Jesus Christ during times of suffering.

– The presence of the Church in healthcare facilities or at home cannot be reduced to the moment of death or when that moment draws near. Christ came so that we could have life and have it in abundance. The Church must be constantly near the sick person in order to achieve a reinterpretation of suffering and pain and to give them meaning. She must also be near healthcare workers in order to give a new meaning to their work. The catechism helps patients and those who care for them to "begin" the Christian life and to constantly begin that life anew. During illness there is not a great deal to learn, but there is much to love.

– Inspiration of a prophetic kind is another challenge of evangelization. Through an evangelical reading of personal, professional, and social events we will be able to live out difficult times with the serenity of those who see the invisible and discover in God new strength by which to rediscover life, even when it is in danger.

– In this context, the organization of the work of evangelization can involve the creation of encounter groups, prayer meetings, and events which promote sharing. In the world of health, live communities can come into being where everybody is able to share everything, but in particular to share those spiritual and supernatural goods which give new meaning to life.

2.4. Pastoral Action in Difficult Situations

Today's world tends to marginalize those who are poorest and those who suffer the most. Here we are dealing with a phenomenon of social exclusion which creates very cruel forms of loneliness. The Church, in contrary fashion, is concerned with those on the margins of society. Jesus Christ himself was like that—he welcomed lepers and lived with sinners. The Church from her very beginnings has dedicated herself to the poorest of the poor. Such has been the case with John of God, Camillus de Lellis, Federico Osanan, Mother Theresa of Calcutta, the Abbot Pierre, and many, many others.

– In this area the great challenge is to create specific units for the treatment and rehabilitation of sick people who present the most difficulties—drug addicts, those afflicted with AIDS, and the mentally ill. At the same time we should not be afraid to stand side-by-side with the homeless, homosexuals, prostitutes, and others.

– Another challenge consists in giving practical support and help to the terminally ill. Today the dying are an abandoned group in the intensive care units of hospitals. We should with urgency resocialize the final stage of life, and this requires a serious effort to relieve suffering and to be at the side of the sick person until the moment of the great meeting which takes place after physical death.

– In the fight against abortion and euthanasia, and in the promotion of life, pastoral action in the world of health must take new initiatives by which to receive and support mothers and expectant women with problems, children who are victims, women who are engaged in prostitution, the young person who has fled from home, and people who have nobody and need the help of other people.

2.5. Pastoral Action

The Church has for long been actively and energetically concerned with health care. Since 1985, through the Pontifical Council for Pastoral Assistance to Health Care Workers and by means of national and diocesan councils, the Church has promoted pastoral action which is practical to the full. As the third millennium approaches, the challenge which faces us is even stronger than before. We are called upon to organize.

– Social voluntary work in the world of health which is free, rooted in the Christian approach to life, and marked by care and concern for those who suffer the most or who are most alone.

– Catholic professional associations of medical doctors, nurses, psychologists, and social workers. Such associations should encourage professional workers to be Christian and courageous in their world of work.

– Basic units within local parishes which concern themselves with pastoral action in the world of health. These should be groups of Christians which act in a specific way to induce lifestyles which respect and promote health, and this should be done in a spirit of fraternal solidarity with those sick or handicapped people who live in their parishes and with a pastoral generosity which encourages those who suffer and are in pain to be seen as the most-loved members of our local Christian communities.

– Movements of social pastoral action where, in addition to the sharing of goods and resources, there is also the sharing of faith and life, and all this in order to help everybody to grow and develop as Christians.

The presence of the Church in hospitals and clinics through the organized activity of chaplains, groups which express a Christian presence (whether professional operators or voluntary workers), groups of visitors, ministering through visits, and other such forms of pastoral action.

2.6. The Bringing of the Good News of Jesus Christ

If it is true that the contemporary world has lost its sense of God and

is immersed in atheism and materialism, individualism, and permissive hedonism, and in a reductive idea of life and relationships, then it is equally the case that the explicit spreading of the Good News of Jesus Christ is a binding necessity and is at the same time also the most urgent challenge which we now face.

– In this situation much depends on whether there is credible testimony to the Gospel message in our proclamation of it and in our own lives. We must communicate the liberating message of Jesus Christ once again to men and to women.

– We should rediscover our own Christian roots and establish a deeper form of civilization which is authentically Christian and thus fully human. At the center of every bearing of the Good News should be the following message: "God loves you and Christ came for you."

– At the same time, without the hope of eternal life, where all evils and pains have been overcome, the human person remains in a condition where he is seriously mutilated. For this reason we must speak clearly about the immortality of the soul and of the resurrection of the flesh. This is a message full of joy which gives a meaning to everything.

– It is not enough to spread and disseminate such evangelical values as justice and peace. We must explicitly proclaim Jesus Christ, his person, the only savior. These are all very strong challenges which pastoral action in the world of health must address itself to during these times of the New Evangelization.

3. The World of Health Care as a Privileged Field for the New Evangelization

1. The world of health is universal; it affects everybody and is for everybody.

– Everybody must be educated for health.

– Everybody turns to treatment in order to be healed.

– Everybody wants complete and overall health.

2. The action and role of the Church is rooted in her very being and is innovative. It has three essential dimensions which are as follows.

– Humanization for everybody.

– Evangelization for those who profess themselves Christians.

– Sacraments for those who ask for them, at least implicitly.

3. The Church strives to achieve health for all through her organized and intrinsic role of pastoral action in the field of health, and, more specifically, she aspires to obtain the following.

– Complete health for the sick and for health workers, for these are the usual bearers of such health.

– The health of the body and of the spirit with a quality of life which is fully sensitive to spiritual and supernatural interpersonal relationships.

– The health of those institutions which have the highest scientific and technological levels, and which promote human relationships and salvific relationships.

Conclusion

Pastoral action in the world of health is one of the great challenges which face the Church during this age of the New Evangelization.

– Not everybody goes to Church, but everybody passes through hospitals.

– Sick people and health care workers, who are the beneficiaries of this pastoral action, should also be the agents of such pastoral work—through the spreading of the word, the bearing of witness, and organized action.

– The action of the Church prepares the way for life and for quality of life.

– Treatment which involves accompanying people during their illness is a wonderful form of evangelization, especially in the most difficult cases.

Mary, you that gave us Christ in the Annunciation, accompanied a person in need during the visitation, continued on your knees at the Cross, and took part in the birth of the first Christian community, help us with the strength of the Spirit to reveal Christ to others, through our testimony of efficiency and humanization, with our fitting word to enlighten decisions and attitudes, and with our generous charity, the special sign of redemptive love which always comes from Your Son, Jesus Christ.

Rev. VITO FEYTOR PINTO
Director of the National Commission for Pastoral Care in Health, Portugal

RUDESINDO DELGADO PÉREZ

Experiencing Suffering and Death in a Healthy Way

Introduction

The suffering which accompanies illness, on the one hand, and the experience of death, on the other, are two realities which are very direct in their impact and which are also inescapable. Sooner or later all of us have to face up to these realities and experience them. But can they be lived through in a healthy, productive, and constructive way? How can this be done? What keys and strategies can help us? These are the questions which I would like to answer in this paper.

Without forgetting about the reality of death, I would like to focus my attention on the suffering which is generated by illness. I do this with much humility and respect, with reserve and fear, for, as the priest, poet, and sick person José Luis Martín Descalzo observed, "Suffering is a mystery and is something we should draw near to much as we draw near to a glowing fire—with bare feet and not with fine theories to illuminate that which cannot be illuminated, not even by beautiful poetic reflections which do not bring out the naked truth."

Personally, I have not had to go through illness nor have I been near to death. But during my years as a hospital chaplain the Lord has given me many opportunities to accompany and be close to the sick and the dying. Furthermore, I have known what has happened to a large number of sick people whose experiences have been written up and recorded by the Department for Pastoral Assistance in Health Care of the Spanish Bishops' Conference. In a moving way I will offer you the witness of Christian sick people. Their witness shows that it is possible to live through suffering in a healthy way and also supplies us with the key by which to reach this objective.

1. Suffering: An Ambivalent Personal Experience

Physical, mental, moral, and spiritual suffering caused by illness is a personal and unique experience for the human being. Nobody can suffer in our place.

It is a profound and deep experience which touches upon the intimacy and the sacredness of the human person.

It is a strong and painful experience. As a young patient said to the Holy Father at Santiago de Compostela, "It is very difficult to recognize that your projects and wishes are less possible, to feel weak and limited, to depend on other people and to face up to loneliness."

It is a frontier experience of life which leads us to touch bottom, to encounter our truth and the truth of other people and of God.

It is an ambivalent experience which can destroy us or help us to grow and to mature, which can close us up within ourselves or open us up to the world in a deep way and to others, which can distance us from God or draw us near to Him.

It is an experience which challenges our freedom. Suffering does not have the last word. In our hands, there is the gift and the task of living through suffering well or badly, of transforming it into generous wine and not vinegar, of obtaining from its bitter flows white pollen like the bees—as the poet Antonio Machado puts it—and of ensuring that it is water from the well which irrigates the orchard and not torrent water which carries away the soil of the earth.

Nunca podrás, dolor, accorralarme.
Podrás alzar mis ojos hacia
el llanto,
secar mi lengua, amordazar
mi canto,
sajar mi corazon y desguazarme.

Podrá entre tus rejas encerrarme,
destruir los castillos que levanto,
ungir todas mis horas con tu
espanto.
Pero nunca podrás acobardarme.

Puedo amar en el potro de tortura.
Puedo reír cosido por tus lanzas.
Puedo ver en la oscura noche
oscura.

Llego, dolor, a donde tu no alcanzas.
Yo decido mi sangre y su espesura.
Yo soy el dueño de mis esperanzas.

—J.L. DESCALZO[1]

Pain, you will never be able to fence me in.
You can make me raise my eyes towards weeping,
Dry my tongue, stifle my song,
Break my heart, and break me into pieces.
You will be able to close me behind bars,
Destroy the castles which I build in the wind,
Anoint all my hours with your fear.
But you will never be able to discourage me.

I can love on the wheel of torture;
I can laugh at the spears which pass.
I can see in the obscurity of the dark night.
Come, pain, you that have never arrived.
I decide my blood and its nature.
I am the master of my hopes.

2. Strategies for Living Through Suffering in a Healthy, Productive, and Salvific Way

It is possible to live through suffering in a healthy way. But this is

not easy because suffering does not allow itself to be brought under control. We have to travel down a long road with steps which go both forwards and backwards; there are vicissitudes, and there are ups and downs.

2.1. Fighting Suffering

Being concerned with fighting pain is more important than applying theories and trying to decipher the reason for its existence. Suffering must not be explained, but fought and lived through. Suffering is, and will continue to be, a mystery.

Jesus adopted a practical approach towards suffering. He did not make speeches, did not like suffering, and did not seek it out. He saw the evil from which men suffer. For this reason, he passed by, healing as he went (Acts 10:38). In this way he manifested what God's will is in relation to the realities of pain and illness.

When faced with passive resignation, a healthy realism leads us to tackle pain, to fight it, to employ suitable means, to abandon questions which lead nowhere, and to adopt the constructive approach embodied in the question "What can I do in this situation?"

El angel del dolor visitó
(en noviembre) mi casa.
Era hermoso y radiante.
Era hijo de Dios.
Era, aunque no lo creáis,
el más alegre de cuantos conoce.
Entró por mis jardines y acarició
mi sangre.
Riéndose, cortó una de mis alas de
trabajo y de prisa
pero dejó intactas las de la ilusión
y el coraje.
Me dijo: Ahora empieza la segunda
parte de tu vida,
gemela de la otra, aunque algo
tartamuda.
Vive. No gastes tus horas en hacerte
preguntas.
Reordena tu escala de valores.
Pon en primera fila la amistad
(tras de la fe, se entiende)
y recuerda que Dios es bueno,
que el hombre es mucho mejor
de lo que él cree,
que el mundo está bien hecho
y que vas a vivir hasta los topes
el gozo mientras vivas
porque resulta que el angel del dolor
y el Belén son el mismo.

—J.M. DESCALZO[2]

The angel of pain visited
(in November) my home.
He was beautiful and radiant.
He was the son of God.
He was, even though you will not
believe this,
The most joyous person I have
ever met.
He entered through my garden and
Caressed my blood.
Laughing, he cut off one of my
wings of work and /hurry,
But he left intact the wings of
desire and courage.
He said to me, "Now the second
part of your life is /beginning,
The bud of the other, even though
a little hesitant.
Live! Do not waste your hours
asking yourself questions.
Reorder your scale of values.
Put friendship in first place
(after faith, you understand)
And remember that God is good,
That man is better than he thinks,
That the world is well made,
And that you will have joy to
the last /moment
You are alive
Because the angel of pain And that
of Bethlehem are /the same."

2.2. In the Face of Suffering Adopt Positive Attitudes and Forms of Behavior

When face to face with the suffering which afflicts the sick person, the patient can embrace positive and productive attitudes and forms of behavior or ones which are negative and sterile. The former will allow him to live out his suffering in a constructive way. The latter, on the other hand, make suffering unbearable and destructive. It is healthy to maintain an energetic and life-based approach, one which is based upon trust and active cooperation with the healthcare staff around one. The shouldering of one's own weakness, active patience, refusing to become indulgent, demanding, or troublesome, feeling oneself useful, being concerned with others, not abusing those who are taking care of one, being grateful and forgiving towards other people—all these, too, are signs of a healthy approach to suffering. "My experience of God led me, during my illness, to confide in myself, to become aware of my strengths, to be at one with my deepest possibilities, to unite my unknown energies, to fight against illness without faltering, to keep a serene spirit, to appreciate the gift of life, and to receive it as one would shoulder a task. To intensify the fundamental meaning of life as love, offering, and giving. Illness was also an opportunity to forget about myself, not to be dependent upon myself, and not to be wrapped up in myself."

To recognize and deal with my weakness without fear, without traumas, without fear and anxiety. This is what we are: we are sick people!

To live illness spontaneously, without trying to create other exceptional circumstances which are not necessary. Not to become indulgent with ourselves, impertinent or troublesome to others. I had the opportunity to allow myself to be guided by simplicity; I had the good luck to be cared for by my close relatives.

To leave other people to decide what to do when it came to being concerned about me, giving me attention, coming to visit me, or telephoning me. I learnt to live the solidarity-inspired presence of other people at a distance, well knowing that illness, like the rest of life's journey, is lived out by each person on his own and within himself, even though at the same time it is lived within the context of relationships with other people.

To overcome the bourgeois and elite spirit according to which, when it comes to ourselves, we must look for the best: the best medical doctor, wherever he may be, the best care, the greatest safety. Personally, I chose to accept the doctor who had been assigned to me, as happens with everybody else. He was a doctor who knew what he was doing, and this was really an example of good fortune!

To confide in doctors. I put myself in their hands without any questioning, with docility, in silence, without asking questions or being difficult. I behaved in such a way as to make their task easier.

To employ a spirit of compassion towards others and to put myself in their shoes and to try to understand the situation they were in. This was especially the case when it came to the healthcare staff who were looking after me. I turned my back on a hypersensitivity about my rights (this is something which should be striven for, above all, before and after the illness). I adopted an approach which appreciated the gift I was receiving and I treated every service as though it were a favor

which had been granted to me. I was neither heavy nor demanding in my behavior. I cooperated in a practical way. I created a climate of welcome and of ease of interaction. I understood their work situation with all its many hours, responsibilities, and even lack of understanding. I forgave failures to which I fell victim, even when caused by incompetence or negligence, even though these failures could have involved serious risks. I forgave from within myself.

But, above all, during my illness I tried to maintain an attitude based upon life, even in the most difficult of moments. Illness was a stage in my life which it was worthwhile to live out intensely, profoundly, radically, and with a certain enthusiasm and joy. Who could assure me that this was not the final stage of my life? And how could I not have hurried to live out that possible moment to the fullest extent possible?" —Jesús Burgaleta.[3]

2.3. Not Shutting Oneself up in Illness

The experience of suffering did not lead Jesus to become hard and to shut himself up within himself. Indeed, it made him become sensitive to the pain of other people and enabled him to "help us in the trials we undergo" (Heb 2:18) and to identify with his brethren who suffered: "I was sick, and you cared for me" (Mt 25:36).

When faced with the risk of becoming totally absorbed in our suffering as though nobody else in the world existed, an effective way of overcoming or relieving our suffering is to break the vicious circle which suffering tries to place us in. Reality does not end in suffering. It can be an opportunity by which we can get to know other people, see their goodness, and to open ourselves deeply to others, especially towards those who are in pain. Nobody and nothing can take away the power to love and the power to offer support.

"I thank God that He gave me the strength to see my reality, but also that He gave me the grace to see the reality of other people, to touch the suffering of everybody, and not to think that my suffering was the worst that there was but to understand that it was only my suffering; and to realize that the suffering of others is strong, stinging, and anxiety-ridden—because it is theirs. I discovered that one can give love and make other people happy with very little—by remembering their names, by a smile, by a pat on the back, by asking how they are, by a joke, by an expression of understanding, and by listening" —Maria Dolores Jiménez Lozano.[4]

"I managed to survive more than thirty-five radiations because I did not concentrate on myself, but dedicated my attention to other people. We had to wait for a long time on the bottom floor of the hospital. We gradually established an authentic friendship. Most people were silent, like me. We allowed the language of our body to talk; smiles, expressions of the soul. A man of my age who had tongue cancer made me understand that he wanted to take his own life. I began to write down a thought for each one of the people who was waiting there. I realized that my slim and brief writings were listened to with interest; indeed, those who were waiting even looked forward to them. One day a woman in a wheelchair arrived on our bottom floor. She gave a loving and encouraging smile to each one of us who was there. I also wrote a thought for her: 'Her smile, which is full of love, here in this basement is worth much more than a million marks.' I regard my experience on the bottom floor of that hospital as one of the most enriching and rewarding of my life" —B.Häring.[5]

2.4. Giving a Word to Illness

When the heart feels the bitterness of pain it cannot be shut up and compelled to keep quiet. Silent pain is not human—it makes people ugly and isolates them. A word can humanize suffering. On the one hand, that word can direct suffering towards God, the mysterious transcendence; and, on the other, it can direct suffering towards other people. When faced with pervasive suffering and imminent death, Jesus did not conceal his feelings. He opened himself outward and needed someone at his side. "My soul is sad until death" (Mk 13:14). And on the cross he exclaimed, "My God, my God, why have yhou forsaken me?" (Mt 27:46).

The person who suffers needs to express himself, to allow his feelings to come out, to explain them to somebody who listens to him. And if he is a believer, he also needs to express them to God.

"The morning of the first of January, after the terrible crisis of New Year's Eve, I sat next to a ciborium in a church which was almost empty, and I brought out my pain with absolute sincerity. I addressed myself to the Lord and talked to him more or less as follows: 'You know, you are going against me. I loved a wonderful man, I married him, and he turned out to be a deceiver who ruined my life. I left my work to look after him while he suffered from illness and depression, and I did all this so well that he went back to being what he was before. As a result, we had to separate. I only had one transfusion and in that moment they injected into my blood the most terrible illness of the century. In less than a year I lost my job, my husband, economic security, my health, and even the hope of a dignified death. Why are you doing this to me? What kind of a heroine do you think I am?'

After this explosion I felt almost blasphemous. I wanted to ask forgiveness, but I realized how ridiculous my attitude had been. If God knows my soul to its innermost parts, what is the use of telling Him that I accept everything if in reality I feel the opposite? Can somebody lie to God in the same way as he lies to men? I believe in God, and I cannot avoid Him. And I believe that He is my Father and that He loves me, even though He does not solve my problems. Perhaps this is because if He did solve them He would be a magician, and my life would be a science-fiction story. I believe that God will be near to me, suffering or being happy with me, in both the darkness and the light" —Maria José.[6]

2.5. Looking for a Meaning to Suffering

As V. Frankl observes, "Healing comes through a rediscovery of the meaning of health, of illness, and of life itself." The serious search for the meaning of suffering, the wish to find a meaning to suffering, keeps man on the path which leads to authentically human health.

"I have found no pleasure in pain; I do not like it. I accept it simply because it is there. I look at the crucifix, and the Cross becomes for me a path towards full life because He is there. In Him I find the peace and the serenity by which to suffer in joy. He is the hope that I do not live alone in pain, but in communion with Him.

Our God is not a God of the dead, but of the living. He wants the life of man and the happiness of man. Pain does not make man happy, and for this reason pain cannot have the last word, and I experience within myself that which is not to be found in pain. There is Someone within you who accepts that pain and takes it on Himself so as to make life spring forth even from within an 'apparently dead' person. His presence does not explain my pain or reduce its intensity—it gives it meaning and helps me to live it out in fullness and joy, hoping that one day my body will be completely broken up and I will able to enjoy his presence to the full, face to face" —Cecilia.[7]

2.6. Discovering, and Giving Thanks for, What Suffering Teaches Us

Suffering in itself is an evil. But it is not an evil which should always and in all circumstances be avoided. It can be a factor which involves wise learning and growth. Léon Bloy says that in the heart of man there are many corners which we do not know about until we arrive at that pain which enables us to discover them.

"The other day I read about the case of euthanasia in the United States of America. A woman aged forty-five chose to die rather than undergo chemotherapy. I respected her choice, but I raised my eyes to heaven and I said to Jesus, 'Thank you for your help, thank you for my choice, thank you because my life has found meaning over these two years, thank you for all your love and the goodness which I have come to know, for those who have always been my friends, for my new friends, for having discovered your Kingdom, for having allowed me to become transformed, for my new heart, for my new values, for the decisions which I accepted with so much peace, for every dawn which you give me, for the two-and-a-half years of life in my family, for having allowed me to keep my joy, my sense of struggle, my desires and wishes, because you support me in my hardest moments, for knowing how to give value to the smallest of things, for everything which I have known how to do, whether well or badly, and for having allowed me to take part in your Gethsemenes. Thank you!" —María Dolores Jiménez Lozano[8]

"I can say that, unfortunately, I had the good fortune to fall ill. By this route I was able to live through certain aspects of life which, while I was well, I would not even have noticed: weakness, being limited in my actions, that which cannot be remedied, the depth of what is profound, pain, relativity, what is important and what is accidental, what is necessary and what is accessory, what is superfluous and what is essential, what is valuable and what is useless, the shouldering of one's own history, the acceptance of what one is, the ability to engage in self-criticism, the prospect of change, the acceptance and recognition of death, being open to the future, desperate hope...." —Jesus Burgaleta.[9]

2.7. Filling and Transcending Suffering Through Love

Only love saves from the destruction to which pain can lead. Love keeps pain from burning us away. In many cases love frees us from despair. And it is love which gives life, which sustains us, which takes care of us, which makes us grow and develop, which prepares us for the loss of life and helps us to give it. Only love, giving, can transform death into a "life-giving act *par excellence*." The design of God in relation to man is love: he who continues to love, even in suffering and death, continues to strengthen himself as a person, and grows notwithstanding the fact that his physical strength diminishes and biological life expires. The filling and transcending of pain and death through love is the most beautiful miracle of the Christian faith.

Jesus accepted suffering when he came into contact with it, and actively employed it as an opportunity to express his love and total trust in the Father, and his love for his brethren. In his pain he was worried and concerned about his mother: "Son, behold your mother" (Jn 19:26). He forgave those who had brought about and caused his death: "Father, forgive them, for they know not what they do" (Lk 23:34). And he responded to the cry of the good thief with the following statement: "Today you will be with me in heaven" (Lk 23:43). In Christ, suffering "is united to love" (*SD* 18). "In received and given love, suffering and death also find their meaning, and although remaining within the mystery which surrounds them, they can become an event of salvation" (*EV* 81).

"The effectiveness of a life is to be found in the truth of its love and no misfortune can take from us the force to go on loving. I could lose my activity, my future plans, my sight, my health.... But none of these losses, or all of them together, would have the power to deprive me of the capacity to love, to receive and to give love. 'While I am capable of love,' I said to myself, 'I am invincible.' The Spirit fills the without-hope of our lives, and transforms it into a thousand possibilities for communion. Even if I cannot see now—for many months I have been unable to see out of either eye—I am happy because others see and know how to enjoy the gift of sight. If I cannot share the joy of those who can use their sight merely because I do not have the same joy, this is because I have allowed selfishness to take possession of me. And this is something which should really be seen as a misfortune! If I open myself to share the happiness of another person, I discover that in me, too, there are other reasons for happiness and other sources of happiness which can be shared with other people" —Antonio.[10]

2.8. Praying

Jesus found in prayer the force and strength which he needed. On the Mount of Olives he prayed constantly: "My Father, if this chalice may not pass me by, but I must drink it, then thy will be done" (Mt 26:39). And on the cross he places himself in the hands of God: "Father, into your hands I commend my spirit" (Lk 23:46).

For the believer, prayer is the instrument which enables him to live the mystery of weakness. To pray is to enter into our inner selves and to discover the place where we place ourselves in contact with God and with his salvific power.

"In praying from the starting point of what I was living, I began to transform my illness into a time of grace. The grace which the Lord granted me was that of understanding that the favor which I asked of Him, and which He wanted to grant me, was, above all, to accept the results of that process, whatever it might have been, as something which was the most fitting and helpful for me. To find the same meaning, or even more, in life as I did before, notwithstanding my loss of faculties. To know that I could continue to be useful and to work for others. To accept

the changes in such meaning in line with the results and to accept them without turning them into some great event which would sadden my life and that of those who were near to me—this was the highest miracle which the Lord wanted to grant me, or, rather, which had already taken place in my innermost self" —Antonio.[11]

"This afternoon during prayer we were invited to ask the Lord for healing and to let Him heal us. It was a prayer, a painful reflection. The tears ran constantly down my face. I wanted to ask the Lord to heal me, but it was impossible for my prayer to arise from my heart because in order to be healed I had to accept that I limp. Before receiving treatment I asked Him to accompany me on my way, to grant me his Spirit and his strength so that I could give a name to what was happening to me and tackle what lay in store. It was by no means easy but now I feel at peace" —Viky.[12]

2.9. Living Through Suffering in Hope

Pain does not have the last word. Suffering passes; life does not. Faith in the merciful and risen Christ leads us to believe that suffering does not have the last word, that it can be lived as a salvific experience and as a constant opportunity to love. Love is the only thing which can conquer death.

"Despite the darkness and the emptiness, I asked myself how pain could annul my hope. Such a thing could not happen unless I became the center of everything—sulking, demanding, and transmitting bitterness to other people.... I felt pain as an experience of 'death', and a series of questions besieged me. Among the questions which I asked myself were these: How is it that in a believer death is stronger than life? If Jesus rose again and there is life and life to the full, why should 'death' sink my hopes? In my deepest being an unbearable joy rose up: It's God! To the extent that one 'dies,' one lives. One lives in another way, but one lives—one manages to touch the 'other' reality" —Cecilia.[13]

Sé que voy a perder mi vida. Pero
no importa; seguiré, sigo jugando.
Y, aunque sé que me estoy
desmoronando,
voy a esperar, sigo esperando,
espero.

¿Dónde quedó mi corazón
primero?
¿Dónde el amor que amaneció
silbando?
¿Dónde el alegre adolescente?
¿Cuándo
mi alma cambié por este
vertedero?

Pero voy a seguir en esta noria
de la esperanza, terco, testarudo.
¡Leventad acta a mi requisitoria!

Tal vez un día se deshaga el nudo.
Y, si no puede ser, dirán:
"No pudo.
Pero murió a las puertas
de la gloria".

—J.L. MARTIN DESCALZO[14]

I know that I will lose my life. But
It does not matter, I will go on,
go on playing.
And even if I am breaking up,
I will wait, will go on hoping,
hope.

Where is my first heart?
Where is the love which appeared
whistling?
Where is the happy teenager?
When
did I change my soul for this
heaviness?

But I will continue on this
waterwheel
of hope—stubborn, obstinate.
I will put what I am accused of on
the record!

Perhaps one day the knot will be
untied.
And if this is not possible, they
will say, "He did not do it.
But he died at the gates of glory."

2.10. Maintaining a Healthy Relationship with Suffering and with God in Pain

A healthy relationship with God, especially during suffering, requires constant purification. At the end of the dark night of suffering we feel, like Job, the living mystery of God, strong in weakness, present in absence, eloquent in silence. A God who looks for man in order to save him, to free him, and to strengthen him. A hidden and humble God who does not impose himself with his power and does not blind with his glory; a God whose presence is discreet and not oppressive, in the same way as the presence of friendship and real love is always discreet and not oppressive. A God who suffers with us so that we can learn to love with Him and like Him. A God, the future of man, who will not allow a life to be destroyed by death.

"The face of God, in whom I believe and who scandalously but really revealed itself to me in this experience, is the same face that I saw in my parents and in so many other people who struggle with all their strength against pain and its causes. They show their intense love by taking part in the pain of the children of their own flesh and in the final analysis accept in silence and powerlessness a love which will not allow a child to be freed by death, but by a final abandonment. Perhaps it is for this reason that my faith now manages to suspect that God was present on the cross of His Son, and loved him without taking any intervening action. There is nothing more immobile than love. Not even God was 'able' to free his beloved Son from death. He did not abandon His Son in final fashion to the power of death, but raised him from the dead. And in this way not only did God prepare us to expect final life, but He also showed us that there is a way of living which constitutes the seed of the resurrection. This is the hope which animates us. In a conversation which I had with my brother (who is terminally ill with AIDS) I ventured to ask him how he felt—given that he was faced with an expected end which was very near—if he believed or not in another life, if he believed in God.... His answer was as follows: 'Now, when I am thirty-seven, I have discovered that I lost my life because I did not learn how to love. I knew only how to use my life. One cannot improvise loving. I do not know if there is another life. If there is not, this means that this hell is over both for me and for all of you. If there is, and if God is waiting for me there, after the family experience which I have had I cannot be afraid of meeting Him" —Emma Martínez Ocaña.[15]

2.11. Being and Feeling Accompanied in One's Journey

To be able to approach and face up to illness, suffering, and death with serenity, with joy, and with inner peace, and to reach the final existential moment in such a frame of mind is only possible thanks to solidarity, company, love, and friendship at the service of others. We can face up to and accept this situation

only when we do not feel alone, when we feel the presence of other people.

"Only the grace of God has enabled me to remain joyful during these recent years. I know that it is by no means a pleasure to be in the Garden of Olives, but, like the Lord, I, too, had 'angels who consoled me.' At times these angels expressed themselves in a simple way through an inner peace. On other, numerous occasions they took the part of the people in these years who have loved me and helped me a great deal. My brothers, my friends, and so many mysterious and unknown people have supported me, and I deem it a miracle that in nearly all the dark hours there always arrived a letter, a telephone call, or a casual meeting in the street which helped me to regain a sense of calm. I must confess with joy that I have never felt so loved as I have been in these years. I emphasize this because I know very well that many brothers and sisters have not had and do not have the good fortune that I have had and have. A family and a sister who suffers at your side with you are gifts which Providence has given me but which—unfortunately—not all sick people have" —J.L. Martin Descalzo.[16]

"What a relief to feel that somebody is taking care of your situation and is not trying to offer you some kind of cheap consolation or to distance you from the truth of reality, however hard it may be, or to imitate your own feelings. The time has come to recognize and to thank the 'angels' who allow you, and have allowed you, as you travel down your road, to rise up, to nourish yourself with the bread of solidarity, neighborliness, free self-giving, and struggle, and thereby to go on walking" —Emma Martinez Ocaña.[17]

It is not easy to live through suffering and death in a healthy way, but it is possible. This is a gift and a task for each and every one of us. I would like to conclude with the final message of those who took part in the National Congress on the Church and Health which was held in Spain in 1994: "To believe in Christ and to follow him, to experience the healing and saving force of his life, his death, and his resurrection, is one of the healthiest and most gratifying ways of living life to the full, and of living through health, illness, and death itself."[18]

2.12. Training Oneself and Preparing Oneself to Live Through Suffering

One cannot improvise dealing with the realities of suffering and death—these are things which we have to be well prepared for. It is important to be aware that they form a part of the human condition, and to grasp that one can be happy despite pain, but that it is impossible to live your whole life without pain. It is constructive to live out the values which illness and death put to the test (solidarity, union, mutual service, generosity, resistance...) and to cultivate those attitudes and approaches which at the right moment facilitate their being experienced (the acceptance of our limits, integrity during such trials, love, radical faith in God...). We must take advantage of the illness of those who are with us and see it as an opportunity for enrichment and self-formation, etc.

The Spanish Bishops' Conference has distributed a publication entitled *Testament of Life*. In this work the faithful are invited to reflect upon life, suffering, death, and the hereafter. It is a profession of faith in life as a gift of God, and in death as a final event of earthly life and as a passage which opens the road to that life which in the presence of God will never end. There should be a wish to die, an asking for help to engage in a human and Christian living out of death, a wish to prepare for the peaceful experiencing of death, near to one's loved ones, and in the consolation of the Christian faith.

RUDESINDO DELGADO PÉREZ
Ecclesiatical Assistant of the Association of Christian Health-Care Professionals (PROSAC), Spain

Notes

[1] J.L. MARTIN DESCALZO, *Testamento del Pájaro Solitario* (Verbo Divino), p. 68.
[2] J.L. MARTIN DESCALZO, "La Visita del ángel del Dolor," in *Revista Vida Nueva*, no. 1., p. 581.
[3] AAVV., *Vivir Sanamente el Sufrimiento* (Edice), pp. 153-154.
[4] J.M. MARTIN MORENO, *Vivir a Tope* (Murcia), p. 15.
[5] B. HÄRING, *Esperienze di Fede nella Malattia* (Borla), pp. 42-43
[6] AAVV, *Vivir Sanamente el Sufrimiento* (Edice), p. 156.
[7] CECILIA PUERTAS, "El Dolor a la Luz de la Fe: Un Misterio de Amor," in *Revista Teología y Catequesis* no. 28 (1989), p. 123.
[8] J.M. MARTIN MORENO, *Vivir a Tope* (Murcia), pp. 16-17.
[9] AAVV, *Vivir Sanamente el Sufrimiento* (Edice), p. 154.
[10] A. LOPEZ BAEZA, *Experiencia con la Soledad* (Narcea), p. 74.
[11] A. LOPEZ BAEZA, *Experiencia con la Soledad* (Narcea), p. 76.
[12] AAVV, *Vivir Sanamente el Sufrimiento* (Edice), p. 118.
[13] CECILIA FUERTAS, "El Dolor a la Luz de la Fe: Un Misterio de Amor," in *Teología y Catequesis* n. 28 (1989), p. 120.
[14] J.L. MARTIN DESCALZO, *Testamento del Pájaro Solitario* (Verbo Divino), p. 26.
[15] ENMA MARTINEZ OCAÑA, "Droga en Nuestra Casa. Bajar a los Infiernos," in *Sal Terrae*, no. 1003, July/August 1997, pp. 605-607.
[16] J.L. MARTIN DESCALZO, *Reflexiones de un Enfermo en Torno al Dolor y la Enfermedad*.
[17] ENMA MARTINEZ OCAÑA, "La Droga en Nuestra Casa. Bajar a los Infiernos," in *Sal Terrae*, no. 1003 July/August 1997, p. 602.
[18] DEPARTAMENTO DE PASTORAL DE LA SALUD, *Congreso Iglesia y Salud* (Edice, 1995), pp. 447-448.

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JORGE MEDINA ESTÉVEZ

The Sacraments: A Source of Health and Salvation

1. Illness

This is not the place to engage in a medical definition of illness. It is enough here to provide an approximate description based upon common experience. Without doubt the term "illness" evokes a condition which is opposed to health. It seems that a valid distinction can be made between "illness" and "defect." A defect which is congenital or caused by an illness is a stable reality which is compatible with a state of health. A person who has had a limb amputated has a defect, but one could not say that he is sick. In more serious cases, one can employ the notion of being an "invalid."

Illness is a reality which is in a state of movement which itself is engaged in a process of evolution. Its most general and constant characteristic is that of provoking an imbalance in the functions of the body in such a way that the harmony which characterizes the state of health is compromised. When this imbalance is such as to compromise the essential vital functions of the body, one can talk about a serious illness which is a threat or which involves the risk of death. Death can be described as the ending of life brought about by this state of imbalance between the different essential vital functions, or their termination, a process which leads thereby to the definitive destruction of the unity of the organism. The survival of certain cells or groups of cells of an organism does not constitute the "life" of the whole to which they belong. One is dealing here, instead, with rather short or artificially maintained vegetative processes.

What seems to be interesting for our purposes is to see the physiological process which we term "illness" as an initial or advanced moment of imbalance in the vital functions, a state which has not yet come to cause death, but which has a relationship with death.

When a person experiences illness, he finds himself in a situation where the human being perceives his mortality and thus his finite nature, his powerlessness, his fragility, and his dependence.

Given that man has a vocation to eternity, the experience of illness should be an appeal to his conscience to face up sooner or later to the question of death, the judgment of God, and his eternal destiny. Like all circumstances connected with life, illness leads us—albeit in a very special form—to remember the pragmatic observation of St. Paul, a statement which is of relevance and importance to all Christians: "While we live, we live as the Lord's servants; when we die, we die as the Lord's servants; in life and in death, we belong to the Lord" (Rom 14:8).

Having said this, it should also be added that old age is a condition which is similar to that of illness. During old age various kinds of imbalance emerge which compromise the harmony and the unity of the living organism, and this is a process which inevitably leads to death.

It is, however, perfectly natural that the Christian perceives illness as a sign and reminder of his finite nature and as an invitation to prepare himself for the advent of eternal life—that is, the final and definitive stage of human existence, for if our earthly life conforms to the wishes of God, our being will always be centered on Him, and there will be no possibility of our becoming separated from Him. Furthermore, our being will achieve its fullness on the day of the resurrection.

Illness is usually marked by pain and worry—conditions which are inherent to this life, but which are destined to disappear in the heavenly Jerusalem: "Here is God's tabernacle pitched among men; he will dwell with them, and they will be his own people, and he will be among them, their own God. He will wipe away every tear from their eyes, and there will be no more death, or mourning, or cries of distress, no more sorrow; those old things have passed away" (Rev 21:3-5). The Apostle St. Paul associates temporal life with corruptibility (cf. 1 Co 14:43ff) and sees the physical nature of the risen in terms of the "spiritual," which from a certain point of view is synonymous with immortality. It is perhaps for this reason that he argues that "the last of those enemies to be dispossessed is death" (1 Co 15:26). Pain necessarily refers to nonpain and this is clearly a valuable concept or notion—although it is certainly negative in literal terms—by which to describe life, harmony, and happiness.

When we employ the terms "pain" and "illness," we usually refer first and foremost to physical or bodily pains or suffering. However, we all know that there are pains and illness which can be called "spiritual" and which do not belong in an exact sense to the category of psychic pains. Whatever the case, the unity of the human being is such that spiritual suffering can have so-

matic consequences and *vice versa*. It is for this reason that the happiness of the blessed in glory, which principally consists of the joyous vision of God, his ineffable being, and his works, also includes full physical harmony and the impossibility of corruption and suffering. In contrary fashion, the condition of the damned involves pain without end, a sort of internal laceration, an imbalance which tortures and which comes from a clear awareness of having rejected the only good which is absolutely desirable and the only object which really blesses, and of not being able to go back on this rejection. Just as blessedness receives the appellation "eternal life," condemnation is called "eternal death" and is described by Holy Scripture with a whole variety of images which evoke suffering: "fire" (Mt 3:12; 18:8; 25:41), "worms" (Mk 9:43-47), "gnashing of teeth" (Lk 13:28; Mt 24:51), "darkness" (Mt 8:12; 22:12), etc.

2. Life

On the horizon of many men today the word "life" refers only to the physical and temporal dimension of their existence. The contemporary world has acquired a very developed sensitivity towards the rights of the human person and, above all, the rights of his physical life. That life is protected by law and is defended against unjust aggressions. Complicated and expensive systems of social security and welfare measures have been developed to help people who are sick or physically or mentally limited. Curiously enough—and in truth this is something which is really scandalous—many systems of legislation allow attacks on the life of the unborn child and see it as something which is legitimate. Abortion in its various forms—something which is atrocious and expressive of a general decadence of moral sentiment and sensibility—has been eliminated from the list of crimes which are punished by society. After the legitimation of abortion we have had to face the legitimation of euthanasia, and it cannot be denied that between the two phenomena there is an inescapable logic of connection. Subsequently, we have also encountered genetic manipulation, and the possible developments in this sphere are highly unpredictable. We must be happy about the growing concern and awareness which is now present as regards respect for life, but it is not possible to feel a certain amazement and indignation when we are faced with the various forms of assault on life which now confront us.

However, in the light of faith, life in its complete meaning is much deeper—it is life in Christ and for God. "For me, life means Christ; death is a prize to be won," (Phil 1:21) declared St. Paul, who added, "And yet I am alive; or, rather, not I—it is Christ that lives in me" (Gal 2:20). The parable of the Prodigal Son (Lk 15:11-32) clearly teaches that life distant from God does not deserve the term "life," but is in reality misery and death. As the father of the returning son declares, the boy who came back to the family home "was dead and has come back to life" (Lk 15:32). The mission of Christ can be summed up by his own words: "I have come so that they may have life, and have it more abundantly" (Jn 10:10), and he himself proclaims that he is "the way, the truth, and the life" (Jn 14:6). When the Apostle St. Paul states with extraordinary force and directness that "for love of him I have lost everything, treat everything else as refuse, if I may have Christ to my credit" (Phil 3:8), in fact he is doing nothing else but expressing his belief that nothing has value if it is in opposition to the Lord. When confronted with the choice of losing their physical lives or gaining eternal life, the martyrs, with wisdom, chose physical death—they decided to surrender their earthly life in favor of the achievement of eternal life.

Every Christian must always bear the perspective of eternal life in mind, and it is in this light that he must judge and evaluate the objectives which arise and the options which go to make up the history of his existence in freedom. The remembrance of death, therefore, is not a tragic remembrance, but an awareness of a normal fact which, though it is not any less painful for this reason, constitutes a staging-post on the road to eternal life—as long, that is, as existence on this earth has conformed to divine law. The remembrance of death is an invitation to give value to objectives and options from a sole valid perspective—that is, in relation to their conformity to the will of God. Temporal life is nothing else but a preparation for, or an antechamber to, eternal life: God concedes us temporal life so that we can deserve the eternal life which is our real end and purpose—indeed, our only definitive end (cf GS 22)—and in the light of which everything else must be understood, assessed, and evaluated.

Eternal life is not only the immortality of the soul, but in the final analysis the life to the full of the whole human being, both body and soul—the place of resurrection on the day of the Parusia of the Lord. This life in its fullness will be the expression of perfect harmony between man and God, a harmony which is the result of the justification and the grace which are the polar opposites of sin, whose consequence is death (cf Jn 3:19; Rom 5:12-21). For this reason, it is not only legitimate, but also logical to affirm that every choice in favor of the rejection of sin is a choice in favor of life, just as every decision in favor of sin in the truest sense possible is a decision in favor of death.

3. The Sacraments: Signs of Life

The teaching of St. Thomas of Aquinas to the effect that the sacraments are commemorative signs of the Passion of Christ is well known. This Christian thinker believed that they demonstrate grace and anticipate future glory. All of this has an intimate relationship with life because the death of Christ constituted a victory over the power of sin and death; grace is real life already present in this world; and glory is the fullness of life. These three dimensions correspond to each sacrament, albeit with the special element of grace, which is particular to each of the sacraments.

The three sacraments of Christian initiation—*Baptism*, *Confirmation*, and the *Eucharist*—are the beginning, the maturity, and the sustenance of the new life which has

been embraced. They are, so to speak, the re-creation of man (Eph 4:24; Col 3:10; 2 Co 3:17; Gal 6:15), the gift of divine adoption and participation in the nature of God (2 Pt 1:4; Jn 6:53-57; 15:4:8), and the beginning on earth of the vocation to holiness and praise of the glory of the grace of God (Eph 1:3-14). It should be remembered that these three sacraments, which introduce grace into life, already aim towards the final and total destiny of the whole man, in his body and soul—a destiny which involves an eternal and glorious life made up not only of the immortality of the soul, but also of the resurrection of the body. One should not understate the importance of the very direct expressions employed by St. Paul: "But your bodies are not meant for debauchery—they are meant for the Lord" (1 Co 16:13); "Have you never been told that your bodies belong to the body of Christ?" (1 Co 6:15); "Surely you know that your bodies are the shrines of the Holy Spirit, who dwells in you. And he is God's gift to you, so that you are no longer your own masters" (1 Co 6:19); and "Glorify God by making your bodies the shrines of his presence" (1 Co 6:20). The Apostle discusses these aspects of the question of Christian chastity with reference to our destiny of resurrection, which is the projection of the resurrection of Jesus Christ (1 Co 6:14).

The sacraments of *Penance or Reconciliation* and the *Anointing of the Sick* make up the so-called sacraments of health, healing, or treatment (*Catechism of the Catholic Church*, 1420ss.) because they presuppose the existence of a serious fracture in spiritual and physical health of a Christian which has taken place after baptism.

Penance seeks to restore health and aims at a "second" justification with the aim of destroying sin, whose consequence is "death," or rather the deprivation of the life of Christ on this earth, of "deification," and, in definitive terms, of the possibility of having access to the fullness of Life in eternity. The state of "death" caused by sin leads to eternal death, which afflicts the whole man unless there is conversion or reconciliation with God. Sin is connected, therefore, with a disaster (perhaps of a physical character as well) which has befallen the human person, and for this reason it is right to understand reconciliation—although it refers in a direct form to "spiritual life"—as having (despite this fact) a corporeal effect (we today would use the term "somatic"). This effect involves restoring the practical possibility of gaining access to life in Christ, whose full expression is eternal life and the glory of the resurrection.

The *Anointing of the Sick* assumes that the person who is anointed is a Christian who has already been baptized, who is still in possession of his rational faculties (which implies the capacity to have sinned, even if only venially), and who has been struck by an illness which places his life in danger, even though there is not an imminent danger of death. Here we encounter a point of special importance in studying the interrelationship linking health, grace, and life. I will return to this subject later in this paper because it requires a separate analysis all its own.

The two sacraments of *Holy Orders* and *Marriage* are seen as sacraments which aim in particular at the achieving of social order within the Christian community (*Catechism of the Catholic Church*, 1534ss). The belief that the other sacraments have only a personal dimension would involve departing from the teaching of St. Paul, who perceives the Church as the "Body of Christ" (Rom 12:5; 1 Co 10:17; 12:12; Eph 4:16: Col 2:19) and thus a community reality within which there exists a solidarity which goes well beyond a mere legal membership (LG 8 and 9). Each and every sacrament communicates graces the benefits of which are received not only by those who engage in them: these sacraments enrich and affirm the ties which exist among the members of the People of God, ties which are first and foremost those of grace and life in Christ. If the two sacraments of Holy Orders and Marriage are seen as referring to the social life of the Church, this does not exclude the fact that there is a social dimension to the other sacraments. It is a statement to the effect that these two play a special role in the sacramental structure of the Church.

The sacrament of Holy Orders transmits the succession of apostolic ministry, which ensures a certain form of the presence of Christ within the community through the exercise—in his name and not through human decisions—of the tripartite ministry of the authentic preaching of the word of the God, of presiding over the liturgical ceremony "in persona Christi," and guidance in the name of Christ of the ecclesial community. Given that the Church is in pilgrimage towards the Kingdom of Heaven, which is her fullness and completion, and given that this pilgrimage is nothing but the consequence of Christ and his growth in every Christian (Eph 3:19; 4:13), the ordained ministry is a ministry of life and salvation in which the dispensation of the ministries of God (1 Co 1:1; 2 Co 6:2), and the power to cast out evil spirits (Mk 3:15) whose action is the root of physical and eternal death (Gen 3:16-19; Sb 2:24), are inseparably bound up.

It should not be forgotten that since ancient times the Church has entrusted to ordained ministers the power to cast out the devil from those believers who have fallen under his power—this is the liturgical activity known as "exorcism." And it should also be remembered that in apostolic action towards the sick—where members of the laity can and must shoulder various kinds of responsibility—it is the specific and exclusive duty of priests to administer the sacrament of the anointing of the sick just as in the same way priests and deacons are the usual ministers of the viaticum for those who are about to leave this world.

One could also say that the Sacrament of Marriage "structures" the Church in the sense that the conjugal community reflects the bridal relationship between the Church and Christ. Christian marriage is a sacrament—that is, a reality of grace and thus of life in Christ. An essential task of Christian marriage partners is that of providing each other with mutual and loving help in their pilgrimage towards the Lord, supporting each other in a permanent form in the promotion of the ideal of holiness, which for the marriage partners must necessarily take place within

the framework of the marriage condition. And, given that holiness is synonymous with the fullness of life in Christ, it is perfectly logical to affirm that marriage is a sacrament of life which not only seeks to secure mutual support in a temporal, physical, or affective sense, but also that its fruit of grace should be necessarily understood within a context of eternal life, precisely at the "wedding of the Lamb," which is referred to in the last of the books of the Bible (Rev 21:9).

This is also to be deduced from the fine teaching of St. Paul in his letter to the Ephesians (5:21-23). Various sections from this text enable us to assert that the Apostle sees the Church as a fertile bride who, through the grace of Jesus Christ, generates children, and certainly not only at the end of her fulfillment in this world, but so that they can respond to a vocation of holiness and eternity. The role of the Christian marriage partners includes their responsibility towards their own children—a responsibility which is truly "apostolic." Children are brought into this world so that they can be children of God, parts of Christ and of his Church, temples of the Holy Spirit, and heirs to the Kingdom of Heaven—that is, so that they may have life and not only corporeal life or the life of this world, but true life, which cannot be such unless it is in Christ. It is therefore right to assert that marriage is a sacrament of the growth of the Church by the path of the natural and supernatural fertility of the marriage partners. It is a sacrament which leads to the existence of new members of the community of salvation who are called to grace and glory.

4. The Sacrament of the Anointing of the Sick

As has already been observed, the direct beneficiary of this sacrament is a Christian, and, furthermore, a baptized Christian, who has his rational faculties and is undergoing suffering which threatens his life, even though that danger is not imminent. The tradition of the Church sees old age and senility as on a par with illness. The time to administer this sacrament begins when suffering is already present and threatens physical life, even though not in an imminent or inevitable sense. It is a pastoral error and a lack of charity to delay the administration of this sacrament until the sick person is dying or near to dying, or perhaps is already in a state of unconsciousness. It is a pastoral error because this sacrament gives the grace by which the cross of illness can be borne, a cross which appears long before the immediate drawing near of death. This pastoral error is based, therefore, on an erroneous idea of the fruit and the grace of this sacrament. There is also a lack of charity which can become objectively of a very grave nature because a Christian is deprived of the sacramental graces whose fruit is precisely that of helping him to bear the reality of the illness or his old age as a form of his life in Christ.

In relation to this whole question, the *Catechism of the Catholic Church* teaches that:

"The special grace of the sacrament of the Anointing of the Sick has as its effects: the uniting of the sick person to the Passion of Christ, for his own good and that of the whole Church;

the strengthening, peace, and courage to endure in a Christian manner the sufferings of illness or old age;

the forgiveness of sins, if the sick person was not able to obtain it through the sacrament of Penance;

the restoration of health, if it is conducive to the salvation of his soul;

the preparation for passing over to eternal life." (*Catechism of the Catholic Church*, 1532).

Illness is a reality which can be ambivalent in relation to salvation. It can be experienced in intimate union with Christ in his painful Passion, in a spirit of penance and offering, and with patience and serenity. But it can also be experienced, unfortunately, in rebellion against God and even with despair and impatience, without thinking of the Passion of Christ, with doubts rather than faith or with a lack of trust in the loving mercy of God. The first of the ways of living through illness described above is that of "experiencing it in Christ" as a salvific condition, the drawing near of the end of this pilgrimage on earth with the eyes of faith resting on blessedness and the House of the Father. This experience involves overcoming the innate difficulty and the repugnance of the situation by accepting pain and death—this difficulty is rooted not only in ourselves, but can also be advanced by the action of Satan, who wants to ensure that the Christian finishes his earthly existence in a lack of trust in the love of God, refusing Him or feeling rejected by Him. This victory can be nothing else but the fruit of the grace of God, whose usual channel in the Christian economy—and because of the circumstances of the illness—is the sacrament of the Anointing of the sick.

The experience of illness or of old age reminds us of the reality which Jesus Christ took upon himself. As the Son of God he emptied himself and took on human nature in a form like ours—without, of course, the reality of sin—and humbled himself to the point of suffering death, and death on the cross. For this reason, the Father exalted him and gave him the name which is above any other (cf Phil 2:6-9). Illness and old age are humiliations which place man in front of the void and emptiness of the meaning of his independence and invite him once again to place trust in God alone. They are a painful purification which constitutes a lesson in humility written into the basic Christian doctrine of the inadequacy of merely human forces in the achievement of salvation and the victorious strength of grace, which "has power to raise up children of Abraham out of these very stones" (Mt 3:9; Lk 3:8) because "nothing is impossible for God" (Lk 1:37; 18:27).

The doctrine of the Church asserts that the fruit of this Anointing of the sick is a profound "purification" of the soul of the person who receives this sacrament (cf DS 1696). How should this purification be understood? Perhaps a comparison with the scars which are left after physical wounds have healed is appropriate for our purposes. A scar in itself is not an illness; it is not painful; and it does not develop in such a way as to threaten health. But it is not beautiful. It makes us

ugly. It is a lack of harmony and bears witness to a previous "disorder." It would be ingenuous to believe that personal sins and, above all, those which were previously a "habit" pass without leaving any traces. A strongly felt conversion which is painfully full of love may completely extirpate the consequences of sin. But feelings are not usually so strongly felt, nor so painful, nor, indeed, so full of love, and for this reason a new gift from God is necessary, a gift of grace which counters the weakness or the imperfection of the conversion—this is the gift which comes through the sacrament of the Anointing of the sick, a sacrament which produces fruit according to the approach and attitude of the person who receives it.

The sacrament of the Anointing of the sick produces certain effects in relation to the condition of the illness which is suffered and helps in enabling that illness to be suffered in a Christian way. Other effects seek to obtain that justification which it is not possible to obtain from the sacrament of Penance. Lastly, there are effects which are principally directed towards acquiring the right attitude and approach by which to enter into eternal blessedness and thereby contemplate face to face the ineffable beauty of God.

