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Health and Power

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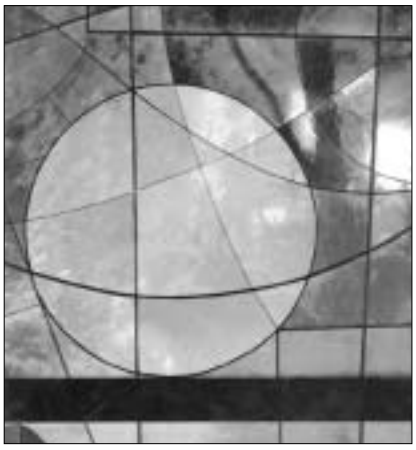

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Joannes Paulus PP. II

ADDRESS OF HOMAGE TO THE HOLY FATHER

Most Blessed Father,

Your Holiness entrusted our Ministry for Health Pastoral Care with the task of expressing the care and concern of the Church for the sick and those who suffer, helping health care workers at a spiritual level. During this sixteenth international conference on 'health and power' we have seen how the various powers in the political, social, scientific, technological, economic and religious fields are also health care workers in the field of health and we have reflected on how to show them, in the light of the Gospel, the pathway to obtain in a more sensitive and Christian way the integral health of the world. We have considered power understood in the light of God the Almighty Father as 'doing truth in love' (Eph 4:15), and thus as the pathway towards the harmony of mankind in the field of health. In this harmony every man and every woman must find the right conditions to achieve their own health, understood as a movement towards fullness, that is, the resurrection of Christ.

We have seen the urgent need to apply these criteria to the health care reality in which we live. Indeed, every year infectious diseases kill seventeen million people in the world, of whom 90% live in developing countries. 95% of the thirty-four and a half million people suffering from AIDS do not have sufficient economic resources to pay for the medical treatment that is required, which is very expensive because of the patents which protect such treatment. There are no up-to-date drugs and medicines, with or without patents, for the so-called 'diseases of the poor alone', such as tuberculosis, malaria, haemorrhage fever, leishmaniasis, certain forms of meningitis, sleeping sickness, measles etc. Of the 1,223 new medicines and drugs put on the market between 1975 and 1997, only thirteen were for the treatment of infectious tropical diseases. It is calculated that the world pharmaceutical budget is between fifty and sixty billion American dollars, of which only 0.2% is dedicated to acute respiratory infections, tuberculosis and diarrhoea diseases. These diseases are responsible for 18% of deaths in today's world.[1]

During this conference we have referred to the various forms of solutions, taken from the Gospel, to these and similar problems presented to us by the use of power in the health care field. Your Holiness has often referred to situations of injustice and the change which must take place in the world so that we can live the love of the Lord.

We are here, Holy Father, scientists and professionals of health care from about sixty nations, feeling much gratitude to you for having granted to us this very important audience. We now await words from Your Holiness that will guide us, and the blessing that will help us to be witnesses to 'hope that does not disappoint' (Rom 5:5) in these fields, which are so arduous and difficult, of medicine and health.

H.E. Msgr. JAVIER LOZANO BARRAGÁN,
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council for Health Pastoral Care.
the Holy See

Note

[1] Mèdicins sans frontières (MSF), 'Briefing Note', June 2000, at htpp://ww.accesmed-msf.org.

ADDRESS OF THE HOLY FATHER

In the World of Health the Exercise of Power should not be Based upon the Desire for Dominion or Profit but should be Animated by a Sincere Spirit of Service

Revered Brothers in the Episcopate
and Priesthood,
Dear Brothers and Sisters!

1. I am happy to extend my cordial welcome to all of you, taking part as you are in the Sixteenth International Conference organised by the Pontifical Council for Health Pastoral Care on the subject 'health and power'.

I extend my affectionate greetings to the President of your Pontifical Council, Msgr. Javier Lozano Barragán, and I thank him for the courteous words that he addressed to me on behalf of those present. My thoughts go to all of you, working as you do in a field which is so meaningful for the quality of human life and the preaching of the Gospel.

The subject of your congress is demanding and complex, in addition to being topical and urgent. In particular, it is singularly useful in renewing the culture of service to health and life, beginning with care for the weakest and poorest.

I observed in my encyclical letter *Sollicitudo Rei Socialis* that 'among the actions and attitudes opposed to the will of God, the good of neighbour and the "structures" created by them, two are very typical: on the one hand, the all-consuming desire for profit, and on the other, the thirst for power, with the intention of imposing one's will upon others..."at any price"'(n.37).

I congratulate you on the fact that during these days of study it is your intention to offer a specific contribution so that in the world of health the exercise of power is not based upon the desire for dominion or profit but is animated by a sincere spirit of service. As is the case with every field, in the sphere of health care as well the exercise of power is good when it promotes the overall good of the person and the whole community.

This harmony is fully fulfilled in the mystery of Christ in whom the Father chose us as His adopted sons and with the richness of grace 'he has made known to us the mystery of his will, according to the purpose which he set forth in Christ as a plan for the fullness of time, to unite all things in him, things in heaven and things on earth' (Eph 1:9-10).

2. By this international conference of yours it is your intention to carry out in the light of revealed fact a detailed reading of the reality of health in all its aspects. In the world of health, different kinds of power encounter each other and interact: from economic power and political power to power

linked to the means of communication; from professional power to the power of the pharmaceutical companies; and from the power of national and international organisations to the power of religious organisations.

All of this gives rise to a thick net of measures in which, on the one hand, the immense opportunities that exist to improve service to life and health are evident, and on the other hand, the risks provoked by powers which are exercised in a way that does not respect life and man are brought out.

To such a vast and complex reality your reflection and debate seek to offer valuable elements for an ethical and pastoral understanding, with in addition an appreciation of the contributions that derive from respectful inter-religious dialogue.

I am confident that useful indications will emerge from these days of study, especially with regard to the social and spiritual action of the Church in the field of health care, considered as a whole.

In order to understand and live out every form of 'power' in the world of health in a correct way, it is necessary to fix one's gaze on Christ. It was he, the Word made flesh, who took upon himself our infirmities to heal them. It is he, who came not to be served but to serve, who teaches us to exercise every form of power as service to the person, especially if weak and fragile. It is he who took on suffering humanity in order to return to it its face transfigured by the resurrection.

3. In drawing near to people in a state of illness, suffering or disability, the Church is moved by the wish to preach and bear witness to the Gospel of life. In doing this, at the same time, she offers a concrete contribution to the harmonious construction of society.

In the face of a widespread culture of indifference and at times of contempt for life, in the face of the unscrupulous search for dominion by some people over others, with the consequent marginalisation of the poor and the weak, it is more necessary than ever before to offer solid criteria so that the exercise of power in the world of health is placed in every situation at the service of the dignity of the human person and the common good.

I willingly take this opportunity to launch a pressing appeal to those who have important positions of responsibility in this important sector so that in a spirit of constructive co-operation they work to promote an effective culture of solidarity, taking into account the conditions of those people who live in countries marked by a worrying material, cultural and spiritual acute poverty.

In this sense, I make myself the spokesman of every sick and suffering person, and also of those peoples wounded by poverty and violence, so that for them and for the whole of mankind there may arise a future of justice and solidarity.

Those who have the gift of faith feel committed in a special way to bear witness through their behaviour to gospel-based hope. Only with love and with service, in fact, can one treat and heal, establishing thereby the bases for a renewed world.

With these wishes I entrust the deliberations of your conference and your persons to the maternal protection of the Holy Virgin, and most willingly impart to each one of you a special Apostolic Blessing.

Health and Power

thursday
15
november

JAVIER LOZANO BARRAGÁN

Inaugural Address

It is a great pleasure for me to inaugurate this international conference on 'health and power' by addressing warm greetings to you all.

In his Letter to the Ephesians (4:15) we find a phrase by St. Paul which seems to me capable of summarising the goals that we intend to pursue at this congress. The version of the Greek text reads *'alezian dè poiountes en agape'* which translates the Latin text literally: *'Veritatem autem facientes in caritate'*, that is to say 'doing truth in love'. This says St. Paul is what we must do to grow as the Body of Christ of which Christ is the head and 'from whom the whole body, joined and knit together by every joint with which it is supplied, when each part is working properly, makes bodily growth and upbuilds itself in love' (4:14). The path, therefore, is that of doing truth in love. I think that this is authentic power. Power, indeed, is not only doing something but rather doing it according to proper truth, and, furthermore, so that it can be authentic power, we must do it in love.

Such is God our Lord. God the Father is all-powerful because he pronounces the full truth, His Son, and He does this with Love, the Spirit. Authentic power is the Most Holy Trinity, the authentic power to do truth in love. The small phrase that we recite at the beginning of the Creed, 'I believe in Almighty God the Father', places us in the mystery of God and explains our faith.

How, then, should we do truth in love in the field of health and medicine? This, indeed, is the subject of our congress. Authentic power is made up of three factors: strength, truth, and love. Strength, and intelligence, and love. Are health and contemporary medicine strength and intelligence and love? What is the reality of our times? How should we proceed so that both health and medicine are true power? What is authentic healing power?

The providing of answers to these questions is the objective of this congress whose subject is, precisely, 'health and power'. We will begin with a vision of the whole which will be elaborated by His Eminence Cardinal Fiorenzo Angelini in the initial prolusion on the theological perspective in the Word of God on health and power. Then prestigious and highly competent scientists in the field of medicine, and eminent theologians from various parts of the world, will dwell upon various subjects that will in turn be sub-divided into three parts: the first will concern the contemporary situation of power and health in the realities that we experience; the second will contemplate at a detailed level the plan of God for power and health; and the third will invite us to adopt concrete lines of conduct so that we can draw near in the best ways possible to the plan of God and do truth in love.

I would not like to finish this brief introduction without first keenly thanking Cardinal Angelini, my most worthy predecessor as President of the Pontifical Council for Health Pastoral Care, as well as all the speakers and chairmen of this congress. I would also like to thank all the participants for their active presence at this conference. As you can see from the programme in your possession, we have given certain spaces to dialogue, which will without doubt be very interesting and during which you will be able to freely make a contribution to out deliberations.

I would like to thank you once again for your participation. You are very welcome.

H.E. Msgr. JAVIER
LOZANO BARRAGÁN,
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council
for Health Pastoral Care.
the Holy See

I. PROLUSION

FIORENZO ANGELINI

The Theological Dimension, the Word of God, Health and Power

The subject chosen for the inaugural prolusion of this sixteenth international conference is so vast that it might appear at first sight to be generic, given that the concepts of power and health and so all-inclusive.

The title of the subject which has been entrusted to me, however, circumscribes it strongly because it refers to the relationship between power and health, the theological dimension and the Word of God.

I would like, however, to make a number of introductory observations.

'Power' and 'health' are global concepts. Which power? Which health?

According to the approach of the programme of this conference it is health itself – understood as physical, mental and spiritual health, and as health care – which constitutes the first, most universal and greatest power, given that – as can be read – 'as a force directed towards life, it is authentic power'.[1]

It seems to me, for this reason and from this point of view, that in the notion of health there is the wish to include also the idea of health care, which, at least in current usage, is more the set of institutions, laws and policies which are at the service of health.[2]

This is because when we address the subject of 'health and power' from the point of view of Christian theology and the Word of God, it follows that by the term 'health' one wants to refer to everything that concerns the prevention, the diagnosis, the treatment and the rehabilitation that is required to improve the physical, mental and spiritual equilibrium of the person from the perspective of that 'health' that draws near to the concept of 'salvation'.

The term and concept of 'power', in the light of the Christian vision of life, does not in the least refer to the notion of dominion;[3] it refers, instead, to the notion of 'service'.[4]

To serve health is to place oneself on the line of the plan of salvation which is health in the fullest and comprehensive sense of the term.[5] To do this with the greatest possible commitment, with effectiveness and credibility, means to exercise power in the most suitable way possible in its dimension of service.

At this point, faced with such weighty subjects, should we not perhaps ask ourselves the meaning of so many meetings, conferences and phrases which, if taken seriously, should be translated into equally concrete initiatives?

Have we ever asked ourselves if we really believe in what seems to us to be not merely incumbent but at times something that we even spontaneously and obviously proclaim in a loud voice?

Are we really aware of what concrete consequences the very many statements of principle, which at congresses, conferences and symposia are even enthusiastically applauded, should give rise to?

In the apostolic letter *Novo Millenio Ineunte* the Pope warned against the risk of 'drowning in a sea of words' which lack efficacy and credibility.[6]

During the course of the stage that preceded the creation of the Pontifical Council for Pastoral Assistance to Health Care Workers, on more than one occasion I observed that in fact its creation went back directly to Christ, who, in carrying out his mission, always associated his preaching with service to the sick and to the suffering in body and spirit. How true it is, as John Paul II stressed in the founding document of this Ministry, that 'the Church, during the course of the centuries, has strongly felt that service to the sick and suffering is an integral part of her mission'.[7]

In this theological approach, much attested to by Holy Scripture, there is also a truth which, from the human point of view, must be seen as obvious. Health, and thus life, is the pedestal of everything. Whatever question is considered, its premise is life.

If there is a subject which really does not lend itself to academic discussions, it is life. We owe it to life if we are here, if we can speak about power and health.

The dramatic events now underway have pushed mankind to rediscover the primary value of life, which can today be attacked in the most subtle and unthinkable of forms.

The important inter-Ministerial document 'The reproductive health of refugees' was issued in recent days, a document addressed to the bishops' conferences of the world. And we must ask ourselves what its implementation will be in the huge work of evangelisation.[8]

And yet if we re-read so many statements and conclusions approved unanimously even in the most authoritative quarters, the risks of very grave attacks on life have always been pointed out and even predicted. But with what results?

At an international conference

which has chosen such a weighty subject, either one takes on essential truths that are accepted in a self-assured way as the reasons which should guide our activities, or it would be better to avoid situations of dramatic inconsistency.

In the field of health care and health we have examples that have marked, and continue to mark, history with unmistakable signs. The signs of *doing*, of rendering faith operative through charity, that is to say through service to other people (cf. Gal 5:6).

San Camilllo de Lellis did not confine himself to saying that for him sick people, and above all the most repugnant, were 'princes'; he served them and he loved them as though they were princes. And yet, amongst the last sentences of the dying San Camillo we also encounter the following: 'Lord, I confess that I have done no good...'[9]

St. John of God, a great innovator in health care and a saint, signed himself 'Brother Zero'.[10]

Albert Schweitzer believed that when it came to the defence and promotion of life there could be no getting away from the need to move from word to facts, and of the whole of his work Lambarené is the masterpiece. The same may be said of the Servants of God Marcello Canadia, the Abbot Hildebrand Gregori, Mother Teresa of Calcutta, and innumerable unknown and silent witnesses.

I have presented these reflections as a premise because I believe that it is incumbent upon me, in these circumstances of scientific and academic relevance characterised by an analysis of health and power, to emphasise the importance of awareness of the need for a strong bond between words and facts, between a statement of principles and their application.

Just as a man who needs service to life is a psycho-somatic unity, so those who are involved in service to life must understand their dedication at all levels – research, study and care – not in a sectoral way but in a total way.

The whole man is to be dedicated to with the whole man; to those who need everything, we give all of ourselves.

Allow me to remember an appeal which after almost twenty years still rings out as being of contemporary relevance, even though it has not been completely ignored given that it was adopted by the very recent episcopal synod.

In 1983 the Ordinary Assembly of the Synod of Bishops was held on the subject of 'reconciliation and penitence in the mission of the Church'. During the deliberations of the 197 synod fathers, there was not even a reference to sick people and to the world of health and health care. The then General Superior of the Fatebenefratelli, Fra Pierluigi Marchesi, was merely there as a 'listener invited to speak'. In his speech, after asking himself where Christ would have been placed if the synod assembly had been held during his time, he went to the heart of the subject of reconciliation and added: 'Modern medicine, with its multiple infraspecialisations, is often accused of proceeding almost to a sharing out of evil in its anatomic parts; is it not the case that the Church as well has perhaps taken part in this sharing out by concerning herself exclusively with the soul of the sick person and his spiritual feeling? We, who by the mandate of the Church and our founders are at the side of the sick, must point out a feeling of impotence and irrelevance as regards what we have to suffer. It seems, on many occasions, not to interest anybody'.[11]

Life is not served *per partes* but in its fullness and wholeness.

I believe, therefore, that we should establish with clarity and concreteness the operative principles that descend from the Christian vision of health and the Christian vision of power. They can be summarised under the three following headings: 1. the dimension of power and the dimension of service to health; 2. one does not serve health unless one serves life, the whole of life, and the life of all people; 3. power as service to life involves an encounter between justice and charity.

1. The Dimension of Power and the Dimension of Service to Health

The dimension of power as service is traced in the dimension of the concept of health as fullness of life. In the opposite case, not only does one not serve life but one cannot even think about or discuss it.

In relation to *health* understood in these terms, the *power* of Jesus was limitless. He 'healed every infirmity' because from him 'there came a force which healed everyone' (Lk 6:17-19). Jesus healed the sick in spirit, the troubled and the oppressed, those afflicted by real and authentic illnesses. To him, indeed, they 'brought all the sick, those afflicted with various illnesses and pain, the possessed, epileptics and paralytics, and he healed them all' (Mt 4:23-25).

The healing power of Jesus was not exclusive to the Son of God, it was not something with which he supplemented his preaching, and at the same time was not something that finished with that preaching together with him. This healing power, or better, this effective service to life, was a part of the gospel message as such. It was a power that Jesus shared with his followers. Indeed, to the Twelve Jesus 'gave the power to cast out wicked spirits and to heal every sort of illness and infirmity' (Mt 10:1).

The preaching of the Kingdom of God must form the context of this healing action.[12]

We can read in the Gospel according to St. Matthew that 'these twelve Jesus sent out; but first gave them their instructions... Preach as you go, telling them the kingdom of heaven is at hand. Heal the sick, raise the dead, cleanse the lepers, cast out devils; give as you have received the gift, without payment' (Mt 10:7-8).

In the Gospel according to St. Luke the association between the concepts of health and power is even clearer in that passage where one can read: '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' (9 Lk 1-2).

If this is, so to say, the theological framework of the relationship between health and power, it follows

that power, understood as service, is service to life, which, in its fullness, is health in its most overall meaning.

The problem arises and increases its expressions when consistent, constructive and effective implementation of this service has to be effected, a service which does not only embrace the world of health care, as the questions and issues which this conference will have to address seem to indicate.

The concept of 'health care' also forms a part of the concept of health, where health care is understood as the health care policy, legislation and planning of each individual country. However, the fully human and Christian concept of health could fully form a part of the specific concept of health care. This is not a matter of a confusion over terms because of the fact that 'health' and 'health care' in some languages are described with the same word and this can lead to some ambiguities.

Health is a goal whereas health care is the set of instruments by which it is achieved. And it is precisely in the identification, and above all else in the application, of these instruments that the theological dimension of the relationship between health and power encounters its most serious and complex problems.

How true it is that at the moment when in advanced societies the full socialisation of health care has been reached, the problem of its humanisation has become more acute and even more dramatic. And this is taking place, in my opinion, because *power,* in the sense of service to *health,* is conditioned by aims that ignore, neglect and even offend the real and full concept of health, which corresponds to the real and authentic concept of life.

The papers that will be given during the course of this international conference will dwell upon the power of the economy, of politics, of information, of the pharmaceutical industries, of international organisations, and of religions themselves, in the field of health care and health, and this will be done according to a threefold approach: reality, the clarification of reality, and the practical initiatives which have to be engaged in.

Rightly, however, before addressing these three subjects and contexts, it is important to focus in on the dual concept of health and power in its relationship with the Christian conception of the world, of the world, and of history.

2. One does not Serve Health if one does not Serve Life, the Whole of Life, and the Life of all Men

Life has a dimension which transcends health in a narrow sense because it calls to mind its origins and its destiny. In this sense there is not an 'exclusive' Christian concept of the defence and the promotion of life, as John Paul II himself has repeatedly observed,[13] even though faith in God the Creator and in Christ the Redeemer enriches an exclusively rational vision of life.[14]

Health as fullness of life is a notion that comes from the profile of the civilisation in which we recognise ourselves. Civilisation refers to a culture, but as regards life there cannot be cultures that involve in part or in whole the negation of life and which circumscribe the right to life in a discretional way.

Today there is a great deal of talk in inappropriate fashion about a confrontation or even clash of civilisations. Civilisation rightly understood is a civilisation of life, and thus there is only one civilisation. Cultures can be different but their concentric point is service to, and thus the celebration of, life. Just as life is unique so also is civilisation unique – to the extent to which it promotes and defends life.

Without defending and promoting the life of everyone one does not defend or fully promote even the life of single individuals. And this, as the Holy Father emphasises, not only as regards the defence against attacks on life but as an attempt to regenerate constantly the inner tissue of culture itself, which influences in a determining way as well the political and legislative choices that are made.[15]

Whilst, however, cultures differ from each other even in an almost essential way with regard to particular ways of knowing, of advancing, and of organising both individual life and social life, all human beings (with certain horrific exceptions) encounter each other in the defence and the promotion of health, given that this is an absolutely request which can never be removed.

If the defence and the promotion of life constitute the field of civilisation where service to life is called to work, it follows that there is a very close bond between civilisation and the ethical and moral vision of the person.

And one is indeed called to adopt a moral approach: face to face with the defence of unborn life and against abortion; face to face with responsible fatherhood and motherhood and against selfish birth control; face to face with the medicine of transplants and against genetic biology that threatens the roots of the personality of the person; face to face with the safeguarding of the right to die in peace and against euthanasia; face to face with the humanisation of medicine and against every bureaucratic and depersonalising form of medicine; and face to face with the employment of all the discoveries of science and technology at the service of life.

More than was the case in the past, human reason must today become aware that it cannot remain a prisoner of advances which, once they have been obtained, reveal fearful limits, and which only a broader spiritual and transcendent vision can suitably control.[16]

The rational analysis of the imbalance, of the ill-being, of the illness that afflicts modern man, the artifice and at the same time the victim of technological progress, moulds a different notion of health itself: a notion which is more complete and comprehensive. This postulates an anthropological diagnosis that reaches the *spiritual patient,* that discovers, so to say, the roots of the evil beyond the mechanisms and the spectrum of the physical and the psyche.

In its expressions of prevention, diagnosis, treatment and rehabilitation, medicine works with rigour and with non-arbitrary methods. There must therefore be a medicine of the spirit, almost an ascetic medicine which helps to prevent, and free the spirit from, the shadow of modern anxiety.

In other words, in order to solve the dilemma: as the artifice or victim of technical progress, man must make a non-scientific choice, an ethical and spiritual choice, that is to say a choice in favour of civilisation. A rational and not an emotional choice.

All this certainly does not involve an ambiguity in the term and the concept of 'health', but rather its necessary completion, because one does not heal man anew if the treatment does not draw on the psyche and one does not heal that unitary nucleus that no term can suitably express if not the term 'spirit'.

The health of the spirit is not only a pre-condition of psycho-physical health, it is also an authentic liberation of resources, and thus an instrument for the real co-ordination of the choices that those who believe and

profess a solid faith in the absolute and primary value of health as life must promote with all their strength and through a concrete and fact-based effort which, unfortunately, encounters difficulty in taking off – something also caused by the insufficient grounding of Christians in this field of pastoral work, a real point of encounter for service to man and a reason for that *ecumenicalism of works* which is a practical transcription of the gospel message and the proclaiming of the Word of God as the Word of Life and of salvation.

The Holy Father has been clear and has guaranteed the full co-operation of the Church with those who work in the field of health care and health, in the name of a conception of 'health' that includes that of 'salvation': an 'overall' health that heals man anew in his totality.[17]

How much the Church can do, not only understood in a hierarchical sense but as a community of believers in Christ in the field of service to the whole of life and the life of everyone, is demonstrated by her presence of over 30,000 Catholic health-care institutions working in the world, with hundreds of thousands of priests, members of male and female religious orders, and consecrated lay members, with millions of voluntary workers, with a capillary distribution of her structures at a local and ground level.

The Pontifical Ministry for Pastoral Assistance for Health Care Workers, or as is said today the Pontifical Council for Health Pastoral Care, was born as a request for co-ordination and fostering. Likewise, the Holy Father also established the Pontifical Academy for Life.

The Pope of human rights is the Pope *defensor vitae.*

The evident gap between possibilities and concrete implementation must be a primary concern of every scientific and pastoral reflection promoted by the Church. Hence I will now move on to the third point.

3. Power as Service to Life Involves a Working Encounter between Justice and Charity

It is taken for granted that the exercise of power as service to health constitutes the principal expression of the duty of justice, understood as an obligation to recognise and to give everyone their due, because of the common destination of goods.

History teaches us that in the field of service to health as well, every commitment to achieve justice has been shown to be insufficient because of the fragility and selfishness of man.

Without the support of charity there has not been either a sufficient or an increasing upholding of justice.

According to the Christian vision, God alone is just and man can be said to be just to the extent to which he behaves in conformity with the will of God.

The attribution of justice, however, is associated in God with His nature, which is that of Love (1 Jn 4:9; 2 Cor 13:11) and thus infinite mercy (Mt 18:12, 23, 25; Lk 15:3-11; 12-32, etc.).

So that power can become service to health, charity is required, and charity by definition is self-giving service without recompense.

There is an equivocal point, however, which must be overcome, and it is that self-giving – the essential connotation of charity – is to be understood as an optional and surrogate choice.

The term and the concept of charity is heavily affected by the ambiguity that is encountered in its understanding and practice by Christians as a form of occasional, discontinuous and optional generosity.

Whereas the duty of justice is recognised as being inescapable from a Christian point of view, the primary duty of charity is often seen as an extra. In reality, one cannot have charity without justice, in the same way that justice, deprived of the impulse of charity, can fall into legalism, into leading to only the minimum being given, into not being able to transform charity into a constant and habitual approach of Christian conduct.

According to a happy observation made by St. Gregory the Great, 'when we give indispensable things to the poor we do not make personal gifts to them but we give them what is their due. More than performing an act of charity, we perform a duty of justice'.[19] This is confirmed in a particularly true way in the service that must be given to health. And the demonstration of this truth, from the point of view of the theological dimension of the relationship between power and health, is offered in the Gospels by the parable of the Good Samaritan, and in the concrete reality of the past and of today's world of the various forms of voluntary work.

The Good Samaritan of the gospel parable (Lk 10:25-37), although lo-

cated in a historical period that was not aware of the present-day advances in care, was a complete figure of mature civilisation. This was because he bent down 'with love' before the wounded man, who called for the recovery of life.

Expressing himself as love, the Good Samaritan, that is to say Christ himself, linked the divine with the human in the synthesis of love. 'Man', writes the Holy Father, 'cannot live without love. He remains a being that is incomprehensible for himself, his life is senseless, if love is not revealed to him, if he does not encounter love, if he does not experience it and make it his own, if he does not participate intimately in it'.[20]

Only in love – which is a spiritual dimension – can civilisation and service to health and life connect: only love, in fact, offers the human condition, which aspires to the safeguarding and the promotion of the quality of life, the highest dedication and the commitment to accompany this dedication with all the constructive instruments that the advance of science and technology are able to offer.

The figure of the Good Samaritan is the point of reference for a full interpretation of the relationship between justice and charity, of a justice that receives from charity the connotations of sensitivity, sharing, and solidarity.

As has been observed, the very origins of the male and female religious institutions as a response to urgent social requests was due to a choice in favour of a form of life, under the banner of self-giving, which had the characteristics of the placing of char-

ity in the realisation of works of justice, given that public institutions and structures were insufficient or unable to provide their incumbent service to life.[21]

In reality, only when within a Christian community the carrying out of the duty of charity ceases to be exclusively an experience like so many other experiences and becomes an educational experience which involves and makes responsible the whole community, will it be transformed into fertile terrain for vocations to love, and thus vocations to the highest and most definitive forms of love.

Health and power, in the light of the Word of God, of the teaching of the Church and theological reflection, exalt the Christian concept of power and health in the name of the celebration of life.

Conclusion

My expression of best wishes in relation to the deliberations of this conference is an invitation to have the courage to make choices that are consistent with our faith. The yardstick for the judgement of God on such consistency was offered by Jesus with the words: 'I was sick and you visited me... Everything that you did for the least of one of my brethren here you did to me' (Mt 25:40).

The Lord does not speak about theoretical statements but about facts and works. Not that speaking about truth is useless, quite the contrary. But, as the Holy Father observed, 'the charity of works ensures an unmistakable efficacy to the charity of words.'[22]

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Notes

[1] In the introduction to the programme of this international conference one reads: '*dieu tout-puissant manifeste son puovoir par sa création merveilleuse. La direction la plus intelligente de la force est celle qui condiot à la vie, à susciter la vie. La santé est une tension harmonieuse vers la plénitude de la view, elle est la force orientée vers la view, elle est le pouvoir authentique'*.

[2] This is a distinction which although very clear, at least in the current usage in Italian, is not equally so in French and English. Cf. *Vocabolario della Lingua Italiana,* Istituto dell'Enciclopedia Italiana, IV, Rome, 1991, p. 322, according to which the term '*salute'* ('health') means the condition of physical, mental, and I would add, spiritual, well-being. The term *'sanità'* ('health care'), without excluding the above-mentioned meaning, means more the set of institutions at the service of health.

[3] The concept of 'power' as service is almost unknown in Italian dictionaries, which define power, *in general*, as a 'capacity, an objective possibility to act', as 'potency', as 'higher capacity' (paranormal powers, powers to perform miracles, and so on), as a 'capacity to influence the behaviour of other people, in influence their opinions, decisions, actions, and thoughts', as 'dominion, possession'; *in particular*, in the legal sense of the faculty to carry out relevant actions (legislative power, executive power, judicial power) or in the sense of a specific property (purchasing power, economic power, power on the market, etc.). Cf. *Vocabolario della Lingua Italiana,* Istituto della Enciclopedia Italiana, Rome, 1991, III, p. 1039.

[4] A gospel text provides a background to this theological conception of health and power. Jesus, from whom there emanated great power (Lk 6:19), said: 'You know that, among the Gentiles, those who bear rule lord it over them; with you it must be otherwise; whoever would be a great man among you, must be your servant, and whoever has a mind to be first among you, must be your slave. So it is that the Son of Man did not come to have service done to him; he came to serve others, and to give his life as a ransom for the lives of many' (Mt 20:25-28). What is meant by 'ransom' is explained in another gospel passage attributed to Jesus: 'I have come so that they may have life, and have it more abundantly' (Jn 10:10). Life as the recovery of health, as the safeguarding of health, and as the fullness of health, and as such, as the fullness of life.

[5] Luke 9:2

[6] 'Without this form of evangelisation through charity and without the witness of Christian poverty the proclamation of the Gospel, which is itself the prime form of charity, risks being misunderstood or submerged by the ocean of words which daily engulfs us in today's society of mass communications. The charity of *works* ensures an unmistakable efficacy to the charity of *words':* The apostolic letter *Novo Millennio Ineunte*, 6.1.2001, n. 50.

[7] Motu proprio, *Dolentium hominum*, 11.2.1985, n. 1.

[8] *La salute riproduttiva dei Rifugiati* (Vatican City, 2001).

[9] M. VANTI, *S. Camillo de Lellis* (Coletti Editore, Rome, 1957), p. 469.

[10] C. NEWCOMBE, *Brother Zero. A Story and Life of Saint John of God* (New York, 1955).

[11] P. MARCHESI, *La riconciliazione nel mondo della sanità. Intervento al Sinodo deo Vescovi, Roma, 29 settembre-29 ottobre 1983*, p. 4.

[12] 'It is very evident that there must be a relationship between preaching and action, between our being in Christ and our being in history... The works of a Christian are *Christian service.* This is the meaning of the relationship established by Christ between preaching the Kingdom of God and healing': S. ROSTAGNO, *Teologia e Società* (Claudiana, Turin, 1989), pp. 112-3.

[13] 'No single person or group has a monopoly on the defence and promotion of life. These are everyone's task and responsibility': the encyclical letter *Evangelium Vitae*, 25.3.1995, n. 91.

[14] 'The issue of life and its defence and promotion is not a concern of Christians alone. Although faith provides special light and strength, this question arises in every human conscience which seeks the truth and which cares about the future of humanity. Life certainly has a sacred and religious value, but in no way is that value a concern only of believers. The value at stake is one which every human being can grasp by the light of reason; thus it necessarily concerns everyone': *Evangelium Vitae*, n. 101.

[15] 'The best way to overcome and defeat the dangerous culture of death lies specifically in providing solid foundations and luminous contents to a culture of life which is opposed to the culture of death with vigour. It is not enough, even though this is necessary and incumbent upon us, to confine ourselves to revealing and condemning the lethal effects of the culture of death. We need, rather, to regenerate the inner tissue of contemporary culture, understood as experienced mentality, as beliefs and forms of behaviour, as social structures which support it. This observation appears to be even more valuable if one takes into account that not only individual behaviour is influenced by culture but also the legislative and political choices that are made, which, in their turn, express cultural pressures which not rarely obstruct, unfortunately, an authentic renewal of society': 'Discorso di giovanni Paolo II ai participanti alla VII Assemblea generale della Pontificia Academia per la Vita, 3 marzo 2001, *L'Osservatore Romano*, 4 March 2001, p. 2.

[16] 'The problems raised or made more acute by technological civilisation, and at the same time the questions posed by the men and the women of our time, converge in reminding us of the dangers of the domination of a one-sided rationality. The scientific approach, the multiplicity of the branches and the contexts in which it carries out its research, the limits to knowledge and its communication, are all factors that throw new light on the possibilities of, and needs for, a universal and consistent use of reason. Human reason imposes itself today, with greater prominence than was once the case, as pluridimensional capacity for knowledge and does not reveal its deep coherence if not the price of a reflection which is as necessary as it is difficult. From a directly ethical point of view...reason appears to be endowed with a multiple and correlative intentionality, as a capacity to decode the world and man as an individual subject, as inter-subjective communication, as vocation to development, that is to say to overcoming, to transcendence': C.J. Pinto de Oliveira, *La crisis della scelta morale nella società tecnica* (Turin, 1978), pp. 65-66.

[17] 'The Church appreciates those who work in this field and offers her support to public structures in order to respond to the needs for the overall care of the person. In this she is moved and sustained by a vision of health that is not the mere absence of illness, but a tendency towards full harmony and a healthy balance at a psychic, spiritual and social level. She proposes a model of health that is based upon the *health-inducing salvation* offered by Christ – an offer of overall, complete health that heals anew the sick person in his or her totality': 'Discorso di Giovanni Paolo II ai participanti al Convegno promosso dall'Ufficio Nazionale per la Pastorale della Sanità della CEI, 12 maggio 2001', *L'Osservatore Romano*, 13 May 2001, p. 6.

[18] 'Man, using created goods, must see the exterior things that he legitimately possesses not only as his own but also as being in common, in the sense that they can benefit not only him but also other people': Second Vatican Council, pastoral constitution *Gaudium et Spes*, 69.

[19] GREGORY THE GREAT, *Regula pastoralis*, 3, 21.

[20] JOHN PAUL II, encyclical letter *Redemptor hominis*, 10.

[21] 'Institutions are very important and indispensable; however, no institution can on its own take the place of the human heart, human compassion, human love, human initiative, when one is dealing with encountering the suffering of another person': John Paul II, apostolic letter *Salvifici doloris*, 11.2.1984, 29.

[22] JOHN PAUL II, *Tertio Millennio Ineunte*, 6.1.2001, 50.

II. THE REALITY

JEAN FOYER

1.The Power of the Economy in the Field of Health

In industrialised countries humans no longer want to think about death and they experience an intense need for health. The progress of science and technology allow an increasingly effective response to this need through prevention and treatment, powerful and effective drugs and medicines, increasingly bold forms of surgery, and forms of research and treatment which are constantly being improved. After deciphering the human genome, the path has now been opened to predictive medicine and gene therapy. Yet all of this has its cost. In industrialised countries, health care expenditure accounts for an important part of the gross domestic product (GDP), which for the most part oscillates around 10%. In the United States of America this figure reaches 14%.

Thus activity connected with health care is economic activity. During the second half of the last century a new branch of economics was established known as 'health economics'. Today this is the subject of research in many centres and institutes as well as being a discipline that is taught. The literature of the subject has become notable and amounts to books and review articles which above all are in English. This new discipline, however, encounters major difficulties. The notions are difficult to define. The World Health Organisation defined health with a famous phrase: 'health is a complete state of physical, mental and social well-being and not only the absence of illness or infirmities'. Well-being is something that is difficult to measure and the monetary value of the production of health care agents and institutions is no less difficult to assess.

However, the work of health economists, which is based upon statistics, provides perspectives that enable us, after a certain fashion, to deal with the subject we have to address: 'the power of the economy in the field of health'. This work involves health being seen in large measure in terms that the World Health Organisation deems to be too narrow, that of the absence of illness or infirmity, with a view to exploring, first of all, how and to what extent the working of the economy can favour, or in contrary fashion deteriorate, the condition of health in a narrow sense, and then to examining how the economy determines the activities of health care systems.

It is clear that these are only very general observations. In the health care field, inequality is very marked, and this is in large measure the result of the workings of the economy. This can be observed within each country and perhaps even more between the countries of the North and those of the South of the planet, according to the terminology used to distinguish rich and poor countries, that is to say the industrialised countries and the developing or less advanced countries. These differences of level and degree partly explain, but they do not completely explain, the differences between health care systems and the changes which have been introduced at the level of systems of funding and finance.

Beginning with these observations, in this paper we will examine: I. the power of the economy in relation to conditions of health; and II. the power of the economy in relation to health care systems.

I. The Power of the Economy in Relation to Conditions of Health

Is the condition of health of a population on the territory of a given State determined or influenced by the working of the economy at a synchronic or at a diachronic level? And, if so, to what extent?

This is a question that must be raised about the power of the economy in relation to conditions of health. The answer to this question is neither univocal nor uniform. The workings of the economy can have positive or negative effects, produce helpful or damaging results, or not have any effects at all anywhere or for anyone.

A. Positive effects

In order to measure improvement in health on the basis of the workings of the economy, economists take into consideration the

relationships between economic growth and, on the one hand, life expectancy, and, on the other, the decline in infant mortality. The first relationship, that between life expectancy and income per inhabitant, was calculated by the World Bank in 1993 and by the United Nations Development Programme. The curve which makes life expectancy rise above the age of seventy-five is surprising, as indeed are the results of the study carried out on the evolution of the GDP growth rate and the inverse growth rate of infant mortality.

This correlation is explained by a set of consequences for standards of living made possible by economic growth. Suitable life conditions prevent the propagation of contagious diseases (tuberculosis). Economic growth also finances education (that of women who bring up and take care of children), prevention programmes, and health systems, to which reference will be made later on in this paper.

The relationship that exists between conditions of health and the variations in economic growth levels within periods of Kondratiev long cycles and of short cycles is something that has been demonstrated.

A major fact that has been noted is that life expectancy increases markedly in poor countries with their economic development, whereas this advance is low in rich countries. We almost seem to have here an obstacle course. Some authorities have calculated that life expectancy increases until the income per habitant is less than 10,000 dollars and then slows after that figure.

The correlation between economic growth and life expectancy has been observed working the other way. Regression, the deterioration of an economy, is accompanied by a reduction in life expectancy. This fact can be observed in the States of the old Soviet Union and the other countries of Central and Eastern Europe. After 1990 (even though, it must be said, before that date the economic situation was by no means brilliant) the average age of Russian men fell back from sixty-five to sixty years of age. Cardio-vascular illnesses and cancer kill people in Russia at twice the level than in the West, and infectious diseases such as diphtheria and tuberculosis have reappeared in force.

In this last case there has been a regression and in many countries advance itself has been very weak if not actually non-existent.

As regards health itself, in the world inequality dominates between countries and within the industrialised countries themselves.

The most dramatic situation is without doubt that to be found in Sub-Saharan Africa where the situation has declined and continues to decline. Africa is responsible for 10% of the world's population, produces 10% of world GDP, and accounts for 2% of international trade. Over the last ten years this continent has experienced a decline in the life expectancy of its inhabitants. It is certainly the case that wars have contributed to the deterioration in the health care situation but diseases and illnesses have also appeared or reappeared to which these stuttering or fragile economies cannot provide a remedy. AIDS appeared in this continent and spread with lightening speed. In some countries of central Africa, 25% of the population is now seropositive. Malaria and infectious diseases are widespread although elsewhere they have been eradicated. Life expectancy in this continent is forty years of age, as it was a hundred and fifty years ago in Europe and North America.

An improvement in the health conditions of these countries will take place with the return of economic growth and development. Development aid in order to reduce such unfair inequalities is one of the great international problems whose urgency is usually recognised. However, a solution seems more to be receding than drawing near.

In every country forms of inequality still exist although the efforts that are being made to correct them are usually more effective, though it remains the case that they are always insufficient. There are always rich people and poor people whose life expectancy is different and who have varying levels of access to care and treatment. However, health care systems act to open up access to care and treatment and if such access is not immediately made equal for all then life expectancy will falter at the same time as income grows greater.

In part these forms of inequality are produced by the workings of the economy.

B. The effects of deterioration

The forms of deterioration of conditions of health caused by the economy are of various kinds. Some affect the whole of the population and these are the results of the attacks on the environment. And then let us not talk here about war. Others are more individual in their impact. Some strike economic agents, and this involves the erosion of human capital; others affect the use of products or services offered by economic activity, that is to say industrial epidemics.

a) The erosion of human capital

The phrase 'human capital' is usually employed by economists (see *Dictionairre des Sciences économique,* Paris, PUF, 2001, chapter 5, p. 103, col. 1). This is not a very happy usage because this term has a very materialistic ring to it. It does not refer to a material good, such as a machine or a quantity of money, but to human capacities, that is to say productive

capacities linked to individuals at the level of talents and knowledge. Because these capacities are a present and future source of goods and services, and thus of income, they receive the appellation 'capital'.

During the previous two centuries, Marx and the Marxists preferred to speak about labour power rather than human capital, which at that time was a term that was not used. They placed a great deal of emphasis on the exploitation of labour power carried out by the working of a capitalist company, and workers' movements called for measures designed to attenuate its effects and to provide a remedy for them. One may observe that the Soviet economy undoubtedly engaged in the abuse of labour power to a greater extent than any other Western economy.

In the countries of the North of the planet, labour legislation has greatly improved – from this point of view – the conditions of employees within a company: the limitation of working hours, the granting of holidays, the introduction of rules relating to hygiene and safety, and the beginning of on-going training. Unfortunately, the same state of affairs in this regard does not rule throughout the world. In a large number of countries children, women and even men continue to be subjected to work in unbearable and also unacceptable conditions, and as a result their health is compromised. Unfortunately, having to put up with these conditions is in many cases something that is inevitable.

The effects of these forms of deterioration are most marked in relation to the sphere of life expectancy. In this context reference is made to *differential mortality.* To a by no means small extent life expectancy is linked to the character and the length of the professional activity that is engaged in. In a large number of countries the law takes into account such activity when establishing the age of retirement for the civil servants and clerks who work in government services. In truth, this age limit, when it is not very high, does not always correspond to how hard the work involved actually is. In France, for example, teachers can

retire at the age of fifty-five. The consequences for life expectancy are more than obvious. Thus teachers belong to the social category that has the highest level of life expectancy.

Industrial epidemics, by means of illnesses or infirmities, lead to a shortening of human life.

b) Industrial epidemics

This term appears a curious one. It refers to phenomena whose theorisation has only been recent. We can well argue that these are really epidemics, that is to say pathologies that afflict a large number of people or a specific geographical area. But these epidemics are not caused by the spread of a bacterium or a virus but by the consumption or use of products offered by certain traders or industries and which in general are very profitable for such traders or industries. At times, the consumption of such products is involuntary – for example that of asbestos, the breathing in of which can cause cancer. Other kinds of consumption, which are without doubt greater in number, are voluntary even though consumers may not be at all aware of the danger. They are many in number and the list is long. At times we are dealing with products consumed by the human organism, such as tobacco, which causes tumours, respiratory and cardio-vascular illnesses in people, and, in addition to the contraceptive pill in the case of women, alcohol and drugs. At times, we are dealing with products which increase damaging developments in humans with bad results for them and others. Motor cars and fire arms are examples of these, but they are only examples from what is a broad list.

The industrial economy exercises a very negative power on health by this route. This is something that is seen as being characteristic of the twentieth century. It is calculated that industrial epidemics afflict young men above all. The proof of this has been detected in France. If we take young men between the ages of fifteen and twenty-five, industrial epidemics as a cause of death have replaced the classical illnesses which are now prevented by vaccination and cured by medical treatment. The deaths of half of the men who die before the age of sixty-five are due to these epidemics and this explains the fact that more men die than women (cf. Meslé et Vallin, 'Transition sanitaire: bilan et perspectives', *Médicine et Science Jove* n. 11).

Legislators cannot allow the development – linked to production and trade – of an economic neo-liberalism which has no limits or brakes. Indeed, in many countries the state seeks to reduce the effects of forms of consumption that generate industrial epidemics.

By experience and use, econom-

ic instruments seem to be the most effective in this regard, and they begin from the elasticity of consumption and price. An increase in the price of tobacco through the imposition of heavy taxes has the virtue of reducing consumption.