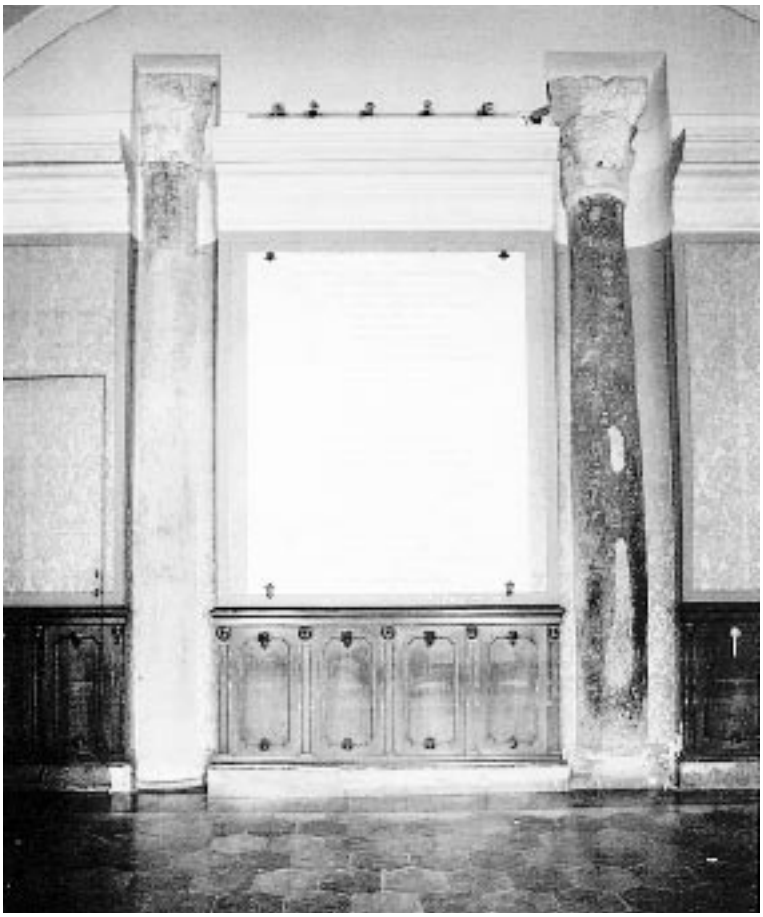
Often the illness finishes and man recovers his health. It can happen, therefore, that this Anointing is received more than once during an individual's life if an illness returns or if the illness grows worse.

For this reason Holy Anointing is also a *sacrament of life*: to live in Christ the condition of threatened physical life, to make the whole of the Body of Christ the fruit of the personal experience of the Passion, and to enter eternal life and the glory of the resurrection through a humiliation and provisional destruction of the body which is endured with the realism of faith.

The seriously ill Christian must receive the sacraments of Penance, the Anointing of the ick, and the Eucharist as a Viaticum. The Body of the risen and glorious Christ which is received in such circumstances is the pledge and the guarantee of the resurrection which awaits the Christian on the day of the Parusia, when the final enemy will be destroyed—that is, death itself (1 Co 15:26).

"This corruptible nature of ours must be clothed in incorruptible life; this mortal nature, with immortality. Then, when this corruptible nature wears its incorruptible garment, this mortal nature its immortality, the saying of Scripture will come true: 'Death is swallowed up in victory. Where, then, death, is thy victory; where, death, is thy sting?' It is sin that gives death its sting, just as it is the law that gives sin its power; thanks be to God, then, who gives us victory through our Lord Jesus Christ" (1 Co 15:53-57).

+ Most Rev. J. ARTURO MEDINA ESTÉVEZ
Pro-Prefect of the Congregation for Divine Worship and the Discipline of the Sacraments, Holy See



ROGER ETCHEGARAY

The Great Jubilee: Year of Grace, Salvation, and Health

This Twelfth International Conference, which is dedicated to the subject of "Church and Health in the World," is to be placed within the framework of our approaching the year 2000 with all its "expectations and hopes."

The opening speech, which we listened to yesterday, given by Cardinal Laghi, really opened up the road to the Jubilee, in a broad and deep way, by presenting Jesus, the Word made Flesh, as the "health and salvation of man." What could I add here after this speech? In essential terms, the grace of a Jubilee is not really so original. It merely takes advantage of an exceptional year—the transition from one millennium to another—in order to draw attention to the divine event, which in itself is very great, but which human practice has reduced to another fact, that of the birth of Christ the Savior. This has taken place to such an extent that, in a truly ignorant way. when looking forward to the year 2000, people have thought only of reserving a table at the banquet to mark this fascinating date!

It is a most positive fact that your conference underlines how health and salvation in the economy of salvation are mutually significant and rich in meaning and that, as a result, it is Christ's intention to bestow them together. A day will come when they will coincide, when death will be vanquished—death, the final enemy to be defeated. At that time glorified man will enjoy perfect happiness, a complete Jubilee, because he will be saved in a complete and overall sense.

I am thinking here of that paralyzed person from Trastevere (during the Jubilee of 1975) whom the Holy Father, Paul VI—himself immobilized by various forms of rheumatism—took into his arms and promised that one day, after the resurrection, he would dance in front of the Lord. Both of these figures must now be impatient of that day when their bones will be healthier than ever and they will dance together in happiness under the astonished eyes of the celestial court!

Church and health in the world. Ours is a curious epoch, given that the phrase "world of health" seems derogatory because it is applied to illness, the world of illness, and its prevention. Unless, that is, Dr. Knock was right when he said that every healthy person is a sick person without being conscious of the fact. Whatever the case may be, healthy people no longer dare to talk about sick people; they no longer know how to talk to those who are ill. It is almost as though these two categories lived on different planets.

What should we say, therefore, as the Jubilee of the Year 2000 approaches, to ensure that the healthy and the sick are always with and among each other, in a community of destiny where man passes from one state to another? The answer is simple. They should live together as much as possible, for each other, and through each other.

From the point of view of the healthy person, the sick person seems to be abnormal. One need only think here of the current phrase "to fall ill." Through this image of the fallen person popular wisdom emphasizes that illness is often an obstacle on the road to life because of the state of dependence and loneliness which it involves.

From the point of view of the sick person, the healthy person seems to be engaged in what is futile, immersed as he is in ambitions and chimeras which he pursues with anxiety. He sees us as being the wrong way round and inside out, and this is a call to those who live on the surface of things to move towards what is profound; it is a call to prayer directed towards those who become dizzy in action.

The great Jubilee must be an opportunity to understand the role of

suffering in the lives of men and Christians. The Church does not canonize suffering—to fight against suffering is also a duty and we should praise those wise people who help to reduce suffering without impinging upon the lucidity of sick people. The only reason why a disciple endures suffering is because his Master underwent it at the outset. "Christ did not come to explain suffering; he filled it with his presence," declares Paul Claudel. He alone can really communicate with those who suffer. We can do nothing but keep quiet or merely point out with our fingers the "Holy Face" of the Crucified One. All the rest is indecency and insolence. During this first year of preparation for the Jubilee, which concentrates upon the person of Christ, how many times have we ourselves carried out what was done by Saint Veronica?

The great Jubilee must also be an opportunity to ensure that the "world of health and health care" is a place which is radically missionary in character and thus a special field for evangelization. Because it is here that in a crucial way we encounter the mystery of man in his most precarious of conditions, and perhaps the most scandalous of them all—that of his suffering.

It is a place where men mobilize themselves to struggle against illness, against being in a bad state. This has been done through some very impressive achievements, without, however, managing to knock down the wall of death.

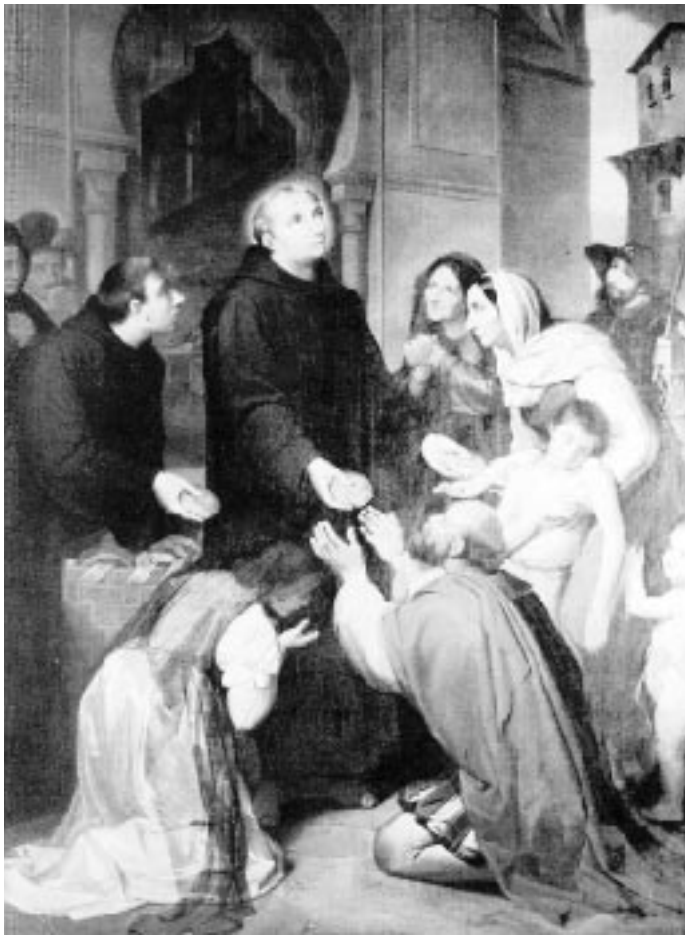
It is a place of coexistence where men (both patients and those who provide treatment and care) from every cultural and religious context train themselves in a face-to-face struggle against evil. But at the same time it is a place where social conflicts become exacerbated.

It is also a place where the question of the real meaning of life and its nonmaterial rewards is raised with the greatest clarity. I am thinking here of that father from Marseilles who showed me his Down son and said, "For God, minor-league people do not exist."

Yes, indeed: the "world of health" is really a field where we can prepare for the great Jubilee and celebrate the great Jubilee, and this is because in that field there strongly resound all the expectations and hopes of mankind, which now finds itself in a state of excitement and in search of health as the year 2000 looms on the horizon. In a very deep sense I would like to thank His Excellency Archbishop Lozano and all those who work with him.

His Eminence ROGER
Cardinal ETCHEGARAY,
Chairman of the Committee
for the Great Jubilee of the Year 2000,
the Holy See

Round Table



Health, Illness, and Healing in the Major Religions

MICHAEL FUSS

Health, Illness, and Healing in the Great Religions

1. Buddhism

Probably none of the great religions has dedicated so much attention to the question and subject of health as Buddhism. The medical concept of *dukkha*—that is, pain—was the point of departure for a penetrating analysis of human existence which led the contemporaries of Buddha to hail him as the "supreme physician." Without mental and physical health it is not possible to lead a sound life. Despite the fact that every healthy body is destined to fall ill and to die, it remains true that without the positive value of health the condition of suffering and impermanence cannot be overcome. Genuine physical and mental health is obtained through an assiduous practice of morality (*sîla*), where body and mind act in perfect harmony. Given that Buddhist morality does not distinguish between "good" and "evil," but instead emphasizes behavior relating to health (*sappâyakiriyâ*) with a view to obtaining the neutralization of *karma* (that which does not engender salvation), health in an overall sense is considered of the highest possible value: "Health is the greatest of goods" (*ârogyaparamâ lâbhâ*).[1] A modern Buddhist writer has linked this statement to that call for "a standard of living suitable to the health and well-being of a man and his family" which is to be found in the *Universal Declaration of Human Rights* of 1948.[2]

One of the essential preconditions for obtaining enlightenment was expressed in the principle of *mens sana in corpore sano*. As a result of an ascetic life among the masters of the forests which was too severe in character, Gautama Sakyamuni became so physically weakened and so debilitated that he was not able to obtain mental serenity. He detached himself from extreme asceticism—in the same way as he had previously moved away from a life of luxury—and proclaimed, instead, "the middle way." He argued that this was the natural precondition for the spiritual life because the path of salvation requires a healthy and robust body. He himself regained his physical strength by eating rice mixed with honey and milk—a diet which he subsequently recommended to his monks for its therapeutic qualities.

"[Rice with milk and honey] confers ten things on the monk:
Life and beauty, ease and strength;
For him intelligence arises from it.
It dispels hunger, thirst, and wind,
It cleanses the bladder, it digests food;
This medicine is praised by the well-farer."[3]

A section from *Anguttara-Nikâya* (II, 143)[4] states that there are two kinds of illness, physical illness and spiritual illness. Whereas man can enjoy physical health for a hundred years, it is difficult to find an individual who has not had spiritual illness for at least a moment. The Buddha drew up a list of the four principal spiritual illnesses which afflict monks—greed, vexation, and discontent with life, all of which lead to a desire for esteem, gain, honors, and fame. In the search for such things the monk enters into a state of vanity and with such impure intentions might go to call on families and preach the dharma. The Buddhist path, which is based upon an analysis of "sustenances" (*âsava*) which give rise to these illnesses, leads on to a healthy and serene life through their destruction.

> "After recognizing this misery that 'pain is born from dependence on sustenances, through a clear understanding of all the sustenances, freed from all the sustenances, the wise man who has well understood that health depends upon a dissolution of the *âsava* which is carried out with decisive diligence in the Doctrine cannot be defined with a name."[5]

The Buddha believed that illness took place within a psychosomatic dimension and was the fruit of a previous karma whereby man was imprisoned by an attachment to illusions. As the body is a "coagulated karma," medical treatment not only eliminates the illness, but also creates the necessary orientations to advance along the path which leads to enlightenment. The problem of physical health, therefore, can only be addressed within the context of overall health.

Healing as an Analogy of Salvation

In his great compassion for the suffering of living beings, the Buddha presents his truth as a therapy which involves the whole physical-mental complexity of his followers, and his analysis of the existential condition of man as expounded in the *Four Noble Truths* follows a method of precise medical analysis. The "everything is dukkha" diagnosis of illness in the first truth is based upon an analysis of its origins, which are located in the "thirsts" (*tanha*) of desires (the second truth). Then healing (the third truth) is aimed at, lastly, at recommending a treatment which consists

of the practice of the "eightfold path" (the fourth truth):

> "It is necessary to see the truth of pain as an illness, the truth of the origins of pain as a cause of illness, the truth of the extinction of pain as the healing of illness, and the truth of the path as medicine."[6]

Some authorities even detect an analogy between this analysis of life and the ancient medical science of *Ayurveda*, with its four divisions: illness (*roga*), the cause of illness (*roganidâna*), the cure for illness (*roganivârana*), and the application of medicine (*tikicchâ*).[7] In the great utopia of *Milindapañha*[8] on the *City of the Law* reference is made to the medicine of the enlightened one, who offers bitter treatment to achieve liberation from the cycle of *samsâra*. Taken as a whole, the hard and severe spiritual transformation is likened to recovery from illness:

> "As if a man were a prey to disease, in pain, and very ill, and his food would not digest, and there were no strength left in him; and after a time he were to recover from that disease, and his food would digest, and his strength come back to him; then...he would be of good cheer at that, he would be glad of heart at that."[9]

The Buddha explains the process of reawakening in the parable of a man wounded by a poisoned arrow who then has to undergo a painful surgical operation. He compares the wound to the field of passions, the poison to ignorance, the arrow to desire, the exploration of the surgeon to knowledge, his knives to noble wisdom, and the Buddha himself takes on the role of the doctor and the surgeon.[10]

The Buddha allows his monks to use many traditional medicines and cures (a long list is to be found in *Mahavâgga*, VI). Generally, however, medical treatment is always subordinated to spiritual exercises. The ascesis of the monk requires the treatment of health, and this is also seen as testimony to the compassion and benevolence of the Buddhist community. The monks can give advice to secular people, but health care and treatment can never become a means by which to obtain alms and must not develop into a source of distraction from spiritual life. In general, the specific treatment of illness, involving such elements as hospitals, clinics, and rest homes, is entrusted to the generosity of secular people or to public authorities. The monks are thus to concern themselves with providing spiritual help.

In ancient times the practice of medical science became a useful way of propagating the Buddhist dharma,[11] and this was especially true in the world of Chinese Taoism, with its practice of alchemy. It was also a means by which to spread the principles of Indian medicine within the various cultures of the time. When we come to survey the work of Buddhist rulers, it may be observed that the Emperor Asoka (the third century BC)[12] prescribed in his second work both medical treatment for men and for domestic animals and the cultivation of medicinal plants for such treatment. Over the centuries many other Buddhist kings in the countries of Theravâda and Mahâyâna have followed his example and all have obeyed Nâgârjuna's exhortation to his king: "Enable the blind, the sick, the humble, the unprotected, the destitute, and the crippled—all equally—to obtain food and drink without omission."[13]

The Paritta: The Practice of Positive Thought

The frequent recital of the *paritta* (in Singhalese the term employed is *pirit*),[14] a collection of twenty-four canonical texts which ward off mental and physical illness, is still widely practiced in popular Buddhism. Acting on a belief in the inherent force of the melodious reciting of sacred formulas, an attempt is made to unblock every mental closure of the patient and to activate the healing powers of his subconscious. A concentration upon positive values not only induces such feelings, but also eliminates a contrary, negative attitude. This is not a magical automatism, but a trusting openness to the truth of the words of Buddha.

> "The *paritta* protects these, but not the others. There are three circumstances in which the *paritta* does not offer protection: an impediment caused by nonsalvific actions (*kamma*), an impediment caused by mental clouding (*kilesa*), and lack of trust. The *paritta*, because it is a protection of beings, loses its protective action as a result of the actions of these same beings."[15]

A readiness to open oneself to the operation of positive realities means, in the final analysis, to open oneself in trusting fashion to the unconditional compassion of the dharma of which the Buddha is the bearer. An awareness of mutual interdependence (*pratîtya-samutpâda*) enables the individual to allow himself to be penetrated and to be fully cured by spiritual joy and happiness. It is within the context of this radiation of universal compassion that we should also understand the frequent invocation of the faithful which is taken from the *Metta-sutta* (Love Sûtra): "Let all beings be happy, with a contented spirit!"

Compassion in the Mahâyâna

In the Mahâyâna two aspects of health emerge from a study of the figure of the Bodhisattva ("king of the doctors," *bhaisajya-râja*) and the hypostasis of universal compassion, which is expressed in the female divinity Kuan-yin. The Bodhisattva who offers himself for the salvation of everyone is seen in the Lotus Sûtra (*Saddharmapundarîka-Sûtra*) as a vase which contains the medicine of the dharma which heals the multitude. Here we encounter the model of the religious teacher who is to be found engaged in his task.

> "If a man is to preach this scripture, he should enter into the room of the Thus Come One, don the cloak of the Thus Come One, and sit on the throne of the Thus Come One... Great compassion is the room, tender harmony and endurance of insult, the cloak, while the emptiness of the dharmas is the throne; making these his home, he preaches to the multitude."[16]

In the parable of the physician, the Lotus Sûtra describes the role of the Buddha as a useful means (*upâya*) by which to achieve salvation. As the spokesman of the dharma, the Buddha sees himself as the universal physician who strives to heal his children by every means possible, even to the point of feigning his own death. The gradual reawaken-

ing of men is compared to the process of healing, and appropriate medicines correspond to their various dispositions: "Seeing the precariousness of the agonies of his children, the father tried the various herbal medicines of his books, which were rich in colors, perfumes and tastes, together with prescriptions."[17] The historical event of the Buddha, his enlightenment, preaching, and death, were a medicine for the healing of the world. And thus it is that physician and medicine coincided in the achievement of salvation.

The figure of the Bodhisattva Avalokitesvara—"he who hears the cry of the world"—has become a hypostasis throughout Asia for the infinite compassion and consolation of the Buddha and is intensely venerated by the people as a help for every affliction. Represented in iconographical terms as Kuan-yin (Kwannon) and thus portrayed as a woman, his thousand arms and thousand eyes express his ability to see and to distance every evil: "The pains of birth, of old age, of illness and of death will be gradually reduced."[18]

In the *Vîmalakîrtinirde-a-sûtra* the wise man Vimalakîrtu takes advantage of a feigned illness to preach on the subject of the precariousness of the human body.

> "The body, which cannot be grasped, is like a ball of foam. The body, which does not last for long, is like a bubble of water. The body, arisen from the thirst of passions, is like a mirage.... The body, which perishes instantaneously and is unstable, is like a flash of lighting. The body, born of multiple conditions, has no master."[19]

Illness reveals the impermanent nature of earthly existence and Vimalakîrti endures it in an approach which aims at the salvation of all men. The noble figure of the Bodhisattva is present in this enlightened secular individual. In his altruism he takes upon himself the suffering of others as a means by which to achieve general salvation. Because he himself is ill he is at one and the same time both a model for health-care workers and also illustrates the mutual relationship between the patient and those who are responsible for his treatment:

> "As long as beings are sick, I myself will also be sick; when beings recover, I also shall recover. And why? For Bodhisattvas, the realm of the round of rebirth lies in beings, and sickness rests on this round of rebirth. When all beings have escaped the pains of this sickness, then Bodhisattvas also will be free of sickness. For example, if the only son of a guildsman falls sick, his father and mother would also both fall sick. As long as this only son does not recover, his father and mother will also both continue suffering. Equally, a Bodhisattva who cherishes beings as his only son is sick when beings are sick, and is free of sickness when they are free of sickness. You asked me where my sickness comes from: in a Bodhisattva sickness arises from great compassion" (*mahâkarunâ*).[20]

Through the experience of their own illness, those who care for the sick must aim to achieve a change in the attitude and approach of patients. Illness should no longer be seen as an evil destiny but as a positive opportunity by which both patients and doctors can achieve salvation. However, infirmity should not provoke the wish for nirvâna in a strictly individual sense, but rather a desire for solidarity among all men. This awareness of universal pain should bring about that active readiness to help others which is compassion. For this reason, Vimalakîrti suggests that the health care worker should engage in spiritual forms of treatment and care.

> "He exhorts him to use his own sickness to have pity on sick beings and drive away their sickness. He exhorts him to recall sufferings previously undergone to promote the welfare of beings. He exhorts him to recall the countless good roots already nurtured for practicing a pure life. He exhorts him not to fear, but to give himself over to vigor. He exhorts him to pronounce the great vow to become the king-physician who heals all beings and definitively appeases the sickness of body and mind."[21]

Contemporary Buddhism

Contemporary Buddhism translates these doctrinal tenets into practical works of medico-spiritual assistance which aim to secure the healing of man. In recent years the effective network of "Engaged Buddhists" has been set up, and this movement is present in a variety of contexts marked by major tensions and difficulties in Asia and the whole world. This movement seeks to apply the spirit of knowledge and wisdom to sociopolitical structures whose injustices and forms of alienation form part of the influences working on *karma*, and strives both to lighten the physical and mental afflictions of the poor and the marginalized and to offer an alternative therapy to the rich West, which is itself today suffering from an anaemia of spiritual values. One of the intentions (and also the attractiveness) of the silent mission of Buddhism in the West is the creation of environmental conditions which work for the health of our world. "Being peace" is therefore the necessary precondition for working for the achievement of spiritual, mental, and physical health.

Just as the young Prince Gautama, the future Buddha, when he addressed the world in his famous "four exits" from the royal palace, encountered a sick man, an elderly man, and a dead man, and developed a profound vocation for the religious life, so at the present time Buddhists recognize the need which exists to penetrate the immense ocean of suffering with the halo of effective charity as a path to illumination.

In India there has been an immense reawakening of Buddhism since Dr. B.R. Ambedkar began his social movement and directed and organized it along the lines of Christian charitable initiatives and the activity of the Hindu Ramakrishna Mission. The struggle for human rights, and, in particular, medical care and educational programs, forms part of the Self-Education Movement, which was created in Thailand by the lay Buddhist, Sulak Sivaraska:

> "The suffering of the present day, such as that brought about at Bhopal and Chernobyl, should move many of us to think together and act together to overcome such death and destruction, to bring about the

awakening of mankind."[24]

Through a capillary system of family units the secular movement of the Risshô Koseikai in Japan promotes health care and social assistance among its members. In a similar way, the Won Bulgyo of Korea has established a network of healthcare facilities. The coherence of spiritual witness practiced within industrial society is undoubtedly something which has a very great appeal.

In addition to promoting cooperation between Buddhists and Christians in many areas where suffering is present, these new liberation movements within contemporary Buddhism have also discovered a new hermeneutic key by which to translate doctrinal traditions into charitable activity. Where there is an identification of the founders of these religions with the suffering and tribulations of humanity—as is present in the following poem from the Indian Dalit Buddhists—there is without doubt the basis for a shared religious responsibility towards the suffering of our time (cf. also Mt 25:31-46 and Vin. I. 301: "Whoever wishes to take care of me should take care of the sick")[25]:

> "Siddhartha, never do I see you in the Jetavana sitting in the Lotus position.... I see you speaking and walking among the humble and the weak, soothing away grief in the life-threatening darkness.... Today you wrote a new page of the *Tripitaka*. You have revealed the new meaning of suffering which, like an epidemic, swallows life's blood."[26]

Rev. MICHAEL FUSS
Professor of Buddhism,
The Pontifical Gregorian University,
Rome

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Notes

[1] *Dhammapada,* 204; cfr. *Majjhima-nikâya,* I 508ss.

[2] Articolo 25; L.P.N. PERERA, *Buddhism and Huuman Rights,* Colombo: Karunaratne 1991, 101.

[3] *The Book of Discipline (Vinayapitaka),* vol. IV (Mahâvagga), traduzione di I.B. Horner, London 1951, 302: "[Conjey] confers ten things on the monk: Life and beauty, ease and strenght; For him intelligence arises from it. It dispels hunger, thirst and wind, it cleanses the bladder, it digests food; This medicine is praised by the well-farer".

[4] "Monks, there are four diseases of one who has gone forth (from the worldly life). Here, monks, we may have a greedy one, full of vexation, discontent with this or that supply of robe and alms-food, lodging, seat, medicines and requisites for sickness. He, being greedy…, conceived an evil longing for consideration, for gain, honorous and fame".

[5] Suttanipâta, 748s: *Raccolta di aforismi,* tradotto da V. Talamo, Torino, Boringhieri, 1979. ["Who knows this bane: 'Ill's caused by sustenance', perceiving sustenance, with trust in none, with cankers quenched, health by right knowledge won, discerning follower in Dharma poised, that lore-adept goes to what none can sum".].

[6] BUDDHAGHOSA, *Visuddhimagga, XVI,* qui citato da Nyanatiloka, *Der Weg zur Reinheit,* Konstanz, 1985, 596.

[7] Ch. ELIOT, *Hinduism an Buddhism,* I. London, 1921, 100.

[8] *Milindapañha. Die Fragen des Königs Milinda,* (tradotto da Nyanaponika). Interlaken, 1985, 300.

[9] *Sâmañña Phala Sutta* 70; tradotto da E. Frola, *Canone Buddhista. Discorsi lunghi,* Torino, UTET, 1967, 86. [T.W.RHYS DAVIDS (tr.), *Dialogues of the Buddha,* vol. 1 London, PTS, 1977, 83: "As if a man were a prey to disease, in pain, and very ill, and his food would not digest, and there were no strenght left in him; and after a time he were to recover from that disease, and his food should digest, and his strenght come back to him; then, …he would be of good cheer at that, he would be glad of heart at that".].

[10] *Majjhima-nikâya,* II 216s; II. 260; in I.B. Horner (tr.), *The Middle Lenght Sayings,* vol. III. London, PTS, 1977, 5; 44.

[11] E. ZÜRCHER, *The Buddhist Conquest of China,* Leiden, 1972.

[12] M. FUSS, A–oka, in: Id. et al, *Le grandi figure del buddhismo,* Assisi, Cittadella, 1995, 112.

[13] NAGARJUNA, *La ghirlanda dei gioielli [Ratnâvalî];* qui citato da R.A.F. Thurman, Nagarjuna's Guidelines for Buddhist Social Action, in F. EPPSTEINER (a cura di), *The Path od Compassion? Writings on Socially Engaged Buddhists,* Berkeley CA, Parallax, 1988, 139: "Cause the blind, the sick, the humble, the unprotected, the destitute, and crippled, all equally to attain food and drink without omissioni".

[14] PIYADASSI THERA, *The Book of Protection,* Kandy, BPS, 1975.

[15] *Milindapañha,* IV, 2., op.cit., 169.

[16] Lotus Sûtra X, 10 G 23s; L. Hurvitz (tr.). *Scripture of the Lotus Blossom of the Fine Dharma.* New York 1976, 181: "If a man is to preach this scripture, he should enter the room of the Thus Come One, don the cloak of the Thus Come One, and sit onthe throne of the Thus Come One… Great compassion is the room, tender harmony and endurance oof insult the cloak, while emptiness of the dharmas is the throne: making these his home, he preaches to the multitude"; Cfr M. FUSS, *Buddhavacana and Dei Verbum,* Leiden, E.J. Brill, 1991.

[17] *Ibid.,* XVI, 5.10.

[18] *Ibid.,* XXV, 20 G 19.

[19] *Vimalakîrtinirde–a,* II 9; traduzione di R. Gnoli, *Testi Buddhisti in sanscrito,* Torino, UTET, 1983, 189s. [S. Boin (tr.), *The Teaching of Vimalakîrti,* London: PTS, 1976, 34: "The body, which cannot be grasped, is like a ball of foam. The body, which does not last for long, is like a bubble of water. The body, arise, from the thirdt of the passions, is like a mirage. …The body, which perishes instantaneously and is unstable, is like a flash of lightning. The bosy, born of multiple conditions, has no master".].

[20] *Ibid.,* IV, 6-7. ["As long as beings are sick, I myself will also be sick; when beings recover, I also shall recover. And why? For Bodhisattvas, the realm of the round of rebirth, this is beings, and sickness rests on this round of rebirth. When all beings have escaped the pains of this sickness, then Bodhisattvas also will be free of sickness. For example, if the only son of a guildsman falls sick, his father and mother would also both fall sick. As long as this only son does not recover, his father and mother wll also both continue suffering. Equally, a Bodhisattva who cherishes beings a his only son is sick when beings are sick, and is free of sickness when they are free of sickness. You asked me where my sickness comes from: in a Bodhisattva sickness arises from great compassion"].

[21] *Ibid.,* IV, 10. ["He exhorts him to use his own sickness to have pityon sick beings and drive away their sickness. He exhorts him to recall sufferings previously undergone to promote the welfare of beings. He exhorts him to recall the countless good roots already nurtured for practising apure life. He exhorts him not to fear, but to give himself over to vigour. He exhorts him to pronounce the great vow t become the great king-physician who heals all beings and definitively appeases the sickness of body and mind".].

[22] Cfr. C. S. QUEEN, S. B. KING (a cura di), *Engaged Buddhism,* Albany NY, SUNY, 1996.

[23] THICH NHAT HANH, *Essere pace,* Roma, Ubaldini, 1989. L'autore fa parte dei "buddisti impegnati".

[24] SULAK SIVARAKSA, *Buddhism in a World of Change,* in: F. EPPSTEINER, *op. cit.,* 9: "The suffering of the present day, such as that brought about at Bhopal and Chernobyl, should move many of us to think together and act together to overcome such death and destruction, to bring about the awakening of human kind".

[25] "Whoever wishes to take care of me should take care of the sick"; VINAYA PITAKA I. 301f. I.B. Horner (tr.), *The Book of Discipline,* 6 vols. London: PTS 1938-1966.

[26] Come citato in A. PIERIS, *Love Meets Wisdom,* Maryknoll NY, Orbis, 1988, 129: "Siddharta never do I see you in the Jetavana sitting inthe Lotus positions… I see you speaking and walking among the humble and the weak soothing away grief in the life-threatening darkness…Today you wrote a new page of the Tripitaka. You have revealed the new meaning of suffering which like an epidemic swallows life's blood".

MARIASUSAI DHAVAMONI

II: Hinduism

Introduction

Medicine was the most important of all the physical sciences whch were cultivated in ancient India. The literature on medicine contains many interesting ethical instructions and reveals a view of life which differs considerably from those contained in philosophical works. Again, those who are interested in Hatha Yoga[1] or Tantra physiology or anatomy[2] in relation to some of the yoga practices will find very useful the speculations of medical schools on these subjects. Their speculations on embriology, heredity, and other such points are likely to interest those who deal with medicine and healing.

Ayur-Vedic Medicine[3]

Ayur Veda[4] is the science of life in ancient India. It is considered an ancient science for there were always people who knew about life, and there were always medicines which acted on the human body according to principles laid down in the Ayur Veda. The Ayur Veda is even considered as superior to other Vedas because it gives us life, which is the basis of all other benefits[5]. Both the Atharva Veda and the Ayur Veda dealt with the curing of diseases and the attainment of long life: the first principally by incantations and charms while the second by medicines. Ayur Veda treats of eight subjects: surgery, treatment of diseases of the head, treatment of ordinary diseases, the process of counteracting evil influences of evil spirits, treatment of child diseases, antidotes to poisons, the science of rejuvenating the body, and the science of acquiring sexual strength. There is a theory that by wind, bile and mucus the body is sustained and that by their decay also the body decays.

Life is divided by Caraka into four kinds: happy, unhappy, good and bad. Happy life is the one which is not affected by bodily or mental diseases, is endowed with vigour, strength, energy, vitality, activity, and is full of all sorts of enjoyments and successes. The opposite of this is the unhappy life. Good life is the life of a parson who is always willing to do good to all beings, never steals others' property, is truthful, self-controlled, self-restrained and works with careful consideration, does not transgrees the moral injunctions, takes to virtue and to enjoyment with equal zeal, honours revered persons, is charitable and does what is beneficial to this world and to the other. The opposite is the bad life. The scope of the science of life is to teach what is conducive to all these four kinds of life and also to determine the length of such a life[6]. The Atharva Veda deals with the treatment of diseases by advising the propitiatory rites, offerings, auspicious oblations, purificatory rites, fasting, and incantations.

Thus we see the connection between the Atharva Veda and the Ayur Veda.

It is interesting to note that the medical practitioners of ancient India went about from place to place (carana-vaidya) and that the sufferers on hearing of the arrival of such persons approached them and sought their help. At the time of the Atharva Veda the practice of pure medicine had been going on. The God Prajapati appears to be the original teacher of the science of life (Ayur Veda) and had learnt this science from Brahma the Creator. Diseases and their symptoms were cured by medicine of various kinds. The Atharva Veda itself mentions only a few medicines which are to be used as amulets for protection not only from certain diseases but also from the witchcraft of enemies. The effect of medical herbs was of the same miraculous nature as that of mere charms or incantations. They did not operate in the manner in which prescribed medicines in the ordinary medical literature acted, but in a supernatural way.

Analysis of the Human Body

The human body is the modification of the five elements, ether, air, fire, water and earth and is the seat of consciousness (cetana). The foetus cannot be produced simply by the union of the semen of the father and the blood of the mother. Such a union can produce the foetus only when the atman with its subtle body, constituted of air, fire, water and earth, and manas (mind, the organ of perception and thought) becomes connected with it by means of its karma. The mental traits of the individual are determined by the state of mind of the individual in its previous birth.

If a healthy man wishes to keep up his health at the normal level, he has to eat things of different tastes without an excess of any particular kind of substance in the body. Diseases are caused through excessive, deficient, and wrongful ad-

ministration of sense-objects, heat and cold, and the misuse of intelligence. The sight of objects with powerful light, the hearing of very loud sounds, the smelling of very strong odours, too much eating, the touching of too much cold or heat, too much bathing or massage are examples of excessive association with sense-objects. There can be also deficient association with sense-objects. The principle of growth and decay is seen in the maxim that the different constituents of the body grow when articles of food having similar costituents are taken and that they decay when aricles of food having opposite qualities are taken.

The qualities of the body are of two kinds: those which sustain and purify the body (prasada) and those which make the body decay and foul (mala). The air (vayu), bile (pitta), and phlem (kapha) may become more or less than their normal measure; they tend to weaken or destroy the body. These three are finally responsible for all kinds of sickness of the body. The most vital centres of the body are the head, the heart and the pelvis. The vital current and all the senses are said to depend on the head. The difference between the head and the brain was known already in the Atharva Veda[7]. The heart is the vital centre of the pranas (vital breaths) and of the manas (mind).

The theory of tastes (rasa) plays an important role in the Ayur-Veda in the selection of medicines and diet and in diagnosing diseases and arranging their cures. Taste is that which could be perceived by the organ of the tongue and it is one, i.e., that of water. They are listed as sweet, sour, salt, hot, bitter, pungent, alkaline, and so on. Water is the origin of all tastes (rasa). All substances, animate or inanimate, are to be considered as medicines, provided they are applied in the proper way and for specific purposes.

Good Life

Good life does not mean only an ethically virtuous life but a life which is free from diseases, and which is so led that it attains its normal period of life. It is wise and prudent life. Lack of wisdom and prudence is the cause of all physical, social, physiological, moral and spiritual evils. Physical diseases are to be cured by medicines and mental diseases are to be cured by right and proper knowledge of things, self-control and self-concentration. There is a close interconnection between body and mind. Out of the body arise the mental disaeses, and out of the mind arise the bodily disease[8]. The physician should try to cure not only the bodily diseases but also the mental diseases.

When the three elements in the body, heat, cold and air are in a state of equipoise, the body is healthy; when any one of them predominates, there is disease. The mind is constituted of sattva (goodness), rajas (activity) and tamas (passivity); when they are in a state of equipoise, the mind is in proper order; when any one of them predominates, the mind becomes diseased. It is the welfare of both the mind and body that is the concern of the physician.

Ayur Veda speaks of primarily the ways in which a life may be good (hita), bad (ahita), happy (sukha) or unhappy (asukha). A happy life is that which is undisturbed by bodily and mental diseases, full of youth, and proper strength, vitality, energy, making new efforts, endowed with wisdom, knowledge, and efficient sense-organs, a life full of good enjoyments, and successful undertakings. The opposite in the unhappy life. The fundamental idea of good life is that a life should be so regulated that the body and mind may be free from diseases, that is should not run into unnecessary risks of danger through carelessness, that it should be virtuous, pure and moral. It should tend to the good of life, body, mind and spirit.

Medical Yoga

The most popular of all traditional forms of yoga is the Hatha Yoga whose object is to achieve complete control over the physical organism. Originally the Hatha Yoga was meant to prepare the body for spiritual development. The value of physical yoga lies in its immediate physical effects: increased bodily fitness, suppleness, and relaxation. Physical benefits of Yoga are listed as follows: to feel physically more alert and fit; lose excess fat, to gain bodily suppleness; to feel more relaxed; to learn breathing control or easier breathing; relief from various ailments, from indigestion, stomack trouble, constipation, etc.; to sleep better and more restful. Mental Yoga has its benefits worth mentioning: calmer outlook, mental relaxation, better power of concentration and mental control, more self-confident, cheerful, and more efficient in physical and mental work.

Many physical ailments are brought about by subconscious activity and tension. Fear or tension dynamically seizes the mind, setting up irritations that manifest themselves as sickness. Modern medicine accepts this fact. Serious illnesses can be stimulated by mental suggestion and inner tension. Medical doctors can begin the healing work but the patient himself must co-operate and realize that healing take place *with himself*. Yogic concentration is a medicine to be self-administered. It requires some personal effort. It asks the sick to "focus" on something remote from their illness at a time when the latter is a subect of absorbing habitas; by it we can make something new of our present lives and something different of our future prospects. By altering our attitudes here and now, we also exert a direct influence on our future. We can practise this concentration by focussing our thought on one point, on one definite object. When we apply concentration by fixing our attention on one significant object, we developed in course of time mental control of a new order. And this goes a long way to foster posivite thinkning and healty outloon on our life. What the nmind dwelles on the mind becomes. As a man thinks in his heart, so is he.

Yoga and Long Life.

It is natural for the artery walls to harden with advancing years.

But one can reduce the pace at which they harden. The breathing exercises of Yoga can help the properly oxygenated blood. Again, cell growth in the body diminishes with advancing years. Air, relaxation and exercise have much to do with aging. The harmony of body and mind can be kept by the Yoga exercises. Apart from aging, the up-keep of general good life is maintained by the Hatha Yoga. Hatha Yoga is a form of Yoga which consists of the regulation of breathing and other bodily disciplines or training. Hatha Yoga is an almost necessary prelude to the discipline of the mind (Raja Yoga). The object of Hatha Yoga is to achieve complete control over the physical organism.

Laya Yoga is that system of Yoga in which the chief emphasis is laid upon awakening and directing the latent force of the Kundalini10, which normally sleeps at the base of the spine. It is a force described as lying coiled up like a serpent (in three coils) in a cavity near the base of the spine. It lies with its head blocking a fine channel which goes straight up the spine and is called Sushumna. In the Laya Yoga it is awakened and proceeds up the channel on which six Chakras are threaded. The six chakras are: muladhara, at the base of the spine, near the anus; Swadhisthana, at the level of genital organs; Manipuraka, at the level of the navel; Anahata, at the level of the heart; Vishuddhi, at the level of the throat; Ajna, at the level of the eye rows. Some modern scholars have associated these chakras with important nerve plexuses in the body.

Normally there is a certain amount of Kundalini force always flowing up the channel, but when more is awakened, and the chakras are alerte thereby, there can be an enhancement of the sensitiveness of the senses and the powers of action, amounting to clairvoyance, clairaudience, etc.

The characteristic material and sensations are: earth and smell, water and taste; light and sight; air and touch; ether and sound; and finally mind.

A comparison can be made with the respective principles of human activity as follows: body, desires and emotions, lower or objective mind; moral and ethical nature; the will; and the higher mind.

Far more important, from the medical point of view, are the 'real' powers obtained by the yogins, especially their astonishing ability to control the neurovegetative system and the influence they are able to exercise on their cardiac and respiratory rhythms. In the case of the pumping and expulsion of liquids by urethra, it is believed that the phenomenon can be explained by insufflation of air into the bladder.

Though the Hindus have an elaborate system of scientific medicine, they also developed theories of mystical physiology in dependence upon their objective and utilitarian medicine or at least in connection with it. Subtle physiology was probably developed on the basis of ascetic, ecstatic and meditative experiences expressed in the same symbolic language as the traditional cosmology and ritual.

Al-Biruni in his description of India gives an account of the connections of alchemy with long life and the restoration of youth. "They (Hindus) have a science similar to alchemy which is quite peculiar to them. They call it Rasayana, a word composed with rasa, i.e., gold. It means an art restricted to certain operation, drugs and compound medicines, most of which are taken from plants. Its principles restore the health of those who were ill beyond hope, and give back youth to fading old age, so that people become again what they were in the age near puberty; while hair becomes black again, the keenness of the senses is restored as well as the capacity for juvenile agility, and even for cohabitation, and the life of people in this world is even extended to a long period. And why not? Have we not already mentioned on the authority of Patanjali that one of the methods leading to liberation is Rasayana?".

Diseases and Medicine

From the time of the Atharva Veda, various kinds of diseases have been known and cures have been suggested. Fever, diarrhoea, diabetes, glandular sores are mentioned. A string made of munja grass is to be tied; the mud from a field or ant-hill is to be drunk; clarified butter is to be applied and the mouth of the sores tobe aerated with a leather bladder. For dropsy a jugful of water containing grass is to be springled over the body of the patient. For all diseases arising from disturbance of wind (vata), bile (pitta), phlem (slesman), fat, honey, clarified butter or oil have to be drunk. In the case of injuries a handful street dust is to be thrown on the place of injury or a bandage is to be tied with sticky mud.

Against heart disease and jaundice, hairs of a red cow are to be drunk with water and a piece of a red cow's skin is to be tied as an amulet.

In general several kinds of diseases are mentioned; those of the head, diseases of the abdomen, navel, heart, diseases of the spine, the ribs, the eyes, the intentines, diseases of the leg, knee, pelvis, and veins. Diseases are divided into three classes: those produced by water, by wind, and by fire, (those which are dry). Some of the cures above proposed are charms with a curative value. In addition to the charm and amulets, and the herbs which were to be internally taken, water was considered to possess great medical and life-giving properties. The medical properties of herbs were often regarded as being due to water, which formed their essence.

All substances are composed of five elements: earth, air, water, fire and ether. All substances, whether

inanimate or animate, are to be considered as medicines provided they are applied in the proper way, and for specific purposes. A particular substance is medicine only when it is applied in a proper way and for specific purpose. The medicative influence is exerted both by virtue of the specific agency of a substance and by the specific agency of its qualities, as also by their joined influence.

Healthy Practices of the Hindus

Prevention is better than cure. Hence the Hindus take many precautions to keep good health and physical fitness. The health principles described already in the Manu Sastras are instructive. 1) A daily walk to a distance in the cool bracing atmosphere of the early morning is very invigorating.

It stimulates the appetite and ensuree a certain amount of rest and relaxation, and renders one better fitted for the day's work. 2) A regular attempt at answering the calls of nature in the morning helps prevent constipations; also other diseases such as piles, dysentery, liver troubles, etc. can be prevented by this practice. The human body is prone to all ills and germs which cause sickness. One has to take care of one's body to be free from germs of this kind. Epidemics such as cholera, typhoid, fever, dysentery are known to spread through water and food. Epidemics occur when the character of the seasons changes and medicinal herbs and water become impure. Hence we have to use only pure water and pure herbs. Fresh air increases health and long life. Fumigation by the burning of incense and performance of homa add considerably to the value of the general disinfection. Only after such purification should one assemble in groups to dine or mix with one another. Two kinds of pollution are observed: one in the case of death and the other in the case of birth. On these occasions there can be disease or germs of disease that can be the cause of infection.

Hinduism gives a prominent place to cleanliness, both physical and moral. The prominent place accorded to bathing in Hindu religion has been responsible for the establishment of cleanliness as an important factor in life. Cleanliness is a sanitary safeguard; to be clean in large measure means to be free from infectious disease; it applies not only to the person but extends to the personal environment.

The maintenance of health in the normal organism is determined largely by the proper relation of the two great factors: activity and rest. A moderate amount of exercise is needed if the body is to be properly developed and maintained throughout life. Musculay exercise is essential to health. Exercise compels increased amount of respiration and the result is the more effective oxygenization of the blood. Food is the source of health; it is also the cause of ill health when taken injudiciously.

The importance of wholesome diet in the treatment of diseases in widely recognised. The common saying is: when the patient is on proper diet, what is the need for medicine? When he is not on proper diet, what is the use of medicine. The best diet is: cereals, grains, roots, nuts, fruits, vegetables, milk, oil, curds, butter, ghee, butter-milk in proper quantity.

When milk is converted into curd (dahi), the milk-sugar (lactose) becomes converted into lactic acid; and the medicinal properties of the lactic acid as well as the bacteria contained in the curd in the treatment of certain intestinal disorders like colitis, dysentery, enteritis, have long been known to the Hindus, as curds of butter-milk formed the essential diet in such diseases. "Just as nectar is indispensable for the gods in heaven, so is butter-milk for humans on earth. No disease under the scorching effects of butter-milk shall augment or grow worse; nor does one that uses butter-milk everyday suffer from disease whatever". (Ayur Veda)

Hindus had known by experience about the existence of food-elements (similar to modern vitamins) and their importance to good health and vigour, although they were not able to demonstrate their chemical nature, now made possible by modern means. The medical doctors prescribed for the sick a diet consisting mainly of vegetable food and water, the lighter kinds of animal food, such as fish, pigeons, and goat's flesh being only occasionally introduced and in moderate quantity. The Hindu classification of food from the point of view of spiritual practice is founded on the theory of three gunas goodness (sattva), passion and activity (rajas) and passivity, dullness (tamas); the religious faith of every man is in accord with his natural disposition depending on food habits.

Rev. MARIASUSAI
DHAVAMONI, S.I.
Emeritius Professor
of the Phenomenology
and Theology of Religion, India

Notes

[1] Hatha Yoga aims at mastering the body in order to transmute it into a divine body.

[2] Tantra gives importance to the total experience of life as constituting an integral part of sadhana (means to acquire the healthy state of the body).

[3] On the exposition of the ancient Indian medicine, we are indebted to the following works: S.N. DASGUPTA, *A History of Indian Philosophy,* Vol. II, chapter XIII, Cambridge University Press, 1932; L. RENOU ET JEAN FILLIOZAT, *L'Inde Classique,* Tome II, Hanoi, 1953, Ch. IX 2.

[4] Ayur Veda is dated atound 900 B.C.

[5] *Caraka Samhita* 1.1.42.

[6] *Caraka Samhita* 1.1.40; 1.30.20-23.

[7] See *Atharva Veda* 10.2.6 and 8.

[8] Mahabharata 12.16.

[9] On medical aspect of Yoga, see MIRCEA ELIADE, *Yoga. Immortality and Freedom,* Routledge and Kegan Paul, London, 1958, ch. VII on Yoga and Alchemy; ERNEST E. WOOD, *Practical Yoga Ancient and Modern,* E.P. Dutton & Co., London. 1948.

[10] On Kundalini Yoga, see EVELON, *The Serpent Power,* Adyar, 1940.

[11] EDWARD C. SACHAU, *Alberuni's India,* Vol. I, pp. 188.89.

[12] See M.A. KAMATH, *Hinduism and Modern Science,* The Sharada Press, Mangalore, 1956.

ABRAMO ALBERTO PIATTELLI

III: Judaism

The fundamental idea which characterizes the position of Judaism in its approach to the topics which we are here subjecting to examination—that is, the whole question of the health, illness, and healing of the individual—is an idea which is found expressed in the first instance in Scripture and thereafter in the Rabbinical texts. This idea lays down that the Divinity is the primary source upon which there depend both physical well-being and the illnesses which afflict man. As Deuteronomy makes clear, "I am he, and there is no God beside me; I kill and I make alive; I wound and I heal" (Dt 32:39).

Experience teaches us that the term "health" refers to many elements which condition and influence the existence of man. The condition of "feeling well" does not refer solely to health and physical well-being—it also involves a variety of factors such as, for example, being on good terms with one's neighbor, economic and professional ease and content, and so forth. A lack of satisfaction in relation to one of these elements causes physical suffering and disturbance at a spiritual and, above all, at a psychological level.

We are often called upon to deal with a condition which is quite normal in the existence of individuals—that is, the shift from a condition of normality, which is that of health, to that of an equally normal condition, given the fragility of man—namely, that of illness—and then, if all goes well, on to getting better. Are we dealing here with natural processes which affect every individual, or do we have before us events which should be placed within a special logic which offers explanations as to why they take place and also strengthens our hope as to their future?

First of all, it is necessary to remember that Judaism emphasizes the Divinity's constant interest in, and concern about, man. In the economy of Scripture, man is a collaborator of God in the work of Creation. As a result, there is an absolute necessity on the part of God to ensure that man's activity in favor of the Creation is healthy and sound: "Unless the Lord builds the house, those who build it labor in vain. Unless the Lord watches over the city, the watchman stays awake in vain" (Psalms, 127:1).

The physical health of man is not a condition that is taken for granted for which no price is to be paid. The Torah, the moral law, envisages something which one could term preventive medicine, to employ a modern medical term. In Exodus (15:26; 23:25), we read: "If you will diligently hearken to the voice of the Lord your God. . . , I will put none of the diseases upon you which I put upon the Egyptians," or "You shall serve the Lord your God . . . and I will take sickness away from the midst of you." In other words, the biblical text declares that health is the result of the care which people take to follow divine injunctions and what is expressed by divine will.

The commandments and injunctions of the Torah taken as a whole—even though this work is not a text of medicine or hygiene—is permeated with compassion and love. It is "a tree of life to those who lay hold of her" (Proverbs 3:18)—that is, a giver of life, health, and well-being for both the spirit and the body.

To pass from the general to the particular, it should be observed that various authorities have studied a large number of scriptural rules and regulations which have a marked significance for the health of man. Thus, for example, there are all the guidelines concerning food—the distinction between animals which can be eaten and those which cannot, the prohibition relating to the eating of blood or animal fat—the precept of circumcision, the rules about conditions of purity and impurity (especially as regards women), and—why not?—the Sabbath day of rest: all these have a health-inducing value for the life of the individual.

Post-biblical rabbinical literature provides a whole host of advice which has the value of preventive medicine in relation to both the individual as such and society as a whole. Such advice is chiefly concerned with food and eating and involves guidelines for how long one should remain at table, the quantities of food which should be consumed, hygiene, and so forth. Advice for society as a whole largely centers around matters concerning ecology.

Maimonides, the famous Rabbi and physician of the twelfth century, dedicated an entire chapter of his work *Mishné Torah* to how health could be maintained and, above all, to the ways in which individuals should conduct their lives. At the end of this chapter are to be found the following lines: "Whoever behaves in the ways I have outlined, I guarantee him that he will never fall into illness: until he grows old, he will have no need of any physician. His body will be whole and healthy every day. Unless his body is in a bad state from the moment of his creation, or if he has indulged in bad behavior from his birth, or if he

has encountered the plague or drought which have afflicted the world" (M.T. Deot. 4:1-19).

It is, therefore, the duty of man to defend and maintain his own health and to protect it by keeping distant from, and avoiding, all danger. It is in this sense that the following lines from Deuteronomy should be understood: "Only take heed, and keep your soul diligently" (Dt 4:9) and "you shall make a parapet for your roof, that you may not bring the guilt of blood upon your house, if any one falls from it" (Dt 22:8).

Some Jewish theologians believe that the reason why the individual is called upon to preserve his own health is the divine plan, which seeks to keep man healthy and sound in order to be able to respect and carry out God's law. Maimonides himself writes, "Man must subject all the faculties of his soul to reason, as has been explained in a previous chapter, and place before him only one goal, which is that of drawing nearer to the Blessed God, to the extent that it is possible for man; I mean to say: to know Him. He must direct all his actions, activity, rest, and words towards that goal so that among his actions there is not one which is useless—that is, not directed towards this purpose. Thus, in eating, drinking, sleeping, sexuality, wakefulness, and activity, he should be concerned only with the health of the body, but the goal of physical health is to ensure that the soul can have healthy and perfect instruments and use them to acquire learning and moral and intellectual virtues..." (Eight chapters, 5)

The question as to why omnipotent, good, and merciful God allows the existence of diseases and evil in the world is dealt with at considerable length in the Bible. The whole book of Job, part of Ecclesiasticus, and a large number of psalms dedicate especial attention to the question of why suffering exists. For the spirit of the believer, this is an acute problem, and an answer has been sought to it over the ages and in every epoch.

Ghershom Scholem writes, "The problem of evil is one of those problems which, when faced up to, render the difference between a purely speculative approach and a religious approach particularly clear. The first tends to relativize evil, to reduce it to an appearance, and after this to go on calmly along one's path, believing that it has eliminated it from the world, or from real being. The religious approach, on the other hand, requires a real overcoming of evil. This approach begins with the profound conviction as to the real power of evil and therefore cannot accept that evil—recognized as a reality—can be eliminated by dialectic artifices, however acute and intelligent they may be (*Le Grandi Correnti della Mistica Ebraica*, Milan, 1965, p. 317).

The Talmud (Berachot 5a) proposes a first attempt at this overcoming of evil: "When man is afflicted by evil he should engage in a careful examination of his own conscience... If he reaches the conclusion that the evil cannot be the consequence of a blameworthy action, he should attribute it to a neglect of the study of Torah... If, however, this does not appear to be justified either, then he is necessarily face to face with a sign of the love of God, in line with what is written: "God punishes him whom He loves" (Proverbs 3:12).

The mystics of the Zohar argue that "the divine forces, taken as a whole, form a harmonious whole." But, as Scholem writes, "Each of these forces or qualities is holy and good as long as it remains united to the others and in a living relationship with them. This is true, above all, for the quality of justice in a strict sense, in judgment and severity—in God and by God—which is the profound cause of evil. The wrath of God, like his mercy, has an intimate relationship with the quality of grace and love—his right hand. This sapphire of severity is thus the great *fire of ire* which burns in God, but which is certainly sweetened and lessened by his grace. If, however, in an abnormal and hypotrophic growth it breaks out and breaks its union with grace, it then escapes with violence from the world of divinity and becomes a radical evil, the world of Satan which is opposed to the divine world" (*op cit*., p. 318).

The Jewish believer accepts evil with faith, but does not love it. He fears it because he never feels certain that he can overcome trials or maintain his faith whole, and he sees in evil an impediment to action. Rabbi Jochanan, when sick, answered to the person who had asked him if he loved evil, with the following reply: "I do not love evil or the reward which it brings" (Berachot, 5a).

The sick person prays to God to be freed from evil: "What profit is there in my death, if I go down to the Pit? Will the dust praise Thee? Will it tell of thy faithfulness?" (Psalms 31:10). And yet faith in the possibility of being able to see the prayer answered is implicit in faith in the Providence of God: "One must bless God for evil, as one blesses him for good" (Berachot 54/a), observes a famous Talmudic saying.

Suffering and pain lead man to look within himself and also accompany him in his search for the nearness of God and involve an intense relationship with God through prayer. "Any prayer which in one sense or another can hope to be heard is subject to this eternal paradox—that with it man hopes to influence the inscrutable divine ways and the eternal decision of Providence" (Scholem, *op. cit*., p. 373).

In the Jewish vision of the world life is something of infinite value, an experience which will not repeat itself throughout all eternity. Release from suffering and illness exalts the value of life and its sacredness: "The Lord has chastened me sorely, but he has not given me over to death" (Psalms 118:18), cries the individual who has been healed and restored to health.

From this experience is born the teaching that nothing within life is ours. What we possess, including life, is a pledge which can be redeemed suddenly when we least expect it. The pledge, however, must be redeemed at the end of the lease and must be returned in good condition to Him who gave it to us. But as long as the pledge, like life, is in our hands, we are responsible for the sense of mission that we must have and for the use of the good that we make of it, in conformity with the words "Chai Chai Hu Yoducha Kamoni Hayom—the living, the living, will praise you as I do today!" (Isaiah 38:39).

Rabbi ABRAMO ALBERTO PIATTELLI
Professor at the Higher Institute of Jewish Studies, Rome

MAURICE BORRMANS

IV: Islam

In Muslim countries hospitals have for some time been one of the special places for the achievement of dialogue between Islam and Christianity. In these places very many Catholic members of religious orders look after sick people or are at the side of those who are about to die. In other countries such members of religious orders are at the service of women who give birth in villages or are engaged in helping nurses who are in need of training for their future "hospital" mission.

It is certainly true that life, health, and the care and treatment which they both require are fundamental values to which Muslims, too, are sensitive and that much the same could be said about other believers and their brothers who belong to mankind. Islam has always upheld the sacred value of such things and has known how to develop the institutions necessary for their protection in those societies which it has inspired or helped to shape.

Although it is the case that during the first centuries of Islam, in Damascus and Baghdad, medical doctors were still and often Christians who had been trained at the medical school of Gondêshâpûr,[1] it soon happened that Muslims excelled in medical research and the treatment of the sick after they, too, had been admitted to the school.[2] It should be recalled that the great names and their great achievements were the results of the work of the Syrians and Persians, who thereby continued the Greek tradition. Hippocrates and Galen were translated into Arabic by Hunayn b. Ishâq, Qustâ b. Lûqâ, Isâ b. Iahyâ and Abd al-Rahmân b. Alî.

Christian and Zoroastrian doctors, and later Muslim doctors, were prominent at the court of the Caliph Abbâside Hârûn al Rashîd in Baghdad, and in the hospitals, the famous bîmâristân,[3] where they organized and developed their art. Abû Bakr Muhammad-al-Râzî (250/854-323/935), the Rhazes of the Latins,[4] won fame in a very special way after working at the hospital of the Rayy. Indeed, his two works, *Al-Hâwî fî l-tibb* and *Al-Mansûrî*, subsequently become classic texts.

Later, the great philosophers of the Hellenizing school, in both the East and the West, were also medical doctors and practicing physicians. It is to Avicenna that we owe the textbook on medicine entitled *Al Qânûn fî l-Ribb*.[5] And in the same way it is to Averroes that we owe *Il Kulliyyât*, which was based on the work of Ibn Bâjja[6] and Ibn Tufayl,[7] who were then followed by the Ibn Zuhr family, who took the Latinicized name of Abenzoar in Spain.[8] Everybody is aware of the great influence which was exercised by Arab medical science on the Western world. One need only think of the translations carried out by Gerardo da Cremona, Andrea Alpagus di Belluno, and very many others. And what should we say about the pharmacopeia and the knowledge of the "less expert"? And in Italy was there not the famous school of Salerno and the important work of Constantine the African?[9]

All this explains why it was that on the threshold of modern times hospitals and healthcare services increased in number in certain Muslim countries which had become committed to modernizing programs of reform (the Ottoman *tanzîmât*, for example) or embarked irreversibly on a similar process of advance during the colonial era. Today, all these Muslim countries have a ministry of health, and thanks to these ministries governments want to respond to the needs of their populations in matters connected with necessary forms of care and treatment. This is done through a network of hospitals, clinics, and centers for the protection of maternity and childhood. To this should often be added the many-sided activities of private or public associations which work to help the physically or mentally handicapped. The Muslim *Universal Declaration of the Rights of Man in Islam*, which was proposed by the Muslim Council of Europe to the Paris headquarters of UNESCO in September 1981,[10] after the first clause, which upheld the right to life, went on to state that "every individual has the right to have his own part of the goods necessary for his life: food, drink, clothes, housing, and all the forms

of treatment which his physical, moral, and intellectual health require" (clause 18).

The third and last project of the *Declaration of the Rights of Man in Islam* of the Organization of the Islamic Conference, which was held in Cairo in August 1990,[11] asserts, in turn, that "each person has a right to medical care and social security, and to all the public aid supplied by society and the state within the limits of the resources which are available" (clause 17, § b). On various occasions, at different conferences, and in a large number of declarations, Muslim medical doctors and theologians have stated and repeated that Islam rejects and condemns abortion, sterilization, euthanasia, and heterologous artificial fertilization.

Health, therefore, is one of the essential values which Muslims want to serve and to protect. But what should be the attitude and the approach of the Muslim believer towards illness, suffering, and death? "Islâm" means 'trusting submission' to the will of the Creator, who is Providence before being a Judge who forgives and rewards or punishes. But when faced with this majestic greatness of Allah, whose transcendence reminds the believer of his smallness, the ordinary Muslim expresses no reproach and does not for a moment consider rebellion when he suffers from a chronic illness or when he sees that the hour of his death is approaching.

Submission, patience, and resignation are the virtues which are taught to him by his father and which are confirmed by the teaching of the Koran: *He knows that everything on earth is headed towards nothingness, but the face of the Lord subsists, full of majesty and munificence* (55:26-27). The Koran also states the following: *Know that life here below is nothing but a game, distraction, a vain ornament, a joust of pride among you, a challenge involving wealth and children; it is like the rain.... Life here below is only illusory enjoyment. Hasten to obtain your Lord's forgiveness and a paradise as vast as heaven, prepared for those who have believed in God and in his messengers. It is the grace of God, a grace He grants to whoever He pleases, and God is the master of immense grace* (57:21-21).

God does as He wishes; it is He who gives health or illness; it is He who decides if our lives are to be long or short, according to his eternal decree. We belong to Him, and to Him we return, the Koran incessantly repeats (12,84): *For this reason the Moslem can make Jacob's experience after he lost Joseph his own. His eyes were misty as a result of his pain. But he mastered his suffering.*

The ordinary Muslim can also employ the prayer of Abraham, which the Koran cites: It is the Lord of the worlds who has created me, and it is He that guides me, nourishes me, and gives me something to drink; He heals me when I am ill; He will have me die and bring me back to life; and it is from Him that I hope for the forgiveness of my sin on Judgment Day. Lord, grant me the power to judge with discernment and let me reach the saints!(26:78-84). Here we encounter the great truth: God is He who gives life (*al-Muhyî*) and He who makes people die (*al-Mumît*). For the believer who has to face up to the vicissitudes of life, therefore, it is a question of entering into the patience of God (is it not perhaps the only *Sabûr*?) and to bring its features into the human dimension—something which is a good *sâbir*. How often the Koran insists on this virtue of patience! *O you that believe! Be patient! Compete in patience and firmness. Fear God, and you will be happy* (3:200) *Whatever good you enjoy comes from God When suffering afflicts you, it is to Him that you direct your prayer* (16:53) *Seek aid in patience and prayer* (2:45) *O you that believe! Ask for the help of patience and prayer. God is with those who are patient* (*Inn-Allah ma(a l-sâbirîn*) (2:153). Thus it is that the believer often repeats the idea that "patience is beautiful" and that it must be linked to gratitude (*shukr*), as the Koran repeats: *There are truly signs for every patient, grateful man* (*sabbâr shakûr*) (14:5; 31:31; 34:19; 42:33). These are the deep feelings which inspire each authentic Muslim during the difficult periods of his life. And before dying the last gesture which he makes, and the last words which he wishes to utter, concern that profession of Muslim faith which is very well known: "There is no God other than Allah, and Mohammed is his Prophet."

It is undoubtedly true that during the course of history and today as well Muslims at a popular level have engaged in various orthodox and heterodox practices. The last two sections of the Koran (*al-muawwadhatân*) are examples of invocations "against the evil of creatures, of darkness, and of the envious," and especially "against the evil of the Tempter, who must be lapidated."

The devotions of the Shiites have included books of special invocations for all the difficult moments of life—for illness, for suffering, and for exile—like that which is attributed to the Zayn al-Abidîn, the *Sahîfa sajjâdiyya*.[12] The *hadîths* of the Prophet of Islam are another source of propitiatory supplications in this field. It is also true that magic practices have not failed to infiltrate the mentality of simple believers who have been little or badly instructed in the Catechism. In such circumstances, the very texts of the Koran become prophylactic means to secure protection against illness and epidemics. Magic is not absent from certain traditional areas.[13] But this should not obscure the usual attitude of the believer, which is that of his own faith. And it is for this reason that Christians and Muslims, in hospitals and clinics, can generously help each other in the exchange of treatment and encouragement, in such a way that believers turn their trials into an act of

submission and oblation in imitation of Job, a figure who is also cited by the Koran by way of example.[14]

And how could I fail to conclude these brief comments on the prospects for dialogue without quoting the famous *hadîth al-Ruqyâ*, a formula used by Christian physicians in favor of their Muslim patients during the first centuries of the splendor of Baghdad which utilizes the "Our Father" and adapts it to these circumstances?[15] It is as follows: "Lord, our God, who art in heaven, hallowed by thy name. Thy will be done on earth as it is in heaven. Let thy mercy reign on earth as it reigns in heaven. Forgive us our sins and our errors, thou who art the Lord of the Good. Allow thy mercy and they healing to descend upon this suffering, so that it may be healed."

May Christians and Muslims help one another, together with other believers and men of good will, to reduce human suffering and to restore "divine" meaning to the health of the sick, at the end of a period of patience which also knows how to express gratitude.

Rev. MAURICE BORRMANS
Professor at the Institute of Islamic Studies (PISI), Rome

Notes

[1] Cf. the article "Gondêshâpûr," in *Encyclopédie de l'Islam* (second edition, Leiden, 1963), vol. II, p. 1146.

[2] Cf. the article "Tibb," in *Encyclopédie de l'Islam* (first edition, Leiden), vol. IV, pp. 779-780.

[3] Cf. the article "Bîmâristân," in *Encyclopédie de l'Islam* (second edition, 1963), vol. I, pp. 1259-1262.

[4] Cf. the article "Al-Râzî," in *Encyclopédie de l'Islam* (second edition, Leiden, 1994), vol. VIII, pp. 490-493.

[5] Cf. the article "Ibn Sînâ," in *Encyclopédie de l'Islam* (second edition, Leiden, 1971), vol. III, pp. 965-972.

[6] *Ibidem*, the article "Ibn Bâdjdja," pp. 750-752.

[7] *Ibidem*, the article "Ibn Tifayl," pp. 981-982.

[8] *Ibidem*, the article "Ibn Zuhr," pp. 1001-1003.

[9] Cf. the article "Constantin l'Africain," in *Encyclopédie de l'Islam* (second edition, Leiden, 1965), vol. II, pp. 60-61.

[10] For the text in Arabic and the translations into French and English of this *Declaration*, see *Islam christiana* (PISAI, Rome), no. 9 (1983), pp. 1-16, 121-140, and 103-120.

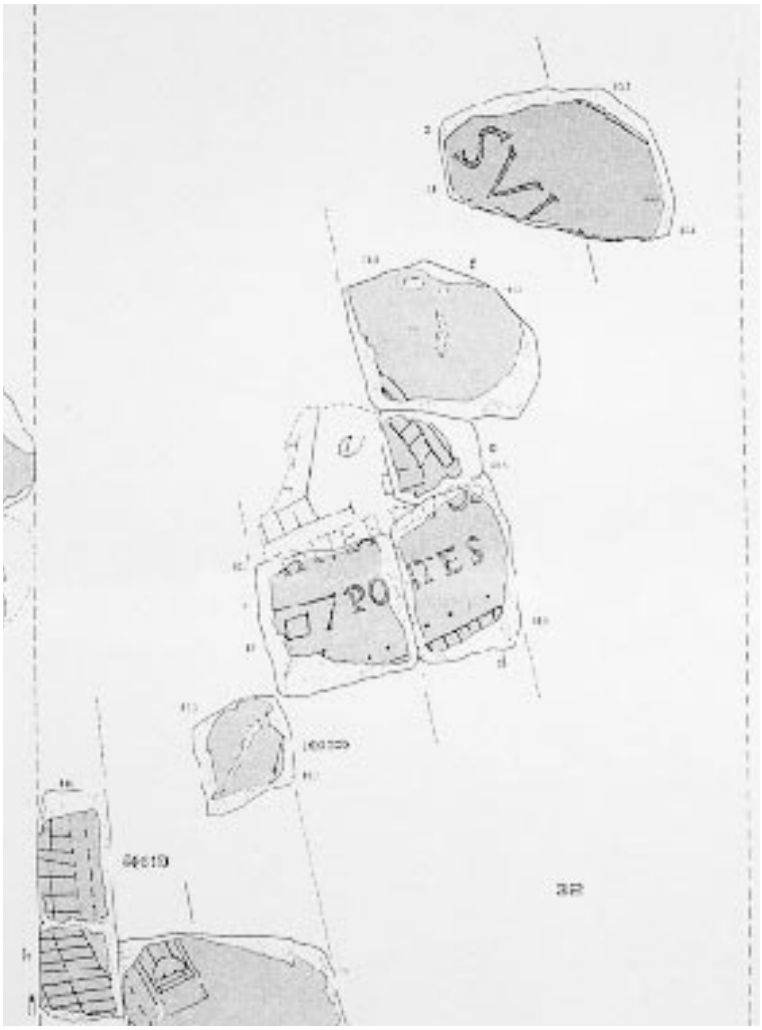
[11] For the French translation of this *Declaration* see *Conscience et Liberté* (Berne), no. 41, first sem. 1991, pp. 110-115.

[12] Cf. in Etudes Arabes-Dossiers, *Textes sur le Shîisme*, no. 84-5, 1993/1-2, pp. 220-230.

[13] Cf. Michel Lagarde, *La Magie Arabe* (Rome, PISAI, 1981), the texts in Arabic and the French translations, p. 112.

[14] Cf. the article "Ayyûb," in *Encyclopédie de l'Islam* (second edition, Leiden, 1960), p. 819, and particularly Jean-Louis Déclais, *Les Premiers Musulmans face à la Tradition Biblique: trois Récits sur Job* (Paris, L'Harmattan, 1996), p. 318.

[15] Cf the collection of the *Sunan* of Abû Dâwûd, t.2, bâb 19: *al-Ray*, and the study by Louis Massignon on this subject in *Opera Minora* (Beirut, 1963, Dar Maaref), vol. I, pp. 92-6.



AFTERNOON SESSION

LUIGI DONATO

Science and Technology at the Service of the Person

A century is reaching its end during which knowledge and technology have advanced with a pace and intensity which would never have even been thought possible a hundred years ago. From our knowledge about the universe—the macrocosmos and the microcosmos—to that about the basic phenomena of life; from means of communication and information to energy and new materials, this leap in knowledge is in view of all and is to be seen around us in daily life.

This process has also led to a profound transformation in the knowledge and methods which are applied to the maintenance of health and the treatment of illness. When those like me who have had the good fortune to live during, take part in, and observe the progress of medicine during the second part of the twentieth century return to the books that were studied early on in our medical careers, we have the impression that we are going back down the centuries. "Wool, milk, and bed" was the treatment which was suggested for kidney complaints. My work on internal medicine recommended "a hot bath and a small glass of marsala" for those who suffered from typhus. The only diuretics were "the mercurials," and it is difficult to say whether their effect was more positive or harmful. Tuberculosis was the subject of long chapters in these textbooks and at the same time was an illness which gave rise to sanitoria which were built on many a mountain. Cardiac decompensation was still treated exclusively with infusions of *digitalis purpurea*, a cure which an English doctor had taken from the secrets of Welsh witchcraft at the end of the eighteenth century, or with nitroglycerine, which in reality had been invented for very different purposes. Surgery was reticently termed "explorative" or more brutally described with the phrase "open and close." It was often the only, bloody way of seeing "from the inside" what the faculties of the medical doctor were not able to "see from outside," despite the various time-honored forms of inspection, auscultation, percussion, and palpation which formed a part of his repertoire.

Today the frontiers of what is possible seem to be continuously expanding. The term "metabiology" refers to the possibilities we have of going beyond the biological limits of life. On the one hand, there is the biotechnological manipulation of the genetic complement in order to cure genetically inherited diseases. On the other, there is the possibility of extending life beyond the life of vital organs by means of transplants and the use of artificial organs.

This continuous evolution has led some people to draw the conclusion that there are no fixed limits to our knowledge, accompanied and sustained as it is by an "unlimited power" to develop new forms of technological advance and progress. Other people respond to such extreme optimism by asking whether man will be able to control such advance and progress and their consequences and wonder whether man will in fact manage to avoid becoming a sorcerer's apprentice. Other observers, lastly, display a pessimism and an ease of judgment which are on a par with the optimism of the first category and assert that scientific and technological progress is the enemy of mankind. Such people often take refuge in a return to magic and pseudomedical alternatives.

This very important point will be returned to later on in this paper. For the moment let us here observe that while science and technology hurtle towards the third millennium with flying banners and increasing speed, the contrast between the unsuppressible and proud impetus towards knowledge, on the one hand, and questions about the effects of the use of instruments and methods which are produced by such knowledge, on the other, remains open, ever present, and unresolved.

"*Est modus in rebus, sunt certi denique fines, quos ultra citraque nequit consistere rectum*." Should this statement from Horace be applied to the dominion of science? Medicine might perhaps be able to withdraw from the conflict between science and its use. After all, the use of science to combat evil might appear to be good by definition. But this consolatory conclusion is too easy, and too simplistic.

We can be happy and proud because today we know how to treat a large number of illnesses which at one time were incurable; in many parts of the world women hardly ever die at childbirth, and infant mortality rates are at most a tenth of what they were during the first part of the century; it is now possible to outlive heart attacks and kidney failure; we are beginning to be able to deal successfully with certain kinds of cancer; and we have learnt a series of rules by which to prevent certain illnesses. However, many of these advances

raise ever more pressing questions about how, and if, the new techniques and methods available to us should be used, and about the distinctions concerning what can be done, what is useful, and what is suitable for an individual patient in a given set of circumstances.

Indeed, the subject which has been given to me does not so much involve science and technology *per se*, nor do I think that it would be fitting for me to provide a survey of the present and of the probable future with regard to scientific progress. I do, however, believe that specific and essential questions should be raised and answered in relation to the employment of science and technology, as the title of this paper has it, "at the service of the person." Here the whole subject becomes much more complicated. We should not ask ourselves *what* medicine can do for man today and will be able to do for man tomorrow. We should, rather, face up to this reality and ask ourselves *why, for whom, how, where, and when* it can and must do things.

And the question is difficult for me from the outset, beginning with the primary approach to the subject which I have been invited to talk about: what does the phrase "at the service of the person" really mean? Is one dealing here with a verbal simplification or a kind of magnetic moral north pole by which to direct the compass of our orientations? I am convinced that this conference believes in the suitability of the second definition—that is, the search for a direction, an ideal path, a practical and moral rule by which to govern the methods and instruments which science and technology have made, and are making, available to us.

But what do we mean by the term "person," which is to found in this phrase? Are we referring here to the individual person or to persons in the plural? And if we are talking about persons in the plural, are we referring to the social consortium to which each one of us belongs, or to the consortium of nations, or even perhaps to the consortium of all humans? All these categories are composed of persons, but service to the individual person is not necessarily the same—or, rather, is not automatically compatible with service to different kinds of aggregations of individual persons.

A second area of uncertainty is encountered when we address ourselves to the context to which the person to whom we wish to render service belongs—that is, service in the form of science and technology. Western society, one might point out, with all its demands and requirements, is very different from the very poor societies to be found in other parts of the world. In one region of Italy—Tuscany, for example—the presence and availability of hundreds of very sophisticated machines which supply various forms of echography may well be seen as insufficient when compared to the diagnostic demand. But I know missions run by Franciscan nuns in Central Africa, in a region which is much larger than Tuscany, where an old echograph is the sole (and very advanced) product of technological civilization. This piece of machinery is employed to distinguish between an abdomen disturbed by the effects of malnutrition and the presence of a pregnancy. So what are we talking about—the first context, the second, or both at the same time? Certainly, we are not dealing with the same thing, and the breadth of situations between these two extremes is obviously very great.

These differences bring us to another area of difficulty, that of the limits which exist to the resources which are available. In all societies, and within homogenous contexts as well, such limits inevitably

pose the problem—albeit with different levels of intensity—of the criteria which should lie behind our decisions, taken as they are in conditions which lie between the extremes of uncontrolled inequality, on the one hand, and complete social solidarity, on the other. The latter, of course, is a goal which is still far off, even in the most advanced societies on the planet. Should there be much for a few or a little for many? Obviously enough, we would like a great deal for a great many, but nowhere is this really possible. So what should we do? What criterion is right and what do we mean by "right" in this context? Are we dealing here with an ethical yardstick or an economic point of departure? Are we using the language of costs and benefits or that of "compassion"? Indeed, Amartya Sen, the great expert on developing economies, observes, "An equal commitment to everybody involves very unequal treatment for the most disadvantaged."

I have tried to produce an answer, but I do not know if this responds to the spirit which lies behind the choice of this subject. My answer is that "the person" spoken about in the title of this paper is not merely the individual patient to whom the medical doctor applies the process of diagnosis and treatment in line with his professional expertise and the instruments and methods which are available. Nor is this person simply an anonymous number in a cold and calculating clinical experiment carried out on a population made up of patients. In both cases, and in all cases where science and technology strive to improve the well-being or to reduce the suffering of somebody, whether poor or rich, small or great, pygmy or Scandinavian, one always comes across a man. For this man the suffering caused by illness is influenced by his emotional ties and his culture—a series of habits, fears, hopes, traditions, obligations and responsibilities, dignity, and reserve which go to make up his existential context and which medical science and technology should never ignore, but always respect.

And thus I find myself at this point agreeing with the words of

Seneca: "If the physician does nothing else but take my pulse and see me as one of his many patients and coldly prescribe to me what I should do or what I should avoid doing, then I owe him nothing, because in me he does not see a friend but only a client."

In the light of this approach to what constitutes a person, I will now attempt to present certain reflections on the subject I have been invited to speak about here today. I will seek to address myself to this subject with reference to two extremes—the poor countries of the south of the world, on the one hand, and the rich industrialized countries, on the other. This limitation of the discussion to two opposing poles constitutes a dialectical simplification because it is more than obvious, as I will emphasize once again later on in this paper, that wealth and poverty can often be mixed together in a broad fan of intermediate situations, and this is true of the geographical and social context as well.

An initial observation may be made: health is not only or primarily a problem which concerns medicine. "*A bello, fame et peste libera nos Domine*." Only a few centuries have passed since the time when, on our continent as well, the yearning for health and social security was expressed in such terms. Today the horrors of hunger, war, and pestilence often meet with the filter of indifference to something which in essential terms no longer concerns us. This indifference is somewhat attenuated by crude television reports, but their effect is reduced by the entertainment value of real or fictional violence, to which cinema and television expose us every day. Our capacity for compassion and indignation comes to be weakened; and, after all, we can simply liberate ourselves from all this by pressing a remote control button.

Health is first and foremost a question of physical safety (I am thinking here of the horrors of tribal wars or religious fanaticism), nutrition, food, and water, and it thus involves agriculture, irrigation, environmental hygiene, and the eradication of endemic infections. Such was the case until only a short time ago in Western countries as well. Only a hundred years have passed, or perhaps somewhat longer, since the discovery of the existence of bacteria. And the same period of time has elapsed since Ernst Semmelweiss proved the relationship between bad hygienic conditions and hospital mortality rates—a fundamental basis for subsequent advances and success in medicine and health care. Thereafter came education and the laying of the foundations of economic self-sufficiency, and it was only with these steps forward that one could seriously begin to speak about the emergence of medicine and health care in a really modern sense.

Fortunately enough, there are today many scholars and experts who with great seriousness employ the necessary global approach to the study of the development of the countries of the south of the world. With reference to Italy in this context, I would like to mention the work carried out by the Luca D'Agliano Research Center in Turin.

In countries in the south of the world science and technology, when it comes to matters of health, are of medical importance only in a secondary sense. Often those in power in these countries see the development of health care in a distorted way—they want to create highly specialized facilities merely for reasons of national pride or in order to imitate the industrialized countries. Thus, for example, a heart-surgery clinic is established where the whole problem of endemic infections remains very far from being solved and where dramatic difficulties of nutrition continue to exist. From this point of view, cooperation between the North and the South must not repeat the errors of the past. Nobody can deny the good intentions of the World Health Organization and the slogan "Health for All in the Year 2000," which has inspired the work of this organization over the last twenty years. However, in practical terms, this mirage has also given rise to delays, false hopes, and erroneous approaches.

What we need to do is to face up to, and tackle, the whole problem with a pragmatic gradualism—in the form of nutrition, education, and the creation of primary systems of health care. This does not mean that we should not in the future aim at more advanced objectives and goals, but such things can only be achieved if they take place against a background of overall advance. The more the moment of self-sufficiency draws near, the more it becomes important to develop higher systems of health care and to ensure that there are suitable structures in which trained staff can apply what they have learnt. Naturally enough, an exception to all this is to be found in emergency action such as that undertaken by the association Medici Senza Frontiere, action which takes place where, and when, the madness of men means that survival rather than well-being is what is really at stake.

To return, however, to the question of "service to the person," as it has hitherto been defined in this paper, I believe that in these countries service to the person also means the avoidance of rapid changes in relation to the traditions and values of the society in which healthcare initiatives are taken, refraining from imposing foreign models solely because they function in other contexts, and a fundamental and full commitment to educational processes without, however, seeking to achieve a mirror image in these societies of what goes on in Western countries.

Finally, I cannot fail to speak about a problem which seems to me of immense and striking importance. I am referring here to birth control, contraception, or what is termed "responsible procreation." That a young woman

may die in childbirth, perhaps after bringing into this world ten children, of whom only three have survived, as often happens, for example, in Central Africa, is not acceptable to a man of my way of thinking and ethical outlook. I am well aware of the admirable work carried out by the missions. I believe that humanity owes a great deal to these men and women, who have dedicated themselves to a vocation which, lived out in silence, every day threatens their very lives, striving as they do to bring some relief to, and to improve the chances of survival of, their less fortunate brethren. I respect life. I believe that it is unacceptable, for example, that in some Anglo-Saxon countries certain patients are classified with the letters "NTBR" (an acronym for "not to be revived"). I reject euthanasia, a subject which every now and then is brought to the forefront of public attention, as being an unacceptable practice. And, in addition, I refuse to treat the subject of the interruption of pregnancies in a lighthearted fashion.

But I must declare quite honestly that I do not understand how it is possible to justify those avoidable deaths to which I have just referred before any judge, in this world or the next. And I cannot prevent myself from thinking that it would have been better if these creatures had never conceived. I do not even think that the idea of "responsible procreation" can be applied with the same rules in all contexts. I am aware of the difficulties which this position meets with in this place, but I believe that it is my duty to declare what my point of view is for reasons of intellectual honesty. To keep quiet would be offensive towards those who have done me the honor of inviting me to talk here today, and for this reason I have held to the view that my ideas and my experience could be of some use and some interest.

I would now like to dwell upon the other extreme—that of the case of the industrialized countries. The aging of the population, the outliving of illnesses or events which in the past proved fatal, and the progress of the technology of diagnosis and of forms of treatment have all meant that there has been a constant increase in the offer and the demand for health. This circle, which one could in theory define as being "virtuous" in character, has had damaging effects because of the increase in costs which it has brought into being. The constant call for new forms and levels of funding, organization, and action has brought with it the danger that the whole system might enter into a state of paralysis.

Increasing levels of general prosperity have acted to accelerate this process because needs which a few decades ago would have seemed wrong, marginal, or even absurd are now deemed to be essential. I am thinking here of the excessive "psychiatricization" of problems connected with social disturbance or individual adaptation, or of the explosion in forms of "aesthetic treatment"—an example, it might be observed, of the "medicalization" of problems connected with self-perception. This has meant that even in health services which generally aim at an approach based upon solidarity—such as ours—there has been an increase in the costs which the patient has to pay. This process has meant that, despite the various kinds of initiative which have been taken to deal with this problem, in reality access to the national health service has become increasingly more difficult for the poorer sectors of the population.

All countries in the West have encountered this difficulty because an increase in the availability of diagnostic instruments and methods has led to a frequently unjustifiable proliferation of clinical tests and examinations. In addition, given that payment is based upon the number of these kinds of inquiries into the health of the patient and upon the number of people who are admitted to the hospital, there is a natural tendency to increase both forms of initiative. In our countries there has emerged a form of real healthcare consumerism, and this is a phenomenon which generates very great waste. It has also provoked the introduction of mechanisms of partial payment by the patient, which means that access to the national health service necessarily becomes more difficult for the weaker and less prosperous sections of society, as is also true of essential forms of care and treatment. This is an even more serious situation given that today all industrialized countries have their own "South"—that is, individuals who live below the poverty line and often do not make use of the national health service or, when they do make use of it, act in response to an extreme emergency.

Once again, therefore, albeit for reasons which are different from those which are at work in the poor countries of the world, processes of health care in rich countries come up against the realities of each society's economy. This means that today the management and the use of healthcare resources, in our countries as well, is conditioned by economic factors. Furthermore, this is something which will grow even worse in the future. In order to meet this problem it will be indispensable—among other things—to overcome the selfishness of certain categories of healthcare personnel. In Italy, for example, such selfishness has led to the renewal of the contracts of hospital doctors on terms which are very burdensome for society as a whole. It is true, as everybody now observes, that the organization of the national health service should move towards a reduction in the practice and length of hospitalization, and to an increase in pre-hospital diagnoses and post-hospital treatment carried out at home or in special residential institutions. But at the same time the way in which human and technological resources are used should also be radically reformed and restructured.

But this objective first requires a solution to a problem which goes even deeper. In hyperspecialized and hypertechnological medicine the general practitioner and the physician of the person is today disappearing, and this is a very great loss. Furthermore, nothing has as yet been invented to counter this tendency. The truth is that even in the present-day (excessive) growth and splendor of medicine by machines and by impersonal method, the true quality of medicine is always influenced by the way in which the relationship between the patient and the med-

ical doctor begins and develops. And, of course, needless to say, in this relationship there are two different individuals with their own separate culture, personality, circumstances, problems, anxieties, hopes, and expectations.

Over recent decades the relationship between the medical doctor and his patient has diminished in importance, almost as though one were dealing with a devalued currency or perhaps with a banknote which had been withdrawn from circulation. People certainly speak about this phenomenon with regret. The idea is not so much that something of value is being lost from sight, but, rather, that such a relationship is something good from the good old days, akin, as it were, to the lace which grandmother used to wear. Of course, this relationship still exists, but both the patient and the doctor tend to experience it as a kind of bureaucratic formality which is introduced into the sphere of what is considered real medicine—that is, a realm where mechanical analyses carry out their schematic, relentless, and categorical judgments as to what constitutes normality and abnormality. In this way, the two key moments—the human moment and the technological moment—increasingly tend to go their separate ways. And one of the greatest challenges which medicine now has to face is how to reconcile its human dimension with its technological dimension.

This is true not only from an ethical/humanitarian point of view, but also in order to improve the effectiveness of technological medicine itself. Without the human relationship with the doctor who knows how to explore, judge, and decide on the basis of his personal knowledge of the patient, the sick person runs the risk of becoming lost in a labyrinth of various forms of technology. There is the danger that he will become reduced to the level of unconnected numbers, lines, and images, and that what will be aimed for is not his own subjectively perceivable well-being, but the normalization of some kind of parameter. Without this personal relationship between the doctor and the patient, the perception of the difference between what is possible, useful, and right for the individual patient in his own personal context, and with his personal, family, and social expectations and hopes, can lead—and, unfortunately, does often lead—to forms of medical response and treatment which are unsuitable and which are carried out simply because they can be carried out with the techniques which are available.

In Western society, too, therefore, there is the very important and compelling need to bring medicine back to "service of the person."

To conclude this paper, I would like to address myself briefly to an assessment of the value of scientific and technological advances, especially in relation to the field of medicine.

My opinion—that of someone who has by now spent half a century engaged in scientific research or the treatment of patients—is very simple: one cannot, and should not, impede man's inescapable vocation to follow the path of "virtue and knowledge." But when advances in knowledge, or the machinery and methods which derive from such kinds of advance, become likely to engage in a "metabiological" attack on man and his system; when the economic implications of new realities and procedures are such as to endanger the financial resources which are available to healthcare services as a whole; and when the results obtained in terms of quality of life are of a dubious value, or when the cost in suffering which an intervention requires is greater than possible benefits; then, beyond all meaningful experimental evidence and every theoretical hypothesis, analysis of all the implications of science and technology must be extremely severe.

I would like to finish this paper by once again thanking the organizers for their invitation for me to speak here today because it has obliged me—as, indeed, does not happen often enough, involved as we are in our strenuous daily duties—to peer deeply into the means, the ends, and the values of our work as doctors and scientists.

Dr. LUIGI DONATO
Professor of Cardiovascular Diseases, The St. Anne School for Advanced Studies, Director of the Institute for Clinical Physiology of the National Research Council (CNR), Pisa, Italy

CORRADO MANNI

Technology or Technicism for the Society of the Third Millennium?

Introduction

At the end of the second millennium medicine is faced with a turning point. At no other moment during the last hundred years has medicine been so near to illness and at the same time so distant from the sick person.

On the one hand, the advances achieved in the world of clinical medicine have brought about a series of unprecedented successes in the area of treatment: many forms of illness and disease which at one time were considered inevitable scourges have been hard-hit, and this has led—first and foremost in the countries of the Western world—to a well-being in people's lives and to a longevity which have never before been experienced by mankind. At the same time the support disciplines of medical science, such as biology and genetics, have brought us very near to the roots of life and to the point where disturbing philosophical, moral, and legal questions now pose themselves. We need only think here of the problems raised by the phenomena of assisted procreation and genetic manipulation.

However, in strident contrast to the triumphs of medical science, we are also in the presence of a growing lack of satisfaction both as regards the patient and in relation to the medical doctor. The former feels that he is subject to an alienating form of medical care which, although it may well with growing effectiveness end physical illness, nonetheless also involves an accompanying increase in that feeling of isolation and psychological dependence which is normally associated with the condition of illness. The medical doctor, for his part, finds himself involved in trying to keep up with the advances of professional knowledge in his field of interest and sees that he is immersed in the ever-more complex diagnostic-therapeutic algorithms of modern clinical disciplines. In such a context he feels that contact with the patient eludes him and the real human nature of his patient becomes submerged within an impersonal mechanism which transforms health care into just another public service. As a result, the delicate and sensitive process of interaction between the medical doctor and his patient becomes annulled.

The reasons which lie behind this state of affairs are in essence four in number and can be adumbrated in the following fashion:

1. The radical epistemological transformation of modern medicine which has taken place in recent times and the influence of support disciplines which themselves have lain behind the advance of modern medical science.
2. The present-day problems and difficulties of instruction and learning in the world of medicine.
3. The processes of massive growth and bureaucratization in the world of medical care.
4. The loss of a sense of the transcendent dimension to human existence.

The Birth of Modern Medicine as a Science

The modern age has witnessed an unprecedented advance in medical knowledge. This began gradually in the seventeenth century with the first discoveries relating to man's physiology and then accelerated from the middle of the nineteenth century onwards. During the twentieth century, it may be observed, advances in medical knowledge have progressed at a breathtaking pace.

These advances cannot be explained without reference to the radical methodological changes which took place within the world of medicine during the seventeenth and eighteenth centuries. Such changes involved a more rigorous scientific approach which moved, however, rather slowly in comparison to the other disciplines at the time. In truth, although the scientific bases of mathematics and geometry had already been firmly established in ancient Greece, medicine itself was still struggling to establish itself as a science when the modern age dawned. It was still considered an art (*ars medica*) and at times a philosophical discipline because it was connected with the discipline of physiology, which at that time was considered a branch of philosophy.

An illustration of this state of affairs is to be found in what René Descartes, one of the founding fathers of the scientific revolution of the seventeenth century, wrote in his *Discourse on Method*. After discovering his own interest in the exact sciences he decided to drop his idea of dedicating himself to those "other sciences...which draw upon philosophy for their principles" (that is, medicine and jurisprudence, which at that time were considered linked). He went on to declare, "Indeed, I believed that on such unsound bases nothing solid could be constructed.... And, on the other hand, although I did not display any contempt for worldly glory, I did not give value

in the least to that which can be obtained through false qualifications."[1] This severe judgement reflects the aura of distrust and of suspicion—if not of charlatanism—which then surrounded the profession of medicine. The marked lack of diagnostic and therapeutic means and instruments which were then available—whose actual effectiveness was never subject to a serious process of testing and verification—makes such a reputation more then comprehensible.

But over the two subsequent centuries things changed very radically—the introduction of experimental methods in the observation of phenomena and the measurement and correct interpretation of such phenomena lay behind the immense advances and strides forward which are very well known. The fragmentary clues and insights of the thousands of precursors of scientific medicine were suddenly placed in their right context rather like the pieces of a mosaic. At the same time the innumerable errors with which they were beset and bound up became clearly evident. It was from this point in time that a clinical knowledge about the forms, symptoms, and development of certain illnesses and a verifiable understanding of the anatomical and physiological aspects of pathological phenomena began to take shape. As a result of concomitant technological forms of progress, therapeutic means and methods by which to control the development of most forms of illness became finally available to the discipline of medicine.

However, all of this was not without its consequences for the mental approach and character of the figure of the medical doctor himself. From the physician who was a "humanist" and a "philosopher" there was shift to a medical doctor who was a "technicist" and an "organicist," the true son, that is, of that positivistic mentality which reached its height during the nineteenth century. His learning and expertise became rigorously scientific and empirical—the approach to the clinical case in hand was analytical and aimed at an overall vision of the pathological process which was responsible for the general condition of the patient, and all this with a view to identifying the cause of the illness and thereby proposing the most effective form of treatment possible for its cure. In this approach everything which was outside the process of diagnosis and subsequent treatment became irrelevant, including emotional participation on the part of the medical doctor in the human experiences of the patient, which, it was said, could interfere with the achievement of limpid objectivity in establishing a medical judgment of the case.

In this way a process of naturalistic rationalization led to a neglect of any historical or personal dimension of the illness, something which became meaningful to the doctor only as a "clinical case" which was lacking in any kind of significant human dimension.

However, this approach led to a denial of one of the most evident characteristics of illness, namely, that it is at one and the same time both an affliction of the body and of the psyche and that for this reason without the treatment of both aspects health cannot be restored to the patient because the very concept of "health" itself refers to both physical and psychic well-being. Overall, when there is an attempt to alleviate the suffering of the patient without reference to his personal and human experiences and difficulties, this involves an accentuation of his spiritual suffering and the consequent risk that the goal of a real cure will not be achieved.

However, at the beginning of this last century of the millennium the emergence of psychoanalysis threw new light upon the interconnection between the human mind and the human body. The discovery of a psychosomatic dimension to many illnesses, and in particular the importance of the role of the actual wish of the patient to get better in rendering treatment effective, made a significant contribution to the positivistic excesses of the previous century. Yet these discoveries, for all their solid scientific bases and evident successes in terms of treatment, have still not produced significant real innovations in the mentality and practice of modern medicine. Today's medical doctor still tends to be rigidly "body-centered" and to deny the psychological aspects of illness, or, when such aspects become so evident that they can no longer be denied, to hand them over to the attention of a specialist. This kind of approach to this dimension of illness both demonstrates an inability to deal with what it involves and accentuates the conceptual dualism of psyche and body. When carried to extremes, this can reduce the spiritual disturbance of the patient to the level of any other kind of technical problem which should, therefore, be approached and handled in the same way.

The Didactic Roots of Technicism in the World of Medicine

We cannot but be amazed at the cultural backwardness of the medical doctor of today's world when we reflect upon the fact that the anthropological-ethical dimension is almost completely absent from his or her training. The university programs of the faculties of medicine have been in need of modernization for over fifty years, and it should be pointed out that the reform of the so-called "Table XVIII" has not brought about significant changes in this regard.

The degree course in medicine remains the longest that there is in the university world and is also one of the most demanding. What needs to be known, which is already very great, increases every year with advances in medical knowledge and research, and the need to keep up with developing knowledge at times does not allow the university teacher to arrive at a necessary overall picture and to place new facts within a general theoretical model. As a result, the textbooks are often already obsolete for the student who enters the course. In addition, the mind of the student is largely occupied in remembering what has been taught, and his time is so taken up with attending lessons that little room is left for deeper reflection upon the real object of his study—namely, man. A critical capacity in a strictly clinical sense is endangered by this enormous mass of information and of new principles and by the crisis which is taking place at the level of teaching.

The body of medical knowledge is now so great as to make specialization indispensable. The figure of the general practitioner has almost disappeared. The basic courses in the degree program are often divided into concurrent courses which are held by specialists. In each separate discipline within the medical area various specializations exist side by side and in the specialization courses themselves there are different special subjects.

This subdivision accentuates the physiological character of contemporary medicine—each specialist focuses on his own area of expertise, and medical doctors increasingly become the treaters of physical organs. It becomes doubly difficult to perceive the man and patient in overall terms when he is seen and understood merely as a collection of organs.

What without doubt makes the situation even worse is the enormous overcrowding of the faculties of medicine in our universities. On the one hand, this impedes attendance at lessons on the part of students, but it also makes the establishment of suitable relationships with patients in the wards more difficult. The vital importance of establishing a good relationship with the sick patient is accepted by all as being—at least in theoretical terms—an essential prerogative of the medical doctor. But for this relationship to be formed there must be daily contact with the patient, and the teacher must transmit to his students his own critical abilities as well as a sound ethical approach, not least by way of example. To employ the words of Jaspers: "The humanity of the doctor is also transmitted through his personality, imperceptibly, moment by moment, through the way he acts and speaks, and through the spirit which prevails in the ward."[2] But this humanity, which is the fruit of ethical awareness and sensitivity and of that mature judgement which is achieved through experience, cannot be written into the exam programs or into ministerial directives. It cannot be assessed in an examination mark. As a result, it is difficult to find a place for it in the evaluation of a candidate who aspires to take part in the medical profession.

Changes in the Social Relationship between the Medical Doctor and his Patient

This tendency towards hyperspecialization and the reduction of medicine to learning processes form a part of distinct general tendencies of our historical epoch which are based upon collective organization and the overpraising of results. And these principles have not failed to achieve a radical transformation in the organization of health care and the nature of the relationship between the patient and the medical doctor. Indeed, in the past this relationship was of a highly individual character—the doctor looked after a limited number of patients whose welfare he could safeguard and whose clinical and personal histories he was informed about. He was more a private or family counsellor than the provider of certain services. The social and economic changes which have taken place during the course of this century have certainly had the very important result of extending health care to the whole of the population, but at the same time they have also led to a radical change in the ways in which this health care is provided. To quote Jaspers once again: "With the release of medical help from the grip of private property and its free bestowal upon the individual, the action of the medical doctor has come to be organized along the lines of a commercial firm. Clinics, medical insurance, and laboratories come between patient and doctor. A world has grown up which makes medicine in its actual practice immensely more effective, but which at the same time comes into conflict with the function of the medical doctor. Doctors become functions.... Between doctor and patient powers grow up whose rules must be obeyed by both."[3]

This planned form of medical care, which, it should be repeated, is positive as regards the possibilities of making the best use of the resources which are available, improving the results of new knowledge, and facilitating the exchange of information and expertise within the profession, nonetheless leaves little space for the development of the personal relationship between the patient and the doctor who is treating him. This is so from the overcrowded offices of front-line doctors right up into the world of hospitals, where, it has been observed, "illnesses are divided by wards, like the products offered by a supermarket; and the doctors passing from bed to bed, rather as though they were on a factory line, strive to discover the causes of what has gone wrong in order to repair the organ which is sick."[4]

This organized form of medicine makes increasing use of an ever-greater range of diagnostic methods and instruments which bring with them the risk that a balanced analysis of the case will be submerged. On the one hand, the low level of clinical experience which characterizes many medical doctors and which is caused by those difficulties in the training process we have already referred to, and, on the other, the pressure exerted by commercial companies, whose power is ever more bound up with the worlds of politics and learning and study, both promote a state of affairs where often useless diagnostic inquiries and therapeutic applications are encouraged. These are, of course, frequently expensive and require a great deal of research.

The increasingly evident recourse to self-diagnosis and self-treatment on the part of the distrustful visitor to the doctor's office is encouraged by this state of affairs. It thus often happens that a patient goes to a general practitioner in the national health service and asks him to prescribe a certain test without offering any other explanations. In the case of the patient who has been admitted to a hospital, such overall developments become expressed in a series of procedures and tests which the patient does not understand and which disorientate him—when, that is, they do not actually inflict suffering on him. When a sufficient explanation has not been given of what their purpose might be, such tests and procedures can appear to him as having no clear purpose at all.

If all this causes suffering in the patient, it also has a bad effect on the medical doctor, who may come to feel deprived of his real role—that of being the restorer of the health of the patient and the intermediary between the patient and his illness. A denial of the human dimension of the patient means the

doctor is denied the satisfaction which contact with his patient promotes. The doctor finds that he is locked into an impersonal mechanism, limited by the requirements of hyperspecialization and interdisciplinary study in his ability to treat his patient, almost displaced in his diagnostic and evaluative functions by an abuse of various kinds of tests, and limited in his range of contacts with his patient by the intense turnover in the hospital wards and by the stressful pace of work to which he is subjected. In such a context the doctor often comes to feel frustrated and perhaps even superfluous. Here we are dealing with the dangers of what might be termed the "anthropological mutilation" of medicine.

Unfortunately, the abuse of methods and instruments of diagnosis is one of the causes which have led over recent years to an alarming increase in the costs of medicine and health care. During this period of crisis in the economic model of the Western world, attempts at reform based upon the goal of reducing the public deficit find in health care costs one of their principal targets for cuts. However, because of the economic pressures which have already been referred to in this paper, the greatest risk of all is that, instead of their leading to a rationalization of the use of technology, we will face, on the contrary, a reduction in the health care which is offered to the weakest parts of society—the chronically ill, the terminally ill, or those people who are without economic resources. At the same time technicism unwittingly supplies a theoretical justification for this kind of policy—when assessed in terms of mere efficiency, health care furnished to sick people who have no prospects of getting better or who are subject to socioeconomic conditions which worsen the prospects for their improvement may appear to be a waste of resources. Thus we can see that a reductionism involving reference to the body alone of the patient promotes a draining of potential ethical support.[5]

The Rejection of Death in Modern Society

But there is another aspect of technicism which requires discussion, and it is rooted in factors which are not so much of a scientific nature, but of a social and cultural character. It is the façade behind which modern society's rejection of death is hidden. The great trust in scientific progress of the modern age has produced in many of us the illusion that human knowledge has unlimited boundaries. Many dreams of antiquity which at one time belonged to the realms of poetic imagination and invention have become reality—man has learnt to fly, to land on the moon, to transmit sounds and images from a great distance, and to solve immensely complicated scientific problems and questions with the help of electronic computers.

Only one ancient myth remains unattained—immortality. Although medicine has been able to prolong the average life expectancy of the human species, the underlying final objective still remains, for the moment, unobtainable. It does not seem possible, or even perhaps desirable, to lengthen our existence here on earth indefinitely. However, psychoanalysis tells us that in the depths of our unconscious we consider ourselves immortal. Although a knowledge of the end of our lives is inevitably rooted in our consciousness, we find difficulty in accepting the idea to the full that we will die. Only a lack of knowledge of the exact moment when death will take place renders its existence tolerable to us.

In addition, many sociological factors make the idea of death unacceptable to modern man. In an opulent and hyperproductive society such as ours is in the West—that is, where material prosperity is all too often seen as the only possible good and where the mass media tend to construct an image of reality made up exclusively of beauty, wealth, and success—the dark sides of life, such as suffering, old age, and death, are increasingly marginalized, almost as though there were an attempt to remove them from general consciousness. In a perspective made up solely of worldly goods, the painful side to existence can only appear as an unthinkable and inexplicable void which has to be exorcised. It is inevitable that a loss of a sense of the transcendent meaning to life deprives its natural conclusion—namely, death—of meaning as well.

Behind the tendency to hospitalize illness there is often found an attempt to conceal this painful dimension of life from the eyes of society in the same way as in certain idyllic American cemeteries there is an attempt to hide the dramatic reality of death behind a front of flowerbeds and the sound of classical music.[6]

But the failure to accept such a reality, its marginalization or concealment behind an exaggerated technicism, and its "medicalization" cannot, on the one hand, prevent this reality from taking place and, on the other, render modern man ever more unprepared to face up to it. In addition, it has increased the suffering of those who are about to die because they have to endure the moral and material consequences of an isolation of which far too often they become the victims.[7]

In each and every one of us the vision of the death of another person provokes discomfort because it reminds us of our inevitable destiny. In the case of the medical doctor, there is added a sense of personal defeat in relation to his own capacities and expertise. This is perfectly understandable, not least because all doctors are aware from the outset that it is not always possible to save those whose lives are entrusted to them. However, it is precisely the tendency to see the death of a patient as an example of failure in treatment which is one of the main reasons behind attempts to delay the moment of death to the last possible instant through the employment of all the means and instruments at hand. In such a circumstance, technicism becomes the doctor's way of hiding his own failure at the level of treatment—whether such a failure is really present or not—and his own frustration. The inadequacy and malfunctioning of each organ is fought against, and the truth that the whole body dies is forgotten.

The tendency to look at the patient's body alone and not at his psychic make-up is a further factor behind this erroneous kind of perspective. The identity of the patient

also becomes lost from sight because it becomes identified and confused with his illness. In such an outlook death is quite wrongly seen as the final outcome of an illness and not as the natural end of a life.

We can see, therefore, how the above-mentioned factors are closely connected. Technicism and body-centeredness may at first sight seem to be mere "professional deformations" of the medical classes. In reality, a closer investigation shows that they are at one and the same time both the justification and the instrument of a more general cultural rejection of death which characterizes not only the medical doctor himself, but the whole of society as well.

Specific Questions Relating to Intensive Care

Therapeutic overkill is strictly connected with the phenomenon of technicism, and this is especially the case in the field of intensive care. This is so because of the presence of a number of factors.

First of all, the mentality of the doctor who is an anaesthetist and intensive care specialist makes it difficult for him to accept defeat. He is used to defending life, not least in very difficult conditions. The right meaning should be given to diagnostic and therapeutical obstinacy by the intensive care specialist. It is made necessary by the seriousness and the rapidly changing character of the clinical situation which this specialist has to deal with and by the fact that his task is to achieve a speedy diagnosis of the patient's condition in order to produce an effective and specific treatment.

Furthermore, the advances of a scientific and technological nature which have taken place over recent years in the field of intensive care have provided the expert in resuscitation—more than is the case with any other specialist in medicine—with ever more effective and long-lasting mechanical and pharmacological instruments of aid and support which enable the life functions of the human body to be kept going when they have entered into difficulty.

Indeed, it is even now possible to keep the physical extracerebral functions of the body functioning, albeit for short periods of time, even in the case of patients whose cerebral functions have ceased forever—that is, in those patients who have undergone "brain death." This kind of intensive care for patients who are to all effects already dead can only be justified—and the point should be made with great force—when the removal of organs for transplant purposes is envisaged. Any other reason for such a course of action cannot be justified in ethical terms. Indeed, we may assert that a patient who has already undergone brain death is an extreme example of the technicistic and physiologistic deformation perpetrated by medicine. We are dealing here with a human body which is entirely dependent upon a form of treatment where an erroneous use of technology can maintain the appearance of life even when this has in fact ceased to exist.

This is the condition most closely connected with therapeutic overkill. Such a policy, it may be recalled, can be defined as being a "treatment of proven ineffectiveness as regards its declared goal, to which is added an elevated risk for the patient and/or a specific kind of danger, and further suffering, where the exceptional character of the means and instruments employed are clearly disproportionate to the objectives of the situation at hand."[8]

The first defining criterion of therapeutic overkill, therefore, is proven ineffectiveness, and thus the actual uselessness of the treatment which is applied. It is based upon an evident contradiction as regards the conventional role of the medical doctor. In this "overkill" there is a stubborn and purposeless employment of treatment which has no positive effects for the patient and which thus destroys its "therapeutic" value and the very nature of what treatment actually is—that is, something which works to the benefit of the patient. This assessment is also to be found in the new Italian code of professional medical ethics, where in clause 13 diagnostic-therapeutic overkill is defined as being "the continued application of forms of treatment from which benefits for the patient or an improvement in his quality of life cannot be reasonably expected."[9]

It is also more than clear that a useful form of treatment, whatever its complexity may be, can never be found in a policy of therapeutic overkill. The employment and application of advanced diagnostic and therapeutic resources which are of a technologically developed character can only be fully justified if this takes place with a view to the exclusive well-being of the patient.

The second criterion, which is not explicitly referred to in the new professional code, is that relating to the dangers of treatment and the risks run of provoking further moral and physical suffering of such a character as to constitute "therapeutic violence."

The third criterion is that of the exceptional character of the means and methods of treatment, which must not be disproportionate to the objectives which the medical doctor wishes to reach.

It is clear that this last criterion is subject to a process of continual revision by medical science. Methods which at one time were considered not appropriate are today of routine and daily application. One need only think of the iron lung and hemodialysis, which are today employed even in the patient's own home. Judgments concerning the actual appropriateness of a treatment must take place within a context of a suitable knowledge of the clinical conditions of the patient and of the real benefit which is to be gained from the application of that form of treatment.