At a more general level, the levying of taxes on damaging articles of consumption which damage health is one of the instruments that is suggested (although in truth such instruments are employed rarely) to finance some of the health system. We are dealing here with making the person who pays into a kind of 'polluting car'.

II. The Power of the Economy in Relation to the Health Care System

At the outset, as long as a country could count on health care professionals (because in fact not all countries had such people), the health care system was free (cf. *Dictionnaire des Sciences économiques,* chap. 'Santé', p. 841, col. 1). The provision of care and treatment was the responsibility of health care professionals who provided their services at times in the day agreed on with patients and in return for being paid by them. The state limited itself to pursuing a light health care policy. The system was rounded off by charity. The very poor were admitted to hospitals which were in fact more like hospices. Free medical assistance was provided later in the place of payment of doctors' fees. Patients had previously been able to take out insurance against illness with insurance companies, and for the less fortunate, private initiatives gave rise to forms of friendly societies.

This system is still the system that is the lot of most of mankind. In countries that were once colonies this has been improved upon, for example by the action of military health services which have had a very beneficial effect of prevention through the elimination of dangerous diseases such as yellow fever or sleeping sickness.

In a system of this kind the poorest part of the population was in a pitiable situation when affected by a serious illness. Poverty struck, if it had not already struck, and often in a definitive fashion.

Thus the idea was born of distributing the costs of expenditure on prevention and treatment to whole categories of people, something that joint action had, however, already begun to do. From the end of the nineteenth century onwards new health care systems were established which were based on this idea. However, the level of economic development had to be such to allow this. This was something that depended on the power of the economy. The economy was necessary in the creation of these systems and tended to determine their breadth and range of action.

A. The economy and the establishment of health care systems

Modern health care systems were born in Europe. Each of them maintains a sphere of action even though they have had imitators in other continents, and over the years they borrowed characteristics from each other. They were created in the most industrialised countries, which had a large and often poor working-class population. For such a system to be necessary there had to be a large number of poor people, and at the same time the economy had to be strong enough to bear the weight of the system, that is to say the management of the costs of the health care system was achieved through drawing on national wealth.

The general idea was to spread the burdens of health care costs across a broad section of people. In order to achieve the social result aimed for this was done in such a way that the payments made took into account the financial situation of the contributors more than the nature and seriousness of the risk covered by the system itself. The first of these systems was that created in Germany in the second half of the nineteenth century by the German Chancellor, Otto von Bismarck. The second was projected by the English economist, William Beveridge, during the Second World War. Both of these systems are usually referred to by the names of their creators.

a) Forming a part of the social policy of Bismarck which sought to link the working classes to the imperial regime in the 1880s, the health care system instituted by Bismarck, sometimes called a 'workers' system' and later imitated in France, was established in 1883. This was an obligatory system of insurance for low-paid industrial workers against illness. Its creation seemed to be possible because in economic terms German industry appeared able to support it. The system was financed by a payment for every insured worker not in relation to the nature or seriousness of the risk but on the basis of the wage received by that worker. Above all else, and it was here that the economy allowed this policy of social reform, half of the payment was made over by the company. Illness was not compensated for *in toto;* 10 or 15% of the costs were to be paid for, and this could be covered through insurance.

When these systems of social insurance were extended to other professional categories with low numbers of wage earners or none at all the adaptation was difficult and at times required some compensations between these systems or even partial funding from the state.

This was an incomplete system which was corrected only in stages and required a long period of time because it did not defend the excluded, the unemployed or those who did not work. Medical insurance of the Bismarckian kind was strictly dependent upon the advance of the economy. The systems of those sectors in decline inevitably developed deficits and those of the growing areas naturally had surpluses. All of this had almost mathematical consequences. The payment rates and the rights to services of the different funds could be different between systems and this was considered unfair by those who received little or who paid more.

Contemporary thought has been concerned with the development of health care expenditure as a part of GDP in relation to the growth cycles of the economy: long cycles lasting fifty years described by Kondratiev (cf. Schilling, *La*

dynamique de longue durée du système de soins, Thèse Montpellier, 1995) or short cycles of five to seven years called business cycles (Y. Ullman, *Croissance et santé – Les Nouvelles théiries de la croissance appliquées aux pays développées*, Thése Paris, Vale de Marne, 1999). These studies have led to conclusions that are at times unexpected. For a long time the phases of prosperity of the Kondratiev cycles experienced a regression or at least a stabilisation of health care expenditure, and the phases of recession witnessed an increase in such expenditure. Social policies tended to compensate for the deterioration in the social situation. In contrary fashion, the cycle which began after the Second World War witnessed in Europe a strong increase in health care expenditure during its upward phase (1945-1975) and a certain slowing down during the subsequent phase of recession (1975-1995).

This inversion was due to the measures of states which to begin with constantly extended social protection to occupational categories which up to that time had not received any benefit at all, and then subsequently sought to check the increase in expenditure because unemployment was reducing contribution payments.

During the short cycle the developments were different among the countries of the North of the planet, that is to say the members of the OECD where the growth in health care expenditure had an inverse relationship to short term GDP. The situation, however, was different in Germany, Austria, Denmark, France and Greece.

This comparison was based upon taking different systems into account.

b) The so-called Beveridge health care system, which was born in the United Kingdom after the Second World War, was imitated if not adopted by the Scandinavian countries and the Mediterranean countries of Europe. This was a state system characterised by the existence of a national health service open to everyone, which was free and financed from taxation. In truth, the idea was not new. The Russians had created a national health care system in 1925 which was then imitated from 1945 onwards by the 'people's democracies', producing everywhere detestable results

which were very different from the results that were obtained in Western Europe.

The financing of health care systems by taxation is connected to the level of development and condition of an economy. One thus explains why developing countries and above all the less advanced countries have been unable to apply a system of the Bismarck kind. They have been unable to create such a system because of a lack of industrial infrastructure.

c) Can we speak about a health care system in poor countries when there are a few hospitals, which are often lacking in modern equipment and certain drugs and medicines?

At the present time, these countries are in revolt against the system of patents on drugs and medicines which, they say, allows the industrial companies of developed countries the power to govern their provision and to establish their price. This system is generally held to be necessary for investment in research. Until the middle of the twentieth century most systems of legislation excluded new drugs and medicines from the world of patents. This was ended because the pharmaceutical industry directed its research towards new molecules, a form of research which was very expensive given that the therapeutic results of a molecule were often worthless. Most countries in the world adhered to the Convention of the Paris Union of 1883 for the protection of industrial property, and they did the same more recently in relation to the Marrakesh Accord of 1994 when the World Trade Organisation was established. This agreement had an appendix on matters relating to the rights of industrial property in relation to trade and was known as the ADPIC agreement. As a result of this agreement, countries passed legislation on patented inventions but now complain about the monopoly conferred on patents, something that makes the owner of a patent able to fix the price of the product. Now, in an amazing turnaround, the United States of America, which previously practically forced poor States to adhere to the ADPIC agreement, has in turn declared that the rights connected with patents on drugs and medicines are excessive: the USA has compelled Bayer to reduce the price of its patented drugs and medicines which are effective in the treatment of anthrax.

From this point of view, the links between an economy and health must be seen not only in synchronic terms but also from a diachronic perspective.

B. The economy and the curbing of the expenditure of health care systems

The American doctrine has brought out the need for concordance between the rates of growth in national wealth and the rates of the various sectors of the economy. Without this concordance, when the rate of growth of a sector is faster than the rate of growth of national wealth it puts the balance of macro-economic relationships in danger. This is especially evident in the growth of health care expenditure (C.C. Thurow, article in the *New England Journal of Medicine*, 1984).

An acceleration in the growth rate of health care expenditure re-

quires a reaction, otherwise this acceleration would threaten almost all the systems. This acceleration is certainly due to the increasing costs of forms of treatment, but in part, also, it is brought about by the system itself. Its success, that is to say prevention and cure, increases both life expectancy and the health care costs generated by ageing.

Now, if limits are not imposed the increase in health care expenditure will involve an increase in obligatory levies, whether in the form of taxation or contributions, and this is something that will have various repercussions. Hence the efforts of legislators or organisms involved in the management of the health care system to curb, stop or reverse this increase. This is a difficult task because carrying it out provokes more discontent and rancour than encouragement and satisfaction. However, the increase in the burdens imposed on companies has unhealthy consequences. A French authority, M. Malinvaud, a member of the Pontifical Academy of Social Sciences, has demonstrated that the countries which impose the highest level of contributions on companies are the ones which have the highest levels of unemployment, for example France, Spain and Italy (see M. Malinvaud, *Les cotisations sociales à la charge des entreprise*, La Documentation Française, 1997). And one may add that not even the burden of taxation is completely innocent even though its repercussions for unemployment are apparently less visible.

The multiplicity of the measures which have been engaged in and the instruments employed well show the difficulties – which are certainly more political in character than economic and technical – that are encountered in halting the tendency whereby law acts on demand, on supply, or on the kind of forms of treatment that are reimbursed, or on the volume of the expenditure dedicated to health. These are measures which are accepted unwillingly by people in various ways and at varying levels. In all these cases, it is the economy which compels a limitation of expenditure or a reduction in, or abolition of, kinds of reimbursement. Here, too, the power of the economy is felt; not without resistance, it is true, but it is felt all the same.

When the measure that is engaged in involves no longer using dialysis for kidney patients because they are over the age of sixty-five, we can well imagine the objections that such a policy can raise.

To conclude this paper, the cost of care and treatment finds its own limits in the possibilities offered by the economy. This is the case in industrialised countries. At the same time, the insufficient character of the resources offered by the economies of poor countries does not allow the provision of the most essential forms of care and treatment and only an enormous effort on the part of the industrial countries can bring about such an improvement.

These are very difficult problems that belong to the future, and we await their arrival.

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Member of the Institute of France,
Member of the Pontifical Academy for Life.

MICHAEL F. COLLINS

2. Power and Health Care Policy

The goal of this symposium of the Pontifical Council for Health Pastoral Care is to examine health care, in its many manifestations, and power, and its many forces, to provide guidance to the Church on how it can enhance and expand its health care ministry and its influence on health care policy and practice throughout the world. Given the state of the challenges facing our world these days, this is a most appropriate undertaking for a Church which has been committed to health care and the dignity of each person.

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,[1] speech to the mute,[2] and hearing to the deaf,[3] curing those with leprosy,[4] caring for a woman who is hemorrhaging,[5] and reaching out for those who could not walk.[6] 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 His 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 and men 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 Sisters of Mercy, the Daughters of Charity and the Alexian Brothers are 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.

I will concentrate my remarks on the subject of Power and Health Care Policy, with a specific focus on Catholic health care and health care policy in the United States. I will draw on my experience as a physician; as chief executive officer of the Caritas Christi Health Care System, a large integrated Catholic health care system in the Archdiocese of Boston, Massachusetts; as Secretary for Health Care Services to His Eminence, Bernard Cardinal Law, Archbishop of Boston; and as the current Chair of the Board of the Catholic Health Association of the United States of America. In that latter capacity, I share the responsibility for helping to shape and influence health care policy on behalf of the Catholic Church's health care entities in the United States.

First, I want to put into context for you the role of the Caritas Christi Health Care System in the ministry of the Church in the Archdiocese of Boston (the fourth largest Roman Catholic diocese in all of North America) and the significant role Catholic health care plays relative to the overall health care system in our country.

I believe that the strength and power of Catholic health care in the United States is derived directly from its unity of mission. For while Catholic health care in the United States is admittedly a collection of large business enterprises, accounting for over 16% of the nation's community hospital admissions and over $50 billion in net patient revenues each year, Catholic health care has been and remains today a ministry first and a business second. Let me underscore that point, because I believe that the source of our power and influence in the arena of health care policy is the Church's health care ministry imperative.

Today in the United States, there are 637 Catholic acute care hospitals and over 500 long-term care, or non-acute facilities. 61 Catholic health care systems encompass a variety of health care services and cover a wide spectrum in the continuum of care.[8] Many of these systems are multi-billion dollar enterprises. The system which I have the privilege to lead will approach one billion dollars in revenues this year, will employ 12,000 caregivers and other workers, and will provide care to over half a million people.[9] But again, I want to emphasize that our strength, our power and ability to influence health care policy is not primarily the function of our operating statement, but is instead, a function of our statement of purpose, our fidelity to mission.

The breadth and depth of Catholic health care's presence in the United States is impressive. There is a Catholic Health care facility in 48 of our 50 states. In addition, there are over 250 different religious sponsors of Catholic health facilities in America, reflecting the rich diversity of religious orders of women and men, of Catholic dioceses and others who live out the Gospel's call to minister to the sick and infirm.

The Caritas Christi Health Care System, drawing its name from the Latin, "the charitable love of Christ," is itself sponsored by the Archdiocese of Boston and is the creation of the vision of our Archbishop, Bernard Cardinal Law. Since its inception in 1985, when Cardinal Law first anticipated the creation of health care systems, Caritas Christi has endeavored to achieve a greater degree of clinical integration and cooperation among Catholic health facilities in our local region to benefit the needs of the individual patient.

In addition to the medical advantages emanating from a coordinated care system, Cardinal Law hoped to achieve two other critically important outcomes. The first of these being the obvious economies of scale which could be gained by having several small independent Catholic health care facilities operate as one larger unified system. These substantial financial benefits could be realized from efficiencies through group purchasing and standardization of products, through coordinated employee benefits and through the adoption of "best practices" in a variety of clinical and business disciplines. The strong institutions could assist those that were not as large, affluent or influential.

However, it is the second reason for coming together, which was truly the overriding impetus for His Eminence's vision and actions, namely the preservation and promotion of the values of the Catholic health care ministry. By uniting under one Catholic corporate structure the modest, albeit important, presence and power of each individual Catholic institution would be enhanced exponentially. Over the past fifteen years, the Cardinal's vision has been realized. The influence of Catholic health care institutions within the Archdiocese of Boston has grown significantly. In recognition of the importance of our values, our voice is sought out and reflected in virtually every health policy debate and decision made in Massachusetts; a significant accomplishment considering the tremendous influence exercised by the large, well-endowed institutions and health systems which are located in Boston.

In addition to the external power and influence Catholic health care wields, the unity represented by the Church's health ministry ensures each institution's fidelity to the Ethical and Religious Directives for Catholic Heath Care Services, as promulgated by the National Conference of Catholic Bishops. These Directives, frequently referred to as the ERDs, were recent-

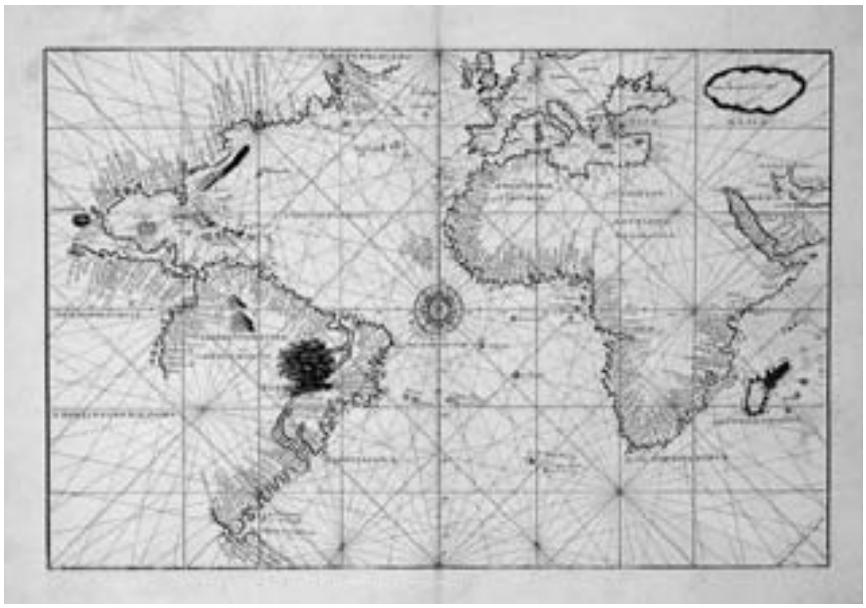
ly revised this past Spring with considerable input from many participants of this conference. The ERDs provide theological direction and witness to a clear moral compass that directs the care of physicians, nurses, pastoral caregivers, hospital administrators and healthcare providers at all levels, in all Catholic facilities.

Such clear definition of mission creates a vibrant consistent Catholic health ministry in Boston and across our country, which in turn, by example, influences the practice of medicine and science in what is arguably one of the most influential centers of health care and research in the world.

Cardinal Law's creation of the Caritas Christi Health Care System has not only served to foster the role of the Church in our own region, it has allowed our health care ministry to share its value-laden, holistic approach to health care (caring for the physical, psychological, sociological and spiritual needs of each and every patient) with a globally-influential local health care market.

To some the Ethical and Religious Directives are viewed as a proscriptive document that solely prohibits abortion, sterilization, in vitro fertilization and euthanasia in Catholic health care facilities. However, a careful reading of the ERDs not only reveals those commitments to Life, it also reveals the normative principles which inform the Church's healing ministry. It is all of the Church's principles which form the foundation of the Church's moral authority, its "power" if you will, to affect health policy and practice on the local, national, and as evidenced by this Pontifical Council, international level. The ERDs offer well conceived, morally based reasoning to the public policy debate in a wide variety of subjects. They offer guidance on the importance of the individual professional caregiver-patient relationship, to more macro issues such as those involving corporate mergers of health care facilities, the social responsibility of Catholic health care facilities to their employees, and issues of justice to the poor and marginalized in society. Each of these areas of guidance and direction, lived faithfully and argued forcefully, form the basis of the Church's health policy advocacy agenda.[10]

The consistency and the strength of our convictions, all founded in a vibrant faith, enhance our ability, as the ministry gathered, to influence the Federal power structure and policy forum on a panoply of policy matters. These include:



1) The need for universal health insurance coverage for the 44 million Americans who today have no health insurance and whose pursuit of quality and timely health care is impeded by that unfortunate reality. The United States is one of the few industrialized nations which has yet to adopt some form of nationalized health insurance.

2) The need to assure that there exists a preferential option for accessible, affordable, quality health care for the poor among us.

3) The need to defend and celebrate the human dignity of each and every human being from the moment of conception to the last moment of natural life.

This unambiguous advocacy for life, for the unborn and for those who are dying, is one in which many faith traditions who share our beliefs look to the Catholic Church in all its power (moral, political, and corporate) to take the lead in this critical public policy debate. That power has its expression in a number of core commitments. As a ministry our imperative is to promote and defend human dignity. Each person for whom we have the privilege to care is made in the likeness of Jesus. In the face of each patient, we must see the face of Jesus. Thus, we are compelled to action by the Gospel's teaching, to heal the patient's illness and to care for the patient's needs following the example and witness of Jesus, who ministered to the ill as such an active part of his life.

As ministry is our imperative, if Catholic health care is to embody that example of Jesus and to transform that witness into modern day actions, to be authentic, Catholic health care must care especially for poor and vulnerable persons. As the Holy Father so beautifully articulates in *Novo Millennio Ineunte*, "...no one can be excluded from our love, since, "through his Incarnation the Son of God has united himself in some fashion with every person." His Holiness goes on to say "there is a special presence of Christ in the poor, and this requires the Church to make a preferential option for them."[11] "Now is the time for a new "creativity in charity," not only by ensuring that help is effective, but also by "getting close" to those who suffer, so that the hand that helps is seen not as a humiliating handout but as a sharing between brothers and sisters."[12]

The needs of the marginalized

in society must become our special and specific responsibility. Through our example and influence, our power if you will, we will encourage others to heed our example to care, first and foremost, with that preferential option for the poor which His Holiness implores us to pursue. As a ministry, we must joyously accept this responsibility.

As entities that have the ability to influence health care markets, we must direct our considerable leverage to the promotion of the common good. In concert with other ministries of the Church, (e.g., those who minister to the social, educational, housing, and pastoral needs of those in our communities) and through an increased commitment to collaboration, we can achieve power through which we must exercise our responsibility for assuring the promotion of the common good.

Justice must be the hallmark of our actions. As a ministry, our example must be visible and vital. Through our actions we must assure that justice for each individual is protected and promoted. Our work places must be authentic to the Church's social teaching. The needs of our patients and the communities we serve must rise above the business needs of our entities.

We must always be true to our ministry imperative first, and our business obligations second. As stewards of an important component of the Church's ministry, we must shepherd our resources with care, and always respond to the call to serve those most in need. As a nation with many blessings, we must redouble our commitment to those in need throughout the world. The needs of our sisters and brothers wherever they live must become our needs, if we are to remain faithful to this call to justice. As our health care ministry is integral to the life of the Church, we must conduct our business and direct our actions in concert with the Church's other ministries.

In the United States, that Catholic health care ministry, gathered and united as the Catholic Health Association, has mapped out specific strategies to advocate for and achieve specific public policy victories consistent with our values, as articulated in our shared statement of identity.[13]

Just as the 12,000 employees and caregivers of the Caritas Christi Health Care System operate daily under a shared mission statement, so too do the 750,000 employees of Catholic health facilities across our country. This shared statement of identity propels our ministry and provides sustenance to our advocacy.

"We are the people of Catholic health care, a ministry of the Church continuing Jesus' mission of love and healing today. As provider, employer, advocate and citizen bringing together people of diverse faiths and backgrounds, our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind, and spirit. We work to bring alive the Gospel vision of justice and peace. We answer God's call to foster healing, act with compassion, and promote wellness for all persons and communities with special attention to our neighbors who are poor, underserved, and most vulnerable. By our service we strive to transform hurt into hope."

That shared vision helps us to provide focus to our ministries shared commitments. Thus our actions and influence lend resonance to our voices to "promote and defend human dignity; attend to the whole person; care for poor and vulnerable persons; promote the common good; act on behalf of justice; steward resources; and act in communion with the Church."[14]

These shared commitments animate our actions and give strength and power to our collective Catholic voice. Some of these intentions may sound more theoretical than practical, but let me assure you that as these issues and commitments are raised in the halls of our government, from the Congress to the White House, the power of our advocacy is anything but theoretical. The Catholic health care ministry's power is real and it is effective.

I would like to offer you but one example of how that vision helps to define a commitment that propels our ministry's public policy agenda. In response to the call of the Catholic Health Association's vision statement, a call echoing His Holiness' challenge to all of us, to pay special attention to our neighbors who are poor, underserved and most vulnerable, we honed a core commitment to "care for poor and vulnerable persons". That commitment causes us as a united ministry to advocate freely and forcefully for a transformation of our health care system in America to one in which all people, regardless of income or infirmity, have access to affordable high quality health care.

Despite record breaking growth in the U.S. economy over the past

decade, the number of Americans without health insurance has increased to 44 million today, and a quarter of those uninsured are children who are among the most vulnerable of the population. A majority of these individuals are in working families. Nearly 40% of the poor and 30% of the near poor lack health coverage, and not surprisingly, this population is two to three times more likely than people with insurance to have problems with access to care.[15]

At the same time, it appears that the lower rate of health care inflation in the mid-1990s has come to an end and health care costs in the United States are expected to rise dramatically and may top two trillion dollars by 2007 accounting for a significantly greater percentage of our gross domestic product. As costs increase, so do the pressures on business and government to scale back health benefits or eliminate coverage altogether. Already, recent cutbacks have compromised hospitals and other providers' financial stability and ability to provide services to needy patients and communities.[16]

Yet, in the face of these realities, the Catholic Health Association, serving as the voice of our Catholic health ministry has maintained its long-standing commitment to health coverage for all. This commitment is based on Catholic social teaching, our justice commitment and our mission to provide service to the poor. For millions of vulnerable, politically voiceless Americans who cannot gain access to health insurance for themselves or their families, the Catholic Church is their strongest, most powerful voice. We represent their best and most powerful hope for a transformation of the U.S. health care system and a reprioritization of our national policies with a focus on meeting the needs of the most vulnerable among us.[17]

As I share with you today these perspectives on the powerful role our Catholic health ministry plays in the development of just public policy in America, I am mindful of the huge disparities that exist in the consumption of goods and services, including health care services, between the United States and the rest of the world. I would be remiss if I did not recognize this reality as a further and arguably even more important challenge for our health care ministry to undertake. However, as Church in communio we can, and we must, leverage our global reach to impact this injustice and bring hope for human dignity to those around the world.

His Holiness captured this challenge beautifully and powerfully in *Novo Millennio Ineunte*.

"In our own time, there are so many needs that demand a compassionate response from Christians. Our world is entering the new millennium burdened by the contradictions of an economic, cultural and technological progress which offers immense possibilities to a fortunate few, while leaving millions of others not only on the margins of progress but in living conditions far below the minimum demanded by human dignity. How can it be that even today there are still people dying of hunger? Condemned to illiteracy? Lacking the most basic medical care? Without a roof over their heads?

The scenario of poverty can extend indefinitely, if in addition to its traditional forms we think of its newer patterns. These latter often affect financially affluent sectors and groups which are nevertheless threatened by despair at the lack of meaning in their lives, by drug addiction, by fear of abandonment in old age or sickness, by marginalization or social discrimination. In this context Christians must learn to make their act of faith in Christ by discerning his voice in the cry for help that rises from this world of poverty. This means carrying on the tradition of charity which has expressed itself in so many different ways in the past two millennia, but which today calls for even greater resourcefulness."[18]

Thus, those of us united and compelled by Jesus' example to bring the Gospel to life in our world, have the awesome responsibility to leverage our time, talents and treasure in advocacy for the promotion of human dignity. We share our responsibility for the Church's healthcare ministry devoted to and guided by the Church's teachings and encouraged by our long-standing commitment to those in need. Our ability to influence healthcare policy is derived from the power of our values and the soundness of our moral reasoning. Yet, let us always remember that the true power we yield is that which is manifested in the example of Jesus' life and sacrifice, and nourished by lives of prayer.

We must recommit ourselves to work cooperatively to extend the powerful vibrant ministry of Catholic healthcare to meet that global challenge elucidated by His Holiness and inspired by the Gospels. Then and only then will we have succeeded in aligning the power of our healthcare ministry with its vast, still unrealized potential.

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Caritas Christi Health Care System
Boston, Massachusetts, USA

Notes

[1] Matthew 20:29-34
[2] Luke 11:14
[3] Mark 7:31-37
[4] Matthew 8:1-4
[5] Luke 8:43
[6] Matthew 9:1-8
[7] KAUFMAN, CHRISTOPHER J. *Ministry & Meaning: A Religious History of Catholic Health Care in the United States.* Crossroads Publishing 1995 New York.
[8] The Catholic Health Association of the United States (1999). *Catholic Health Care in the United States.*
[9] Caritas Christi Health Care System (2001). Statement of Operations.
[10] National Conference of Catholic Bishops (1997). *Ethical and Religious Directives for Catholic Health Care Services*, 6-8.
[11] POPE JOHN PAUL II (2000). *Novo Millennio Ineunte*, 49.
[12] POPE JOHN PAUL II (2000). *Novo Millennio Ineunte*, 50.
[13] The Catholic Health Association (2001). *Uniting For Transformation*, 9.
[14] The Catholic Health Association (2001). *Uniting For Transformation*, 6.
[15] The Catholic Health Association (2001). *Uniting For Transformation*, 7.
[16] The Catholic Health Association (1999). *United Voice for Change, Expanding Health Coverage for the Uninsured.*
[17] The Catholic Health Association (1999). *United Voice for Change, Expanding Health Coverage for the Uninsured.*
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VINCENZO MARIA SARACENI

3. Power, Health and Society

1. It is well-known that today health is unanimously recognised in the principal documents of international institutions adhered to by States from every continent as an inalienable right to be guaranteed to man, and also how the notion itself of health is broadening from being the mere condition of absence of illness which weakens, threatens, compromises or destroys the ability of the human organism to function, to that of a general state of well-being in which, in addition to the traditional contents, are included also the healthiness of the environment in which existence takes place and the mental reward linked to the quality of life achieved by each individual.

In this sense, indeed, the idea of health seems to be increasingly linked to the contents of the much more complex and over-arching concept of the quality of life.

This objective, born from the link between health and quality of life, bears witness to the strengthening during the post-industrial era of a much more ambitious aspiration than that connected with the mere satisfying of the primary needs of the maintenance of the complete psycho-physical ability to function of the organism, and is thus characterised by the wish to achieve the full realisation of one's own being, in addition, naturally, to one's relative psycho-physical potential in relation to the natural needs of inter-subjective relationality and social recognition within an environmental context which is both integral and a stimulator of expressiveness, imagination, creativity, and ludic spontaneity.

The quality of life, therefore, pre-supposes the subsistence of a general well-being of the body and of the spirit of man, the availability of resources which are not only sufficient but also suited to the satisfying of needs that are not only elementary: that is to say a balanced and welcoming integrity both of physical spaces and of the social spaces in which the experiential experiences of each individual are located.

From this point of view, therefore, the concept of health can well be seen as the core of that humanistic civilisation towards which the Christian Churches and other consolidated religious confessions, in addition to various philanthropic contexts, strive in order to direct the history of contemporary mankind, marking, thereby, the advent of a new anthropocentrism which is more mature than that already known in the West because it is also nourished by the contribution of cultures which are different from Euro-North American culture.

This anthropocentrism is certainly in the main the fruit of Western speculation inherited from Greek thought, which with Plato and Aristotle formulated the basic concept of the subjective identity of man, which was affirmed for us in an ambiguous dualistic perspective of a net separation between the spirit and matter.

And yet it was this, finally freeing itself from such a dualistic encumbrance which had conditioned the development of European ideology for centuries, with the overcoming of Western anthropological dualism, which adopted, in the first place, the Judeo-Christian perspective on human beings. The human being was seen in terms of the inseparable unity of soul and body, that is to say as a person, whose value is absolute, of exclusive value and unrepeatable specificity, whose defence, therefore, was seen as being a sacred task.

In addition, the neo-anthropocentrism seems also to be the result both of the constant respect paid by oriental philosophies to the natural environment and to the calm acceptance, specifically in the customs of Afro-Asian peoples, of the laws which govern them. Nor does it seem of negligible importance that in them is to be found that further ethological humus in which is present the need for community and the social vocation of that inter-subjective sphere which is both consolidated and binding, territorially defined as well, which is specific to the clan and tribal mentality which forms a part of the culture of so many peoples of the South of the world.

The new seed of global anthropocentric culture, which is certainly in a state of progressive expansion even though it is also countered by strong negative elements, seems however to be able to positively condition contemporary public opinion and can be an instrument by which it will be possible to achieve a higher level of guarantee for the health of man within the framework of a world balance that is more suited, in the distribution of wealth, in the determining of priorities and in political practice, to this need.

The establishment of a widespread cultural sensitivity in relation to these values, through the theoretical upholding of rights, is the first fact which has to be registered.

In this sense, we have before us, without any doubt, an advance of significance because the solemn proclamation of the principle of the right to health comes to be placed, in a clear way, as the necessary programmed basis for the political action of the United Nations Organisation and all the national States which belong to it, and represents the strategic objective principle towards which the efforts made by governments with suitable operative initiatives are directed. If world politics is no longer without goals, or rather, if the founding aims

which are pursued by world politics at the level of ideals are today shared by everyone at least in the declaration of intentions and seem no longer to be bound up with the logic of power, one cannot but greet all this as a notable step forward.

It would seem, therefore, that health, at least in its albeit evanescent realms of good intentions, must and can be finally freed from the conditioning of power so as to be restored wholly to the naked truth about man within an anthropocentric perspective.

2. However, the emphasis on proclamations, even though it should rightly not be considered lightly, should in the same way not be underestimated when we come to consider the objective analysis of things are they are, which, in fact, are very far from being what is solemnly acknowledged and theoretically guaranteed.

Indeed, the same praiseworthy humanistic impetus directed towards establishing the society of well-being and to raising quality of life, which is in itself an admirable impulse of civilisation, can, however, generate an intensification of the process of compromise between health, power and oligarchic social systems, given the objective increased need for resources that the present-day qualitative condition of existence requires. These, in fact, are means whose availability is still inseparably bound up with the exercise of power and social control.

We need, therefore, to avoid the danger of not addressing ourselves, at a practical level, to the question of the persistent link between law and health, the possession of power and the condition of society. We are dealing, therefore, with not concealing the brutal truth of the continuance of a close correlation between the defence of health and the power of wealth, knowledge, and communication.

This is a situation which brings about the establishment of a dual and heavy discrimination.

The first very painful intolerable and abysmal form of discrimination is that which has taken place between the evolved societies of the northern hemisphere of the planet and the peoples of the South of the world, with the result that only in the opulent nations can one consider the objective of widespread prosperity as something that has been partly achieved and which is realistically obtainable.

The second form of discrimination is the increasing inequality, within the developed areas of the world as well, to be seen in the different levels of the defence of the good health and the forms of conditioning that health care experiences at the hands of power, which, as is the case with rich countries of the planet, is organised in a sophisticated and refined way which expresses the multinational productive systems of a capitalist character.

In this area, the reasons for concern are profound and connected to the increase in expectations which themselves are bound up with the guaranteeing of health understood as quality of life. These are expectations which are not met as regards the hopes of poor peoples but which often, at the same time, are not equally and congruously achieved within the privileged regions of the planet.

In relation to this set of questions and issues it is opportune to examine the question of the relationship, or perhaps the subsistent intertwining, between power and health, taking as a point of departure an analysis of the instruments by which health is defended.

During the history of civilisation it can be observed that the defence of health has been achieved through the specific features of a practice and a science, namely the art of medicine, which especially in the West has taken on a highly scientific profile.

We should, therefore, concentrate our attention on this last element.

A careful and general reflection on medicine immediately allows us to recognise the difficulties which are to be encountered in contextualising the subject of analysis because the practice of medicine has never been an activity which can be placed within a framework whose contents are certain and broadly shared. It has also represented the mirror of a relative specific cultural model, in relation to which one can – indeed, one must – admit that there are forms of medicine which are generated by different cultures, and thus there are forms of medicine which are correlated to customs and cultures.

It is certain that the art of medicine – although at every time and in every civilisation a reflection of social custom – has increasingly acquired its own autonomy and a more marked configuration when compared to ancient practices – at times to do with witchcraft and witchdoctors – as knowledge in the anatomical field and the pharmacological field has been consolidated following the emergent methodology of analysis and the applied experimentation of knowledge.

However, the autonomy and independence of medicine has always been strongly conditioned by its self-expression as the representative model of a defined socio-cultural model. This is why an examination of the relationship between medicine and society and power appears to be the most useful instrument by which to identify a sufficiently inclusive picture of medicine which is able to grasp in real terms its historical and present-day substance.

From this point of view, medicine has always been seen as a subject that could not be circumscribed to a specific field, that of science rather than art, or rather that of magic rather than the technical, but rather the subject of a many-faceted discipline expressive of the equal complexity of the object of its study: man.

It is thus recognised that the relationship that exists between medicine, society and power is located in and depends upon the strict and in-

separable relationship which exists between them and the whole universe of the human.

This link between the art of medicine and the existential sphere of mankind is not an accessory but a determining fact because it involves the ontological quality of medicine and characterises its basic aspects.

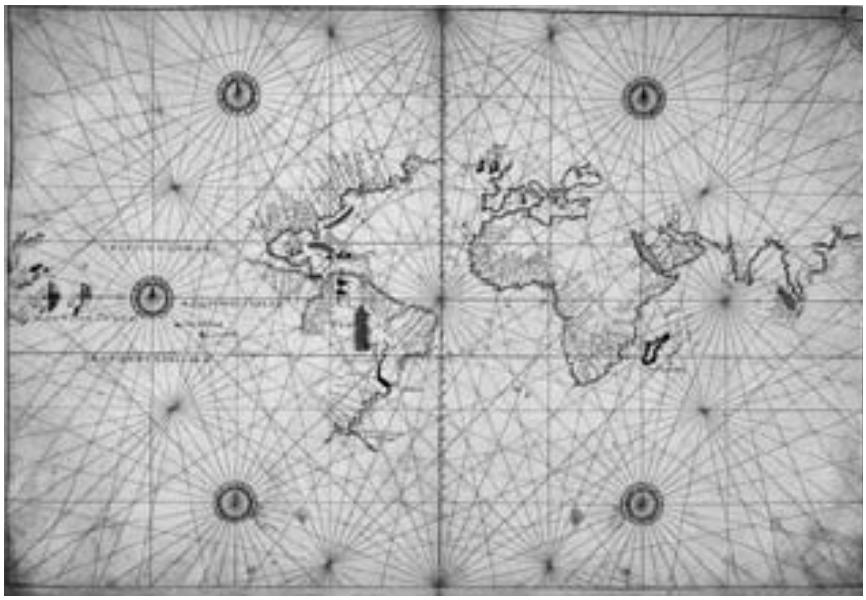
It is observed here that in every society the health of man has always been a prerogative of medicine, which has easily been able to acquire a lordship of value at time bordering on sacredness, where the sacred is closely connected with the miracle-working event of healing obtained through the application of medicine, and from which comes a kind of ritual and totem-like respect for medicine. Hence also a mixture between medicine and power because nothing more than the art of healing appears to be able to affect the destiny of men, taken individually and in terms of social organisation.

To this *liason* between medicine and power, seen from the objective point of view of their effects on the very existence of men, one must add that there belongs to the art of medicine the power of both physical and psychological power which can be exercised over patients through actions involving the examination and the handling of bodies and which are bound up with the activities of making a diagnosis. These, indeed, are the basic operations specific to medicine which bring about in the patient an attitude of self-abandonment and subjection, certainly reinforced by his or her condition of crisis, which in relation to the medical doctor places him or her at varying levels of subordination.

This reality can lead one to see the exercise of power as an inherent fact in the art of medicine, that is to say that it is intrinsically connected with every therapeutic action, and thus a constituent element of the same art.

From this there can but follow the attribution of a fundamental social relevance to medicine and its establishment as a (professional, scientific and practical) productive area of specific systems within society. But there also follows from this the difficulties to be encountered in establishing an organic identity for the model of medicine, which is rather complex and which necessarily refers to a number of domains of development (science, practice, profession, art) which are clearly very different.

If this profile is valid for every concrete historical situation of the various epochs and territorial contexts, it is nonetheless the case that the nature and the scale of power linked to medicine can be differentiated according both to the level of efficacy of healing activity and to the dominant cultural model of society as regards the question of death and suffering.



It cannot be doubted that the role played in this sense by medicine has acquired increasing weight with its technological-scientific development and the progressive weakening of the custom of accepting death, a consequence of the expansion of the crisis of the religious and transcendent concept of the creation which characterised in an over-arching way Christian societies in the northern hemisphere.

Modern medicine was born with the culture of the French revolution, which established the medical body in a professional sense by giving it the task of the overall defence of the health of citizens, but at the same time it developed with the almost contemporary process of widespread industrialisation. This last phenomenon, in favouring the develop of research and experimentation as functional elements in the expansion of the productive processes, promoted and imposed the technical qualification of medical-therapeutic practice – something which led to extraordinary results in the field of chemical discoveries, above all the discoveries relating to pathogenic micro-organisms.

This was an event which during the course of the nineteenth and twentieth centuries not only became more established but also extended itself with dramatic advance, bringing about, thereby, very major forms of progress and advance at the level of health care.

Indeed, through new surgical techniques, mass vaccination and increasingly sophisticated forms of pharmacological treatment, there was a notable increase in the ability to tackle the various pathologies and to defeat epidemics which at one time had been seen as killers.

However, the spectacular increase in the technologicalisation of medicine, the refinement of its scientific and professional qualities, and the intensification of its therapeutic effectiveness all ended up by producing in the developed world extremely relevant consequences in relation to the relationships which subsist between medicine and health, which have, indeed, been profoundly altered.

There has been a gradual attribution of an excessive importance and significance to the role played by medical practice in the positive trend within health care as provided in industrialised countries, with a neglect of other equally important

factors such as the improvement in socio-economic conditions, the decrease in the birth rate, the increase in respect for basic rules of hygiene, and the improvement and refinement of diet. This bestowal of a myth upon medicine has in turn generated a worrying division between medical action and the treatment of health. This has arisen because of the overly valued potential of medicine which, first of all, has increased the recourse to the medicalisation of many merely physiological elements with a deresponsibilisation of patients who have developed personal reactive impulses in relation to maladies, and secondly has created a new category of illnesses such as iatrogenic pathologies (I am referring here to the side-effects of drugs and medicines, erroneous surgical operations, therapeutic errors, etc.). There has taken place, that is to say, an invasiveness of medicine, which has sought to affirm itself as an end in itself, as a practice directed first and foremost to the exercise and production of power which is extraneous and at times even damaging in terms of the defence of health. This phenomenon has been defined by Ivan Illich as medical iatrogenesis in his rather harsh and provocative analysis of this reality.

In parallel fashion, the massive introduction of developed and advanced biomedical technologies and the dramatic advances registered in the world of transplants have provided the art of medicine with a real and authentic ability to manipulate life and death, which is auto-referential as the mere expression of scientific research, which justifies itself in terms of this autonomous function, and is only partly directed towards producing health.

This change in tasks performed by medicine as regards health, that is to say the placing of this art at the service of the corporative interests of the medical classes in an ideological initiative directed towards sanctioning its own arbitrating and guaranteeing function in social planning in the health-care field – reducing thereby its traditional ancillary role in favour of the advance, the defence and the recovery of health – can produce in the context of societies dominated by free-market logic further dangerous consequences because it makes the practice of medicine considerably more vulnerable to the conditioning effects and the needs of the market. It follows from this that medicine, which is apparently freed from every teleological basis, including the traditional one of a Hippocratic matrix, runs the major risk of seeing itself placed within a framework which respects parameters which are purely economic in character.

And a resulting serious injury to the defence of health would be evident once a situation was really created where in health care the primary aim was located in the pursuit of the greatest possible profit which would be sought after with such facile methods as a general pursuit of an increase in the sales of drugs and medicines, in the number of admissions to hospital, in surgical operations, and in clinical activity, when the need, validity, efficacy of the forms of treatment proposed were not attested to with exhaustive certainty.

The above-described compromise between power, medicine and society, which has a direct affect on the realistically obtainable level of guarantees and development as regards health to the benefit of all, lead us to perceive a need to restore the historically real close link between therapeutic action and the defence of health through the recovery of authentic shared roots, such as indeed proposed by the neo-anthropological cultural perspective. But the direct link which should be re-established or developed between medicine, health and the specific domain of human beings involves a need to connect the practice of medicine and the condition of healthiness to a system of founding values which represents their final ends, that is to say which establishes parameters for everything according to criteria of morality. From this consideration I think must be born a conviction about the intrinsic objective ethical character of both medical action and the defence of health. But if health, and with it medicine as its instrument of preservation, are considered as belonging to the ethical sphere, it is evident that their intertwining with power in every social context has to be governed by an ultimate purpose, which, in line with incontestable ethical canons, is inherently linked to the achievement of the good of the human creature.

It is indeed man, in his unity as a person and his indiscriminating value, who is the centre of that cultural plan of global civilisation proclaimed by the United Nations and which corresponds to the hopes of, and embodies the expectations of, all the peoples of the world. And yet how is it possible to give concrete developments to the orientations of the programmes outlined by the United Nations which are fully in conformity with the needs of shared morality?

3. The central question to be resolved today is that of power. This problem involves both the use of power and its configurations in an increasingly unified system of various powers – such as scientific power, technological power, economic power, political power, and information power – which knowingly or otherwise end up by manipulating man in an overall and all-encompassing way.

This takes place in its most accentuated way in the West but by now this also affects almost every society on the planet, given that we are now faced with the mounting phenomenon of globalisation.

In contemporary society, indeed, we are confronted with an insinuation of a rather dangerous idea: the often successful attempt to define the exercise of power as a neutral expression of an objective availability of scientific, technological, and professional knowledge, that is to say a cultural capacity supplied by and bound by the mere respect for parameters of rationality which are refined by research, experimentation, and logical speculation.

In this way, power is said to be totally divorced from any interaction with any definite identity, whether political, philosophical or religious in character, and, being emptied in this approach of any partial vision which pollutes the serenity or equity of its use, it would end up by being exercised without any impediment because it would be necessarily directed towards the benefit of man according to the specific criteria of rationality.

Hence, equally, an implicit and acritical justification of the systematic arrangement of the various powers, which, taken together and

constituting the origins of the exercise of power understood in a unitary sense, could not but correspond both to an objective basis and to a substantial comprehensive logicality that would be advantageous for society.

Thus rationality should be the guarantee for the equity of power and the source of its legitimacy and freedom, and should be identified as responding to the needs of man.

In turn, freedom would be the only ethical point of reference and would end up by being a norm in itself.

One may add that this conception, and practice, of freedom seek in a decisive fashion to define themselves in a social system, in political institutions, and in legal arrangements and contexts of a connaturalistic nature, where, that is to say, each possesses its own space which is undisturbed by power and where neither can call to account the workings and the choices of the other.

This is an approach in total contrast with the humanistic vision of reality described above, because it helps to shape the organisation of society on the basis of the system of power as given and wanted, as being something rationally founded, and to crystallise the subsistent relationships between the different societies of the world according to present-say arrangements, which are determined by the availability of the resources, knowledge and technology provided by the various nations of the world.