To conclude, it should be observed that just as therapeutic overkill is not a matter of its complexity or its aggressiveness, but of whether its intensity is appropriate to the actual conditions of the patient, so, in the same way, it is not the intense use of technology which determines technicism, but the goal towards which it is directed. Thus the medical doctor "must look at all the forms of technology available with a certain detachment, much as he would consider what methods he would choose to achieve a certain end."[10] This end, it must be repeated once again, must be that of treating and caring for the patient, not his illness.

A Return to the Hippocratic Approach and the Christian Vision

The critical revision of technicism has led to a rediscovery of the ancient Hippocratic approach to medicine. In this holistic way of thinking the illness is not a mere phenomenon of the body, but an expression of a man's imbalance as regards his body and the world which surrounds him. For this reason the medical doctor must treat the patient as a whole and in cooperation with the patient himself. A paternalistic and positivistic relationship based upon dependence is set against an interdependence which takes place within a relationship of interaction between the doctor and the patient.

The opposition between these two rival forms of practicing medicine was already evident during the days of ancient Greece. In his *Laws* Plato distinguishes between the doctor who is a slave and treats slaves and the doctor who is a free man and treats free men. The first kind of doctor examined the sick slaves in special treatment centers. He never explained the reasons for their illness and never listened to what the sick slaves had to say. He hurriedly prescribed what he thought was best for the patient and then went on to another case. The second kind of doctor looked after people who had the status of being free. He analyzed their illnesses with reference to what had caused them and to this end engaged in conversation with the patients and those who were closest to them. He informed the patient about the illness he was suffering from, or insofar as the patient could understand what he was being told, and never prescribed remedies before obtaining the patient's agreement as to their potential effectiveness. The sick person wanted to know about his illness and its treatment so that he could reach an independent decision. His trust was great, but by no means blind. Plato relates an anecdote about Aristotle, who, when he was ill, said to a doctor who was prescribing a treatment for him, "Tell me why you are doing this, and if I am convinced, I will do as you tell me."

However, this kind of relationship cannot exist without real mutual respect, and this is something which is based upon a knowledge of the patient in his entirety, without any kind of reductionism.

This return to a more "human" dimension of the relationship between the medical doctor and his patient naturally takes on a new meaning in the Christian view of charity—the treatment of illness is an opportunity to give one's neighbor one of the greatest of gifts: health. And this is understood in terms of physical and moral well-being and the restitution to the sick man of his dignity. "The approach, which is full of humanity and love for the sick person and which is rooted in an integrally human vision of sickness and animated by faith, finds expression in this therapeutic effectiveness of the relationship between the doctor and his patient."[11] The healthcare worker must so steward his relationship with the patient that his sense of humanity strengthens his professional skill and his expertise is made more effective by his ability to understand the sick person whom he is to treat.

An understanding of the real needs of the patient is a fundamental prerequisite for medical ethics. Among other things, it guarantees that the technology and methods available to the medical doctor remain confined to their role as instruments—that is, techniques employed but never ends in themselves.

Technical methods must be evaluated with reference to their ethical acceptability, which is a yardstick to determine if they are compatible with a human approach. To put it another way, their employment must be carried out in defense of, and with respect for, the dignity of the human person. Science and technology "cannot on their own demonstrate the meaning of existence and human progress. As the creation of man, from whom they spring and develop, their purpose and their limits must be based upon the human person and the person's moral values."[12]

It is for this reason that "science must be united to wisdom. Science and technology are in the vanguard—that is, they push back their frontiers every day. Wisdom and conscience point out to them the inviolable limits of man."[13] "Our age, more than in past centuries, needs this wisdom so that all new discoveries may become more human."[14] Hippocrates said that the physician should love wisdom—*iatros philosophos isotheos*: the medical doctor who is a philosopher is like a god. The doctor, indeed, draws upon scientific knowledge, not with the attitude of one who thinks that he is all-powerful, of one who declares that he is sophos, or wise, but with the belief that he is philosophos, the person who loves every form of knowledge because he knows the limits to his own knowledge and never tires of trying to increase it.

Professor CORRADO MANNI
Director of the Institute for Anesthesia and Resuscitation at the Catholic University of the Sacred Heart, Rome

Notes

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[10] REISER S.J., *La medicina ed il regno della tecnologia,* Milano, 1983, p. 316.

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SILVIO GARATTINI

New Therapies in Medicine

Over the last decades the advances in medicine in relation to forms of treatment and different kinds of therapy have certainly been greater and of more significance than over the last millennia. This has been the result of the great strides forward in scientific research which have advanced our basic knowledge and allowed such knowledge to be applied to the development of new pharmacological therapies. It has further permitted the effectiveness of such forms of treatment to be tried and tested in controlled clinical studies. A long list of illnesses which can in large measure now be cured is the result of this combined effort on the part of experimental laboratories and clinical centers of research throughout the industrialized world. Great hopes today reside in the future possibilities of advances in molecular biology. The hope here is that through the identification of genic and proteinaceous structures modern pharmacology will have new targets at which to aim in the certain belief that subsequently—although within a space of time which it is difficult to predict—new therapeutic instruments will become available. Table 1 presents an albeit simplified vision of the most promising forms of intervention in this whole area, even though it should be stressed that the outlook and the information we have available are certain to change very rapidly in the future.

However this paper will seek to avoid a triumphalistic tone or present lists of possible imminent discoveries. Instead, it will concentrate on a series of facts and factors which bring out how these new therapies do not always meet the needs of all sick people but rather are designed—although with obvious exceptions to satisfy the interests of the great pharmaceutical multinationals. It seems to me that such an observation is very appropriate in the context of an international conference such as that which is being held here during these few days, and in this place.

Table 1: The Development of Modern Biotechnology as Exemplified by New Products(3).

- New therapeutic agents of a proteic nature (recombinant products).
- New strategies and new products which can modulate the action of specific genes (and more specifically gene therapy, antisense oligonucleotides).
- New strategies and now composites which can block the activity of peptides and proteins through biological action (monoclonal antibodies, soluble receptors, selex).
- New approaches in the screening of molecules produced by organic synthetic chemistry (combinatorial chemistry).
- New methodologies for the rational development of molecules of a classic kind produced by organic synthetic chemistry (rational drug design).

Clinically Available Products

Insulin, growth hormone (hGH), erythropoietin (EPO), granulocyte-macrophage-colony-stimulating factor (GM-CSF), granulocyte-colony-stimulating factor (G-CSF), interferon alpha, interferon beta, interferon gamma, follicular stimulating hormone (FSH), interleukin-2.

Products in Use at an Experimental Level

Anti-inflammatory cytokins: receptor antagonist of interleukin-1(IL-ra), interleukin-4, interleuin-6, interleukin-10, interleukin-13.

Growth factors: neuronal growth factor (NGF), thrombopoietin (TPO), basic fibroblast growth factor (bFGF), acidic fibroblast growth factor (aFGF), platelet derived growth factor (PFGF).

With regard to levels of actual innovation in the availability of new drugs, a recent study[1] demonstrates that of the thousand pharmaceutical products or so registered in Italy during the period 1984-1992 less than 2% actually represented an improvement on the therapies which were previously available. An analysis of the products registered in line with the required procedures of the European Union during the period January 1995 to May 1997 shows that only six proximate principles—out of thirty-one pharmaceutical products whose commercialization was formally authorized—involve a real demonstrable advance and an advantage for sick patients.

There is also a great gap between what is produced in terms of research by the pharmaceutical industry (which by tradition is concerned with the development of new drugs and medicines) and the actual therapeutic needs of sick people. The same may be said to a certain extent in relation to the interests of the national health service which administers therapies and pays for them on behalf of patients.

Rare Illnesses

There are about 5,000 illnesses which be classified as being rare because of the fact that their incidence is very low, even though it should be pointed out that what is rare in

one geographical region can be relatively frequent in another. The United States of America and Japan have used different parameters by which to define rare illnesses (respectively one in a thousand and one in ten thousand) while in Europe the tendency has been to avoid a purely statistical approach. Rare illnesses are in large measure genetic in origin and are identified as such in the various branches of specialized medicine. Our knowledge about these illnesses is relatively limited even though thanks to projects such as Telethon there have been recent major advances in the identification of genetic failings or changes. Rare illnesses can also be environmental in origin and caused by special situations of local pollution.

In general,there are very few therapies designed to treat these rare illnesses and often such therapies are not of proven effectiveness. Table 2 lists all the therapies which are used in the treatment of hemolytic uremia. In reality it is very difficult for specific therapies to emerge because the know-how for such a development—in fundamental terms—exists only within the pharmaceutical industry, and because this industry is not interested in dedicating large resources to an undertaking which does not give a suitable economic return. For this reason, rare illnesses are deemed "uneconomic" and the drugs and medicines for rare illnesses are usually defined with the denomination "orphans".[2]

Table 2: Therapeutic Responses to the Uremic Hemolytic Syndrome and Thrombotic Thrombocytopenic Purpura

• Splenectomy	1936[12]
• Glucocoticoids	1959[13]
• Blood Exchange	1959[14]
• Heparin	1960[15]
• Anti-piastrinic Agents	1972[16]
• Plasma Exchange	1976[17]
• Plasma Infusions	1977[18]
• Prostacyclin	1979[19]
• Vincristine	1979[20]
• Immunoglobulin	1985[21]

It is calculated that all the rare illnesses counted together represent at least 10% of all pathologies and for this reason it is not acceptable that those who suffer from rare illnesses come to be condemned to being deprived of the hope which springs solely from the existence of new research into new drugs and medicines. We should among other things emphasize that rare illnesses contribute to our understanding of illnesses which are more common. For example, without the illnesses which are connected with hematic coagulation our understanding of the processes of hemorrhage and thrombosis would be less advanced and sophisticated. Research into rare illnesses should not be dedicated solely to the development of drugs and medicine or to the advance of genic therapy. Preventive steps in the form of genetic advice, or in the future perhaps genic modifications connected with techniques of assisted fertilization are equally important in this respect.

Tropical, Infectious, and Parasitic Illnesses

For opposite reasons the illnesses present mostly in developing countries must be considered "uneconomic" in the above-mentioned sense. Indeed, even if new drugs and medicine were to be discovered for the treatment of malaria, leprosy, tuberculosis, schistosomiasis, trypanosomiasis, and filariasis, the patients who would benefit from such drugs and medicines would not have the economic resources to buy them. And yet, as table 3 makes clear, these illnesses are very common in today's world.

Table 3: Data on the Most Widespread Tropical Diseases

Illness	No. of Victims	Notes
Malaria	300-500 million	1.5-2.7 million deaths every year (including about one million children under the age of five.
Chagas' disease	18 million	45,000 deaths a year
Schistosomiasis	200 million	
Onchocerciasis	17.6 million	
Filariasis	100 million	
Leishmaniosis	12 million	
Trypanosomiasis	300,000	

Source: WHO: 31/7/1995

The research conducted into these illnesses is limited and is largely concerned with the protection of American military personnel working in regions at risk. The World Health Organization has a research program which is still in being (TDR—Tropical Disease Research) to discover and develop drugs for the treatment of such illnesses but its resources and funding are so completely inadequate (about twenty million American dollars) that the program is not really significant. The contributions of the industrialized countries to this program are in decline, which is a scandal, and the funds allocated by the European Union to research programs for the developing countries are also very inadequate.

It should be emphasized that never before has modern research been able to provide such important information on those receptors, enzymes and genes of microbes and parasites which could be very promising targets for the discovery and development of new pharmaceuticals. In the same way one could well envisage the development of new vaccines through the employment of our new advances in knowledge in this area. However, suitable economic resources for such undertakings are totally lacking and thus there are severe obstacles in the way of the establishment of groups of researchers who could develop and advance tropical medicine.

Drugs and Medicines for Non-Responders

Therapies which are considered effective, even in relation to the most common forms of illness, are not effective for all patients who are treated with them. These patients are deemed to be resistant or are termed "non-responders," and for them effective therapies must be found. To give some examples of this phenomenon, it may be remembered that about 30% of patients with serious depression have an insufficient response to the usual anti-depressive drugs (the tricyclamols or inhibitors

of the serotonin uptake); that 10-20% of patients who are carriers of helicobacter pylori (a micro-organism which is thought to be responsible for duodenal ulcers) do not respond in any meaningful way to the current types of therapy (antibiotics + inhibitors of the H2 receptors or the inhibitors of the protonic pump); and that about 7% of patients who have had a myocardial heart-attack subsequently die even though they have been treated with fibrinolytic drugs.

Non-responders find themselves in a situation where they do not have suitable treatment and they thus constitute a small proportion of patients as a whole. They are in a category very like that which consists of people who suffer from rare forms of illness. In this case as well the low number of patients who might benefit from a new therapy means that such a therapy is not developed for reasons which are fundamentally economic in character. From a narrowly commercial point of view, it is of course better to develop drugs and medicines which could appeal to a large market.

Illnesses such as cancer are in a very different situation. Here one is dealing with a large number of patients and the economic incentive to produce pharmaceuticals which are successful with forms of cancer which are resistant to the usual anti-tumor drugs continues to be of a significant force because the market remains favorable.

The Need for Comparative Studies of Pharmaceuticals Which Belong to the Same Therapeutic Category

Contrary to what is generally believed, and as has already been pointed out, really effective "new therapies" in the pharmaceutical field are relatively rare. Indeed, the market is dominated by copies of the same proximate principles which are present under different names, or by analogues which do not offer real advantages when compared to the original prototypes. Table 4 sets out the number of analogous substances which are available for twenty-three proximate principles which can be defined as being "prototypes" and are thus real innovators in the field. There are 199 such similar substances and over seven hundred products which compete on the market for the prescriptions made out by members of the medical profession. Table 5 describes the excess of pharmaceuticals which exist for cardiovascular treatment.

In reality, the development of many analogues does not meet the real needs of patients but is the outcome of a commercial attempt to make inroads into the market. For this reason the analogues of existing drugs are also known as "me-too" products. Although it cannot be denied that in certain rare cases a "me-too" drug does indeed offer greater therapeutic effectiveness or perhaps better results from a side-effects point of view, in the vast majority of cases the "me-too" drugs do not offer any particular advantages over the prototypes, not least in econom-

Table 4: Some Classes of "Me-Too" Drugs in Italy (1994)

No.	Class	Active Principles	Pharmaceutical Products
1	Cephalosporins	28	122
2	NSAID	23	109
3	Benzodiazepines	17	36
4	Heparins	15	25
5	Tricyclic antidepressants	14	18
6	Beta-adrenoceptor blockers	13	14
7	Iron salts	13	42
8	Glucocorticoids	12	34
9	Beta-adrenoceptors agonists (aerosol)	11	20
10	ACE inhibitors	11	26
11	Sulphonamide antidiabetics	11	17
12	Ca^{++} antagonists (dihydropyridines)	10	36
13	Prokinetics	8	24
14	Urinary antiseptics	8	40
15	H2 antagonists	7	39
16	Nitrates	7	23
17	Fibrates	6	19
18	Fibrates (selective)	6	12
19	Benzamides	6	15
20	Bile acids	5	24
21	Anthracyclones	5	4
22	Serotonin uptake inhibitors	5	8
23	5-HT3 antagonists	4	9

Table 5: Some Classes of Proximate Principles and Products Distributed Free by the National Health Service for Cardiovascular Therapy

Pharmacological Class	No. Proximate Principles	No. Products (confections)
Cardiac Glycosides	1	8
Diuretics	15	38
Anti-arythmics	7	17
Beta-adrenergic blockers	16	53
Anti-hypertensives	3	12
ACE inhibitors	18	70
Alpha-adrenergic blockers	2	15
Angiotensin II receptor inhibitors	1	3
Nitrates	4	51
Calcium antagonists	10	99
Simpatomimetics	1	1
Heparins	2	35
Oral anti-coagulants	3	5
Anti-piastrinics	2	14
Hypolipemisers	4	21
Hypocholesterolenisers	4	16
Total93	458	

ic terms. For example, the eight analogues of captopril (the first inhibitor of the conversion enzyme of angiotensin II with an anti-hypertensive action), like the large number of non-steroid anti-inflammatory drugs (NSAID) or the twelve analogues of diazepam which have an ansiolytic effect, are in essential terms completely the same except for certain minor differences which are irrelevant from a therapeutical point of view.[4] However it should be added that their equivalence is not totally proved because the clinical studies which have been carried out do not exclude that some of them in fact have a minor different effect.

Indeed, what generally interests the pharmaceutical industries - and this in the absence of rules which require real and effective comparative studies—is the proof of an effective analogous effect to the products which already exist (equivalence) in order to enter the market. For these reasons we now lack a sufficient number of serious and controlled studies by which to establish what the real equivalence of these analogues is in relation to the original prototypes. In the same way it cannot be imagined that the pharmaceutical companies will in fact carry out this research because were a drug to be found to be inferior to others they would run the risk of losing their market possibilities.

Whilst in the past research was conducted to discover analogues which were in some respect new—even though clinical trials and testing did not actually demonstrate that they had any particular advantage - today many studies which are very intricate begin clinical trials and testing with the sole objective of trying to demonstrate an equivalence to the existing drug (see for example the case discussed in table 6). Without wanting to enter into statistical details for which the reader may wish to consult the specialist literature(5-6), it is none the less true that the study of equivalence raises question of an ethical nature.

Indeed, in order to meet ethical requirements clinical tests and trials must be so organized as to provide a certain answer and must examine the hypothesis that an advantage is being gained for the sick person. They expose many patients to tests and trials knowing from the outset that the new drug can only be equal to those which are already on the market and they are not sure that it is not inferior. This is not ethically acceptable. What we need to do here is to go more deeply into the problem and to involve ethical committees and groups of patients with a view to modifying the existing legislation. In this way it will be possible to ensure that purely market-motivated interests do not transgress the rights of patients. It could be objected that in this way medical progress comes to be obstructed. But nothing could be more erroneous because when too much space is conceded to products which are destined to increase the market then the resources available for the discovery of really new drugs, and the efforts made to produce them, are correspondingly reduced. The analysis of the pre-clinical characteristics of a new proximate principle should have more importance paid to it above all else when it is possible to demonstrate that the new product works by a mechanism which is different from that of the existing pharmaceuticals.

Table 6: The Question of Equivalence[11]

The relationship between cost and effectiveness allows health services to choose the cheapest treatment possible from a number of alternative therapies of equal effectiveness and safety. It is important to establish if a therapy is as equally effective (without being necessarily superior) as another form of treatment which on the basis of the results of clinically controlled studies is the best possible therapy for a specific pathology. The methodology of the clinical trials on effectiveness is not always applicable to the realm of equivalence. The trial is useful in detecting differences between forms of treatment but if two therapies are not different in terms of their clinical effectiveness they should not necessarily be considered equivalent. Certain guidelines suggested by the European regulatory authority (CPMP Working Party on Efficacy of Medicinal Products, see footnote 5 for details) seek to prevent methodological errors which involve an uncritical reading of the results of a trial in terms of "equivalence" rather than "non-difference." Despite such warnings, the interpretation of the results of a trial often gives rise to a number of doubts and uncertainties.

An Example

The INJECT trial (6) compares two thrombolytic strategies in the treatment of acute myocardial infarction. It is argued that a new tissue plasminogenous activator (tPA) is able to reduce mortality by 1% in patients treated with steptokinasis (SK) after the heart attack. But given the difficulty of demonstrating this theoretical advantage an attempt is made to verify if the experimental treatment is at least equivalent to the standard treatment.

Mortality in the first month of the infarction is 9.5% in the SK group and 9% in the tPA group—a reduction of 0.5% which would suggest a band between a possible reduction of 1.98% and a possible increase of 0.96%. The worst result which could be envisaged, therefore, is less that the 1% increase in mortality adopted as the criterion of equivalence in the protocol of the trial. This result draws even further away from the pre-established limit of the 1% excess of death-rate incidence if only those patients who have received the treatment are taken into account and if a less conservative test is applied subsequently—the maximum excess of mortality in the tPA group, as compared to the SK group, becomes only 0.7%. The conclusion as a result is that there is an equivalence between the two forms of therapy.

But there remains the fact that a potential added risk of 1% (or of 0.7%) is disproportionate and thus rather unacceptable if applied to an event which has an incidence of 9% and a pathology which is widespread in the population as a whole. Expressed in figures, this would mean considering as equivalent to the standard present-day treatment something which when applied to the 500,000 patients afflicted by infarction every year in Italy could indeed save 900 lives but could in addition also sacrifice over 400. Doubts and uncertainty increase when one considers the safety of each form of treatment—for example, over 6,000 patients in the tPA group, compared to 5,000 in the SK group—could suffer a cerebral ictus in the immediate post-heart-attack period.

In conclusion, it should be observed that though this consideration may well appear surprising, a judgment of equivalence requires even more caution than a judgment of effectiveness. Furthermore, the scientific data and proof relating to the equivalence of different forms of treatment require an improvement in the methodology of the trial which has, however, provided very important results in terms of defining the effectiveness of pharmaceuticals.

It could also be argued that this restrictive approach could impede the development of general drugs (those which are copies of the proximate principles which have gone beyond the patent stage and which are sold under a general name in the place of products with a commercial name). However, in this case the goal in studying the equivalence of such general drugs in relation to the original products is that of reducing the price which has to be paid. And therefore the aim is to obtain an advantage for those—whether public authorities or private individuals—who have to buy pharmaceutical products.

The Reduction of the Number of Patients who are Treated to no Effect

The use of large number of drugs and medicines has favorable results only in a small proportion of patients who receive this kind of treatment. In general, these are pharmaceuticals used in primary or secondary prevention which have to be administered for many years or even for life. For example, the use of aspirin in patients who have survived a myocardial infarction reduces the mortality rate by 4% each year. In a million of patients this means 40,000 less deaths every year—a very high figure which fully justifies the use of aspirin. However, if one looks at the matter from another point of view, it becomes clear that 960,000 patients are exposed to a drug without gaining any advantage in terms of mortality rates but at the same time have to endure serious side-effects (gastric ulcers), although this happens in only a few cases.

The "Woskop" study (7-8) revolved around an examination of the use of pravastatin (a drug which reduces hypercholesterolemia) in a work of primary prevention. It revealed a decrease in the mortality rate of 2%. This means that in treating a million people it is possible to save 20,000. But in this case, too, 980,000 people were treated without gaining any benefit in terms of mortality incidence, and at the same time were exposed to the possible risk of cancerogenesis.(9) For the problems connected with the use of statine in the treatment of hypercholesterolemia see table 7.

It is clear that *ad hoc* studies could be used to understand the characteristics of patients who respond positively to treatment as opposed to those who do not respond in such a way. Such studies would allow us to identify those people who do respond and thus to diminish the number of patients who are treated to no effect. However it is unlikely that such studies will be carried out directly by pharmaceutical companies because this would lead to a very significant reduction of the potential market for their products.

Table 7: Hypercholesterolemizing Pharmaceuticals: What Advantages?

A Model Path: The Case of the Statins

Pharmacological Effect:	
• Biochemical	By inhibiting the hydroxymetilglutaril coenzyme A (HMG-CoA), the statins reduce the synthesis of cholesterol and the production of LDL by the liver. In this way, they reduce the level of cholesterol in the blood by 20-25%.
• Biological	They reduce the arteriosclerotic plaques.
Clinical Effectiveness	They reduce coronary episodes by a third: from 8.5% to 5% in secondary prevention and from 7.9% to 5.5% in primary prevention. They reduce general mortality rates by a third: from 11.5% to 8.2% in secondary prevention and from 4.1% to 3.2% in primary prevention.
Epidemiological Effectiveness	They increase by four months (74.5 years) the life expectancy of a man of 59 with medium to high levels of cholesterol (260mg/dL). They are given to 30 patients for five years to avoid: 1 coronary event and 1 death in secondary prevention. They are given to 110 patents for five years to avoid: 1 death in primary prevention.
Cost Effectiveness	In a man aged 59 with medium to high levels of cholesterol one year of added life costs $5,400—that is, a little more than 9 million Italian lire.

The benefit/risk and risk/benefit dimension of a therapy is never made sufficiently clear. Although rich in evaluations and information, the example of the statins which have here been taken as a case study has many rather unclear aspects. For example, the fact that the survival curve of the patients treated with statins in the trials cited above tends to diverge progressively in comparison to the survival curve of the control group might induce one to believe that a treatment which went on forever could guarantee an effectiveness superior to that observed during the period of the trial. In reality, we still do not know the risks which this treatment involves for patients in the long term. We know only that these grow with the use of the pharmaceutical within the population as a whole. If the cancer-inducing effect of statins detected in animals were to be confirmed in man as well, what would be the benefit/risk relationship of a treatment over a long period? And given that the question can still be posed profitably—what would be the relationship between cost and benefit?

Concluding Observations

The examples given above well demonstrate that there are broad areas of therapy which are deficient or are dealt with in a way which is not constructive. All this arises from the fact that our society has delegated the vast majority of activities devoted to the discovery of new drugs and medicines to the pharmaceutical industry. It is clear that one cannot ask, and one cannot oblige, those who are engaged in the pursuit of profit to deliberately turn their backs on the making of profits. The development of knowledge and techniques in the sphere of therapy and treatment, and a greater awareness of the rights to fairness which sick people possess, means that the problem much be approached from a different angle in order to provide answers to new needs. We should not

in some way penalize the work of the pharmaceutical industry which should, rather, be improved so that the discovery and the use of new drugs and medicines is not conditioned by purely economic factors.[10]

We should urgently create new ways of promoting new therapies understood in the broadest sense of the term—without reference to narrowly commercial considerations. This objective can be reached by a number of routes. First of all we should mobilize new resources for research and render the approval of analogues of existing products more difficult. This can be achieved through the limitation of the number of registrations in a way which corresponds to the presence of the pathology or through demanding more detailed comparisons with drugs and medicines which already exist. As has happened in the United States of America and in Japan, in Europe, too, we should introduce legislation which, through exclusive rights to commercialization and a series of incentives to carry out clinical research, would facilitate the availability of "orphan" pharmaceuticals for rare illnesses and tropical diseases.

Secondly, we should introduce suitable fiscal incentives at a European level for those who carry out research which has no industrial relevance. These incentives could take the form of contributions, interest-free loans, tax reductions, the tax deductibility of certain social costs, and so forth. Thirdly, we should set in motion a series of projects at both a national and an international level. In Italy the creation of a "National Medical Research Council" to deal with the needs of the national health service could be a useful body by which to promote research into therapies which are of public interest. At a European level, the fifth program of the European Union may offer a great opportunity in this direction, especially as regards rare illnesses and "orphan" drugs which in truth constitute a problem which goes well beyond national boundaries. Lastly, one could envisage the creation of an agency at a European level to provide grants and contracts by which to finance and promote all the therapy research which is necessary to our healthcare systems.

In conclusion, it should be observed that today there exist very real opportunities for the creation of new therapies. However, we need to remember that not all therapies have an interest for the pharmaceutical companies. For this reason, we should develop alternative strategies to those which at the present prevail.

Professor SILVIO GARATTINI
Director of the Mario Negri Institute for Pharmacological Research, Milan

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ELIO SGRECCIA

The Potential and Limits of Scientific and Technological Progress

Experimental Science and Technological Support

This title is very general and requires certain key clarifications at the outset. In the first place this paper will address itself to scientific and technological progress in the biomedical sphere even though it is fully realized that this progress exists within a framework of the development of modern science where other factors of a cultural and social character are also present.[1]

Furthermore, it seems to me clear and evident that this paper should dwell first and foremost upon the possibilities and limits in an ethical sense of such scientific and technological progress.[2]

It is known that there can be other limits to scientific and technological progress—for example, an absence of suitable funds, a lack of freedom, or failures at the level of education, but in this paper it is ethical limits that will be referred to and analyzed.

One final clarification should be made in relation to the meaning of the phrase "scientific and technological progress," a phrase which links science and technology together and emphasizes their mutual bond.[3] In this paper the word "science" is taken to mean *experimental science*, that is, science involving the experimental method as begun by Galileo and Bacon and carried on in medicine by C. Bernard.

By *science* one means the process of the acquisition of knowledge through the observation of objects, facts and natural phenomena employing a systematic and rationally convalidated system of an inductive character guided by a rationality which is directed towards understanding causes. The application of the experimental method to science has brought a characteristic rational model to the process of inquiry which looks for causes in facts and phenomena through the reproduction of the processes involved in order to discover the laws which govern the phenomena of the universe. The experimental method is marked by its own logical structure which begins with the observation of facts based upon the previous acquisition of knowledge, then proposes an explanatory hypothesis, subsequently engages in a repetition of the process in a laboratory or real life, and then concludes with a verification of the results and conclusions. It should be emphasized that this rational process is not by its nature merely technical or almost mathematical because in the formulation of the hypothesis there is space for inspiration or intuition, for creativity, and at times for chance itself—what can happen is that by accident in the search for a result a causal connection is discovered which was not actually being looked for at that moment.

By *technology* is meant the applied consequences of scientific discovery but today it is also clear that technology is connected to observational/instrumental research as well. This is because there exist forms of technology which are engaged in the extension of knowledge and for this reason technology itself helps to promote its own system of knowledge. It would, for this reason, be simplistic to posit a net division between science and technology, and thus between scientific progress and technological progress.

After making these necessary and elementary preliminary observations, I believe that ethical debate about the guiding values and the binding limits which regard scientific and technological progress in the biomedical field should concern itself chiefly with highlighting and clarifying two points which are themselves interconnected:

a) What is the *epistemological basis* of the relationship between experimental science and technology on the one hand and ethics on the other? What is being asked here is whether there is a reason which can be justified in rational terms for allowing ethics to intervene in the development and application of scientific and technological progress Or is one dealing with what is in reality an intrusion? And if there is such a reason what space should ethics have in the field of scientific research and its various phases of application? This is the problem which is usually defined and described with the phrase "epistemological justification."

b) The other question, which follows on from the first, and in relation to which contemporary public opinion is markedly sensitive, is that of the autonomy of science, and from this there flows the problem of the limits which should be placed by ethical imperatives and requirements on scientific and technological progress.

It is upon these two hinge areas that this paper will concentrate its attention in summarizing fashion, and in accordance with the time

that is available.

As a general framework within which to consider these two chief questions, there should however be placed the fact—which is acknowledged by everybody—that scientific and technological progress in the biomedical field has over the last fifty years experienced an exceptional acceleration. J. Bernard argues that two revolutions have taken place since 1937. First of all, there was the discovery of the sulphamides in that year, which, "after millennia of powerlessness gave man the ability to conquer illnesses which had for a long time been fatal—tuberculosis, syphilis, the major forms of septicaemia, infections of the endocrine glands, and disorders of the chemistry behind moods."[5] To the discovery of the sulphamides should be added the discovery of penicillin.

This first revolution was supported and promoted by the processes of clinical experimentation, whose rules and rational spirit had been formulated by the famous scholar and expert C. Bernard.

The other revolutionary stage in this story was marked by the discoveries in genetics and molecular biology which began with G. Mendel and are now being carried forward by genetic engineering and gene therapy.

The advent of the experimental method was certainly a factor for acceleration. But a further element in this acceleration was to be found in the joining together of science and biomedical technology in a close bond of interdependence. One cannot imagine, for example, the carrying out of genetic diagnoses without the creation and the application of techniques which make such diagnoses possible. In the same way, the discovery of the structure of genes and the reading of the genetic code would not have been possible without such a preliminary and vital first step.

The experimental method and the use of increasingly sophisticated forms of technology have engendered this further acceleration in the biomedical field. The joining together of scientific and technological knowledge has also had another effect—the opportunity not only to know, but also to manipulate, engineer, and produce changes in the connecting links of natural causes and structures.

The dream of the first experimental age was to understand the secret of nature, to discover the laws of nature. The idea of the researcher today, supported as he is by the expert in technology, is to intervene and to change in order to obtain results which would not be obtained through the normal natural processes. I would say that the researcher of the past was moved by the spirit of Ulysses and that his counterpart of today is often animated by the impulse and the hubris of Prometheus. Karl Popper's idea that the linking together of science and technology has produced a "world number 3" is well known.[6] In the opinion of this scholar the world of culture and productivity are to be seen within society as the outcome and result of man's intervention in the realm of nature.

A further causal factor has been illuminated by sociologists, that of a social and economic character. Today we are becoming ever more aware that science and research are increasingly dependent upon the requirements and demands of society both from a cultural and an economic point of view.[7] We do not need to go deeply into details by way of example to detect the connection between research policies, funding, and scientific and technological progress. This is true not only as regards military research or competition between states but also in the medical field as well. The relationship between science and the economy is not in itself negative as long as the intention is to respect life and respect authentic human values, and to defend and promote health and conquer illness. But it often happens that the goals are of a very different kind. One thinks here of research which is carried out in the areas of contraception and pregnancy avoidance, and birth control, or in the military field. But attention will now be turned to those two key questions which have been deemed of essential importance to the ethical discussion conducted by this paper.

The Relationship between Scientific/Technological Progress and Ethics

A Justification

Certain investigations suggest that the idea that there can be ethical limits to research is not very widely held among scientists. An inquiry carried out a few years ago into the interests and concerns of scientists produced the following results.[8]

Independence in Research	90%
The Pursuit of Knowledge	80%
Functions and Responsibilities	50%
The Management of Research and Politics	40%
Ethical Questions	25%
Science and Faith	5%

Robert Nozick's affirmation to the effect that "microscopes and telescopes do not reveal ethical elements"[9] is certainly provocative, and Renato Dulbecco observes that "for centuries scientists kept themselves distant from the tragedies of history and defended the independence and the *neutrality* of their role within society. With Baconian and Cartesian pride, they rejected every attempt at control and interference by, and from, each and every quarter—whether government, churches, or other kinds of authority."[10]

At the same time we know—and the rise of bioethics bears witness to this—that an impulse towards ethical reflection has often come from scientists before coming from philosophers: Potter was a researcher who posed ethical questions; after the discoveries relating to DNA it was the researchers and the discoverers themselves who imposed a moratorium on their work after the Gordon conference of 1973; and the first elaboration of ethical rules in relation to genetic engineering was the work of the Assilomar Conference of 1975, which was attended by the most important experts in the world on the subject of *in vitro* genetic manipulation.[11]

Many people have supplied an answer which in reality appears to be the most obvious: the need for bioethical reflection occurs at *the moment of practical application*. It

is believed that experimental research is by its very nature neutral and that its practical application requires a previous bioethical analysis of possible consequences and risks.[12] This is true because nobody could deny that before proceeding to apply a scientific discovery in the biomedical field—for example, the technology relating to the restructuring of DNA—it is first necessary to pose a series of bioethical questions about the goals, consequences, risks, and so forth which are involved. However, a recognition of the role of bioethics and what justifies it only at the moment of practical application is insufficient and limiting, as will be demonstrated. Ethics and bioethics are relevant at the stage of experimental research as well. For example, they are also present at the very moment of initial programming.

Other scholars and experts admit that in general there is an *intrinsic ethical element* within scientific research, but only in the sense of loyalty to the canons of research itself. Such an ethical element, for this reason, is to be found in methodological honesty and rigor, in exact truthfulness in the communication of results, and in a transparency of the procedures employed so that they can be checked by the scientific community. This "intrinsic ethical element" in research is a valid deontological requirement for every kind of science, and it is thus also essential to bioethics, which is concerned with biomedical research.

In the opinion of some authorities, this intrinsic ethical element includes certain essential features which are indeed defining aspects of research. Merton has listed them in what he terms "Merton's paradigm": *Communism*, which means placing the results at everybody's disposal; *Universalism*, which means evaluating the results, whatever their source; *Disinterestedness*, which means exactly that; and organized *Skepticism*, which means systematic doubt. The acronym CUDOS has come into being to describe this list of qualities. Other experts and scholars have added the notions of *Originality* and *Humility* to this list, and the ability to engage in a *Recognition* of other people's talents and capacities.[13]

Some people, however, have been rather skeptical as regards these codes, which always imply a basic and shared moral truth. They observe that with the dominion of economic interests, research has become PLACE—private, local, authoritative, commissioned, and expert.[14]

But leaving such skepticism to one side, one cannot limit the ethics of scientific research in the field of the experimental sciences—and particularly bioethics in the field of the biomedical sciences—to these codes of correctness. Indeed, we must learn to distinguish between the category of what is necessarily required in order to guarantee the sound ethical character of an action, on the one hand, and what is sufficient for a judgment of full ethicality, on the other.

For example, that a surgeon should know how to plan an operation and engage in the techniques of such an operation to the full is a necessary requisite of professional ethicality. But it is not sufficient for it to be safely asserted that his action is ethical from all points of view (in the validity of his suggestions, in the obtaining of consent, in respect for the higher good of the person, as, for example, might happen in a transplant of organs for which there are many ethical preconditions).

For this reason, beyond these two links, which undoubtedly exist between scientific research and ethics (the link at the level of practical application and the link at the level of the ethical code of the researcher in his respect for the methodological procedures of the research itself), there are other links which are no less important. They are first and foremost connected to the actual *intentions* the researcher has in mind.

Both the researcher and the organizers and the financial backers of research are human persons and can have good or perverse intentions, or intentions which are merely utilitarian in character. The organization and direction of the research is always a project and reveals or conceals a strategic goal which could be directed towards the treatment of an illness, or an increase in agricultural, industrial, or pharmacological production, or could also have a goal involving manipulation or the alteration of biological processes, as in the case of experimental attempts to achieve procreation between species or to alter the genetic inheritance of an individual. In all truth and sincerity, it is clear that neutral research does not actually exist.

This kind of ethicality or non-ethicality at the level of the project itself, in addition to having a relevance in itself and of itself, also has important implications for those who cooperate at a lower level. Such people have the right to know the goals of the project they are participating in and have the right/duty to raise objections when in all conscience they do not feel that they can take part in a substantial sense in a project which they do not think is right. Neither the claims of scientific secrecy nor those of industrial secrecy can remove this right from those who participate in a substantial sense in a project that is in itself wrong or intentionally aberrant. In the field of bioethics one can hypothesize many situations of this kind—for example, the beginning of research into finding an abortifacient such as the RU 486 pill.

Another link between research and ethics lies in the realm of *experimental procedures*—we are dealing here with the ethics or, rather, the bioethics of biomedical experimentation, with all the questions raised by the carrying out of experiments on man (consent, risks, experimentation on children, the mentally ill, those who are unconscious, foetuses, etc.) and also on animals.

Indeed, ethics in relation to goals are not enough. There should also be a corresponding call for an *ethicality of means and of methods*. Even when the ends are good—the giving, for example, of a child to a sterile couple—the procedures which are chosen may well not be legitimate. They could wound the dignity and the life of the human person (for example, the loss of surplus fertilized embryos). The principle of "*non sunt facienda mala ut veniant bona*" is of great relevance here.

But in my opinion the deepest link encompassing all the others, which are always connected with the operational aspect (ends, procedures, methods, and risks), lies in a *need of an integrative character*.

Indeed, we should not forget that the experimental method is by its very nature a contraction of reality. This is because it only considers the experimental and quantitative aspect while the deepest and broadest aspect, the ontological nature and the axiological value of reality, escape the procedures of the experimental method.[15]

If the scientist, for example, carries out research on a human embryo, he cannot limit himself to observing the ethicality of the results and the procedural aspects in terms of methodological correctness, or ask questions about the application of his results. He must also ask himself what a human embryo really is, if it is a human being, and whether it has the value of a human person or not.

It is from the answers to these questions that all the other bioethical answers flow—when the full character of what is real has been clarified, then all the other ethical requirements relating to ends, means, risks, and so forth become understood. This element was lucidly explained by K. Jaspers, the scientist and philosopher, when he observed that experimental science in itself is not able to understand and perceive the qualitative aspect of reality, nor the deepest value of its nature, and cannot on its own by its own method even discern the ends themselves of science and scientific research. This is because all of this would require a decision regarding the goals of human activity and the life of man.[16]

The most recent epistemologists, such as Popper and Eccles, have also emphasized this limited character of experimental science, both in relation to its methodological procedures and as regards a more overall observation of reality.[17] For this reason, the link between science and ethics, or, rather, between scientific research and ethical research, is not a question of option or a recent fashion, but is a many-sided need which springs from within the scientific procedure itself.

Naturally enough, as has already been observed, if the question comes from within research, then the answer requires an *integration* of the experimental aspect with reality as a whole and thus should take place within *an ontological and axiological perspective* of the living being the research is being carried out on. For this reason the drawing up of criteria by which to engage in a judgment becomes necessary—criteria which cannot be supplied in their entirety by the scientific research itself, but which must be deduced from the complete vision and overall meaning of the reality which is under consideration.

I would like here to refer again to the example which has been given above: if the experimentation is conducted on an embryo, whether or not it is for a therapeutic reason, we must first ask what the global reality of the human embryo (ontology) really is and what its value (axiology) amounts to. Once the conclusion is reached, for example, that one is dealing with a human being, of an individual human, then it becomes necessary to ask questions about the meaning of experimentation on a single human being, and, as is the case with a minor, the duty of the researcher must be made very clear.

In order to decide when using such criteria one should as a result clarify what man is, what his value is, and what his destiny is. And when one refers to a man as a man, to his origins and his destiny, one is inquiring into what links all men together in the same set—namely, their dignity and their transcendence.[18]

In conclusion, and applying what has been said in this paper about the relationship between science and ethics—and, consequently, of the relationship between biomedical science and bioethics—it is possible to affirm that the bioethical justification does not involve only the moment itself of research and the method of research. In the final analysis, bioethics relates to biomedical research in the form of an *integrative vision*.

Furthermore, if we consider medicine in terms of assistance and organized health care, then the ethical factor becomes even more relevant, and the organic link between scientific knowledge and ethical norms of behavior becomes even more evident. Studies carried out over recent years in the field of medical anthropology[19] have revealed the radical inadequacy of a unilateral scientific approach to the concept itself of illness, health, prevention, and all the rest. The influence of the "personal," psychological, and spiritual factor in the whole field of health care is a decisive element not only in assessing the well-being of the patient, but also in evaluating the health-care worker or professional himself.

As regards the organization of health care, it is by now well known that this requires as preconditions education in relation to health, the cooperation of citizens, and a guiding criterion in order for the concept of justice to be authoritative in the allocation of resources and in the supply of structures and services. The ethics of the economy and the ethics of health care encounter each other on the social plane in one of the most important categories of public expenditure to be found in the advanced democracies.

The concept of *integration* invoked here as a method of achieving contact among different kinds of knowledge and different types of discipline has been well described by the theologian Lonergan when discussing the relationship between theology and the other sciences.[20]

The Independence of Science and its Meaning

The independence of science can be understood in different ways and can be seen as being in varying ways linked to the ethical factor of responsibility. In order to answer this question about the possibility of the independence of the scientist, we must think about science in reference to different kinds of criteria.

It is possible to see the experimental sciences in the context of their specific project, and we see that at this *first level*:

a) each of these sciences has an area of thought and thus sees reali-

ty from a precise angle—the objective of physics is not the same project as that of chemistry, or of biology, and so on;

b) each of these sciences has its own research methodology which is the outcome of its own thought and its own research history;

c) and, lastly, each of these sciences has its own criteria of judgment by which to assess and validate its own specific results.

As Agazzi observes, "a decision can be judged as being politically sustainable even though it has disadvantages from an economic point of view."[21] In this sense science has its own independence.

Everybody believes that this first level of independence is legitimate. Vatican II, in its constitution *Gaudium et Spes*, enjoins respect for the legitimate independence of science: "The holy council, referring to what the First Vatican Council taught, declares that there are two orders of distinct knowledge, that of faith and that of reason, and that the Church does not forbid the arts and the human disciplines to use their own principles and their own methods in their own specific fields. Recognizing this just freedom, the Church thus upholds the legitimate independence of learning and especially of science."[22]

There then exists a *second level* where the independence of science is seen as being *independence from values* or *value-free*, as independence from external checks and controls, and, finally, as independence in the activity of research and its application. To use a historical example, those who built the atomic bomb made a decision which was independent of a process involving an examination conducted from the point of view of, and in relation to, moral values.

It should be made clear that this second level is often taken as one single block containing all three "freedoms," something especially in relation to the radical conception of the independence of science. However, there are some authorities who, although they believe that independence from values and controls is legitimate, also admit that society should choose the right course to follow when practical action is involved.[23] Others accept controls on science, but only in order to defend and safeguard public health.

We also have to analyze a *third level*, where, above all, the responsibility of the scientist is emphasized, and where as a result independence is limited and subjected to guidance and direction. This responsibility is emphasized in debate[24] with reference to two separate areas—the field of pure research and the field of applied research.

a) In the field of pure research the responsibility of the scientist is certainly directly dependent on his code of professional ethics or his internal ethics (rigor, veracity, objectivity, etc.). But it also requires an examination and assessment of his means and instruments of research, the conditions in which he carries out his research, and the effects which the publication of the results of this research could have. All of this, naturally enough, also applies in a situation where pure research at the outset is directed solely towards the acquisition of knowledge and does not have other debatable ends—in a situation where, indeed, a bad end could even damage a procedure which is in itself good. One example of this can be found in the field of genetic research, where the aim is to discover the maps and the sequences of certain genes or the entire human genome—in this project the means and the conditions of such research must be subjected to close examination.

b) But there should also be scrutiny of the field of applied science, where various instances of further responsibility have been pointed out. H. Jonas has observed with great emphasis that today's applied science often involves the expropriation of a result which is then communicated and applied by others. This expert employs the metaphor of the train and the passenger—the passenger chooses the train in order to go in a certain direction, but he cannot determine the speed of the train, where it stops, or when it stops. In the same way the scientist, for example, can indeed decide whether to publish the results of a specific scientific discovery, but he cannot dictate the various ways in which that discovery comes to be developed or applied in practical terms.

This fact arises from the organization of our society, where industry takes patents and applies them to the productive processes. It is obvious from this point of view that one should also be aware of the possible consequences of the practical application of a research project from its very inception.[25]

In this situation and in this perspective the responsibility of the researcher is most keenly felt at the moment when the research project is conceived and programmed and when the results are communicated, and this is especially true of applied research. As a result, the teams of scientists who receive public funds run the risk of losing their independence and not being able to control the way in which the results of their research are applied. And, even worse, there is also the risk that the process of research will turn out to be a stage in a process which produces the lethal instruments and technology of war.

When we reflect upon the recent employment of deadly weapons in the war against Iraq, we come to realize the extent to which science contributed to the construction—and on both sides—of means of destruction and, furthermore, that scientists had no say at all in relation to their use.

Independence and Responsibility: The Recomposition of a Harmony

In order to achieve a harmony between independence and responsibility we need to look for a point of encounter not so much in pragmatic mediation but in *anthropological integration*. Experimental science and technology—the latter is bound up with experimental science—arise from man and are called in the same way as all forms of human activity to operate positively for the integral good of each man and of all men. For this reason, ethics, subordinated to independence and responsibility, can only be ethics with an anthropological and personalist foundation.[26]

This integration of the person is even more necessary given that ex-

perimental science—because of its very special and specific epistemological character—does not consider the whole of human reality, but only its quantitative, verifiable, and testable aspects. For this reason, its knowledge is concerned with a dimension of what is real which does not represent the whole of reality. And because of this the independence of its procedures and its goals has to presuppose a reference to the totality of reality, where what is experimental is only one feature. This is especially true when the reality which is observed experimentally is not a material reality, but the realm of life or the human object himself, as occurs, for example, in biology and medicine. One can never speak about absolute independence when the field of experimental research refers only to a dimension of a greater reality.

For this reason, from within the independent procedures of science, independent in the sense we have employed hitherto, there emanates the need for anthropological integration. Science must refer to the individual man and to society because it is man that does research, because it is the good of man which is the end of scientific and experimental research, and because the field itself which is explored by the experimental sciences represents a real—albeit sectorial—dimension of reality.[27]

It should be added, if we want to be objective and clear, that the value of science and the inherent values of scientific research do indeed represent a set of important values because they can bring about incalculable benefits for mankind. But at the same time they do not constitute the highest and ultimate good of human life, which, indeed, must not be endangered in the name of science and technology. The human person can and must be enriched and improved by a set of individual, social, moral, and even religious and transcendental values. Among these are to be found the values promoted by science, which, however, are not the only such values, nor can they be placed before others which are more fundamental, such as respect for life, or which are higher, such as the moral good of the individual and society. Indeed, in order for the values within the person to become harmonized, they must also be considered in terms of their respective importance and predominance.

What we have to do, therefore, in this personalistic and integrated conception of the values of science, is to correct what Husserl called "the subjective blindness" of the scientist and what H. Jonas calls "refraining or feigning," in order to point out and condemn that approach of forced neutrality which leads the scientist at times to deliberately ignore the person to whom scientific speculation is connected in terms of ends,[28] and to "refrain" from considering the moral and anthropological problems which arise in relation to his research, in order to remain loyal to the objects and goals of his own speculation.

In order to give practical expression to this harmony between the values of the experimental sciences and those values which are more generally anthropological, between the independence and the responsibility of the scientist, one can conclude this paper with the following overall guidelines:

1. One must respect the independence of science at the first level—independence in its own field, and in the specific method and criteria of judgment which are characteristic of each form of science. This legitimate independence is also enriched by the values which exist within science as such. These immanent values which are present within science as such are described by Pelligrino.[29] They are the pursuit of an expansion of knowledge, the freedom of research (in the sense used and explained above), the universality of results, the verifiability and the falsifiability of the results which have been obtained, methodological rigor, the accuracy of written accounts and observations, the objectivity of interpretations, honesty in publication, the communication of results, and the acceptance of controls and criticism.

This legitimate independence and these values within research should be recognized, defended, and promoted. It is in this sense that the independence of science and scientific research should be seen and upheld.

2. There must be no acceptance of that level of independence which involves an attempt to obtain an independence from values controls in action. This would mean a misunderstanding of the nature and the anthropological function of science and scientific research, and their conversion into an absolute. Furthermore, in medical and bioethical questions in general—that is, where research and its methodology have an immediate application in relation to man and society—such a form of independence would be absurd. As, for example, is the case with this kind of independence in the field of genetic research.

3. When we come to controls applied by society, it should be observed that these must relate solely to questions of safety and thus the common good. For this reason, the state must not impinge upon the preceding level of independence, that of the first level.

In order to guarantee this fact it often happens today that there is support for the mediation and role of self-control on the part of scientists themselves in conjunction with control by public authorities.

The delicate question of funding in a certain way also conditions the independence of research. Research financed by the state and by industry may be exposed to influences and directives which are not always legitimate and which are not government's proper province for action. For the means and ends of research to be legitimate, its conditions and application must be respected and subject to controls. However, all this means that the scientist must not see himself as a salary-earner or an official. Both as an individual and as the member of a professional category, he must know how to defend the purpose and goals of his research and its results in order to guarantee the rights of man and the inescapable values of morality, in the same way, that is, as he defends a patent and the scientific worth and integrity of his discoveries.

We should observe that this kind of independence is often not defended enough, even by those who reject the legitimate control of the

state in its safeguarding of the common good. But in this area, precisely, we are drawing near to a fourth conclusion.

4. The scientist's acceptance of the nature of his responsibility as outlined in section 3. The responsibility of the scientist in relation to his research involves not only respect for the inherent professional ethical code to which reference has already been made, nor does it come into play only when that research finds practical application, as though there could be neutral research, but morally relevant and compelling technology.[30]

The ethical aspect of research, and thus the nature of the responsibility involved, concerns both pure research and applied research. It concerns the goals and objectives of research; its justification—not least with reference to the common good, resources, and urgent needs—its methods, and especially its experimental method—and the circumstances in which, for example, the consent of the individuals involved is obtained and the communication of the results is carried out.

This responsibility derives, above all, from the constant need to unite the approach of experimental research—which is necessarily quantitative in nature and limited to experimental elements—with an overall and anthropological approach which must take into account the aspects and features of individuals. Furthermore, the moral order in the exercise of the independence and responsibility of the scientist does not constitute a prison or a constraint, but both a widening of outlook and a further evaluation of what constitutes the total meaning of scientific research.

Precisely at the moment when the experimental dimension becomes complete and unified in such personalistic and subjective values, the ethical moment itself increases in weight and relevance.

It is obvious that in order to unite the meaning of independence and the meaning of responsibility within scientific research, our culture should not only lay special emphasis on the "reasons for the employment of instruments and methods," but should also be able to locate the methodology of research within a suitable framework. Its own physiognomy should be respected and linked to that speculative and contemplative thought which belongs to philosophy. It should also be linked to theology in the search for a wider unity which emanates from the "splendor of truth."[31]

Most Rev. ELIO SGRECCIA
Vice President of the Pontifical Academy for Life

Notes

[1] For the birth and development of modern science see P. ROSSI, *La Nascita della Scienza Moderna in Europa* (Laterza, Rome, 1997). For the relationship between scientific progress and social evolution see G. STATERA, *Manuale di Sociologia Scientifica* (SEAM, Rome, 1996), and G. STATERA AND L. CANNAVÒ (eds.), *Sociologia della Scienza e Politiche della Recerca* (Sociologia e Ricerca Sociale VIII/24, Angeli, Milan, 1987).

[2] J. BERNARD, *La Révolution Thérapeutique* (Institut des Sciences de la Santé, Paris, 1989); E. CIARAFANTI, "L'Evoluzione della Medicina ed i Problemi che ne Derivano," in *Federazione Medica*, 1982, XXXV, 4, pp. 292ss; R. DULBECCO, *Ingegneri della Vita* (Sperling-Kupfer, Milan, 1988); A. FRANCHINI, "Le Grandi Scoperte della Medicina," in E. AGAZZI, *Storia della Scienza* (Rome, 1984), pp. 184ss; and J. CH. SOURNIA, *Storia della Medicina* (Dedalo, Bari, 1984).

[3] E. AGAZZI, *Il Concetto di Progresso della Scienza* (Feltrinelli, Milan, 1976); E. AGAZZI, *Filosofia della Natura: Scienza e Cosmologia* (Piemme, 1997); C. MITCHAM, "Philosophy of Technology," in *Encyclopaedia of Bioethics* (New York, 1995), vol. 5, pp. 2477-2483; STANLEY J.REISER, "History of Medical Technology" in *Encyclopaedia of Bioethics* (New York, 1995), vol. 5, pp. 2472-2476; and A. BOMPIANI, "L'Ethos del Ricercatore," in AA.VV, *Principi Etici e Deontologici nella Ricerca Biomedica alle Soglie del Terzo Millenio: Aspetti Giuridico-Normativi* (in press).

[4] E. SGRECCIA, *Manuale di Bioetica* (Vita e Pensiero, 1994), vo. 1,pp. 65-101; E.SGRECCIA, "Autonomia e Responsibilità della Scienza," in the volume by A.G. SPAGNOLO AND E. SGRECCIA (eds.) (Vita e Pensiero, Milan, 1994), pp. 39-49. I. IACOBELLI (ed.), *Scienza ed Etica: Quali Limiti* (Laterza, Rome, Bari, 1990); E. AGAZZI, *Il Bene, Il Male e la Scienza: le Dimensione Etiche dell'Impresa Scientifico-Tecnologica* (Rusconi, Milan, 1992); G.COTTIER, "Criteri de Giudizio Etico sulla Tecnologia," in AA.VV, *Etica e Trasformazioni Tecnologiche* (Vita e Pensiero, Milan, 1989), pp. 65-84.

[5] J. BERNARD, *De la Biologie à l'Ethique*, *op. cit.*, p. 22.

[6] K. POPPER AND J. ECCLES, *L'Io e il Suo Cervello* (Rome, 1982).

[7] G. STATERA AND L. CANNAVÒ (eds.), *Sociologia della Scienza e Politiche della Ricerca* (Angeli, Milan, 1987).

[8] A. ARDIGÒ AND F. GARELLI (eds.). *Valori, Scienza e Trascendenza* (Foundazione Giovanni Agnelli, Turin, 1989), p. 33.

[9] R. NOZICK, *Spiegazioni Filosofiche* (Milan, 1987), p. 447.

[10] R. DULBECCO, *Ingegneri della Vita*, pp. 13-14.

[11] National Institute of Health (NIH), *Guidelines for Research Involving DNA Molecules* (1977). *See also E. Sgreccia, Manuale di Bioetica*, vol. 1, (Vita e Pensiero, 1994), pp. 234-236.

[12] E. SGRECCIA, "La Risposta nella Trascendenza," in J. JACOBELLI (ed.), *Scienza e Etica: Quali Limiti* (Rome, 1990), pp. 163-173.

[13] R.K. MERTON, "Priorities in Scientific Discovery," *American Sociological Review*, 22(1966), pp. 635-659. See also A. BOMPIANI, *L'Ethos del Ricercatore*, in press, Ufficiale Pastorale Universitario del Vicariato di Roma.

[14] See A. BOMPIANI, *op. cit.*

[15] J. LADRIERE, *I Rischi della Razionalità* (Turin, 1978); E. AGAZZI, *Il Bene, il Male e la Scienza* (Milan, 1992); E. SGRECCIA, *Il Progresso Scientifico*; and A. BOMPIANI, *Bioetica in Italia*, pp. 187-220.

[16] K. JASPERS, *Der Arzt im Technischen Zeitalter* (Munich, 1986). For the Italian version see *Il Medico nell'Età Tecnologica* (Milan, 1991); and REALE-ANTSIERI, *Il Pensiero Occidentale*, vol. 3, pp. 457-462.

[17] *Ibid*., pp. 707-779.

[18] S. VANNI ROVIGHI, *Elementi di Filosofia*, vol. 3 (Brescia, 1963), pp. 189-269.

[19] L. DELGADO, *Antropologia Medica* (Milan, 1991); Jaspers, *Der Arzt*; J. VEDRINNE, "Ethique et Professions de Santé," in *Médecine et Hygiene*, 1984, 11, pp. 1171-1173; M. VIDAL, "Etica de la Actividad Scientifico-Técnica," in *Moralia*, 1983, 4, pp. 419-443: L. VILLA, *Medicina Oggi. Aspetti di Ordine Scientifico, Filosofico, Etico-Sociale* (Padua, 1980).

[20] LONERGAN.

[21] AGAZZI, *Il Bene, Il Male e*, p. 12.

[22] VATICAN II, *Gaudium et Spes*, no. 59; E. AGAZZI, "Autonomia e Responsibilità della Scienza," in CATTORINI (ed.), *Scienza ed Etica*, pp. 135-147; E. PELLIGRINO, *Autonomia Scientifica e Responsibilità Morale*, pp. 173-188.

[23] R. DULBECCO, *Ingegneri della Vita* (Mondadori, Milan, 1989).

[24] See in particular the works already cited by E. AGAZZI, but reference should also be made to H. JONAS, *Il Principio della Responsibilità* (Einaudi, Turin, 1990).

[25] E. MORIN, "Tesi sulla Scienza e l'Etica," in CATTORINI (ed.) *Scienza ed Etica*, pp. 165-172.

[26] E. SGRECCIA, "La Risposta della Trascendenza," in J. JACOBELLI (ed.), *Scienza ed Etica. Quali Limiti?* (Laterza, Bari-Roma, 1990), pp. 163-167.

[27] This approach was already evident in the thought of Jaspers and has also been present in such recent epistemologists as K. Popper and J. Eccles. It is has also been expounded by such philosophers of science as J. LADRIERE, see his *I Rischi della Razionalità* (SEI, Turin, 1978), and Agazzi (for his views see the works cited above).

[28] E. HUSSERL, *La Fenomenologia Trascendentale* (La Nuova Italia, Florence, 1974). It is well known that Husserl doubts the objectivity of scientific and even mathematical knowledge precisely because they involve the subject. Apart from the phenomenologist thesis, it is necessary, following Agazzi, to distinguish the truth of objectivity.

[29] E. PELLIGRINO, *Autonomia Scientifica e Responsibilità*.

[30] I make similar observations in my brief work *La Risposta nella Trascendenza*, pp. 163-168.

[31] G. GISMONDI, *Etica Fundamentale della Scienza* (Cittadella Editrice, Assisi, 1997).

JOSÉ ANTONIO PAGOLA

Towards a Holistic Existence

At a conference which takes place on the threshold of the year 2000 and which is concerned with the hopes and ambitions of the world's health, there could not fail to be a wish to move towards a more holistic form of care for the person. This modest paper seeks only to point out certain key guidelines and suggest some practical policies which should be followed.

A belief underlies this paper: starting from her Christian conception of man, the Church must cooperate decisively in the search for the integral health of each and every human being. This could be her greatest service to the health of man over the next decades.

1. Certain Basic Guidelines

1.1. The Return to the Person

"Illnesses as such do not exist. We know only sick people."[1] The quotation comes from Ludolf von Krehl, but it represents an awareness which is becoming ever more widespread and from which certain important consequences must be drawn. "Illness" is an abstract concept which exists only in concrete men. Reality is the sick person.

For this reason, when medicine manifests itself as a "science of nature" which treats illness in technical fashion as an objective process, and without an awareness of the sick person who is living out this process in relation to his own unique and unrepeatable originality, human illness is deprived of its personal and historical character; the human individual is reduced to a mere organism, and in this way there is a serious anthropological mutilation of the medical treatment which is practiced.

As the eminent Professor P. Laín Entralgo has observed, "Human biology...is a discipline which in essential terms is distinct from animal biology.... Man is not an organism; he has an organism which belongs to his being. He is his organism, but he is also "something more," and thus all the realizations of his being correspond to a number of his entitative dimensions, but require the participation of the whole of his being."[2]

When medicine seeks to get to the essence of an illness with pure objectivity through an analysis of its symptoms, an identification of its causes, or a study of its consequences, it should not forget that these symptoms emerge in a specific moment in the history of a human individual, that the past of this person has in some way acted upon the genesis of his illness, and that there are consequences for his life plans.

Obviously enough, one should not deny the great advances which medicine—understood as a science of nature—has achieved over the centuries, nor should we ignore its effectiveness in taking care of and treating the organism. But at the same time we should remember that seduction by scientific objectivity and by technological achievement should not lead us to forget the human individual himself. Medical care must not only be concerned with illness—it should also address its attention to the sick person.

1.2. A Complete Vision of Human Illness

Illness is not only a biochemical problem or an alteration in the biology of the individual. It is also an experience which affects the human being in his totality. The sick person is not only a "body" and is not even a mere "living being." He is a person, a being endowed with intelligence and freedom, a bearer of values, a creature engaged in relationships with other human beings, someone with a conception of himself and of the world, someone with a life project and responsibility in relation to his own destiny.

As Viktor von Weizsäcker, the great pioneer of anthropological medicine, declared, "The illness of man is not the breakdown of a machine... but of himself."[3] It is for this reason that we must concern ourselves with the various dimensions of human illness. We should not only look at its biological dimension, but also its psychological, spiritual, familial, and social dimensions.

The increasing specialization of medicine has without doubt led to many very positive advances in our knowledge about, and our treatment of, the sick organism. But such specialization can also lead to a unilateral and fragmentary kind of care which neglects the totality of the human individual. The technological and hyperspecialized medicine at the end of the twentieth century requires deep revision, and this should be inspired by an anthropological vision of the human being as seen in his "integrated totality." As the eminent Professor Sandro Spinsanti has made clear, "in order to return to a vision of totality we must go against the trends of contemporary medicine, which has

followed the path of fragmentation and specialization. Indeed, the healer has lost sight of the fact that behind every sick organ there is the totality of the individual."[4]

1.3. Interdisciplinary Cooperation

Today it is not enough to refer to the "humanization of medicine." We need to make clear that such humanization will not take place unless an interdisciplinary cooperation is promoted which takes care of the patient in his totality as a human being. In discussing the need to find a new paradigm by which to liberate medical care from its present-day biological reductionism, Dr. G. Acevedo recently stressed the importance of the dialogue which V. Frankl called for between different disciplines, with a view to ensuring that through a multifaceted approach such disciplines address man in his totality and place themselves at the service of his complete and integral health.[5]

This certainly does not mean ignoring the importance of biomedical science and its contribution to human health. It involves, rather, complementing and enriching this technical assistance with other disciplines and human sciences such as anthropology, psychology, ethics, theology, and sociology. P.Laín Entralgo argues that in reality "there should be no lack or pain where the medical doctor is unable to extend his range of action. At least in the spirit, he should be trained in relation to an immense sphere and direct his eyes towards the totality of what within man is asking for help."[6]

Interdisciplinary cooperation requires a recognition of the multidimensional character of care for the sick person, with each discipline being aware of its own limitations and its specific responsibilities towards achieving an overall perspective. No form of reductionism is acceptable when we care for a sick human being. As Dr. Acevedo observes, "no scientific discipline can limit itself completely to one or other sector and seek to obtain total results thereby."[7] Reductionism in care for the sick person (whether in the form of biologism, psychologism, or spiritualism) is at heart a pseudoscientific process which does not address itself to the needs of the human being in his totality.

2. Towards Holistic Care

2.1. Medical Action at the Service of the Sick Person

Scientific and technological progress must not obscure the fundamental goal of medical action, which is none other than "always helping, treating wherever possible." The more sophisticated and complex the development of health technology becomes, the more we need to affirm the role of *homo adiuvans*, of the health worker. This person is not only an able user of medical technology and techniques, an observer of what is happening within the patient. He is a "healer," a person at the service of the patient, in line with the original etymological meaning of the verb *therapeuein*, which means "to serve."

This does not in the least mean to adopt a negative position towards technological medicine or to undervalue professional service. On the contrary, it involves raising this work to its most human level by placing it at the humble—but at the same time more real—service of the "being in pain," the sick person.

It would be a mistake to continue with the development and advance of medical technology without asking questions about man in his totality, without reflecting more upon the reason for and purpose of this technology, or without responding to the many needs of the patient, who asks to be taken care of, treated, and healed not as a thing or an organ, but as a human being who is in need of help. In contemporary medical language it is the custom to use terminology of a warlike character, and thus medicine is compared to a battle against illness (the fight against cancer or AIDS, victory over illnesses which at one time were incurable, defeat in the face of death, etc.). At times a language which is humble and responsible and at the service of the patient, who is a fragile and suffering being, but always in search of life and salvation, would give better expression to the real nature of medical action.

2.2. Looking After the Different Needs of the Sick Person

We can move in an effective way towards holistic care only if we promote suitable services which cater to the different needs of the patient with a view towards the totality of the person. This means not only developing contacts and cooperation involving the medical doctor and other professional figures (the psychologist, the chaplain, the social worker), the patient's relatives and friends, specialized volunteer workers, and so forth, but also establishing, coordinating, and integrating the services of psychological, spiritual, social, and family support within the healthcare facility.

This interdisciplinary approach becomes even more urgent in the case of those who are terminally ill. In such circumstances one is not dealing with the re-establishment of the health of the organism, but with facing up to the various needs of the patient which arise with the impending death of a human being. When we face the inevitable and imminent death of the patient, what is of importance is not to treat him, but to take care of him, reduce his suffering, and accompany him on his path. It is at this moment, above all, that the sick person should receive assistance in his needs, which are not only physical, but also emotional, familial, spiritual, and religious.[8]

2.2.1. Psychological Care. Although it is easy to discern a certain distrust and lack of faith when there is a psychologist present at the side of the patient, it is clear that psychological help can, and must, complement the biomedical approach. This is true, above all, where patients have special needs of a psychoemotional character (one thinks here, for example, of surgical operations which lead to the patient becoming an invalid, of the removal of the female breast, of amputations which involve a deterioration of the patient's self-esteem, etc.).

At the same time, very important problems such as the reduction of pain require not only treat-

ment of physical suffering, but also attention to moral suffering or to the emotional reactions which might arise when the patient is faced with the prospect of a negative prognosis, the possibility of a possible separation from those he loves, the fear of death, and so forth.

This concern with the emotional and psychological aspects of the sick person on the part of a specialized service must not lead to reducing the responsibilities of the other health workers. In the same way, it should not involve an impoverishment of their relationship with the patient—a relationship which should always involve attention to his reactions and his suffering during the evolution of the illness. On the contrary, this concern must be shown within the framework of close cooperation and act to make all the healthcare personnel more conscious of the problems it faces—something which will enrich the therapeutic relationship between the patient and those who are engaged in treating him.

2.2.2. Social Assistance Attention should also be paid to social assistance, especially in the case of those patients who, because of the nature of their illness or because of various factors of a social or familial character, are more in need of help: invalids or the chronically ill who have a very low quality of life, patients who have a family or social environment which is marked by conflict or in a poor state, elderly people who have to endure loneliness or isolation, young people afflicted by drugs or AIDS, or the mentally ill.

Such attention can embrace a very broad field of social help in relation to both the hospitalized sick and the chronically ill, as well as those convalescing in their own homes—problem-solving as regards family life or the workplace, advice and help in dealing with bureaucratic problems (pensions, legal recognition of invalidity), economic help to deal with material needs, etc.

Such social assistance must manifest the care and concern which each and every society should display towards its least defended and neediest members. When suitably integrated into healthcare facilities, such assistance would significantly improve the care which is given to the poorest sick people within society. At the same time, we should not forget the incisive observation of S. Spinsanti, who tells us that "when faced with a hospital population which is increasingly composed of the chronically ill and elderly people, the 'healing' action of social assistance is indispensable."[9]

2.2.3. The Cooperation of the Family. We should not forget that illness can generate a whole set of needs which should be adequately faced up to, even though they are not the exclusive responsibility of the health worker. There are sick people who need security, love, and self-esteem; some patients need encouragement and energy in moments of demoralization; others search for company in order to deal with their own loneliness or for hope in order to face up to their own illness or death. Here we are dealing with people in need who must be cared for more in terms of friendly proximity, affection, and unselfishness beyond a strictly professional perspective.

In a significant number of cases, the family can play a fundamental role, and this is especially true when it comes to being at the side of the terminally ill patient. It is certainly true that families are often not prepared or able to provide this "healing" proximity. For this reason, the healthcare facility should not only play a primary role in ensuring a suitable presence of relatives alongside the patient, but should also provide consultation and appropriate advice for the case at hand.

2.2.4. Different Forms of Volunteer Work. Similarly, we should not exclude the cooperation of various forms of specialized volunteer work, either, which can draw near to the sick person with friendship and unselfish solidarity. In some cases its presence can be of great importance in liberating the patient from the isolation which he has to undergo in the hospital environment, in expressing the proximity of the human or religious community to which he belongs, and, at a more specific level, in helping him to experience his illness in a way which is more closely linked to the values, symbols, and beliefs which give a meaning to his life.

We well know that there are difficulties in the organization of this kind of voluntary work within the healthcare system—the need to avoid forms of abuse and forms of injurious interference, the training of volunteer workers, and so forth. But we should, nonetheless, encourage what is already being done in this area by striving to achieve methods and forms which are increasingly suitable to the tasks at hand. (10) In this sense, it seems to me that the Church should continue to promote cooperation among her lay members within the realm of pastoral assistance and should ensure that the Christian community is close to, and concerned about, sick people.

2.3. Spiritual and Religious Assistance

In spite of its value, religious care is often discredited as being something which is of secondary importance. Medical care is exclusively concerned with the sick body of the patient. Psychological assistance frequently ignores the spiritual and transcendent dimension of the person and confines itself to a recomposition of the human psyche in a process which is closed within itself. Religious care is thus often seen as an action which is not necessary, or which is even inappropriate. In this way health professionals and chaplains or pastoral teams work in a state of mutual ignorance, without discovering the complementary character of what they do or finding suitable channels by which to cooperate in an overall system of care for the patients they have before them.

However, each patient, whatever his or her religious vision, faith, or existential approach towards life, has the right to be respected and seconded in his requests and needs of a spiritual character. Serious illness and the proximity of death are experiences which are intense and touch the person in his inner being. The sick person may need to have wounds healed which

come from the past, to find a meaning to his own pain-filled experience, to deal with feelings of guilt, to open himself with trust to mystery, to reconcile himself with who he is and with God, to ask for forgiveness, to feel accepted, to leave this life with hope and peace.... There cannot be holistic care if this spiritual, transcendental, and religious dimension is not attended to. Hence the need to give new weight and importance to religious assistance, which should be seen not as something which is detached from the other forms of health care, but considered as an integrated service concerned with the totality of the sick human being.

This religious and spiritual assistance is of special importance when we come to consider the case of the terminally ill. The Church must work to ensure that no sick person is abandoned to his fate, to waiting for a death which is expected in one way or another, as though no help or closeness is required except that of the practical monitoring offered by the other systems of assistance. Someone has to take care of him as a person with a transcendent destiny and must offer him the help which is needed to live through his death in a suitable, responsible, and trusting way.

It is within this context of overall care that the Christian accompaniment of the sick finds its real meaning. Prayer with them and for them, the celebration of the sacrament of reconciliation, receiving Holy Communion, and the sacrament of the Anointing of the Sick, where the Church asks for and seeks complete health for the sick by offering them the salvific grace of Christ.[11]

Rev. JOSÉ ANTONIO PAGOLA
General Vicar of San Sebastián, Spain

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Round Table

The Impact of the Environment on Health

JOSÉ ANTONIO MERINO

Ecology, Creation, and Health

Over the last thirty years the ecological movement has been characterized by a vigor, an intensity, and a militancy which have promoted a new and widespread awareness of ecological problems and issues. Subjects such as the improvement of the environment, the quality of life, innocuous forms of technology, recycling, and so forth are discussed in all social contexts and are the expression of a new sensitivity towards the deterioration of nature, fields, the seas, rivers, woods, cities, food, and all the rest.

As a science, ecology has neither created nor promoted the ecological movement in all its various forms and expressions. But it has provided necessary information about nature and the environment, and has also stimulated and fostered a strong and widespread concern about the deterioration of the natural world. Ecology has stressed an obvious and evident fact—that man can act without limitations and without controls in relation to nature without suffering the consequence, in the short or medium term, of going beyond certain safe limits. The human species is a part of nature. And in the opinion of certain analysts of nature man, through his uncontrolled behavior, is now sawing off the branch on which he is standing.

As a branch of biology, ecology gave rise to the idea of the protection of nature. And from the ecological awareness felt by the biological sciences we passed on to other sciences which have also drawn attention to man's transgressions of the natural world. The discipline of demography is opposed to the galloping growth of the world population and to various forms of overpopulation. The discipline of ethnology has condemned the attacks on ethnic groups and minority cultures by societies and cultures which are stronger and more technologically advanced. The discipline of sociology has engaged in a kind of *apologia* of *natural* man and has accused Western man of having become domesticated. All this has had an evident impact on economic science, on political science, and on industrial society itself and has had immediate repercussions for psychology, philosophy, and theology. From an interdisciplinary perspective, ecology sees man as being inherently rooted in the natural world, and when this world is violated, man necessarily experiences the consequences of that action. In this way, ecology emerges as the "link between the natural and the social sciences," to employ the subtitle of the book *Trattato d'Ecologia* by E. Odum. This means that the social and economic problems and difficulties which are expressed in forms of inequality and injustice are intimately influenced by the way in which ecosystems come to be seen and treated.

As Edgar Morin emphasizes, ecological awareness presents us with serious issues and compels us to question the underlying assumptions of industrial civilization: the Cartesian separation of the subject-man in relation to the world, which is held to be a moldable object, and the victorious and operative idea, which is to be found in both the Marxist and the capitalist worlds, of man the conqueror of nature. At the present time there is a marked interest in ecology because nature is a world we have lost and which we cannot abandon, for it is our natural homeland in which we all live, move, and exist.

A certain number of supporters of ecology speak about a planetary or global ecology because they want to insert natural, technological, and cultural elements into an overall system. Nature is the suitable horizon of society, but society cannot be hostile to nature. Instead, it must integrate itself into nature. Pure nature is not possible in the same way that pure society is not possible. The nature-man-society-technology coordinates must be enlightened by guiding principles—that is, principles of a cultural character, which overcome the dialectic of an irreducible antagonism and give rise to a union of communion and solidarity.

The complex systems of the real world (the natural world, the technological world, and the human world) should not develop their inner practical potentialities in antagonistic approaches, but in integrating and interconnected dimensions. As Morin writes, "Our pluri-ecological universe is a universe in which everything is organized from the departure point of innumerable interactions between its physical, chemical, climatic, plant, animal, social, economic, technological, and ideological component parts".[1]

The new science of ecology strives to highlight fundamental and urgent issues and difficulties connected with the life of nature, the life of living societies, and the life of human societies—that is, the relationship between man and nature in all its breadth and from the point of view of its many aspects and features. For Moring, "general ecology is the first science which as a science (and not as the outcome of the tragic applications of its knowledge, as has been the case with nuclear science and as will be the case with genetics and the science of the brain) requires a direct process of awareness. This is the first time that science, and not philosophy, has

raised the question for us of the relationship between mankind and living nature."[2]

During the course of history the human species has profoundly altered ecosystems, and some of these changes have been irreversible, as has been the case with deforestation and the excessive transformation of land into terrain for the pasturing of animals. Industrialization, urbanization, the development of applied forms of technology, the enormous demographic increase, automation, and rationalization have all caused a serious and profound destabilization of certain ecosystems which were in themselves previously stable. In Europe and North America this process has taken place in an extreme way for about a century and a half, and it has progressed to such an extent that the damage which was caused to the environment over the previous millions of years appears in comparison to be on a very small scale, and this was because man confined himself to a forest and rural economy.

The destruction of the environment which is being carried out at the present day by the world economy and by powerful forms of technology will severely endanger the survival of humanity during the next century. Scientists go on repeating and demonstrate that the burning of fossil fuels and the pollution of soil, water, and air by contaminating elements and chemical fertilizers will lead to the destruction of flora and fauna, to a profound change in the climate, and to a threat to human life itself. *Advanced* industrial societies have disturbed the organic equilibrium of the earth, and, if they do not change direction, the world will move towards the universal *ecological death* discussed by ecologists and the supporters of the ecological movement. There is also talk of a "gigantic dissolution of our environment."[3]

It is proclaimed that the danger of an ecological collapse of the earth is greater than that of a nuclear catastrophe because the latter is possible only as long as ecological catastrophe is the inevitable destiny of humanity. This destiny is held to be in the cards if changes are not effected in economic policy and in the project of uncontrolled and irrational growth and development.

Analysts of the environment usually offer an almost Dantean picture of the deterioration of nature. They argue that we are living at unbearable levels of pollution and that we are threatened by an eco-catastrophe. The proof of this is said to be found in toxic clouds, acid raid, the progressive destruction of coasts, chemical waste, the greenhouse effect, the erosion of the ozone layer, the destruction of the ionosphere, and so forth. All this is the result of a series of causes which are connected to, and generate, the ecological crisis. But the principal factors which are said to be of greatest impact are pollution, the shrinking of natural resources, policies in relation to armaments, and overpopulation. These questions, however, require separate comment.

Both in America and in Europe a terrifying word has entered into the vocabulary of social discussion: "earthmurder." The era of technology is bringing out—and at a very deep level—the ontological meaning of the terms "to possess" and "to have." We are face to face not only with the loss of certain goods which we possess, but we are also up against something more radical in character—the loss of what we are. With great wisdom G. Marcel has declared that "pollution seems to be the inevitable and materialized consequence of a specifically metaphysical error."[4] In seeking to conquer nature, man has disfigured it. The wonders of technology have provided great progress for man, but they have also produced a *fragmented world* and have denatured mother-sister earth, as St. Francis would have said. The ecological problem has such dimensions that it cannot be reduced to the biological and physical sciences, as it was at the outset of the whole debate. It should be seen and discussed, instead, in terms of an interdisciplinary approach and method of understanding.

The distancing of man from nature is influenced by a previous philosophy which was implemented at an unconscious or conscious level. Ever since the beginnings of philosophical thought, or at least in the Western world, we have encountered opposition between man and nature and the dualism of man and nature. Both modern philosophy and modern science have emphasized and worked according to this dualism. The traditional divisions between me and not-me, between subject and object, between body and soul, between thought and matter, and between inner world and external world, have repeatedly expressed the duality of man/world, and all this derives from a vision of the cosmos which man has created for himself.

Modernity has been characterized by the enormous ascendancy of subjectivity, by the imposition of intelligence, of the will, and even of man's image of himself. The subjectivity which has thereby been unleashed has principally expressed itself in man's dominion over nature during a technological age which has not confined itself to, or stopped at, the world of things and irrational beings, but has gone on to experiment (with boldness and audacity) even on the very nature of man. It has done this by such routes as biochemical action, psychical invasions, and experiments in genetic engineering. The triumph of subjectivity seems to based upon, and to be justified by, man's uncontrolled domination of nature.

The pollution and the deterioration of nature have anthropological and metaphysical roots which must be examined and understood in order to achieve a new and constructive dialogue between man and nature. Mother earth cannot be seen as a mere technical possibility, as an unending quarry—that is, as a storeroom to which recourse can constantly be made by human beings. It should be seen, rather, as a vital and necessary horizon of our being in the world. Man needs nature in the same way as nature needs the spirit. The relationship between man and nature will be re-established only through a metaphysics of love and by means of an ontology of participation infused with respect.

Notwithstanding the philosophical assertion that man and the world are a system and are called to share the same human and planetary history, the development of the actual and historical reality of man and the world, or man and nature, is not convincing and frequently provokes a feeling of abandonment, hostility, or exile. In his *Letter on Humanism*, Heidegger talks of displaced modern man not only because of the oblivion of being, but also because modern man does not feel welcomed and protected by the world horizon. Nietzsche bore witness to this reality in his forceful descrip-

tion of this displaced being. Earlier, Hegel had expressed it in his concept of estrangement, and later on Marx was to employ it in his repeated use of the term *alienation*. The feeling of exile and of being uprooted is so emphasized and felt in our epoch that "the displaced being has been transformed into the destiny of the world"[6], and has provoked in not a few people an attitude of permanent aggression and a propensity towards contained or unleashed violence.

The harmony or disharmony between man and nature arises from whether man treats nature as an object to be used or interprets it as a vital space which cannot be reduced to an instrument or used at whim, because nature is *neither there, nor in me, nor against me, but with me*. Both nature and every natural thing have their own value and meaning, and in Ortega's view "not to recognize that every thing has its own condition, which is not that which we want, is the real 'cordial' sin which I call capital sin because it is rooted in a lack of love. Nothing is so illegitimate as filling the world with our manias and our blindness, the draining of reality, and the imaginative destruction of pieces of what is."[7] We need to realize that natural things, too, have their depth, interiority, and special dimension which easily escape the worries and anxiety which are experienced by man.

Modern rationality brings with it a strong impulse to subjectivity and self-awareness. The individual subject who affirms himself does so at the expense of the objectification of both internal and external nature. The individual subject who grows independently when he turns to his respective objects in knowing and acting becomes autonomous, independent, and impenetrable. And unconsciously he accentuates the tendency to self-exaltation and to absolutizing his acts of reflection and emancipation. The rationality of thought which becomes absolute tends to manifest itself in the domination and subordination of everything man depends upon or is conditioned by. Absolute reason becomes transformed into absolute will and into the will to power, although it is indeed masked by civilized forms.

When what *I think, want, feel, and evaluate* is a programmatic expression of an uncontrolled subjectivity, one falls into the myth of the absolute self, for whom other people, things, and nature are seen merely as means and instruments. This leads to an undermining of authentic human relationships with nature and a mutilation of the complementary realities of the human being. The process of rationalization, which began with modernity and which became accentuated with the Enlightenment movement, has certainly gained a great autonomy for man, but it has also brought with it a dehumanization of nature and a denaturation of the human world. Following the thought and approach of Piaget, we can assert that this process should be understood as a *decentralization of the image of the world* which has had inevitable repercussions for the relationship between man and nature.

Man polarizes himself towards the world through a spontaneous and natural movement. By his behavior he opens to the world and to the things with which he shares his existence, which is defined by his link with the world, which he tries to understand through ontological affinity. Because of the intentionality of thought and the centrifugal movement of the self, we see ourselves thrown far beyond our subjectivity, which is placed within a world antecedent to the self and which involves us in a series of real or possible relationships. The world is an ingredient of human existence, the circumstance of my self, in the sense that Ortega gives to the concept of circumstance, and it belongs to the analytics and the structure of the life of man. This is because human life is essentially of this world, for man's own corporeality is intrinsically and constitutively inseparable from what is of this earth. To be in the world means necessarily to have something to do with what is not in the world, and this something is living. This implies making and making oneself, a making of the world and a making a world of oneself. To live is not only to express this binding tie between the self and the world, but it also implies the discovery of the existential connection and the existent dynamic which are within the whole world and which, because of the presence of man, is already the human world. By this route, subjectivity and objectivity are two necessary and inescapable poles of the self/world system.

In structural terms man is a relational and connecting being. But it is not easy for him to engage in a relationship because we are conditioned and subjected to our cultural *schemata* and to the environmental and dominant prejudices which model different visions and readings of reality in the human mind. The natural ingenuousness of the Pre-Socratics has been lost, and we live with a will impregnated by suspicion and fear which distances us from reality. "We bear the world within us," declared Unamuno, when commenting on the lives of Don Quixote and Sancho.[8] This fact requires a revision and a purification of the spirit. Every vision lies behind a person's own experience, and this is expressed in a practical approach to his life and to nature itself.

In order to achieve an integral and integrated understanding of the real world, which is at the same time both technical and natural, we need to overcome those systems which exclude. These systems are positivism-idealism, scientism-voluntarism, objectivism-subjectivism, and all the rest. We need to achieve the widest and deepest relationship possible with reality through all the forms of knowledge which are available to us. To do this, mere communicative reason is not enough—we need to obtain a communicative existence which is based upon an ontology of constitutive being-present. This, in turn, involves a new way of living in the world and of treating things, and a new way of looking at nature and of learning to listen and to respect all beings.

In a humanized vision of nature the scientific-technological aspects are not in the least opposed to the values of the spirit or to the spirit itself, in the same way as mechanics are not opposed to mysticism. As Bergson wisely observed, the technical body "expects a supplement from the soul, and mechanics require the mystical."[9]

In this way mechanics, which have bent many men towards the earth, can help them to raise themselves and to look above themselves. Through a profound humanization of nature and things, man will obtain a new form of existence in the world and will cooperate in the construction of a more habitable and welcoming environment.

The message of the Old Testament offers a theology of the creation where the relationship be-

tween man and nature is understood as beginning with that of the relationship between the Creator and the creature. This is perfectly underlined in the profession of faith of the first chapter of Genesis and in the wisdom literature and the prophetic writings. Man is a created being, like nature and all the other beings and things which are to be found in nature. God appears as a great Lord, freely creating the human being and the other beings on the earth. The whole of the Creation is radically distinct from God, and for this reason pantheism is excluded. At the same time, the whole of created reality is good. Not only man is good, but also all the other creatures. As a result, a Manichean approach is ruled out. The goodness of nature, and of what lives within it, is a property which comes from its Creator. However, the human being is described as a reality which is distinct from the other natural realities, although he does not in the least lose his definition as a creature. This makes him king of the Creation—as long, that is, as he uses it and does not abuse it.

The command "Govern the earth" is not a license to exploit and destroy, but a divine imperative to ensure that man will humanize nature and link himself to it in a fertile way and in joyous fashion. The Apostolic Constitution *Gaudium et Spes* (no. 34) states on this subject: "Man, created in the image of God, received the commandment to place the earth under him and everything within it, and to govern the world in justice and holiness, and thus also to bring himself to God and the whole universe, recognizing in Him the Creator of all things, in such a way that in the subjection of everything to man the name of God could be glorified over the whole of the earth." For this reason, the uncontrolled exploitation of nature, or its deliberate deterioration caused by man, go against the design of the God of the Bible.

Nature and history involve and condition each other in reciprocal fashion in the Bible because God achieves his mystery of salvation through historical and cosmic actions. The message of Genesis about the Creation not only has a protological significance—because it dwells upon the first Creation—but also contains an eschatological meaning because within it there is already a move towards the *New Creation* which is made up of history and nature. In the Book of Genesis primordial passivity does not predominate. There is, rather, the founding and transforming action of all the component parts and elements of the universe. Man is a collegial member of this cosmos. He does not have a promethean subjectivity, but a guiding and solidarity-based subjectivity. His action in relation to nature must be an act of cultivation or of culture because his task is to cultivate and steward his own habitat. The anthropocentrism of the Bible is very distant from the anthropocentrism which has dominated Western culture since the Renaissance. This is because, while, in the latter, overbearing and self-sufficient subjectivity stands out, in the former there is concern with other creatures and things, in addition to solidarity, which is expressed in the *imago Dei*. Biblical man cannot be a merchant of others and of other things. In his conscience there resounds the voice which asks him about his brothers and sisters and the world.

The whole of the New Testament gives prominence to the mediating and exemplifying action of Christ, the Word made Flesh, the creator and reformer of all existential categories and the various orders of the real world. If Christ is the only Savior, and the Creation is an act of salvation, this means that the Creation and Christ are intimately linked. This is what was declared by St. Paul, for whom Christ was the interpretive, explanatory, and applied key to the story of salvation and the natural world. If everything revolves around Christ, the mediator and the lord of the Creation, in whom everything is recapitulated (Eph 1:3-10), then it must be concluded that the whole of the universe is pervaded by Christic references.

The whole world should be seen and interpreted in the light of a universal Christocentrism—in the perspective, that is, presented seven centuries ago by John Duns Scotus and described during this century by Teilhard de Chardin. The individual who wants to engage in an in-depth examination and interpretation of the whole of the Creation from a Christian standpoint will inevitably encounter a Christological urgency. If one returns to the cosmic Christocentrism along the lines of the thinking of St. Paul, then all terrestrial realities are seen in a special perspective imbued with meaning and communication.

Christianity sees the whole of nature in the perspective of the risen Christ, who is the real point of convergence between nature and history. For this reason, the pollution of nature, the exploitation of cultivable fields for reasons of pure selfishness, the dissipation of natural resources, and irrational, uncontrolled consumerism, like all other forms of aggression against nature or a part of nature, are an attack on the divine plan of the Creation and lead to disorder in the world, with unpredictable consequences which will inevitably have an impact on man himself.[10]

The Creation is not merely a vague image of God—it is his gift and comes from his self-revelation. For this reason, it is the language and the manifestation of its author. From this point of view, it seems to me appropriate to offer here a synthetic vision of an ecological theology of a Bonaventurian stamp which is profound in its contents and elegant in its expression. For St. Bonaventure the world is a sacrament of allusive qualities and references because it is entirely penetrated by presences pointing to the Great Presence—that is, to God.

Bonaventure's vision of the cosmos is based upon exemplarist philosophy, a school of thought which emphasizes the likeness and the relationship which exist between creatures and the Creator. God is love and the supreme good, He is *diffusivum sui*, and He is open and communicative through his dynamism as the Creator. God is infinitely good and communicates this goodness, which is transformed into the source of all beings. In the same way in which the cosmic structure itself carries within it this mark of communication, it is a requirement of its expression that the whole of the Creation reflect its own origins, its own structure, and its own purpose.[11]

The metaphysical structure of being contains three fundamental truths: originated being or received being, interiority or being in itself, and communication or being in communion. This means that the whole of created reality is dependent, consistent, and referent in such a way that the cosmos is an ontic

synthesis where union, likeness, and relation are intertwined and manifested. God created this world, where in some way He is present, given that the world, beings, and men are the expressions of invisible divine ideas which have acted as a model. The Creator has left his impress on things and other created beings. (12) All created beings are the appearance, impress, or image of God. This likeness, whether clear or confused, distant or near to the divine, is not a poetic or romantic category, but an ontic reality. It is not something which is accidental, but something which is substantial, and an essential property of beings.[13]

The whole of the world is a book on which the creative Trinity is impressed in legible and accessible characters.[14] The whole of the *expressive likeness*[15] of divine ideas is based upon an ontology of expression which contains *ideal truths* which are distant from the *factual truths* of modern epistemology and are incomprehensible for the positivistic mentality. Present-day scientific thinking, which is based upon empirical and experimental forms of knowledge, can only with difficulty understand the *truth* of the metaphors of things which Bonaventure offers us. However, it is only by going beyond *factual truths* that it is possible to understand the profound meaning of the existence of man and the profound and meaningful value of nature.

If every being is a word (a written logos), it must also be a memory (the recollection of its author), just as it is communion and bond (all belong to the same lineage) and a celebration (because it expresses divine joy). Pure realism amounts to a lack of perception of reality, and pure positivism is a lack of a vision of this same reality. The Bonaventurian vision is a symbolic and participatory realism which re-evaluates the practical, sees it as a language, and relates it to a universal communion.

Bonaventurian thought, in its ideas about nature and natural beings, requires the adoption of human behavior and existential attitudes which are based upon respect, communion, and brotherhood with all such beings because it is based upon an ontology of love. This ontology, more than involving a knowledge of things, leads to knowing how to live with them, and this knowledge is called *wisdom*. Man is not *opposed to* nature but *lives together* in nature and with nature. Within the human being there are to be found, and there take place, the most hidden movements and hopes of the Creation. Man is a *medietas* between spirit and nature, between the finite and the infinite. He is a microcosm in which matter and spirit harmonize in a perfect synthesis, but not a complete synthesis. Man neither dominates nor manipulates the Creation—he presides over it and gives it explicit meaning because everything has been created with a view towards him.[16] For this reason, man and nature harmonize in a theological, cosmological, and hermeneutic project.

In the book of the Creation, St. Bonaventure discovers and writes about a whole universe of beauty and harmony because every natural thing—even the lowest on the scale of beings—reflects a ray of divine light. The penetration of Bonaventure's intelligence, a loving intelligence, is marvelous and filled with a sense of discovery.

The whole universe is a world of divine noise and expression. And to discover this fact one needs only employ one's senses in an operative way. For this reason, "he who with so many splendors of created things does not see is blind; he who with so much noise does not hear is deaf; he who with all these effects does not praise God is dumb; he who with so many clues does not perceive the first principle is a fool. Open, therefore, your eyes, draw near to the spiritual ear, explain the lips, and apply your heart so that in all things you may hear, listen, venerate, glorify, and honor your God, so that the whole world will not turn against you."[17]

Nature, God, and man are profoundly interrelated by theological motivations, but also by an ontological kinship and by epistemological and hermeneutical principles. However, at times man is very wise in science, but ignorant in wisdom, a great knower of laws, but an exemplary know-nothing when it comes to sapiential principles.

For St. Bonaventure, nature is very far from being an unwelcoming, dark, and hostile reality in its relationship with man. Nature is seen and interpreted as a home, a dwelling, and as a place to live where the human being feels that he is in his own familiar environment. Man is not a gypsy without a home or an uncomfortable citizen, nor is he a tenant who feels that he does not belong to his own habitat, as, indeed, is suggested by J. Monrod with unrestrained pessimism in his book *Il Costruire e la Necessità*. On the contrary, there is an intimate relationship between man and nature. And in this vital dynamic of coexistence there is no room for those forms of aggression, violence, or destruction which are against the natural world—that natural world which is our necessary complement.

The whole of the Bonaventurian universe—interpreted from the point of departure of religious experience and of an experienced theology—has great harmony and beauty. But at the same time it is a natural-practical world because we live in it, move in it, and exist in it. St. Bonaventure would propose—were he alive today—an ecology of unlimited horizons which give rise to an aesthetic approach lived out by the whole of the Creation and to brotherhood among all the beings in nature where there reigns not aggression and exploitation, but harmony, service, and good will, all expressed in an attitude of solidarity and mutual help.

St. Francis of Assisi had a paradigmatic existential approach which requires special comment because it gave rise to an important spiritual and cultural movement. St. Francis felt himself not only intimately linked to all men, but also to all the beings in the Creation, giving them, indeed, the tender name of brother or sister. He never formulated a theory of the ontological unity of the real, but instead lived out the cosmic harmony with such intensity that he created a special theory and vision of man as a being in the world. In his universe there was no room for possible contamination because within it everything was harmony and openness, respect and courtesy. He who sincerely sings and celebrates neither contaminates nor diminishes nature, but offers others a new way of dwelling, being, connecting, and living and thereby establishes the most effective anthropological bases by which to achieve healthy and health-inducing relationships linking man, his actions, and nature.

In St. Francis poverty certainly had roots in the Gospels, but it also had ontological and cosmological

origins. Whoever possesses dominates; and whoever dominates destroys. Francis loved life and everything within it with infinite tenderness. For this reason, he could not corrode or destroy or diminish the wonderful gift of the Creation. Only tenderness and sympathy can effectively oppose the plagues of deterioration and relationships of death.

Francis was a saint, not a scientist; a practical man and a practitioner, not a theorist or a theorizer. But the experience he underwent was an expression of his interior archeology and his religious vigor, both of which can help to create a type of man who knows how to dwell in the world in a way which is different from what we are used to nowadays. Francis did not have a theory about the world, but a utopia of the world. This is not a mere recollection—it is a provocation which induces a crisis in the contemporary conscience, which lives according to the habitual imperatives of a set of ethics based on consumption. His art of living, and of being in the world and with things, constituted an invitation to create a universal dialogue which is able to see beyond the scientific and ontological assumptions of subjectivity and objectivity, of externalism and internalism, and of materialism and spiritualism.

This man of poverty did not have a spirit which feared nature, as though things were inhabited by dangerous spirits that needed to be placated or obeyed. Such an attitude is that of excessively archaic minds that have not yet gone beyond primitive animism. He did not even have a romantic spirit which was the projection of his own feelings onto the world. Romanticism is a characteristic of modern subjectivity, an approach which employs nature to peer into an individual's own consciousness and inner feelings. But both the archaic mind, with its fear, and the romantic mind, with its tumultuous emotions, do not listen to the voice of nature. Instead, they project onto it their own fears or feelings. However, in Francis a real desire to hear the whole of the Creation is to be found, and in the Creation he perceived the mute voice and the silent sound of God the Creator, Father of all beings. And in this rich and shared silence he could *sing in, of, and with* all the beings of the author of the Creation.

In his *Cantico delle Creature* we perceive that there intertwine at an essential level the religious, aesthetic, and poetic experiences. In the Saint of Assisi internal archeology and external ecology achieved a perfect synthesis. If this *Cantico* springs from the depths of his existence, this means that its author achieved cosmic brotherhood and took part in its power and its message, thanks to the fact that he had previously created a great emptiness and absence within himself. As a result of his radical poverty, Francis was able to live out and to perceive the natural gift of all the beings who make up the mystery of the Creation. Nature offers itself and opens itself only to those who have liberated themselves from themselves and have eliminated forms of resistance and opaqueness. Before approaching all other beings in a fraternal spirit, Francis freed himself from the weight of his own selfishness and egotism. Only the free and freed man is able to discover, take part in, and sing about the irresistible vitality of the Creation. Only men of this kind attract the world to a new complete existence and new cosmic fraternity. Max Scheler observed that St. Francis of Assisi was "one of the best sculptors of the soul and the spirit in European history"[18] because he managed to live within his own person, and in a synthesis which can only with great difficulty be equalled, love for God, for men, and for all the beings in nature. In this way a real utopia and a complete existence were achieved which can serve as a paradigm by which to learn about, and live within, the world and to live together with other people and other things.

Man will find and maintain his normal health, his human balance, and his complete harmony when he manages to live a balanced integration between his interiority and his externality, and between his own individuality and necessary biodiversity. In this way he will be in communion with all the beings in nature. Quality of life implies a process of humanization and men of quality. Both from a biological point of view and in a psychological and affective perspective, the health of man depends not only on what he eats, drinks, touches, and breathes but also on everything which complements him as a linked and connected being to practical nature with all its beings and all the things which are in it. But this dimension of communion with nature requires that contemporary man not only have a new set of planetary approaches and environmental ethics—it also means that he should learn to live in the world and to treat nature and all the things which live in it in a fraternal spirit, in the same way as he must also respect and safeguard microsystems and macrosystems.

Rev. JOSÉ ANTONIO MERINO, OFM
Rector of the Antonianum Pontifical University, Rome

Notes

[1] E. MORIN, *Il Pensiero Ecologico* (Florence, 1988), p. 102.
[2] *Ibid.*, p. 127.
[3] G. PICHT, "Umweltschutz und Politik," in E. Von Weizsacker (ed.), *Humanokologie und Umweltschutz* (Stuttgart-Munich, 1973), pp. 80-94.
[4] "The Philosophy of Gabriel Marcel. Marcel's Autobiography," in P. A. SCHILPP AND L. E. HAHN (eds.), *The Library of Living Philosophers* (Illinois, 1984), p. 240. G. Marcel refers to the contamination of the environment as "an infinitely more essential degradation which attacks in the same way as man, believing that he can become responsible for his own destiny, separates himself from what could be called his ontological roots." —G. MARCEL, *En Chemin, Vers Quel Eveil?* (Paris, 1971), p. 202.
[5] M. HEIDEGGER, *Carta Sobre el Humanismo* (Madrid, 1970), pp. 35-39.
[6] *Ibid.*, p. 37.
[7] ORTEGA Y GASSET, *Meditaciones del Quijote* (El Arquero, Madrid, 1970), p. 45.
[8] M. DE UNAMUNO, *Vida de Don Quijote y Sancho* (Col. Austral, Madrid, 1981), p. 176.
[9] H. Bergson, *Les Deux Sources de la Moral et de la Religion* (Oeuv. Compl., du Centenaire, Paris, 1963), p. 1239.
[10] Of the vast literature on this subject special reference should be made to: J. B. COBB, *Is It Too Late? A Theology of Ecology* (Beverly Hills, 1972); G. LIEDKE, *Im Bauch des Fisches. Oekologische Theologie* (Kreuz Verlag, 1979); J. L. RUIZ DE LA PENA, *Teología de la Creación* (Santander, 1986); J.MOLTMANN, *Dios en la Creación. Doctrina Ecológica de la Creación* (Salamanca, 1987); AA.VV., *Questione Ecologica e Coscienza Cristiana* (Brescia, 1988); AA.VV. *Ecología y Creación. Fe Cristiana y Defensa del Planata* (Salamanca, 1991); J. MERINO, *De la Crisis Ecológica a la Paz con la Naturaleza* (Madrid, 1994); *Biblia y Fe* 47 (May-August 1990); *Concilium* 237 (July 1991), pp. 139-153.
[11] ST. BONAVENTURA, *Il Sentent*, d.1, p. 2, a.1, q.1.
[12] *Il Sentent*, d.3, p.1, a.1, q.2, fund. 4.
[13] *Il Sentent*, d.16, a.1, q.2, fund. 4.
[14] *Hexaémeron*, col. 2, no. 12.
[15] *Ibid.*, col. 12, no. 4.
[16] *Il Sentent*, d.25, p. 2., a.1, concl.
[17] *Itinerarium Mentis in Deum*, c.1, no. 15.
[18] MAX SCHELER, *Esencia y Formas de la Simpatía* (Buenos Aires, 1950), p. 121.

CARLA GIULIANA BOLIS

Protecting Health in the Workplace

About 45% of the world's population and a high proportion of children above the age of ten—especially in the developing countries—make up the workforce of the planet. Work is essential for man because it ensures the production of food, goods, and services, and the economic and social development of society as a whole. Work is also a solution to the problem of poverty. We need, therefore, to invest in human capital through better education, the training of workers, and the improved safeguarding of their health.

Human capital and investment in human capital are thus of great relevance and importance at every level in promoting the improvement of the quality of work, the social advance of the worker, and the economic progress of a country. We should also be aware of the fact that technology and investment in human capital in many instances make up for a lack of natural resources, as the economies of certain countries in Southeast Asia well illustrate. The availability of modern productive machinery and methods does not suffice if there is not also a workforce which is suitably trained and defended in relation to the quality of life and the safeguarding of health in the workplace. Overall, one can assert that investments in human capital seem to be very effective in the improvement of standards of living and levels of health.

The interaction between the worker and the workplace, both from a physical point of view and in psychological terms, is very important. A work environment which functions well can promote and favor the well-being and the health of the worker. In contrary fashion, a place of work which is not favorable can induce physical and mental alterations in those who work within it and amount to a burden of suffering for the worker, his family, and society itself.

It is interesting to observe how in historical terms work and the workplace have progressively changed in order to adapt to new circumstances. We have thus passed from hard agricultural work—including the domestication and rearing of animals—to the industrial and urban revolution, which was very much based in its initial stages on manual labor, and on to the present-day technological revolution. Today, in the Western world, work does not require a great physical effort, but there is a greater demand for technical and intellectual competence and skill on the part of the worker. This greater demand for such competence and skill has increased the social and psychological stress connected with the world of work. Stress at the workplace may be the result not only of the tasks which the worker has to perform or the impact of environmental factors, but also of organization itself—how work is arranged and the hierarchy of the company.

The burden of work, the need to meet deadlines, responsibility, and levels of conflict are the principal factors which contribute to psychological stress. All of this not only has marked consequences for the relationships which exist between people within the workplace, but can also affect life within the family. It can also lead to the appearance of clinical physical symptoms. Certain examples of pathologies linked to stress are listed in the following table:

Table 1: Possible Negative Effects of Stress Upon Psychophysical Health

Physical Effects
Allergies
Arrhythmia
Articular and Muscular Pains
Gastrointestinal Disturbances
Headaches
Sleep Disturbances
Neurovegetative Alterations
Psychological Effects
Anxiety
Depression
Appetite Disturbances
Inability to Concentrate
Irritability
Phobias
Social Effects
Apathy
Problems in Family and Interpersonal Relationships
Effects on Work
Absenteeism
Increase in Behavior at Risk

The revolution which has taken place in the world of production has not been of the same character in all parts of the world. It is largely a phenomenon of the developed and industrialized countries. In the developing world, at the present time, manual labor is still very widespread. For these reasons the strategies for safeguarding health at the workplace must vary according to the context and country which is under consideration.

It is possible to identify certain primary objectives and strategies

in relation to the improvement of health in the workplace. The World Health Organization and the International Labor Organization operate with great effectiveness in this area. The following table lays down certain primary objectives for this whole field:

Table 2: Primary Objectives for the Safeguarding of Health in the Workplace

Improvement of national and international policies.
The ever-greater development of controls for work environments and the health of workers.
Improvement of the services offered as regards labor medicine.
The development of standards of reference which are based upon proven scientific evidence of risk.
The identification of biological indices of the risks of exposure to toxic substances.
The development of information networks and reference data and the promotion of research programs.
The development of permanent training programs for workers in order to promote their professional skills.
The development of information programs on the health risks of various kinds of work activity, with a view to achieving improved levels of prevention.

—In the evaluation and assessment of the risks of work it is necessary to be aware of the fact that the length of the working life has increased over recent decades. There has thus also been an increase in the average age of workers. It should also be noted that the proportion of women who work has also risen. The safeguarding of health at the workplace must, therefore, take such differences and changes into account. As occurs in all branches of modern medicine, there must be a classification and understanding of the risks and pathologies which are involved for each age group and sex.

Special reference must be made here to the phenomenon of child labor. The work carried out by minors escapes control, analysis, and forms of defense because reliable data do not exist on its character, range, and extent. In addition, the world of child labor is often deliberately concealed or ignored by people. It is very important to safeguard the growing human body because for biological resons children are not ready and prepared to deal with stress, toxic substances, the risks of infection, and all the rest. There should, therefore, in today's world be far greater controls of the whole sphere of child labor.

In a holistic vision of health in the area of work we should also be aware of such other important and relevant factors as the climate. Indeed, special attention should be paid to the fact that conditions of heat or cold or excessive dampness can create serious physical ill-being. This is particularly the case where an especially hard and intense form of physical activity is required in the work a person performs.

In developing countries in many instances it is also necessary to increase the controls over the presence of the carriers of infectious illness or the existence of diseases provoked by parasites. Such a concern should not be limited to developing countries alone—one thinks here of the risks to which health workers or slaughter-house employees are exposed by the recently discovered and identified pathology of "transmissible spongiform encephalopathy," a rare but devastating condition.

One of the most feared risks to which the worker can be exposed in his job is the presence of toxic substances. Many of these can be cancer-inducing; others can act in a damaging way on the human nervous system. In addition to being directly exposed to such harmful elements, the worker can also be the carrier of such substances into the home through their being present in his clothes—this, of course, only takes place if suitable preventive measures are not taken. A good program of prevention or of constant checks should therefore ensure the effective presence of (a) methods of personal hygiene at the workplace and (b) controls at the home of the worker. We should also produce biological indices which provide information on the consequences of short-term and long-term exposure to such toxic substances.

Special attention should be paid to substances which cause cancer, and in particular to those which have a long-term effect and operate over a considerable period. This is a subject which is also of great importance because there is often uncertainty in discussing such substances about the relationship between dosage and actual effect. In the middle of the eighteenth century it was proposed that certain illnesses could be caused by work conditions or by toxic substances which were present within the workplace. In Italy Bernadino Ramazzini wrote about this whole question in his work *Trattato di Medicina del Lavoro,* which was published in 1705. In 1775 the English doctor Percival Pott discovered and described the presence of cancer of the scrotum in London chimney-sweeps, and related it to exposure to chemicals produced by coal burning which then remained in the chimneys which these sweeps had to climb.

Another important aspect of health in the workplace relates to the use of toxic substances in agriculture. Agricultural workers—unlike workers who work in an urban environment—often lack suitable health services. Often such access is limited by long distances, and this is especially true in the case of developing countries. It should also be pointed out that many of the technological innovations in the world of agriculture and the use of chemical fertilizers and plant protection products which have been introduced to improve agricultural productivity have not been accompanied by a parallel improvement in the levels of information provided to agricultural workers about the risks which their work involves. The industrial countries are not immune to such risks—one thinks, for example, of the epidemiological correlation between the presence of Parkinson's disease and the use of herbicides in certain parts of rural Canada. It is thought that in such cases these herbicides damage the working and tissue of the human brain.

Furthermore, there are important interactions between the lifestyle of workers and environmental factors in the workplace. For example, a worker who drinks

too much is more exposed to the risks of having an accident at work if he has to perform difficult manual work, operate dangerous machinery, or drive a motor vehicle. Similar problems arise from the use of various forms of drugs, including psychoactive substances. Smokers are more exposed to the possible consequences of inhaling toxic substances from the atmosphere and in particular substances which are cancerogenous. For all these reasons, we should develop programs to safeguard health in the workplace which take these factors into account. We should also ensure that there are suitable controls on workers themselves.

A suitable and nutritious diet constitutes another aspect of the whole question of workers' health and bears upon performance on the job and in daily life. In many industrial countries canteens exist in the workplace, and these offer a balanced diet at a very accessible price, but in many work contexts in developing countries such a service is not always available.