It seems evident that such a framework of relationships between the exercise and the system of power, on the one hand, and of society, on the other, all directed towards consolidating the existing equilibriums in which only the general interests of the rich peoples and those more particular and narrow general interests of multinational oligarchies, conditions in a determining way the health-care panorama, making, in fact, health a privilege of the few rather than a human and civil right which every man should be considered as having and enjoying.

We need, therefore, in order to set in motion in concrete terms the implementation of the proclamations approved by the United Nations and supported by the constant and incisive action of the Churches and non-governmental organisations engaged in voluntary work, to extend the philosophy and the behavioural models specific to integral humanism to the use of power and social organisation as well, attributing to both that same humanising purpose that belongs to anthropocentric culture. We need, therefore, to connect power and society in a higher reality, that is to say in a system of shared values which as such are unanimously recognised as being able to regulate the exercise of the former and the organisation of the latter. And this operation will not involve the feared risk of the ideologisation of power or society, that is to say their definition in terms of a totalising abstract identity, whether religious, political or philosophical in character. The guarantee regarding this risk is the constant and sole reference to the value of man and its ontological roots, as well as the fundamental need for a subsistence of a widespread sharing of the a feeling that the professed values are held in common.

This pathway, which obviously pre-supposes a spontaneity in adherence, appears to be complex and difficult, but it is possible. Yet it can only be born from society itself as a maturation of the experience of belonging to a given community which expresses values and customs that bear comparison with other similar communities and together with which embodies a series of unitary elements of ethical identity.

It will then be a society composed of the coming together of various groups and modelled on a scale of a few freely accepted founding values which will condition the exercise of power according to the needs of an intrinsically but generally perceived morality and at the same time which will establish for that exercise of power a system of rules which will make it, in corresponding fashion, structurally limited.

This result presents itself as being decisive in the achievement of the humanistic objective of the defence of health because the subordination of power and its exercise in a way which respects the ethics of values is a high purpose available to man for every individual and social action, and in particular for his operative instrument, i.e. power: both so as to dismantle all the modern ideological suggestions directed towards providing some kind of theoretical justification for the defeat of the weak for the purposes of progress, that is to say in real terms the strong and the prosperous, and so as to unmask the inconsistency of that above-mentioned attempt to establish a new moral universality that affirms that it is based on the ethics of free power.

It will also be, lastly, the development of a more authentically human social tissue, that is to say one based upon the instinctive perception of the irreplaceable subsistent relationship between man and the world, made up of an aware perception of a shared foundation for identity and destiny amongst all men, together with the recognition of an organic functional capacity within nature at the service of the never to be repeated and high value of the human existence which will allow – with an inexorable flowering of a strong feeling of mutual solidarity – a journey of hope towards the goal of a level of quality of life which corresponds to the dignity of man, which must, indeed, be guaranteed, *quod est in votis*, to all the peoples of the planet.

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LUCIANO ONDER

4. Medical-Scientific Information

The title of my paper, 'medical-scientific information', may appear a little cynical, but medical-scientific information has enormous power because it influences the behaviour and the choices of millions of people. It does this often in a radical way and in a very short space of time.

For this reason, I think that it is not only a specialisation of journalism but much more: it is a real and authentic sector of medicine because upon it depends prevention, our well-being, and often our way of treating people as well. Its consequences are enormous and affect social and ethical realities and questions. More than any other sector of journalism it has an ethical dimension.

Good information contributes to bringing about good medicine, and is useful to the citizen. Bad information aggravates problems and damages the citizen. To summarise: medical-scientific information can help health but at the same time it can also damage it.

All this is well known by medical doctors and by journalists who are concerned with medicine.

In 1984, in Washington, at one of the first meetings on AIDS, the scientist Robert Gallo, in answering the question as to how it would be possible to stop the spread of the epidemic, answered that hindering this new illness could be achieved by methods that were not strictly medical and clinical but involved the use of information supplied by the mass media: "Everything depends on you journalists and results will be achieved if you provide correct information which is useful to the citizen and which is not sensational in character".

Robert Gallo was right: in all Western countries the epidemic was checked thanks in part to correct and well-directed information, and this information had an educational role and a role of prevention. 'If you know it you can avoid it', 'Don't die because of ignorance' were the messages of the campaign of prevention to which the Western mass media made a major contribution. These were campaigns which through the mass media achieved good results, above all in relation to the categories at risk to whom they were directed.

The importance of good information which contributes to prevention and education has been emphasised at every congress. At the congress of hospital cardiologists held a few days ago, for example, Prof. Pierluigi Prati of the San Camillo hospital observed: "the number of heart attacks and cardiovascular illnesses has decreased over the last decade by 20%, in part as a result of information which has made citizens understand what the cardiovascular risk factors are and how important it is to correct them."

In substance, the more the citizen is informed the more he or she is able to control what affects his or her health. "If you are responsible suppliers of information you will also be educators", Karl Popper said to journalists when emphasising that information, if it is good, must always become an instrument of education and have pedagogic effects.

It is not always easy to understand everything given the great amount of information that reaches the general public. My job is to do with information supplied through television, a medium which has enormous power. Viewers often experience news in a merely emotional way when in fact they require a cultural grounding that we Italians do not acquire at school. We may think here of how much emotion and little rationality has marked the news about electromagnetic rays, the side-effects of medicines such as Lipobay, and impoverished uranium, over recent months.

When it comes to this medical-scientific information one must bear in mind those who are watching or reading; it must have, to express the point briefly, an ethical dimension and a pedagogic role.

In France the Committee of Bioethics issued a 'Statement' on 31 May 1995 for journalists or newspaper editors on questions which had been raised about scientific, biological, and medical information.

Section '5' of this document reads: 'the limited number of journalists who have a real scientific grounding the committee finds worrying when it comes to the actual efficacy of information. In acknowledging that the scientific journalist has an important pedagogic role it is to be hoped that such a grounding should be considered as being indispensable by the editors of newspapers and made a pre-condition for entrusting a journalist with a story'.

Section '11' is concerned with the ethical dimension of professional training. 'The committee recommends that a journalist has an appropriate ethical sensitisation which takes into account the situations that may emerge as a result of the information that is provided.

Moved by the desire to be newsworthy, journalists often, for exam-

ple, forget that words such as 'imminent' or 'forthcoming' in the context of a scientific result can even mean five or ten years.'

These recommendations of the French Committee of Bioethics are very relevant today in Italy as well. This is because in this country journalism does not always take into account the ethical dimension of the profession and does not always have a pedagogic role.

Often science produces news of the worst sort and what ends up on the front page is only the bizarre, the curious, the sensational, and the scoop. Information is often screamed forth in the form of absurd headlines, is often deformed, and ends up by creating illusions or false hopes: in practical terms everything is put on the same level, both that which is really proved and that which is the product of the fantasy of the journalist who writes the article.

As Umberto Eco has observed: 'In Italian journalism a special phenomenon is often to be encountered: facts do not become words but very often words become facts. This is 'virtual' information by which often everybody discusses something that in reality does not exist...this is disinforming information, where only the spectacular is news'.

And it has been precisely the area of medical-scientific journalism which over the last few years has produced examples of disinforming information: in 1995 the UK 101 (the so-called anti-cancer protein of Bartorelli; in 1996 the UROD method (for the rapid treatment of drug-addicts); and in 1997-1998 the MDB (the Di Bella method for the treatment of tumours).

I wonder whether this is a primarily Italian or also a European and worldwide phenomenon. In Italy news such as that about electromagnetic waves, the side-effects of drugs and medicines, biotechnologies and OGMs and enriched uranium, is broadcast to the point of blocking development and creating a health care emergency. These are examples of news which force citizens to align themselves on one side or the other, on the Right or on the Left, in favour or against, without paying attention to the scientific facts and proposals.

All this, needless to say, is of no use to the citizen, it damages the interests of sick people, and prevents their treatment in the most suitable way.

The Statement of the French Committee of Bioethics concludes with a specific invitation directed towards journalists:

'It is important to consider that the public which receives scientific information is not a general and amorphous mass. One is dealing here with sick people, their families, their associations, and their medical doctors; all young people of a school age, faced with the dangers of AIDS or drugs, their parents and their teachers; and lastly, the animators of great social solidarity such as voluntary work associations, blood donors and organ donors. All those citizens who experience the impetuous development of biomedical knowledge and power; all those who create and disseminate information must think about these people.'

Recently, *L'Osservatore Romano*, in discussing news events, stigmatised certain kinds of information and invited journalists not to create illusions about the treatment of tumours and to consider that behind the news there is always man, the suffering person, the weak person. And it is of these that one has to think.

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Journalist
Italy

SALVADOR ROFES I CAPO

5. The Power of Health Professionals

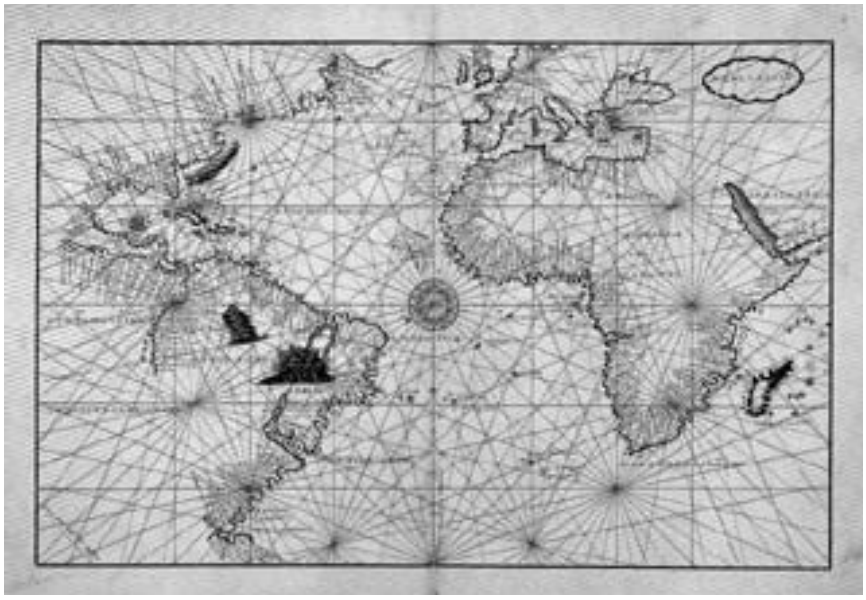
I have to acknowledge that the title of the paper I was asked to give is in itself an example of diplomacy and sensitivity since the logical title would have been 'the power of medical doctors', the power that is to say of those who have really held or still hold power. As you will have understood, I will principally refer to the power of medical doctors because other health professionals (nurses, psychologists, physiotherapists etc.) have been for many years, and in many place still are, under the dominant and abusive power of medical doctors who knowingly or otherwise have prevented them from enjoying a professional profile of greater relevance than has hitherto been the case.

I do not believe that this perception present in Western Europe is very different in other parts of the world. In an excellent article in which Dianna Kenny and Barbara Adamson[1] analyse the control exercised by medical doctors over the other health care professions in Australia, it emerges that 73% of the people surveyed, those who were not medical doctors, did not feel that they were treated fairly because professionals with a greater number of years of service behind them were more appreciated by medical doctors than themselves, and the young such professionals felt that they were appreciated very little. The conclusions of this research amount to a request for respect and consideration on the part of medical doctors in relation to the other professions and a recognition of the fact that the two parties cannot operate without each other.

This 'dominance' has also been brought about by a confusion located in the conversion of the role of the medical doctor into that similar to a priest, and this to the point that the medical doctor has been invested with divine power, something from which certain moralists are not excluded – people who, no doubt in good faith, attribute to nurses and other professionals the role of being subordinated to, and being the obedient executors of, the orders of the medical doctors. One needs only re-read some moral tracts that were studied not more than fifty years ago in some nursing schools to understand the historical evolution of the medical doctor as a powerful being. This was also rooted in the fact that many medical doctors usually came from a middle-high social class whereas the other health care professionals belonged to middle-low social classes, something that in itself gave them a certain social overbearance. Today this factor has lost its relevance.

It is not strange that with these precedents the power to treat, the power to listen to the sick person who needs to explain the story of his or her life – which is so bound up with his or her health problems – to a professional who knows how to listen and wants to listen (this is something which often costs medical doctors a great deal), the power of oral and non-oral language made up of words and actions that inspire peace during moments of anxiety – which are indeed the real power of the nursing profession – are values that have been put to one side, values that are silent but nonetheless vital. It is time for medicine to give emphasis to the value of interdisciplinary teams in which, I hope, the real force of the value of nurses and of other health care professionals will emerge, and for many medical doctors to begin to understand the role and power of these professionals.

After explaining these past factors I will refer to the power of medical doctors. I will begin with the conclusions of a paper on this subject given by Prof. Diego Gracia at an interdisciplinary seminar on science and power held at the University of Comillas in Madrid in 1987. Diego Garcia said: "Does the medical doctor still have power? As an individual, he has less than ever before. But medicine as an institution today has greater power than it has had in any



other age of its history. The life of man has never before been so medicalised. The power of medicine has never been greater".[2] This premise is shared by Feidson and Mecchanic who affirm that medical doctors are losing power to the benefit of the profession,[3] and by Eric Tangalos, the director of internal medicine at the Mayo Clinic, who in a number of recent declarations to *El País* has observed with emphasis that 'the model of the authoritarian and paternalistic medical doctor is finished. The medical doctors who practice today have to negotiate with the patient'.[4]

I believe that the words of Diego Gracia, expressed some fifteen years ago, today have, if this is possible, greater vigour, and I agree with them to a great extent. The epoch is coming to a close when in rural Spain (and I believe in other countries, especially those of Southern Europe) the doctor, the teacher, the parish priest and the civil guard were the people who really wielded power. The medical profession is losing power day by day but in contrary fashion medicine as such is increasing its power in our societies: medicine as scientific, moral, political, social (etc.) power.

Medical doctors lost power when medicine was socialised, when hospitals were transformed into companies, and when primary care transformed country doctors into a team of community care. They continued to lose power when they were told that they had to engage in management because medicine with its enormously increasing advance involved such costs that it was necessary to establish priorities. We moved from the principle of doing good to the principle of justice. The health care professional was largely transformed into a functionary who received a fixed salary at the end of the month, on whom society made increasing demands and who is now face to face with terms such as productivity, efficacy, efficiency or the supervision of resources, for which he has received no training at his medical school. In addition, he is face to face with a series of right or wrong judicial questions which disorientate him. As Prof. Gigli writes so well, mutual trust is increasingly replaced by legitimate suspicion where the patient and the medical doctor see each other as potential enemies.[5] From the medical doctor are required certain results and thus death, as the outcome of an illness, is called into question and attributed to the failure of science. It seems that everything is reduced to the application of the technical. In a survey carried out amongst a representative sample of Norwegian medical doctors published recently in *The Lancet*, over a half acknowledged that they had received pressure or threats from their patients or their patients' families. These 'threats' seem to counter the taking of decisions by medical doctors and lead to excessive requests for diagnostic tests, which in turn can give rise to an increase in erroneous positive results when the probability of the illness is low.[6]

During the second half of the

twentieth century we witnessed a series of strikes by medical doctors which would have been unthinkable many years ago. I remember that I took part in 1971 in the first strike of resident medical doctors to take place in Spain, and I remember the social impact that this had for the country. My scandalised section head made me leave an assembly and rebuked me for my attitude which to him seemed outside any Hippocratic logic and very far from the professional code of conduct. To me what seemed unreasonable was to work in a social insurance hospital and not have social insurance myself, to receive a very low salary, and to work more than sixty hours a week. But this phenomenon was not only seen in Spain. One should remember the strikes by medical doctors in Australia (1984), France (1995-6), and Germany (1996), various strikes in the provinces of Canada, a massive strike in Spain in 1995, and many others in different parts of the world.[7] Those who hold power, who feel satisfied and motivated usually do not adhere to a strike.

In a recent article published in the *Diario Medico*, J.C. Sandeogracias[8] maintains that the superman of health care is dead and that wanting to embrace an unsustainable situation made up of loneliness, because of a lack of support or a condition of powerlessness, can transform the person involved into a professional corpse.

In medical literature we can find numerous references to the 'burnout' syndrome, which is a palpable demonstration of dissatisfaction of a person with his or her work. In the view of Carlos Obesco, a professor of ESADE, 30% of medical personnel experience a mental malaise, and the overall index of satisfaction in a survey carried out in three large hospitals in Barcelona, Spain, reached only 47.94 in the case of those who worked as medical doctors, a figure, however, which decreased to 29.67 if the satisfaction of those working in a hospital was subjected to examination.[9]

In a macro-study of the nursing profession in Catalonia, carried out in 1990 by the Catalan Union of Hospitals, that is to say the great association of Catalan hospitals, it was demonstrated that a third of the 26,000 female nurses in Catalonia said that they were tired and had thought of leaving the profession.[10] One of the principal causes of this situation, apart from the working hours and the salaries, was the lack of professional recognition. I would like to repeat the point, therefore, that something must be lacking in these professions if discouragement and a feeling of dismay has entered their ranks.

Why do health care professionals, together with teachers, suffer from the syndrome of burnout in such alarming proportions? Can it be because of a lack of motivation, because they work in a role that was different to the one they dreamed about when they were students? In Spain, the syndrome of burnout experienced by medical doctors has been baptised the Tomas syndrome in memory of the brain surgeon in the work by Kundera 'The Unsustainable Lightness of Being'. The Tomas illness is a disturbance that affects the identity of the health care professional and its principal symptom is a loss of self-esteem accompanied by lack of motivation and boredom in daily work, the absence of hopes for career advancement, and the belief that only in another place would it be possible to work on a scientific basis. Amongst the trigger factors are the attacks, among others, on status (the reduction in power) and affections (an overly technical approach to the relationship between the patient and the medical doctor).[11]

The medical doctor as a person is losing his power as a charismatic leader or as an overbearing leader according to the case in hand, as we have seen in our medical schools or films, with the typical scene of the professor surrounded by all his pupils ready to listen to every scientific or banal word that falls from the mouth of their mentor but ready at the same time to satisfy the smallest whims of their chief. I remember a professor of surgery in my medical school who was one of the most brilliant people that I have ever met with an operating instrument and who had an assistant of whom he boasted that he would pick up the sheets he threw to the ground. One of the favourite 'graces' of the above-mentioned professor when he had an invited guest was to allow a sheet of paper to fall to the ground and then to say: "you'll see that X will hurry to pick it up", and this was something that the poor assistant did right away.

Situations such as these would today be unthinkable. Today medical doctors undergoing their professional training have recognised working hours, rights and salaries and when they choose the hospital for their training they do not search out this or that professor as was once the case but adhere to hospital 'A' or 'B' where the team of professionals and the technology have replaced as an attraction that which was provided by 'barons' and their schools, who had what Corono, quoting Max Weber, defines as 'charismatic dominance'.[12] As medicine became stronger, this charismatic dominion

was replaced by a legal-rational bureaucracy.

We would be unfair if we affirmed that the power achieved in history by the medical class was sought solely by professionals. It was specifically society itself that conceded a part of this power to medical doctors because medical doctors had the task of ensuring the survival of mankind. And furthermore the fact of power is not in itself a negative factor if it is exercised in a reasonable way, with good sense, and with a spirit of service.

But the losing of power does not mean that it has all been lost. There are still fields in which the medical doctor continues to be powerful or indeed very powerful. And power can be employed by professionals for the good of their patients or for their own good. Let us now see what these different fields are:

Power over people and their decisions. I am referring here to the power that can envisage a good result for a surgical technique or the fact of directing and treating the patient on the basis of a correct diagnosis which is something that in itself is innate to the profession. I am referring to the power of the taking of decisions by patients. The answer to the typical question: "if you had what I've got would you operate, Doctor?" can tip the scales towards one or other decision. But in this field, as well, medical doctors are rapidly losing the role granted to them by history.

In a recent article published in *Diario Medico,* Antonio Castillejo of PriceWaterhouseCoopers writes as follows: 'As Internet creates equal opportunities in gaining access to scientific knowledge, the principal source of safe information (the medical doctor) is changing and is becoming transformed into the technician who makes prescriptions'.[13] If we observe that 30% of the consultations that take place on Internet concern health care subjects, we can see that the figure of the medical doctor, whose diagnosis was in the past received with reverence and without any discussion, is being weakened in the face of more informed users (who are at times excessively informed because they are not able to filter the information in a correct way). Self-help groups have also helped to bring about this loss of power.

And if we look to the future, when the human genome could be the principal axis of the diagnosis, prevention and treatment of many illnesses, only a small elite of experts will be able to answer the questions of increasingly informed users whose natural source of information will be Internet.

The power of medical doctors, and the power of their decisions, which still exists in relation to sick people, must be exercised on the basis of the classical principles of ethics, but at the same time they must be exercised with transparency and honesty, given that the patient is an adult who has to the full the right to be informed about his or her own illness and the possibilities of treatment.

As Dr. Gregorio Maranon used to say, the medical doctor must see his chair as his best instrument, by which to be seated, in an unhurried way, at the side of, or face to face with, the patient, where he must and can exercise his power of information and understanding, being aware of the fact that the value he gives to time is very different to that given to time by the worried sick person.

Moral or ethical power. Until a few years ago the relationship between the medical doctor and the patient was guided by the principle of doing good and the moral norms that governed the profession were dictated by theologians and experts in morality. One could not speak specifically about medical ethics or bioethics in medicine but of professional codes of conduct which affected the approaches and attitudes of the medical doctor. When the patient began to claim his rights and his share of power in the taking of decisions, medicine was obliged to reflect upon its own ethics and bioethics began to grow with great force. But the professionals began to realise that there are decisions which cannot be taken solely with patients and their families and needed as a consequence the support of experts. They thus set up ethics committees which hospitals came to equip themselves with.

The power of an ethics committee is enormous. This power is not *'de facto'* because it is not binding but involves moral support at the moment when decisions are taken in certain cases of vital transcendence. Curiously, this power is not obtained individually (although the opinions of great experts on bioethics are very much appreciated). Rather, power emanates from the team of health care professionals and its assistants.

Economic power. 25% of the funds that the autonomous government of Catalonia allocates to public health care depends on the pens of medical doctors who write out prescriptions for drugs and medicines in the context of a clinic. These figures are similar to those of other countries. If we analyse the budget of an intensive care hospital, we can see that 60-65% of that budget is spent on the salaries of the staff and personnel (for the most part health-care staff and personnel) and 15-20% on pharmaceuticals and health care material. This leads to the conclusion that the good or bad use of health care resources is in the hands of health care professionals.

Medical doctors exercise their economic power at the level of absences from work or incompetence. Some days of absence because of pleasure or so as not to have to face up to the claims of a worker cost the public purse hundreds of millions of pesetas a year.

The question we can ask ourselves is to what point professionals are aware of their immense power in this field. In my opinion, they are aware of it to a very small extent but if a manager, whether of a hospital or of some kind of administration, bases his own management on going against the medical doctors, he can be certain that he will be faced with a failure in the short or medium term.

However, as Donald Light, with reference to American medical doctors, observes: 'doctors earn more today than ever before, but they are more miserable than ever before'.[14] This is because it is the buyers of health care services (administrations, insurance companies and so forth) who indicate the prices to suppliers, that is to say the medical doctors themselves, who thus find themselves increasingly defenceless in relation to such major interests.

Power in the mass media. A simple letter to the editor of a daily newspaper in which the section head of a heart surgery department reported that because of the long waiting list some patients could die if their surgical operation was not carried out in good time, sparked a political storm in Spain of very great proportions and obliged the central and autonomous governments to allocate

greater sums for the reduction of waiting times as regards these kinds of operations. Some people could argue that it was the media which in this case had power but it is clear that without the first letter condemning the situation which had been written by a prestigious surgeon the subject would not have acquired the resonance it did. The popularity in the mass media, and the frequency of their appearance in the mass media, of traumatologists attached to football teams and who treat leading players, constitute a secure source of earnings in their private surgeries.

The appearance of a medical doctor on television to speak about the specific subjects of his medical specialisation is seen as a dogma of faith by ordinary people who associate popularity with infallible knowledge without ever asking themselves why and how that person has been asked onto the programme.

Power in universities. The struggle for a university teaching chair is something different in faculties of medicine than is the case in other branches of higher education. Whereas in most faculties of medicine such chairs are the culminating point of a university career, in medicine and in particular in the clinical disciplines they are an external projection of prestige for private medicine, although it should be said that sometimes great theoreticians have turned out to be mediocrities at a practical level. Universities, which for some born lecturers are the only way they have of communicating their knowledge to their students, have been transformed for some people into a refuge to obtain that social recognition that society had been progressively denying them.

Scientific power. Few sciences in the world are as much afflicted by the 'printing fever' as medicine. Publishing (at times it does not matter how and what) is an obligation for a medical doctor undergoing training, and those who are already established are always involved in a race to obtain a publication, often in English, in the scientific journal which has the highest 'impact factor'. For some medical doctors, to have the largest number of publications possible in one's CV has become an obsession which could be logical for those who still have a low professional profile but which is ridiculous for certain chiefs who compel their name to appear in work carried out by members of their own team but in which they have not taken part at all. Who does not remember the struggle over the intellectual property of this discovery or another or the discrediting to which certain work that is presented with too little rigour and too hurriedly is subjected because there is a fear that it will be superseded by other publications?

The power of 'personal favours'. There is no other profession in the world where personal favours and free consultations are more requested. Family relatives, neighbours, and friends oblige the poor medical doctor to see X-rays, complex analyses, at times belonging to a specialisation different to the one he belongs to, in relation to which he must give a free and high-level opinion. I do not believe that this phenomenon exists in other professions. Because of the fact that he is a medical doctor, it is believed that he must be always ready to help and that he can be disturbed at any moment. There is a clearly a certain power of social recognition in his being obliged, in addition, to be very cautious, because I know of the case of a medical doctor who studied the X-rays of a friend for nothing, committed an error in his diagnosis, and was then taken to court.

And what about the favours that are asked to ensure that a cousin jumps a waiting list because he has been told that he would not be operated on for six months? Or that haughty neighbour who does not say 'hello' when she passes by on the stairs but who runs worried to the door of the 'civil servant doctor' when her child is suffocating on a chicken bone? Here the medical doctor certainly continues to have his modest but important part of power without realising that once the problem has been solved the same neighbour will pretend not to recognise him.

I have tried to provide a very personal vision of what I think about the power of health care professionals and it is very possible that some of you do not share my opinion. It is also certain that perceptions will be different according to the culture of each country and my culture is influenced by an overly Spanish, and perhaps a little pessimistic, view of the subject. I believe, however, that everybody will agree with the premise with which I began my paper, that is to say that there has been a loss of power of health care professionals in favour of the power of medicine. It is a good thing that the power of authoritarianism, of impunity and of paternalism has been lost, but it is possible that the swing of the pendulum has excessively punished these professionals, amongst whom, without doubt, there are many people who act with a desire to serve and with dedication to others and who today feel disappointed.

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Notes

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ERIC-PAUL PÂQUES

6. The Power of the Pharmaceutical Industry

Introduction

In order to review the "power of the pharmaceutical industry", we should firstly define what we mean by the term Power.

The word POWER refers to the idea of being able to do something, in other words to carrying out an action. The fact that someone has carried out an action gives him authority over someone or something. So authority is the feature of commanding, dominating or imposing one's will.

Although both the terms power and authority are very similar in meaning, the fact remains that one follows from the other and they are therefore not synonymous. We should make a careful distinction between them and show that, although the pharmaceutical industry sometimes has both of them simultaneously, in other situations it may have the scientific, technical and commercial power to do something, but it does not have the authority to impose it.

Having defined the notion of power, we need to agree about the object of the pharmaceutical industry's power. By the pharmaceutical industry, we mean all the companies whose common denominator is the power to market therapeutic and/or diagnostic products. This definition includes companies whose business ranges from research through development and production to marketing, companies which only produce and sell, and companies which only sell products.

On the other hand, this definition excludes the world of start-ups – companies which focus exclusively on therapeutic research or on the development of new technologies. These companies, which attract a lot of interest because they are supposed to bring out important innovations in treatments and technology, are not, strictly speaking, pharmaceutical laboratories. They are governed by other economic factors since they generally do not have their own revenue or it does not come directly from sales of their drugs.

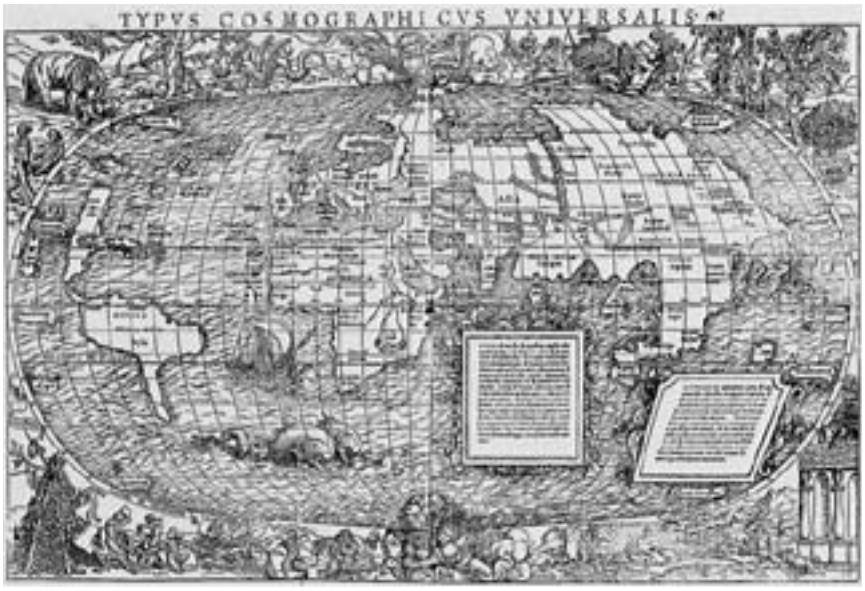
Economic power

If, as we have just seen, the pharmaceutical industry exercises its power by discovering, producing and selling drugs, this means that, through those drugs, the industry has the ability to preserve or restore people's physical and mental health, insofar as this can be achieved through its products.

Through the drug treatments it supplies, the industry has an impact on life and death, health and sickness, comfort and discomfort. By exercising its power, the pharmaceutical industry is given an authority based on the stakes – health – and consequently from the impact of this on the economic, political and social situation of a society.

It goes without saying that the state and future of a nation depend mainly on nutrition, hygiene and medical care. These three elements have a direct effect on the physical and moral health of populations and are translated into birth and mortality rates, longevity and quality of life.

Medical care has, therefore, a decisive impact both from a micro- and macroeconomic point of view. Both the international demographic pyramid and the financial and economic situation in countries are profoundly dependent on the quantity and quality of the medical care provided. With regard to the medical, social, economic and political consequences of the services provided by the pharmaceutical industry, it is not surprising that the industry is subject to a great deal of legislation passed by both national and supranational bodies. The world of health – of which the pharmaceutical industry is just one mainstay – is obviously



an economic force which cannot be ignored since it affects nations' economics, firstly by putting a strain on budgets and secondly by contributing substantially to the nation's economic health. In this sense, the pharmaceutical industry's power to ensure the health of populations also guarantees the strength of these populations. In terms of health, this also gives rise to the question of sharing strength between countries.

Financial power

Having said all that, it is important to note that we say pharmaceutical industry and not industrial pharmacy.

Although the two terms combine both the industrial and pharmaceutical business, the current term pharmaceutical industry emphasises the commercial, economic and financial nature of the business in question.

In this way, we should realise straight away that it is a business with a profit-making *purpose* whose *objective* is the area of health. The all-important question is therefore how far the objective is subject to the purpose, in other words, how power and authority are exercised with all the responsibility a question as fundamental as health demands.

In the same way as other sectors of the economy, the pharmaceutical industry has considerable financial power. In the year 2000, turnover in this industry alone was more than 360 billion dollars.

Even though the pharmaceutical industry as a whole represents a considerable economic and financial force, it is still a sector which is very divided as there are more than 10,600 laboratories throughout the world. The 30 leading international laboratories cover about 70% of the market, i.e. an average of only 2.3%.

By way of comparison, there are only about twenty car manufacturers. The top three together represent about 60% of the market.

The figures help us to measure the extent to which the pharmaceutical industry is split when compared to other sectors of the economy.

However, the pharmaceutical industry is undergoing a great deal of change. There is no doubt that, helped by economic pressure, our industry is becoming more concentrated and that in ten or twenty years at most, we will find ourselves in a very similar situation to that in other sectors, with the top five international companies dominating more than half of the market. The power and authority of the pharmaceutical industry will not only be profoundly changed but will also be massively increased since not only the industrial sector as it is, but also laboratories, will have become a substantial part of this sector. (The same trend towards concentration on the part of customers, HMOs, hospitals, etc.) This trend towards concentration is due, amongst other things, to the appearance of generic products which lead to an erosion in prices and therefore in the profit margins as soon as the patent for a drug runs out. Another factor contributing to this concentration is the exploding cost of research and development. The cost of the research and development needed to develop a new drug is currently estimated at more than 500 million dollars.

In order to maintain its profit margins, the sector is responding by stepping up its sales efforts, expanding its activity into other regions, whilst improving the effectiveness of its tools of innovation. One way to achieve these objectives is for companies to group together and power to be monopolised.

Since the pharmaceutical industry has the privilege of creating, developing, producing and selling diagnostic and therapeutic drugs, the all-important question is to know to what extent the subject of its business will be subjugated to its purposes. We know that the purpose of any industrial activity is to ensure the continuance of that activity. In other words, the questions will be: which drug, for which indication, at which price, for which patient, of which country and all this for which profit margin?

Having said all this in plain language, we should also point out that although the pharmaceutical industry has the capacity and power to discover, produce and sell drugs, it is not up to the industry to make unilateral decisions about which product will be marketed in which country, or what the indication or the price will be. Although the pharmaceutical industry has substantial technical, scientific and commercial power, its authority is rather limited as it is probably the economic sector with the most controls. Clearly, this is not a free market economy.

The pharmaceutical industry's decision-making power is exercised at very different levels, but particularly in the following areas;

– choosing the therapeutic indication on which research will be focused;

– and the price at which the drug will be marketed.

It is clear that this decision-making power is not unilateral but is the product of interaction between at least three partners, i.e. the patients, directly or through their doctors, the governmental bodies concerned, and the industry.

Power to innovate

The pharmaceutical industry is, at it were, the only organisation in the world which has the technical and financial capacity to discover and develop drugs. This quasi-monopoly gives it enormous power and responsibility in terms of the type of drugs developed.

All decisions relating to the therapeutic indication on which research will centre take at least three elements into account: the scientific and medical validity of the therapeutic approach under consideration, the ethical dimensions and also the economic reality.

Let us take depression as an example of a therapeutic indication. We soon agree that from a medical and ethical point of view a treatment should be found for this condition – one of the possibilities being treatment with drugs.

Using drugs to treat the condition not only responds to a medical need and falls within the commonly accepted ethical context but also satisfies the necessary economic criteria because it involves a population of patients who come from

rich countries, a population which is growing and has satisfactory purchasing power. Against this background, we can conclude that depression is an indication which is basically accessible and attractive to the pharmaceutical industry.

Likewise, the treatment of bacterial or viral infections (AIDS, hepatitis, etc.) is a field of activity which is accessible and acceptable

to the industry, both from the point of view of therapeutic need and in terms of ethics and economic constraints. In fact, as in the case of depression, there are enough people who can get drug treatment, so investment is justifiable from an economic point of view. However, unlike depression, the need for treatment is at least as great in underprivileged countries and, if conditions for accessing the drug are favourable enough, these populations will also benefit from scientific and therapeutic progress.

The same cannot be said for other diseases specific to underprivileged countries. Nothing or too little is being done by the health authorities about these diseases which still have no treatment.

It seems that the choices the pharmaceutical industry is making are geared more and more towards deluxe indications.

As we have already mentioned, the costs of research and development have increased enormously. This explosion is partly due to the sophistication of research and development tools, but also to the attitude of the licensing authorities and those whose job is to fix retail prices and/or reimbursement rates.

Although a group of 1,000 patients was needed a decade ago for the clinical development of an antibiotic, the number has increased more than tenfold and the cost has risen from two million to 100 million dollars. By setting up an increasingly strict and demanding framework, the bodies responsible for approving drugs – such as the FDA in the United States and the EMEA in Europe – quite rightly wish to prevent the marketing, or limit the use, of drugs which could have serious side effects, even though they are rare, even very rare, i.e. between 1 in 1,000 and 1 in 10,000. Not only is no one questioning this principle but it is also gaining support from all sides. However, the zero risk temptation is not without serious consequences because it puts a brake on therapeutic progress and the spread of this progress. It is an illusion too that zero risk is attainable and the pharmaceutical industry will one day be able to supply patients with highly effective drugs with no side effects.

The explosion in the costs of development due to this desire to minimise as much as possible the exposure of populations to the risks of side effects and the restrictive attitude of the authorities towards approved indications, these two factors, combined with the authorities' increasing reluctance to agree a satisfactory price and/or reimbursement rate for the industry, are causing a noticeable shift in business towards deluxe treatments. These are commonly called lifestyle therapy, for which a certain group of patients and also the health insurance schemes in some countries are willing, if necessary, to foot the bill. With regard to this type of indication, evaluation of the three criteria mentioned – medical validity, ethical criteria and economics – is rather different. In fact – if we take two well-known examples – the need for treatment for erectile dysfunction and the morning after pill may be less obvious than it is for myocardial infarction. And although the ethical question is more complex, we have to admit that, insofar as these types of drugs are not subject to a price or reimbursement fixed by a government authority, and there are many people who wish to stay young, beautiful, healthy and immortal, the industry is finding an area where its economic criteria are satisfied.

The merit of these examples, whether it is myocardial infarction, depression, antibiotics or lifestyle drugs, is that they raise one or two questions:

– Thanks to its capacity for innovation, the industry is pushing back the boundaries of knowledge and what is possible, and as a result is generating new ethical questions. Does the industry have the right to make an ethical decision in advance or should the ethical question be debated by society first?

– What price is a society like Western Europe willing to pay to save life, preserve or restore health or even ensure the comfort of its citizens?

– Is there a scale of values between a society's need to treat its patients suffering from depression, cancer or heart trouble and another society's need to overcome the spread of infection through hygiene programmes?

– And if man's underlying dissatisfaction leads to insatiability, is it the industry's right or duty to define the limits of what is acceptable and what is not?

– What is the benefit which legitimises a particular ethical decision?

It is also important to tackle the question of the area of treatment chosen by the pharmaceutical industry in the light of what we understand by health.

Once upon a time in countries like ours and even today in underprivileged countries, the notion of health was easily defined by the fact that you were firstly alive and secondly that your physical and mental condition was such that you could work in order to support yourself. Also, it seems to me that the notion of health was adapted to the rhythms of life.

However, the notion of health changed profoundly during the last century in the West to the point where we can talk about a change in paradigm because it is no longer a

question of being alive but of living forever in physical and mental comfort. For a ninety-year-old, health means running in the marathon and experiencing the sort of passion one had as an adolescent.

The pervading hedonism has profoundly changed our expectations of the pharmaceutical industry. We no longer just expect drugs which prevent and fight disease so that we can continue to meet our obligations, we want drugs which guarantee us comfort, wellbeing, even happiness. In this sense, the pharmaceutical industry, with the aid of the drugs it supplies, is in danger of transforming itself or having itself transformed into a dispenser of happiness.

Although the industry can prevent and heal physical and mental illness, it cannot be used to treat metaphysical anxiety.

Being unhappy is not the same as being ill. If that much is clear, it must also be clear that the industry does not have the right to stand in for other authorities nor to define the boundaries of ethics nor to give verdicts about a patient's condition, a notion which, God knows, is ever-changing and relative.

Health, which used to be centred mainly on a condition which could be viewed with relative objectivity, is now turning into a myth of immortality, of life without suffering or discomfort. By holding health up as a myth, regarding it as sacred, the reality of death is being refuted ever more radically, even violently, and as a result absurdities in treatment occur. At an extreme level, we expect the pharmaceutical industry to eradicate death and disease and ensure that consumers do not have to bear the consequences of their actions, either physically or mentally.

And although patients hope for all these benefits from those whom they would like to regard as magicians of life – you only have to read the headlines in the press – they do not like this industry which reminds them that there is no treatment without risk and that health has a price.

Depending on the choices it makes, depending on how it responds to excessive and extravagant expectations, depending on how it uses its power and the credulity of its customers, the industry will reduce the patient to the level of a consumer by becoming an industry for well-being, or it will remain credible by continuing its efforts to preserve and restore health.

The cost of drugs

The question of the cost of drugs is particularly emotional and reflects the tension between the right to health on one hand, and common perceptions about the authority and power of an industry which gets rich from illness.

Health is generally regarded as the most important commodity to which every human being has a fundamental right. But does fundamental mean free? The question of cost takes on a highly sensitive dimension when one looks at the monopoly granted through obtaining patents. It is a widely held belief that the drugs industry not only has a monopoly on research and development tools but also legally protects its discoveries and exercises price control. If, indeed, the industry does have a monopoly on research and development, it also invests an enormous amount of capital in projects with a high financial risk. According to the current logic of economic models, it hopes for the appropriate return on investment. So during the initial protection period, which in practice is about ten years, the industry is only partially subject to the laws of supply and demand and, as a result, prices are generally very high. However, it is important to note that in many countries these prices are not worked out but fixed by government authorities and that if the market is worth the stakes, competition will soon appear with rival products causing price erosion. In addition, as soon as the drug, becomes generic, prices will drop suddenly and very significantly.

If the industry has reached its profitability targets, civil society also takes a substantial and lasting profit from the innovative effort because the generic drug is now available at a very modest price. If during the period of exclusivity only the most privileged strata of society and the richest countries can treat themselves to these expensive treatments, they can also be regarded as the financiers of innovation. In other words, we are dealing here with a mechanism for redistributing wealth.

The United States of America, where prices are still unfixed, finances a substantial part of the research and development effort. Whilst the American market represented about 30% of the world market in 1980, it reached 40% in the year 2000 and will probably reach 50% by 2010. The main reason for this is the erosion of prices in other parts of the world, particularly Europe and Japan.

So, for example, some products cost five to ten times more when you cross the frontier between Canada and the United States. One wonders what will become of innovation in treatment when the United States refuses to bear the financial costs of it.

The question of price is particularly heated in countries where the price of drugs is not fixed and the vast majority of citizens do not have medical insurance. This is obviously the situation in many countries which are economically weak, but is also the case in the United States, broadly speaking.

As we have seen, in choosing the therapeutic indications on which it focuses, the pharmaceutical industry is deciding who – rich and poor countries or only rich countries – will have access to which type of health, basic treatment or deluxe treatment.

Implicit in this choice is the question of price, profitability and consequently, perpetuity. This choice draws a line between those who will have and those who will not have access to health.

Let us polarise the situation so that we can examine the extent, but also the limits of the pharmaceutical industry's power and authority.

At an extreme level, we could say that the drugs industry is faced with the choice of either providing remedies for the important infectious diseases in the third world – diseases which claim millions of lives every year – or of solving health problems in rich countries. Answering this question means, in other words, giving up the idea of

making a profit, or ensuring one's financial *raison d'être*. The first attitude would call for a complete and total rethink in the sector to guide it in a new direction, that of saving the underprivileged.

This reductionist approach to the problem probably does not get us very far. It would be extremely ambitious to imagine that the pharmaceutical industry could save the third world. The question of health will never be resolved without the active participation of govenements, international organisations and NGOs, nor without setting up the necessary infrastructure effectively and permanently,

What emerges from all this is

that although the industry has a duty to face up to facts and provide answers to the ethical and social questions which are asked, we would be mistaken in implying or suggesting that it has the power, authority or responsibility to save the world. This type of simplification leads to a bogus debate in which the victims are still today's underprivileged.

The problem of making health care accessible to everyone comes down to guaranteeing everyone's fundamental right to life. This problem is not a problem for industry, as recent events concerning AIDS in South Aftica have wanted us to believe, but a problem for society. We just have to look at tuberculosis which affects more than 25 million human beings throughout the world and causes more than three million deaths every year. An effective drug to fight it, no longer covered by patent and accessible at cost price, is available. However, for many reasons, but mainly the incompetence of the parties concerned, this problem, which is medically and technically solvable, continues to wreak havoc.

All the same, the industry can in principle phrase its response to the ethical and social problems by putting a limit on its profits. It can draw this limit by developing drugs needed mainly or exclusively by the most underprivileged and/or putting forward treatments which concern both the rich and poor, but adjusting the price.

Up till now, the industry has adopted the two approaches more or less voluntarily. Firstly, it has on several occasions and quite recently agreed to make treatments available to the most disadvantaged under the best possible financial conditions. The example of laboratories which have decided to supply certain sections of the populations with their AIDS treatments at cost price, shows how difficult it is, in the light of the reactions it has caused on the other side of the Atlantic, for the industry to adopt an attitude which reconciles its responsibilities to society and its economic imperatives. Giving up some of its profit for the benefit of the sick in South Africa caused a very virulent reaction from AIDS sufferers in the United States who demanded to have the drugs on the same terms. I would like to say that the lead ought to be taken here by States, particularly rich countries.