In addition to giving rise to the various problems and difficulties which have been described in this paper, the industrial and technological revolution has also had a major impact on the general environment. It has contributed to the pollution of the air and water, and this is something which has placed the health of the entire population—and not only the worker—at great risk. This fact suggests that the defense of health at the workplace and the safeguarding of the health of society as a whole are closely interconnected. Today, any advance which takes place in the world of science and technology can have a great impact upon work, workers, the workplace, and the environment.

This observation emphasizes the responsibility which science and technology bear in relation to the health of man. Exactly the same may be said about national and international bodies and associations which seek to safeguard that health.

Professor CARLA GIULIANA BOLIS
Professor of Comparative Biology at The University of Milan, Italy

RICCARDO COLASANTI

The Impact of Immigration on Health

The medicine of migration or rather of emigrants in their host country is a subject of great importance within the context of world health and health care. There are more than one hundred million immigrants in the world and at times they have no healthcare rights at all in the nations where they live. Such rights are also often very weak and frequently not utilized either because these immigrants do not know about them or because they are little understood.

Our experience is based upon our work with 30,000 immigrants in Rome. It has been going on since 1983 and is organized by the Church of Rome and more specifically by CARITAS. This latter body has always been very concerned with such people and in most cases is the only organization which safeguards the well-being of these immigrants.

Emigration is one of the most traumatic experiences that an individual can undergo. It is a wound because it not only involves a departure from a home culture of friendships, climates and horizons but also, and above all else, because it involves the need to overcome a barrier of poverty which is not removed at the moment of immigration. And although it is very easy to imagine how hard the condition of the immigrant really is, he or she is often received in the host country with attitudes of hostility.

I would like in this context to quote from a newspaper article: "They arrive like locusts.... They are dirty and sad people who speak too much. Entire tribes which migrate towards the North where the fields have not been devastated, where you can eat, where you can drink; they go to live where their relatives are, and live among them, remaining separate from the people which has received them. They work for a low wage and now and then have fun with the knife or perhaps with an accordion."[1]

This piece from the press could be very easily cited with reference to the controversies and polemic of the present day, as we have seen on our television screens not least with regard to the recent immigration from Albania. But in fact it comes from the edition of a French newspaper—*La Patrie*—published in 1896. It is a reference not to immigrants from Africa or from Asia, but to Italians, or rather to Italians from Romagnola, Sicily, and Naples.

Once again we encounter a familiar relationship. On the one hand, there is the person who feels a sense of aversion and fear, and on the other the immigrant who experiences distrust and above all else the smashing of a dream—that of the promised land of a Western Eden which in fact turns out to be a land of blood and of pain.

This attitude, which is marked by hostility, control, and the employment of the police, is also to be seen in the world of health and health services. The immigrant is often seen as a health danger. As a carrier of epidemics. In short, as a plague-spreader.

The idea that there should be health and disease controls at the frontier is now very widely held. This would certainly be scientifically valid if it did not have connotations of social prejudice. Nobody, for example, would think of subjecting an American to a health check at the frontier, and this is true even if he came from an area where AIDS was endemic. However, the idea that there should be checks where the patient is black and comes from Kinshasha comes spontaneously to mind. History repeats itself. First the Italians and the Spaniards were poor, in the kind of context which is described above. Today it is the Africans and the Albanians. But they have all been seen as being different.

Beyond the usual prejudices—which are also present in academic and institutional walks of life—the immigrant is not generally afflicted by those tropical diseases which do not exist in the host country and he is fundamentally in good health when he arrives in our country, even though he comes from countries where serious infectious diseases are endemic and where health care is nearly always of a very low level.

The reasons for this paradox are to found in the fact that the migrant population is not representative of the population from which it comes. Those who leave their own country are the young (between the ages of twenty and thirty), the strongest and the most healthy (the sick and the weak tend to remain in their own country), and in the case of certain nations (for example Ethiopia) those from the higher intellectual and social strata. Furthermore, with regard to many African nations one is not dealing with emigration from the rural areas where, indeed, tropical diseases such as schistosomiasis and trypanosomiasis are most usually to be found.

The emigrants leave from the

capital cities. The movement is from the cities of the third world to the cities of the first world, and follows on from the first wave of immigration which took place from the country to the towns.

These factors lie behind a kind of social creaming effect, a process of selection which takes place at the point of departure. This is the so-called "healthy migrant" effect. To put it in other terms—the immigrant population from the third world is, in fundamental terms, in good health, and certainly in much better conditions of health than one would usually be led to believe.

Unfortunately, healthcare facilities and healthcare workers in European societies tend to believe that immigrants have those transmissible tropical diseases which are very rare in our countries.

It seems to me that it is possible to summarize the three barriers which the immigrant has to overcome and their corresponding healthcare difficulties in the following, albeit brief, way:

1. The Economic Barriers

The state of poverty in which the immigrant lives engenders illnesses connected with that process of psychophysical impoverishment which takes place after arrival and is caused by very bad living conditions and poor nutrition and diet. There is a process of energy katabolisis which becomes noticeable after a variable period of time—one to two years. On the whole, the immigrant arrives in a good condition of health but because of the difficulties of social integration which he experiences, and the economic poverty he has to endure, signs of physical degradation begin to appear which over a long period evolve into forms of illnesses caused by impoverishment. Here we are dealing with a central social problem in medicine for immigrants, and this is an authentic axiological factor behind most of the pathological processes which are to be encountered within this category.

It is therefore evident that any form of healthcare initiative or action cannot be divorced from attempts to improve the housing, work, and nutritional conditions of the immigrants. It is not enough to make sophisticated instruments of healthcare available without seeking first of all to find a solution to the poverty in which these people live. They fall ill because poverty drains them of their psychophysical energies. What are needed are social solutions and not healthcare remedies. It seems clear that the institutions of public health, as a part of the work of prevention that they carry out, should engage in a detailed analysis of the basic ways of living of immigrants and in this investigation should avail themselves of the best statistics that are available.

2. The Cultural Barriers

These are like architectural barriers for the handicapped. None of us pays attention to a step or to a door with a high-up handle. We do not seem to have before us a difficulty. But if by ill-fortune we acquire a physical handicap and we have to live in a wheelchair, then that step becomes an insuperable barrier and that handle a painful problem. Exactly the same may be said about cultural barriers or obstacles. We do not want to understand how difficult it is for people who have only a poor grasp of our language and customs to gain access to our national health service. Without seeing a father who is accompanying his child who is afflicted with heart problems and is trying to explain the situations with words and gestures which come from his cultural inheritance, it is not possible to understand his sense of powerlessness—and I repeat the point—which is like that felt by a handicapped person.

What links us to him is the pain which we see is like ours, but how difficult it is for us to understand him and make ourselves understood! We are not dealing here merely with a problem of language, there is also the question of culture and of religion, and in particular it should be observed that health is bound up with the body and thus modesty mixes with ignorance, popular opinions, and legends.

Cross-cultural medicine is a very real difficulty. A knowledge of the ethnology and cultural anthropology of the country of origin is not enough. Indeed, in leaving his country to seek a new sociocultural context with all the very great problems of integration that this process involves and with an ineradicable background which is always present, the immigrant patient deforms his natural expressiveness in seeking to adhere to a new cultural model which is not real, but that of his dreamworld and thus permeated with expectations which are nearly always the product of the mass media.

Different levels of confusion emerge and with them corresponding needs for interpretation. These various levels are as follows.

a) *The level of linguistic incomprehension in general*. This is often marked by a frequent use of an intermediate language by which the immigrant tries to express himself to an Italian speaker, and this is something which gives rise to serious instances of incomprehension (for example, an Ethiopian patient whose native tongue is Amharic may try to explain his health problems to an Italian doctor with the little English that he knows and which the doctor, for his part, manages to understand.

b) *The level of linguistic incomprehension caused by shifting semantic meanings in different languages*. For example, the word "kidney" refers to somewhat different concepts in different cultures. In Somali, for example, it also refers to the lateral region of the abdomen. This phenomenon leads to frequent diagnostic errors when the first test is carried out.

c) *The level of incomprehension caused by divergence in the meaning of symbols*. For example, the image of cancer in Italy does not have the same of charge of anxiety and of social fear as in Ethiopia.

d) *The level of incomprehension caused by divergences in cultural customs*. In Ethiopia, for example, a medical doctor who asks a lot of questions at the first examination of the patient is considered ignorant because the man who is expert is thought not to need to ask such questions. Exactly the opposite is the case in the Western world.

e) *The level of incomprehension caused by differences in philosophical, religious and moral beliefs*. It is more than obvious that our culture has a positive judgement of a standard type of model patient who through patience, an ability to resist pain, and obedience to medical doctors, displays the characteristics of the pious Christian.

At all these levels is to be found the possibility that there will be misunderstandings between the patient and his doctor, and at all these levels efforts must be made to improve the mechanisms of interpretation and diminish areas of potential discord and friction. All this must be done in the awareness that it is not enough to offer the right to health care if this takes place within unclear relationships caused by the cultural distance which exists between healthcare institutions and a multicultural population.

3. The Administrative Barriers

Here we encounter an unending waltz—rights and concessions which appear and disappear. In all nations there are absurd situations and numberless complications. In practice, the healthcare status of the citizen is not recognized—principally because beyond the whole area of costs and payments there is no clear awareness of the problem.

In addition, there is a whole series of special difficulties which merit particular attention and consideration, and they are as follows.

3.1. The health problems of women and children within a context of emigration and immigration.

In practice, the period of pregnancy of a woman who emigrates is one of great loneliness and difficulty. It must be followed with special attention and support by healthcare workers and institutions. The same may be said of children who are born during emigration and immigration. Such children often have the known capacity of children to integrate themselves culturally, but they also often suffer from separation from their parents or from being abandoned by their parents.

3.2. The Problem of Imported Illness

a) Tropical Diseases

As has already been observed, even though it would seem logical to lay emphasis on all those medical strategies which strive to expand medical expertise and treatment in this area—both as regards funds and in terms of structures which offer systems of diagnosis—it should be stressed that this is really a marginal problem.

The epidemiological importance and relevance of imported tropical diseases is reduced by the fact that many of these diseases cannot be transmitted to our climate because the conditions do not exist for their spread—the absence of the necessary carriers, the low-level presence of faeces in the environment, and so forth.

It would be more helpful to establish training courses for general practitioners on tropical diseases who could then recognize the rare cases they encounter. In this way expensive and useless diagnostic procedures provoked by an excessive degree of worry about the problem could be avoided.

b) Non-Tropical Infectious Diseases

Under this heading we should only consider those diseases and illnesses which have such a slow incubation period that emigration is possible when the individual is in an apparent state of good health. One is thinking here of diseases such as leprosy, tuberculosis, the HIV infections, and Lues etc. Given that AIDS is now present throughout the world, it should be stressed that in the case of tuberculosis the precarious living conditions which immigrants have to endure in Italy are a very important co-factor in provoking this illness.

3.3. The Problem of Psychiatric Illness

The incidence of psychiatric illness has not risen in the immigrant population. Erroneous diagnoses caused by confusion arising from linguistic problems are more likely to be present than actual examples of mental disturbance.

3.4. The Problem of Illness Caused by Traumas and Violence

Within the overall category of immigrants there is a subsection which has emigrated for political reasons or whose members have had to endure the suffering of war and other forms of violence. It is not unusual to encounter pathological symptoms, especially of an orthopaedic character, which require a major operation or the employment of false limbs. It should also be observed that orthopaedic problems are also often present because of traumas caused by street-life in Italy or by the results of illnesses which have disappeared in our country such as polio.

3.5. The Problem of the Relationship of the Immigrant with the National Health Service

It is absolutely necessary for the national health service to be helped by instruments of explanation which make clear how that service works, both in relation to how that service functions and as regards the philosophy behind it and the forms of response it offers.

This is also necessary for the Italian population, which is often unable to understand the workings and profile of the national health service. In this way a certain process of training will be made available which, if carried out with suitably simple and appropriate mechanisms, will be another channel by which to help the immigrant, who often has a difficult relationship with the realities of Italian society and is unable to deal with the disordered bureaucratic administrative processes of our country.

Given the almost worldwide diffusion of this malady, campaigns for information and prevention must be launched for the benefit of immigrants who come from areas of the globe which are still relatively immune to this malady.

In conclusion, I would like to make a number of key observations.

There is a great deal of talk about the defense of life—of the unborn child, of the embryo, and of the dying. But I believe that the

denial of health care or its provision in a superficial or incomprehensible way is also a bioethical problem. If the ethics of medicine amount to the study of correct and erroneous forms of behavior, then I believe that the first form of incorrect behavior is the denial of health care, which should be seen as the sin of sloth with regard to health.

I believe that the field of pastoral action in the world of health care and bioethics must extend not only to the battles which go back to the crucial starting points of the fight against abortion, euthanasia, and (now) cloning, but also against medical sloth—that is, to against a lack of interest on the part of those who govern. To put it succinctly, where there is a man who suffers from some form of illness, there Christ himself is suffering, and in the future He will ask us why we did not come to his aid.

This is not a question of healthcare policy or technology, and I certainly realize that it may appear ridiculous to those who have to deal with great international problems to mix charity with budgets and Christ with international politics and diplomacy.

But we find ourselves here, in the sacred site of the tomb of St.Peter, and we must remember that our history was built on this, and continues because of this.

And because of this they will not prevail.

The Apostle Peter, who is buried in the ground on which we walk said, to the crippled man, "I do not have gold or silver, but I will give you what I have. In the name of Jesus Christ of Nazareth, rise up and walk!" And in the same way, as doctors, as Catholics, and as disciples of Christ, we must perform the same miracle and say to all the populations that live in despair and pain, and in the name of Christ, "Rise up and walk!"

The immigrant is a person without a homeland. And this pain was shouldered and experienced by Christ when he said, "I was a foreigner and you brought me home." Christ himself was born an immigrant in a foreign land. Bethlehem was not Nazareth. Nobody knew Joseph or Mary. The Son was born like one of today's immigrants. And Egypt was the place where refugees fled.

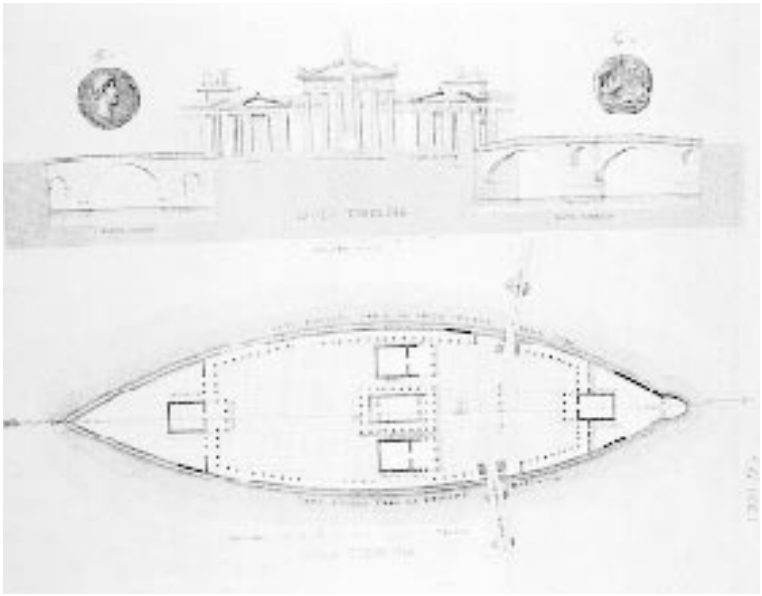
Catholic medicine is not the medicine of the cleanest hospitals, or the highest presence of Catholic thought. It is where such thought becomes true and is made flesh. Over the last few years the special discipline of healthcare economics has come into being, a discipline where health care is seen as a kind of company. I would not like to transform hospitals into companies and thereby transform patients into customers. Christ as a customer? A deformation, indeed!

The flame which must burn bright is the deepest flame of all—the flame of the poor and sick Christ who is in all of us who are sick and poor. For the millennium which is soon to arrive we need a form of Catholic medicine which is committed at a local and global level to the physical and mental salvation of all those who suffer in the name of Christ, without any clouding of the issue or any kind of ambivalence.

Dr. RICCARDO COLASANTI
Scientific Secretary of the Fernando Rielo School for Advanced Study in the Biomedical Sciences, Italy

Note

[1] Quoted by Franco Foschi in "Medicina e Migrazioni," Proceedings of the First International Conference on Medicine and Migration: Problems of the Physical and Mental Health of Immigrants from Developing Countries (Edited by Frighi, Urrechúa, Cuzzolaro, and Colasanti, 1988).



WALTER OSSWALD

Responsibilities Towards the Future

Since i was rash enough to accept the invitation to deal with such a vast theme in such a limited amount of time, i feel that the least that can be expected of me is to define what kind of problems i will try to cover and in which way i will endeavor to approach them.

My contribution, albeit a small and modest one is situated in the general frame of this conference, namely the expectations and hopes that at the turn of the millennium the catholic church nurtures in what concerns the world of health and the health of the world. Thus i will address the following points : responsibility towards the future generations; main areas of medical intervention with prospective influence; practical aspects.

1. Let us then consider first the question of the responsibilities of present man towards future fellowmen. There has been a heated discussion in the field of ethics about eventual rights of the future generations, the positions defended going from a firm stance on the existence of actual rights, which must be accounted for, to an outspoken negation of such rights. The rationale of the last named position is, of course, that rights are ascribed to persons and that therefore not yet existing individuals, like the members of the future generations, can not claim rights, which they are unable to uphold or defend, in the same measure as they are not subject to the duties which would be inexorably linked to their presumed rights. Although there is certainly a gross exaggeration in evoking the rights of generations to come, this does not allow us to disentangle this question from the contemporary bioethical discussion. On the contrary, one dares say that the general view, shared by most experts, is that although the future generations are , strictly speaking, devoid of rights, we, the present tenants of the world, have serious and moral obliging responsibilities and duties towards our successors.

We are morally accountable for our actions and liable to be called for account (note that this is an almost *verbatim* quotation of the synonymy of the word "responsible" in the oxford universal dictionary); if this will happen now or later in our life or even when our presence on earth has long ceased is not relevant to our problem. The christian belief is that being creatures we are not owners but merely managers of the goods entrusted to us, therefore having a mandate to pass to the future generations these earthly goods in the best condition, if possible in improved condition : these are treasures which we must preserve and increase in accordance with the parable of the talents (mt. 25, 14-30). We do not face here any major discrepancy with the intellectual disposition of non-believers who on different reasons reach the same conclusion, namely that we do have responsibilities towards future generations (for a detailed exposition see agius, hottois, jonas, renaud). Moreover, it is a generally hold view of public opinion that our children and their descendants should have a nicer life and enjoy a better world than those that we call ours. Thus (and not ignoring the practical difficulties, like "should we abstain from central heating so that fossil energy is preserved for people living in 2050?" Or "is it mandatory to reject all wood artifacts in order to stop deforestation and future desertification?") We conclude that the teaching of the church, the dominant opinion in bioethics and popular feeling all underline the moral obligation of present man towards future generations.

Which duties are then imposed upon us? First of all, to preserve the human species from extinction. It may appear as a far-fetched possibility to thus consider the possibility of a danger of extinction of mankind and it is true that our species is not in the list of endangered species. However we do not have to resort to science fiction to identify potential dangers for the human species. The extreme example would be a global war with atomic weapons, and we know that we have been dangerously near to such an event in the past and nobody can totally exclude this eventuality from future history. Lees dramatic, more insidious, slower-acting factors are already present and may ultimately prove to be lethal for the human species if they increase in uncontrolled and exponential ways, i.E. If they are not actively harnessed. I refer to chemical pollution, global heating, depletion of the ozone layer, radiation hazards linked to power stations and atomic waste, wars, strict fertility control, alterations of the genetic pool due to biomedical intervention, exhaustion of energy and food reserves. The demographic implosion observed in the so-called western world and the general decrease in number and motility of spermatozoa certainly do not allow us to overemphasize

this question but certainly represent facts the significance of which can not be ignored. We have not the right to leave to our descendants a world in which they can not live with dignity, even worse, a world which would kill them. As paul ricoeur said, when commenting the neokantian formulation of hans jonas "always act in such a manner that your actions may be compatible with the existence of human life on earth", being human is a value in itself and the being has a value, superior to non-being, which is neither a value nor a non-value. Life is thus accepted as a value, if not the supreme value.

2. The second part of this contribution has as its goal an imperfect and swift overview of present day medical interventions which will be capable of exerting a profound influence on future generations. In fact, biology and the branch of this science which we call medicine (and which also deals with important non-biological factors) have witnessed such advances in knowledge and technological breakthroughs that the applications of new methods thus developed will certainly affect our descendants. This should be stressed because it represents an absolute novelty and gives origin to new challenges; contrary to what used to happen (at least till the industrial revolution and / or the biological revolution) our deeds have neither a geographical limit nor a temporal restraint. What we do here and now may affect the "global village" and those who, having no memory of those who lived before them, will inhabit in 50 or 100 years this planet.

The first thing which comes to mind is of course genetic "engineering", i.e., Man-induced changes in the genome. If the germinal line is hampered with, the traits thus changed will be transmitted to descendants. This is of course the reason why such type of genetic engineering is generally prohibited, at last in those countries where a correspondent legislation does exist. The fact remains, however, that genic therapy represents a great hope and probably will become a routine procedure in the next century, and that gene therapy aiming at the germinal line is clearly the most important advance to be obtained. In fact, if and when put into practice without the danger of altering parts of the genome other than the pathologic ones, it will result in cure of the afflicted individual and of his lineage, thus ultimately conducing to eradication of the disease.

Genetic engineering has also been proposed with the goal of "betterment" of humans. This is clearly an untenable proposition which does not resist even a superficial ethical review. One could invoke a number of reasons why it would be illegitimate to resort to this eugenic measure : who would define which traits are "better" (more intelligent, stronger, more able for certain skills, aesthetically more pleasant people?), Who would select the "reproducers" to be improved, who would be responsible, etc. Fortunately the prospects of a technical feasibility of this enterprise are very remote, but the theoretical question reminds us again that not all that is feasible is ethically acceptable.

A more realistic approach to interventions in the field of health which may affect future generations allows us to detect a number of already existent medical factors, as for example measures in the area of human fertility and reproduction (contraception, medical assisted procreation, abortion, sterilization) large scale immunization, prevention and treatment of cardiovascular and malignant diseases, advances in care and treatment of pregnancy and neonatal related diseases, better control of infections diseases (including viral ones), etc. Although the impact of these factors and of their future development is difficult to ascertain, it appears safe to conclude that at least our next progeny will still experience a further reduction in prenatal mortality, an increase in life expectancy (with the consequence of an aging society and a society of the aged) and a shift from communicable to non communicable diseases. Degenerative conditions and dementia being characteristic of old age, they probably will contribute in a very large measure to the sick list of the future.

3. Concerning the practical aspects implicit in the above considerations, it appears that our responsibilities towards future generations are manifold, even when restricted to the world of health. First, because we can not extricate measures directed to preservation and improvement of health status from social, politic and economic decisions, taken in global dimensions. For example, clean water supply and food distribution are absolutely essential to health, but their availability to all human beings depends on taking and implementing decisions which are outside the health system. Second, because it is evident that the health education must be reinforced, promoting healthy lifestyles and making people aware of their own responsibility in keeping their health and adopting patterns of life which exclude causes of self destruction (alcohol, tobacco, other drugs, hiv). Health professionals having an important role in health education, other professions are needed in order to achieve the goals of health education (teachers of all grades, journalists and communication experts, authorities, ministers of religions, etc.). Third, health professionals will have to enter into concerted actions with all those concerned with the environment in order to preserve and improve what still can be saved and to avoid leaving as an inheritance a devastated and bleak world. Fourth, all efforts must be made in order to guarantee access of every person to means of prevention and treatment already available. This is of paramount importance, as justice (or equity) and charity demand. Fifth, those of limited or absent capacity to defend their rights must be specially protected and their presumed concerns voiced by their advocates; this applies to the unborn in their mothers wombs, to the physically and mentally handicapped, to people in old age, when viewed in the perspective of future, this means that what is undertaken now in order to defend the life and health of the embryo and fetus, to unravel the causes of mental disease and to devise methods of preventing and treating the conditions which afflict the aged persons will certain-

ly result in benefit for the mankind in the future.

The catholic church (and i am referring, of course, to the whole community of the faithful) is aware of the challenge represented by this situation. It looks back on a long tradition of service to the destitute and sick, many of its saints having dedicated their lives to this glorious service. An impressive number of orders and institutes which has its main activity centered on health care and through the many hospitals, homes, faculties of medicine, charitable institutions, the church keeps in activity has a profound impact on global health: in fact, it is the largest international health care provider of the world. We, at the international federation of catholic medical associations, are confident that the catholic church will be able to answer the challenge and contribute to the aims of improving the prospects of future generations in a global way, fostering their physical and spiritual development, increasing the health and the well-being of all people, stimulating solidarity and mutual help, giving new impetus to research, promoting fundamental values and caring with passion for the sick and the poor. In its ambitious program for the next century (in the form of the draft of "health for all in the century") the world health organization voices its concern with the prospects for health for the present and future generations and emphasizes the need for a global alliance for health. Let me conclude by stating my belief that catholic health professionals and institutions, as well as the whole community, are ready to contribute to this alliance, without relinquishing their principles and knowing that their experience, commitment and impact may significantly contribute to the "mutually beneficial change" that the **who** expects to result from such a partnership.

Professor WALTER OSSWALD
Emeritus Professor of Pharmacology and Therapeutics, Porto University Medical School, President, International Federation of Catholic Medical Associations (FIAMC)

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MARIE HENDRICKX

Health and the Universal Destination of Goods

"You that listen to me, do as the earth does. Produce fruits like her, never show yourself to be inferior to inanimate nature. She does not nourish her fruits to enjoy them, but to provide a service. You, on the contrary...are difficult and unapproachable, you avoid encounters so as not to be obliged to provide the smallest of alms. You know one word only: 'I have nothing, I will give nothing, because I am poor.' Yes, you are poor; you do not possess anything. You are poor in love, poor in goodness, poor in faith in God, poor in eternal hope."[1] This passage from Basil the Great on the subject of wealth is famous. We could quote others from his works, or from Gregory Nazianzen, Gregory of Nyssa, John Chrysostom, Ambrose, or Augustine.[2] I have quoted this particular passage because it gives clear expression to the Christian vision of material ownership. The tradition of the Church has always interpreted the order of the Creator, "Fill the earth and subdue it," (Gen 1:28) as a sign that the goods of the earth are for everyone and for the human community as a whole.[3] The New Testament severely condemns riches which are sought after for their own sake. They have a value only as an instrument by which to live out the logic of the Kingdom, the logic of free giving and of selfless welcome in a better way. The passage from Luke on the subject (Lk 16:9-13) and the injunction which reads "Make use of your base wealth to win yourselves friends" may be interpreted as meaning: "Use what you have to re-establish real solidarity among men."

We can still find this view in the thirteenth century in the writings of St. Thomas Aquinas.[4] For this authority, the right to property is justified with reference to its end—a rational use can be made of what one possesses. It is used to greater effect to the advantage of everyone. This doctrine was never really challenged, but gradually fell virtually into disuse. The textbooks on morality from the seventeenth century onwards tended to ignore the social function of property. Those who explain Christian life in terms of the fundamental precepts (for example, H. Noldin) center teaching on the economy around the seventh commandment, "Do not steal," and those who want to build existence around the virtues (for example, D.M. Prummer) approach it in terms of justice with reference to the notion "Render to each man what he deserves." In these two cases one begins with the idea of property and then goes on to develop an analysis of the duties of each individual in relation to other people's goods. Responsibility towards what the individual himself actually possesses is almost forgotten. In this way of thinking commutative justice becomes more important than distributive justice.[5] We are dealing here with a general tendency of society, resistance to which requires a great deal of virtue and independence of spirit—indeed, to be holy, in keeping with the vocation of every Christian, has always meant to go against the current as well.

Individualism and Materialism

The deepest reason for this change in approach is to be found in the appearance of materialism and individualism—two elements which characterize the modern Western world. The idea that our civilization is marked by these two cultural elements is certainly not an original one. What is, however, original is an emphasis on the fact that these two tendencies are intrinsically linked to each other and that they developed together almost at the same time, towards the end of the Middle Ages, and they could only be superseded by the movement of society itself.

I would like to observe that these developments had positive effects in terms of the pursuit of truth. An awareness of individual reality and the fundamental character of material reality was indispensable. The problem was to place these experiences in a more exact context—that is, within a more inclusive context.

We should speak first and foremost about *individualism*. Whereas medieval society was seen spontaneously as a natural unit in relation to which an individual never dreamed of asserting his own originality and distance, the culture of the Renaissance witnessed the spread of institutionalized interpersonal ties. This phenomenon was manifested at an intellectual level with an epistemological question which was posed with a new intensity—what weight can be given to a shared form which enables us to bestow the same name on individuals of the same species? One was dealing here with the problem of universals. In order to solve this problem William of Ikham, in the fifteenth century, did not hesitate to develop a nominalistic system based upon an absolute empiricism according to which what is real is composed of individuals strictly isolated from each other. The concept of human nature seemed to this thinker to be without value in the order of reality.

Empiricism and nominalism rapidly led to the idea that everything is matter or arises from matter. This seemed to explain all physical

and vital phenomena. We encounter here the *materialism* which is already to be found in the thought of Gassendi (1548-1655) and which is clearly expressed in the work of Thomas Hobbes (1588-1679).

Materialism and individualism are bound up with and converge in a vision of society in which each turns in on itself. Indeed, if material goods are the only goods which hold weight in reality, their possession very quickly appears to be an instrument by which to increase one's own reality, and their being shared emerges as an actual diminution of being. There is a tendency to confuse being with having, and because what is material cannot be shared without the portion of each being diminished, the other man may be seen as an adversary, an enemy. What he possesses I do not have. This increases his being and diminishes mine at the same time.[6] Against such a rival, the spontaneous reaction will always be one of diffidence—of defense, if I am the weaker, or of aggression, if I am the stronger. We are not distant here from the idea of the struggle for life where the strongest triumph.

In modern society this becomes translated into the more civilized, but essentially similar idea of ruthless competition. Competition, profit, gain. The two industrial revolutions—the first, which began in the middle of the eighteenth century and which was characterized by the importance of energy, and the second, whose beginning can be located in about 1880 and which involved the first systematic application of information to industry[7]—are the distant, but necessary fruits of this new relationship with the world and with other people. The inevitable corollary of such developments was a heightened praise for efficiency combined with a materialistic aspiration to comfort which centered around the enjoyment of consumer goods—something aroused in a host of ways by advertising—in order to advance an economic machine in which all those who have a real say in things find their reward.

Do we need to insist on the fact that this mentality discourages the practice of sharing? Moreover, some ask why we should care about the poor. In the world of efficiency, charity has no place and is, moreover, counterproductive. We all know the classical sophism employed to escape responsibility: "The more is given to beggars, the more beggars there will be, and the less beggars are encouraged to produce, the less money will be available to help beggars." The director of a charitable undertaking, it is said, will endanger the existence of that undertaking and will, from that moment onwards, behave like a bad director.[9]

Most of the leading human voices in our culture need, it seems, to rediscover the very concept of a solidarity which is not based upon self-interest. In the general view, the community is far from being the naturally and hierarchically ordered society envisaged by Christian culture during the Middle Ages, but which medieval man was not able to put into practice. Indeed, he would only be able to acquire the instruments to achieve such a culture through the experience of democracy, and these instruments were shared responsibility and dialogue within independence with a view to achieving a shared destiny. Today we must deepen the purpose of democracy, and this is because, although we have improved the methods by which to achieve real human community, it is also true that we have almost lost such an ideal. Ideas such as "common good," or "the universal destination of goods," must be re-examined and re-explained to the contemporary world. Such, indeed, has been the entire purpose and goal of the "social doctrine" of the Church since it was first propagated by Pope Leo XIII.

Body and Health

A culture which loses sight of the fact that, at least in ideal terms, we must use the material resources which are available to the advantage of everybody must be avoided at all costs. This is because such a culture would develop a broadly selfish conception of the body as an object of enjoyment, and would reduce health to well-being. Suffering and even mere pain would appear as absolute evils which are without meaning. Physical and psychological development, deemed to be "spiritual," is seen by the New Age as a substitute for paradise and held to be something to which everybody can aspire and which can be reached by one's own efforts through access to a kind of gnosis.[9]

In such a culture, medicine would think more about the individual than the person. It would oscillate between mere concern at being effective to a wish to achieve the immediate satisfaction of the customer. The body would be seen as being an instrument, a machine whose different parts must be kept in a state of good health or replaced, if this is not possible, with "spare parts," to use Jacque Attali's phrase.[10] The idea is cannibalistic because very quickly the bodies of the poor will come to be used as a source of spare parts to be transplanted into the bodies of the rich.[11] Another form of cannibalism, this time practiced by the whole of society on its undefended members, is research on embryos which are later destroyed in their hundreds. Such a policy is sometimes justified with the argument that results are reliable only when they come from experiments carried out on human material, and sometimes because laboratory animals are said to be more expensive.

When faced with a patient who is about to die, the medical doctor often wants to give free rein to his drive for effectiveness and thus keeps the body alive for as long as possible. This is because he believes that death is an absolute defeat for his skills and competence. Moved by such a consideration, he engages in a policy of therapeutic overkill—as long, of course, as he does not allow the wish of the patient to escape from suffering to prevail and therefore engages in a policy of euthanasia. In both cases the medical doctor fails to help his patient to face up to his trial and through that travail to become what in his innermost being he most desires—to enrich the transcendental dimension which is at the root of the dignity of each human person.

But it is not only the attitude and approach of the medical doctor which brings out contempt for, or ignorance about, what really constitutes human dignity.[12] This ignorance or contempt is demonstrated by two expressions which are often used nowadays in order to describe our relationship with our bodies—"This body is mine" and "I am my body." As Rémi Brague well shows,[13] neither of these two phrases sufficiently explains why the human body should be respected more than the body of any other superior

mammal. The fact that it is "my" body does not bestow upon it any special kind of dignity. Furthermore, although it is true that "I am my body," it is also true that "I" am infinitely more than my body, and to forget this fact is to allow me to be treated as a number.

What constitutes the dignity of my body is the fact that it is the practical and indispensable support for numberless possibilities and in particular of the possibility that I have, as a human being, not to be totally conditioned by my body, but to rise above it and to use it for a purpose which goes beyond it. It is the possibility which allows me to enter into relationships with others, to put me at their service, and to selflessly place the good of others before my own. I will explore this point in greater detail later on in this paper. For the moment, with reference to the subjects of health and the universal destination of goods, we shall seek to comment briefly on what the World Health Organization (WHO) has to say on the subject within the framework of the "New Paradigm for Health." We will see that this initiative, which is certainly the outcome of much good will and generosity, does not manage to go beyond the confines and the orientations of the contemporary materialistic-individualistic mentality.

The "New Paradigm of Health" of the World Health Organization

First of all, we should ask ourselves what a paradigm is. The term "paradigm" forms a part of the vocabulary of the New Age tendency. In current diction this word refers to an example and to a model. When it is used by the World Health Organization it seems to be a way of understanding and perceiving everything which surrounds us and a new way of entering into a relationship with reality. In the opinion of Dr. Hiroshi Nakajima, the Director General of the World Health Organization, this paradigm involves "a global vision where health is at the center of development and the quality of life"[14] and, more precisely, a set of criteria by which to establish and order priorities in matters relating to healthcare policy.

The definition of health suggested by the World Health Organization—"a state of complete physical, mental, and social well-being"—is to be naturally connected to the obsession of our age with comfort, but, unfortunately, it appears that this international organization has set an impossible goal for itself, an endlessly elusive horizon. Indeed, a state of complete "social" well-being is clearly impossible in the context of general competition which individualism engenders and provokes.

This ambition appears even more utopian when it is observed that Dr. Hafdan Mahler, Dr. Nakajima's predecessor as Director General of the World Health Organization from 1973 to 1988, gave the organization the aim of achieving "health for all by the year 2000."

It is certainly true that this objective is heavily blurred in meaning, and particularly by the idea of "primary care." But it is also true that in this striving for optimal results WHO has really brought about a reduction in endemic diseases in whole populations and has made their living conditions improve. These are realities which the Church esteems and to which she must contribute with all her energies. Unfortunately, the achievement of this goal by WHO is still quite distant.

Those at the head of the WHO are face to face with inevitable financial difficulties—the funds for health are simply not there. The available economic resources, they say, are restricted. It is not possible to increase them, at least in real terms.

There seems to remain only one possibility—change the meaning of the terms employed. "Health," for example? No, this would be impossible—it is a part of the very core of the World Health Organization itself. Perhaps, then, the word "all"? But this cannot be changed without changing the ethical view involved, and some fear, therefore, that WHO will increasingly tend to constitute and present itself as a normative expression of ethics. And it is exactly this which tends to underlie the "New Paradigm of Health," which is based, not upon the health of the individual, but on the health of society as a whole.[15]

The World Health Organization believes that it may be necessary to strike a balance between the Hippocratic Oath (which dictates the rules of medical ethics in relation to the individual patient) and the rights of public health, and thus of society as a whole. As an almost inevitable result, some illnesses might be treated less and some parts of the population might receive less medical care.

This may seem to be justified when the criterion of "life expectancy without handicap" is introduced as a means by which to decide upon the allocation of healthcare services. This criterion is used to determine priorities in the healthcare field and thus to decide upon what aid in this sphere should be employed for in each individual country. It is based upon the concept of "life year corrected by infirmity"—that is, the number of years which each person can hope to live without handicap in a specific region of the globe. In a utilitarian context where illnesses are approached in terms of cost and benefit, this policy, if we are not very careful, might lead to a terrible result—it would be considered useless to treat people who are afflicted by illnesses which, after being cured, leave behind disabilities, for this would prolong useless and burdensome forms of existence within society. To some extent, it might be thought necessary to treat illnesses which can be treated at low expense and with a high probability that workers will regain good health rapidly.

Consequently, despite statements of principle to the contrary, health runs the risk of no longer being a right of man in the sense of "rights for all." Everyone, in theoretical terms, has the same right, but in a context shaped by their "life expectancy without handicap," something, of course, which varies according to age and geographical region. Accordingly, a Congolese would not necessarily have the same right to be treated as a European or an American, or an elderly person to receive the same medical attention as a young person.

Furthermore, the new wide-ranging definition of health has meant that what was once considered as lying beyond its field (reproductive health or genetics) is now placed within the healthcare sphere. In the same way, a new scale of aims and goals has arisen within the field of health care. Indeed, these objectives have become new human rights which are vague and empty and which need to be defined, as Marguerite Peeters has rightly ob-

served.[16] In this way, bogus human rights have been created (the right of the woman to genetic health) which really act to undermine authentic human rights (the right of a child to life).

The slogan "health for all by the year 2000" remains valid, but there is a risk that it will only be so for a population which will first be decimated by the illnesses produced by poverty, "controlled" by contraception, abortion,[17] and euthanasia. The ideal which seems to be aimed at, but which, apparently, no one dares to openly profess for the time being—although, in this view, it is clearly present—is that "there should be fewer of us, but we will be healthier and richer"!

From One Paradigm to Another...

We are enclosed within a system of thought and an economic system which, whether we like it or not, lead us to utilitarianism, unless, that is, we manage to put up strong resistance to contempt for man, and especially for those who are poor, weak, or dependent on others. How should all this be fought against? It is often said that we are experiencing a period of cultural transformation. Is there a way of taking advantage of this fact to disseminate a healthier vision of man, of his relationship with his own body, and of his relationship to his possessions? The incredible enthusiasm aroused by the figure and the message of the Pope, in particular among young people, is perhaps a sign of hope, of a propitious moment which we should take advantage of in order to help people rediscover the values which our materialistic and individualistic civilization has systematically buried.

First of all, we should ask ourselves what this cultural change really amounts to, a process which might provide us with the opportunity to promote a humanism which, in addition to fostering a more equitable and harmonious form of community life, would also be an authentic path by which to preach the cause of Christ. In order to do this we should use a small work entitled *Humanisme et Technique*, written by Bruno Jarrossom, a professor at the School of Electricity. This work is subtitled *L'Humanisme entre Economie, Philosophie et Science*. It is a part of the series *Que Sais-Je?* of November 1996. I do not think that this book is especially original, but it has the evident merit of presenting the question in clear terms—above all, in its description of the move from what is called the "mechanistic paradigm" to the new "complex paradigm" of our period, a shift which took place in the early 1960s.

The Mechanistic Paradigm and Conquering Man

Bruno Jarrosson describes the mechanistic paradigm—within which most of us have developed—as a representation of the world which to begin with should be seen as a break with the Aristotelian vision of things. It appeared during the seventeenth century and was based upon three axioms—the absolutism of reason, the quantification of the world, and the normalization of time.

This system advanced the idea of determinism and thus of the governance of the future. Man, in this outlook, thinks he can build the future in line with his own wishes and that he can master his own destiny. This led him to an unprecedented development of technology and to a major leap forward in production. The mechanistic paradigm, when applied to the economic system, rendered possible the greatest and most spectacular advance in production that the world has ever known. Since the first industrial revolution, which began in about 1750, the overall productivity of the West has increased by about 3% a year,[18] a figure that is absolutely gigantic.

The mechanistic paradigm placed the world at the service of man and gave him the means by which to dominate it. But this domination, because it took place in an individualistic-materialistic context, made the pursuit of profit the engine of society, and this involved catastrophes for mankind. These are catastrophes which can gradually be superseded, it is certainly true, but only through an exit from the context which provoked them—that mentality which dissolves human ties and overvalues material gain, which encourages those who have the power to get rich and to dominate those who do not have this capacity, and to condemn them to poverty and to misery. Workers managed to improve their conditions only by uniting to change power relationships. A calm society whose chief sources of conflict are removed and where everybody has an interest in maintaining order can perhaps be the outcome of this process, but a harmonious society will never be possible, a society which, as Aristotle and his disciples proposed, fosters friendship among its members. As has already been observed, society no longer pursues community as its ideal.

The Complex Paradigm and Disturbed Man

From 1900 onwards the fine construction of regular lines built by modern science was shaken and then completely reshaped through the absorption of quantum physics and the theory of relativity.

Quantum physics upset Newtonian physics to the very core and undermined its accompanying philosophical armor, especially *determinism*. Quantum physics impeded a deterministic vision of reality. The only representation of the future which became possible was the probability that a specific situation would evolve in a certain way. There was also a shift in the notion of *the separation between subject and object*. Every measure was an interaction between the subject and the object and modified both. Neutral observation at a distance from the object was no longer conceivable. At the same time the same quantum object was poorly delineated in space.

As a result, matter could no longer be conceived as something which was exclusively material. It was an interaction. Everything could no longer be reduced to the sum of its parts, and causality became more elusive, order unstable, and disorder could arise and constantly return.

The theory of relativity allowed people to understand that time and space interpenetrate to form the texture of the universe.[19]

The complex paradigm certainly provoked a change in our relationship to the world. Just as the men of the previous generation had the impression that the universe was at their service, so contemporary man discovered that he is surpassed by

his environment and by the consequences of his acts. Current man feels vulnerable and powerless. He is faced with incredibly frightening questions. Cardinal Lustiger has listed two of them.[20]

Excessive arms have given the major industrial nations a striking power, and the destruction of the whole of mankind is now possible. Man, from this point of view, has become responsible for his own history and it is now for him to decide whether that history should continue or not.

Ecological commitment is now a primary responsibility of humanity. The technological and economic exploitation of nature is no longer limited to giving value to nature or to developing it to improve the lives of men. There is a danger, rather, that such exploitation will upset natural systems of balance, exhaust resources which cannot be renewed, and make original "natural elements" ever rarer and short on the ground—something which will involve the suppression of the immunity systems on our planet.[21]

Perhaps in such torments we can perceive a way of overcoming the amateurism of the "golden sixties" and achieving more solid values which can construct the real bases for existence. In order to ensure that they really constitute an opportunity, we should distance ourselves as much as possible from that individualistic materialism which threatens to impede our generation as it has impeded Western civilization for four hundred years. We have to develop and modify our culture in order to overcome what is blocking it. We must strive to inquire deeply into our reality in order to get a clearer idea of the resources which it actually offers us.

An Opportunity and a Risk

We must rediscover the truth about man. The man of the complex paradigm is a great enigma for himself, and this is much more than is the case with the man of the mechanistic paradigm. For the former, another person seems irreducibly distant, similarly closed up within his personal history and in his interpretation of his life and events.

Two great dangers threaten the task of the reorganization of values to which we should address ourselves. The first is the abstractness of wealth and the second is moral relativism.

The Abstract Character of Wealth

After about 1973 we entered into the third industrial revolution,[22] a process which has been characterized by the absolute primacy of information, which, indeed, has become more important than matter itself. The man who controls information is rich or can become rich in a few seconds. The man who is outside such circles is out of the game and condemned to being subjected to the rules of others.

This process has gone hand in hand with the increasing internationalization of the world of business and trade (globalization). Governments are no longer the masters of economic processes—their place has been taken by the multinationals, whose actions often have dramatic repercussions for whole populations. The world of politics is now dominated by the economy and increasingly finds it difficult to take the human dimension of things into account, and this will remain the case as long as financial interests are at stake.

Being rich is now no longer thought of in mental terms as amounting to the ownership of land or houses, but as a financial mass whose principal goal is self-expansion and the conferment of consequent benefits. In this way, one might say, wealth becomes abstract, but, of course, in being such it loses every kind of limit.[23]

Moral Relativism

The second danger—namely, moral relativism—seems to derive from the fact that life in community is no longer an ideal and no longer has a purpose. Individuals are simply placed side by side, and every individual speaks his own language, which is based on his point of view. The easiest solution for every problem becomes that of compromise—it is not worth it to fight for the truth; we might just as well negotiate; every person can surrender a little piece of his vision of man. This is the price to pay to ensure that science and technology go on guaranteeing us greater comfort.

Whether intellectual laziness is governed by indifferentism or by one ideology or another, the result is the same. We find the third phenomenon which Cardinal Lustiger condemns as being characteristic of our age: man arrogates to himself the right to decide which people should be defined and treated as persons and which should not. Universal human brotherhood based upon shared origins (the Bible refers to Adam and Eve) was denied and negated half a century ago and expressed itself in genocide. This danger has not been eliminated and can always reappear. We know that it remains a danger because we are witnesses to the advance of biology and medicine.[24]

Towards a Higher Vision of Man

The logic of profit condemns the weak man to death and deprives the strong man of an awareness of what life really is. We should, therefore, struggle against this logic with all the energy and force at our disposal. But this is not enough. We need to encourage our contemporaries to embrace another vision of themselves; we should help them rediscover the joy of living because this is something which is intimately bound up with the joy of giving. But how can this be done? I would like to propose two paths—the first is the rediscovery of our community aspirations, which involves leaving individualism behind us; the second involves giving new value to the social dimension of property. This last should imply the sentiment of "my goods are for other people" and "for me" at the same time, and exist to favor communication with others. This approach involves leaving materialism behind us.

The Social Instinct

It seems that the first question which we should pose concerns happiness. What makes man happy?

First of all, we can observe that within man there are fundamental instincts which operate at a primary level, the nonfulfillment (or the nonsublimation) of which makes him very unhappy. The classical textbooks on anthropology talk about a "natural inclination" towards self-preservation and a "natural inclination" towards life in society.

It is certainly true that the social instinct can always be portrayed as

something which springs from the instinct towards self-preservation, that what comes first within us is a radical egocentricity, and that the desire to live with others is merely an expression of the impulse to use them for our ends. But such a deeply-based pessimism cannot be based upon convincing proof and can only argue that the self-sacrifice and the devotion to those who suffer, in addition to altruism in all its forms, belongs to some kind of expanded selfishness. Furthermore, if our attachment to ourselves involves an attachment to others, this means that egocentricity no longer exists. The man who gives his life for another person necessarily prefers that person to himself, even though he is happy at the thought that his action will be seen as being heroic.

The book written by Jarosson ends with a question about the relation between comfort and happiness. Although he does not criticize the hedonistic and consumer mentality of our age, he nonetheless cannot fail to observe that material wealth is not enough. Only love, he declares, can give us a reason for living. "We must learn to love loving...,"[25] he writes. André Maurois observes in his memoirs that the greatest happiness of his life—"the rare moments of ecstasy"—were those in which he "was freed by love or charity" from vain worry about himself (*Mémoires,* 1, p. 335). This is something which medical doctors know—there are people who die happy even though they are weighed down by a painful malady because of the simple fact that happiness depends more upon the loving presence of other people than a mere physical state.

In this way perhaps we can hazard a definition. To uphold this definition we would need volumes of biographical reference, and to promote it volumes of philosophical thought and reflection. But I ask you to accept it as it is, upon the basis of your experience of life—happiness is to be found in a happy relationship with one's neighbor.

As Emmanuel Mounier has said, the prospects for the person are open: if the body can be described as "an opening onto the world and myself..., the person seems also to be a presence directed towards the world and other people, without limits, mixed with them in a perspective of universality. Other people do not limit the person, but make him be and grow. The person only exists when he is directed towards others, knows himself only through other people, and finds himself only in other people."[26]

The human being is capable of free giving and selfless welcome, and here we encounter the thought of John Paul II, something which we should propound and expound. We should merely emphasize that it is in this freedom, whether fully achieved or not, that there is to be found the authentic liberty and transcendence of man as compared to the higher animals.

The Universal Destination of Goods

The social doctrine of the Church has never understood the universal destination of goods as something which is in opposition to the right to private property. In *Rerum Novarum* Leo XIII states that "if we declare that God has given it [the earth] in common to men, this does not mean that they must possess it in a confused way, but, rather, that God has not given it to one man in particular and has left the delimitation of property to the wisdom of man and the institutions of the peoples."[27]

Private property is a natural right. Man is created body and soul and cannot live without the resources of the earth. He is also created intelligent and capable of meeting his own needs and looking after his future. Only property can give him the instruments and means to do this. However, in the Christian vision of things we are not absolute masters of what we possess, but, as Michel Schooyans observes, only "managers of a world placed at our disposal, at the disposal of others, and of future generations." (28) And we are called to engage in a social use of what we possess.

Ever since 1891 the social doctrine of the Church has always striven to make people more aware of their responsibilities when it comes to the relationship between their goods and individuals who are in a state of poverty and acute want. In this way this doctrine has given a more solemn form to a constant teaching of the Church which has existed since her beginnings. It was, however, in Vatican II and its pastoral constitution *Gaudium et Spes* (69-71) that what had been sought after for almost a century was clearly expressed—the idea that private property is an *instrument* by which to achieve more effectively the universal destination of goods.[29]

The goods that I possess are not directed principally to my personal enjoyment, but to serving all men. The more I use them to help others to grow in their humanity, the more they will help me to grow.

Another Definition of Health

Our relationship with the world seems to be an extension of our relationship with our own bodies. My attitude towards my possessions reflects my attitude towards my body, and thus the two are intrinsically linked. If the Church tells me that the goods of the earth must be placed at the service of everyone, she also tells me at the same time to place my body and my person at the service of other people. The phrase "My body is mine" is true if it means that no one else but me has the right to treat my body as an object to be used. But it cannot mean that I have this right. My body is not an object which I possess or which other people can come to possess. My body, my physical life, are an opening for me. My body is the practical form of all my relationships with the world and with other people. My body is the expression of my person, its material expression, because my nature is such that there is nothing in me which does not pass through matter. I am infinitely more than matter, but I am anchored in the real through my corporeal dimension.

How, therefore, should health be defined? To be in good health cannot mean merely "well-being in relation to my body" or "feeling good." The treatment of someone does not mean placing him in a state of blessed satisfaction where he needs nothing at all, and even less in a state of enjoyment where he can "do well in life," to use the common phrase, by bringing people and goods into his orbit.

To treat someone, rather, involves re-establishing and maintaining to the full his ability to engage in interaction with the world and with other people. It means fighting with him

and for him to ensure that he remains free and able to connect with his neighbor. It means helping him to choose to his utmost ability the paths of selfless welcoming and free giving.

For this reason we must rediscover an objective criterion by which to define health. To this end we can draw inspiration from what Bishop Sgreccia, in his textbook *Manuale di Bioetica*, says on the subject.[30] The dynamic balance to which he refers has the goal of achieving physical life, which we can describe simply as energy, an active force which makes possible relations and exchanges with the world and with others. For those who believe in a religious sense, this force is by the nature of things a gift from God.

In defining health as a balance, it acquires an objective criterion which makes easier the distinction between what is therapeutic overkill and what is necessary treatment. We can also more easily distinguish between "luxury medicine" and "basic medicine," and this is something which will enable us to engage in a reform of social welfare which is based upon greater justice. Lastly, men of good will are given an improved point of departure by which to achieve a more suitable relationship with their physical condition and state.

The goal of "health for all by the year 2000" is certainly a utopia, but it is also an objective to which we can really draw near and for which we should indeed fight. The "right to health" to which the World Health Organization refers can thereby become a real right—I have a right to what helps me to maintain my biological balance and to restore that balance if it has been lost because of an illness or an accident. Furthermore, I have the right to what helps me to maintain or restore the greatest biological balance of which I am capable. All human beings have this right in an equal way and to the same extent.

Conclusion

In this paper two key ideas have stood out. Materialism and individualism are bound together, they lead to an instinctive perception of the other person as a rival and an adversary, and they destroy the ideal of society as a community.

Our relationship with the world and possessions is an extension of our relationship with our own bodies. Just as a person may come to see his body as an instrument for pleasure, so other people can be used selfishly by him and there can be an excessive exploitation of the environment.

The result of such processes is that there is now an urgent need for a higher vision of man, a rediscovery of the fact that we are really free only in giving and selfless welcome. It is here that we encounter the sources of joy.

The prophetic role of Christians in achieving a more equitable distribution of the goods of this world lies, above all, and paradoxically, in an opening up to each and every man and to the affirmation that every individual, whatever his age or condition, has something irreplaceable to give to the whole of humanity, albeit at a very mysterious level. It is in the family that respect for others, self-giving, and sharing are learnt, and for this reason the Church will never be able to lay enough emphasis on the need to protect the family and to help it to carry out its mission with great generosity.

But perhaps the preaching of the mystery of the person leads to a preaching of the mystery of God, and perhaps it is only the love with which the God-Man loved us to the point of death which will enable us to love other people unto death....

Dr. MARIE HENDRICKX
Professor at the John Paul II Institute for the Family, Rome

Notes

[1] BASIL OF CESAREA, *Homélie sur la Richesse* (Lk 12:18), 6, 3.6, (Paris, 1935), 21.33.

[2] These passages are published by F. QUERE-JAUMES AND A. HAMMAN in *Riches et Pauvres dans l'Eglise Ancienne* (Paris, 1962).

[3] See the Pontifical Council for Justice and Peace, *La Destinazione Universale dei Beni* (Rome, 1992).

[4] THOMAS AQUINAS, *Summa Theologica*, II-II, q. 66.

[5] E. CHIAVACCI, "Proprietà," in *Nuovo Dizionario di Teologia Morale* (Rome, 1990), pp. 1030-1040, 1034-1036.

[6] T. HOBBES, *Léviathan* (Paris, 1996), p. 59.

[7] B. JARROSSON, *Humanisme et Technique* (Paris, 1996), p. 59.

[8] B. JARROSSON, *op. cit.*, p. 90.

[9] C. SCHONBORN, *La Vie Eternelle* (Paris, 1992), pp. 46-50.

[10] J. ATTALI, *L'Ordre Cannibale, Vie et Mort de la Médicine* (Paris, 1979).

[11] In 1994 the press provided accounts of the frightening results of an investigation carried out by the UN Committee Against Discrimination and for the Protection of Minorities, which described the discovery of a trade in organs among countries of the South and the North, with horrible details about the street children of Brazil, Honduras, etc. See *Avvenire*, August 25, 1995, 1.9.

[12] J.P., "Fin de la "Dignité Humaine" en Ethique?" in *Concilium*, 223 (1989), pp. 51-7.

[13] R.BRAGUE, "Le Corps est Pour le Seignieur," in *Communio*, V, 6 (Nov. 1980), pp. 4-19, 5-6.

[14] H. NAKAJIMA, *Address to the 44th World Health Assembly*, May 7, 1991.

[15] Speech by Dr. Nakajima to the Executive Council of the World Health Organization, January 12, 1992.

[16] The reports drawn up by Marguerite Peeters can be found at the Center for the New Europe, Research Park, De Haak, B-1731 Zellik, Belgium. See in particular reports 7 (October 1995) and 16-21 (December 1995 to March 1996).

[17] What appears to be the priority of all priorities is "genetic health" or "reproductive health," to which Dr. Hiroshi Nakajima referred explicitly at the Cairo Conference (speeches to the Executive Council of WHO, 3 May 1994 and 16 January 1995). This implies, as an indispensable instrument, the regulation of fertility, which in the opinion of the conference involves the interruption of unwanted pregnancies. The commitment of the World Health Organization to abortion is confirmed, for example, by the pamphlet *Women's Experiences of Abortion in the Western Pacific Region* (Women's Health Series, vol. 4), which was published by a local section of the World Health Organization. Information provided by the press in April 1995 followed in the same direction—a campaign of anti-tetanus vaccination, promoted by the WHO, turned out to be a mass program of abortion. Employing the excuse of a vaccine, hundreds of women were given injections of chemical substances which react against the hormones of the mother at the beginning of pregnancy, thereby causing the death of the unborn child. These women are now sterile, and all of their future pregnancies will lead to a miscarriage. The World Health Organization denied the facts, but after an inquiry by the Supreme Court of Manila this vaccination program was blocked. Various documents of the WHO bear out the active participation of this organization in the anti-demographic policies of the United Nations.

[18] B. JARROSSON, *op. cit.*, p. 35.

[19] See here B. JARROSSON, *op. cit.*, pp. 41-2.

[20] J-M. CARDINAL LUSTIGER, "La Nouveauté du Christ et la Post-Modernité," in *Communio* 15 (1990).

[21] J-M CARDINAL LUSTIGER, *op. cit.*, p. 18.

[22] B. JARROSSON, *op. cit.*, pp. 62-66.

[23] E. CHIAVACCI, *op. cit.*, pp. 1037-1039.

[24] J-M CARDINAL LUSTIGER, *op. cit.*, p. 15.

[25] B. JARROSSON, *op. cit.*, p. 118.

[26] E. MOUNIER, *Le Personnalisme* (Paris, 1949), p. 38.

[27] See the Pontifical Council for Justice and Peace, *De Rerum Novarum to Centesimus Annus* (Rome, 1991).

[28] M. SCHOOYANS, address at the Pontifical Academy of Social Sciences, 25 November 1994.

[29] E. CHIAVACCI, *op. cit.*, p. 1037.

[30] See E. SGRECCIA, *Manuale di Bioetica, I. Fondamenti ed Etica Biomedica* (Milan, 1988), p. 37.

Round Table

International Cooperation for Solidarity

JOSÉ A. PUJANTE

I: Nongovernmental Organizations

We often ask ourselves if the peoples of the earth really behave fraternally towards each other, and the answer which we give to this question may lead us to believe that humanity has become dehumanized. With bitter skepticism we have to admit that the relationship between the peoples of the globe at times does not even come near to the categories of friendship, of good neighborliness, or of mutual respect. Yet these values are essential to the achievement of concord and harmony among nations.

Coexistence has been difficult since the beginning of time, and tolerance has not always ruled the way tribes, ethnic groups, and nations have behaved towards each other. This lack of brotherhood is at the root of the sadly real lack of solidarity which has been demonstrated during history. It has also been the cause of the precariousness of the brief periods of peace which have taken place during the existence of mankind.

The selfishness of the developed world is often the cause of an unfair distribution of goods. This attitude of egoism must form part of human nature. One can readily observe that at both an individual and collective level the advance of ontophylogenetic behavior by people comes to be expressed in a tendency to ignore those who are less privileged. For this reason it is very important to inculcate goodness of heart in young people so that in the future they will be able to express the generous and warmhearted features of our species, and thereby subsequent generations will enjoy a more equitable, harmonious, and balanced world.

Still today, as in the past, some people possess a great deal, and others have very little (although, with the passing of the centuries, situations have often changed, with civilizations experiencing prosperity and then falling into decay, or vice versa). From this imbalance, and from a certain flicker of compassion, there springs the need for cooperation, which is an act of fraternal love, philanthropy, and charity towards one's neighbor, an expression of solidarity which is based upon purely humanitarian aims and does not have any commercial or speculative aspects or motivations.

Cooperation, in essential terms, is nothing but the triumph of a wish to give practical expression to the best and most noble aspect of the person, of the human being—to help those who are in need, as, indeed, we are reminded to do by Holy Scripture, and as Jesus during his ministry preached to us through his example.

There can be no doubt that in recent years a large number of organizations with very different outlooks and ways of doing things have dedicated themselves to this onerous task of serving their fellow men in very difficult situations, very hostile contexts, and very adverse conditions. These groups have gradually secured the participation of people from different backgrounds and have provided their help to those places in the world which are most in need. They have done this thanks to the contribution of experts in logistics and planning, but also thanks to their ability to overcome very great obstacles. We are dealing here with a large number of volunteer workers, full of enthusiasm and tenacity, who have been able to perform the daily miracle of restoring health to those people who thought that they had lost it forever. These arduous tasks have been carried out without making distinctions based upon race or religious belief. Such, indeed, is the real patrimony and wealth of humanitarian organizations—the people who work for them. This is something of which we are all well aware.

It would be useless to discuss here the history of such bodies over recent decades. Nearly all of them have been established or reorganized in line with the standards of nongovernmental cooperation. Some have been a kind of "rebel" complement to the activity and initiatives of the governments of various countries; others have been the "alter egos" of governments and have acted together with them in order to secure the approval of programs and projects which could be paid for out of public funds only with great difficulty in democratic societies. Others, lastly, are simply independent and autonomous. What I have said here is no secret, in that all these elements can be found in the network of actions and grants where astronomic sums of money are involved and where economic resources are transformed into a valuable treasure which is administered in the name of solidarity.

However, some time ago, when those various sectors of modern civilized society which were dynamic and involved felt especially motivated by the wish to help their suffering brothers and sisters of the third world, many men and women consecrated their lives to be next to those in need and gave the best of themselves to save the

sick in both a spiritual and a physical sense. They did this without thinking about the risks of being infected by very serious diseases or worrying about the possible reactions of tribal witch doctors to what was going on. Some of these people were secular; others, as we well know, were members of religious orders.

The history of humanity cannot be written without reference to missionaries. In the same way, one cannot speak about humanitarian cooperation without mentioning these people. For many centuries they have gone from one end of the planet to another, following the instructions of their orders and congregations, and they have settled where there is most need of them. In the name of the Church they have carried out this arduous work of evangelization for almost two thousand years not only to save souls, but also to heal bodies. This two-thousand-year experience is a rich inheritance which enables us all to feel proud of their spirit of sacrifice, their self-denial, the lives they have been able to save, and the hope they have been able to restore to millions and millions of unfortunate people.

From this point of view, I remember that I recently saw scenes in Rwanda which graphically express how certain sets of facts and episodes can sweep aside the efforts made by generations, much like a river in full flood. The armed conflict involving the Hutu and Tutsi tribes has produced many casualties. In the under-equipped hospitals and health facilities the male and female missionaries who look after such people without making any distinction as to tribal membership have often heard them exclaim, "This god whom you taught me to believe in is not so powerful as you led me to believe if he cannot prevent my wounds from killing me. He can't be so good as you say since he allowed my children and all my family to die unjustly. This god does not love us. The gods of my ancestors were better—they protected us. I won't pray any more." Although these are ways of thinking which form part of human nature and are readily comprehensible during moments of despair, especially when there is an animist religious background and an ancestral culture which has deep roots in the atavism of many generations, they nonetheless demonstrate how fragile what the missionaries have built up piece by piece really is.

There can be no doubt that today's missionaries are and have always been the pillars of modern-day cooperation and the seedbed of nongovernmental organizations. The former are simple and the latter are sophisticated, but they are both involved in admirable initiatives and forms of activity in a very complicated world which is subject to the dictates and many-sided shifting realities of political and economic interests, the power of information, the good will of people, hypocrisy, and also—why not?—innocence.

After making clear that cooperation in the healthcare world goes back to the actions of the missionaries, it should also be pointed out that one is not only dealing with a nostalgic vision of the past, but with a modern-day situation where in the name of the Catholic Church thousands and thousands of men and women work in their missionary lands far from their own homes. The example of Italy brings this point out very well. In Italy there are 50,000 diocesan priests or priests of other kinds, and 16,000 priests are missionaries in far-off countries. Most of these, in addition to their apostolic commitment to the faith, are chiefly engaged in missions involving the provision of health care. In this pastoral activity the Church is able to demonstrate both her capacity to preach the Gospel and the extent to which she is an ecumenical point of encounter and contact between different Christian denominations—Protestantism, Orthodoxy, etc.—and a point of interreligious contact with very different doctrines and beliefs—namely, Islam, Judaism, Buddhism, Hinduism, and so forth.

The history of missions, and especially their pastoral activity in the healthcare field, is certainly the richest part of the modern and contemporary history of the Church. However, this point has not always been brought out to the full. In acting as a missionary, the Church, in addition to engaging in evangelization, also turns herself towards Jesus, towards the suffering and the sick of the entire world, living with them and accompanying them until death. On how many occasions has the activity of missionaries served as a substitute for the failings of the healthcare systems of third world countries when their innocent populations have become the victims of wars or natural catastrophes? The question remains unanswered.... But, as I have said, the Church, through her duty and her mandate, could not but place herself, like Christ, among the sick, the real physical, biblical, and metaphysical place where human reconciliation takes place because man does not become reconciled to himself or to others if he does not respond to this need for physical and spiritual health.

Our much-loved Cardinal Fiorenzo Angelini, who deserves our fullest admiration and esteem, captured the essential dynamics of what I have just described and outlined it in the following incisive words: "Almost a stereotype designates St. John of God, St. Camillus de Lellis, and their followers as apostles of the sick. An apostle is he who is invited to evangelize. An apostolate among the sick involves going beyond a restrictive idea of pastoral activity in the healthcare field. And the missions, which have experienced increasing growth—especially starting in the age of these two saints—have discovered in pastoral activity in the healthcare field their most important and rewarding area of action, thanks in particular to the birth within the Church of numerous religious institutions for men and women, many of which, indeed, have dedicated themselves to missionary work *ad gentes*."

It is obvious that after the example given by religious missions, society itself went on to create its own secular missions. Aware that the state could not deal with the urgent and many-sided needs of developing countries, the first associations sprang up, the outcome of high ideals and the embryos of what were to become today's nongovernmental organizations. Only twenty years ago a group of

dreamers gave rise to aid projects for depressed areas of the planet without any other form of support than that of popular campaigns. They obtained timid, or at times enthusiastic, social backing and some contributions from individuals or private companies. In very fortunate cases there was a symbolic economic or logistic participation from public authorities. However, with the passing of time, more complicated kinds of organizations and associations gradually emerged. Governments already allocated parts of their annual budgets to the cause of cooperation in different countries for humanitarian, political, or commercial reasons and did not pay much attention to these potential lobbies and the cultural role they could play. Few people imagined the important part that would be played by nongovernmental organizations in the not-so-distant future.

Nongovernmental organizations have certainly proliferated in dramatic fashion. Some of them are of a religious and denominational character, and others are not. Some are openly political, and others are not. Some have a clearly defined ideology, and others do not. Some want to work in certain specific countries and have a single central office, and others have become authentic multinationals, truly powerful machines, around which revolve companies and institutions, volunteer workers and paid professionals with salaries equivalent to their counterparts in the world of private business. In some of these organizations—and what is the point in denying the fact?—corruption arose. Obscure figures were able to operate freely and had an opportunity to play on the heartstrings of society through powerful images of black people in advertising campaigns in the mass media. The handling of "humanitarian products" which were "highly sensitive material" did not keep the baseness of the human being from displaying its most contemptible aspect in the exploitation of scenes of suffering and the pain of other people in order to take advantage of them by playing on such serious elements as the feelings, good will, and spontaneous reactions of the public.

Fortunately enough, however, the fight against fraud and illegal activity has enabled the rottenness to be eradicated and the good name and the respectable action of these admirable organizations have been vindicated. The whole burden of the work of solidarity cannot fall on nongovernmental organizations alone, and these bodies cannot generate the funds necessary for the financing of their expensive projects. Government grants, the public money of every taxpayer, should be wisely distributed among those nongovernmental organizations which present plans for initiatives which are well thought out and suitably programmed.

In Spain, in 1992, when, that is, the need to create a legal framework for the various forms of activity connected with the world of international cooperation became recognized, a long process was embarked upon which culminated, in July 1997, in the Cabinet's approving a bill which after difficult parliamentary debates will now be submitted to both houses of parliament. This prospective new law has six sections or fundamental parts. The first is concerned with the Spanish policy of cooperation and defines how it should be regulated in legal terms, its goals, how and where it should be applied, its principles and its priorities. The second part deals with the planning, forms, and methods of bilateral and multilateral public cooperation. The third part defines the responsibilities of the operational bodies engaged in cooperation. In the fourth part are to be found the information and data on the material side of this policy. The fifth section deals with the personnel of the government civil service who are to manage the policy of cooperation. The sixth and final part concentrates on nongovernmental cooperation and defines what the private organizations dedicated to cooperation and growth are, their public profile, systems of aid and financing, and fiscal incentives.

Although this may seem an obvious point, this law expresses the fundamental objective of Spanish cooperation in favor of growth and development—the struggle against poverty in third world countries. In order to avoid a number of ambiguities this law also defines what nongovernmental organizations are and sets out a governing statute. The overall intention is to improve the policy of cooperation from a qualitative and quantitative point of view. To this end an "Interterritorial Cooperation Council" will be set up which will harmonize the actions of public authorities (whether national, independent, or local) and private bodies and also engage in an exchange of information on questions relating to the various projects which involve cooperation.

This is an important step in the process of placing Spain within the framework of countries which dedicate a part of their national budgets to the cause of humanitarian aid. Almost none of these countries allocate as much as 0.7% of their gross domestic product to this end, even though many areas of society call for the implementation of such a figure with a certain insistence. What is achieved every year in this area is, however, of real consequence. It should be recognized with realism and in a historical perspective that in a few years Spain has gone from being a recipient of aid to being a supplier of aid. Almost five years ago, when the aid provided by Spain began to be somewhat substantial, the Committee for Aid and Development (CAD) of OCDE invited the Spanish government to produce a law on cooperation to ensure improved coordination of aid and better long-term planning.

One of the new aspects of this law is the creation of special "funds for cooperation and development" administered by the Ministry for Foreign Affairs and intended for the poorest countries of the world. These funds are different from the "funds for aid and development" (FAD) which are distributed by the Ministry for the Economy and linked to obligatory contributions from the receiving countries (the Ministry for Foreign Affairs manages 38% of the money allocated for cooperation, and the Ministry for the Economy is responsible for 62%).

Overall, the government plans to allocate 190 billion Spanish pe-

setas in 1998 to cooperation, of which about 8 billion will be given to various nongovernmental organizations for 252 projects. The total sum requested by nongovernmental organizations for the 848 projects which they proposed was 18 billion Spanish pesetas.

There are a large number of ways by which to contribute to cooperation. The Autonomous Community of Catalonia has for some time been in possession of instruments which allow it to channel aid which comes from various sources to the implementation of humanitarian projects in a very broad range of countries. The presence of a highly motivated and solid society inclined to shared organization and solidarity has meant that this proverbially generous people has been able to promote initiatives where once again civil society has preceded the work of public authorities.

In addition to the funds supplied by private and popular initiatives, in 1997 the government of Catalonia provided aid amounting to 1.45 billion pesetas in favor of cooperation in developing countries. This sum exceeded previous levels even though this policy in favor of less-favored nations has been going on since 1994, being organized by the Commissioner for Foreign Action, a special department of the Catalonian Cooperation Council, which has as its members representatives of various areas of civil society and of different kinds of nongovernmental organizations. Most of the projects and programs which have been approved in this area, it should be pointed out, are concerned with the provision of health care.

The description which is offered of the need for economic aid is in itself an expression of the philosophy which lies behind this law: "cooperation to secure development is an ethical duty of every democratic society and of every people that, like the Catalonian people, declares that freedom, justice, and equality are the supreme values of collective life. Solidarity is strictly linked to these values, and this is something which must exist among the citizens of our country and in relation to those people most in need in developing countries. In the context of a world in which globalization and socioeconomic interdependence are on the increase, the problems of underdevelopment are acquiring ever-greater importance. For this reason we should encourage the value of international solidarity within society, a value which involves individual and collective concern, knowledge, and action in favor of cooperation with other peoples in order to find the best ways of improving their living conditions and their democratic, economic, and social development. In order to respond to the increasing concern and awareness of the Catalonian population, which has traditionally been sensitive to the needs of the third world, the government of Catalonia encourages and coordinates a policy of cooperation through support for the initiatives which spring from civil society. These initiatives are in large measure promoted through nongovernmental organizations and other nonprofit bodies and institutions which work in the field of cooperation and solidarity."

There can be no doubt that most of these projects are concerned with cooperation in the healthcare field. They are freely and independently conceived and promoted by nongovernmental organizations and supported by government authorities. Their aim is the reduction or the elimination of the causes of poverty and the raising of levels of hygiene and health in the populations who receive this aid.

In addition to this policy of cooperation, which has been embraced by the "President's Office" within the Ministry of Health, the Catalonian Institute for Health (ICS) has also encouraged procedures by which to contribute to improving initiatives in the field of cooperation dedicated to health care. This has been done in a complementary fashion without there being any new economic contribution—material and human resources alone have been involved.

This institution is responsible for public health and is about to be transformed into a healthcare corporation. It has 32,000 employees and is the most important employer of labor in Catalonia. In 1995 the Office for International Healthcare Cooperation was created, with its headquarters in the central office of its parent institution.

This new body is to supply those instruments and methods by which the doctors, nurses, and paramedical personnel at hospitals and early intervention facilities in the large ICS network will be able to link up with cooperation projects drawn up by the various nongovernmental organizations. Obviously enough, it was important to ensure that this institution, as a public health body, did not behave like a macro-nongovernmental organization. This would have been an erroneous action by the government, an interference of dubious morality in the territory of others, and an illegitimate usurpation of roles and functions. It therefore seemed more sensible to provide the increasingly wooden state administration with means by which its employees and civil servants could be helped to leave their jobs in the national health service for a short while—keeping, however, their jobs and in many cases remaining on full pay—in order to link up with specific cooperation projects, after having asked for special permission to do so.

For such a large and intricate institution it was very important not to fall into the net of bureaucracy. It was necessary to facilitate and ensure the effective working of such permission so that members of the state apparatus could make themselves available to this nongovernmental organization when called upon to do so, in certain situations of great urgency, and work right away in aid and cooperation projects in countries in Africa, Asia, and Central or Latin America.

A normative legal corpus has been drawn up which addresses itself to such procedures and circumstances. This ensures that this large category of professional men and women working in the civil service can achieve their wish to make themselves useful, to help their fellows who are suffering, and thereby give a new meaning to their own lives beyond the grayness of everyday events and the routine of work at urban healthcare facilities where health is already guaranteed. All of this, as has al-

ready been pointed out, is carried on in a situation where these professional people retain their salaries and where the nongovernmental organization does not provide any kind of payment, unless, that is, a special arrangement has been made and the salary is deliberately not accepted. This new motivation on the part of healthcare workers in the exercise of their vocation—and at the same time this opportunity to offer the best of their lives to sick people who are very much in need—is without doubt a suitable complement to the work which, as has already been emphasized in this paper, missionaries and innumerable members of religious orders already tirelessly carry out in the name of the Church.

Man is undoubtedly the best actor in initiatives. In other words—and to use language which is more suitable to the end of this century—human resources are the most valuable patrimony of organizations. Institutions are no exception to this rule. It is well known that the people who work for them are their strength, and it is in relation to this spirit of service to the community, to society as a whole, both within and beyond its present frontiers, that we must frame and develop various government policies in this field.

This fulfilling initiative which has been promoted by the Catalonian Institute of Health has given many healthcare workers—doctors, nurses, psychologists, social workers, helpers, technicians, or mechanics—the hope that they will be able to engage in cooperation and has also given the hope of life to many anonymous recipients of their good will and their actions. The work of such people in these distant corners of the earth will not be sterile.

I will spare you a detailed description and summarize in a very brief and direct fashion the four great guidelines and conceptual objectives which we have in mind and which seek to implement the underlying philosophy I have outlined above.

The first major category is made up of principles which govern how to manage things so that civil service staff can leave jobs for a while and work in cooperation projects which are run by various kinds of national and international nongovernmental organizations.

The second such category deals with how to organize modes and channels to ensure that through various kinds of nongovernmental organizations it becomes possible to take care of patients from countries of the third world who cannot receive medical or surgical treatment in their own countries, in hospitals and healthcare facilities within the health service run by the Catalonian Institute for Health. In the main, nongovernmental organizations make themselves responsible for the transport of the sick person, and the national health service pays for the costs of care—which at times become very high. Obviously enough, a clear process of selection is at work in this procedure.

The third category of aid in the field of cooperation involves information storage, which in the case of computer archives is of a "virtual" character. Such a system enables us to classify all the material we have available—namely, material resources and healthcare equipment—and place them at the service of nongovernmental organizations which ask for them and later send them on to third world countries. Most of the equipment which is no longer used in the hospitals of industrialized countries because it is out of date can be employed to very good effect in the poorly-equipped healthcare centers of impoverished countries, where it represents very advanced technology.

The fourth and final category involves the definition of procedures which can update the professional skill and knowledge of healthcare workers in countries whose precarious health systems have been destroyed and that have thereby become unaccustomed to work and engage in treatment in normal conditions—in this way losing familiarity with new techniques and elementary advances in the field of medicine and care. A few weeks of special visits organized by appropriate channels with colleagues in modern health centers and daily practice in wards and surgeries can enable these people to update their professional skill and knowledge, exchange ideas and experience, and learn new forms of diagnosis and treatment. This is undoubtedly something which can be of great help to patients in their home countries if applied in a suitable way.

Approaches of this kind, with real support and cooperation among governmental and nongovernmental organizations, are to be found in most of the developed countries of the world. The old continent of Europe, which is building its common home with material from many quarters and in a variety of architectural styles, has not forgotten that it should also act in a unified way to allocate substantial funds to the cause of cooperation. The countries of North America and Asia which are able to engage in a similar policy have also organized funds to help less favored nations. All of this will probably be improved and built upon, as happens with nearly everything in life. But in a certain sense this is something to be appreciated because things today could certainly be very different. During other periods of history, as I observed at the beginning of this paper, those in need and sick people in poverty would have been left to fend for themselves in a demonstration of what was a weak and highly inadequate sensitivity towards such questions and such people.

I would like to express my strongly-held belief that these funds really reach their humanitarian and fraternity-inspired destination, and I would like to reject the temptation to believe, as is suggested by certain forms of information, that there are people who enrich themselves with this money. I want to trust in the goodness of human nature, even though such an approach often seems rather difficult.

The Pontifical Council for Pastoral Assistance to Health Care Workers has an important role to play in this keenly-felt crusade, in this noble struggle against injustice in order to build a new world where compassion shines forth among the peoples of the globe. This Pontifical Council has an especially favorable position when it

comes to directing and managing this campaign, whose goal is undoubtedly of the very highest order. On the one hand, there is the obvious influence that this Council exercises on the members of religious orders engaged in missionary work, both men and women, and, on the other, we see that it has the ability to make a direct impact on countries in many different parts of the world, to act at the very highest levels of international organizations such as the United Nations, the World Health Organization, and UNICEF, and of various forms of nongovernmental organizations which act at a worldwide level, and to deal in an ecumenical spirit and an interreligious perspective with the questions and difficulties which are raised by international cooperation in the health field.

From its inception the Pontifical Council for Pastoral Assistance to Health Care Workers has demonstrated its full potential and shown how positive it can be in its activity designed to help humanity in pain, the humanity which suffers in silence and dies as a result of illnesses which in the West can be cured at very low cost. The Pontifical Council does not forget all these human beings, to whom Cardinal Fiorenzo Angelini (with whom we are much linked by affection) has constantly drawn attention. Cardinal Angelini, of course, was the *alma mater* and the president of this ministry of the Curia Romana. There can be no doubt, after eleven international conferences such as these, that he managed, toether with his staff, to express to the world the strong and meaningful tie which exists between the Church and the world of health care, particularly on the threshold of the third millennium. It is fitting that at this moment we should honor His Eminence Cardinal Angelini. With nostalgia, but with the firm determination to continue his work, we should so organize our efforts that the new president of this Pontifical Council, Archbishop Javier Lozano, is able to continue on his pilgrimage—both real and virtual—in order to spread his message and pastoral action in favor of sick people throughout the world.

The initiatives of the Pontifical Council for Pastoral Assistance to Health Care Workers have always received the support and blessing of the Holy Father, who has continually expressed his vocation and strong wish to be close to the sick and infirm—that part of the population which has been deprived of the divine gift of health and which requires our selfless cooperation. During his apostolate John Paul II has given priority to the creation of worldwide awareness of the importance of providing health care to the poorest of our brethren and to the dying. This Pontifical Council for Pastoral Assistance to Health Care Workers is the best instrument we have to take the coordinates of this path of salvation to everywhere on earth.

The pontificate of John Paul II astounds public opinion with its dynamism. This is a pope who travels (in almost twenty years he has covered the distance between the moon and the sun over three times). He is a pope of the mountains (and I, who humbly share this passion with him, well know the value of the solitude of the peaks as a school for life, a place to meditate upon existence, the mystical, and the metaphysical). He is a missionary pope, for he has dedicated a large part of his journeys to the countries of the third world to share the suffering and the pain of those who are ill and infirm. In addition, he has reached out to other denominations and faiths in the most open form of ecumenism, to ensure that Jewish and Muslim believers, to take just two examples, can bring the subject of cooperation in the health-care field into the synagogues and mosques and thereby contribute to sound and positive forms of coexistence.

Even Indro Montanelli, an intellectual and veteran philosopher who works in the guise of a journalist, recognizes and appreciates the intense work which has been carried out by this pope and has expressed the view in public that he is an "agnostic and admirer of John Paul II," whom he considers to be one of the greatest figures of the last part of this century. There can be no doubt that the sowing of spiritual and moral values which has been promoted by the Pontiff will be a stimulus for all those of us who during the third millennium must go on helping those who are most in need.

Life is not only about carrying out various projects and undertakings—it is also about trying to learn from various kinds of experience in order to become better and more complete. I would like to say that, in addition to engaging in various kinds of professional and academic activity, I have also had the good fortune to get to know many countries at first hand, many of which are underdeveloped and where living conditions are authentically pitiable. I have been to some of these countries to engage in cooperation and to promote humanitarian missions. I have visited others to climb mountains or to encounter other cultures as an amateur anthropologist.

After twenty-six years of mountain life I had the privilege one happy day (May 16, 1993) to reach the summit of Everest in the Himalayas. During the third month of the expedition, after great efforts and a serious accident, which took place a week before our triumph, I reached the point where the earth ends and the skies open. I have described my life with the Sherpas, devout Buddhists, in many of my books because I feel great respect for their religious beliefs. I have the same attitude towards the credo of the Nepalese Hindu porters, who, indeed, expanded our spiritual horizons. Up there at the very summit of the world, more than forty degrees below zero, blown by icy winds, you get the feeling that you are in a temple without walls where all gods and all religions are present. You cannot see God, but you feel His presence. You cannot perceive other gods, but you sense their presence. Up there, in that simple pinnacle of hostile ice, between Nepal and Tibet, above the clouds which cover China and India, the human being feels small and recovers the humility which he has lost. So great is the majesty of the Creation, which is displayed in such splendid fashion beneath his feet and which so greatly eclipses what he has just done that nobody feels that his exploit is worth any-

thing. During that solemn moment nothing higher exists on the face of the earth, and the grandeur of nature towers over the vision of the man who at that moment reflects on matters, thinks of those he loves, and of those who are living and those who have died. And he feels very near to an immense presence which fills his whole being.

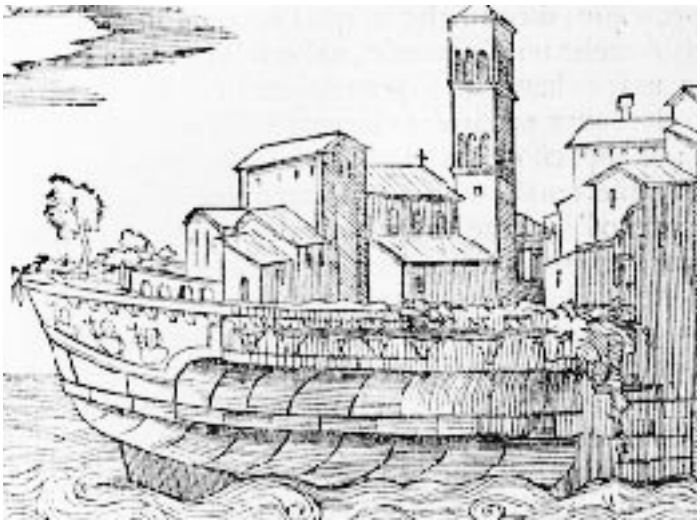
Yes, up there, at top of the world, you feel very near to God and to men. Curiosity envelops you, and you want to remain there to see if it is possible to enter the firmament even more, which at nearly 9,000 meters is an almost black blue caused by the lack of oxygen. But this is not allowed you. The human being has to return to physical meadows and the material valleys to which he belongs, where he can breath and go on living his earthly life. While you descend from Everest after this astounding mystical experience, you dream of finding a better world and secretly nurture the hope that something has changed while you were lost in the clouds. But, unfortunately, when you return to civilization, you hear that wars are still going on, that poverty, hunger, and acute need are ravaging the less protected populations, that epidemics are causing thousands of horrible illnesses, and violence is claiming its victims; that children are dying at birth because of the lack of sufficient care; that mothers experience pathologies because of an absence of clinical attention; that women are raped and forced to have abortions; that vaccines and drugs and medicines pile up in military stores while patients die from illnesses which can be cured; that torture is practiced; and that experiments are carried out on human beings...while another part of the same global village, 20% of the overall population, controls 80% of total resources and wastes them in superficial things or superfluous luxury. As I observed at the beginning of this paper, it is probably from this imbalance that there arises the need for cooperation. This imbalance has injurious effects. And if, as I believe, it does not please the Creator, should it not also wound the human conscience? By these words I want to bring out only a part of this crude reality. Ladies and gentlemen, all human beings have the right to be happy. God has not bestowed this right upon only some inhabitants of our planet. Everybody, by the simple fact of being human, deserves dignity, respect, and health. But it will not be easy to break the system of harmful and unjust distribution. If we are really all equal, at times I think that some are more equal than others....

It has been an honor for me to present these thoughts of mine to an audience which is so distinguished and which is well aware of the transcendent importance of suitable campaigns for prevention and missions for healthcare cooperation aimed at achieving cure and treatment, an audience made up of doctors, surgeons, or teachers. When the Holy Father concludes the work of this conference and we go back to our own countries, we will carry with us the belief that all of us can do something to help our sick brothers and sisters, not only in the places where we work every day, but beyond our national frontiers, beyond the comforts of our monotonous tasks as citizens. There is a universe full of work to be done which awaits hands which are ready to do it, even though it is certainly true that real need is also to be found close at hand. If charity is, as I believe, the essence of cooperation, then any person of good will can be useful. Through nongovernmental organizations or any other kind of institution—the important thing is that the results are the product of honesty, of ethics, and of an unstained professional code of conduct.

Even though we will not be able to achieve a perfect world, we need to engage in those actions which will allow us at least to create a better world, helping those who are in need and seeking to bequeath a world which is more just and peaceful to subsequent generations.

I would like to thank you for your kind attention.

Dr. JOSÉ A. PUJANTE
Director of the Office for International Health Cooperation, Barcelona,Spain



IVAN MARÌN

II: Cor Unum

My dear friends,

I would like to add my congratulations to those already expressed for the Pontifical Council for Pastoral Assistance to Health Care Workers, the institution which is responsible for this Twelfth International Conference—an event which seeks to affirm that Jesus Christ is the salvation of the world.

I have been asked to present a paper on the subject of "international cooperation and solidarity from the point of view of my experience at *Cor Unum*."

The subject is of great topical relevance. This is because solidarity is spoken about all over the world, for the many evils from which humanity suffers spring precisely from a lack of solidarity among men and peoples, and in its ministry at *Cor Unum* the Church has a real promoter, director, and guide for cooperation and solidarity among the peoples of the globe.

I have divided my paper into three parts:

1. *Cor Unum* as a generator of universal solidarity among peoples in order to achieve complete and overall development, in line with the thought of Paul VI.
2. *Cor Unum* and solidarity as a virtue, in line with the thinking of John Paul II.
3. Guidelines for action.

1. *Cor Unum* as a generator of universal solidarity in order to achieve complete and overall development in line with the thought of Paul VI

Pope Paul VI initiated a practical application of Vatican Council II in the sphere of the Roman Curia after that council had produced its results.

On July 15, 1971 he created the ministry of *Cor Unum*, "solicited by duty to charity to encourage the universal human family along the path of reciprocal and sincere solidarity" (this quotation is from the official letter which established the Pontifical Council *Cor Unum*). Aware of the immense number of initiatives and institutions which live out and practice in a variety of ways the virtue of charity and thereby promote cooperation and help at a national and international level, the Holy Father wanted to create a ministry which acted as a stimulus, promoter, and guide by which to intensify solidarity inspired by charity.

Paul VI responded to the term "solidarity" by using the pastoral language of the Church. He declared that the creation of *Cor Unum* was a project which he had borne in mind for some time, perhaps from the moment when he issued his Encyclical *Populorum Progressio*, because he wished "to ensure that in the vast sphere of Christian solidarity among peoples and the progress of men inspired by real charity there will be a more secure linking of all the energies and initiatives which arise from within the Church" (from the official letter which established *Cor Unum*).

Furthermore, the Pope wished to open up the horizon of universality to all the initiatives which were already present within the Church and which were certainly rooted in the creative impulse of evangelical charity. The Pope wanted the whole spirit and all the words of the *Constitution* of the Council, *Gaudium et Spes*, as applied to the Church in the contemporary world, to become visible and concrete in their expression.

Universal solidarity was not something which exclusively concerned the initiatives and the institutions of the Church. Paul VI extended the following invitation to the bishops of the whole world and to all the faithful of the Church: "It therefore seems to us suitable to create a special ministry which offers, so to speak, the opportunity for a shared encounter to the whole People of God with regard to the above-mentioned subjects of solidarity and development, which should be given practical expression in line with the unchanging principles of the Gospels" (from the official letter which established *Cor Unum*).

Although the many needs of the peoples of the world, which were outlined in detail by Paul VI in the Apostolic Letter *Octogesima Adveniens*, made the Pope fully aware of the urgent necessity for establishing the *Cor Unum* ministry, this did not mean that the Church was beginning a new form of work. Thus Paul VI wrote, "As in past centuries, so in our times the Church believes that it is her duty to serve men with diligent commitment and in an authentically humanitarian spirit, having been established by the Son of God, who "did not come to be served but to serve," (Mt 20:28) (from the Letter cited above).

The Christian solidarity which Paul VI enjoined for all the members of the Church, both clergy and members of the laity, was also applied to the nations of the world. "It is our task," he observed, "to remind all the nations that they have the same duty towards solidarity as is incumbent upon all individuals." Referring to the Encyclical *Populorum Progressio*, he reminded the different nations that "what is surplus in the richest countries must be used for the poor countries" (from the Letter cited above). In order to achieve these great objectives, Paul VI created the Pontifical Council

Cor Unum for the human and Christian promotion of peoples.

2. *Cor Unum* and solidarity as a virtue in line with the thinking of John Paul II

During the solemn commemoration of the twentieth anniversary of the Encyclical *Populorum Progressio*, John Paul II demonstrated the persistent validity of the social doctrine of the Church and enriched it with new elements when he published his encyclical *Sollicitudo Rei Socialis* (SRS).

It is important to examine the concept of solidarity with reference to everything which John Paul II has done to enrich it if we want to apply it with consistent continuity to pastoral activity.

It should be remembered that halfway through the twentieth century two antagonistic positions held sway with regard to social questions: on the one hand, there was the ideology of individualism, which established a capitalistic system of the exploitation of man, and, on the other, there was collectivism, which proposed a system of the exploitation of man rooted in state totalitarianism. The Church addressed herself to this whole area in terms of the concept of "the social" and since 1963, with the social Encyclical *Pacem in Terris*, she has approached it from the perspective of "solidarity."

In *Gaudium et Spes*, the Pastoral Constitution of the Church for the contemporary world, the Vatican outlined the theological basis for solidarity. John Paul II has said that his Encyclical *Sollicitudo Rei Socialis* is an application of this document of Vatican II (SRS, 7).

In the overall magisterium of John Paul II and particularly in his addresses in Latin America the subject of solidarity has been dealt with twenty-nine times.

During his address to FAO, which was delivered in 1987, the Holy Father laid stress on how solidarity meant openness, responsibility, and interdependence.

John Paul II has emphasized that *Populorum Progressio* gave practical expression to the condemnation which Vatican Council II made of the situation of acute poverty. In addition, he has also made clear that this publication drew attention to the global dimension of the social question. He has further stressed that such a planetary perspective on this situation was a new departure and that such an approach also involved the conversion of a moral obligation into a duty to engage in solidarity (SRS 7,8,9).

On many occasions and in nearly all world contexts John Paul II has condemned the growing gap which exists between the industrialized countries and the developing nations of the world. He has condemned the absence of solidarity shown by those who support financial and economic mechanisms which increase the wealth of the few, but continue the poverty of the many.

The diagnosis made by John Paul II in SRS is even more valid when he declares that the root of the social problem of the world lies in the presence of conflictual nonsolidarity.

3. Guidelines for Action

To conclude this paper, and with a view towards keeping the hope of those peoples in need alive and fostering the good will of the many people who work to promote cooperation and solidarity in the world, I would like to outline and discuss a number of key points.

a. The redemptive love of Christ is a solidarity-inspired love. "Caritas Christi Urget Nos" (2 Co 5:14).

Today, as yesterday, the love of Christ continues to inspire new forms by which to live out human fraternity; it thereby acts to expand horizons until the day when they will be truly universal. The dynamic of the solidarity-inspired love of Christ involves a preference for the poor and the marginalized, and for those who suffer from hunger, who are sick, or who endure any kind of serious lack.

b. The development of a new solidarity

Solidarity and cooperation are not fashionable subjects. But they are parts of a new spirit which is expanding and growing in the heart of man. This spirit must be understood as a vocation and a task which is located in the heart of man, in his innermost part, where love has its dwelling place. Its aim is the achievement of the Common Good. Solidarity advances by taking communion as its central point, without which there would not be a real recognition of human dignity. This awareness of communion from which human solidarity draws energy requires that special interests take second place to the common good—that is, to shared interests—and thereby abandons selfishness and every form of exploitation and manipulation.

c. The universal destination of goods

Solidarity draws inspiration from the solidarity-inspired love of Christ. It has at its base human and supernatural fraternity; at its center love and charity; involves sacrifice and self-denial; and helps us to understand that the universal destination of goods at the service of all men is a requirement of justice itself.

d. The Church as a generator and promoter of cooperation and solidarity

The Church continues the salvific work of Christ and "works to re-establish and reinforce unity at the very roots of humankind" (*Dominum et Vivificantem*). She thereby promotes reconciliation, which must express itself in new works which take place within and outside the Church, and which manifest a spirit of brotherhood, fairness, and justice which must spread and develop throughout the world.

Finally, I would like to bear witness to what very many Catholic organizations which operate in the social and charitable world are presently doing. They are trying, by many means, to teach and to achieve solidarity among the peoples of the world. They dedicate themselves to providing help and assistance in critical situations created by natural disasters or by the hand of man. And they are involved with the various areas which impinge upon the overall and complete development of man. These bodies and organizations, some of which are members of *Cor Unum*, cooperate in an effective way together to ensure that this important ministry of the Pope is really at the *heart* of service to charity and a point of communion for the innumerable works and initiatives of the Church which foster and encourage cooperation and solidarity.

Most Rev. IVAN MARIN
Archbishop of Popayán, Colombia

LUC TROUILLARD

III: Catholic Charities

Caritas and Advocacy

Since its May 1995 General Assembly, the Caritas "family" has clearly defined a number of work priorities for the 1995-1999 period. Number one among these is *the political dimension of Caritas action*

1. The stand taken by Caritas undoubtedly springs from a very profound understanding of its mission. It is also explained by the evolution of the international milieu, which for different reasons has recently discovered the importance of "civil society". It is becoming habitual to invite NGO's to "make their contribution", "to put forward recommendations", "share the follow-up process" in the framework of a growing number of commissions, conferences, work groups...*The "culture" of the relations between international organizations and representatives of civil society is in the process of changing*. Whatever be our attitude to this evolution (one of enthusiasm or scepticism, accompanied by the fear of being "manipulated"), the current cannot be reversed; in the absence of a world government, and in the face of the resistance of national sovereignties, civil society appears to be in reality an objective ally in the promotion of ideas "without frontiers"...

The challenge facing Caritas does not seem to be in the first place that of conscientisation of the leadership of the member organisations: the will to act has been clearly affirmed. It is no more a question of the recognition of its right to speak out: the presence of Caritas within the framework of civil society (where it can unfold itself) is unquestioned. *The challenge is rather on the level of the practical mechanisms which have to be put in motion to ensure that the will to act produce concrete proposals, capable of fostering the action of the Member Organisations*.

2. The "comparative advantage" of Caritas derives from its local roots and the universality and permanence of its network. *Its "influence capital" is amassed above all on a national level*, before making itself felt on the international level.

Every decision maker, even international, is in the first place a citizen of some country, rooted in a nation, and bound to a national political system. The fact that he takes part in the decision making on an international and inter-governmental level cannot be divorced from this basic fact. From this follows that an opinion expressed in a national context has a greater chance of being heard than the same opinion (directed to the same people) in an international context.

Example: During the first semester 1996, Italy presided over the inauguratory Inter-governmental Conference of the European Union. For that occasion European Caritas had prepared "common positions" on certain points which seemed essential to them. It is clear that these "common positions" presented by Caritas Italiana to the Italian decision-makers, have been better accepted than the same, had they been presented to the same decision makers by Caritas Europe (or C.I.). In the eyes of the people concerned, it is Caritas Italiana that carries weight and not the international structures of Caritas, perceived more or less as "disembodied", without a hold on reality.

The same observations apply to the opinion makers, to the media, to public opinion in general. In other words, *the efficaciousness of all international effort at influencing (or "politics") depends essentially on the way it is relayed on the national level.*

Our structures and methods of work should take this into account.

3. Public positions and the credibility of Caritas

Caritas cannot make itself heard in the cacophony of the "global village" save in those areas where it enjoys a certain credibility in public opinion. These areas are not necessarily those in which *we* think we have something to say...

For example, a strong position of Caritas on the struggle against poverty will be far more credible than on the safeguarding of the environment (even if the safeguarding of the environment is an element in the struggle to overcome poverty). In the same way, Caritas will be better listened to as a defender of displaced persons than as an advocate of the rights of women or of children in general (even though women and children form the great majority of displaced persons.)

In other words, whatever be the wealth of our convictions, we have to take our position in matters on which Caritas enjoys greater credibility with public opinion.

On the other hand, every member organisation has its own strong points and the fields wherein Caritas is credible can vary from country to country. The credibility of Caritas in Sudan, for example, does not base itself on the same realities as in Poland: the local political priorities vary from country to country and do not always lend themselves to action on an international level.

The option proposed here is as follows: *on an international level, the "political" action of Caritas should be carried out primarily in the fields where its credibility is more commonly acknowledged. Re-*

taining this option we are at the same time helped to relay on a national level the work done on the international.

Focusing on the synergy between the international and national levels, and concentration on the "influence capital" in those fields where it enjoys credibility, are the two options on which international political action of Caritas can further itself.

Advocacy and the Engagement of the International Community

The 1995 General Assembly approved a workplan which included, as a major priority, advocacy on poverty and exclusion. The approved paragraph reads as follows:-

The globalisation of the economy and the causes of poverty and injustice: "Study of the causes of exclusion and/or marginalisation (moral, cultural, political ...).This study ....must come up with tools which can be used by Caritas organisations in the work of education and lobbying. This work should probably be done on a regional level and the results of the Copenhagen Summit may be able to offer some practical elements."

This work should be based on the results of U.N. Summits held during the past decade.

1. General Background

1.1 Over the past six years, the United Nations has convened nine global conferences: the Children's Summit, the Education Summit, the UN Conference on the Environment and Development, the World Conference on Human Rights, the International Conference on Population and Development, the World Summit for Social Development, the Fourth World Conference on Women, Habitat II, and the World Food Summit. Through this series of events, the world community identified the most important sustainable development issues, established priorities and objectives, and recommended the means to achieve these objectives.

1.2 The main responsibility for the implementation of the "action programmes" that came out of these conferences lies with the participating countries themselves, as in the case of international conventions. These texts, although signed by Governments' representatives, are not legally binding. It is for each government to decide on their actual implementation.

1.3 The conferences accordingly envisage an important collaborative effort for the UN system and other multilateral organizations, non-governmental organizations and the private sector in general. "The forging of creative and fruitful partnerships between the many actors from the national and international public and private sectors, including the civil society, is perhaps the most formidable challenge on which much of the success of the sustainable development endeavour will depend in the years ahead."[1] The stage is set for a new "culture" to develop. The focus of our action should probably be shifting from global thinking and writing to local (national) action on the basis of existing recommendations and conventions, including those coming out of local grassroots groups and organizations.

2. The Critical Role of Caritas

2.1 There appears to be a growing readiness, among UN and other international institutions, to work more closely with Caritas and vice-versa.

Recent discussions with WFP, UNESCO, UNHCR, UNAIDS and the World Bank bear out this desire for closer cooperation given the extent of the Caritas network. The reasons for this change of heart over the last few years are:-

– a growing awareness that money alone does not guarantee development. People's participation and ownership of projects by the main actors are vital to sustainable development.

– an appreciation that the "market" does not automatically create social justice. On the contrary, "extreme liberalism" can be harmful to 'poorer' countries and populations. Hence the need for a healthy and just "civil society" which can act as a catalyst to ensure that economic life can be shaped by moral principles. As the North American bishops have recently written, "Economic choices and institutions must be judged by how they protect or undermine the life and dignity of the human person, support the family, and serve the common good."[2]

As a church-based organization, Caritas can help to illuminate the conscience of decision-makers from a sound basis of socio-pastoral action at the grassroots level.

2.2 The UN documents provide a solid basis for advocacy work to improve the lives of millions of people. These texts are signed by the vast majority of governments, which makes them the perfect instrument for advocacy work at the national level (the same applies to international conventions).

The time has come for Caritas to invest in its capacity to draw out the best from these "raw materials" and work them into practical advocacy instruments for use at the national level. The urgency of improving Caritas advocacy action at the national level has long been acknowledged and most recently confirmed in the strategic planning process where every member replying to the discussion document stated that advocacy was of vital importance but had to be accompanied by suitable training for members.

The Copenhagen Summit: An Opportunity for Advocacy Action by International Catholic Organisations

"We know how to reduce poverty. Our weakness is follow-up and implementation"
(M. Sandström, World Bank)

1. For the community of nations, this Summit marks a new way of considering the "Global village". This is of course a discreet change, still overlooked by the numerous inadequate decisions taken, but still a real change: the world recognises that a healthy economy is no longer a sufficient guarantee against the growth of exclusions. Only ten years ago, this admission would have been unthinkable, during the period when discussions were at a standstill because of an ideological war.

The commitments made at the Summit and the display of intentions therefore open up new prospects: the Summit has offered itself a "vision"... but did not provide the means of pursuing it.

The States did not wish to take really courageous decisions. However one result has come out of the Summit: there is now a new consensus upon which "civil society" can build

medium and long-term actions.

The Summit results are presented in the form of two texts: the "Declaration" (which includes ten "commitments" - some will say the "new ten commandments"...) and the "Programme of Action", which provides a practical context for the ten "commitments".

2. A sampling of commitments made (excerpts from the Programme of Action)

"Strengthening implementation and monitoring mechanisms, including arrangements for the participation of civil society in policy-making and implementation and collaboration with international organisations." (83,i)

"Effective implementation of the Copenhagen Declaration on Social Development and the Programme of Action of the Summit requires strengthening community organizations and non-profit non-governmental organizations in the spheres of education, health, poverty, social integration, human rights, improvement of the quality of life, and relief and rehabilitation, enabling them to participate constructively in policy-making and implementation. This will require:

Establishing legislative and regulatory frameworks, institutional arrangements and consultative mechanisms for involving such organizations in the design, implementation and evaluation of social development strategies and programmes;" (85, b)

"Enabling institutions of civil society, with special attention to those representing vulnerable and disadvantaged groups, to participate in the formulation, on a consultative basis, implementation and evaluation of policies related to social development;" (72, b)

"Providing equal access for girls to all levels of education, including non-traditional and vocational training, and ensuring that measures are taken to address the various cultural and practical barriers that impede their access to education through such measures as the hiring of female teachers, adoption of flexible hours, care of dependants and siblings, and provision of appropriate facilities." (74, 1)

"Setting specific target dates for eliminating all forms of child labour that are contrary to accepted international standards and ensuring the full enforcement of relevant existing laws, and, where appropriate, enacting the legislation necessary to implement the Convention on the Rights of the Child and ILO standards, ensuring the protection of working children, in particular of street children, through the provision of appropriate health, education and other social services;" (55, d)

"Strongly considering ratification and full implementation of ILO conventions in these areas, as well as those relating to the employment rights of minors, women, youth, persons with disabilities and indigenous people;" (54, c)

"Elaborating, at the national level, the measurements, criteria and indicators for determining the extent and distribution of absolute poverty. Each country should develop a precise definition and assessment of absolute poverty, preferably by 1996, the International Year for the Eradication of Poverty; " (26, d)

"Developing quantitative and qualitative indicators of social development, including, where possible, disaggregation by gender, to assess poverty, employment, social integration and other social factors, to monitor the impact of social policies and programmes, and to find ways to improve the effectiveness of policies and programmes and introduce new programmes." (83,h)

3. What next ?

The process begun in Copenhagen coincides with a particular moment in the life of the Caritas family: this is the realisation of a much-needed "institutional" ("political") commitment, included as an integral part of the Caritas mission. The theme of the C.I. Assembly General is an example of this realisation, as are the series of seminars on the theme of the "global economy" which were held recently in several regions (Africa, Latin America, Asia).

Let us try to imagine the form which could be taken by a Caritas "follow-up" of Copenhagen.

Aim: ensure that the signatories keep their word. "Post-Copenhagen" offers Caritas a practical area where they could quite easily fix aims within their capabilities, based on the intentions/commitments signed in Copenhagen.

These aims, which could vary from one region or country to another, would in fact be summarised by one single aim: *remind political leaders of their commitments, ask them to be true to their signatures, ensure that they keep their word.* It is therefore not a question of reworking analyses already carried out on the state of the world, nor of redesigning a vast panorama of the "World according to Caritas". It is rather a question of organising "vigilance" focused on a small number of practical aims which have been promised or committed (albeit timidly) in Copenhagen.

Organised around a small number of aims and along precise lines, "post-Copenhagen" work could also be an area of fruitful cooperation with other NGOs, starting with Church NGOs.

There are more and more World Summits. Their usefulness can hardly be measured by the visibility of their short term "results" (hasn't the concept of "Human Rights", lacking from the collective conscience before 1948, taken several decades to make its presence felt?). The "globalisation" of the economy, through its effects, leads to the appearance of "globalisation" of social thinking: can we remain indifferent (or overly modest) with regard to this evolution?

Let us conclude, on the practical level, with the European Parliament's comments. It "notes the increase in world summits and considers that if such summits, including the Copenhagen World Summit for Social Development, are to be successful, a sustained effort must be made at the level of the United Nations with the full cooperation of the member states to ensure that the commitments entered into by national governments are speedily put into effect and regularly monitored."[3]

M. LUC TROUILLARD
Secretary General
of Caritas Internationalis

Notes

[1] United Nations Staff College Project (Turin)
[2] A Catholic Framework for Economic Life, 1996.
[3] Resolution B4-0367/95 - L.1-

MARIA PIA GARAVAGLIA

IV: The Role of the Red Cross

The gaps among the peoples of the world and particularly the unequal development of the various countries of the globe affects the whole planet. In particular, the great disparity which exists in the levels of growth and development of the countries of the North, on the one hand, and of the South of the world, on the other, is a problem which experts and politicians believe is now written into the economic and political realities of the world. It is a problem which has been studied and examined for nearly a century, with a view to finding a radical and definitive solution.

But although, on the one hand, the South is paying the price of the consequences of this gap, it is also true, on the other, that the North is not without responsibility for the exploitation which took place in the past and the deliberate creation of the dependence of these countries in the present. All this is evident from the dramatic statistics and data which emerge from an examination of this overall situation.

Hunger, chronic malnutrition, illness, and overpopulation form part of a dramatic—if not catastrophic—planetary state of affairs which has to be dealt with by the cooperation which is expressed and carried out in a whole variety of forms by the international community.

At the present time, the international community as a whole sees as the goal and objective of such cooperation in favor of growth and development the establishment of living conditions which enable the dignity of each and every individual to be defended and upheld.

One uses the expression "at the present time" because up till the 1950s the term "growth and development" was employed to refer exclusively to economic activity understood solely in terms of profit.

With decolonization and the achievement of their independence, most countries subject to these processes were not able to achieve economic independence as well, both because of the total exploitation of their territory by the colonizers and a psychological attitude of dependence towards the imperial power.

The lack of previous independent economic activity prevented suitable growth and rapid development.

By the end of the 1960s a relationship of colonial dependence had been replaced by a relationship of dependence based on aid which was legitimized by international law, but in the 1970s—in different fashion—international cooperation sought to ensure that the development plans of developing countries were in the hands of those countries themselves and also engaged in a policy of encouraging direct trade. The aim here was to ensure that such countries became the agents of their own future. This strategy and approach was described by experts and international workers in this field with the appropriate phrase "trade, not aid."