Furthermore, the pharmaceutical industry is involved in, and is even initiating, health programmes which it knows from the outset will bring no financial benefits. For example our laboratory is running a nutrition programme for babies in South America for several years and actively supports the movement for palliative medicine in Europe.

The question is not of knowing whether the pharmaceutical industry does or does not have the fight to act like any other industry, but the drugs industry itself must define how generous it is.

Against this background of the relative, not absolute, it is interesting to study the underlying paradigms which govern our economies.

As stated by Professor F.J. Radermacher of Ulm University, European logic is generally based on the paradigm of equality (the right to health insurance, social security, right to education ...) whilst North American logic is based on the principle of who is the strongest (anything goes, each man for himself...). The world of economics and consequently the drugs industry are increasingly subject to the paradigm predominating in North America. This leads to exaggerated expectations of profitability on the part of shareholders and company chairmen, The notion of "shareholder" value has blinded chairmen and shareholders alike who, obsessed by money, forget that – when all is said and done – you cannot take it with you and hope stifles expectations. It is important that the European paradigm is used as a counterbalance – as Hendersson from the Organization for Economic Development so rightly said – not to suppress capitalism but to channel it towards social, economic and environmentalist goals.

In order to manage a company, it is imperative to be responsible and respectable, whatever the sphere of economic activity, but in health particularly. Neither respectability nor responsibility can exist without generosity and detachment.

What is kept rots, what is given away flourishes.

(Auvergne proverb)

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PIERLUIGI ZUCCHI

7. Religious Power and Health

Introduction

'Health and Power', the general title of this sixteenth international conference, and the more specific subject of 'Religious Power and Health' which has been entrusted to me, fit perfectly into present-day social needs and indicate the aspirations and the goals embraced by the Church in the sensitive field of health care as well.

The relationship between religious power and health, which is indeed a closely connected tandem and has for that matter been present in all the epochs of the Christian era and is linked to the close mutual ties of each element, is rightly re-proposed today with an attention and interest that is even more marked than was the case in times past. This relationship is to be located within a wider context of the dialogue produced by the interaction between the Church and the temporal order, between the Church and the state, and between the Church and political, economic and cultural life. From a historical point of view, there have always existed, and there still exist, currents of thought which have denied and deny that the Church should have any power in the temporal sphere, just as for that matter there exist systems and men of culture who expect the Church to provide concrete solutions.

Saint-Simon, for example, in his work 'Nouveau Christianisme', in addressing the Pope of that time, expressed himself in the following terms: 'Your predecessors sufficiently developed the theory of Christianity and sufficiently propagated that theory. You should concern yourself with the application of doctrine. True Christianity should make men happy not only in heaven but also on earth. Your task is to organise the human species according to the fundamental principle of divine morality. It is not enough for you to preach to the faithful that the poor are the loved children of God; you must employ with frankness and energy all the means of the active Church to rapidly improve the moral and physical state of the most numerous class'.

From this approach one grasps the marked importance of the immanent character of the mission of the Church, which necessarily must always be in constant dialogue with the inescapable parameters of the transcendent order.

The Definition of Power and Health

I will commence, therefore, with a definition of power and health and then dwell upon the various more specific aspects of the subject of 'power and health'. The term 'power', according to the most widely accepted meaning of this word, means the possession by an individual or collective subject of the ability to achieve his, her, or its own goals in a specific sphere of social life despite the contrary wishes of other people or forces. Many scholars have disagreed with this very restrictive and widely criticised definition, and they have adjusted it or even replaced it.

Popitz argued in favour of the idea that other parameters should be inserted into the definition of power, parameters such as 'authority', understood as a kind of power based upon prestige; 'dominion', understood as institutionalised power; 'violence', understood as the extreme expression of power; and 'technical action', which, by increasing effectiveness, is said to increase the potential of (social) power. Luhmann, for his part, maintained that 'power is nothing else but a code of generalised symbols that makes possible and disciplines the transmission of selective services from one subject to another'. The definitions of power and also the currents of thought of the scholars just referred to provide a reductive vision of the concept of power, and this is not acceptable to the Christian vision because it is to be identified, and exclusively, with a utilitarian and not an ontological approach.

I will attempt, therefore, to provide an ethical definition of power by identifying it as a *parameter exclusively referred to man as a person, as a property within the perspective of being, and thus Having in relation to Being, by which entity it is necessarily and not accidentally directed.* This ethical contextualisation ennobles the concept of power not only from an axiological point of view, that is to say with respect to values, but also from an ontological point of view, because it becomes an entity in relation to being. Power, therefore, defined in these terms, can aspire to enter the axiological hierarchy of values because it leads to the realisation of ethical parameters of life. This is because it becomes an objective instrument in the transcendent design of God for man.

One understands, therefore, how only the dimension of authority open to transcendence can find concrete expression at the level of power, whereas authority closed to transcendence can descend to incomprehensible levels which can give rise to authoritarianism or even violence or abuse. In this way, the move from *wanting* to *wanting to do* takes place through the lived experience of *being able to do.* Hence one grasps the fundamental role of the incarnation of transcendence in political power – a phenomenon which is the full expression of the sacred on behalf of man.

Power, therefore, must be exercised as a service, to the benefit of man as a person, as indeed Leo XIII emphasised in his encyclical *Rerum Novarum:* 'power comes from God and is a certain participation in di-

vine sovereignty and must be administered taking this as an example, which with paternal care provides for individual creatures as much as it provides for the whole universe'. The most important pedagogic teaching in relation to power comes from Jesus, and even though it concerns above all else those who occupy a position of responsibility within the hierarchy of the Church it cannot fail to apply also to those who occupy positions of responsibility in other sectors – for example, the leaders of nations. 'You know', affirmed Leo XIII, 'that those people who are held to be the leaders of nations have dominion over them and exercise power over them. Amongst you, however, this is not the case; whoever wishes to be great

amongst you will be a servant, and he wants to be the first amongst you will be a servant to everyone'. This was a new way of introducing and conceiving the concept of power as authority *(auctoritas)* which concerned both the order of salvation and the order of the creation. It will not be, therefore, the members of society who are at the service of those who hold power but these latter who will be at the service of the former. All Christians, therefore, members of the laity and those who belong to the Church hierarchy, are called to be witnesses in a new world in which power works to free itself from its immanent prerogatives and moves towards transcendent positions to become a more effective instrument of divine providence. Merleau Ponty wrote: 'a Christian is an element of disturbance as regards established power since he or she is always elsewhere and it is never possible to be certain about him or her. But for the same reason he or she also disturbs revolutionaries who feel that he or she is never totally with them'.

Power, therefore, must be at the service of the person, that axiological entity which represents one of the great conquests of Christianity. The concept of the person, in fact, is lacking in classical culture and in all other cultural contexts (Sgreccia). Today more than ever before it is precisely through religious power in sensitive contexts such as health care that it is necessary to emphasise with force the value and the primary importance of the human person, who is increasingly threatened by forms of totalitarianism which can be traced back to different cultural and political trajectories. It is commonly observed, how variegated collectivist, but also individualistic, positions tend to want to influence Christian language with grammatical rules that are not acceptable from an ethical point of view because they are based upon force and overbearance and not upon human values which are certainly more incisive, such as those which are based upon love and brotherhood amongst men.

Coming, instead, to the definition of health, I believe that nothing needs to be added in the least to the definition proposed by Javier Lozano Barragán (2000) who affirmed that 'human health is a movement towards spiritual, social, psychological and physical harmony and not only the absence of illness, which makes the person able to carry out the mission which he has received from God, according to the stage of life in which he finds himself'.

Religious Power and Health Care Culture

One of the fundamental functions that religious power exercises specifically in the sphere of health care is that of promoting the message and the values of the Gospel by incarnating them in the cultural physionomy of each individual, especially if that individual is sick. This form of inculturation finds its perfect model in the incarnation of the Son of God. With the Incarnation, in fact, 'the divine is incarnated in the human and the human is fulfilled in the divine, but in such a way that the divine is not lost in the human and the human does not dissolve in the divine' (G. Pittau, 2000). One of the principal tasks, therefore, that the Church continually gives herself in exercising her religious power, above all in the world of health and health care, is that of fertilising every culture, which thereby becomes new because it is enriched by Christianity. In this work of inculturalisation we should not, however, reduce Christianity to mere humanism and we should avoid humanising and relativising the mystery of God revealed to us by Christ or divinising man or a certain cultural trajectory. The whole of this great effort engaged in by the Church finds a broad terrain for implementation in the sphere of health and health care, where the teaching of charity is exercised. The teaching of charity must, first of all, educate man to safeguard himself from those exaggerated forms of functionalism by which everything that is useful, that produces, that makes a profit, with the euthanasia-inspired elimination of any entity that is not productive, including a human entity, is held to be true. From all this one grasps the marked importance of the presence within a society which is so consumistic, pragamatistic and hedonist in character of a strong religious power which is able to advance with authority the co-ordinates by which it is possible to defend and promote the interests of everyone, and above all of the weakest members of society.

The Relationship between Religious Power and Faith-Science

Another aspect to bear in mind when we are addressing the context of health care is the relationship between religious power and faith-science. Catholic health care workers must always aim for the truth and be able to communicate it so as to enter into contact with other cultures. The search for Truth always springs from Love. It is from love of truth that the passion for research is born. The scientific method which the researcher adopts in the inquiry he or she has to carry out constitutes the criterion of discernment with regard to the truth to be loved and the non-truth not to

be loved. To stress the relationship between science and faith means to stress the relationship between science and love for the truth. Religious power in the domain of health care can find its incisive point through the instrument of an evangelising dialogue directed towards the suffering person. This dialogue, therefore, represents the first moment of the communication of the truth whose acceptance arises from the truth itself. And the transmission of faith acquires great incisive strength when an appropriate grammar of communication is employed.

Religious Power and Communication

In our society, indeed, the transmission of culture seems to be marked by contradictions such as the incapacity for dialogue, or, in contrary fashion, the spasmodic and constant search for points of encounter. In a consumistic and hedonistic society, communication is often distorted and is projected very far away from the essence of truth and the real reasons of life. Today the bodies dealing with information and the raising of awareness exercise great power, which, when not based upon ethical premises, runs the risk of transforming this giving of otherness into objectives that involve the search for profit or cultural manipulation. Every form of dialogue at the root of every power, and above all religious power, is based upon the acceptance of otherness as the diversity and freedom of the other person, and these are parameters by which man must enter into relationships and interact with the every day. Religious power, therefore, in every context, but in that of health and health care above all else, tends to welcome and understand the needs and the forms of diversity of the other through dialogue and the communication of right words represented by Love and Truth: 'this last can be greater than Love only if we believe that Love is the Truth in which we have believed' (Schinella, 2001).

The Incisive Character of Religious Power in Health and Health Care

The increasingly present and pressing relationship between the expressiveness of the tangible parameters of religious power and health and health care transpires in our society with increasingly marked force. However, economic sponsorship seems to be obtained with increasing difficulty and the provision of concrete help to the confessions constitutes, as other researchers also emphasise (Ferrari and Iban 1997), one of the most sensitive features of the present state of affairs. Economic sponsorship directed towards the needs of the Church has such an effect on the ecclesial institutional structure that it is 'the mirror in which she can gain self-understanding, understand her relationship with the state, as well as her position in relation to the faithful' (Helmut Pree, 1993).

Religious Power and Models of Finance: or Having in Relation to Being

Every religious structure, in order to exercise power directed towards the ethical needs of man, must necessarily have forms of finance, and thus economic resources supplied by public and/or private bodies. In Europe the models for the financing of the various confessions differ from State to State according to the sensitivity of the legislature. Indeed, there are States which prohibit the provision of any kind of state finance to confessions, amongst which may be listed Ireland, Holland, Portugal and Great Britain. In France, instead, the constitution, since 1958, has emphasised its own secular physiognomy, or rather secularist physiognomy, and thereby not allowed many opportunities in this area. On the other hand there are countries which tend to provide oxygen to and nourish their own religious confessions as long as these exercise correct religious power within society and in this sense have inserted into their own constitutions forms of state finance. This is something which takes place in Belgium, Denmark, Germany, Italy, Spain, Hungary, Sweden, Finland, and, outside the European Union, Norway and some cantons of Switzerland. The diversified forms of economic support provided by States which are prepared to help religious confessions in this way bear witness to an ethical identification of the basis of funding and the social relevance of the religious factor, a factor inherent in every community which wishes to define itself as being civilised.

Religious Power and Health in the World

Never before has man been so forced to accept such marked and growing discrepancies in income and health. The move towards greater justice between the peoples of the world and towards a globalisation of rights to help the poorest and the weakest amongst us seems to have experienced recurrent inhibition despite the efforts of international meetings, including those which have taken place recently. The Erice Conference of 26 March 2001, on 'Fairness and the Right to Health', provides us with data which are truly disturbing because: 1) the populations of the richest and most industrialised countries have an average life-span near to eighty years of age whereas the populations of many countries in Africa and Sub-Sahara have life expectancies which are at times even lower than forty; 2) the people afflicted by HIV/AIDS in rich countries have free drugs and medicines available to them which are effective against this infection and illness, whereas people afflicted by HIV/AIDS in poor countries often do not have access to this kind of treatment; and 3) almost nine hundred million people in the world do not have access to essential health care services. These data clearly emphasis the systematic dismantling of the principles of the safeguarding of the dignity of the human person, respect for life, and fairness, and indicate that health is increasingly becoming a consumer good.

From this utilitarian view of health, one can grasp how important it is for the Church – the great bearer of universal ethical and spiritual values which it proposes with authoritativeness *(auctoritas)* – to strive in an increasingly incisive way to enter and be present in immanent situations of power *(potestas)* so that this is directed towards man as a person, made in the image and likeness of God, who should be defended from conception until

death. This personalist position of Christian ethics should stimulate a strong moral responsibility on the part of scientists. Man, therefore, must be placed at the centre of the world, and above all at the centre of the world of health and health care, as a person.

The *person* in this way must be seen as the fundamental entity be-

tween the natural world and the spiritual world, who is provided with *will* as self-determination by means of which every individual establishes a relationship of transcendence with his or her own acts which he or she can dominate and direct in relation to a goal represented by *moral value.* Religious power specifically bears upon this moral value by trying to create ethical directions in defence of the progress of man. 'For the Christian', as Cardinal Tettamanzi observes, 'progress is not only to be blessed (when it is placed at the service of man), but constitutes more specifically a blessing, an uninterrupted echo of the blessing of God, who has entrusted the world that He created specifically to man, to his intelligence and to his dominion'. 'The essential meaning of this...'dominion' of man over the visible world', emphasises John Paul II, 'which the Creator himself gave man for his task, consists in the priority of ethics over technology, in the primacy of the person over things, and in the superiority of the spirit over matter' (John Paul II, *Redemptor Hominis*, n.16).

Religious power, therefore, in its relationship to the world of health and health care as well, provides a teaching which is very incisive in character with the result that the Christian feels responsibility and gratitude in relation to such a valuable gift.

The medical doctor and the man of science are required to engage in prudent and ethically rigorous vigilance so that progress comes to be expressed in an increasing service to man, to the whole man, and to all men. Hence the absolute and undelayable urgent need for an alliance between science and wisdom. Our epoch, more than was the case in past centuries, needs this wisdom so that all its new discoveries become more human and to ensure that men of science bear in mind that what is technically possible is not necessarily morally licit. The Magisterium of the Church, with its own moral authority, constantly seeks to exercise in the sphere of health care a religious power which emphasises that only 'awareness of the primacy of values allows a use of the immense possibilities placed in the hands of man by science that is truly directed towards the promotion of human person in his or her entire truth, in his or her freedom and dignity' (John Paul II, Apostolic Exhortation, *Familiaris Consortio,* n. 8).

The medical doctor and the scientist can also exercise power in the domain of the world of health and health care. Science, indeed, gives man power, even though ethical parameters should be placed on the use of this power.

Scientists, in fact, are able to allow the employment of the results of research but they must not become the arbiters of the destinies of the world (E. Agazzi, 1980). Religious power which is well exercised, therefore, must not only seek the defence and promotion of the health of each and every man but must also sensitise the doctor-scientist, who as a human person has the duty to respond to certain particular values such as the good, the right, and the honest, adopting an approach of loving responsibility towards the suffering person.

Still, absolutely one of the most important values in relation to which the medical doctor both as a human person and as a scientist must be made sensitive is the value of the life of man and of nature. From these observations one understands that the highest result of *physical health* in a patient must begin with the acquisition of the concept of *ethical health* on the part of the person looking after this state of physiological necessity, that is to say the medical doctor. One grasps, therefore, how the sensitisation of religious power as regards the cultural formation of the medical doctor is of fundamental importance and how the medical doctor must be educated first as a person and then as a medical doctor with regard to his or her moral responsibility towards the values of love for nature, for the human person, for life, and above all else for God, the source of eternal life.

Religious Power and the Defence of Life

The value parameters of axiological ethics applied to theological ethics lead us at the present time to an examination of one the most burning questions to involve man as a person, namely the defence of life from conception until death. Religious power, exercised by the Magisterium of the Church, rightly goes on emphasising, and above all in the world of health and health care, the untouchable principles of life seen as a transcendent gift (Honings, 2001).

In present-day society, in which principles based on hedonism, on pragmatism, and on consumerism prevail, the ethical concept of the *sacredness of life* seems to have few chances of being listened to because it is in a utilitarian way counterposed by that of the *quality of life,* which is seen as an absolutely inalienable parameter for the upholding of the rights of the individual, and this as if respect for the value of life was not also something which involved its quality as well. Hence one can well understand that whereas contemporary man encounters difficulties in understanding the ontological reasons for respect for life, it is easier for him to reflect upon its anthropological reasons when he observes that contemporary culture is fragile at the level of ontological reason but very receptive as regards inter-subjective relations. Religious power, strong in its transcendent ethical position, constantly stresses the distancing from freedom – con-

ceived in nihilistic and anarchistic terms – which is involved in the often exaggerated position of the omnipotence of technology, which tends to favour solely narcissistic personalities, or rather immature personalities, which are in a perennial state of conflict and subject to the most serious psychopathological forms of cyclothemia marked by continual swings from depressive syndromes to facile forms of schizophrenic violence.

We need to emphasise deep respect for life beginning *ab ovo* with the principles of the Magisterium of the Church and by proposing in an incisive way a set of ethics of life and thus of motherhood, not in the sense of an ethical regulation of motherhood but in the sense of a set of ethics which sees motherhood as its paradigm, of a set of ethics, that is to say, 'that begins with an awareness that life is sharing and is developed in the form of a decision in favour of the self-limitation of one's own dominion and as a welcoming of, and care for, the other person who is a value in himself or herself' (Tettamanzi). We must, therefore, stress that life must not be thought of as an objective and anonymous good which belongs solely to another person but should be seen as an axiological parameter representing the good and health of everyone. This is because every man tends to progress and to evolve only with the progress and the evolution of the life of another man and a lack of receptiveness to the possible or actual life of another person leads to an inevitable reductionism in relation to his or her own life as well. It is indispensable, therefore, for us to create points of reference for mental, physical, and ethical health for ourselves and for others, where the other person is, first and foremost, an end, and not a means by which to provide solutions to one's own concerns and goals.

We need, therefore, to follow an anthropology rooted in a metaphysical sense in ontology, bearing in mind that to welcome life must inevitably place us in a position to welcome suffering and pain as well.

Religious Power and Pain

On this point, to bring out how much religious power, as a transcendent and immanent entity, can be incisive in the sphere of health and health care, I would like to draw attention to the most important points of the results of research published two months ago, research which I carried out with Prof. Honings, a moral theologian, and with Prof. Vogelin, a medical physicist, on the relationship between faith, prayer, and pain. In this paper, we demonstrate, with scientific data and an accompanying statistical analysis, how faith and prayer, which are *a priori* entities of religious power, can raise the pain threshold, or rather enable the patient to feel less pain, when he or she is afflicted by painful syndromes. An initial study (Zucchi, Honings, 1996) was carried out on a sample of 120 patients with very encouraging results. Stimulated by this outcome, the authors expanded the case study to include 1,104 patients and examined whether the transcendent element of faith and prayer could influence the results of treatment and the pain threshold in different ways according to the various pathologies taken into consideration.

On entering the ward or clinic the pathology responsible for the situation of pain was ascertained. The various pain-inducing pathologies thus encountered were divided into four groups: central pain, oncological pain, articular pain, and myofacial pain. The patients were then sub-divided according to a random criterion (the chance allocation of patients) into two groups – the 'S' (study) group and the 'C' (control) group. Each group was composed of 552 individuals. The incidence of the pathologies of the two groups was the following:

central pain: 157 patients (69 C and 88 S);

oncological pain: 236 patients (109 C and 127 S);

articular pain: 358 patients (190 C and 168 S);

myofacial pain: 352 patients (184 C and 169 S).

The distribution of the various pathologies of the individuals subjected to examination in this trial is described in Table 1.

Both groups received pharmacological treatment involving non-steroid pain-killers and vitamin C administered parenterally. Group S also received a therapy known as the 'spiritual transcendence test' (STT) which was made up of reflection on a reading taken from a passage from the New Testament. This passage, taken from the First Epistle of the Blessed Apostle John, was given to the patient, who was then asked to read it with care and attention. This passage was the following: 'God is love; and he who dwells in love dwells in God, and God in him... his love has had its way with us to the full, so that we can meet the day of judgement with confidence. Love has no room for fear; and indeed, love drives out fear when it is perfect love, since fear only serves for correction... we must love God; he gave us his love first. If a man boasts of loving God, while he hates his own brother, he is a liar. He has seen his brother, and has no love for him; what love can he have for the God he has never seen? No, this is the divine command that has been given us; the man who loves God must be one who loves his brother as well. Everyone who believes that Jesus is the Christ is a child of God, and to love the parent is to love his child. If we love God, and keep his commandments, we can be sure of loving God's children. Loving God means keeping his commandments, and these commandments of his are not a burden to us. Whatever takes its origin from God must needs triumph over the world; our faith, that is the triumphant principle which triumphs over the world' (1 John 4:16-21; 5:1-4).

The treatment lasted ten days. On the first, fifth and tenth days a psychophysical assessment of the pain experienced by the patients was made both immediately before and two hours after the treatment. This treatment involved giving medicines to the control group (C) and medicines together with a reflective reading of the passage from the New Testament to the study group (S).

The psychophysical assessment of the intensity of pain was carried out using a visual analgic scale (VAS). This VAS scale was a ten centimetre-long simple straight graph whose initial and final points corresponded to a subjective estimation by the patient of the highest and lowest levels of pain that he or she perceived. The patient registered the level of pain perceived by placing a sign on 'L' (Fig.1). At the end of the treatment, that is to say at the end of the tenth day, the patients were

Pathology	N. of cases			
	C1 -298	C3 – 352	A2 – 254	A4 - 200
Migraine	13	19	6	5
Cluster headache	19	22	14	12
Tension headache	53	55	50	42
Trigeminal neuralgia	5	7	6	5
Deafferentation pain	6	9	6	5
Pancreatic heteroplasia	9	12	7	5
Pulmonary heteroplasia	12	16	8	6
Gastric heteroplasia	14	17	13	10
Renal heteroplasia	7	9	7	6
Vescical heteroplasia	7	9	7	6
Uterine heteroplasia	5	7	6	5
Testicular heteroplasia	3	5	5	5
Spinal arthrosis	68	72	60	50
Scapulohumeral periarthritis	2	3	7	6
Gonarthrosis	8	10	8	5
Coxarthrosis	13	15	8	5
Rheumatoid arthritis	5	7	7	5
Backache	31	35	13	10
E.D. sciatica	18	23	16	7

Table 1 - Different pathology distribution into 4 subgroups:
C1 = believers treated with STT;
C3 = believers not treated with STT;
A2 = agnostics treated with STT;
A4 = agnostics not treated with STT.

asked whether they were believers or not, and thus two typologically classes were obtained: 'C' (believers), made up of 650 individuals, and 'A' (agnostics), made up of 454 individuals (Fig. 2).

To sum up, the results of this study were the following:

a) the patients who were believers had a *higher initial threshold with regard to the perception of pain* than the agnostics, and thus felt less pain. We can describe this phenomenon as the 'faith effect'. The patients who were believers also had a better analgesic response when they received only the medicines (the control group) and this phenomenon was even more marked when the medicines were accompanied by prayer (the study group).

b) the patients of the study group who also received treatment with prayer had a better response to the

Fig. 1 - VAS Scale: L is a segment on which the patient marks the level of pain perceived. The segment between the marked point and the point of "no pain" is measured in centimeters.

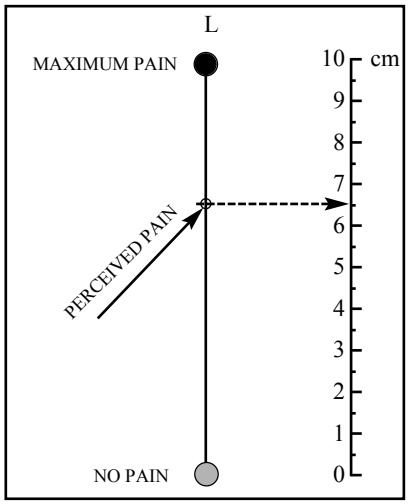
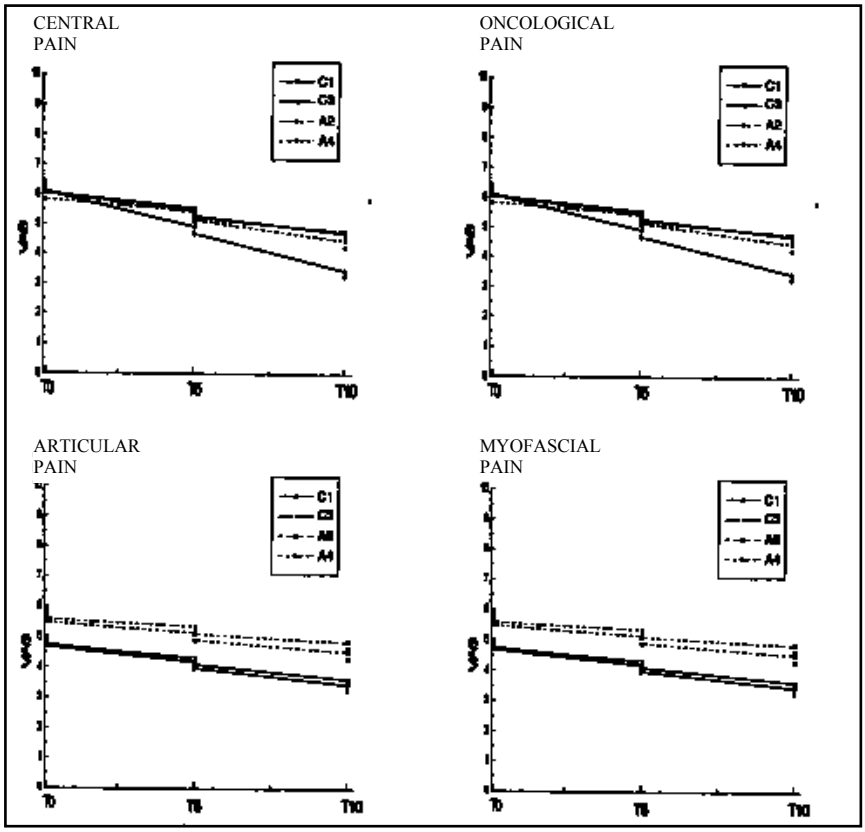


Fig. 2 - Average values of VAS in 6 determinations made on 1st, 5th and 10th day in patients with different pathology: central, oncological, articular and myofascial; of classes:
C1 = believers with STT;
C3 = believers without STT;
A2 = agnostics with STT;
A4 = agnostics without STT.



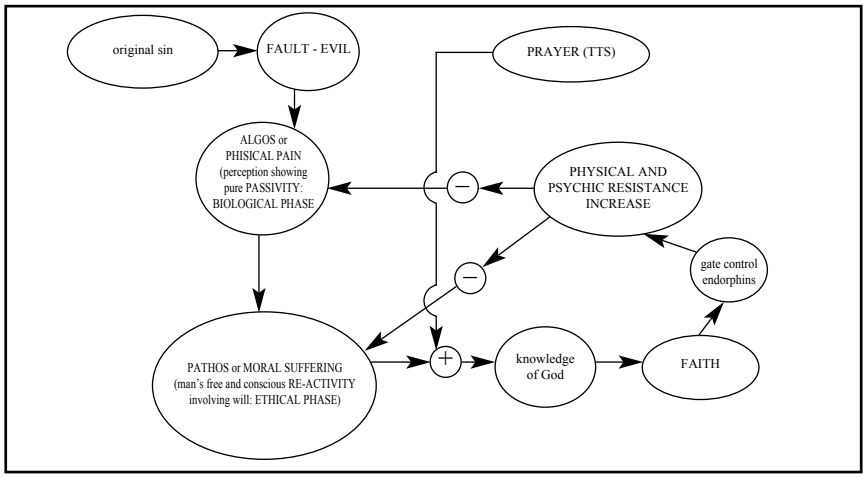


Fig. 3 - Pathophysiological mechanism which points out how faith and prayer modulate the perception pf a painful stimulus.

pharmacological treatment than those who were not treated in this way, *whether they believers or agnostics*. We can describe this phenomenon as the 'prayer effect'.

The Effects of Faith and Prayer in the Various Sets of Painful Symptoms also Vary According to the Different Pathologies Subjected to Examination

In the case of *central pathologies* (for example of the cephalus), the faith effect has a lesser effect in terms of basic perception of pain, but if the condition of faith is linked to prayer this produces a better result in terms of the effects of treatment (the prayer effect). It may be suggested, therefore, that the stimulus of prayer in these pathologies activates and regulates the neurophysiological and neurochemical mechanisms which were previously inhibited by excessive and disordered central activity.

In the case of *oncological pathologies*, the *faith effect* is more important that the prayer effect. We can attribute this phenomenon to the special psychological condition of 'alarm' in which the patient finds himself or herself. In this condition the mechanisms by which pain is inhibited are forcefully activated and they are less receptive to other external stimuli, such as that produced by a thoughtful reading of a passage from the New Testament.

In the case of *articular and myofacial pathologies*, faith and prayer produce similar effects, and from this it can be deduced that the mechanisms at work in these conditions are equivalent.

The physiopathological mechanism by which the condition of faith and prayer modulate the perception of a painful stimulus can be explained in the following way (Zucchi, Honings, Voegelin, 2001, Fig. 3):

a) *neurphysiologically:* through the activation of the descendant inhibitory bands which modulate the condition of the injurious stimulus bringing about a lower perception of pain (the 'gate control theory', Melzack and Wall, 1965).

b) *neuropharmacologically:* through the freeing of endophines, endrogenous substances of an opium-like character with an analgesis effect, which block the algonenic receptors at both a central and a peripheric level.

Conclusion

From this study it can be demonstrated scientifically that *religious power,* through the transcendent element of *faith* and the instrument of *prayer,* can operate within such a sensitive context as the world of *health*, in which, indeed, it can have a *therapeutic* effect and as a consequence a beneficial impact on clinical results, opening people's hearts and minds in the very special circumstances of illness, suffering, and pain.

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III. THE ILLUMINATION OF REALITY

DIEGO GRACIA GUILLÉN

1. Power and Health in History

Introduction

The word 'power' now has a strongly negative connotation. Reference is made to the power of money, to the power of the mass media, or to the media powers or to political power and so forth, and this always involves clearly pejorative tones or meanings. We remember the famous phrase of Lord Acton: 'all power corrupts and absolute power corrupts absolutely'. However, the term 'power' cannot be reduced to its merely negative dimension. And this not only because it has a clearly positive dimension but above all else because power is a fundamental ingredient of human life. Human existence is certainly not possible without the presence of a complex system of powers. Hence the need to analyse this term with precision.

The theses that I will seek to defend in this paper are the following. The first is that history consists of the consignment of power to human beings and this makes them able to do things, to construct their own lives; thus history is a process which involves the transmission of possibilities. The second thesis is that history, as a process of the transmission of possibilities, has always had an ambivalent character. This means that in it there is never the creation of positive possibilities which do not have as their collateral consequence the appearance of negative possibilities as well. In other words, history both makes possible and makes impossible at the same time, or makes positively possible at the same time as making negatively possible. Health, in this sense, is a positive possibility of life and illness is a negative possibility. The third is that the result of the historical transmission of possibility is what we call human culture, which should thus be defined as a system of human powers which are both negative and positive. The fourth thesis is that these powers always have a moral dimension and thus that there should be a clear differentiation between the dimension of power of actions and their dimension of what ought to be. There are things that one can do and there are things that one must not do, and there are things that one must do and things that one cannot do. The fifth and last thesis is that there is never perfect concordance between the order of power and the order of what ought to be, and thus nobody completely does what he can and must do, and this is the reason why every human life and every moral project to a certain extent ends in failure. Hence the need for a superior reality, a supreme power, which all cultures have always defined as divine power.

I. History as a Process of the Transmission of Possibility and Culture as a System of Power

The term '*potere*' ('can', 'to be able') in Italian has two distinct grammatical functions; it is both a verb and a noun. As a transitive verb, '*potere*' is the ability to do something and always of necessity refers to a subject which can be grammatically represented by a noun ('Pietro can fly') or by a pronoun 'I', 'you', 'he' ('he can fly') etc. When, in contrary fashion, it functions as a noun it is preceded in Italian by the masculine definite article '*il*' ('the') ('the power of multinationals'). It is one thing to say 'I can' and another to say 'the power'. The difference between the two meanings of the Italian word '*potere*' is important. The first in time was the first of the two, which has a concrete nature, whereas the second is an abstract noun which is thus seen as being posterior in time and derived from the first. 'Power' as a noun always results from the actuation of the capacity or potential of the human being to act and to do things. As is well known, this is

what led Aristotle to differentiate between potential (*dynamis*) and the act itself (*enérgia*). Potential or possibility is one thing; power is quite another. The Latins translated these ancient Greek words with *potentia* or *facultas* on the one hand, and *actus* on the other. In other words, when we substantiate power we transform it into a reality that is underway, the result of the actuation of a potential or faculty. Powers exist, they are a reality, and in their turn they become the source of new possibilities. Hence there exists a dyanmic of power. Power begins as a human creation, the result of the exercise of a potential or internal possibility. But this human creation, which is strictly subjective, ends up by objectifying itself and becoming transformed into a reality, which in turn is a source of new possibilities. This is what with Hegelian terminology one could term the 'dialectic of power'. Power as potential belongs to what Hegel would call the 'subjective spirit' because power as an act or reality, the system of powers, constitutes the plot of the Hegelian 'objective spirit'.

This allusion to Hegel is relevant because it demonstrates the importance of power in history. Indeed, history is the process of the transformation of natural resources into possibilities and powers, or, to employ other terms, it is a process of the transmission of possibilities; and culture, the result of historical actuation, is the system of powers that human beings construct beginning with natural resources. History is the process of the transmission of possibilities and culture is the result of this process, the system of resulting powers. Just as possibilities always become objectified and end up by gaining distance in relation to the individual that created them, so we should say that culture is the system of powers that human beings create on the basis of resources.

Taking this as our starting point, various terms which are very important in life and history acquire meaning. The first is the term 'wealth'. Wealth is always a possibility of life. The person who has more possibilities of life is richer, and the person who has less such possibilities or none at all is poorer. It is a mistake to think that wealth is to be identified with resources. Wealth is not resources, except in those rather rare cases where natural resources are in themselves possibilities of life. This happens rarely. The normal thing is that resources need a process of transformation in order to be transformed into possibilities of life. Oil was a natural resource but it acquired meaning and value for human beings when they invented the combustion engine. This means that resources are natural but that possibilities of life are historical. Thus the process of the transformation of resources into possibilities, that is to say the process of the generation of 'wealth', is what is known as 'labour'. This is another term which it would be wise to retrieve. There cannot be wealth without labour. Adam Smith began his great work *On the Nature and the Cause of the Wealth of Nations* in the following way: 'The annual labour of every nation is the basis from which derives all the provision of necessary and convenient things for life, what the nation consumes every year and always is the immediate product of this labour, or in what is bought by that labour from other nations'. Wealth, therefore, is the same as labour because labour is necessary so that natural resources can be transformed into possibilities of life.

An example will clarify what has been said hitherto. Beginning with the resources of nature, and the exercise of his potentials or faculties, that is to say through work, a human being is able to construct, for example, aeroplanes that permit the rapid transportation of people and goods for long distances in an incredibly short time. Once invented and built, aeroplanes become substantive realities because they have a life that is independent of those who invented and built them. They are realities the possession of which confers power. For example, to possess warplanes confers military power; for this reason we say that those who have a large number of warplanes have great military power etc. In turn, these realities, these powers, increase our possibilities of life. Thus, for example, they allow us to move from one place to another, something that was impossible for man two centuries ago, impossible even for Leonardo da Vinci, who nonetheless dreamed of flying. In short, powers give us the possibility to do things that the men of previous generations could not do.

From all this we must conclude something that is important, that is to say that culture is a system of powers that becomes transformed into a source of historical possibilities. History, therefore, is the process of the transmission of possibilities. This is what has been proposed by among others Heidegger and Zubiri. History is the process of the transformation of natural resources into possibilities of life. This is what human beings do on the earth, always with the same objective, that of influencing in the best way possible their ways of life on the planet. We are always dealing with the modifying of nature to the advantage of human beings with the objective of making their lives better, healthier, more beautiful etc. What happens is that human beings know no means of transforming resources into positive possibilities of life that do not collaterally also generate negative possibilities. As Kant observes in one of his famous passages, a medicine and a poison are often different only at the level of intention. A knife can be used to eat or to inflict a wound, and atomic energy can both heal and kill at the same time.

This explains how culture is a complex system of positive and negative powers, and probably an increase of the former is inconceivable without an increase in the latter as well. Thus the increase in prosperity is a source of new illnesses such as, for example, the so-called illnesses of civilisation. There can be no doubt that illnesses are negative possibilities of life, just as health is a possibility of life. These last powers are defined as being good whereas the others are defined as being bad.

To recapitulate, therefore, it should be said that history is the transmission of possibilities and that culture, which is the result of the historical impact of man on nature, is a system of powers. We have seen, for that matter, that such powers can be positive and negative, that the first are called good and the second are called bad. From this it

emerges that all of them are always and necessarily the subjects of a moral definition. This is the second point, the request for ethics of power, the analysis of powers as powers of good or of evil.

2. Power and Duty: the Powers of Good and the Powers of Evil

Human beings because of their own biological condition are not a mere natural reality but a moral reality. The Spanish philosopher

Xavier Zubiri explained this by comparing the biological reality of human beings to that of animals. Animals, declares Zubiri, in order to live must adapt to the environment or disappear. When during the course of biological evolution a being is born which is incompatible with the environment in which it has to exist, its life becomes impossible and as a result the animal disappears. An animal of the African desert would die at the North Pole and in the same way the penguins of the Antarctic would die out in the equatorial zones. Physical disappearance means that the transmission of the genetic information to descendants does not take place, or that it is very seriously compromised, as a result of which its ecological space comes to be occupied by another being with more suitable biological properties for that specific environment. This is the law of the 'survival of the fittest', which was established by Charles Darwin.

An animal either adapts to its environment or it disappears. This led Zubri to say that an animal lives in natural 'rightness', that is to say in an 'adjusted' way to the environment. The case of human beings is completely different. First of all, human beings do not adapt to the environment in which they live according to the mechanism described above. The early pre-Socratic thinkers realised this. In more recent times this fact has led reference to be made to the biological 'impotence' of human beings, or even of their 'eccentric' or 'deficient' character. If the adaptation of man to the environment depended only on the mechanisms that we have explained above, without doubt he would already have disappeared from the face of the earth. His biological penury is very evident. Man does not have a good sense of smell, nor good sight; he is not very fast and does not have great muscular force. The Darwinian law of the survival of the fittest would have made him disappear a long time ago.

The only biological superiority of human beings is to be found in their intelligence. This was a new quality in the evolutionary process that allowed them to adapt to any environment by means of a mechanism that was completely different from all those that had gone before. Intelligence, indeed, allowed human beings to adapt the environment to themselves rather than having to adapt to the environment, as had happened during the whole of biological evolution. In other words, intelligence is not adaptation *to* the environment but the adaptation *of* the environment to human beings. This adaptation of the environment is what we call 'culture'. For this reason, human beings do not adapt naturally to the environment like animals do, but through intelligence they must do, *facere*, their own 'adjustment', their own *iustitia*. They must engage in their own adjustment, *facere iustum*, and thereby 'justify themselves'. All of this leads Zubiri to say that man is not a natural animal but a moral animal; he does not live in natural rightness but in moral justice.

It follows from this that all the activity of human beings on the earth, everything that we call 'history' and 'culture', is a process of justification, that is to say moral activity. Morality is not something added to human reality or a quality enjoyed by certain people, or something that we exercise through specific acts of our lives. Morality is the intrinsic and essential condition of human beings such that they cannot be moral in all their acts. In other words, the process of the transformation of nature into culture, which is what human history is, takes place through their own moral character.

Now, given that culture is as we have seen a system of powers, and history is the process of the transmission of possibility, it follows that these powers will be positive or negative, good or bad, according to whether they condition the life of human beings to good or bad effect. There are good powers and bad powers according to whether they condition the lives of men to one of these effects.

There is a first kind of power of evil, what Zubiri calls 'malevolence'. This is the physical impossibility to do something that corresponds or belongs to human beings in virtue of their own natures. This is, therefore, a physical defect which impedes something from being 'done' and as a result impedes a possibility of life as well. The doing, the *facere*, is altered, and in this sense reference is made to evil. What is malevolent corresponds to what is classically understood as 'physical ill', a bad adaptation to the environment. Illness is malevolent because it does not allow us to do certain things with our lives. Health, in contrary fashion, is benevolent because it is a source of possibilities of life.

There is, however, another kind of deeper and more serious evil, moral evil, bad intention. This is what 'malice' is. Malice is a source and root of possible evils, or to put it differently the negative intention to make possible or the intention to make possible in a negative way. Here we have a deeper level than the level previously mentioned because it adds bad will, the wish for evil and the wish to do something evil. If we have defined history as a

process of the transmission of possibility, we must now say that malice is the transmission of negative or positive possibilities. History is constituted through acts of bad intention or malice, or in contrary fashion through acts of good intention.

And more may be said. In history there is not only malevolence and malice but also the malign, which is inducement to evil, that is to say drawing others towards evil. The person who does this is not only bad but also malign. It is for this reason that the Bible calls the devil 'the Malign One', *ponerós*. The term appears with a certain frequency in the Gospel according to St. Matthew (5:37; 6:13; 13:19; 13:38), the Gospel according to St. John (17:15), in the letters of St. Paul (Eph 6:16; 2 Th 3:3), and in the first letter of John (2:13; 2:14; 3:12; 5:18; 5:19). In the Lord's Prayer, in Italian, God is asked to deliver us not from evil but from 'the Malign' (in the Latin translation, *a Malo*).

Lastly, there is 'wickedness'. Wickedness is the objectification of evil; the transformation of evil into an objective spirit, that is to say into culture. And, if one wants to put it another way, evil transformed into power, the power of evil, the culture of evil. Malice is subjective; it is bad intention. But the acts of bad intention and the acts of inducement into evil, and thus the acts of malice and wickedness, become objectified, they are transformed into objective spirit, into culture. This is the objectification of evil, the culture of evil. Evil acquires substance and its own life. From simple bad intention we have passed to the power of evil; evil that is to say understood as cultural and historical power. This is what the Bible means when it speaks about the powers of the Evil One (Lk 10:19; Ap 13:2), and *a sensu contrario* of the 'Powers' or 'Potencies' as angelic categories (the Powers of good: Rom 8:38; 1 Cor 15:24; 1 Pet 3:22).

Many years ago, in 1935, Zubiri wrote: 'together with original sin and personal sin we should introduce as a subject into theology sin of the times, *historical sin.* This is the 'power of sin' as a theological factor in history, and I believe that it is essential to say that this power acquires concrete, historical forms according to the times. The world, in every age, is endowed with special graces and sins'.

Malevolence, malice, the malign and wickedness, and their opposites, constitute the ethical geography of power. The first three cover the area of power as possibility: as physical possibility (malevolence) and as moral possibility (the morally negative intention of malice and of inducement into what is malign). Finally, there is objectified power, the objectification of power: wickedness.

All of this can be applied to the subject we have before us – that of health and illness. It is obvious that health is a positive value and that illness is a negative value. As physical or biological characteristics, health and illness belong to the first of the above described levels, that of malevolence and benevolence. But every human act, as we have already said, has a strictly moral dimension, and thus what we do with our bodies, with our lives and with our health has such a dimension as well. Health and illness are not therefore mere physical phenomena but also, and at the same time, moral facts. Above all else it very much depends on correct, wrong and unhealthy objective structures; and thus on incorrect, inhuman and unhealthy historical and cultural structures. Illness is not a mere individual phenomenon, it is also social; and thus social and historical structures condition the health and illness of individuals and populations in a radical way. For this reason, the problem of health and illness is not merely a question of power but also of duty. The power that does not adapt itself to duty is in itself a negative value. These are specifically the powers of evil.

3. The Power of the Real: from Obligation to Binding

As we have already seen, power has a number of dimensions. There is the economics of power, the sociology of power, the psychology of power, the ethics of power, and so forth. And there is also, and here I want to refer to the conclusions of this paper, a metaphysics of power. We may remember, for example, the 'will to power' of Nietzsche.

This subject of the metaphysics of power has been studied a great deal, starting with Nietzsche, and above all else by philosophy during the twentieth century. The reason is the following. Modern philosophy, which began with Descartes and culminated in German idealism, and especially in the work of Hegel, always began with subjectivity and self-awareness as the principle and foundation of the whole of philosophy to the point where the self was

what necessarily had to take the philosophical initiative and go intentionally towards the non-self, that is to say towards things. The natural result of this kind of procedure was, obviously enough, idealism. Contemporary philosophy has sought to engage in metaphysics beyond idealism, to go beyond it on the basis of a radicalisation of the point of departure. The original experience of human beings is prior to any initiative of the self or the subject. The radical wonderful thing is that we find ourselves with things that appear to us in a surprising way in the field of the consciousness and which are imposed upon us without any active intervention on our part. More than the 'position' of things on the part of consciousness, as idealism had it, we should speak about 'imposition'. Things impose themselves on us, they exercise 'power' over us. Here we have this word once again. But now it does not have a historical, cultural or ethical meaning, but a strictly philosophical and metaphysical one. Reality imposes itself on us. It was for this reason that Heidegger said that the primary, original element is not so much the *ousia* or substance of the ancient Greek philosophers but rather the *parousia*, an ancient Greek term which as is well known means 'presence', 'manifestation', or 'revelation'. It is not we ourselves who reveal things but things which reveal themselves to us. Everything, human life, history, is a constant process of revelation. Reality reveals itself to us and in so doing imposes itself on us as well.

Zubiri made a number of precise observations in relation to this picture. His thesis is that reality not only reveals itself but also imposes itself on us. This means that reality has 'power' over us. This is what he calls the 'power of the real', the beginning and foundation of the phenomenon he calls 'binding'. Given that reality does and can tie us, it binds us (this is the meaning of the Latin verb *religare*, to bind), and we are, whether we like it or not, bound or joined to the power of the real, which imposes itself on us in its triple condition of 'ultimate', 'possibilising', and 'impelling' power. The power of the real is our basis, it provides us with possibility, and it impels us. This is, therefore, a power that provides possibilities. We are once again here in the dialectic of power and possibility which has been our subject from the outset. And it is in addition an impelling power. This means that it pushes us forward, it forces us to engage in life, for and beginning with real things, starting from reality. For this reason Zubiri says that 'binding' is the foundation of every 'obligation'. We are obliged because we are bound. In other words, the power of the real is the foundation of our moral obligations, of the promotion of positive powers and the avoidance of negative powers.

Zubiri goes further and says that binding is the natural foundation of positive religion. St. Thomas Aquinas said that grace does not destroy nature but improves it. We must state something similar in relation to binding which is not destroyed or annulled by positive religion but improved by it. When one moves from binding to religion, the foundation of the power of the real is to be identified with a personal being, God, and the three characteristics of the power of the real that we have pointed out, that of 'ultimateness', 'possibilityness' and 'impellingness', acquire a new character which is resolutely religious, which Zubiri calls 'worship', 'supplication' and 'refuge'. Those who would like further clarifications on this point may read Zubiri's book *El hombre y Dios*.

I would like to conclude by alluding to a rather surprising fact which is at the base of the relationships between binding and obligation. This is the fact that there is no human life which does exactly everything that it should do, and thus there is no moral life which is absolutely fulfilled. This means that in history there necessarily co-exist the powers of good and the powers of evil, given that nobody does completely what they should do. Hare calls this 'the moral gap'. Every moral life finishes in one way or another in failure. Hence the need for supernatural and trans-historical healing. Obligation necessarily leads to binding.

Conclusion

In synthesis we should say that history is the transmission of possibility and that culture is the objective system of powers. Without these, human life is impossible. This means that power is not in itself good or bad but is inescapable for human life, and thus is the condition for the development of man to take place. The problem is that these powers can be negative or positive. Health is a positive power and illness is a negative power. Health is a positive power because it provides us with the possibility to do things, to realise our lives, whereas illness impedes this. This is from a moral point of view. But there is a second dimension to power which is not physical but moral. There are moral and immoral powers, and thus ones that are positive or negative from a moral point of view. This means that power cannot always be confounded with duty. This then led us to study the moral dimensions of power, above all the negative dimensions: malevolence, malice, the malign, and wickedness. All of these, and especially the last three, are morally negative powers. The last, the power of wickedness, is structural and thus supra-individual; it has a social and historical character. It is the power of economic, social and cultural (etc.) structures, those which are morally negative. To this power we refer when we speak about economic powers, or media powers, etc. Lastly, we saw that it is not possible for positive powers to exist in history without there also being corresponding negative powers. For this reason, moral life finishes in one way or another in failure. Nobody can do everything that they should do, and should not do everything that they do. Failure is inherent in every moral life. This explains why there is a need for a reality which cannot be historical and must be trans-historical and supernatural. Every life needs redemption and salvation. This is the goal of religion. This healing power is God. He is, therefore, the ultimate power over health and illness, good and evil, life and death.

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2.Theological Reflection on Power and Health

Premise

'All authority in heaven and on earth has been given to me' (Mt 28:28). It is significant that this phrase, with its reference to power, is to be found amongst the last words of Jesus before he returned to the Father. Perhaps for our present-day sensibility one could expect everything except a reference to such a subject. And yet it is precisely this text which allows us to verify from closer to hand the meaning of the power to which Christ was referring and its influence in the history of mankind and in our personal existences. In order to understand to the full the biblical meaning of power, and more directly the meaning that is implicit in this text, we should engage in a brief survey. The term expressed by ancient Greek does not appear often in Holy Scripture; however the concept seems to cut across the whole sacred text in a transversal way. The king, the prophet, and the messenger are all invested with the power that is given to them by God and He remains the guarantor of every power with which man is invested. In addition, He alone is the righteous judge of every use that is made of that power. If somebody abuses the power that has been entrusted to him or her then this power is taken from him or her and given to another person. The case of Saul is certainly emblematic on this point.[1]

If we fix our attention on Jesus of Nazareth, one of the most evident elements which comes to the fore is his own awareness that he has received his power from God, with whom, indeed, he constitutes a single unity: 'I and my Father are one' (Jn 10:30). He, in fact, is invited to make people know the will of God, he does what he has seen the Father do, and he proclaims the same words. The first power that strikes his contemporaries is the authority with which he teaches (Mt 7:29); and with the same power he forgives sins (Mk 2:10), heals the sick, casts out evil spirits, and carries out all kinds of miracles (Mt 9:8; 10:1). His resurrection, furthermore, allows us to see in him the fullness of divine power. As the text with which we began puts it, '*all* authority' was conferred on him, and this, therefore, was global power, which extended to 'heaven and earth', that is to say to the whole creation. For every person he became the bearer of salvation which was marked by a cosmic dimension. This salvation opens up to, and reaches out to, every man, in every land and in every age.

The Icon of Icarus

This premise was needed so as to engage in a further theological reflection, which, in the contemporary context, seems to bear upon power in relation to health. In a period such as ours, which is subject to one of the most complex cultural changes that has ever taken place in the history of humanity, the relationship between power and health is not at all obvious. That there exists a power *of* health is increasingly one of the advances that characterises the progress of contemporary science and technology. That there exists equally a power *over* health has emerged as a subject of reflection and debate bearing upon the various domains of social, political and ecclesial life. From whichever angle one seeks to approach our set of questions and issues, it appears clear that the relationship with power involves man in the first person to such an extent that one can affirm, without fear of contradiction, that the management of this power is of determining importance for the very subsistence of man. The power over life and death which man in some fashion seems to have gained must be managed with profound discernment so that the power of this advance does not turn against him, overwhelm him, or make him succumb.[2]

One could easily read the trajectory of modernity and seek to describe the precursors of post-modernity with reference to power. That man in his advance has achieved a set of forms of knowledge which allow him to enter the most concealed avenues of the mystery of nature and the creation is a fact which should make us happy. The ability achieved by man to transform nature and to modify the conditions and the relations between different elements has allowed him to achieve within himself such an energy that he has imposed it on nature itself with the passing of time. Holy Scripture is aware of the force of power and of the kind of exercise of power that man is called to engage in. From the first pages of Genesis, the sacred author tries to make us understand that it is essential for man to live by the power that has been given to him by nature. In him there is a propensity to this exercise because he has been created in 'the image and likeness of God'. However, he is responsible for this power. The sharing in divine power imposes on him a responsibility in relation to the creation which has no parallel. His 'dominion' (cf. Gen 1:28) over nature is not, and cannot be, realised in total autonomy; it is in close relations with other things so that everything can be maintained in its original order and led to the final end to which it has been destined. To summarise: in living by the power which has been entrusted to him, man increasingly understands himself.

Strongly marked by this relationship, the ancient era was more greatly characterised by fear about nature and by a sense of its inviolability. Modern man, in contrary fashion, is fascinated by advance and by the power to impose his authority on nature. Is it not obvious, therefore, that in this moment of epoch-making change the question should be raised: how will post-modern man

relate to nature? Will this be a reality which can still be transformed or will it react in such a way as to go against man and his boldness? A reference to the myth of Icarus in this context may lead to a teaching that is not without significance. Attracted by the desire to fly, the young Icarus went higher and higher without realising that his wings were made out of wax. If on the one hand his flight towards the sun provided him with a fascination which led him to risk what was unthinkable, on the other hand, it brought with it his destruction. The calls and the shouts of his elderly father, Daedalus, were of no use: after experiencing the joy of freeing his son from the slavery of the labyrinth he had soon to experience the sadness caused by the tragedy of his death.

Nature is not without a soul. It too carries within it an order that the Creator of everything placed there so that it could be developed, certainly, but not altered. The power achieved by man today over nature seems to elevate him to the level of a creator. The fascination exercised by this advance, however, is not without its consequences. It brings with it results that modify the relationship which hitherto he has had with the creation. It is for this reason that the myth of Icarus emerges as an icon which should be thought about. The power of man is a shared power. If, on the one hand, it allows him to see his supremacy over nature, on the other hand it forces him to see himself within a wider process of nature which he cannot subvert because he does not belong to it to the full. He is called to be a guarantor because what comes from his hands can reflect his power but also his limitations.

Without balance and without discernment in relation to power, it is illusory to think that it can really serve the progress and civilisation of mankind. The impetus behind the natural need to provide a support to his own life obliges man to discover new means and instruments by which to achieve the certainty of his own safety. The availability of such means and instruments, however, must lead to a consideration of the character and the nature of the need and of its satisfaction. In the discovery of increasingly new stages, indeed, a separation from a necessary ethical judgement which assesses not only their effectiveness but also whether they are necessary and good, is something which cannot be justified. Every kind of advance can fascinate; but it can also deceive. Power which is achieved can certainly express an exercise of authority, but if it is not accompanied by a cultural defence it leads to disaster. As is well known, power and its exercise belong to the development of the creative activity of man, but because of the complexity of relationships which are brought about, questions and issues arise and ethical reservation is required as a normative moment for real discernment.

This dimension allows us to understand that in power there is a dual connection: on the one hand, there is the discovery of the energy specific to the activity of man by which he shapes and subordinates the creation; on the other hand, there is an awareness of his own power and of the further principle that he has to establish the objectives of power itself and its limits.[3] This consideration leads to power being always and only seen as a gift made over to mankind. If mankind does not experience it as such – the fruit of free-giving and not of a search – it will be difficult for mankind to live with it with the due responsibility and within the horizon of a service. It must be stewarded with care because it is kept in 'earthen vessels' (2 Cor 4:7). As is well known, we are face to face with a process of self-awareness which requires the assuming of responsibility.

Power as Responsibility

The principle of responsibility in this context imposes itself as a fundamental element in the approach to power. It is paradoxical that modernity, which arose under the banner of the search for the autonomy of the individual who had become mature and responsible in his actions, has handed on to post-modernity an individual who is in a state of great crisis regarding the principle of responsibility. As regards our subject of analysis, it is of undoubted importance to try to understand the assuming of responsibility which is specific to science. The power that science has over health, and which expresses itself broadly in the power of experimentation, seems to be absolute. The objective of health and well-being is seen as a principle whose unstoppable character becomes imposed as a result of the specific peculiarities which it possesses because of the fact that it is an expression of progress. To require that science, in addition to the power that at a practical level it possesses in an undeniable way, also acquires a responsible approach to its processes and the conclusions that it reaches, is, however, an inescapable act which the whole community cannot withdraw from. A wild kind of experimentation which often and increasingly involves the use of fertilised human cells certainly demonstrates the Janus-faced countenance to which science is subjected. To give science a serene and benevolent face is a task which cannot be delayed. One might say that it is a service of power which approaches science as awareness of

a readiness to engage in the provision of service to man, something which can never be against nature.

In every cultural context genuine sapiential reflection allows the discovery of the dangers of power. The presence of evil in our actions is not an invention designed to paralyse progress but an experience which is undergone every day. Power can lead to disaster through pride, arrogance, and contempt for law. To move ahead we need moderation, justice and above all else humility. This is a word which has fallen out of fashion and yet it is the only term which allows us to grasp the real meaning of things. This is because it is able to place them in their right context. If modernity has wanted to eliminate such a virtue by identifying it with weakness, post-modernity must be able to grasp its deepest meaning and return it to the position of which it has been deprived. Humility, indeed, expresses the force of freedom. To welcome it means to know how to choose the direction to be given to life, what meaning to give to death, and what weight to give to what surrounds us. It is characteristic of the humble person to perceive the essential and to live according to it, relativising the various forms of the ephemeral which tend to deceive and to conceal the real meaning of life. This approach is not something to which post-modern thought can be insensitive given that it has been able to grasp an important feature of epoch-making change by recognising the weakness of reason. If reason has become weak, however, this is not due to its incapacity to grasp truth but to the pride with which it has wanted to organise and arrange everything. A retrieved sense of deep trust in reason and its abilities can favour a renewed sense of power and greater readiness to direct powers towards a good which knows how to be universal.[4]

And it is in this context that the words of the Apostle become normative for us: 'for when I am weak, then I am strong' (2 Cor 12:10). The weakness of man, argued St. Paul, becomes almost the pulpit from which God make His power felt and allows its signs to be verified. What makes man powerful is not his self-enclosure or his mere trust in the instruments of his science, but his opening himself up to the other through an act of the greatest trusting self-abandonment. The experiencing in his own existence of the weakness of illness can allow him to grasp the essence of life and to perceive the strength by which to resist. Each person, because of his or her personal dignity, is called to give meaning to pain so as not to leave space in his or her own existence to non-meaning and to the absurd. The power of health is also the power with which its absence is received and meaning is given to its non-presence. The power that is developed through being confined to a bed allows us to reach what often escapes us: the power of our inner being, even though it is dressed in the clothes of fragility. The power of health, however, is what favours an understanding of what is essential in life. John Paul II rightly writes in *Salvific doloris* that: 'those who share in the suffering of Christ have before their eyes the paschal mystery of the cross and the resurrection... this means that weakness of all human suffering can be permeated by the same power of God, which was manifested in the cross of Christ. In this approach, suffering means becoming particularly susceptible and particularly open to the salvific powers of God, offered to mankind in Christ. In him God confirmed that He wanted to act especially through suffering, which is the weakness and the nakedness of man, and wanted specifically in this weakness and this nakedness to manifest his power. With this one can also explain the recommendation of the first letter of Peter: 'if one suffers as a Christian, let him not be ashamed, but under that name let him glorify God'' (n. 23). In this sense the words of the Apostle acquire greater meaning: 'I can do all things in him who strengthens me' (Phil 4:13).

Health as a Concrete Sign of Redemption

We bear within us the signs of our membership of nature. More than any other reality, our body allows us to experience ourselves as being written into the limits of nature marked by sin. In this sense, the Apostle Paul was rightly able to say: 'the creation itself will be set free from its bondage to decay' (Rom 8:22). In the light of the resurrection, indeed, 'this perishable nature must put on the imperishable' in order to bring out the glory of those who have believed in the risen Lord. Healing from illness and the acquiring of security in relation to health which can be felt in one's own body can lead to an understanding of how privileged the con-

dition of man was before the ruin of sin took place: the *goodness* and the *beauty* of man and the creation (Gen 1:3), where illness, mourning and weeping did not exist. Christians, however, read the value of corporeity not only in the light of the creation but above all within the horizon of the resurrection, the real centre and origin of faith.[5] It is in this space that the health of the body takes on all its full value, which the creation cannot supply. With the reference to the creation, in fact, faith is inevitably brought back to the mark of sin imprinted into the flesh; with the resurrection of Christ, instead, the body is raised in the glory of the intra-triune life where there is neither sin not death but only fullness of meaning and glory. The resurrection says life and fullness of life without end. Christ transformed all of this in his risen body as a foreshadowing of, and a pledge for, the same destiny for us. In this, faith perceives the ultimate provocation that is given to intelligence so that we can think of going beyond the limit imposed on it by sin because of the freedom of the creation.

In the light of the resurrection, Christian faith affirms that the body is much more than a mere anatomical extension. It represents, instead, a reality without boundaries which is certainly placed in history, space and time, not, however, to be subordinated by them, but, rather, to live out in them its own vocation to move towards the infinite, expressing within itself the same infinite and eternity. In the resurrection the body remains the principal agent, an entity which is in no way deprived of its nature. It is filled, instead, with its fullness. What various historic epochs may have obscured with their arguments about the body does not hinder us from affirming that only Christian thought has known how to lead corporeity to the highest levels of comprehension by placing it in the most intimate spaces of nearness to God. No religion could allow itself to come to insert the transformed corporeity of man into the life itself of the Trinity. Only faith in the incarnation could allow a reaching of the most extreme consequences of God making Himself man. Health as a condition which is imposed on every creature out of respect for the dignity of the person, and of every person, allows us to understand the central contents of the Christian faith. It indicates the pathway that we are called upon to follow: to live – beginning with the present moment a – personal existence that is full of meaning and of sense so that the promise of fulfilment can be perceived and experienced, and this is a fulfilment where there will be no illness, lament, or death.

Conclusion

We live with our gaze fixed on the future but we are full of a sense of tradition and of our past. In his famous *De la Démocracie en Amérique* ('Democracy in America'), A. de Tocqueville wrote: 'there will thus come an epoch when we will be able to see in North America a hundred and fifty million men who are equal, who all belong to the same family, who will have the same starting point, the same civilisation, the same language, the same religion, the same habits, the same customs, and through whom thought will circulate in the same form and will be marked by the same colours. Everything else is a matter for doubt – this, however, is certain. Here, then, we have a fact which is entirely new in the world and which even the imagination cannot grasp to the full'.[6] The challenges that have come together in recent years within the ambiguous term 'globalisation' have, as is known, distant roots. We increasingly live in cities which are the same. The world is becoming increasingly small and perhaps monotonous as well because of an inability to link shared originality with special tradition. But everywhere on earth there is man with his strengths and his weaknesses. A smile, like a tear, does not have a particular cultural connotation: it has only the force of feelings and the spirit, something which is specific to man.

It is in this context that the value of health and the fragility of illness must be placed and located. In the world in which we live it is intolerable that the power *of* health has boundaries which act to relegate the advance of science to a few advantaged hands. By its very nature, this power opens up to a universal vision which is capable of including within it above all those who most need well-being. This power allows us to offer them a ray of hope which will enable them to look at the future in a different way. The dangers of power *over* health which acts to privilege only a fortunate few are real, but it impoverishes those who possess it. Indeed, a limiting use of such power would turn against those who possess it because it would only act to place them at its mercy. The more medicine moves forward, the more it seems to bestow value upon the spirit. It is not unusual for medicine to recognise that the health or the illness of the body begins with the health or the illness of the spirit. Are not the illnesses which are most commonly encountered in the West those which are connected with the condition in which modern man lives?

The specific responsibility of believers brings with it the proclaiming of hope in the resurrection. We know that the body lives in the condition of having been redeemed and saved, but in us this certainty comes from the force of conversion. Power should be transformed and should receive that *metanoia* which is needed for it to return within its proper confines. This is the condition by which we can draw near to new and positive advances that will allow us to live out power as an act which participates in a call which points out the mission to be followed and not only a role to be performed.

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Notes

[1] Cf. *1 Sam* 15:23; 16:14.
[2] Cf. JOHN PAUL II, encyclical letter *Redemptor hominis*, n. 15.
[3] Cf. R. GUARDINI, *Il potere* (Brescia, 1963, or 1951), p. 13.
[4] The subject is addressed by the encyclical of JOHN PAUL II, *Fides et Ratio.* For an application to our subject see cf. J.L. BARRAGÁN, *Teologia e medicina* (Bologna, 2001), pp. 47-58.
[5] Cf. C. ROCCHETTA, *Per una telogia della corporeità* (Turin, 1990) and M. TEANI, *Corporeità e risurrezione* (Rome-Brescia, 1994).
[6] A. DE TOCQUEVILLE, *De la démocratie en Amerique* (1835, II, Conclusion).

BRIAN JOHNSTONE

3. The Moral Frontiers of Power and Health

As was said by Cardinal Angellini in his opening address, those who deal with health care issues from within the Catholic tradition must communicate with those who are also concerned with promoting health but do not belong to that tradition. In this presentation I will propose a way in which we might do this. In other words, I will seek to show how we might present the Catholic position to others, in the realm of "public reason." By public reason I mean those ways of thinking and judging without which it would not be possible for people to live together in a pluralistic but unified democratic state such as Italy, or the United States. Public reason requires that when positions are taken on important matters, touching the protection and fostering of human life, these must be justified. They must be justified, not only by arguments which are coherent with a particular group's convictions, but which are communicable within the society as a whole. Only if such reasons are communicable to others, will they be able to collaborate or to criticize; without such collaboration and criticism a democratic society cannot exist.

The case I wish to argue is this: In the terms of such public reason, it is possible to develop a notion of minimal justice, which could be acceptable to all. Further, with that notion of justice in mind, if we are confronted with two patterns of society, one of which excludes some from participation in society, without reasoned justification, while the other does not exclude any from society, then the second ought to be preferred on grounds of justice. In particular, I will seek to show that the pattern of society based on the liberal view excludes some, while that corresponding to the Catholic position does not.

First it is necessary to define the terms of the argument. In a general sense, the term 'power', means the capacity of a subject or a group to control other subjects or groups or entities belonging to the natural or social environment, by acting upon them. In the social context, power refers to the authority to require the obedience of others and the capacity to influence their behaviour. Every society is a system of relations of power, ordered in some form of hierarchy, and structured for the purpose of fostering cooperation or competition.

Power is essential to human society. The task of ethics is to discern the principles which ought to guide the use of power in human society. These principles will be based on justice. In the context of this conference, I propose that a social-political system ought to be considered just, in a positive sense, when it sustains the participation of all its members in the system, and, in a negative sense, when it prevents the exclusion of some of its members by others. Thus, the first point in my argument is: the use of power in matters of health care, ought be governed by justice, understood as justice as participation.

A key place in the social doctrine of the Church, as expounded by Pope John Paul II, is the right of all persons to participate in economic and political life.[1] Participation is grounded in the sharing of a common humanity. Justice as participation requires that society be structured in such a way as to make possible and sustain the engagement of all in its activities as free, intelligent agents. Society therefore ought to have appropriate structures to protect this participation, which is the foundation of democratic order.[2] In other words, justice as participation requires that each member of society be given the power necessary to contribute in this way, and prohibits the prevention of any member from attaining and exercising such power, without reasoned justification.

In this paper I propose to discuss one case of the use of power in the sphere of health care. It is noteworthy that when the issue of power is raised in the bioethical literature in general, it is discussed, for the most part, in terms of the informed consent of the patient. This raises the question of the moral status, in relation to power relationships, of those who are not capable of consent, either by reason of developmental disturbance, or because of the loss of mental capacity, or because they have not yet reached the stage of development at which consent is possible. Consider in particular, the situation of the human embryo. Today we are faced with questions as to whether it is morally permissible to clone a human embryo, for experimental or therapeutic purposes, where this entails the destruction of the embryo. Such actions are instances of the use of power. This is the particular "frontier of power" that I propose to discuss here. How then does justice as participation relate to the use of power in respect to the human embryo?

In the next step in the argument, I will make a connection between the use of power, justice as participation, and a relevant text of the Magisterium on the state of the human embryo. John Paul II says in *Evangelium Vitae:* "From the standpoint of moral obligation, the mere probability that a human person is involved

would suffice to justify an absolutely clear prohibition of any intervention aimed at killing a human being."[3] I will take up this position and relate it to arguments which are made in the public debate on this issue.

In the arena of public reason, there are two major positions. The first argues that to be a person means to have certain "onto-

logical" attributes now, at the relevant moment at which the act of destruction of the embryo is to take place. It is argued that because it lacks these ontological qualities, the embryo cannot participate in society, and *therefore* cannot have a right to participate. By ontological qualities I mean, for example, the status of being an ontological individual, or having the capacity for consciousness. It will be argued in this paper that, on the contrary, it is not required that this entity have these ontological attributes now, at that moment when its destruction is contemplated, for example at day 2 or day 14. It is sufficient that the embryo will, in the normal course of events, in the future, attain that level of development which reasonable people would accept as constituting him or her a person, with the rights to participation in society which we enjoy. It is not necessary to establish precisely when that level of development is reached. It is sufficient to maintain that the embryo, from the moment of conception will, unless something untoward happens, attain that level.

Thus, it is not necessary to prove that the embryo is an ontological person, or even that it is an ontological individual. It is sufficient that we can designate it as "this entity," to provide the basis for an argument that it ought not be killed. We could of course, providing we make the meaning clear, call such an entity a "person," but then it must be taken, not in an ontological sense, but in a moral sense, that is as meaning "an entity which may not justly be removed from participation in society," or, in other words, killed.

As I suggested, if we examine the various arguments that have been produced, for the embryo's right to life and against it, we find that they are governed by two interests. These interests manifest themselves in two different ways of placing the burden of proof, that is of deciding what it is that must be proved if an argument is to be successful. The structure of the two types of arguments can be presented as follows:

1. The human embryo is not to be considered as a person, unless the contrary can be proved.

But the contrary cannot be proved.

Therefore, the human embryo is *not* to be considered a person.

The onus of proof is on those who deny the first premise. What must be proved, in this case, is that the embryo *is* a person.

2. The human embryo is to be considered as a person, unless the contrary can be proved.

But the contrary cannot be proved.

Therefore, the human embryo *is* to be considered a person.

The onus of proof is on those who deny the first premise. What must be proved is that the embryo is *not* a person. The key issue in the arguments is where the burden of proof is set. The arguments, either for the embryo's being a person, or against this, are not conclusive when considered in themselves, apart from the assumptions about where the burden of proof lies. The reason why neither side in the debate can ever convince the other, is that their respective arguments never meet each other. Each side is arguing on a different presupposition about what is to be proved.

With the help of this framework, illustrating how the two opposed arguments function, I will now analyse first the liberal and then the Roman Catholic position. The meaning of the word "liberal" in the present context means a certain way of arguing, based on certain presuppositions which I will now explain.

The liberal view, adopts the first type of argument, that is, it presumes that the embryo is *not* a person. This is not always stated explicitly in the relevant texts, but it is implicit, for example in the argument of Justice Blackmun, of the U.S.A. Supreme Court, in the Roe v. Wade case of 1973 which, in effect, allowed abortion in the U.S.A. The question the court dealt with was whether or not the state has a compelling reason to prohibit abortion. It was decided that such a prohibition would violate the woman's right to privacy.[4] Note that by interpreting the issue as one affecting only the woman's *privacy*, any consideration of the embryo's being a person, with rights, is excluded from the outset. This is a private matter for the individual woman; the embryo does not enter into consideration. The structure of the Italian Law 194/1978 seems to be essentially the same: it is implicitly assumed that the embryo is not a person.[5]

At this point, I am concerned with the form of the argument. It is evident that it is presumed that the woman has rights, and the embryo does not. The burden of proof is then placed on those who defend the embryo. But once this form of argument is accepted, since no apodictic, conclusive arguments are available which can

prove that the embryo is a person, the argument will inevitably be won by the liberal view. The argument is decided from the moment the burden of proof is laid on those who would defend the embryo's right to life.

I have claimed that this position presumes the embryo is not a person. It might be objected that those who hold this view, do not simply presuppose it, but prove it by argument. I would contest this. The arguments that are usually presented in support of the liberal view are not really arguments in themselves, but summary statements of unstated presuppositions. I will now seek to support this assertion. The arguments are usually based on two points, consciousness and interests.

According to the first, to be a person means to have consciousness, or at least the capacity for consciousness. Consciousness is a word taken from the writings of John Locke. Commentators have been unable to decide on what precisely Locke meant by it, but it is still nevertheless used in this argument.[6] The human embryo, it is said, does not have consciousness. Therefore it is not a person. We can note the assumption: to be a person, an entity must have consciousness. Thus, in brief, where there is no consciousness, there is no person and so there are no rights.

The second argument is from "interests". Ronald Dworkin argues that what gives a being moral status, is its capacity to have "interests".[7] An interest is indicated by the presence of a psychological condition, for example the feeling of disappointment and frustration. Such conditions are unlikely to be present prior to the point of cortical formation.[8] Therefore, before this point, the embryo has no interest in surviving. Therefore killing that embryo is not against its interests. There may be other reasons why an embryo should not be killed, for example, it may be the object of very strong positive feelings on the part of its parents, who would suffer greatly if were killed. But, according to this view, there are no reasons, inherent in the being of the embryo itself, why it should not be eliminated.

Note that both arguments are designed to defeat the counter argument. They do not prove anything positive. Thus, what we need to examine is the foundation for the basic assumption, namely, that the embryo is not a person and so has no rights, unless the contrary can be proved.

Both arguments, in fact, presuppose a form of the contractual theory of human society. According to this theory, human society comes into being by reason of a contract, as in the theory of John Locke. Further to be able to make a contract, one must obviously be conscious. Therefore, to be a person, one must actually possess consciousness, or at least the capacity to return to it, when it is temporarily absent. Since a embryo does not have consciousness, it does not count as such a person, and so has no rights. Similarly, the second argument appears to presume that society and its structures exist to protect the individual interests of its members. Therefore, an entity which does not have interests does not enter into that sphere protected by society.

We can now examine these arguments. The conclusion, namely that the embryo is not a person and has no rights, does not follow even from the contractual theory itself. Locke himself accepted that there must exist some kind of morality prior to the contract, and that there were natural rights inherent in the state of nature, prior to the contract.[9] We can add that if there were no morality prior to the contract, then the contract itself could have no moral binding force. Even if we accept that human society is based on a contract, and that this contract requires consciousness on the part of those making the contract, it does not follow that only those who have consciousness are protected by the morality which is prior to the contract, nor does it prove that only those who actually have consciousness could be recognized by the contract itself as members of the society, having a right to life. Nor, again, does it follow that only those who actually have interests merit protection by society.

To prove the liberal case, it would be necessary to prove two things: first, that the pre-contractual morality does not protect the pre-conscious embryo, and second, that the kind of contract which was made by conscious beings, *could not* also protect that embryo. No such proofs are offered. Why would it be necessarily unreasonable for those who make the contract, to recognize the pre-conscious embryo as a member of the community, and so to accord it rights? No proof is provided for this assumption.

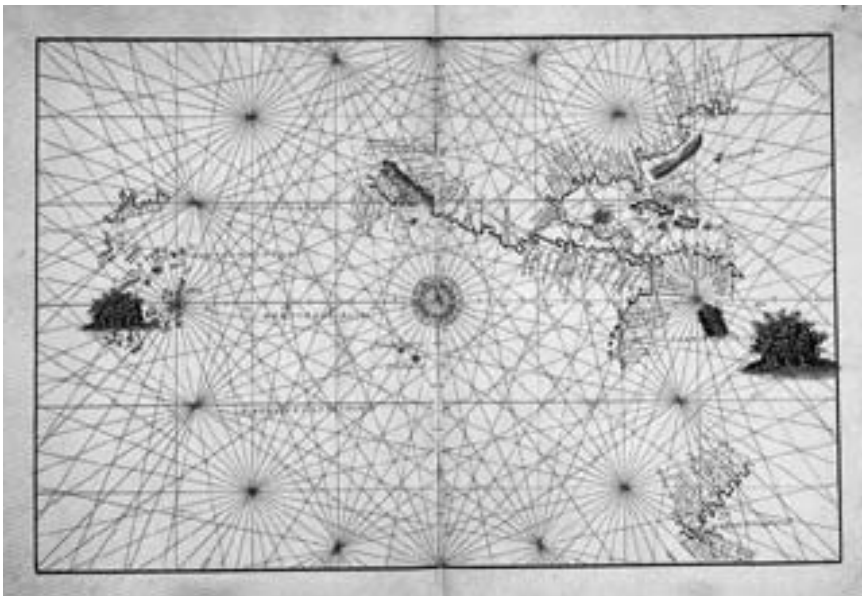
John Rawls, in his well known work *A Theory of Justice*, sought to show what the ideal contract makers would include in the contract.[10] Specifically he argued that a just social and political system should be so structured so as to protect those who might end up at the lower levels of the hierarchy of society. This is a feature of Rawls's theory which makes it attractive to those who are committed to equality in society. But even here it is simply presumed that the pre-conscious embryo is not to be included among those who ought be so protected. I would argue that this does not follow from Rawl's theory itself. All that follows is that a pre-conscious being cannot make the contract which forms the community. It in no way proves that this pre-conscious being cannot be protected by the terms of the contract. To assume that such a being cannot be so protected is an assumption and nothing more.

What this means is that the liberal position, which assumes that the embryo is not among those who must be protected by a just society, and requires that it is those who claim basic equality of rights also for the human embryo, who must prove their case, is based simply on an unproven assumption.

I will now examine the notion of "reason" that is adopted by the liberal position. We can do this by examining the arguments of the liberal view as presented by John Rawls. The central question is: what is the ideal society? The classic answers have been (1) that which would meet the approval of an ideal, neutral observer, (2)

and\or that which is based on a freely entered contract.[11] The problem which both seek to deal with is the ineradicable tendency of human beings to seek their own egotistical advantages. Thus, there is need for the ideal neutral observer, who, free from egoism, could judge objectively. Let us, however, take a closer look at the ideal observer. Surely there would be a danger, or even a likelihood, that we would create the ideal observer in our own image, reflecting our own desires and prejudices. How can those who construct the ideal neutral observer be sure that they have, in fact, conceived such an ideal observer, when the only criteria of evaluation is the very ideal they themselves have constructed?

They would claim, of course, that the exclusion is not an arbitrary decision of will, but is "reasonable." However, as I have argued, they have not shown that this is so. Furthermore, the "reason" to which they appeal, turns out to be not reason as such, or timeless, universal reason, but a version of reason which emerged at a particular period in history. To assume, as the liberal view does, that this way of reasoning must be that of all reasonable people, is merely an assumption. We could recall here the critique of the liberal position by philosophers such as Alasdair MacIntyre.[12]



In the section of his later work, *Political Liberalism*, where he deals with the abortion question, Rawls argues that any reasonable balance of the three values, namely, "...due respect for human life, the ordered reproduction of political society over time, including the family in some form, and finally the equality of women as equal citizens, ...will give a woman a duly qualified right to decide whether or not to end her pregnancy during the first trimester."[13] But, I would argue, the balance will move this way only if it is already presumed that the rights of the embryo do not have equal weight with the rights of the woman concerned. That is to say, Rawl's argument entails that particular way of placing the burden of proof, which was criticized in the first part of this paper. That is, it simply presumes that the embryo is not to be considered a person, and thus shifts the burden of proof onto those who would defend the embryo. I have sought to show the weaknesses of this position.

Furthermore, I argue that the way in which the onus of proof is apportioned, is itself a moral judgment about the allocation of power. In the first instance, those who adopt a theory, which excludes the embryo from the human moral community, have assumed to themselves power to decide who is to be admitted to that community, and the criteria by which they are admitted.

In the second theory, that supported by the Catholic Church, there is no such imposition of power on the embryo and no such exclusion of the embryo from participation in the human community. Rather the embryo is accepted for what it is, and can become, simply because it is a human embryo, and therefore, has the potential to develop into the kind of being, whom we unquestionably accept as a person. To express this somewhat differently: it is not being claimed, of course, that the embryo has the capacity to consent to a contract, and so enter society. It is we who do have the capacity to consent, who ought to consent to the embryo's belonging to that community. Why ought we?

An element of the embryo's reality is that it does have the capacity to develop, through time, into the kind of being we would certainly call a person. We cannot arbitrarily exclude the element of time, without leaving aside an aspect of reality. The reason why it is excluded, is because the notion of reason which the liberal arguments employ is one that excludes time. It is a version of the kind of supposedly timeless reason, which is presumed by the liberal view.[14] My argument is that we cannot think morally about a human embryo without thinking in terms of time.

The argument is made that eliminating the embryo now is not the same as eliminating another human being, since this embryo is not yet a human being. But that is to fall back into one particular way of setting up the case. To exclude time and history from the notion of reason, is simply to accept uncritically a particular, time conditioned, notion of reason in our argument. An ethical argument which simply leaves this out is an incomplete ethical argument. If the embryo is destroyed now, there will never be the person who would have been otherwise. That is, this embryo will never be able to exercise the capacity to participate in society, a capacity which it already has in potential.

At this point those who refuse to acknowledge a right to life on the part of the embryo will argue: but the embryo has only the *potential* to participate in the community, and to be a person, it is not an actual participant or an actual person. I have already provided the basis for a reply to this. This objection is not really an argument, it is simply a re-statement of the assumption that the embryo is to presumed to be not a participant in society, and not a person, unless the contrary can be proved. That is to say, it simply repeats that way of allocating the burden of proof which I have previously shown is without foundation. We may, for the sake of argument, grant that the human embryo, is only a potential, ontological person. But even if this could be established, it does not necessarily follow that the embryo is not a person in the moral sense, such as I have explained earlier.

Consider now the position adopted by official Catholic teaching. Note that the positions expressed in the documents are stated very carefully. It is said that the human embryo *probably* is a person, and *the contrary cannot be proved.*[15] It is clear that this position also entails placing the burden of proof in a particular way, namely on those who claim the embryo is not a person, in the sense described above. They are required to prove the contrary, and, according to the document I have cited, cannot prove their case. I would ague that this is correct. As has been claimed above there are no apodictic arguments available which can prove that the embryo is not a person, or that it is a person, independently of the assumptions made concerning the burden of proof.

The official documents of Church teaching do not claim to have provided apodictic proofs for the personhood of the embryo. The arguments for the thesis that the embryo is probably a person work only on the basic, prior assumption that the embryo is to be considered a person, unless the contrary can be proved. Thus the position taken by these Catholic documents rests on an assumption just as does the liberal position.

In the first part of the paper, I sought to show that the liberal argument depends on the way it places the burden of proof, and argued that this was based on an unproven presupposition. Could the supporters of the liberal position not argue that the Catholic case is also based on an assumption which is not proved?

It is generally assumed, in public debate on the matter, that the Church's position on the status of the embryo rests not on considerations of reason, but on religious faith. Let us grant, again for the sake of argument, that in the last analysis the position of the Church on the status of the embryo ultimately rests on convictions of faith, and cannot be categorically proved in terms of public reason.

Now let us take the same criteria of public reason and apply them to the liberal position. According to these criteria, it would have to be admitted that the liberal position, because it is based on an unproven assumption, would have no more secure rational grounding than would the Catholic view, which is presumed to be based on faith. Thus, in terms of public reason, there is no basis for preferring the liberal position over the Catholic.

We come back, then, to the moral thesis which was proposed at the beginning of this article. The Catholic position, does not exclude any from participation. The liberal position on the other hand, does exclude some from participation and, therefore, needs justification for so doing. But, as has been shown, it fails to provide this. It therefore entails the exclusion of some from society, without rational justification, which public reason would require. On the moral grounds of justice, therefore, the Catholic position is to be preferred.

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Notes

[1] JOHN PAUL II, *Centesimus Annus,* (Rome: Libreria Editrice Vaticana, 1991), nn. 34, 35, 46.

[2] *Centesimus Annus,* n. 47.

[3] JOHN PAUL II, *Evangelium Vitae* (Rome: Libreria Editrice Vaticana, 1995), n. 60.

[4] RONALD DWORKIN, *Life's Dominion* (London: HarperCollins, 1993), 7.

[5] *Legge n. 194 del 22 maggio 1978. Norme per la tutela sociale della maternità e sull'interruzione volontaria della gravidanzia.*

[6] CHRISTOPHER FOX, *Locke and the Scriblerians: Identity and Consciousness in Early Eighteenth-Century Britain* (Berkeley: University of California Press, 1988), 32.

[7] DWORKIN, *Life's Dominion,* 18.

[8] DWORKIN, *Life's Dominion,* 18.

[9] LOUIS DUPRÉ, "The Common Good and the Open Society," in *Catholicism and Liberalism,* eds. R. Bruce Douglas and David Hollenbach (Cambridge: Cambridge University Press, 1994), 179.

[10] JOHN RAWLS, *A Theory of Justice* (Cambridge, Mass.: Belknap Press, 1971), 118.

[11] RAWLS, *A Theory of Justice,* 188.

[12] ALASDAIR MACINTYRE, *Whose Justice? Which Rationality?* (Notre Dame: University of Notre Dame Press, 1988).

[13] JOHN RAWLS, *Political Liberalism* (New York: Columbia University Press, 1993), 243.

[14] MACINTYRE, Whose Justice? Which Rationality? 346.

[15] *Congregation for the Doctrine of the Faith,* Declaration on Abortion, AAS 66 (1974) 738, Note 19. "...it suffices that this presence of the soul be probable (and one can never prove the contrary) in order that the taking of life involve accepting the risk of killing a man, not only waiting for, but already in possession of his soul." [Official translation]

SERGIO PINTOR

4. The Approach of the Church to 'Power and Health'

1. The Contemporary Relevance and Complexity of an Analysis of this Subject

With respect to 'power and health', the Church, when it comes to her action, is called upon to ask questions about herself with a healthy realism which is specific to an authentically gospel-based approach and directed towards educating and to fructifying the possibilities of good: without, therefore, demonising prejudices but also without easy accommodations or forms of compromise.

From this point of view, such an analysis appears to be of especial contemporary relevance today. Indeed, although on the one hand, economic and scientific-technological advance and progress (specific to one part of the world) have offered new opportunities for human growth and development, on the other hand – and this is something that is demonstrated by daily experience – they have also provoked the proliferation of new forms of manipulation, of arrogant powers, of struggles for power, and of forms of alienation, which, although they can have detrimental outcomes in all sectors of human co-existence, have them in an even more dramatic form in the field of care for life and the health of people.[1]

What is being discussed here is not power with the positive possibilities for manipulation that it offers to human action and its existence as socially and organically organised reality, but rather the use and the exercise of power, entrusted to human persons in their limited condition, in concrete situations, and in various roles.

The serious question that we must reflect about, and act in relation to, is that of the 'forming of the consciences' of people, something observed with extreme clarity fifty years ago by R. Guardini when he stated that whereas down the ages power over what exists, over men and things, had grown on a vast scale, the seriousness of feeling oneself responsible, clarity of conscience, and force of character had not been up to the level of that growth. It was evident, he maintained, that modern man had not been educated in the correct use of force and power. And with especial vigour he perceived that in proportion to the extent to which the conscience of man does not recognise the responsibility of power, devilish forces come to take possession of it.[2]

Two elements or aspects, however, seem to me should be considered together in order to supply a concreteness to the analysis.

a) The complex and ambiguous intertwining of individual forms of power, which are often anonymous, with consequences in the sphere of caring for the health of people.

b) The scenario of the needs of the world, with the challenges of poverty, which were referred to by John Paul II in his apostolic letter *Novo Millennio Ineunte.*[3]

'Our world', writes the Pope, 'is entering the new millennium burdened by the contradictions of an economic, cultural and technological progress which offers immense possibilities to a fortunate few, while leaving millions of others not only on the margins of progress but in living conditions far below the minimum demanded by human dignity. How can it be that even today there are still people dying of hunger? Condemned to illiteracy? Lacking the most basic medical care? Without a roof over their heads?'

In the face of these realities the Church and Christians are called upon to ask themselves, and raise, questions which favour wise discernment; to condemn the large number of attacks that there are on respect for life and the dignity of every person and the great deal that does not correspond to the criteria of justice; to provide an input of ethics and of solidarity; to promote concrete approaches and practical working choices which favour a use of every form of power which is more respectful of the good of all men.

How can we not ask ourselves, for example, about the consequences for health of an exploitative use of the powers of the mass media with their frequent intertwining with the ever-present tempting idolatry of money, of power, of self-seeking, and of power? But the same question is applicable to the use of political, economic, professional...power.