During the 1990s we have seen a new concept gain ground—that of cooperation for "long-term sustainable growth and development." The goal here is to achieve the elimination of poverty in all its forms throughout the world. This concept, which was applied to the whole area of growth and development, was adopted by the United Nations in December 1991 in the form of a resolution of the General Assembly.

This new kind of long-term process of growth and development envisages cooperation between the world's poorest countries and the most advanced countries of the globe, and not the other way around.

In the so-called "third world" 1,500 million people suffer from chronic hunger, poverty, and illiteracy. Their governments are becoming ever more unstable. Coups, civil wars, and revolutions give a good idea of the gravity of the levels of underdevelopment which exist in many poor countries in Latin America, Africa, and Asia.

Education, urbanization, and industrialization are the primary preconditions to achieving a possible solution to the problems of these countries, and these countries must develop their own economic and industrial know-how and not—I repeat the point—trust to, and rely upon, a dependence on the world's most industrialized countries.

The Church, too, has widened and modernized its concept of solidarity and cooperation. This is a process which has been well under way for a long period of time.

In the Encyclical *Sollecitudo Rei Socialis* John Paul II stressed the duty which everyone has to strive to solve the problems of marginalization which beset these third-world countries. In such countries poverty has reached unbearable levels both for their peoples and for others. As the Pope makes clear in this encyclical—a work where solidarity is rightly seen by many as being its *leitmotif*—"We are all called, indeed obliged, to face the tremendous challenge of the last decade of the second millennium, not least because the present dangers threaten everyone: a world economic crisis, a war without frontiers, without winners or losers. In the face of such a threat, the distinction between rich individuals and rich countries, on the one hand, and poor individuals and poor coun-

tries, on the other, will have little value, except that a greater responsibility rests on those who have more and can do more."

The same idea is repeated by the Pope in his *Centesimus Annus* where he states that there exists a collective responsibility to promote development and further invites everybody to cooperate and to make their own special contribution.

It is in this light and in this perspective that the international governmental organizations act with the primary goal of creating a network of pan-human institutionally-expressed solidarity.

However, such organizations do not always manage to implement their cooperation programs to the full and in a way which is not selfish. In particular, they are not able to meet the needs of underdeveloped countries because they are often incapable of detaching themselves from the political and economic interests of the world's most powerful countries.

But the concept of solidarity, as has already been pointed out, must overcome the self-interest of countries themselves, and the international movement of the Red Cross and the Red Crescent achieve such independence from the political goals of governments thanks to its role as a humanitarian organization which is in institutional terms apolitical.

Indeed, the Red Cross is a non-governmental international organization and thus an international association which is governed by its own rules and regulations. Its aim is to coordinate—at a worldwide level—that broad movement of international aid which acts, obviously enough, under the symbol of the red cross.

The Red Cross movement is made up of a series of different bodies and organisms organized in line with the local laws of the countries where they are present and operate. There are one hundred and seventy-one such entities which work in the field of humanitarian aid, and each of them represents the Red Cross or the Red Crescent in the same number of countries. These local bodies operate at a transnational level and are coordinated by two large organizing bodies—the International Committee of the Red Cross and the International Federation of the Red Cross and the Red Crescent. When analyzing and discussing the action which is taken at the level of international cooperation, it is necessary to point out that there is a major difference in the fields of action of the Committee and the Federation.

The International Committee of the Red Cross carries out its tasks first and foremost during, and in anticipation of, armed conflicts. It is thus concerned with questions relating to the improvement, development, and spread of international humanitarian law and the practical protection of the victims of war. The International Federation, on the other hand, was explicitly created to coordinate and promote the humanitarian aid of the national societies of the Red Cross and the Red Crescent during times of peace. Its aim, above all, is to encourage those kinds of activity which are directed towards defending the health of peoples and promoting social well-being both through prevention and through the implementation of aid programs when natural calamities take place. In this last endeavor, help is given to the victims of disasters by all means possible, and in such circumstances the work of international aid of the national societies of the Red Cross and the Red Crescent is coordinated and directed by the Federation.

At an international level, the Red Cross is an association which has a worldwide network which is unique in its sphere. This is because it has an immense potential power and can call upon its national societies in order to mobilize solidarity workers throughout the globe. Indeed, in 1996 122 million volunteer workers and 284,000 officials helped some 20.6 million people.

As has always been the case, last year as well the Red Cross occupied the primary position in terms of action taken to deal with various forms of catastrophe.

Economic, political, and ecological factors have increased the number of aid initiatives for which the Red Cross was responsible: unprecedented flooding in Africa and the consequences of the large numbers of political deaths in Africa and of the racial conflicts in the Great Lakes region, to name only some of the most obvious. Once again, the most important and substantial aid missions were carried out to help refugees fleeing from the violence of war which involved, in Rwanda alone, for example, hundreds of thousands of people.

The Red Cross movement acts in the field of humanitarian aid with reference to seven fundamental shared principles which were adopted at the twentieth international conference of the Red Cross held in Vienna in 1965. These principles constitute the spirit and the ethic of the Red Cross; they both guide the Red Cross and act as its pillar. They capture the goals of the movement and express the means by which these goals are to be achieved.

I would like to refer to some of these principles—those, indeed, which are closest to the subject which is being discussed in this paper here today.

The first and fundamental principle is that of *humanity*: "*Born from the wish to provide aid without any form of discrimination to those wounded on the field of battle, the Red Cross, at both an international and national level, strives to prevent and alleviate the suffering of men in all circumstances. It seeks to protect life and health and to respect the human person. It promotes mutual understanding, friendship, and lasting peace between all peoples.*"

It is not, therefore, only aid in the strict sense which is the first concern of the Red Cross. Our movement believes that the prevention of suffering is another one of the primary goals of its activities. It is for this reason that all Red Cross workers throughout the world strive to promote education about health, knowledge about the fundamental principles of international humanitarian law, and the principles of the Red Cross—principles which in our opinion should underlie and motivate the conscience of each and every man.

The action which the international committee implements and promotes in favor of the development, control, and extension of international humanitarian law is a fundamental basis for peace among men. Indeed, given that it is impossible for war to be abolished, it is of crucial importance that within each man there is formed and developed a conscience which is based upon such law, which is indeed defined as "humanitarian"—so that man

and his dignity are respected in all their various aspects and features.

But the Red Cross does not see peace exclusively as the mere absence of wars, but as a dynamic process of cooperation between all states and peoples. Such cooperation should be based upon respect for freedom, independence, national sovereignty, equality, and the rights of man, in addition to a just and equitable distribution of those resources which are necessary to meet the needs of the peoples of the world.

In order to respect the human person, it is necessary to respect his life, his freedom, his physical health, his ideas, and his customs. And in order for this to be achieved the Red Cross has adopted a second principle: *impartiality*.

The Red Cross "*makes no distinction based on nationality, race, religion, social condition, or political loyalty. It works only to help individuals according to the degree of their suffering and gives priority to the most urgent forms of aid*." In this way ideas of superiority and inferiority are eliminated, and each man is given equal dignity.

A third principle guarantees the correctness of the action of the Red Cross: *neutrality*. "*In order to ensure everybody's trust it refrains from taking part in hostilities and at all times from controversies of a political, racial, religious, or philosophical character.*"

Because, as we have seen, the Red Cross acts in times of armed conflict, as well as at other times, it places its organizational structure at the service of everybody without favoring or supporting the special interests of any one state in particular. This is what guarantees it being able to secure the trust of everyone.

But there is yet another principle which ensures this—*independence*: "*The Red Cross is independent. The national societies, which help public powers in their humanitarian activity and are subject to the laws which govern their respective countries, must, however, maintain an independence which always allows them to act according to the principles of the Red Cross.*"

Even though each local national society is funded in the main by the state to which it belongs, it must nevertheless conserve its own autonomy as regards political interference and influence. This is because its sole and exclusive goal is to engage in humanitarian action to help those who are weakest.

Universality is a further fundamental principle of the Red Cross, and in a world which is increasingly interdependent the will and impulse to cooperate to save man is ever more relevant and appropriate.

Every action of solidarity, every program of development promoted by the Red Cross, is based upon an overall vision of needs. Employing such an approach, the Red Cross seeks to produce suitable answers and forms of organization. Isolationism is by now obsolete and no individual, no country, should act alone, even if such a thing were possible.

All development and aid programs of the Red Cross seek to strengthen the ability of the local populations to deal with situations of crisis. The help that we provide tries to promote that ability and to give such populations the means and the strength by which they can become the real managers and protagonists of their future.

The objective which the Red Cross has adopted for the end of the millennium is that of contributing to the improvement of living conditions and thereby achieving a decrease in the vulnerability of individuals, not least through the implementation of aid programs, which themselves are linked to programs for the prevention of catastrophes. "Dignity for All" is what the Red Cross is striving to achieve for the next millennium.

Taking care of those wounded in war, help for the handicapped, visits to prisoners of war, aid for the victims of earthquakes, the communication of news to distant family members, help for refugees, courses in hygiene, the giving of blood, the protection of populations in occupied territories, development projects for the third world, the outlawing of man-mines—all these forms of activity are the product of one single idea: to help those who suffer, and to do this without any form of discrimination.

MARIA PIA GARAVAGLIA
Extraordinary Commissioner of the Italian Red Cross

LUIS ARANCIBIA

V: The Experience of *Manos Unidas*

In 1960 a group of lay women created the movement which we now know as *Manos Unidas*. It arose as a response to the appeal of the then president of FAO, Dr. Sen, and was supported by the World Union of Catholic Women's Organizations (UMOFC). A group of women belonging to Catholic Action thus began the first campaign against hunger to be conducted in Spain. This was the beginning of what in 1978 became *Manos Unidas*, an organization which now supports about a thousand development projects every year in more than sixty countries in Africa, Asia, and America and which promotes a great deal of educational activity and consciousness-raising in Spanish society and Spanish institutions through a network of seventy-one diocesan offices and the constant service of over seven thousand volunteer workers. These years, therefore, have witnessed important growth and organizational advance, but, unfortunately, the reasons behind FAO's original international appeal against hunger, poverty, and underdevelopment are still with us and remain features of this world. Fortunately enough, however, the spirit and the commitment of the many Catholic men and women (and people of good will) who have created movements such as *Manos Unidas* continue to be a reality which is prophetic and full of hope in our world.

Poverty and Inequality: Two Realities of Our World at the End of this Century

Our planet has almost 5.6 billion inhabitants, and a third of these live in a condition of absolute poverty and consume less than the basic minimum (equivalent to 360 US dollars per capita every year). A fifth of the population of the planet suffers from hunger; a quarter does not have access to drinking water, and there are 800 million unemployed.

At a world level poverty continues to be the most striking fact before our eyes, the most relevant feature of this world at the end of this century. When we speak about poverty today, we refer to the daily reality of most of the inhabitants of this planet.

This poverty should be seen as a broad and intricate reality which goes beyond a mere lack of economic resources and involves the whole individual and the entire community from a variety of angles. One is dealing, therefore, with a reality connected to other various aspects of what is usually presented to us. In the first place, when we speak about poverty, we are speaking about real people, poor people, excluded people. Poverty is not some kind of abstract, disembodied, or theoretical reality, but something involving the personal histories, mistaken paths, and unfulfilled hopes of real men and women who have a face, a name, and a life to be lived. We have to generalize and engage in abstractions when we want to engage in social analyses, but, in doing so, at the same time we must not lose sight of the practical and daily realities to which these concepts and statistics actually refer.

As I observed above, although closely connected to the unequal distribution of goods and possessions, poverty is a reality which is much more complicated in character than the mere lack of economic resources. Poverty has many aspects—malnutrition, illiteracy, high infant mortality rates, unhealthy environments, unemployment, and so forth—and if we want to eliminate poverty, this means that we must employ a many-sided overall policy. In addition, there is the phenomenon of the lack of respect for poor people, the low levels of individual and group dignity, a low level of community organization, the loss of values and of cultural identity, and poor information about collective and individual rights and duties. Poverty is also generally followed by the degradation of the environment, by wars and armed conflict, or by a lack of respect for human rights. These are all phenomena which arise very easily in a context of general poverty which is itself reinforced by such elements. What we need, therefore, are not only economic resources, but also, and in a global sense, personal and corporate resources which foster a life worthy to be lived and promote the social space necessary for participation in political, socioeconomic, and cultural life. Poverty can also be identified with a lack of health, which is defined by the World Health Organization as physical, mental, and social well-being.

Poverty in a World of Inequality

Over the last forty years mankind has taken unimaginable steps forward in the scientific and technological fields, and in the social and political spheres as well. Indeed, there has never been such a well-developed consciousness of the rights and the dignity of man. The benefits of this progress are concentrated in a relatively low number of countries and in the hands of a few people. A large proportion of the countries in our world have benefitted from this progress in only an indirect way, and this progress itself contains propensities towards exclusion and

inequality. The indices of satisfaction of basic needs, even though they are now at levels which could be described as scandalous, have improved over the last decades in nearly every country of the world. Notwithstanding this fact, the distribution of well-being has not made many advances, and injustice continues to grow in an alarming fashion. The report of the PNUD shows that economic growth "has failed for a quarter of the world's population, in absolute and relative terms, and eighty-nine countries are now in a situation which is worse than ten years ago."

Economic polarization has become more marked both between countries and within countries. As a result, the report of the PNUD goes on, "if present tendencies continue, the economic disparity between industrialized countries and developing countries will pass from the unjust to the inhuman." One worrying fact illuminates this scenario: the wealth of 358 multimillionaires is greater than the income of the countries which host nearly a half of the world's population (45%). Hunger and poverty have always been phenomena which affect the community at large. The great feature of our age is that for the first time both can be avoided.

The phenomenon of poverty seems to be intimately linked to the growing inequality between the North and the South of the planet. Over the last thirty years the differences between rich and poor countries have doubled. (1) Many factors indicate the close tie between preexistent poverty and the growing inequality of our world. Pope Paul VI made this very clear when he condemned the fact that "the rich are getting richer at the expense of the poor, who are getting poorer." This relationship can be seen from many angles which demonstrate that poverty and wealth are "two sides of the same coin" and not independent or isolated phenomena.

Poverty and underdevelopment are intricate and complicated realities with many faces which have nothing to do with ill-luck, and even less to do with divine plans. The existence of inequality and injustice in our world are not a matter of chance—they have real and practical causes.

Nor is poverty the fruit, at a primary level, of individual situations or attitudes. It is not personal elements (character, talents, personality, etc.) which determine the poverty of individuals, even though it often happens that poverty prevents people from expressing themselves to the best. Poverty and underdevelopment have structural and specific causes, which are as follows.

* Unjust international relations among countries of both a commercial and political character and in relation to financial, technological, and cultural balance, which are characterized by the domination of some countries by others, by the dependence of some countries upon others, and by the supremacy of selfishness over cooperation. As the Spanish bishops have observed, "It is, therefore, necessary to condemn the existence of certain economic, financial, and social mechanisms which are manipulated either directly or indirectly by the more developed countries and which, in their workings, favor the interests of those who manipulate and also end up by suffocating or conditioning the economies of the less developed countries."

* Social, political, and economic structures within the countries themselves of the South of the planet, which even more forcefully reproduce the inequalities and the injustices which take place at a worldwide level.

Each one of us, as social beings, through our own indifference, forms of behavior, habits, conduct, and values, are accomplices in the creation of this injustice and this inequality. The Spanish bishops have stressed that "in those structures there act and exercise influence individual people who bear their own responsibilities." We believe that "in their personal or public decisions all must see this relationship in a planetary perspective and observe that there is an interdependence between their own kinds of behavior and the acute poverty and underdevelopment of very many men and women" (*Sollicitudo Rei Socialis*).

The Action Which Has Been Taken to Change This Situation

In the face of these realities (whose causes can be identified) governments and international institutions have seen cooperation in favor of growth and development as the means by which to promote the elimination of poverty and encourage the harmonious forward movement of the countries of the South of the planet. Even though there are some precedents in past centuries, cooperation in favor of growth and development, like official policy promoted by specific institutions, became stronger after the Second World War in most European countries and in North America.

Official cooperation in favor of growth and development was the outcome of various different factors: the impulse that the United Nations sought to give to human advance in the decades which followed the development which was begun in the 1960s; the interest which the old imperial powers had in maintaining close and privileged relations with their former colonies; the traumatic experience of the Second World War; and, lastly, the keen awareness that peace must be constructed in justice. Over the years the reasons for the promotion of a policy of development and aid have changed. In the 1970s new countries in the South called for such aid; there was the idea of a New International Economic Order, and there was also the approval of the 0.7% figure for aid provision. Aid was also used as a strategic weapon during the Cold War and more recently has been influenced in its form and contours by the internationalization of the world economy and the appearance of worldwide problems such as the environment, immigration, drugs, and security. Within the framework of the intricate and complicated relations between the North and the South, cooperation for development and growth is a broad concept which embraces a set of very different actions whose principal objective is that of favoring the development of the peoples of the South of the world. Our historical experience demonstrates that the practical exercise of aid for development is greatly influenced and conditioned by the interests of the countries which supply that aid.

At the present time cooperation is an area in crisis, in the etymological meaning of the term.

There is less and less money available. In 1994 the countries of the OCDE dedicated 57.737 billion dollars to official aid, a sum equivalent to 0.3% of their overall GNP.

This is the lowest sum to gave been given over the last twenty years and is less than half the figure to which the United Nations committed itself.

There are many reasons for doubting its usefulness because after fifty years of activity it can be seen that many countries in the South of the world have only slightly improved their general standards of living.

The governments of the aid-providing countries are becoming ever less interested in what happens in these regions of the world (something which is especially true in relation to the very poor countries).

It can be observed that there is a growing deviation between the original objectives of cooperation ("the elimination of poverty") and present-day practice. Aid has become transformed into an instrument by which to serve the interests of the donor countries.

An assessment of these four decades of official aid in favor of development and growth is not very edifying. Despite this fact, we should not lose sight of the truth that aid for development is a very small part in relative terms of a series of very much wider relations between the North and the South of the planet. For this reason, such aid cannot be the remedy for the problems we have outlined above (which, indeed, require much deeper changes and transformations), nor should it be the central ambition of our plans, namely the promotion of human and sustainable growth and development. Official aid in favor of development, however, must represent a decisive and direct contribution towards a transformation of the living standards of the many people, communities, and populations in the South of the planet.

Private Initiatives

A long time before governments began to engage in cooperation, many groups and organizations had already begun to pursue such a policy. In the main these were people who had been sent to developing countries for religious and evangelization motives and who, in addition to their denominational missionary activity, worked in favor of the social development and the material prosperity of the populations where they practiced their religious mission. It has already been observed that from 1960 onwards—the year when the World Campaign Against Hunger was first launched—many private organizations which already existed responded to this appeal by uniting, and others were established as a part of this campaign. From that moment their numbers have constantly increased, and the same may be said of the resources which are allocated to this area, by both religious organizations and secular associations. At the present time such bodies are responsible for about 10% of the total resources dedicated to cooperation. We will now turn our attention to examining how cooperation works in practical terms by taking *Manos Unidas* as a case study.

The Experience of Manos Unidas

Manos Unidas is a Church organization whose action is based upon the Gospels and upon the social doctrine of the Church. It is grounded upon the belief that each individual has inviolable rights and dignity and that, as was stated in the Puebla Declaration, "each human life in itself deserves respect, and every form of social life must be based upon the common good." We are aware that we live in an unfair world, where, as has already been pointed out, most people do not have access to acceptable living standards.

We are also, however, of the secure opinion that this reality can and must be transformed and that we are called to live in a better way in a world where freedom and equality are not mere utopian concepts. The arrival of the Kingdom of God requires our commitment and our work. We are aware that we all have a part to play in the transformation of our world, a world in which in some way we all participate in forms of injustice through our individual and social behavior, but where we all, at the same time, can participate in the promotion of solutions to these forms of injustice.

The Objective of Our Work

The purpose of *Manos Unidas* is the fight "against hunger, malnutrition, acute want, illness, underdevelopment, and the lack of education" and "against their causes—injustice, the maldistribution of goods and opportunities among people and countries, ignorance, prejudices, a lack of solidarity, and insensitivity." In the same sense the Development Program of the United Nations refers to human development as a "process of the expansion of the gamut of choices of people, which runs from a physical environment in a good state of health to economic and political freedoms."

We well understand that development is an unfinished process for which we are all responsible and in which we are all involved, and that transformations are required—social and individual changes which must guarantee living standards of a suitable level for all.

This kind of development has the following characteristics.

Completeness. Development is not only economic improvement, but includes different aspects of the individual and society. "Economic development and social progress must advance together and operate hand in hand so that all social groups and categories can participate in a suitable way in the increase in wealth" (MM 73).

Humaneness. The goal and the objective of development must be the individual man or woman, and this must be based upon a complete or overall vision of both. Development must seek to "make man himself the responsible agent of his own material improvement, of his own moral progress, and his own spiritual development" (PP & E).

Sustainability. Development which respects and stewards the environment and does not endanger the living conditions of future generations.

Participatory and community basis. Development must be constructed through the participation of everyone in the interests of everyone.

Orientation towards "being"—rather than "having"—more. For the form of development which we aim to construct to be overall and to be seen as the center of the human being, its objective must be, in fundamental terms, not to have more but to be more. Despite this fact, we are aware of the urgent need that exists to ensure suitable living standards and we recognize that this is an indispensable fact in guaranteeing that individuals have the opportunity and ability to develop.

Inclusion of all the southern countries as main actors. Develop-

ment may not be imposed, provided, or conditioned in its character from the outside. The beneficiaries of development must be active agents and not merely passive objects of their own development. They must establish their priorities (which do not always coincide with ours) and make clear their rhythms and their needs.

Criteria for Action

The initiatives we take must favor the transformation and the alteration of our world, both in the North and the South of the planet. It is for this reason that we wish to proclaim hope and want to engage in constructive criticisms leading to proposals, and why we do not wish to become involved in mere acts of charity or philanthropy.

We want to be an institution for solidarity which, starting with giving and generosity, promotes relationships based upon brotherhood with the peoples of the South. We define solidarity alone the lines suggested by *Sollicitudo Rei Socialis*: "Solidarity is not only a shallow and vague feeling provoked by the wrongs suffered by people who are far away or close at hand. On the contrary, it is the decisive and constant determination to work for the common good—that is, for the good of each and every individual so that everyone is really responsible for everyone else."

Our role involves not only bringing the poor out of poverty—it also means providing them with the conditions and the means by which they can eliminate poverty by becoming the masters of their own destiny. In the short term, projects and educational initiatives are a useful response to real needs. In the medium term they bring about structural change: they enable poor people within society to demonstrate their needs and to express their point of view with a certain forcefulness.

This action should be based upon cooperation and dialogue with local churches and organizations in the South, and this should be done without any attempt to impose our model of doing things. The experience of years of work makes clear that our activity should not start from a position of superiority or the imposition of our model of society. The countries of the South of the planet are complementary to us and reveal our failings and our limitations.

Policies for Work

In order to carry forward its work, *Manos Unidas* has established two main policies: 1) to make the Spanish people and Spanish institutions aware of the problems of the South through a policy of development education; 2) to cooperate with the countries of the South so that through financial, technical, and human support they can become the masters of their own destiny by means of the implementation of *development projects*.

Development Education

In Spain, and sometimes within a European framework as well, *Manos Unidas* engages in development education. The need for such an initiative is based upon a recognition of the responsibility which the North has for the underdevelopment of the South, upon a recognition of interdependence as an essential element in our world, upon experience of work in the field of projects which illuminates the potential, but also the limits of such projects, and upon awareness of the influence and the role which we should have within our own societies.

The fundamental objectives of *development education* are to make public opinion more sensitive to, and aware of, the realities of the countries of the South, analyze the causes of their poverty, and promote a change in values, attitudes, and behavior in our citizens.

Development education involves condemning and putting pressure upon groups of power and institutions in order to bring about structural changes which promote justice. "It is essential that we apply pressure to those who hold political power with a view to producing changes which liberate poor people from these forms of oppression."[2]

Development education, therefore, is much more than information—it seeks to promote participation, bring about critical awareness, foster individual and social change, and engender enthusiasm. It is an invitation to engage in a different way of seeing the world and of approaching the world.

The individual attitudes and social structures which we wish to change are those which directly or indirectly bear heavily on the experience of the poorest peoples of the world. We must emphasize, in particular, the promotion of tolerance, pluralism, cross-culturalism and support for native cultures, the correct distribution of goods, austerity and the economic relations between the North and the South, respect for the environment and nonconsumerism, the advance of freedom, participation, and the struggle against every form of slavery or violation of human rights. Furthermore, we must condemn hunger, the lack of health, well-being, and education, and their causes. We should uphold work in favor of peace, and we must criticize the expansion of armaments and their sales and condemn violence.

Fields Where Development Education Takes Place

Our ways of feeling, thinking, and acting and individual and collective attitudes and values fuse together in the various contexts in which we gradually learn to be what we are. Such contexts are the mass media, the different levels of formal education, social organizations (parishes, youth clubs, associations). There is also a less defined but very important context—the street, the images and messages which we receive in public spaces. *Manos Unidas*, in its promotion of development education, thus takes various forms when it comes to expressing itself in practical terms: education in the formal sphere; publications and audiovisual material for parishes, associations, and private individuals; the mass media and advertising; campaigns of consciousness-raising; contacts with public authorities; campaigns of condemnation; coordination with other organizations of the Church and nongovernmental organizations.

The Criteria for Our Work in Favor of Development Education

All our initiatives to raise funds must have a significant component of development education and consciousness-raising. We do not want, therefore, to promote activity which, although it increases the funds available, leads people to embrace or continue to have attitudes and values to which we are opposed and which we are fighting against—namely, consumerism, materialism, the destruction of the environment, violence, discrimination, and so forth.

Our message and the way in which we communicate it must be consistent with what is laid down in

the "code of conduct" drawn up to govern images and messages about the South. Thus we must avoid everything which could involve generalizations which conceal diversity; idyllic or exotic images; images which accuse; pathetic or catastrophic images; everything which tends to emphasize the paternalism or the feelings of superiority of the North.

It is our hope that, rather than becoming the voice of those who have no voice, our work will give a voice back to those who do not have one, thereby helping to encourage direct knowledge of the problems which we face, to promote the participation of the poor and the excluded in their own societies and in the world, and to create conditions which will enable such people to express their own views and opinions.

We have chosen forms of development education which will bear fruit in the short and medium term. Our ambition is to influence individual and collective value systems and to transform institutions and groups of power, and we are therefore well aware that we are engaging in a policy whose results are difficult to assess. We are not aiming primarily at results which can be seen immediately.

Development Projects in the Countries of the South

Support for the implementation of projects in countries in the South is another primary goal of nongovernmental organizations. Such organizations have very different approaches to this whole area. I would like here to outline what *Manos Unidas* aims at, and to refer, where necessary, to how it does things in practical terms.

Cooperation in the implementation of projects seeks to help poor people in fashion that they can become the masters of their own destiny. These projects involve the provision of material supports and instruments which can promote development and improve the living standards of local inhabitants. These are, however, stages on a journey, links in a longer and more intricate chain.

There are different kinds and categories of such development projects. They can be distinguished from each other in the following ways.

* *Emergency aid*, when there are natural catastrophes or military conflicts. In essence, such aid involves dealing with certain basic needs through the provision and distribution of food, medicine, clothing, and so forth. We are dealing here with initiatives which are urgent and short in duration, even though at times (for example, when refugees are involved) they can last for longer periods.

* *Rehabilitation*. This is promoted immediately after humanitarian aid once conditions have arisen which allow an elementary reconstruction of infrastructures.

* *Food help and security*. The aim here is to guarantee access to food to a population which has a structural nutritional deficit. In the main, this has been limited to the sending of food supplies (with the occasional distribution of excess requirements). At the present time it involves other elements: the purchase of seeds, tools, storage systems, distribution systems, etc.

* *Development projects*. These have a wider temporal horizon and involve planned actions which are the outcome of the initiative of the local population receiving help in order to improve a situation of want.

Manos Unidas recognizes that there are different forms of work to be done in the development project field, under the following headings.

Social: homes, water supply, human rights, organization, means of communication, social infrastructures, etc.

Agricultural: machines and tools, training, irrigation systems, silos, the selling of products, farm animals, etc.

Support for women: educational courses, cooperatives, organization, professional training, self-employment, etc.

Educational: schools, literacy, training of teachers, informal education, bilingual education, working with specific kinds of materials, etc.

Health care: healthcare infrastructures, equipment, the training of personnel, nutrition and vaccination, etc.

Among the many projects involved, overall projects are the most favored. The projects supported by *Manos Unidas* and, on the whole, by nearly all the organizations operating in the field of development often have the following characteristics in common.

They are always *the work of a local group*. The projects are always allocated to, and carried out by, a local group of representatives.

They are *development* projects of a lasting character which seek to eliminate the causes of poverty. For this reason we do not support projects which merely provide assistance or are meant to deal with an emergency.

They are *nongovernmental* projects and only under exceptional circumstances does the state take part.

In line with what has just been set forth, during the procedure where projects are approved the following criteria are employed to decide upon whether a project should or should not be adopted.

* The extent to which the local population which will benefit from the project will take part in the different stages of the project.

* The socioeconomic situation and condition of the population to be helped.

* The support which the project can give to the community and the positive benefits which could accrue for the critical awareness and self-esteem of that community.

* The solidity, maturity, and rigorousness of the project.

* The project's inclusion in a long-term development strategy.

* The future viability of projects once our support has come to an end.

* The availability and exploitation of resources.

* The employment of technology which is suited to local needs and characteristics.

When we come to discuss *the role of the North* in these projects, it should be observed that there is great diversity, which ranges from organizations where the whole of the process (from identification to assessment) is in the hands of such organizations (or their local representatives) to those bodies which are only offices and which deal with the sending or receiving of funds. *Manos Unidas* does not seek to draw up development projects on its own, and for this reason it does not engage in the planning or implementation of such projects. This, instead, is the work of local organizations. Emphasis is placed first and foremost upon contact with local groups and beneficiaries through visits and other forms of meetings, with the drawing up of papers, the production of assessments, and so forth.

Some Proposals to Make Cooperation more Effective and Solidarity-Inspired

After outlining the general situation, this paper has briefly discussed the different causes of poverty and analyzed the remedies which are available to us. I will now present certain solutions and policies which could guide future activity in this whole area and by which poverty and its causes could be eliminated.

Individual Change Is the Beginning of Everything

If we are all responsible for the growing poverty to be found in this globalized and interdependent world, at the same time we can all be a part of the solution. Personal change, changes in our values and principles, our thoughts and beliefs, and in particular in our forms of behavior, attitudes, and conduct are decisive elements which at times are much more important than we think in the struggle against all forms of poverty.

On the whole, the first step to be taken is that of overcoming indifference. We must open our eyes and look at the suffering of many men and women as something which belongs to us and not to other people. Our work springs from the conviction that we cannot remain indifferent to the suffering of so many men and women, and we want to take upon ourselves "the joys and the hopes, the sadness and the anxiety of the men of our time, and, above all, of the poor" (*Gaudium et Spes*, no. 1). There then follow the questions, analyses, and thought which oblige us to go beyond sentimentalism and immediate but short-lived reactions. Individual action, commitment, and transformation then take place as a consequence of this process, and these are things which, in turn, act as a stimulus for further action.

The Construction Among Us All of an Authentic Culture of Solidarity

It is probably true that the most urgent task which nongovernmental organizations, Catholic organizations involved in cooperation, and all those citizens who are "moved" by the South have to deal with is the promotion of an authentic culture of solidarity in the world which surrounds them.

The increasing interdependence of our planet, a recognition of our participation in the causes (and also solutions) of worldwide inequality, and an awareness of the dissatisfaction which is caused by the consumeristic and materialistic culture of our societies—all these are factors which must lead to the promotion of new social values.

What we need is a culture of solidarity which, in relation to the peoples of the South of the planet, promotes, among other things, the following.

The dignity of men and women as a criterion by which to judge and assess everything.

Universal awareness, global citizenship, sharing in the human family.

The productiveness of differences, the richness of encounters between the races, cross-culturalism.

Austerity and simplicity, in contrast to consumerism and waste.

Respect for nature, a harmonious relationship with the environment.

The construction of a *just and lasting peace*, reconciliation and dialogue, the nonviolent resolution of conflicts.

The Transformation of Structures

We have seen that the deepest causes of poverty are to be found in the structures which dominate our world and which shape relationships at an international and national level, and we have also observed that these are relationships which are based upon the domination of some people by others. The elimination of poverty also requires the transformation of institutions, legislation, and policies, both at a supranational level and within each state. This, in turn, requires an increase in our ability to analyze reality and, above all, obliges us to produce real alternative proposals which will bring about improvements in the life conditions of poor people and will involve elements enabling them to escape from their predicament. Our capacity to influence the spheres and forums where these policies are decided will depend upon the extent to which we are able to produce lucid and rigorous diagnoses and proposals.

The peoples of the South insistently call for action in this area. The Church's invitation to celebrate the end of our millennium with a jubilee is an excellent opportunity to "cancel debts, free slaves, and return lands." Some of the tasks in this regard which we have before us at the present time are as follows.

* A new approach to the problem of *foreign debt*, something which is compromising the future of many countries.

* The search for fairer *commercial relations* which will facilitate the growth and development of the poorest peoples of the earth.

* The reorientation of *official development aid* so that its real and effective end becomes the elimination of poverty.

* The transformation of certain *international institutions* to ensure that suitable development policies are applied on a worldwide scale.

* The enactment of severe international legislation on the *sale of arms* and its rigid application.

Support for Initiatives Which Are the Seeds of Utopia and Hope

In the face of acceptance or habit, we are called upon to be the builders of peace. This is especially true in relation to the poor and the disinherited of this world. For this reason, among other things, we must support initiatives which arise from people themselves and are small steps towards achieving personal dignity and independence and the social cohesion and cultural self-expression of a people. When understood in these terms, the projects which we support will not only become means by which to improve people's living standards, but will also lead us to continue on our path because they enable us to become aware that everything can indeed be changed.

To conclude this paper, I would like to stress that our work of cooperation is called to be a work by which to reconstruct hope, to sow the seeds of utopia, and to give early expression to the Kingdom of God.

Dr. LUIS ARANCIBA
Coordinator of Education for Development at Manos Unidas, Spain

Notes

[1] In its famous report of 1992 the PNUD estimated that the difference between the richest 20% of the population and the poorest 2% increased from 30 to 1 in 1960 to 60 to 1 in 1990.

[2] Special report issued to commemorate the thirtieth anniversary of Manos Unidas.

ALAIN LEJEUNE

VI:The Point of View of the International Federation of Catholic Pharmacists (FIPC)

The search for physical and mental health, for that state of well-being which is the aspiration and hope of all those who suffer, involves and touches upon one of the most ancient of debates.

In *Ecclesiasticus*, in the Old Testament, Ben Sirach the Wise refers not only to the role of the medical doctor, but also to that of the pharmacist, whom he describes as being "he who prepares pleasing remedies and perfumed oils." This demonstrates that from that far-off time there has been a need to have medicines which are suitable for patients and accepted by them and that the professions of the medical doctor and the pharmacist should both be complementary and have their own specific functions.

All civilizations, from the most primitive to the most modern, have sought to provide an answer to the suffering and the sickness of the individuals who have belonged to their populations.

In countries which have been created only recently health has acquired a very great importance, and the development and growth of peoples passes through two forms of action—education and health care.

By health care we mean both the advance of general standards of hygiene (the provision of drinking water, sewage systems, sanitary care, etc.) and the availability of both preventive (health education, vaccines) and curative therapies.

The spirit which guides the work of the FIPC is the outcome of a slow process which was begun by the various associations of Catholic pharmacists well before the outbreak of the Second World War.

Such cooperative action began with the collection, sorting, and preparation of medicines and drugs which had not been used or which had gone beyond their expiration date but which were still efficacious; they were then sent to missionaries working in distant clinics and dispensaries overseas.

At times this cooperation was organized by a pharmacist who dedicated a number of years of his life to service in a certain place, in a hospital, a maternity clinic, or medical school, both as a person engaged in the provision of treatment and more generally as an educator.

Some of our associations are still engaged in the collection of drugs and medicines and send them either to centers which are in need of such material or make them available when catastrophes take place. To this category belong such bodies as AFPC-Solidarité in France and Orbi-Pharma in Belgium (a center for the distribution of drugs and medicines for dispensaries, missions, etc.).

Other associations act in agreement with the pharmaceutical companies and receive those drugs and medicines which have six months remaining before their expiration date. These associations then prepare these drugs and medicines to be sent to places where they are needed.

For some years, however, geopolitical needs have required a deeper study of, and reflection upon, our idea of what international cooperation really amounts to and should actually involve.

This paper will now be dedicated to an examination of the best ways by which to approach this question, a subject which is of primary importance, and is often a question of life and death, for many populations of the globe.

What does it mean to cooperate?

It means acting together with someone.

Cooperation is the action of cooperating. It means, as the dictionary reminds us, working together (*cum labore* = to work together). The dictionary also tells us that cooperation is a policy of economic, technological, and financial aid towards developing countries.

This definition leads on to another question:

Does health come within the field of technology, the economy, or finance, or is it in the province of the rights of man?

Naturally enough, our vision as Catholic pharmacists places us within the approach involving the rights of man, for we have a human conception of the dignity of man which is based upon the values of the Gospels and upon the value of Christian charity.

In the *Universal Declaration of Human Rights* the following articles impinge directly upon how we should see things in this whole area.

– Arts. 1 and 7, the equality of individuals (in fundamental needs, and in education)

– Arts. 2 and 3, the right to life and to freedom

– Art. 5, human dignity

– Art. 12, respect for private life

– Art. 16, the right to marriage and to a family

– Arts. 18 and 19, fundamental freedoms (religious freedom, free-

dom of thought, freedom to belong to a trade union, political freedom, etc.)

– Art. 24, health and medical treatment

– Art. 27, scientific progress and, naturally enough, "love one another," the basis of charity in the teaching of Jesus Christ.

The sphere of action as defined in this way distances us from every risk of engaging in "the charity business," in relationships based upon dominion and being dominated, or humanitarian money-making—that is, a money back system.

The *human patient* is at the center of our concerns and cares.

For us international cooperation has been a field for very deep thought and reflection which has taken place with reference to geographical questions and to matters and issues relating to quality.

We placed emphasis, above all, on the *East-West axis* at a time when the Berlin Wall had not yet fallen. Our activity was of a strictly humanitarian character and sought to provide aid through our Austrian association to our brothers and sisters on the other side of the Iron Curtain. In the main this involved supplying them with drugs and medicines which they did not have. In this undertaking our Austrian brothers and sisters drew upon the support of our German association.

After the fall of the Berlin Wall matters in this area developed further, although at that time we already gave support to an embryo of the Polish association which arose when Solidarity began to emerge.

Today this East-West axis includes a large number of contacts in Romania, in the Baltic countries, in the Ukraine, in Russia (during an international conference devoted to ethical questions held in Belgium we received representatives from Russia), in the Czech Republic, and so forth.

We should not forget two associations which are already active—in Poland and in Slovakia, countries where we have already held international meetings.

Cooperation with these new colleagues has involved, above all, the *exchange and description of Western pharmaceutical practice*, something which is considered and understood in terms of the expression of a liberal profession. Such developments are now being studied and examined.

I cannot fail to observe the steps taken in relation to the Middle East by the associations of Belgium and Italy, within a rather less traditional kind of East-West axis. The association in Belgium has for many years maintained a practicing pharmacist in a hospital in Jordan, and the association in Italy has developed a network of relations with Israeli and Palestinian pharmacists. The French association has been very active in Lebanon, and has been supported in that country by the Order of Malta.

The North-South axis has involved first and foremost the provision of suitable assistance to healthcare personnel in Africa.

The *African program* which we adopted in Paris in 1993 was especially ambitious. This program chooses one country in particular and then seeks to branch out in concentric circles. Its point of departure has been Cameroon, where we have been welcomed very well. An Association of Catholic Pharmacists in Cameroon is now operative in that country.

This *solidarity program* revolves around three basic axes, which are as follows.

* The pharmaceutical axis, involving the *accessibility of drugs and medicines*;

* The Christian axis, involving the dignity of man and a bioethical approach which is based upon the spirituality of the Gospels and the Magisterium of the Church.

* The Catholic axis, involving an overall approach and systems of training which can help the improvement and advance of matters relating to technology and questions concerning values.

1. The Accessibility of Drugs and Medicines

This requires thought and reflection about infrastructures, and in particular the provision of help by which to set up cooperatives for the purchase of drugs and medicines for our brothers and sisters, suitable places where they can be kept and stored, and so forth.

Because drugs and medicines can involve by no means negligible costs for the patient, it seems to us to necessary to make known what the less expensive *essential drugs and medicines* are and to promote an awareness of them on the part of both government authorities and pharmacists and patients themselves.

It should be observed that a well-drawn up list of less than thirty products enables us to treat and help 80% of prevalent forms of illness.

However, these drugs and medicines are resisted for a large number of reasons—they are less remunerative for pharmacists, involve lower profit margins for importers and fewer opportunities for "reduction" at all levels, provoke suspicion as to their quality, etc.

As a result, our activity has followed the recommendations of the World Health Organization in relation to essential drugs and medicines and has sought to promote their use and guarantee that they come from trustworthy and reliable sources.

Although essential drugs and medicines are much less expensive than specialized pharmaceuticals, they still remain very costly for a large number of Africans.

We are also developing the idea of creating small solidarity-based associations of *mutual insurance* which allow access to treatment and drugs and medicines. In order

to promote this policy we have appealed for support from associations which specialize in this field in Europe.

Our present-day activity of supplying drugs and medicines continues thanks to the support which is provided by our brothers and sisters, who dedicate a great deal of voluntary work to shipping out drugs and medicines which they have collected and sorted or products which have been received from pharmaceutical companies.

In doing all this, naturally enough, we follow the guidelines of the World Health Organization, which affirms, in its directive of May 1996 ("Guidelines for Drug Donations WHO/DAP/96.2"), that drugs and medicines are an essential element in international humanitarian aid, but that in this area there is also a need for certain rules and regulations (the analysis of needs, quality, information, shared international denomination - DCI or INN, etc.).

In the same way we follow the observations made by the Belgian Ministry of Health concerning the *relevance of expiration dates* to the utility of drugs and medicines. In *Folia Pharmacotherapeutica* (April 1997, vol. 24, no. 4, p. 29) the Ministry analyzes the employment of drugs and medicine after they have gone beyond their expiration dates. This particular article is based upon two other articles which were published recently in *The Medical Letter* (38, 65-66 and 90, 1986).

Many solid drugs and medicines (compresses and capsules), if well preserved in their original packaging, retain most of their effectiveness for one or two years after their expiration date. The same cannot be said for drugs and medicines which are produced in liquid form.

However, certain drugs and medicines require warnings because of the toxicity which can develop over time. In handing out drugs and medicines, it is the pharmacists who should be responsible for this side of things.

2. Respect for Human Dignity

Advances in medical bioscience are a major source of hope in the treatment of certain diseases, but they also involve important questions, especially as regards the condition and status of the individual who becomes the subject of medical experiments on humans.

The degeneration which took place in the United States of America at the end of the 1960s (without forgetting the Nazi experiments and their discussion at the Nuremburg trials, a process which provided us with the first code of biomedical ethics—the Nuremburg Code—after that offered by the ancient Hippocratic Oath), gave rise to a number of scandals (where cancerogenous cells were injected into elderly people, hepatitis was injected into weak children, and syphilis was injected into poor black people) which came to bear the name of the cities where they had taken place—namely, Brooklyn, Tuskegee, and Willowbridge.

These scandals formed a background to the development of the discipline of bioethics. In this development the works by Van Potter—*Bioethics: the Science of Survival* and *Bioethics: A Bridge to the Future*—played a special part. The very term "bioethics" and the concept itself were the invention of these important publications.

Following the publication of the *Belmont Report* in 1975, the Congress of the United States of America decided to establish two centers dedicated to the study of bioethics—the Hastings Center and the Kennedy Center, in Washington and New York, respectively—and these became the most famous such centers operating in this area of study in the world.

The regulation of clinical experiments on man has involved the rise of centers for clinical studies in Europe, a continent which, in turn, began to establish its own ethics committees (the French CCNE goes back to 1984).

In Belgium a famous abuse led to the Charleroi trial on cerebral biopsies in 1985.

In the West ever-increasing controls have led to clinical experiments being increasingly conducted in developing countries. As a result, the FIPC decided *to introduce bioethical concepts and principles into Africa* in line with Christian values and values rooted in ancient moral custom—those, for example, which forbid murder, slander, and stealing.

From the first conference on the subject, which was held in Yaoundé in 1994, and on to radio and television debates, major questions emerged from the great attention paid by the mass media to this whole area. Committees of medical ethics or bioethical associations have come into being in Cameroon, Tunisia, Algeria, and other countries.

The bioethical society of Cameroon joined with the FIPC to organize other pluralistic and multidisciplinary international conferences (Yaoundé, 1996) which led African authorities to promulgate a *Resolution on Bioethics in Africa*, which was passed unanimously in Yaoundé in July 1996 during a conference of the heads of state and heads of government of the Organization for African Unity.

But the advance of science should not allow our African friends to remain inactive. In Cameroon in 1985, during the "International Days for Bioethics" the *Project of the UNESCO Declaration on the Human Genome* was discussed and debated. The large number of amendments, observations, and comments which were made during the discussions which followed within the framework of the International Committee of Bioethics of UNESCO were much appreciated.

Such cooperation in the field of bioethics is a human and legal-scientific element and factor which is of great value. In this way we can participate in the development of an important and leading sector of biomedicine and ethics. We are engaging in this activity in cooperation with all the other African faiths and denominations—Animists, Muslims, Protestants, and Catholics alike. At the same time we always invite experts from all the disciplines which are involved in this area of study. (The FIPC, it may be observed, is in contact with Cardinal Arinze, the President of the Pontifical Council for Interreligious Dialogue).

3. Training

The training of scientists, and of pharmacists in particular, is expensive. Furthermore, such training lasts a long time, and for those involved it often requires leaving their country for many years. This very frequently takes them away from their roots and prevents them from taking part in the development and growth of their region.

With their diplomas in their hands, our pharmacists are very often Westernized in cultural terms when they return to their countries of origin.

Their efforts and the financial efforts made by everyone could be better utilized through the provision of training at a local level. It would not be a question of the students having to move but of *visiting professors* coming to their countries for a few weeks to teach until the time when local teachers are able to perform this role.

We are making efforts to ensure that pharmacy is taught where it does not yet exist. This will happen within a very short time in Cameroon in line with what has already taken place in Rwanda. (In this area the FIPC cooperates with the Congregation for Catholic Education, which is headed by Cardinal Pio Laghi).

While waiting for this general project to take off, our various national associations are already financing *mini-projects* which are often the work of our young members. The list of countries which are being helped in this way is long and involves all the continents of the globe, from Romania to the former Yugoslavia, from the Congo to Burkina Faso, and from Lebanon to Palestine.

Together with our Spanish friends, we are beginning a project in South America and in the Caribbean with a view to developing our already numerous contacts.

One instrument for such developments will be the *Manifesto of Catholic Pharmacists*, a document which sets out what pharmacy should be from an independent, ethical, and solidarity-inspired perspective and which presents certain guidelines in relation to the medicines and drugs of the future. These guidelines are directed towards making sure that pharmacy acts to benefit patients rather than working to the monetary advantage of businessmen.

More than ever before, we believe that there cannot be a dispensing of drugs and medicines without the presence of pharmacists. This is because, as a result of his scientific curriculum, the *pharmacist is the specialist in drugs and medicines*.

In a world in a state of great change we are beginning to see pharmacists taking an interest (insofar as their training allows them to do so) in diet and the environment. These are factors which are very important in hygiene for life and health.

Their professional expertise is also an essential link in the prevention of illness and in educating people in matters relating to health. They have a role to play in the fight against the modern plagues of drug-addiction and addiction to different kinds of pharmacies.

In his role as an agent of public health, *the pharmacist is a front-line actor*. Is it not the case that tens of individuals enter his shop every day to ask his advice? He is a healthcare worker engaged in giving advice about drugs and medicines. He is also a worker who, in response to a serious illness, can suggest that a person go to a medical doctor or a health center. *The pharmacist is a health adviser* who gives his advice without asking a fee.

He is also a *rear-line healthcare worker in the world of public health*. He guarantees the quality of the drugs or medicines which he prescribes and he is the last barrier of security for the patient when there is an error in the prescription which the latter presents. The pharmacist is also the person who makes clear how the drug or medicine involved should be used correctly.

We are also developing and promoting the concept of "pharmaceutical care," where the pharmacist, acting within a health team, is an important element in providing the first forms of treatment to the patient. This is especially so in the case of treatment used to respond to the aging of the population and in the development of palliatives.

For the FIPC, therefore, international cooperation within the context of solidarity is based upon the advance and progress of the professional competence and expertise of its members with a view to providing a guarantee for patients and also upon the development of ethics, which are the basis of respect for the rights of man, upon the meaning of the Good Samaritan, upon the promotion of access to treatment and in particular to drugs and medicines, and upon the basis of mutual solidarity, which is an essential element in achieving the goal of health for everyone.

Dr. ALAIN LEJEUNE
Industrial Pharmacist,
President of the FIPC

HIROSHI NAKAJIMA

VII: The World Health Organization

There is surely something paradoxical about the idea of planning and institutionalizing solidarity. Solidarity seems easier to understand as a movement of the heart which finds its life and strength in the realm of personal relationships. Making it a formal obligation or the objective of a policy or an administrative structure might seem unnatural and present the risk of bureaucracy.

Certainly, this danger exists, but there is also the danger of seeing virtue only in spontaneity and the immediate community. The need for solidarity we are discussing this morning reflects an ethic of responsibility which goes beyond emotion, clan loyalty or utilitarianism. This ethic defines the responsibility that individuals, nations and generations have towards one another, based on recognition of the common destiny of all human beings within their own societies, as inhabitants of the same planet, and participants in history. It is this understanding of solidarity, discovered and rooted in individual human relationships but extended to the universal, that the World Health Organization seeks both to promote and to embody in its work of international cooperation.

At this point in the evolution of our knowledge, technology and society, at the dawn of the 21st century, health seems to me the field of human endeavour that most clearly represents the progress, the hopes and the contradictions of our changing world. Remarkable advances haave been made and continue to be made in the life sciences in such areas as molecular biology and genetics, immunology, medical imaging and surgical techniques. Research and improvement continue in the production of drugs, vaccines, diagnostic tools and other medical devices. Considerable advances have been made in the neurosciences. The current revolution in communication technology opens up unprecedented possibilities for medical education and practice.

But every potential step forward also brings with it potential dangers. Technology is only a means. The uses to which it is put imply choices about the kind of civilization we want to live in, and these choices concern everyone. WHO is particularly aware of this ethical and social dimension in the development of science and technology.

International cooperation is essential for access to information, the accumulation of knowledge, and intercultural dialogue on the directions this process should take. WHO is ideally placed to organize the meetings and exchanges this requires. It also has a decisive role to play in promoting the kind of research - both pure and applied - that responds to public health needs. WHO makes information from the field available to the laboratories, the universities and the political decision-makers. Conversely, one of WHO's responsibilities is to ensure that the results of research are made known to their potential users and translated into practical opportunities.

Indeed, the central concern of WHO, the impetus for all its activities for the past 50 years, is to make health accessible to all, starting with primary health care and essential drugs. In this it gives concrete meaning to the Declaration of Vienna (1993) on the right of all people to "benefit from the fruits of scientific progress and its applications", which WHO wants to promote in the interests of peace and for the benefit of humanity.

WHO works through the national health services of its 191 Member States. A major lesson we have learnt from this practical experience is that multidisciplinary and intersectoral cooperation is essential for the coherence and effectiveness of our health intervention. For this too is solidarity: a generous spirit which transcends specializations and professional rivalries so that knowledge and know-how can be shared by those who need them.

Thus for certain objectives we need to work closely with other sectors such as education, housing, employment, agriculture and insurance, and confront them with their responsibilities for health. For instance, the control of infectious diseases such as malaria, dengue haemorrhagic fever, cholera and tuberculosis requires not only the development of health infrastructure but also sound management of the environment, as well as education in the home and at school. It also requires coordination between national reference laboratories and international epidemiological surveillance networks, and between national and international quality control authorities for pharmaceutical and food products. In other words, behind the apparent simplicity of urgent local needs there is an often highly complex aggregation of technical, logistical, eco-

nomic and human imperatives. Today the globalized movement of good, ideas, capital and people makes international cooperation a necessity for all countries, including the most industrialized. In this context too, it is clear that solidarity is something that has to be organized if it is to be effective.

But cooperation and solidarity must aim to foster autonomy, not dependence. Here the importance of respect is paramount, and it is this that inspires WHO's current effort to build new partnerships for health.

Firmly grounded in concrete human situations, cooperation should be based on respect for persons and cultures, their freedom, their knowledge and their own capabilities. Local dynamics must be supported, not replaced.

The status of women must be promoted, for their access to health services, proper nutrition, and education is an important factor for the health of the population as a whole.

In societies disrupted by migration, armed conflict and rapid urbanization, it is essential to strengthen or reconstitute human and social solidarity between family members, between generations and between the rich and the poor. This is indispensable for the control of health problems related to poverty, exclusion and risky lifestyles and behaviour. But the solidarity of personal and community relationship is not enough. Public health, as its name implies, is the responsability of the public authorities, whose duty it is to protect and promote health, particularly by means of political, economic and normative measures.

Thus drug addiction or violence certainly require medical services, but above all they require social measures of treatment and prevention. Likewise, diseases linked to working or environmental conditions require a review of industrial and technological choices in view of the human and health costs involved, both within a given society and beyond it, and in many cases for future generations as well.

Finally, the new century will bring with it a much larger proportion of elderly people in the population of the world, and this gives particular prominence to the solidarity that must exist between the generations. Even more than by its technological achievements, the success or failure of our civilization will be judged by the modes of social integration it puts in place, and by the quality of human relation it manages to maintain, particularly with regard to the very old.

In many cultures, the physical body serves as a metaphor for the social and political body, symbolizing oneness in diversity and helping us to understand solidarity as both a natural fact and a necessity. WHO's policy follows this same logic of interdependence. But beyond the solidarity between the parts of an organic whole, our international cooperation is based on ethical values, starting with the equal dignity and rights of all human beings and all peoples. In 1998 we will be adopting a health-for-all policy that has been revised to respond to the concrete demands of the 21st century. In doing so our Organization and its Member States will be reaffirming our commitment to the fundamental values of equity, solidarity and respect, and seeking to show through our activities the universal scope of these values.

We are very much aware that, as in the past, these activities and these values will benefit from the invaluable support of the staff of the 22,000 health institutions of the Catholic Church spread throughout the world, often working in conditions of extreme hardship among the poorest and most vulnerable of the poor. To all of you I express my gratitude and the gratitude of WHO.

Dr. HIROSHI NAKAJIMA
Director General,
World Health Organization