The subject of this analysis, therefore, cannot be 'power and health' as viewed in a relationship of abstract realities, but the approaches that people have or should have in the practical service of power (whatever it may be and at any level) in relation to taking care of the health and the life of every person in his or her specific individual conditions, at every moment of his or her existence, and in every country that he or she is to be found. Approaches in the exercise of a form of 'power', therefore, that to a certain extent and in various ways concern not only those who act within great powers – upon whom there certainly falls a great responsibility – but in reality concern everybody: every person called to exercise the 'possibility-power' of looking after his or her own health and the health of other people; every institution or structure which is more directly involved in the world of health and health care, but also every institution and structure of a political, economic, scientific, educational, mass media... character, and this because of the consequences that they can have for health care.

2. A Basic Ecclesial Approach

The basic approach that the Church is called upon to adopt in re-

lation to the relationship of 'power and health' is inscribed, and takes form, within that approach so authoritatively outlined by the Second Vatican Council, especially in the constitution *Gaudium et Spes*, and within the magisterium of social doctrine: an approach in dialogue with temporal reality, whose legitimate authority it respects, but into which one must bring the strength and the explosive light of the Gospel.

An approach, therefore, exclusively based upon the truth and gospel-inspired charity, at the service of the good of the human person, with an overcoming of the risks of an ideological, spiritualistic or temporalistic approach.

Indeed, 'the specific mission that Christ entrusted to his Church is not of a political, economic or social order; the end, in fact, that he established was of a religious order. And yet from this religious mission there spring tasks, light and strength which can help to build and strengthen the community of men according to divine law'.[4]

'The Church is inseparably a 'mystery' of communion and faith, and, at the same time, the sacrament-sign-instrument of an overall salvation which is full and universal for man. She is the bearer of the possibility of a 'new life' in the Spirit, and thus the witness to a Christian faith that is translated into ethics, the fruit and manifestation of the love of God. For this reason, the Church cannot but feel herself involved in concepts and norms of individual and social human behaviour, that is to say in a specific realisation of the human person, not only as regards his or her inner being but also as regards his or her social dimension, in which the human person must fulfil himself or herself as 'a human being for others'.

This is why the Church feels propelled to take on – as an expression of her faith and her charity – the mission of 'permeating and developing the whole of the temporal order with the gospel spirit',[5] and this includes the relationship of 'power and health'.

3. Certain Fundamental Criteria for the Purposes of Illumination and Discernment

Illumination and discernment as regards the approaches of the Church towards 'power and health' can be achieved more effectively in the light of certain fundamental theological-pastoral criteria. We are dealing here with strongly unitary 'criteria' which are directed towards thinking about, illuminating, interpreting, assessing, and renewing the practical ways of acting in the exercise of power and in the field of health and health care.

3.1. The Christological-Trinitarian criterion (or the criterion of free-giving-gift-service)

The first and fundamental criterion by which to define the approach of the Church in discerning the goodness or otherwise of any form of exercise of power with reference to health is that of placing oneself in a relationship with God and His action, as He has manifested Himself in history and was fully revealed in His mystery through His Son Jesus Christ and in the gift of His Spirit.

To believe in God, the omnipotent and only Lord, to look at His action in the exercise of His 'lordship', projects a decisive light and suggests extremely concrete consequences for the approaches which should be adopted in relation to 'power and health'.

First of all, this criterion involves a recognition that every form of human power is limited and must recognise that its 'roots' are in God, from whom it comes and by whom it is constantly judged.

The exercise of power by God in Revelation shows itself as power for the good of the human person and never as power of man over man: a power that is shared in by men – not only by some men but by each man in a different way.[6]

In Jesus Christ, in particular, the power of God was expressed in doing good to people, in liberating them from physical and moral maladies, from sin, in even triumphing over the extreme limitation of humans – death – so as to reveal God, the Lord of Life, more fully.

One should not forget that the power of God in Christ was essentially 'salvific', it was completely directed towards defeating the 'forces of evil', which are destined to disappear with the final arrival of the kingdom of God (one thinks here of the parables of the gospels and the description of the miracles also to be found in the gospels).

His is a 'power' which transforms and liberates: a transformation which comes from God and not from the power of man. In the action of Jesus such power took above all else the form of service to the person and service for the human person. A 'service-power' which in the person of Christ was identified with the whole of his existence, which became a life offered and donated for the salvation of other people.

This identification of service with existence leads to a perception of another characteristic of the action of God which has a paradoxical aspect: the exercise of a power which manifests the whole of its nature and its strength in powerlessness, that is to say in a choice of 'non-power'.

It is significant that the manifestation of the saving power of God in his Son Jesus Christ was actuated in the 'non-power' of the passion and death on the cross: the supreme manifestation of 'power' as love and donated life which became 'non-power' in order to achieve the health-salvation of all men. But, at the same time, revealing itself to be a greater power, able to triumph over evil, sin, death, and to restore people to a fully realised life.

To look at the action of God and allow oneself to be illuminated by it becomes the fundamental criterion in assessing and constantly converting every form of exercise of human power which bears upon taking care of the life and the health of the human person.

Nobody can think that they exercise a power which comes from themselves alone and not from God. Therefore a person must strive to exercise power with an awareness that a received 'power-task' is being administered; to exercise it not on its own but in co-operation with all the other 'power-tasks' that God has entrusted to every person.[7]

If God alone is the Lord of life, no person can arrogate to himself or herself power over life: he or she should attain power to take care of life with responsibility, with respect, and in a way which co-operates with the plan of God.

Nobody in the sphere of health care can think of legitimately using any kind of power as power over a person (perhaps exploiting that person for other ends and not respecting him or her in his or her overall dignity). That form of power should be used as a 'power' for the person, for

his or her authentic and overall good; as an exercise of power which expresses itself in the exercise of a service which is strongly linked to the meaning of his or her own life and profession.

This is a criterion which, albeit in a realistic awareness of the connatural ambiguity and limitedness inherent in every exercise of human power in relation to health care, can in fact open up a perspective that is exalting and illuminating: that of an exercise of power which is translated into an exercise of overall service to the person and for the person, for his or her personal good, and for the common good.

3.2. The ecclesiological criterion (the criterion of communion-brotherhood)

The Church exists to be 'in Christ as a sacrament or sign and instrument of intimate union with God and of the unity of the whole of mankind',[8] and she was established by Christ 'as an instrument for the redemption of all men'.[9]

And to this Church, taken as a whole, through the Apostles, was entrusted the power of Christ directed towards the salvation of men: 'All authority in heaven and on earth, he said, has been given to me; you, therefore, must go out, making disciples of all nations, and baptizing them in the name of the Father, and of the Son, and of the Holy Ghost, teaching them to observe all the commandments which I have given you. And behold I am with you all through the days that are coming, until the consumation of the world'.[10]

She is called to exercise this power according to the charge received from Christ himself and according to the model he represents: 'You know that, among the Gentiles, those who bear rule lord it over them, and great men vaunt their power over them; with you it must be otherwise; whoever would be a great man among you, must be your servant, and whoever has a mind to be first among you, must be your slave. So it is that the Son of Man did not come to have service done to him: he came to serve others, and to give his life as a ransom for the lives of many'.[11]

The exercise of power within the Church is to be located within an organic and fraternal hierarchical relationship, where nobody can exercise power by lording it over others but where each person, with different and complementary ministries, tasks and gifts, has the possibility-power of serving other people, for other people with other people. Where, if special attention must exist, then it must be directed towards the weakest, smallest, most fragile, poorest, and most suffering members of the Church.[12]

This is certainly a matter, as a precedent and in the light of precedence, of a criterion which directly judges and illuminates each Christian in the practical exercise of his or her power in relation to health care (both those who exercise a hierarchical power, people devoted to the consecrated life, and members of the

lay faithful...), and which is offered at the same time as a criterion and wise model for every exercise of power that wants to be fully human in the world of health and health care.

In concrete terms, as a consequence, the Church and all Christians within the Church are called to:

– be the first to be illuminated and converted by the gospel-based exercise of each and every form of power;

– bring the light of the gospel message and the orientation of a Christian ethic, of a high human content, so that the exercise of power in the world of health and health care is implemented under the banner of service to the person, for his or her good and for the common good;

– commit themselves to the promotion of a culture of service by educating consciences;

– offer witness and credible models for the exercise of power as an authentic and effective service to the person in taking care of life and health (both at the level of individual Christians, whether religious or members of the laity, at the level of Christian communities, and at the level of institutions and structures...).

3.3. The anthropological criterion (or the criterion of 'functionality' for man)

In reality, every form of power, and even more every exercise of that power, is based, at least at an implicit level, on a certain vision of man and his destiny, from which spring criteria employed in judgement, a hierarchy of values, and forms of behaviour.[13] Power exercised without a horizon of transcendence and reference to God, without an objective criterion of good and bad (that is to say without an ethical criterion) is immediately exposed to strong and often dramatic risks of dehumanisation.[14] The Church interprets the relationship between power and health from the point of view of Christian anthropology, seen in all its originality, depth, and unity, where the human person is revealed in the mystery of Christ in all his or her incomparable dignity.[15]

For this reason, the approach and action of the Church must always be based upon a dual and inseparable loyalty: loyalty to the action of God and loyalty to the real needs and the overall good of the person, to the point, indeed, of being fused into a single approach of love and service.

The action of the Church, like the actualisation of the salvific practice of the service and care of Christ, the 'physician of the body and of the spirit', must always be turned towards and concerned with the human person in his or her overall dimension and totality and in his or her concrete existential, cultural and relational condition. And this to the point of discovering and recognising in the face of every person, to whom is directed the exercise of any form of power in the world of health and health care, 'another myself', 'the human face of God', or to put it another way, 'the divine face' of the human person.

Beginning with this vision and centrality of the human person, many aspects could be subjected to

serious discussion and could decisively change for the better the relationship between power and health.

3.4. The historical historical-eschatological criterion (or the criterion of concreteness-hope)

As a result of a complex intertwining of question and issues, factors, and interests which today bear upon 'power and health', as the Church we are also called to deal with this historical moment, and to draw from it, with wise and courageous discernment, its positive elements and new possibilities for service in health care. However, we also called to identify, counter, and convert its negative elements and every cluster of evil and sin that wound the dignity and the real good of the person.

This is an approach of constant historical mediation which is not easy, and which, while it interprets contemporary reality in the light of faith and in a spirit of ecclesial communion, at the same time places it within the horizon of the merciful action of God and the future fulfilment promised by Him, when the power of the health-inducing and saving love of God will be revealed to the full for the sake of all men and the power exercised by men will be judged only by the love by which it was inspired and carried out.

This eschatological criterion illuminates and relativises every form of exercise of human power to the point of recognising its limits and powerlessness, and at the same time illuminates the profound and health-inducing meaning of the spiritual and sacramental service-power exercised by the Church in the world of health care as well.

But this future horizon, which the pastoral action of the Church in the world of health and health care must bear constantly in mind, does not remove the concrete commitment to change everything in the exercise of power today which does not correspond to the plan of God and to respect for the human person. Indeed, it acts further to require it and to strengthen it.

In fact, as the Second Vatican Council well brought to mind: 'the expectation of a new earth must not weaken but rather stimulate solicitude in work concerned with the present earth, where there grows that body of new mankind that already manages to offer a certain prefiguration of what the new world will be...'[16]

4. The Forms of Mediation by which the Church Expresses and Concretely Translates her Approaches Connected with Power and Health

The approaches that the Church is called upon to live out in relation to 'health and power' must be an expression, a sign and an instrument of the same salvific-health-inducing action of God and of the 'power' of Christ which was transmitted to her through the Apostles.[17] This is a power which in fundamental terms consists of the gift of, and of participation in, the salvific and health-inducing 'energies' of God in order to continue – through their actualisation – the evangelising mission of Christ, with his freeing action from every force of eveil, and thus of the possibility given to the Church to exercise them in the field of health care as well, and to do this for the overall salvation of people.

This is a mission and a spiritual power which should not be confused with the powers of this world, yet which is not as a result 'disincarnated' because in reality she judges them, she relativises them, and she opens them up to their real meaning; she opposes them when they serve evil and she directs them to serving good.

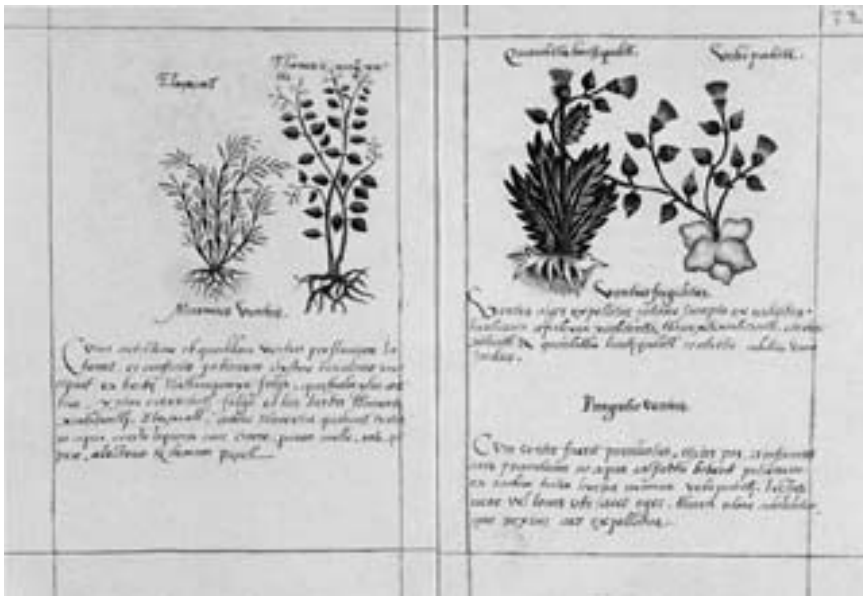
One might say in a schematic and functional way that the Church is called to express her approaches to 'power and health' through her prophetic action (through the service of the Word); through her liturgical-sacramental action (through the celebration of the Easter of the Lord); through her action under the banner of communion-brotherhood; and through her action under the banner of witness and service to charity and the promotion of what is human.

4.1. Through her prophetic action (an approach based upon prophecy)

The Church is called upon to bring, and herself live out, the message and the light of Revelation and of the Gospel in the complex intertwining of those (large and small, institutional, group or personal) powers which interact with one another in the field of health and health care. And as a result, in the light of the Christian message, to condemn, and help to overcome, everything that does not correspond to the real good of the human person, whether it is personal in nature or collective and shared in character.

The prophetic approach of the Church in the field of 'power and health' must be characterised in general by a constant reference to the Word of God, incarnated in concrete situations in order to illuminate them, by a spirit of freedom and of courage, and by a great force of hope.

In particular, it would appear that the Church is called to engage in:



– the exercise of a wise critical discernment;

– the formation of consciences as regards the meaning and the ethical purposes that must always inspire any form of exercise of power in the field of health care;

– education in the meaning of responsibility and diversified and complementary co-responsibility in the exercise of power in health care;

– a teaching and pedagogic approach which illuminates, with the values of her social teaching, the relationship between power and health (the dignity of the person, his or her inviolable rights, interdependence, justice, charity, etc.);

– the formation of all baptised people, and especially members of the Christian laity and those dedicated to the consecrated life who are active in the world of health and health care, so that they can grow in a faith which is more mature, with all the implications of gospel-based and ethical action that spring from this in the sphere of the exercise of power in the field of health care as well;

– the promotion of a culture based upon gospel-based values in the field of power and health.

4.2. Through her liturgical-sacramental action (approaches based upon, and rooted in, liturgical-sacramental celebrations)

Approaches rooted in the liturgical-sacramental action of the Church are certainly not 'marginal' in calling upon and changing in a positive sense the way in which the relationship between power and health is lived out. If this action is recognised as the source and culmination of the very life and action of the Church, we should seriously ask ourselves how it could contribute towards a more correct interpretation of the relationship between power and health. The perspective adopted must be that of a liturgy which is authentically paschal – with all its mystical, existential and historical content – as a transforming and saving communion of God with us, and as an opening up to hope and the future.

What consequences should the fact of being baptised and confirmed, and taking part in a community which celebrates the Eucharist, with a sharing in the life-mission of Christ, have in that world where Christians enter into a relationship with other people and exercise any form of power in the field of health and health care?

We might ask: does not the very celebration of the 'healing sacraments' (reconciliation and the anointing of the sick), prayer, and the spiritual care of sick people and the suffering provided by the Church have something to say about the way in which the relationship between power and health should be lived out, about the need for conversion and reconciliation, about the limitations of every form of human power, about our responsibilities to care for one other, about the 'powerlessness' that emerges in the hope in the 'power' to love, a power which is God?

4.3. Through her action under the banner of communion-brotherhood (approaches under the banner of communion and brotherhood)

Because of the gift of communion between God and ourselves, the Church and we ourselves are called: to be a sign and instrument of a new way of living together; to enter into relationships with other people in an organic and fraternal communion; to welcome each other reciprocally in a diversity of tasks and in an effective recognition of equal dignity; to reconcile ourselves with one another and to communicate with each other in a way that respects the freedom of each person and the truth. However, this requires a constant commitment to unmask and overcome those dynamics which are often dominant in human behaviour. For example: the logic of exploitation, of power for its own sake, of exploitation, of depersonalisation, of the primacy of having over being, of indifference towards other people and their own dignity and rights, of forms of communication in the mass media which serve certain power interests, of individualism, etc...

In the light of this banner of Christian communion-brotherhood, certain ecclesial approaches follow as regards the specific field of the relationship between 'power and health', and they are:

– the ability to think about and to discern problems and their most suitable solutions, with all the people involved, in order to achieve a more correct relationship between power and health;

– the approach of wanting to share and of knowing how to share what one possesses and what one is with a view to promoting the common good in the field of health care;

– the approach of one's own and other people's aware responsibility to engage in sharing;

– the approach of openness to respectful and fraternal inter-relations;

– the promotion of a spirituality of communion.[18]

4.4. Through her action as witness to charity, to service, and to the advance of man

The Church is called to express all her being and her action in terms of charity and service.

For this reason, Christians must live out and promote every form of power in health care as an authentic service and gift of life for other people, constantly testing and purifying their own actions in this light.

All people within the Church, at different levels and in their various tasks, are called in the field of health care to offer the witness of Christian charity, both within religious health care institutions and structures and within the civil community.

In the context of different and recurrent forms of the search for power for its own sake (and thus the struggle for positions of power as well); in the context of an exclusive concern with one's own interests even to the disadvantage of justice and the dignity of other people; and in the context of an exercise of power which is indifferent to ethical values, the witness of service and charity on the part of the Church and Christians is required to make present and operative the signs and values of the kingdom of God.

In particular, it seems that today approaches involving witness need to be urgently promoted, and these may be listed as follows:

– an effective spirit of service in charity in all those who, in the name of the Church, work, and exercise any kind of power, in the world of health and health care;

– an authentically gospel-based approach which is characterised by prophetic freedom and ethical coherence in the management of any form of power in the world of health and health care, and in the establishment and maintenance of relationships with the various centres of such forms of power;

– an approach of solidarity towards the weakest, most fragile, and poorest amongst us;

– the bearing of witness by trained Christians of those gospel-based and human values which can contribute to the creation of a new 'culture' in the world of health and health care, and to the creation of a power which is seen and exercised as a service which respects the dignity of every person and the common good.

5. The Approaches and Concrete Perspectives that Must be Programmed

In the light of the elements described so far in this paper, and almost in the form of a concluding and operative summary, reference may be made to certain approaches and concrete perspectives that must be promoted by the Church within the relationship of power and health. These are complementary approaches which interact and which should be borne in mind and promoted in a constant endeavour of training at all levels, and which, in addition, should always be assessed and renewed at the concrete level of action.

5.1. The approach of humility

The first approach that is required in the context of the complexity of the interacting mechanisms of the relationship of power and health – and in the context of so many different and often anonymous powers – seems to be that of profound and serious 'humility'. Humility in the sense of 'awareness of limitations', of the gravity of the problem, and of a readiness to engage in research to understand the 'truth' in the exercise of power. The relationship of 'power and health' is, in fact, located in front of a crowded crossroads made up, at one and the same time, on the one hand, of an encounter with a plurality of borderline human situations (the precariousness of people and situations, moral and physical maladies, ethical anti-values, fears and worries, illness, disability, suffering, death), and on the other hand, by a plurality of possibility-powers to do good but which are also charged with ambiguity. In other words, we are face to face – in a rather acute way in the case of the existential situations (of limitations and possibilities) that are involved – of the mystery of the human person with his or her meaning of being, with his or her relationships, with his or her action, and with his or her own life.

This is an approach of humility which must place every form of exercise of power before God, within the framework of the relativity and relationality of every form of human power and its powerlessness.

And without ever forgetting that the human person, even though he or she can have power over many things, often does not have power over his or her own power.

5.2. An approach of wise discernment

Strictly connected with the previous approach is the approach of critical discernment which should allow an identification, in the practical exercise of various powers in the field of health and health care, of those aspects which work against the search for the common good and the good of the individual person. This should be done in order to point out the necessary corrections and changes. This is a form of discernment which must be constantly carried out in the light of the plan of God in order to condemn, with regard to the exercise of powers connected with health care, on the one hand the limits, the risks, and the anti-values that are involved (not in a general and rhetorical way but with specific reference from within), and on the other, in order to promote meaning, the responsible conscience, and the possibility of doing good.

5.3. An approach of responsibility and co-responsibility

The promotion of approaches of responsibility in the exercise of every form of power in the field of health and health care is of especial importance. This is a responsibility which applies to everybody and which should be recognised and developed in everybody. And not least because every person has opportunities, whether large or small, to act in relation to his or her own health and the health of other people. These are possibility-powers which everyone must be helped to be aware of and to use well, beginning with those who actually exercise most power in the world of health and health care and thus have greater and more evident responsibility. All people are required to have approaches of co-responsibility at every level.

The task of recognising, appreciating and co-ordinating all the different energies that are at play in order to promote and achieve the common good in health care is the task above all else of those who exercise functions of public authority and public service, but this is also something that applies to every individual.

5.4. Approaches of service

The promotion and formation of an authentic approach of service in the exercise of any form of power in health care is probably the most perceived and urgent ethical requirement to be found at all levels. In this context, the Christian community is called to be the first to bear witness to the 'charge' received from Jesus Christ, who 'came not to be served but to serve' (cf. Mt 20:28). The charge, that is to say, to exercise every form of power not as dominion over others and for its own sake but as 'service' based upon the commandment of love towards every person in his or her totality and in any condition. 'A charge' to live as Christians wherever they work in the world of health and health care, but which at the same time applies to every society and civil community so that it can become more authentically 'human', and above all where people live out existential situations of worry, illness and suffering, and thus where they are most in need of help and love.

5.5. An approach of dialogue, interaction, and co-operation

The Church is and must feel that she is a full co-participant in, and in communion with, all men in their experience of the questions and issues connected with the relationship of power and health. She sees in each person, with his or her different responsibilities and capacities, and beginning with the weakest, the ill and the suffering, practical opportunities to be shared and put together in order to improve the quality of health care. Positive co-operation between people with a more organic composition of powers – based upon specific ethical values in a shared orientation towards the search for the common good – can become a 'corrective' factor in relation to certain 'pre-powers' and an instrument to appreciate to a better extent the resources that are necessary in the world of health and health care, beginning with the primary resource – people.

An orientation towards the shared goal of the common good which places the real and overall good of the person at the centre of things can favour a constructive co-operation between different powers and capacities in the field of health care, thereby helping to overcome the risk of the accumulation and the domination of powers, of sterile parallelisms and harmful oppositions.

5.6. Approaches of a solidarity which is open to all people, beginning with the weakest, the most disadvantaged, and the poorest

In the exercise of different forms of power in the field of health and health care we should promote a dynamism of solidarity as an ethical and social approach, a form of solidarity understood as a 'firm and persevering determination to involve oneself for the common good: or rather for the good of everyone and each person, so that everyone is really responsible for everyone'.[19] This requires, on the one hand, a decisive effort to overcome what is in contrast with effective solidarity, that is to say the absolute desire for profit and the thirst for power;[20] and on the other, the making of choices and the exercise of every form of power in the field of health and health care where care for the last and in particular the weakest and the poorest constitutes the point of departure.[21]

And it is only by taking these people as a point of departure, and not those people and classes which for various reasons are privileged and more defended, that one will have a guarantee that attention will actually be paid to the dignity of everyone and that there will be a real orientation towards the common good.

From this point of view, in health care there should also be recognition of, support for, and appreciation of, the apparently weak powers of the weakest and smallest, the sick and the suffering, and we should remember how God Himself, in His Son Jesus, took on the exercise of power in the very powerlessness of the Cross, and through this became for all men a source of 'health' and of 'salvation'.

5.7. Approaches involving readiness to help and a concrete commitment to create a formative process, of both a preparatory and on-going character, which involves all those who exercise any function or power in the field of health care

A formation which does not end merely in technical capacities, however fundamental and important they may be, but which concerns the totality of the person in his or her unity as well as the promotion of his or her overall human growth and development, and this in the light of a set of ethical values which can be assessed in relation to behaviour with adequate parameters, in the same way as technical capacities are also assessable. For that matter, experience shows that technical capacities, although they are indispensable, on their own and without an ethical input do not guarantee a growth in humanity, and thus do not guarantee in the field of health and health care a better and more human quality of care.

Conclusion

In conclusion, one can observe that in the face of the questions and issues and the challenges which are at the present time raised by the relationship of power and health, the Church, in all her realities and with the approaches of all her members, is called upon to be the living gospel-based parable of that God who never ceases to amaze us because being rich and powerful in His divinity He became poor and humble for us by taking on the condition of a servant,[22] and this in order to take care of us as a 'good Samaritan'[23] and thereby to heal us. A gospel-based parable of man as an awake and responsible 'substitute administrator'[24] who is called constantly – and one day definitively – to render account of the exercise of the gifts and the powers that he or she has received before God, who is able, once again, to amaze us by showing that He is a servant 'God' in all His power: 'Blessed are those servants, whom their master will find watching when he comes; I promise you he will gird himself, and make them sit down next to meat, and minister to them'.[25]

Msgr. SERGIO PINTOR,
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Notes

[1] Cf. G. MACCARO, *Medicina e potere* (Dedalo, Bari, 1975); AA.VV, *La médicine face aux nouveaux poivoirs*, compts-rendus du 5éme Congres de la Federation Européene des Associations Medicales Catholique, Lisbone-Fatima, 1984; cf. *A Saude e o Poder, Accao Medicin*, n. 1/2, 2000 (Lisbon).
[2] Cf. R. GUARDINI, 'La fine dell'epoca moderna', chap. IV, in *ibid., Opere*, vol. XII (Ed. Morcelliana, Brescia).
[3] *N.M.I.*, 50.
[4] *GS*, 42, in EV 1/1450.
[5] *AA*, 5.
[6] See *CCC* 1884 which declares: 'God has not willed to reserve to himself all exercise of power. He entrusts to every creature the functions it is capable of performing, according to the capacities of its own nature. This mode of governance ought to be followed in social life'.
[7] Cf. *CCC*, 1884,
[8] *LG*, 1.
[9] *LG*, 9.
[10] *Mt* 28:18-22.
[11] *Mt* 20:25-28.
[12] Cf. *1 Cor* 12:12-26.
[13] Cf. *CCC*, 2244.
[14] Cf. JOHN PAUL II, *Centesimus annus*, 45-6.
[15] Cf. *GS*, 22:14.
[16] *GS*, 39.
[17] Cf. *Mt* 28:12-20.
[18] Cf. *N.M.I.*, 43.
[19] JOHN PAUL II, *Sollicitudini rei socialis*, 38, in *EV*/10 n. 2650.
[20] Cf. *Ibid.*
[21] Cf. *Ibid.* n. 42.
[22] Cf. *Phil.* 2:3-11.
[23] Cf. *Lk* 10:25-37.
[24] Cf. *Lk* 12:35-48.
[25] *Lk* 12:37.

5. Inter-religious Dialogue

DALIL BOUBAKEUR

5.1. Islam

In Islam the idea of health is bound up with the condition of spirituality. Health is the harmonious relationship which exists between the human organism and its spirit or soul *(nafs),* which means that the person is the totalisation of the objectives of the creation, the ultimate realisation of human nature wanted by God.

The Koran 95-4:

'In truth we created man in the best form'

In the Koran there is a grace and a healing.

The Koran 82-6,7,8 *(Al infitar)*

'O man, who deceived you about your noble Lord, who created you, moulded you, and gave you harmony and shaped you in the way He wanted?'

The condition of health is thus the realisation of everything that confers power on man in order to maintain, restore or achieve that intelligent and clear force - health.

Everything should normally work towards the health of man, of the nation and even of the world so that the interaction between man and nature finds a balance between the needs and the exchanges which are required for the conservation of all the infinite potentialities of the creation.

If the ethics of the sciences of life and health seek to maintain the human person in his dignity but also in the transcendent sense of his existence, it is even more indispensable that the need for a relationship – for encounter – with the other is kept alive and constant. A relationship of nearness, of inner-self, of intimacy which expresses itself in terms of shared responsibility.

To move out of oneself means to be concerned with others, their suffering, and their death, before worrying about one's own death.

For Islam, illness comes from God and illness does not take place without God having first envisaged the remedy. Hence the power to act on health is nothing else than a prayer uttered to God for us to understand the means by which to restore physical but also mental and social health.

In his 'Kitab ach-chifa', the great Arab physician Avicenna wrote that 'the art of medicine is made up in part of experience and science, and in part of the decision inspired by God at the moment of the intervening act'.

Muslim, Jewish and Christian medical doctors, such as Averroez, Razes, Abalcassin Azzahrawi, Maimonides, and Honyan (Johannitius) honoured and esteemed Islamic-Arab medicine for many centuries.

'Lord distance me from the mad idea that I can do everything!' said Maimonides in his famous prayer for medical doctors.

From this medicine and these medical doctors there sprang a humanism which transformed the mythological power of priest-doctors and the miracle-workers of antiquity – the holders of a mysterious power which conferred a mystical function on the practice of medicine – into a modern and scientific vision of medical power.

Thanks to the transformation in knowledge and to the enlightenment of religious faith through the application of knowledge and science, the most overall vision of man was what came to impose itself on the power of the medical doctor and the art of healing.

To respect man means to recognise him and to see him in all his transcendent humanity.

Are the forms of medicine which takes care of human life and the pharmaceutical industry which continues to provide new molecules or systems by which to restore health based upon an ethical foundation which is acceptable for ever, or, in opposite fashion, in forgetting about the humanity of man do they not do anything else but create therapeutic palliatives for virtual health?

From the prevention to the healing of illnesses, medicine has established its own power, which was empirical in the night of times but which has now become scientific in order to alleviate human suffering. This respect due to man is opposed to abdication, abandonment, and death: prevent, alleviate, do no harm! These are the three fundamental rules of classical medical ethics *(primum non nocere!).*

If power is defined as an operative capacity at the service of intelligence, this must guarantee its specific effectiveness as regards universal utility through ethics of good and evil which refer to:

1. Kantian morality which sees good only in that which can be universalised as an imperative of reason;

2. a more up-to-date vision of the ethics of responsibility which involves respect for humanity *as it is* and all of whose present and future (genetic and environmental) potentialities must be protected; and

3. lastly, spiritual ethics which allow every religion to propose its own vision of respect, humility and proportion in an absolute affirmation of the ultimate meaning of existence.

For Islam, religious ethics establish human norms and values within the constituent and indissoluble tie which links man to the God of the creation.

Man, in relation to God, is bound, by creative love and faith, to engage in a moderate use of his powers in order to respect natural balance so as to work for the salvation of the whole of mankind.

Islam says that only in Almighty God is there real force and real power.

How, then, can we have faith in the power of men when this power deprives entire African populations of drugs and medicines which are essential to combating AIDS because of mere commercial reasons,

and this at a time when this disease is ravaging the continent?

Where is justice? Where is the collective interest? To uphold the right to health of each and every man means to recognise the dignity of the human person and to affirm his or her rights, pre-eminent amongst which are the right to life and the right to health.

Power and health must, therefore, obey other impulses than the law of the market or the (economic and political dominion) of the strongest.

Religious ethics must unceasingly remember the primacy of man and the imperative duty of solidarity, and should not allow anyone in the world to be without the right to health, to nutrition, and to prevention.

If we are not careful, the medicine operating at two speed levels which differentiates the rich and the poor will really create a clash within humanity between the minority which gains from three-quarters of the resources of mankind on the one hand, and the immense cohorts of peoples who live in acute poverty, malnutrition and under-development on the other. This will lead to a crisis of the whole world because the planet will not have known how to respond to the desperation and the slow death of thousands of millions of individuals and above else of children who die every day in silence.

Does power mean indifference?

In the face of natural disasters which are a source of major misfortune for thousands of people, such as for example in Bangladesh, Algeria or Colombia, the exercise of power in matters relating to health does not involve only sending food and the personnel of aid organisations, which are swiftly left behind by the scale of the disasters.

In Afghanistan is the fact that bombing is accompanied by dropping food parcels not in some way absurd?

For this reason, in order to achieve new ethics in relation to the exercise of power in the world of health, there is an urgent need for:

1. ethics of general interest on a world scale;

2. ethics of responsibility towards humanity of today and the future;

3. ethics based on a humanism of respect for, and protection of, every human being in relation to his or her opportunities to life and to survival, to which he or she, indeed, has a right;

4. ethics of economics in relation to health, certainly, but also based upon a more equal distribution of wealth and the protection of the environment of the earth and the atmosphere;

5. ethics that make solidarity with poor countries a primary urgent need so that populations can remain in their countries and on their land, which has been made more productive, in order to avoid unstoppable movements and forms of immigration from the South to the North of the world, whose effects we have only just begun to see;

6. an intention to eradicate great pandemics such as AIDS, malaria, kwashiokor, and all the viral fevers connected with a disproportionate use of antibiotics.

Where is our world and our planet going?

In the 'crisis' that we are experiencing at a worldwide level we can observe that at the origins of injustice there are the denial of the right to live and a lack of solidarity which increasingly deepen the gap between the rich countries of the world and the other countries.

Authorities are still powerless when it comes to re-establishing order and justice for populations that fall victims to famine, a lack of water, and slow death by AIDS, which in Africa is spreading.

The irruption of intercontinental terrorism after 11 September 2001 shows that a fracture has occurred between the countries of prosperity and those countries which are in a state of need.

Nobody is any longer immune to the most sophisticated and mad forms of violent terrorism.

Ignorance, malnutrition and obscurantism are the sources of a fanaticism and violence in the poorest countries, and seem to draw towards Bin Laden cohorts of supporters, who in their logic of the pariahs of the earth, observe with satisfaction that they, too, can make people afraid and make other people experience the worry of their daily hopelessness.

In Conclusion

There is neither innocent knowledge nor innocent power. All forms of progress bring the seed of potential calamities, the risks of growing aggression, and men more closed up within their resources. Genetic manipulation, alienation caused by psychotropic drugs, information-technology police – all these deviations of modernity provoke prudent reflection.

Some perceive a world of violence and oppression to which badly used science has contributed.

Others, on the contrary, referring to the evolution of regulated systems, see the universe not as a static entity but as an evolutionary system, and remember the faculty possessed by man to adapt his behaviour to the new technical instruments brought by progress and which each new power can use for the good of mankind, as long as knowledge, power and morality are associated with health, because 'science without a conscience is the ruin of the soul'.

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A.R.K. PILLAI

5.2. Hindu Philosophy Offers Solutions

God Almighty created the universe, and all that we see in the world including human beings, the sun, the moon, the stars and the constellations are all part of His grand design and everything works to exact schedule as per the will of God. He is Supreme. He desires that human beings live in peace and harmony, work for the betterment of others and ultimately reach godhead after a series of incarnations.

Humans are different from animals, they are bestowed with a mind and intellect to fulfil the basic obligations. Most of the advancements that we see are the contributions made by the humans under this grand design. However, we have a definite cycle of life and duration on this planet. The mysteries of creation and growth are not known to us and still remain in the secret realm of the Grand Master.

According to Hinduism, we are on the face of this planet out of our own volition, propelled by our cravings and desires. Our soul is permanent and indestructible, but we assume new bodies and new lives, when we are born as incarnations. We carry with us the '*Karma*', the net result of our good and evil actions of previous lives. We are born with the *vasanas* (inclinations/ tendencies) as a result of such *karma* of the past. Our tendencies, thought forces and action drives are by and large directed by *karma*.

However, fate can be altered by well directed and timely action according to Sage Vasishta (a great Saint). Sage Vasishta in his long discourse with Lord Sri Ram had espoused some of the secrets of life and given the prince a blue print for action.

God incarnate Shree Krishna in his advice to Arjuna stressed the need for performance of duty on time and this is the core of *Bhagwad Gita*.

Karma

The Supreme Lord wants people to live in peace and harmony, do selfless work for others and keep on spiritual advancement till they reach the state of *moksha*, merging with the Infinite. We are given free will to think and act to comply with the Divine plan. Soul by itself cannot execute things and that is why we have a human form and body. We are not bodies but souls which are encased in human bodies and this distinction has been made clear in various texts. We need to ensure that our body and mind are in a state of perfect health to achieve the tasks assigned.

It is the will of the Lord that all His creation and living beings live in peace and harmony. That is why He has ordained a *dharma*, universal law for each one of them. *Dharma* is this law governing the conduct of man. *Ishwara* (God) has endowed man with intelligence for strict compliance. We must look upon the world as belonging to the Lord and it is our duty to conduct ourselves to conform to this belief. We are nothing before the Supreme Power and the creator of the universe. Our intelligence must guide us on the path of *dharma* and a life of righteousness in the midst of worldly life. For this purpose, we can look upon God for support.

Love everyone, live a life of sacrifice, serve mankind and make substantial advancement in spirituality are some of the important tenets of Hindu faith. *Dharma* serves us in life and the afterlife. We must be careful to follow these tenets assiduously during our life so that these will take us to a desirable state after we depart from it. *Dharma* is the insurance for afterlife. In the famous epic *Ramayana*, it is said that Queen Kausalya gave her son Lord Rama a sound piece of advice. She said that *dharma* alone would protect him during his fourteen years of exile in the forests and adds further that He should protect *dharma* with courage and steadfastness. It was a call to observe *dharma* with unwavering faith to gain everlasting bliss. Lord Rama is known as the greatest *Purushothama*, the most righteous king who ever lived.

The Hindu faith stresses the *Karma* theory and points out that man gets rebirth with the *vasanas* (tendencies) of earlier incarnations. The effect of earlier deeds will have relevance to present life and that is why men fall under three *gunas* (qualities). These are described as *Sattva guna* which denotes a high state of goodness, clarity and serenity; *Rajas guna* means speed, action and passion; and *Tamas guna* denotes sleep, inertia and sloth. It is believed that all undesirable developments are due to an imbalance in the *gunas* and the Lord decrees that man should go beyond the three *gunas* and dwell in the *Atman* (Supreme Reality). We must outlive this inheritance from previous lives and achieve salvation.

Health of body and mind are imperative for the successful conduct of *dharma* and life as a whole. Hinduism has answers for all gnawing problems. Life is not a bed of roses, it has its ups and downs even for the mightiest. The Hindu religion enjoins men to lead virtuous lives with peace and harmony, to be ever helpful to others and devote energies to seek God.

Proper health and equanimity are essentials to reach this goal. Sage Patanjali in his *Yogasutra* (a treatise on Yoga) outlined elaborate steps of *yoga* practices to maintain perfect physical and mental health.

Yoga

Yoga is a science and those practising it have to follow the rules governing it. The general feeling among people is that yoga is postures and meditative techniques without understanding the importance of *pranayama* exercises (*prana* means breath and *yama* means pause or regulating).

The word *yoga* means to join, in simple language. What are the two things which ought to be joined by the practice of yoga? According to the highest conceptions of Hindu philosophy, of which yoga is an integral part, the human soul or the *jivatma* is a facet or partial expression of the over-soul or *paramatma*, the Divine Reality which is the source of substratum of the magnified universe. Although in essence the two are the same and are indivisible, still the *jivatma* has become subjectively separated by *paramatma* and is destined, after going through an evolutionary cycle in the manifested universe to become united with Him again in consciousness. This state of unification of the two in consciousness as well as the mental process and discipline, through which this union is attained, are both called yoga.

According to the Hindu conception, there are four principal *yoga* divisions. Each carries with it the practice of correct and severe discipline. *Jnanayoga* is the exploration of the intellect beyond the normal boundaries of the human mind. *Bhaktiyoga* relates to devotional aspects to the supreme Lord. *Rajayoga* covers inner concentration while *Karmayoga* means disinterested action undertaken more or less directly on behalf of the Divine.

Apart from these four great *yogas* and their diverse variants and combinations, other classic yogas exist and these are *mantra yoga, japayoga, layayoga* and *tantric yogas, agniyoga* and *hathayoga*. *Hatha Yoga* is the yoga of the physical body and although it is within the framework of Hinduism, it has been practised by other religious groups like Sikhs, Jains, Parsees and Mohammedanns, sometimes under other names.

Hatha Yoga

Hatha Yoga offers several advantages for mankind. It can be practised by believers and nonbelievers in any part of the world. *Hatha Yoga* can be successfully practised by all, because it is not a religion and it does not demand or presuppose adherence to any specific philosophy, church or faith. It is a unique discipline with unparalleled beneficial effects.

Swami Sivananda has thrown much light on *Hatha Yoga* principles for the benefit of lay people

and seekers alike. Life and all its activities should be regarded as being part of the sublime action of nature. The *sadhak* (the adept) can perceive that through his heartbeat is expressed the song of universal life. If we ignore the needs of the body or if we look upon them as ungodly, then we neglect and deny the Greatest Life of all of which they are a part and we falsify the doctrine of the unity and the ultimate identity of matter and the spirit. The humblest of physical needs, when viewed in this light, take on a cosmic significance. The body is nature, its needs are those of nature, when man rejoices it in *shakti* (goddess) rejoicing through him.

If we are to fully appreciate this, it is necessary to perfect the manifestation of the body. Man who seeks to become master of himself must accomplish it on every plane – physical, mental and spiritual – since all are interrelated, being aspects of the same universal consciousness which exist in him. By the techniques of *Hatha yoga*, the adept seeks to acquire a perfect body which becomes an instrument sufficient to the harmonious function of mental activity.

The *Hatha yogi* wishes to acquire a body as strong as steel, healthy, free of sufferings and ready for long life. He is a master of his body and would vanquish death. He rejoices in the perfection of his body with the vitality of youth. An important aim of yoga is to accumulate and conserve every ounce of vitality possible.

We do not by any means have to accept this doctrine to practice *Hatha yoga*. The postures may look painful to the uninitiated, but for the trained adept they never induce discomfort or pain. We have everything to gain by *Hatha yoga* but nothing to lose.

The ancient sages suggested eight stages of yoga to secure purity of body, mind and soul and final communication with the Infinite. These eight stages are known as *Ashtangayoga*.

These are:

1. *Yama* (social discipline) including restraint and abstention. The moral principles under *Yama* are *Ahimsa* (non-violence) S*atya* (truthfulness) *Asteya* (not to covet and acquire others' possessions) *Brahmacharya* (celibacy – moderation in sex between married couples) *Aparigraha* (non acquisitiveness – abandoning wealth and means of sensual pleasures).

2. *Niyama* (individual discipline) covering rules of conduct towards oneself which are physical and mental. Cleanliness (S*haucha*), contentment (*Santosha*), austerity (*Tapas*), self-study (S*wadhyaya*) and surrender

to God (*Ishwara Pranidhara*) form the elements of *Niyama*.

3. *Aasanas* (postures) – there are many asanas.

4. *Pranayama* (Breath control) – The aim is to stimulate, regulate and harmonize the vital energy of the body.

5. *Pratyahara* (discipline of the senses) keeping the sense organs under restraint.

6. Dharana (concentration) helps the mind to concentrate on a particular object.

7. Dhyana (meditation) deep meditation destroys the baser elements and helps to develop higher qualities (*satvik guna*).

8. *Samadhi* (self realization) The meditator, the act of meditation and the object meditated upon, all merge into a single vision of the entire cosmos. Supreme happiness, free from pain or misery, is experienced under *samadhi*.

Illusion

The modern world has brought remarkable advancements in our lives. Look at the array of modern achievements: quick and safe air transportation, phenomenal breakthrough in science, technology, nuclear science, electronics, computer science and its applications, modern medicines, biotechnology and in fact in almost all departments of human vision and creativity. The western world is highly advanced in these areas while the developing countries are in the process of development. National and per capita incomes have registered high growth, food availability is much better, average life expectations have gone up and the quality of life in general is much better than before, thanks to the all-round development.

While progress has been spectacular, there is the other side of the coin. The population has grown considerably, exerting pressure on land, water and other natural resources. Nuclear and other weapons of mass destruction have proliferated. Fundamentalism and terrorism have shown their ugly heads everywhere. New diseases and drug resistant diseases have sprung up and we have few answers to these maladies. People have become more money-oriented, pleasure-seeking and intolerant to others' needs and aspirations. Diseases of affluence and those arising out of abject poverty exist side by side. Pollution levels have gone up, so also ozone depletion causing anxiety. Except for a handful of affluent nations, the national budgets for heath in many countries are woefully inadequate and the galloping population growth may throw out of gear all the planned efforts to usher in "health for all".

In conformity with the main theme of the sixteenth international conference, we recognize that health is a harmonic tendency towards fullness of life and this God-given power is authentic.

In the light of the changes brought about in modern society it is imperative to press for higher budget allocations for health and environment on the one side and promote steps to improve health awareness of people from ancient texts of different faiths on the other. Some of these precious storehouses of knowledge would have been lost to the community as linkages were lost, but we can still dig up relevant information, ascertain its validity and usefulness to modern society.

Solutions

While it is necessary to extend our search for excellence in science, technology, medicine and allied areas, it may be worthwhile to bring into focus available systems from far corners of the world for the benefit of mankind. A tilt in public perception needs to be engineered, though such an effort may encounter resistance from a pleasure-loving society as well as vested interests.

Here are some thoughts for the improvement of public health in a simpler but effective way:

Since ancient times, man has realized the need to maintain a healthy, strong and clean body; to follow *dharma;* and to experience the divinity within himself. *Yoga* deals with health, strength and conquest of the body. It also lifts the veil of difference between the body and the mind and leads the adept to perfect health, harmony and peace. The *yoga* practitioner unravels himself from the external body to the self within. Thus, the adept moves from ignorance to knowledge and from darkness to light.

Aims in life

Man has mainly four aims in life: *dharma, artha, kama and moksha*. *Dharma* is the universal law for man. Our intelligence must guide us on the path of *dharma* and a righteous life. Without *dharma* and ethical discipline, a good life and spiritual attainment are impossible. *Artha* is the acquisition of wealth for self-reliance, independence and higher pursuits in life. It cannot give lasting joy if health is in peril.

A weak and poorly nourished body is a fertile ground for diseases and worries. An unhealthy person cannot achieve his aims in life because of his handicap.

Kama means the pleasures of life, which are entirely dependent on a healthy body. The weak and the sick are not able to achieve the pleasures of human life. It is difficult for such persons to adhere to spiritual disciplines as well.

Moksha is liberation. The healthy and enlightened man achieves power, pleasures, wealth and knowledge. Such an elevated person rises above his *satvik, rajasik* and *tamasik* qualities and thus escapes from the grasp of *gunas*.

The body is the abode of *Brahman* (the Supreme being). The light within us is like a ripple in the vast ocean of bliss – that which we call *Brahman*, the Absolute, the Infinity, the Highest. We are that ripple, we are a wave. We should have the confidence that the light of life is within us. We must also know that we are the master of our destiny, no one else created that destiny for us. No one else can ask anything, we have to light our own lamp.

Initially, the disturbances of the external world and its charms and temptations will disturb man and create problems for him. That is because the desire is weak, it is only a tiny flame. But when that flame is protected and allowed to grow, no one can stop it. Once this stage is achieved, he need not protect the flame, because it burns up all that disturbs him. The fire and light is really with us. That is why the great *Upanishads* say 'Thou are that, thou art the Absolute'

Thus, we can achieve an absolute healthy body and mind by following the practice of *yoga*. It is inexpensive and can be done in one's own privacy. It can be done by the self without resorting to any external help. *Yoga* is a boon to mankind and by creating proper awareness, a gradual shift towards acceptance is bound to spread worldwide.

Pranayama – breath control

It may be difficult for the average citizen to follow all the intricacies of different *yoga* practices. But *Hatha yoga* principles with suitable structuring can be learnt by citizens even in today's busy schedules. Experts in the field of *yoga* have to share their thoughts and design a suitable structure and level which can be followed by the people. However, health should become a 'felt need' among the people. Improvements are possible for 'seekers', that is why it is said in the Holy Bible 'knock and the door will be opened'.

Pranayama is conscious prolongation, retention and exhalation. Inhalation is the act of receiving the primeval energy in the form of breath and retention is when the breath is held in order to savour that energy. In exhalation, thoughts and emotions are emptied with the breath. Then while the lungs are empty, one surrenders the individual energy. 'I' is the primeval energy, the *Atman*. The practice of *pranayama* develops excellent physical health, steady mind, strong will-power and sound judgement. These are not however, exhaustive. There are much more than what is listed here. According to the *Upanishads*, *Pranayama* is the principle of light and consciousness. It is equated with the real self. *Prana* is the breath of life of all energies in the universe. *Prana* is the hub of the wheel of life. Everything is established in it. All beings in the universe are born through it and live by it and when they die their individual life goes into the cosmic breath. If breathing stops, so does life.

Indian sages knew all these secrets over the generations. As said earlier, *Prana* means breath, respiration, life vitality, energy of strength. *'Ayama' (Yama)* means stretch, extension, expansion, length, breath, regulation, prolongation, restraint or control. *Pranayama* thus means the prolongation of breath and its restraint. Patanjali in *Yogasutra* describes *pranayama* as the controlled intake and outflow of breath in a firmly established posture.

Pranayama is an art and has techniques to make the respiratory organs to move and expand intentionally, rhythmically and intensively.

It consists of long, sustained subtle flow of inhalation *'puraka'*, exhalation *'rechaka'* and retention of breath *'kumbhaka'*. *Puraka* stimulates the system, *rechaka* throws out vitiated air and toxins while *kumbhaka* distributes the energy throughout the body. The movements include horizontal expansion, vertical ascension and circumfrential extension of the lungs and the rib cage. This disciplined breathing helps the mind to concentrate and enables the *sadhaka* (practitioner) to attain robust health and longevity.

Pranayama is not just automatic habitual breathing to keep the body and soul together. Through the abundant intake of oxygen by its disciplined techniques, subtle chemical changes take place in the *sadhaka's* body. The practice of *asanas* (postures) removes the obstacles which impede the flow of *prana* and the practice of *Pranayama* regulate that flow of *prana* throughout the body. It also regulates all the *sadhaka's* thoughts, desires and actions, gives poise and tremendous will power needed to become a master of oneself.

Erosion in faith

People in the earlier generations had a stronger faith in God and this belief in God Almighty was unshakeable. During the last half century or so, there has been a dramatic erosion of faith. This may be partly due to the fact that science and technology offer proof for findings. In that process, things beyond our senses and beyond normal comprehension were relegated to the background. God Almighty is supreme and His powers engulf the whole universe. But most of nature's mysteries are beyond the realm of ordinary mortals unless experienced through strenuous discipline and *sadhana* (practice). Thus contemporary society has become cynical of faiths, all faiths – this tragedy has befallen all sections of people. Ego and pride have taken over instead, leaving very little for the supernatural.

God has been and continues to be the anchor in the lives of men and one could always take shelter under His loving umbrella. Through delusion, this anchor went out of focus for a large part of the population. The ups and downs in life gave rocky jolts and modern man is in the grip of anxiety, depression and neurosis, whereus staunch believers have equanimity after surrendering completely to the Supreme Lord. Anxiety, depression and neurosis take away opportunities for quality life during the prime years. A concerted effort should, therefore, be made by all faiths to revive acceptance of God as the central theme in life.

Negative thoughts as well as passive thoughts swell in the

minds of a large number of people. These thoughts have a debilitating and crippling effect in the lives of people. Ancient sages of India laid down procedures in *Yoga* to encourage positive thoughts and nip in the bud negative and passive thoughts. The *Upanishads* say 'wake up' you are in the state of deep sleep of ignorance. You can become free of this ignorance and misery, you can understand the real goal of life. People with negative thoughts are usually dull, withdrawn and sick. Medicines seldom act on them because their minds rejects good things and also the curative power of drugs. Training of the senses and preparing the mind for the ups and downs of life are possible through *yoga* and meditation. Imagine how wonderful our planet would be if all people were positive-minded. *Yoga* has answers for this.

Chakras – power centres

There are seven power centres in our body known as *Chakras*. They are like power houses in the body. The manifestation of cosmic force is expressed through these centres which energize and govern the corresponding regions of the body. The vital force of *shakti* (power) in the body is organised in these specific centres. These are not physical centres, but they do have physical correspondence to the various plexuses of the body. The centres called *chakras* help to organise the physical body, although they cannot be perceived by means of the bodily senses and organs.

The *chakras* are located along the central axis of the body in conjunction with the spinal chord. Energy is usually focused in one or more of these centres to the relative exclusion of others.

The *muladhara chakra* (the root *chakra*) is at the perineum. Fear and insecurity are the major emotions and attitudes associated with this *chakra*. Those who are integrated at this centre have feelings of stability and security. At *muladhara chakra*, *kundalini* (*shakti*) is resting dormant at the base of the spine. Those who awaken this force from its latent to its active form become the dynamic geniuses of every age and culture.

The second *svadhishthana chakra* (hara plexus) is situated within the section of the vertebral column corresponding to the genital area. It is about halfway between the navel and the sex organ. Those who achieve mastery over this *chakra* get controlled expression of sexuality and the person gets free from enemies and shines like the sun. His words flow like nectar in expressing the wealth of his wisdom.

The third is the *manipura chakra* (solar plexus) located in the abdomen above the navel. Integration at this *chakra* helps assimilation of food and leads to cooperation and dynamic energy.

The fourth is *anahata chakra* (heart chakra) located in the region of the heart. *Anahata* is the centre where compassion, selfless love and empathy find place. This *chakra* motivates one to be active and *rajasik*, but at the same time it gives emotional maturity.

The fifth is *vishudha chakra* (throat *chakra*) located in the vertebral column in the hollow the throat. *Vishudha* means sacred. The sense of hearing is controlled by this *chakra* and it is the seat of creativity and receptivity. Devotion, surrender to God, trust and willingness are the qualities associated with it. Musicians and artistes are said to have their energy concentrated here.

The sixth *chakra* is *ajna chakra* (third eye) located inside the space between the eyebrows. *Ajna* means command. One who has mastered this level has inner vision, sees all things clearly and acquires higher intuitive knowledge. Logical judgement and intuition to the full are its attributes.

The seventh is *sahasrara chakra* (crown or lotus *chakra*) located at the soft spot at the crown of head. One who has attained this level can be in a state of *samadhi* – spiritual absorption of a high level.

Empowering the seven *chakras* through the *yogic* practices can give the *sadhaka* practically everything that one can wish for. This is by no means a myth but a certainty. The Japanese method of healing – *Reiki* – also gives universal energy at these *chakras* after proper initiation by a master and through effective *sadhana* (practice).

Sound

Mantras are given out by the people of wisdom and the evolved souls. Every *mantra* has a presiding deity. The deity is invoked by chanting. Of all the mantras, the most powerful and significant is the one with the single syllable called the *Pranava Mantram – OM*. It pervades life and runs through one's *prana* or breath. Every mantra includes the *Pranava, Om*. Without *Om*, no sacred chant has power. *Om* represents both the manifest and unmanifest.

The *Gayatri Mantra* is a powerful *Mantra* and is an invocation dedicated to the Lord Sun. It is recorded in the *Rig Veda* (sacred text). By chanting this mantra, the devotee is seeking for spiritual unfoldment.

There are several other mantras for appropriate needs and uses and if we can understand that mantras have tremendous powers, the purpose is well served.

There is a special practice called *'suryanamaskaram'* (devotional exercise to propitiate the Sun God) which is a powerful way to get sparkling health, good worldly happiness and spiritual advancement.

Diet is an important input in keeping good health. Hindu literature and ancient sages laid down minute details regarding diet. Vegetarian diet is the one best suited to man for physical health and spiritual development. If the correct type of food is taken in appropriate quantity and intervals, the person will have no problems with health. It is said that 'let food be thy medicine' meaning that proper food prevents any illness. It is preventive and curative. It is enjoined in the Nature Cure that alkaline foods should form 75% of daily diet and the rest may be acidic foods. There are lists showing division of these vegetables into alkaline and acidic varieties.

The Hindu code also lays down *vratas* (observing fasts) appropriate to age and situations. These fastings not only allow the system

due rest but also allow proper digestive power. Use of clean water, juices and fluids is also given in detail. These prescriptions are time-tested and if followed properly can promote good health. Milk and milk products, though not strictly vegetarian, are recommended because the cow is not hurt by giving its milk.

There are clear and definite instructions for preserving the sound health of infants, children and women. Special emphasis has been given to the pregnancy period and for lactating mothers.

Ayurveda

Ayurveda is a system of health care provided in ancient Hindu texts. It is based on *Ashtangahridaya* principles (emphasis on eight systems) and formulas are made from herbs and fruits. These are preventive, curative and restorative in nature and have no side effects.

Ayurveda texts were written in *sanskrit* and were open mostly to traditional *vaidyas* (healer families). Probably there was some secrecy attached to the administration of medicines and also there could have been a small number of entrants into this field. The texts written in palmira leaves could not withstand the ravages of time. Very little research work was initiated towards improvements in diagnostic procedures or *materia medica*, with the result that *ayurveda* had given way to modern allopathic system. However, a small section popularises this system and *ayurveda* is showing some revival symptoms. But the fact remains that *ayurveda* has definite answers for preventive and curative aspects of human health.

The Ancient Hindu System outlined four *Ashramas* (life stations) depending on the age factor. These are *brahmacharyam* (childhood and youth) *Garhasthyam* (family life) *vanaprastham* (beyond the middle age) and *sanyasam* (leaving worldly life to become an ascetic). The Hindu texts have prescribed activities, dharma, food patterns, exercise, rest and spiritual activities appropriate to the age and life station of the person. These are eminently suited for people at all stages for maintaining glowing health and cheerfulness.

Ahimsa

Hindu philosophy has all along focused on *dharma*, the law of righteous life and adherence to *Ahimsa* (non violence) to all living beings through thought, word and action. Because of the *Ahimsa* doctrine, the Hindus have followed a path of live and let live policy. That accounts for several invasions and the week-kneed efforts of the people to defend their homeland.

Hinduism emphasises an absolute tolerance to all other faiths. India has followers of almost all faiths in the world and they have been living together in peace and harmony over the centuries. Peace and harmony coupled with *Ahimsa* doctrine promote good physical and mental health and the daily prayers include a passage *'Loka Samastha Sukhino Bhavanto'* (Let peace and happiness be with every living being).

Fundamentalism, terrorism and disputes among various sections and nations in the world are threatening life on this planet. Man has perfected nuclear bombs and weapons of mass destruction. Terrorist attacks have increased on a global scale. Religious intolerance has created gulfs among various faiths. No religion has ever promoted strife and conflict. However, the texts are twisted, misinterpreted and flouted for sectarian gains. Conflicts of this nature have killed millions of people, maimed a large number and rendered a few millions refugees. It is necessary to bring sanity and sobriety in such a troubled situation and ensure enjoyment of life and property to all people with promise of good health.

Change for progress

A craze for material wealth, selfish pursuits and enjoyment of sensual pleasures have been the popular pattern everywhere. The longing for worldly pleasures is on the rise. These are temporary and fleeting in nature but modern man is not aware of this truth. We have a heritage and wisdom from ancient days. But these are available to a microscopic minority of ardent seekers. They seek seclusion to progress on their own paths. In this process there is an inherent risk of these pearls of wisdom being lost to humanity forever. It will be a thousand pities if such a fiasco is allowed to ruin us.

Wisdom must prevail to harness the principles and procedures laid down in sacred texts and the sayings of the ancient sages of Hinduism philosophy. Similar efforts to bring out truths from other faiths must also be made. Having done so, eminent world leaders must come together and bring out principles and procedures appropriate to the understanding of the modern man. Governments of various nations may be advised to encourage the popularisation of these beneficial steps.

The media may have to change its present day 'news value' concept to give wider coverage of progressive concepts. The existing trend of sensationalism to increase readership scales may be given a second look. The visual media including cinema and the television need to bring healthy practices to the fore by adopting a kind of self-censorship. The media is very powerful and can reverse the trends, bringing about a healthier

and more wholesome attitude among people. A determined and well-planned beginning has to be embarked on and that too without loss of precious time. By doing this, the media can engineer a shift for the common good.

Struggle against leprosy

The struggle against leprosy and social stigma went on and on through the centuries. In 1982, India had the largest number of patients; 4 million out of a global count of 12 million. India's fight against leprosy has produced spectacular results and the patients are about half a million. WHO and the government deserve compliments. Equally significant is the heroic struggle and sacrifices made by rev. sisters, doctors, paramedics and several thousands of volunteers.

I have been associated with leprosy eradication work in India for nearly three decades now. The Indian Leprosy Foundation (ILEF) of which I am the Founder President, is a national voluntary organisation committed to a leprosy-free India. The media has made a significant contribution in India's fight against leprosy. ILEF thanks God Almighty for giving us strength to serve the poor, neglected, ostracized leprosy patients all over India with dedication and a spirit of brotherhood. (www.indianleprosy.org)

Changes do not occur by mere wishing. An unwholesome trend can only be stopped by wise leadership and a planned effort. The international conference convened by the Vatican is, certainly a monumental step in this direction and deserves world recognition and acceptance.

May God Almighty bless this wonderful global initiative so that people can eventually sublimate and edify their lives.

I thank you all!

Dr. A. R. K. PILLAI
President of the Indian Leprosy Foundation India

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CHIN-LON LIN

5.3. Buddhism

Background

It all started 2.546 years ago (545 BC) when Buddha was born "a prince" at the foothills of Himalayas.

Buddha found the path to Enlightement (Nirvana) at age 35. Preaching for 45 years, recorded by Buddha's disciples, the basic teachings of Buddha were:

1. *The Truth of Suffering:* The world is fall of suffering. Birth, aging, sickness, and death are the natural courses of life and are all suffering.

2. *The Truth of the Cause of Suffering:* The cause of human suffering is undoubtedly found in the thirsts of the physical body and in the illusions of worldly passion which we root in the intense desires of physical instincts.

3. *The Truth of the Cessation of the Cause of Suffering:* If desire, which lies at the root of all human passion, can be removed, then passion will die out and full human suffering will be ended.

4. *The Truth of the Noble Path to the Cessation of the Cause of Suffering:* In order to enter into a state where there is no desire and no suffering, one must follow the Noble Eightfold Path: Right View, Right Thought, Right Speech, Right Behavior, Right Livelihood, Right Effort, Right Mindfulness And Right Concentration.

The primary sources of all human unhappines are desire and ignorance, and from these primary sources, greed, jealousy and foolishness arise and become the three fires of the world. These raging fires not only burn the self, but also cause others to suffer and lead them into wrong acts of body,

speech and mind. To quench these three fires, one must observe the precepts, practice concentration of mind and have wisdom.

Human beings tend to move in the direction of their thoughts. Mind is the origin of everything. People must closely guard their minds against impropriety and misfortune. They must eliminate thoughts that stimulate greed, jealousy and foolishness, but encourage thoughts that stimulate charity and kindness.

People cling obstinately to wealth, honor, comfort, pleasure, excitement and most importantly "egoism". This is the very source of human suffering. One should get rid of a selfish mind and replace it with a mind that is carnest to help others.

There are Four Unlimited States of Mind that the seeker of Enlightenment should cherish: Compassion, Tenderness, Gladness and Equanimity. One can remove greed by cherishing compassion; one can remove anger by tenderness; one can remove suffering by gladness; and one can remove the habit of discrimination by cherishing an equitable mind.

Tzu-Chi (Compassion Relief) Foundation

Buddhism was trasmitted to China, and subsequently to Taiwan. Our Dharma Master Cheng-Yen was born in 1937 and exposed to the teaching of Buddha at a young age due to her parents' illness; she left home in 1961 at the age of 24 years; formerly became a Buddhist in 1963; studied under Dharma Master In-Shun and was instructed to devote her life "For Buddhism, for all living beings". Master Cheng-Yen founded the Compassion-Relief (Tzu-Chi) Foundation in April 1966.

The Mission of Charity: She started charity work on a small scale in the eastern part of Taiwan, and provided clothing, food and even housing for the old people and kids who were left behind when young people moved to the western part of the island to seek work.

The Mission of Medical Care: The Master soon realized that behind poverty there was often illness and there was no modern medical facility in the eastern part of Taiwan at that time. In addition, most private hospitals required a deposit before admission which many people could not afford. So she opened a 700-bed modern hospital that required no deposit before admission in August 1986.

The Mission of Education: After the hospital opened its doors, the Master found that recruiting of capable nurses, physicians and other medical personnel was a very difficult task for this remote eastem town; therefore she founded the nursing college in 1989 and then the medical school in 1996. These schools have had several classes of graduates and provided the much-needed man-

power. Other colleges, such as Humanities and Life Sciences, were established and together they formed the Tzu-Chi University. In addition, an elementary school, junior high and high schools were built and in the year 2000 and we celebrated the completion of our "Complete education" programs: from nursery, kindergarten, elementary school, junior high school, high school all the way to colleges and postgraduate doctoral programs.

The Mission of Culture: Education should not be limited to the classroom or schools. It should be able to reach a larger audience. The Master was invited by the Ministry of the Interior to speak to a large audience on June 18, 1990 on the topic of "Purifying the Mind with the Tu-Chi Spirit"; the lecture was also broadcast on television and received much praise from the public. The Master was invited to lecture around the island the next year. The speeches were very influential in guiding people toward doing good and promoting social harmony. Through periodicals, books, radio broadcasts or TV programs, the stories of good people and good deeds were reported and human goodness received praise and great (selfless) love in the world was advocated. It culminated in the inauguration of the Tzu-Chi's own TV station in 1998.

For the past 35 year, our organization has been devoting itself to these four major missions. And because of practical needs, our organization expanded into International Disaster Relief, Bone Marrow Donor's Registry, Environmental Protection and Community Volunteerism. Together, they formed what we call "One Step, Eight Footprints".

As an extension to The Mission of Medical Care, and in response to rising needs, we established the Tzu-Chi International Medical Association (TIMA) and carried out regular free medical missions to remote areas around the globe and provided much needed medical care to thousands who cannot afford modern medical care. In addition, we try to establish a network of medical facilities within the island of Taiwan in order to provide top-quality, tender loving medical care to the people on the island of Taiwan.

The Building of a New Modern Hospital

Inception and Construction

More than ten years ago, a group of caring people, including the former major of Dalin, were troubled by the lack of a modern medical facility in Chia-Yi county. A horrible story had been told about relatives dying from car accidents on the freeway when they rushed, and wanted so eagerly, to visit their loved ones who had been admitted to hospitals either in Taipei or in Kaoshiung. They formed a committee to promote the idea of building a modern hos-

pital in Dalin and they searched all over Taiwan, inviting all possibile parties to come to Dalin and they finally went to Hualien. When Master Cheng-Yen heard their stories. she promised them that if they could come up with suitable land, Tzu-Chi would build a hospital at Dalin.

It took them five years and over 200 meetings with the local, county, provincial, and central governmental officials to finally secure this piece of land, formerly

a sugar cane field, from the National Taiwan Sugar Company.

The design and construction took another five years. Thousands upon thousands of people all across the globe contributed to the construction fund and many more helped in the design and construction process. The hospital is the crystallization of countless people's love and caring.

Thousands of people all across the world donated and helped to build this hospital in Dalin which is a small town in Chia-Yi, a county to the south of Taichung.

Patient-centered design

We designed the entire hospital with the patient in mind; we have a spacious entry hall and a large lobby with a high ceiling. Greeting the patients is a large mural depicting the Buddha and his disciples attending another of his disciples who thought that the way to enlightenment is through self-realization and never cared about anybody else, but when he was sick, nobody came to help. So the Buddha came in person to take care of him and when the Buddha and his disciples wiped down his sweat, the disciple suddenly realized that the way to enlightenment is through helping others. This is basically the mission statement of our hospital: "To care compassion, to give with joy".

We use low counters so patients can sit instead of standing in line waiting to register. We used calligraphy scrolls, paintings, and floral arrangements to decorate the hospital in such a way that patients feel at home.

In the basement, where we house our radiation therapy department when the patients lies on the treatment table, he/she can enjoy not only beautiful scenery around him/her but also the white clouds, blue skies and flying birds we project on the ceiling.

In the palliative care suite, we provide a furnished living room, an entertainment area, and a dining area together with a kitchenette so that a family can prepare food for our patients. In addition, we created a rooftop garden, complete with shrubs, vines, colorful flowers and a gazebo. It is set in such a way that the hospital bed can be rolled out onto the garden, so that our terminally ill patients can fulfill their last wishes which often are just to enjoy the moonlight, the sky and the little breezes at night.

In the intensive care units, we tried to provide natural lighting as much as possible in an effort to reduce ICU psychosis. We put in a nurse's alcove between two beds and installed a Clinical Information System (CIS) so that all monitored data, including parameters from ventilators, are recorded automatically into the computer and the nurses can be with patients at their bedsides almost all the time.

Advanced Technology

We put in the most up-to date version of medical equipment and design the hospital with an e-hospital concept, working toward a totally film-less, paper-less environment.

We created a high-speed electronic highway (1 GB/sec) inside the hospital, which serves as the backbone for the transmission of all clinically relevant data between different departments. We have also successfufly integrated our system so that through one single line, a single monitor, we can view patients' medical records, lab data, EKG images that includ X-rays, CTs, ultrasounds and even arthroscopy, endoscopy pictures and pathology slides.

Our Direct Radiology (DR), which captures X-ray images directly into the computer, is the first one in Asia. Our triple-energy linear accelerator is among the first ones in Taiwan. Our ultrafast multi-slice spiral CT can obtain and regenerate images at a high speed so that almost real time 3-dimensional images can provide the surgeons with excellent anatomic details otherwise unavailable.

Our fully automated chemistry analyzer automates not only the blood analytic process but also the reporting process so that the technologist does not have to copy the result and enter into the computer manually.

We imported a tunnel-type-cleansing machine from Japan so that our surgical instruments can be automatically cleansed, ultrasonically agitated, dried and sterilized.

Tender, loving, comprehensive care

We try to use the most advanced technology to provide tender, loving medical care in the following manner:

Convenient: We provide transportation to and from the hospital for those elderly people living in remote areas with no means to get to the hospital.

Comfortable: We make even illiterate old people feel at home.

Complete: We provide complete arrays of services so that patients can obtain a one-stop complete medical care.

Continual: We provide not only inpatient services but prevention, after-discharge home care as well.

Comprehensive: We feel that treating the disease is not enough,

we need to take care of the patient as a whole, including his body, his mind and his spirit.

We agree one hundred percent with the motto of the City of Hope "There is no profit in curing the disease, if in the process, we destroy the soul".

Conservational: We also realize that our resources are limited so we practice conservation, we limit our use of disposable materials and throughout the hospital our physicians, nurses, technologists alike use reusable bowels, chopsticks, cups and wash their utensils after each meal.

We recycle our garbage, re-use our water, and provide a green environment to reduce energy consumption.

Computer-based: We created an ultra-fast electronic highway inside the hospital and successfully integrated our hospital information System (HIS), Picture Archiving, Communication System (PACS), Laboratory Information System (LTS) and Clinical Information System into one system so that most if not all a patient's clinical information can be accessed through one single line, one single monitor.

Cost-effective: We care and we are community-oriented.

Community-oriented: We believe that medical care should not be limited inside the four walls of the hospital.

Compassionate:

Follow the spirit of devoted physicians

As part of our inaugural celebration, we organized an exhibition of devoted physicians who had helped Taiwanese people in the past 100 years and the stories were quite touching. This began with Dr. Jacob Maxwell who founded the first western hospital in Taiwan, the Sin-Lau hospital in Tainan, 135 years ago. For over 90 years, he and his son devoted their lives to taking care of Taiwanese people. Dr. George Leslie Mackay, the famous dentist who founded the Mackay Memorial Hospital in Taipei with a branch in Taitong, pulled over twenty thousand teeth. Rev. William Campbell risked his life and helped the blind people in Taiwan.

The famous Dr. David Landsborough, who founded Chang-Hua Christian Hospital, cut the skin from his wife's thigh and transplanted it onto a small boy who suffered from severe burns requiring skin graft but had no donors available. According to that small boy who later on turned to be a great pastor, "Although the skin graft didn't take, it deeply implanted into my heart forever". Dr. George Guishue Taylor who devoted himself to help the patients with leprosy died while aboard the ship on the way back to Canada. His last words "Bury me in Formosa, the island I loved the most".

We follow the spirit of all these great physicians and provide top quality medical care to our countryman and to be the life-keeping cornerstone of Yin-Lin, the Chia-Yi region of Taiwan.

Conclusions

We follow the principles of Buddha's teaching and our Master's commitment to do everything "for the sake of Buddhism, for the sake of all living beinges". Besides work in the areas of charity, education and culture, we have worked hard in the area of medical care: we established the Tzu-Chi International Medical Association to provide free medical care to those in need around the globe. And we are establishing a network of medical facilities within the island of Taiwan in order to provide tender loving medical care to the people on the island of Taiwan. The first general hospital opened in 1986 and the second one opened its doors in August 2000.

Patient-centered design, high technology, spacious building, together with warm and courteous staff, provide a unique kind of medical service. It is patient-centered, convenient, comfortable, comprehensive, continual, complete, compassionate, conservational, community-oriented, computer-based, and cost-effective. It is all based on the Buddhist principle of "To care with compassion, to give with joy".

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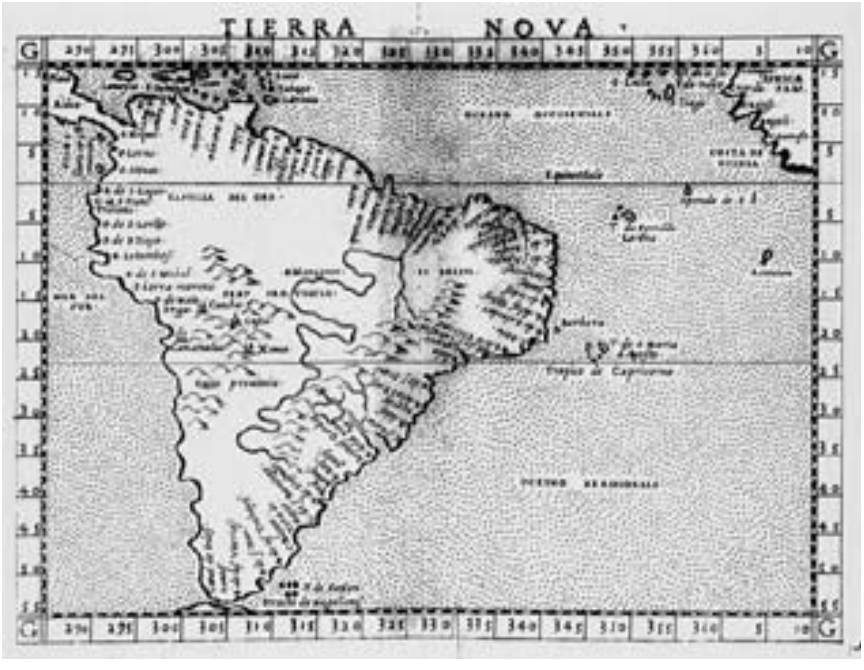


IV. PRACTICAL ACTIONS TO BE PROMOTED

FRANCESCO SILVANO

1.What Should be Done in Relation to the Economy and Health

Premise

The subject that I am about to address in this paper seems to me to involve two characteristic factors: the first is an expression of the complexity of a question that links, as we will see, aspects which can be reduced to a single unity only with difficulty, and the second is an expression of a concreteness which places emphasis upon doing. And doing means that initiatives should be taken, that situations underway should be modified, that elements of change should be introduced, and that what has to be done and with what objectives should be established. It means beginning with a situation held to be imperfect, which is in need of measures of intervention, in order to reach a goal which ensures new guarantees, with correct visions, and with pathways directed towards going beyond the contingent towards a dynamic of positive evolution.

If there was enough time to engage in a detailed analysis of the causes which have brought about a divergence between the economy and the management of health, at a world level or even at merely a national level, I would have to deal here with this subject employing an approach that would of necessity be faulty and incomplete.

It is, therefore, preferable to proceed by rapid references in order to bring out points of reflection and in order to throw light on areas of darkness which often in a strongly contradictory way tend to be transformed into basic postulates. Thus it happens that the basic question is cancelled out *a priori* in order to make way for messages that can obtain easy forms of agreement and spontaneous support. I am referring here to the concept which is strongly advocated within hospital strategies of the centrality of the patient, a centrality that can acquire a meaning only if beforehand one proceeds to a change in the management structures and of the forms of behaviour of the health care workers by investing in the formation of a new culture. This, however, is something which requires years if not decades before it becomes *mens*, that is to say an accepted mentality able to inspire tasks and actions in people's daily relationships with reality.

The Order of Priorities

The establishment of an order of priorities between health and the economy might appear to be totally superfluous because it is clear that tools are at the service of man and not the other way round. To say that health takes pride of place and that economic profits have to be defined with reference to the defence and promotion of people's health seems to be almost taken for granted and to be something that is not deserving of particular attention.

However, if the horizon of reference is expanded it emerges that at the centre of economic activity in its widest sense the defence of the dignity of the person does not find a place. Indeed, this dignity is subordinated and conditioned by the desire to defend and promote legitimate and non-legitimate interests. The person is taken into consideration as a productive factor or as a factor in decision-making in a process of the acquisition of goods and services and is not seen as a subject who is worthy of the highest level of defence and promotion possible.

Proof of this in the health field is to be found in the fact that only recently has the concept of the defence of health made a timid appearance. This concept finds expression in systems of information, training, and prevention. Previously it was the case that all interest appeared to be directed towards the principle of providing care and treatment to patients.

The dignity of man cannot be conditioned by economic factors. There can be different lifestyles, and different requirements dictated by historical factors and/or factors of custom, but the person must be defended in relation to his or her

freedom, which is also made up of the certainty of seeing his or her primary needs met.

This does not remove the fact that one has to take into account the resources that are available, towards which greater attention must be paid the more apparent the separation between needs and the ability to meet them becomes. There is no space for idealistic temptations or illusory formulas at the level of principle. However, it is vital to set out an approach which is as loyal as possible to the principle of change and is as consistent as possible with the appeals made by the Holy Father in relation to the need to restore to all men the prospect of living in justice, where justice means having the forms of care and treatment which are necessary in situations of illness or involves being able to prevent the spread of destructive pathologies.

Inequality and Subsidiarity

When the encyclical *Centesimus Annus* was published, men and women of good will were moved by feelings of keenly-felt gratitude towards the Holy Father, not only because of his courageous condemnation of continuing social imbalances, but also, and above all else, because he had brought out how erroneous it was not to address the question of a fairer distribution of resources.

Unfortunately, after the usual oral exercises of commentators, many of whom did not even read the texts referred to, there emerged only silence, something which is a comforting way of ignoring the risks and dangers and of not feeling the impact of the call to become involved. Everything has remained as it was twenty years ago, and other appeals, such as the insistent call to reduce the debt of developing countries, are not listened to or are only marginally listened to. However, looking at things closely, the situation has become worse, generating negative consequences within a globalised economic system and increasingly creating a reality characterised by worlds that are in opposition.

The rapid spread of the HIV virus, which has taken place in a context characterised by the absence of protective barriers, now raises the prospect of the extermination of whole populations. And while the West boasts that it has reduced infant mortality levels to negligible proportions, it is the case that in some African countries about 20% of children die during the first years of their lives. In the West, in Italy, the expenditure of hundreds of millions of lire takes place to save the life of a child who is afflicted by congenital heart deformations, at a time when the same sum in the Congo or in Rwanda would heal or lead to the survival of hundreds of children.

On the one hand we have the 'excessive' culture of the defence of life, and on the other, the culture of resignation and of the acceptance of death in a context where suitable means of support do not exist, where regularity in the provision of aid and suitable structures are absent. Yet, beyond the tragedy of 11 September and the inevitable consequences that are being generated and will continue to be generated by that event, our world has discovered the idea of globalisation, generally understood as a modality involving the passive receiving of influences generated by those who have greater power and resources, something which demonstrates a worrying inability to draw upon the positive in order to contain the negative effects generated by situations of excessive misery and the drama of having to die of hunger. One could argue that in reality the industrialised countries have committed themselves to acting and have drawn up new strategies and allocating funds for co-operation. But, to look at things closely, we are very distant from a serious approach to the problem if it is the case, and indeed it is the case, that two years ago at the Conference of Kyoto it was even argued that measures taken to spread Internet and the services offered by the Web would have brought about a radical move forward for the economies of poor countries and given rise to a virtuous spiral of social advance. Unfortunately, the wise men of Kyoto did not take into account the fact that countries like the Democratic Republic of the Congo have no basic infrastructures, beginning with the supply of electricity, and are thus excluded from the Internet. In the same way there was a wish to blind oneself to the fact that in the Congo the opposing interests of super-powers bring about the non-employment of resources and the death by hunger of hundreds of thousands of people.

What, therefore, should be placed in opposition to modern globalisation if not the dimension of that kind of globalisation which arose on the shores of Lake Galilee with Jesus' invitation to the Apostles to evangelise the world? If not that action defined as 'subsidiarity' which down the centuries has been in reality the primary expression of the presence of the defence of the culture of care for pilgrims and the sick?

Recently, John Paul II observed that when the Lord said to Moses 'I will walk with thee', He wanted to declare that He wanted to be present in the world, to intervene through His presence, because He is interested in what man experiences, dialogues with man, and looks after him.

Subsidiarity is born from this awareness that mankind is not an abstraction or a term derived from a definition made by sociologists, but rather a reality which is rooted in the self and knows how to understand the needs and the aspirations that define man.

Subsidiarity is not the ultimate and definitive answer to the failings of an economic system which is fragile and exposed to the unpredictable nature of events. It is, rather, an important sign of the desire to feed hope by appreciating even the smallest contribution which is translated into a support for brothers and sisters who need to live with dignity in the plan which God has for them.

The Connection between Income and Health

The role played by environmental variables and variables connected with forms of behaviour can be examined with reference to one of the most widespread indicators of the conditions of life of a population. I am referring here to the factor of the growth in economic prosperity which finds its most essential expression in the parameter of *pro capita* income. Recent studies have demonstrated that there is a strong correlation between death rates and economic growth and development: the reduction of death rates is in fact associated with an increase in average income.

However, the connection between income and health is not a matter of easy interpretation because an increase in income influences a set of variables such as the level of education and health care expenditure, which in turn, and in an autonomous way, bear upon the level of health. These are a series of rather complicated interactions which have not been sufficiently investigated.

It is a matter of fact that given equal incomes, higher levels of education are associated with better conditions of health. This is because a higher level of education leads individuals to be more careful about risk factors, more effective in recognising the symptoms of an illness, and more rapid in deciding what actions to take. And it is at the same time possible that better conditions of health will favour the growth of individual income. On the other hand, those people who are less educated suffer more frequently from bad conditions of health because of a spiralling process in which the different variables are at one and the same time both a cause and effect of successive changes.

It is however possible that an increase in income has an effect on life expectancy which is in part positive and in part negative. The positive effect is connected with an improvement in conditions of hygiene and diet; the negative effect is associated with forms of behaviour which damage health, and this is something which we observe every day.

All other conditions being equal, it is possible to posit that the relationship between income and health first involves an increase and then

involves a decrease. Indeed, where there are very low incomes the relationship is positive and is linked to factors such as basic diet, whereas beyond a certain income the relationship is negative because of the greater presence of harmful forms of behaviour and situations such as stress, unbalanced diets, a sedentary life, smoking, alcohol, and rapid forms of transport.

It is equally interesting to study the connection between income and death rates, putting together on the one hand poor countries and on the other rich countries. The results of the research which has been carried out in this field indicate that in developing countries life expectancy increases regularly in relation to an increase in the average *pro capita* income, whereas in developed countries life expectancy increases with a reduction in inequalities within society as a whole, and this means that in the Western economies health is linked to the configurations of income distribution rather than to the average levels of income. It follows from this that in rich countries a further reduction in mortality levels can only be achieved through the adoption of active policies and measures directed towards the redistribution of income.

The Role of Health Care Systems

An analysis of the role of health care systems in the promotion and defence of health shows that given that the growth in *pro capita* income is usually associated with an increase in the size of resources allocated to health, health care expenditure as well is statistically correlated to a reduction in mortality rates. This is a principle that encounters a specific and special confirmation in the field of child mortality rates, which are closely correlated to the various levels of expenditure on health care.

There is also a close positive correlation between the level of *pro capita* income and the relationship between health care expenditure and gross national product: as income gradually increases, the scale of resources allocated to health tends to grow and this phenomenon expresses itself in time and space. The ageing of the population, the spread of medical technology, the modification in conditions of life and work, and the development of social legislation all constitute equal leading factors behind an increase in health care expenditure higher than that registered in relation to gross national product. This is a constant in time: in Italy we have gone from 3.6% in 1960 to about 12% in 2000.

It is also interesting to observe that the level of the defence of health grows with the quantity of services supplied, but as the use of health care services gradually increases, the increase in health registers levels which are increasingly modest in scale (in economic terms this would be expressed as an example of decreasing marginal returns). However, the constant increase in the quality of health care services supplied to the population produces effects on health which are in part positive, in part dubious (the reduction of the autonomous defence systems of the human organism, the increasing medicalisation of states of ill-being), and in part negative (iatronegic illnesses, in particular in hospitals). Furthermore, mortality rates and illness rates are today related to risk factors which can be removed in the main by non-health care measures and initiatives (one thinks here of the phenomena of drugs, of over-eating, and of traffic accidents). Lastly, the marked discrepancy between the real effectiveness of health care services – measured in terms of the working conditions of health care structures – and theoretical effectiveness measured in terms of ideal or optimal conditions, helps us to understand the

weakness of the relationship between the quantity of services provided and increases in levels of health. In essential terms, one reaches a conclusion which is banal and taken for granted: we need to address questions of organisation and test the efficiency of the services that are provided.

In the light of these observations, we have to engage in a critical rethinking about medicine and its present-day way of operating in the defence and promotion of the health of society as a whole. In truth, the health care policies of advanced and developed countries seem today to be profoundly obsolete when the changed needs and requirements of the population are taken into account, and this at a time when, in fact, major improvements can be obtained right now by avoiding an increase in health care systems of a traditional kind through the employment of policies involving a conversion of expenditure in favour of those measures and initiatives whose positive effects are higher, and through the setting in motion of a process of co-operation between sectors, which also involves the sectors outside health care in a strict sense, and which is able to promote the defence of the conditions of health of the weakest categories of society above all.

We need to act beginning with strong ideas capable of directing the reform of health care systems and then move towards objectives which correctly take into account priorities and expectations, and in so doing avoid their subordination to the defence of special interests and promote real emphasis on attention being paid to the roles of the prevention and the promotion of health.

A Health Care Service as a Company

Reference has already been made to the economic impact of the cost of health on gross domestic product, and it has already been emphasised that this impact tends to increase despite the commitment, which is more declared than real, to a containment of expenditure. It is worthwhile, in relation to this point, to consider the fact that the health care system absorbs more than double the value of the agricultural production of our country and that it constitutes the largest service 'industry', exceeding by a large degree the values of the electrical or telephone sections.

And yet beyond the many proclamations and declarations of principle, and in contrast to what should in fact be a primary point of reference for policy at the level of organisation, we are face to face with the singular phenomenon of health care planning subject to a constantly changing set of laws, rules and directives, and this to the point that such planning is contradictory and unable not so much to implement reforms but even to set them in motion. A cause of this is certainly to be found in the excessive complexity and lack of precision which characterises our legislation, but above and beyond any other factor we encounter the inability to project an organisational system which is structured in such a way as to provide effective answers to needs and requirements. Numerous examples could be given of this but I will confine myself to citing one which is especially significant. The Italian health care system is structured into three levels, which in turn have their own sub-levels: the local provision of care based upon the general practitioner and non-hospital specialists, the health care district, and the hospital sector dedicated to serious cases. The health care district, which should be the bridge at a ground level between the general practitioners and hospital treatment, has been for some time planned and defined in terms of its functions but it has never actually been established. Looked at from the point of view of a company this is equivalent to depriving a company which distributes products of a warehouse for storing its final products or of production materials or a network of distribution.

We are therefore in the presence of an absurd situation, which is to say the least paradoxical, but the fact is that attention is exclusively centred around the question of the role of medical doctors or around the projecting of the hospitals of the future or around the indiscriminate reduction of the number of hospital beds.

It is certainly not an easy task to govern this complexity. Indeed, it involves: freedom from certain influences, such as, for example, the defence of corporate interests; the provision of instruments suitable for the promotion of necessary changes; great balance in the evaluation and assessment of factors; continuity of action over time and a commitment to follow a leading path avoiding the risks of lateral dispersion; a widespread consensus on the part of all the subjects involved; and suitable instruments for the supervision and monitoring of the processes of implementation.

Moreover, if one thinks that in a period which has been so much marked by a different distribution of powers and responsibilities, powers and responsibilities which have been transferred from central government to the regional executives, the answer at the level of planning which has been identified is one based upon a commitment of the regional authorities not to exceed the limits of expenditure linked to the provision of funds, one can understand why not only has it not been possible to govern this complexity but that the opposing result has been achieved of an increase in the gradient, and with the inevitable negative consequences.

The Actors of the Health Care System

A system is not necessarily a set which is consistent in terms of its component parts. This is because often – as happens in the case of health care – the different actors normally follow diverging interests and trajectories. The problem is that of conferring coherence on a set of parts by reducing the areas of conflict and identifying common denominators.

In the health care system there are the consumers, the producers, and the state, which deals with the provision of public funds.

Consumers who are free to direct their choices do not know what they really need and aspire in a general way to being guaranteed that they will be in good health; they depend upon the decisions of those people who are responsible for managing the services of care, the costs of which are borne by a third party; they engage in an emotional assessment and evaluation of the quality of the services provided according to the circumstances involved and the kind of relationships which have been established; and finally, be-

cause of the spread of the Internet they gain access to information directly without knowing how to filter or assess that information, thinking, indeed, that they can know more than medical doctors, on whom they bestow a marginal role.

Producers have an obvious interest in providing and selling the largest number of services possible, often without ascertaining whether these are suitable and effective necessary measures. They can manipulate information to their own advantage and generate an additional demand. And they tend to reduce their commitment where a strong ethical sense is absent, adopting the alibi of the need to contain costs.

Furthermore, neither the consumers nor the producers have to face the consequences of their choices because medical services are provided free of charge and a third party is responsible for footing the bill. And the patients do not encounter the application of a brake to the price of the services and the same may be said of the medical doctors in relation to the purchasing power of their customers. Hence there arises a structural excess of demand and the efficiency of the system receives no incentive at all.

The system of public funding is maintained by a system of taxation on incomes and it distributes funds according to presumed health care needs (it is no accident that still today in the allocation of funds no reference is made to such differential factors as average life span, incidence of illness, and the concentration of certain pathologies in specific geographical areas).

The illusion that forms of care and treatment are anyway always due, and that needs even if not real should be meet, means that people ignore the fact that we are faced with the reality of a system which has been rendered precarious by a scarcity of resources and by the creation of elements which act to increase health care expenditure (this is because research and technological development allow the treatment of illnesses which at one time could not even be diagnosed).

What Should be Done?

It is not easy to give practical answers to this question, not least because in recent times, for a reason which has many roots, we have been witnessing the self-affirmation of a model of comparative health care based on activity belonging to the private sector, on the principle of knowledge, on the risks run by a company, on reducing the inefficiency of public services, on the offer of 'hotel' services to support health care services, on the employment of marginal professional resources utilised in the public sector, and on many other factors as well.

It would be inappropriate to talk about subsidiarity, or of real competitiveness, when one considers that private health care absorbs a figure equal to about 30% of the resources of public health care, just as in the same way it would be wrong to suggest that health care will disappear from the welfare panorama – this is because in no Western country could a citizen be deprived of his or her right to health or subordinated to a guarantee which is directly proportional to the level of his or her individual income.

We thus need to examine the reasonable paths that should be followed, paths that revolve around the following principle areas:

a) The wisdom of increasing the funds allocated to prevention. This is one of the most neglected headings even though it is often the subject of programmes which seek to capture public attention (one need only think here of the campaigns for the prevention of breast cancer, for the reduction of the phenomenon of obesity, for vaccinations, etc., which are then followed by sporadic initiatives and measures promoted by voluntary workers but not inserted into a plan of action for all the individuals at risk). Recently, the Italian Ministry of Health published a pamphlet for families which is admirable in terms of the style it uses to communicate what it has to say but less worthy as regards its contents. This pamphlet should have been sent to twenty million families, co-habiting couples, both residents and non-residents, but its publication and distribution stopped at about a tenth of the necessary figure. The phenomenon of migration has affected our country, and not only our country, and has shown how the new presence of immigrants brings with it pathologies that have not been treated for some time (tuberculosis, for example, to cite one among many), and how indispensable it is to promote initiatives intended to contain these phenomena and to prevent their spread amongst the healthy population, with a cost/benefit ration which is very interesting in terms of the limitation of factors which increase health care expenditure.

And prevention means an ability to educate, to provide schoolchildren from the outset of their schooling with a mentality capable of interpreting signs and acting in consequence, and to promote in a constant way the formation of a social conscience which is based upon the principle of *'neminem ledere'*.

b) The best and most effective possible use of resources. Even a superficial and rough analysis of the resources employed enables us to assert that the bureaucratic apparatus of the health care system is responsible for a half of the overall expenditure, and thereby constitutes a structural cost which is unacceptable for a system which must produce the defence and promotion of health and measures of care and treatment. Furthermore, no study has been carried out, and no hypothesis has been drawn up, on the possibility of action to be taken to assess and evaluate the productivity of the personnel employed, the distribution of work responsibilities, or the efficiency of the system of management.

The computerisation of procedures, the automation of processes, and self-certification should have produced a notable reduction in the structural costs but the results have in fact been totally irrelevant. The primary reason for this is to be found in the interaction with the trade unions which, in return for a non-violation of the spaces of inefficiency, have guaranteed political support.

Another clear example of the real possibilities of reducing the structural costs is to be found in the by now well-known desire not to eliminate peripheral hospitals which generate not a health care service but political facilities which confer prestige on the local authority of that area. The results of this are well known because in these hospitals are to be found health care workers who have not managed to find a post within the more qualified hospital network, the consequence being that such peripheral hospitals have become either staging posts on the way to more qualified hospitals or emergency clinics or clinics for elderly people in chronic situations. It would be useless to observe that side by side with the negative economic profile (a small structure has imbalanced costs compared to the services which are provided) there is also the negative dimension of the actual quality of the services that are provided as well as the risk that the patient will not be looked after and treated in an efficient way.

No attempt has been made to remedy this serious negative situation through the systematic employment of new forms of technology and in particular telemedicine. This is because the placing of health care within the Net could turn out to be a boomerang which reveals the forms of inefficiency which are present.

There are many unproductive headings of expenditure which go from uncontrolled procedures for purchases to the investment in equipment for the purposes of image-building which is then not utilised because of lack of skills, and on to waste in prescriptions for drugs and medicines and the negative influences produced by the university-hospital tandem.

c) The creation of a national and regional health care information system able to allow the exercise of effective control over all the items of expenditure. It is truly a dramatic and striking fact that for electoral reasons the only existing check on the dynamic of the consumption of pharmaceuticals was abolished without there being produced any suitable instruments for a control of the original source of costs represented by prescriptions made out by medical doctors directly responsible for patients. In the same way it is dramatic and worrying that there is the intention, on the part of central government, to create a national health care information system which is so complicated as to be impossible to use: this is the classic and injurious tendency to do something so that it can be said that something has been done; with the further complication that the service must know how to interact with twenty-one different regional systems and with hundreds of local hospital structures, each of which has its own resources, its own procedures, and its own specific software.

The only deduction that can be drawn from this reality, which only apparently is based upon valid criteria, is that we should have little trust in a future which will be dominated by traditional factors and low levels of encouragement to actually bring about change.

Ethical-economic Aspects

In the world there has been underway for some time a debate. This debate, beginning with an awareness of the scarcity of available resources, seeks to establish the fields of action *a priori,* and in doing this substitutes the notion of the defence of the individual with that of the notion of safeguarding collective interests.

In other terms, there is an attempt to define the rule of utility in a way that it has precedence over that of the individual right to the defence of health and there is a wish to favour the provision of care and treatment to people who are able to work in the productive circuit rather than to those individuals who are a factor of unproductive cost for society. In this way is established the principle that the young newly-born child does not have a right to live because were he or she to be treated this would necessarily bring with it the consequences of intensive care for newly-born children, in the same way that foetus ecography is used to block any life marked by malformations or chronic pathologies before it is born through engaging in the practice of abortion.

Certain dramatic examples have drawn the attention of the mass media, but the really demonstrative fact is that to be found in the reality that the birth of individuals suffering from the Down syndrome has been progressively reduced to the point of being eliminated, thereby depriving mankind of an alive spring made up of affections, tenderness, purity, joy in living, and intelligence.

On the other side of the life cycle, reflection has arisen on the consequences of the extension in the average lifespan for the economic system, which is called upon to face up to the undertaking of providing for the support of unproductive elderly people who are only capable of absorbing the resources of the pension systems and asking for very expensive forms of care and treatment because of the chronic nature of those illnesses which afflict people in this age band.

The danger that the dignity and inviolability of the person will be subordinated to economic considerations is very much present. There is a subtle advance in increasingly large levels of support for such a development. There is also an encouragement of the tendency towards a selfish assessment and evaluation of one's own interests and an elimination of readiness to help in relation to one's neighbour, even though that neighbour is one of one's own parents.

This is the painful fruit of the abolition of ethics in relation to conduct, and as regards state institutions this is the fruit of the elimination of a concept of economic government based upon the defence of the common good, which necessarily involves, as a primary factor, the defence of the weakest members of society.

In moving towards my conclusion, I believe that I have run the risk of not being concrete in my proposals by favouring an analysis of the situations and the causes that are behind so many forms of ill-being and uncertainty, of so many solutions which are precarious in their assumptions and their implementation. For this reason, I think it is incumbent upon me to make a final observation, which is well-known

but at the same time ignored by nearly all citizens.

I am referring here to the ethical aspect of forms of individual behaviour: we all know the scale of the waste that is involved in asking for drugs and medicines and how much impropriety exists in turning to health care structures for care and treatment. The waste in this way of limited resources means taking resources away from those who are in need, it means ignoring one's weak neighbour, it means engaging in a form of behaviour which by analogy – and this is not a paradox – is theft, a wrongful removal marked by serious consequences. We have before us darkened consciences, it will be said, but indifference is no alibi, as indeed the pursuit of one's own interest is no defence. By now we have to return to a very different social approach and develop an awareness of the fact that the most effective form of defence there is is the defence of the common good.

Conclusion

A health care system is a social organisational machine which has to meet a plurality of calls and requirements, which are variable over time.

The economic factor is a natural reference point for this system but it cannot condition it to the point of rendering it inefficient.

The economic system and health care policies must find a basis in common which cannot but be ethics and in particular the defence and promotion of the dignity of human life. The quality of life is not therefore the starting point of the system, and it cannot take the place of the value of the person.

It is possible to reconcile the various factors in play, but on the condition that one knows how to govern complexity, defining reasonable objectives and working in a continual way over time.

The appeal does not finish with the authorities of government but concerns all health care workers and all citizens who want to be men and women of good will and workers of peace.

Dr. FRANCESCO SILVANO,
General Secretary of the Child Jesus Hospital, Rome.

JOHN P. FOLEY

2. Power in Health Care Research and the Mass Media

After the tragedies of the mid-twentieth century in which people were condemned for war crimes for their experimentation on human subjects, and the mass media rightly reflected the outrage in public opinion regarding such atrocities, it would seem that there should exist a wellspring of sympathy for those who seek to preserve and protect the dignity of human life.

Such, however, is not always the case.

While remarkable technical advances have been made in all manner of biological and genetic research, such advances have not always been paralleled by an unconditional respect for the sanctity of human life at all stages of development from conception through to natural death.

In fact, it would seem that the media have sometimes been conditioned to view criticism of certain types of research and experimentation not as a laudable defense of human rights but as obscurantist opposition to scientific progress.

Let us consider some examples.

Stem cell research, the use of embryonic, umbilical, or adult spinal cells for the possible treatment of Parkinson's and Alzheimer's diseases, has elicited great interest.

Many scientists consider that the optimal way to obtain such cells is to destroy embryos conceived through "in vitro" fertilization.

You would think that the media might, in their coverage, consider:

1) first, whence do such embryos come;

2) second, what are such embryos;

3) third, can they legitimately be destroyed, even for the apparent good of another?

The answer to the first question is that such embryos come from the union of a female egg and a male sperm outside of the normal method of such union through sexual, especially marital, intercourse.

Does it ever occur to the media to ask: is this right? Are we morally entitled to do everything that we physically can do? What are the consequences of such actions for society, for marriage, for human love?

The answer to the second question is that, if the embryo is the result of the union of a human female egg and a human male sperm, then the result is an embryonic human person. If this is true, is not the direct destruction of such an entity for the use of its component parts tantamount to an act of murder, of infanticide and of consequent body snatching or plundering of body parts?

The answer to the third question is included in the answer to the sec-

ond. The direct taking of innocent human life is always and everywhere wrong from the first moment of conception until the moment of natural death. If the foregoing principle is not true, then what are the consequences for society? Who is safe? At what age? Under what circumstances?

Instead of asking these very questions, the media often portray those who raise such questions as fanatics eager to condemn those

who suffer from terrible diseases to lives without relief.

The media seldom ask the question of why frozen embryos exist in the first place — and, because they seldom ask it, they see no difficulty in deliberately producing new embryos so that further scientific research might proceed.

Thus, from a policy of using cast-off living human beings for scientific research, they are willing to tolerate and even support a policy of deliberately producing living human beings to supply laboratory needs.

George Orwell wrote a book entitled "1984"; that was nothing in contrast to 2001, and, in this case, the result is not a space odyssey to explore new boundaries for human development but the deliberate production of human lives in order to destroy them and, in so doing, to destroy all moral boundaries of respect for the sacredness of human life.

Closely related, I think, to the question of harvesting and of producing embryos for stem cell research is the question of euthanasia. When is grandmother no longer considered useful? When does the ending of her pain become not her gain but that of those who inherit her wealth or plunder her body for parts to be used in others?

Do the media, which seek to emphasize the end of pain for those who are suffering, ever offer a reflection on the meaning of human life and on its sacredness?

I fear that, from mid-20th century media, which saw and condemned a mechanistic and instrumental view of the human person for what it is, a violation of intrinsic human dignity, we have come to a media situation in which there is no recognition of the inviolable and inalienable rights of the weak in the womb or near the tomb.

We are witnessing the canonization of a Darwinian survival of the fittest through the destruction of the defenseless, and the media — which should be the "whistle blowers" in society, to warn us about the dangers ahead — have instead become accomplices in the silent slaughter of the youngest, of the weakest and of the oldest in our society.

I was in the United States last summer when President George W. Bush gave his speech about his policy regarding stem cell research. I frankly thought it was a masterpiece. He reviewed the moral and scientific situation and said that he would favor government support for stem cell research on cells taken from the umbilical cord and from the appropriate organs of consenting adults. He also said he would allow funding of research from what he called stem cell lines which had already been developed from embryos which had already died. In other words, he would not support government funding of that research which would result in the direct taking of innocent human life.

In fairness to the media, they praised him and admitted that they were surprised by the moral sophistication of his reasoning; it was obvious that they were expecting a much less intellectually adept treatment of the question.

Government leaders and judges in the United States have not always provided such sound moral leadership, and indeed some population control policies in the foreign aid programs of the United States continue to give offense and instill resentment in the recipient nations.

For example, former President Corazon Aquino of the Philippines told me on one occasion that her government had been pressured by the then government of the United States to accept the distribution of contraceptives as a condition for receiving economic assistance. She indicated that she declined on moral grounds – but stories such as these are seldom reported in the media because they go counter to the current line of "political correctness".

I mention this example because contraceptives pills and devices are often represented by donor nations as health care assistance, and the combined economic power of donor nations and the media power of "political correctness" put tremendous pressure on the governments of recipient nations to make moral concessions for economic gains.

Now, of course, the media have other interests, and the subtleties of stem cell research and the controversies over population control policies have given way to the much more graphic coverage of terrorism and war.

In media coverage of medical treatment, however, it is most important to remember the power of advertising.

How can we expect critical coverage of new medicines or new treatments or even of government distribution at home and abroad of contraceptive pills and devices when pharmaceutical companies

spend so much on advertising in media which are now struggling to survive in the face of a worldwide economic recession?

I know that pressure — whether direct or more subtle and indirect — can be and is sometimes brought to bear not to give unfavorable coverage to certain items because such coverage would hurt the interests of advertisers and perhaps of the publication or network itself. In a very small way, as an editor, I was occasionally subject to such pressures — which, thank God, I think I resisted successfully. In fairness, I should note that, in my case, such pressure was not brought by pharmaceutical companies.

When moral objections are brought against certain medicines or treatments, however, it is interesting to note that moral objections do not bring income to publications or networks; the new medicines and treatments often do bring such income. Moral objections can be considered by both pharmaceutical and publishing executives as petty annoyances not worthy of consideration, especially not in light of the vast profits to be made with new drugs and the advertising and promotional expenditures connected with them.

I acknowledge and praise the great advances made in medical technology and in the development of new drugs. I know how costly such research must be and how necessary it is to protect patents for new medicines so that pharmaceutical companies are not discouraged from investment in further research for the benefit of the human race.

It is interesting to note, however, that you do not see many media campaigns supporting generic rather than specific drugs or medicines – even though such generic drugs could save consumers and governments millions, even billions of dollars. One reason that generic drugs can save millions for consumers is that there are no expensive advertising campaigns for them – and this is why they are often overlooked by media which live from advertising.

Regarding media coverage of health care and indeed biotechnological matters, I would recommend several basic principles:

– first, have journalists who are prepared not only in medical technology, but also in moral philosophy;

– second, never, never, never let considerations of actual or potential advertising income influence editorial decisions (at Time magazine, this used to be called the "separation of church and state" – of editorial content from advertising – a separation which I have seen eroding even in that publication);

– third, do not equate technological capability with moral acceptability; not every technological breakthrough is necessarily a moral triumph; thus, do readers the favor of subjecting technological advances to valid moral criticism;

– fourth, do not become prisoners of political correctness in publishing only what people want to hear.

At the beginning of these reflections, I mentioned that the media in the mid-20th century were not afraid to identify certain forms of medical experimention as atrocities – and perhaps such reporting was made easier because the experiments were often sponsored by hostile powers on helpless prisoners of war or on innocent civilians kept in concentration camps.

Such experiments are still going on, however, on embryos which are destroyed so that research can take place and, as some media have occasionally reported, on human "guinea pigs" who may sometimes not realize that their rights are being violated or who have not been able to give informed consent. I am thinking particularly of mentally retarded persons who, in some societies, have been sterilized and of the terminally ill and elderly who run the risk of being assisted to a premature death.

When our Pontifical Council for Social Communications published its study in "Ethics in Communications", it emphasized three principles: truth, the rights of the human person and the common good. In the coverage of health care and of biotechnology, these three principles have a special importance:

– first, it is necessary to know the truth – scientific, economic and moral – about medical discoveries and health care policies;

– second, the rights of those who are suffering and especially the inviolable right to life must be treated as paramount;

– third, the implications for the common good and not merely the economic profit for a few must be considered.

Jesus said that the words, "I was sick and you visited me", would be among the special titles to enter into eternal glory.

The most important power in health care is not governmental power or media power or even medical power; it is the power of God and the moral power which comes from seeking to do His will in caring for the sick, the troubled and the elderly. We truly need doctors, nurses, technicians and indeed scientists who see in the face of the suffering the image of Christ.

The media coverage of those motivated by this moral power can do much to stimulate others to give that human, compassionate care so needed by those who ought to be not objects of scientific and medical experimentation but subjects worthy of our love and concern as they pass through a personal crisis on their pilgrimage to eternal life with Jesus, our suffering Savior, who triumphed not only over sin, but also over death.

Thus, the media coverage of the sick and of those who care for them should not only inform our minds, but also touch our hearts to unleash in the service of the poor and sick what the late Mother Teresa rightly identified as the power of love.

H.E. Msgr. JOHN P. FOLEY
Titular Archbishop of Neapolis in Proconsulari
President of the Pontifical Council for Social Communications, the Holy See

IGNACIO CARRASCO DE PAULA

3.What Should be Done with the Power of the Professionals of Medicine?

1. Introduction

The term 'power' may appear out of place when it is applied to the health-care profession. Power as the pure and simple capacity to impose *de facto* one's will on things and on people seems to be located at the extreme opposite of the spirit of selfless devotion to one's neighbour which, in ideal terms, should animate those who work in the field of health and health care. In the Hippocratic tradition, the practice of medicine is seen as a service, in the sense that the learning and the experience of the medical doctor is wholly and unconditionally subjected to the achievement of the interests of patients as regards their health and their psycho-physical integrity. The *Charter for Health Care Workers*, published in 1995 by the then Pontifical Council for Pastoral Assistance to Health Care Workers, not only defines the medical profession as 'service to life' but even makes this concept the central axis of the whole document.[1] The Geneva Declaration of 1948 – the point of reference for medical doctors throughout the world – declares, indeed, that the medical doctor consecrates his or her life to 'service to mankind'.[2]

It does not seem to me that there has ever been any dispute about the fact that the medical profession is one of the human activities which require great altruism and self-denial. However, it does not seem to me to be improper that at least on one occasion – in the context of an international conference of health and power – our attention should be captured (not to say challenged) precisely by the power of the professionals of medicine, although to some people it may appear that in this way at least a shadow of suspicion is thrown over the medical classes. Power, all forms of power, for right or wrong, do not enjoy unlimited trust and confidence on the part of the ordinary citizen.

Whatever the case, nobody can ignore the fact that a medical doctor has effective power, both in an individual form and in a corporative form, at least as regards the values and the customs to do with life and health and health care. Often a medical doctor is able to impose his or her own will (preferences, interests, goals) not only on certain things but also on people, at least to the extent to which things and people fall into the category of the healthy and the sick. Because of a biotechnological development which until recently was unimaginable, medicine has provided a spectacular demonstration of its power. Not only has it broken down ancient barriers which were at one time considered to be insurmountable, but by now it seems that no goal can be ruled out *a priori*. And if these advances have been received by public opinion in general with admiration and hopeful trust, there

have not however failed to be voices which have been worried about this development and even hostile to such an upsurgence of power. In this sense, for example, our newspapers every so often alert us to researchers who are deemed to be 'sorcerer's apprentices', while in the Anglo-Saxon world there is a condemnation of the arrogant tendency of certain scientists to play at being God. In a parallel line, in a speech given in 1995, John Paul II warned scientists and medical doctors against the temptation of 'seeing themselves as the masters of life' rather than 'its experts and generous servants'.[3]

However, I would like to observe that reflections of this character concern not so much power in itself as its deformed use. What arouses concern is not so much the ability to extend our dominion over nature – something which is in fact a necessary pre-condition for progress – but the possible use of force in all its forms, from its open forms to its hidden forms and on to its clearly pernicious forms: arbitrariness, fraud and deceit, arrogance, abuse, tyranny, etc. As far as I am concerned, I would like for the moment to exclude from our reflection the phenomenon of deviations, to which I will return later, in order to concentrate my attention almost entirely on the specific and precise power of the professionals of medicine, that is to say on the influence – wished for or otherwise – that they exercise, as qualified servants of life and health, upon individuals and upon society as a whole.

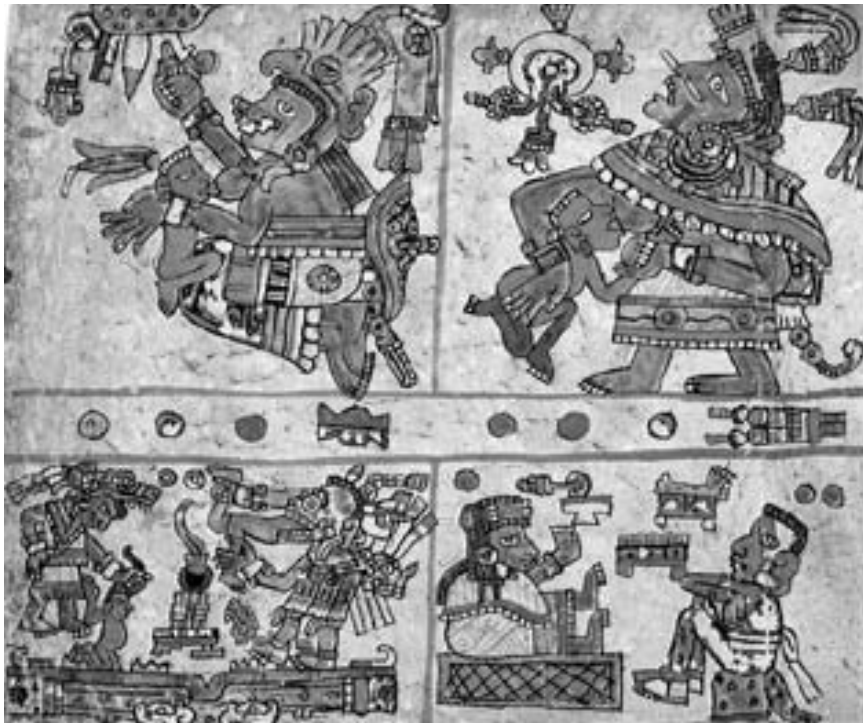
This is obviously a complex and partly elusive subject, and for this reason – taking into account

the time which is available to me for my paper – I will confine myself to dealing with certain aspects and will emphasise those that I consider most useful in providing an answer to the question which has been posed by the organisers of this international conference, namely: 'what should be done with the power of the professionals of medicine?'

2. Power and Authority

To begin with, it is a good idea to remember a first relevant distinction – the distinction between power and authority. Power and authority share the capacity to impose on other people one's own will, but they do this in very different ways. Whereas a person in a position of power has effective means by which to force others to submit themselves to his or her will, the person who has authority does not necessarily need to employ physical coercion. Authority, indeed, pre-supposes above all else moral force, which, as such, is recognised and accepted by other people when they perceive in authority a suitable instrument at the service of the common good and not something which benefits those people who are in charge. Authority rests upon trust. Power, on the other hand, can do without trust: it does not need the acknowledgement of others. Indeed, in fact, it tends to promote and to privilege specific interests. It is for this reason, as I have already observed, that in relation to power the most common attitudes are those of distrust, fear, and where possible, resistance.

In all advanced cultures the medical doctor has always enjoyed and still enjoys notable authority as regards the life and health of all people. This authority springs from the proven ability of the medical doctor to point out and even to prescribe what is good, right or suitable for health, and to prohibit what is contrary or damaging to health. Furthermore, the authority of the medical doctor also derives from the status of service to life that the medical profession as such has been able to acquire for itself in modern society. It is for this reason that the authoritativeness of each individual medical doctor is relatively separate from his or her personal and professional intrinsic qualities. Every medical doctor knows that to begin with he or she can count on a substantial cheque that is credited to him or her by the trust that patients place in his or her professional qualification. Equally, the medical doctor well knows that his or her authority would not survive the disappearance of trust on the part of the patient.



Leaving to one side the exceptions that naturally are not absent in every free profession and which in themselves are not relevant, I believe that the authority of a medical doctor is fully justified. Furthermore, I think I can state, and I will try to demonstrate this later on in this paper, that this is a necessary good for the success of his or her activity, and as a result for the well-being of the patient as well. Hence one cannot conclude that the authority of medical doctors should be maintained at any cost: trust should never be taken for granted because – and I repeat the point once again – once the credit given by the patient no longer exists authority ceases to be present. For this reason we should be careful about the temptation to want to substitute authority with effective power. An error of this kind, for example, can be at the root of a certain kind of reading of the principle of 'silent consent' in the field of transplants, at least to the extent to which the principle is interpreted as an attempt to seize (by law) those organs to be transplanted that otherwise (by authority) we would not be able to obtain. I am not saying that authority can make legitimate use of coercion, precisely because in the world of transplants the use of force would be clearly damaging to the dignity of the presumed donor.

3. The Crisis of Medical Power

Having reached this point, and taking up the question posed by the organisers of this international conference, we can also answer with a counter-question which is deliberately provocative: is medical power today really so great that we should worry about it? Should the medical doctor be listed amongst the lords of the contemporary world or amongst its victims? Is her or she the real

master of biotechnological progress or does he or she merely represent a mere cog in a machine which is above him or her? Does our society bestow upon professionals of medicine the same authority that it bestowed in the past? Can the medical doctor really condition in a decisive way the choices made by individuals and the options adopted by the community? And so the list goes on.

I am not sure that I can provide reliable answers. Indeed, perhaps these questions are artificial questions which disappear at the very moment that they are formulated. However, they help to call our attention to another phenomenon of a contrary nature which is very worrying: the dual and growing tendency, which has been going on for years, to reduce the power and authority of medical doctors.

The first tendency begins with a critical position, which from many points of view is a correct position, against the old-style medical paternalism, and ends up with an approach which is widely spread in the field of medical ethics – that of rejecting every form of authority on the part of the medical doctor, or at least which subordinates that authority and even substitutes it with the authority – or better still the autonomy – of the patient. The only power bestowed on the health-care worker is that of providing information, and according to some people this should only be done on the request of patients.

The second tendency, on the other hand, takes the form of a governing law of a socio-economic kind which imposes a duty to establish the inviolable limits of the level of the financing of health-care resources,[4] limits which are decided by other centres of power – *in primis* political centres and commercial holdings – which are outside the medical classes and which obviously limit their ability to choose.

Paternalism as a limitation of the decision-making role of the patient by the medical doctor, who feels that he or she is justified because he or she acts in the name of the good of the patient himself or herself, has deserved all the criticisms it has encountered and which have consigned it to the basement. The patient has the inalienable right to decide about everything regarding his or her health. However, this right is not maintained through a cancellation of the authority of the medical doctor. Indeed, it requires the authority of the medical doctor otherwise the information, the suggestions and the predictions of the clinic would not have any value; they would be unreliable facts and the final decision of the patient would not have any rational basis.

As to the tendency to marginalise the medical doctor from the planning and the management of health-care policy, it is clear that this grows when the medical classes are seen by the strong powers as constituting an obstacle to the achievement of certain goals of socio-economic policy. Here as well there is a strong risk that the loss of authority by the medical profession will give rise to harm being done to the health of citizens, and especially the least well-off.

4. The Deviations of Power

In the context of the medical profession another phenomenon has appeared today which is apparently connected with alternative medicine but in reality is something to be placed at the other extreme. I am referring here to the 'new medicines', which are in reality new attempts to broaden the sphere of the power of medical doctors into fields which only in a general sense can be seen as belonging to service to life and health. These are practices which wear white overalls, but whose heart beats with rhythms and for goals which are far from the Hippocratic tradition.

First of all, we encounter the so-called medicine of desires: medicine which offers itself as an instrument to fulfil a certain wish as long as it does not overly hurt the sensibilities of post-modern culture and can be reached by technological means. This is medicine which revolves around the law of supply and demand and which is thus ready to generate new desires and to try to satisfy them with attractive promises of incredible performances, for example in the field of assisted procreation: a made to measure child, cosmetic surgery, the charm of silicone, of sport – the exploit with nandrolone. However, this is a power that is not able to preserve or to improve health; indeed there is the risk that they will threaten it. These medicines of desire offer only the surrogate for certain goods (fatherhood/motherhood, beauty, physical strength, etc.) which are denied by mother nature.

There is also the medicine of disproportionate aspirations because it seems to build a new man, and if necessary to steal the fire of the gods to provide him with the breath of life. This is a Promethean medicine, and perhaps the one which most represents a culturally pluralistic society which is economically globalised and strongly technological. The temptation of power is so strong that in order to increase it that there is a decision to set conscience to one side and to sacrifice what has to be sacrificed: people, whether embryos or the elderly in the first instance, and then feelings, rights...

Finally, there is a medicine that exchanges greater access to power with a readiness to serve the interests of the powerful. Medicine which co-operates in the state control of births, in the suppression of handicapped babies or babies with genetic illnesses, before or after their births, in programmes to liberate sexual habits and customs, and in the future perhaps to reduce the burden of an increasing number of unproductive elderly people.

Paradoxically, these deviant forms of medical power invoke service to health and mankind. However, in their language these are expressions which have lost their authentic meaning. Firstly, because the health of the patient is subordinated to another interest and secondly because the diagnostic/therapeutic clinical action is substituted by an action which is clinical only at the level of exploitation, of the operating instruments of the trade, and which in fact does not have any of the in-

tentions or the meaning of real service to health.

One could object that health – according to the definition of the World Health Organisation – includes the complete well-being of man. But it is precisely this definition that confirms what I have just said, because the formulation of the World Health Organisation conforms to political goals, that is to say it represents an attempt to broaden to the greatest possible extent the field of competence, indeed the power, of the World Health Organisation itself. Furthermore, the World Health Organisation has reduced the level of its own position by making clear that the 'new universalism' of the instruments of health means coverage for all (human beings) and not coverage of everything that technology can offer.

5. What Should be Done with Power?

At this point I think that it is opportune to move on to the critical-reflective stage in relation to the question: what should be done with the power of the professionals of health? In my opinion, to start with, it is necessary to reformulate the question in order to make it more concrete and manageable, for example in the following way: what should be done to restore greater transparency to the authority of medical doctors and prevent such authority from becoming a power at the service of the interests of third parties? Amongst the many good things that could be listed, I will confine myself in this last stage of this paper to only four.

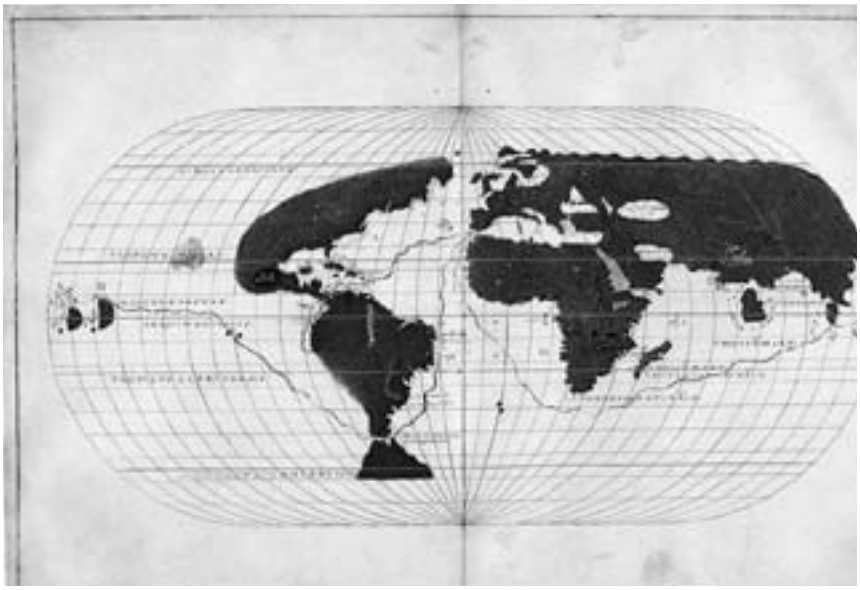
Firstly, scientific progress in the biomedical field, something that is rightly welcomed by everybody for the good of mankind, at the same time increases the power of the professionals of medicine. However, it does not necessarily increase their authority. For this reason, the promotion of progress for the sake of progress is something which has no sense for medical doctors – the promotion of progress should only take place when such progress is at the service of life and the health of man.

Secondly, weakness, infirmity, and in the final analysis, death, are connatural to the existence of man. A medical doctor can limit their consequences but he or she must not throw out false promises about gaining dominion over death or illness. With the authority of somebody who lives with such things every day, the medical doctor must, instead, help the patient to understand the meaning of these realities and engage in a correct reading of the experience that he or she is undergoing.

Thirdly, both the medical doctor and the patient are defined by the relationship that the illness establishes between them. They are allies and almost companions on a journey. The tie which binds them is not specifically a contract in the technical-legal sense of the term but a pact of trust based upon the humanity that they share. This means that the medical doctor must always act not so much because he or she is legitimised by his or her own learning and conscience but because he or she is authorised by the trust of the patient.

Fourthly, whatever the case, the authority of the professional of medicine is dependent on the recovery of the primary importance of service to the sick person – every sick person – as *uomo patiens*, as he or she feels that he or she is and as he or she sees himself or herself, that is to say in need of respect, care, and help. The patient is the person that medicine has sworn with pride and honour not to dominate but to serve with total loyalty.

Prof. IGNACIO CARRASCO DE PAULA,
Professor of Moral Theology, the University of the Holy Cross, Rome, Italy.



Notes

[1] The *Charter for Health Care Workers*, indeed, employs the concept of service to life, people, and man twenty times. The definition is taken up by the encyclical *Evangelium Vitae*, which calls medical doctors 'guardians and servants of human life' (n. 89).

[2] The World Medical Association, the Geneva Declaration of 1948, reviewed in Sydney in 1968.

[3] Speech to two workshops promoted by the Pontifical Academy of Sciences, 21 Dec. 1985, n. 2. *Evangelium Vitae*, as well, warns that medical doctors 'can be strongly tempted at times to become manipulators of life, or even agents of death', something that is against the 'intrinsic and undeniable ethical dimension of the health-care profession' (*EV* n. 89).

[4] The reference to the work *Setting Limits* by D. Callahan is more than evident.

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BERND PASTORS

4. Practical Actions to be promoted in Relation to the Power of Pharmaceutical Industries

As we all know, the situation for many of our partners in the countries in the Southern Hemisphere is characterized, among other things, by:

– a lack of medicines, i.e. they do not have adequate access to essential drugs

The WHO[1] and many of its partners, as well as Action Medeor, regard four factors and five groups of actors as having a decisive influence on this situation.

The *factors* are:

– *rational selection and use,*[2] – this requires defining which drugs are most needed and ensuring that they are used as intended;

– *affordable pricing* – this depends, amongst other things, on transparent price information for healthcare providers and consumers, competition amongst manufactures of quality generic drugs, the use of TRIPS safeguards where necessary,[3] reduced duties and taxes and improved distribution;

– *sustainable financing* – this requires, amongst other things, reliance on a viable financing mechanism, social health insurance, better use of "out-of-pocket spending" and donations;

– *reliable health and supply systems* to ensure continuous availability and assured quality of essential medicines. Many countries have made progress through a mix of public, private and NGO involvement in pharmaceutical supply systems.

The *actors* are:

– *the governments of developing countries* – the overall stewards of each country's health system, who are responsible for its performance and regulation. The effective regulation of drug purchasing and distribution, as well as the tax policy towards essential drugs, are also governmental responsibilities.

– *the governments in industrialized nations*[4] who can use financial assistance to directly support the domestic policy of many developing countries. They may also give incentives to manufactures to produce appropriate products and make them available at affordable prices.

– *the pharmaceutical companies,*[5] whose principal role is to research, to produce and to sell effective drugs for major health problems. The most powerful incentives are in the large markets of the high income countries, as is shown in the history of product development. Thus, only 13 of 1233 new drugs that reached the market between 1975 and 1997 were specifically approved for tropical diseases!

– *the consumer groups and NGO's* such as Action Medeor, who are long-term major supporters of the essential drugs concept, with its focus on equity and access, both through their advocacy and their use of the model of essential drugs in emergency relief and health development work.

– *the international agencies and foundations,* who also play a role in supporting better access to essential drugs. This is part of WHO's mandate as the global health agency – the work of UNICEF and UNFPA as global purchasing bodies for vaccines and, for example, UNAIDS, which represents the rights and needs of people living with HIV/AIDS everywhere.

Let us have a look at one of these actors, the pharmaceutical companies. Their task is to research, manufacture and sell medicines for the good of human health whilst maximizing their profits. These companies are now generally international concerns, which must operate according to the rules of the international capital market and show a profit for the sake of their shareholders. Under these constraints, the essential requirements of hundreds of millions of people who live in abject poverty are not taken into account.

– They have no access to simple and cheap essential drugs;
– They have no access to affordable, newly developed medicines, such as the new drugs against AIDS;
– They have no access to urgently needed new drugs for malaria and tuberculosis, because the development of such pharmaceuticals is not considered likely to produce sufficient profit – in sharp contrast to the so-called "lifestyle drugs" for overcoming obesity, baldness or impotence, for which there is a huge market.

What practical actions can we take in conjunction with the pharmaceutical industry in this situation?

Here are a few examples:

Improve the access to essential drugs *through the creation and maintenance* of a worldwide supply network for affordable, high quality essential drugs in cooperation with pharmaceutical companies, along the lines of the work of the German Medical Aid Organization, action medeor.

For more than 37 years, Action Medeor[6] has supplied around 11,000 partners in around 130 countries with essential drugs; every year about 4,000 parcels of drugs valued at approximately 18 million DM are sent to our partners abroad; 50% of all consignments have a value of only 1000 DM, 85% of them are worth under 5000 DM. Thus Action Medeor is primarily involved in many small health projects throughout the world.

This aid work is financed either through private donations, public contributions or by reimbursement of the cost price by European third parties. By permanently stocking a warehouse of medicines with a value of 700,000 DM, Action Medeor can also provide rapid assistance in emergencies, such as during the current Afghan refugee crisis.

Action Medeor buys its essential drugs, freshly manufactured by European pharmaceutical companies in bulk and can then forward them on, quickly and cheaply, to its partners.

An improvement in access can also be achieved *through the establishment and maintenance of local, central procurement agencies in the recipient countries*. Such regionalization can lead to a faster and more effective access to essential drugs, it strengthens local structures and leads to long term assistance; for example, action medeor is supporting the setting up of central procurement offices in Uganda, the Cameroon and in Kosovo. (Picture of Kosovo pharmacy)

Access is improved *through the use of drugs according to the actual essential requirements of the people;* the compilation and development of national essential drug lists, the publication of treatment guidelines, training and supporting healthcare professionals in the rational use of drugs and the establishment and maintenance of quality assurance facilities are helpful here.

Examples from the work of Action Medeor

– Medeor Manual, (treatment guidelines)
– Medeor forum, (training and supporting health-care professionals)
– drug donations; (dto.)
– disposal of unwanted/outdated drugs (dto)

Access can be improved by:

The creation and maintenance of drug production facilities in the developing countries,[7] wherever this is technically sensible and feasible. Know-how can be transferred from the industrialized nations to the developing countries, bearing in mind the markedly different situation in Africa, Asia and South America.

Access to essential drugs is also improved by the development of sustainable models for the financing of healthcare systems, such as the creation of local health insurance systems that can also finance the requirements for drugs. For example, funds from Misereor and Action Medeor were used in Damongo in northern Ghana to help set up a health insurance system. In-patient costs as well as the necessary drugs are being financed through annual health insurance contributions. Currently, around 30,000 people are members of this insurance scheme, which was developed by a church hospital in Damongo. It has been working very successfully for the past four years.

It is important that there is an international exchange of experiences gained by the worldwide NGOs working in these fields with their partners in the developing countries.

Action Medeor is a member of Medicus Mundi International, an international umbrella organization of some nine national Medicus Mundi Organizations and other NGOs, such as CUAMM in Italy, all of who have collected many years of valuable experience in the area of cooperative medical development work.

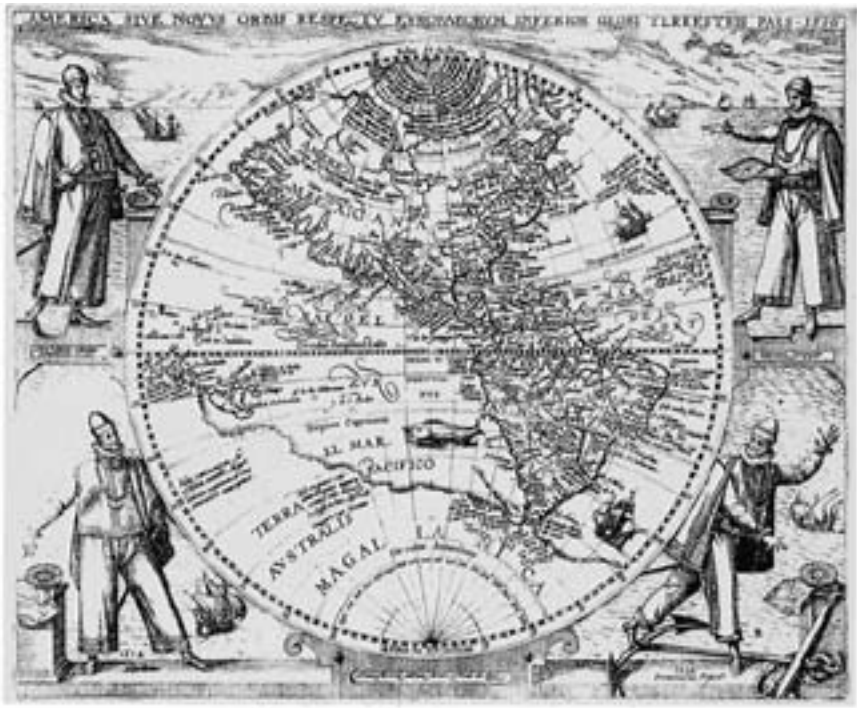
Cooperation instead of Confrontation

Also important is a national program of dialogue with the pharmaceutical industry in the industrialized countries.

An example from Germany:

Since the beginning of the 1990s, there has been an intensive dialogue between the two Christian churches which work together in the ecumenical "Joint Conference on Church and Development" (GKKE) and leading mem-

bers of pharmaceutical companies, who currently participate as representatives of the Association of Research-Based Pharmaceutical Manufacturers (VFA). action medeor, together with the Medical Mission Institute, Würzburg, The German Institute for Medical Missions, Tübingen, and other organizations, are also involved. The aim of this national dialogue is to reach a common view and produce joint positions on basic health care supply and services in the poorest countries of the world and to carry out joint projects.[8]



Under the slogan "cooperation instead of confrontation", the representatives of the GKKE and the VFA recognize that individual groups working alone can only offer solutions for parts of the health care system. Many problems of health care supply, such as the access to essential drugs, can only be solved by the constructive collaboration of all those concerned.

The dialogue between these different organizations is tackling current topics and discussing them in an objective and factual way, while the international lobbying campaigns initiated by MSF9, Oxfam or the German NGO BUKO denounce the serious shortcomings in the TRIPS regulations within the WTO agreements in a bold manner using the mass media.

The national dialogue seeks to reach the greatest possible measure of agreement on the responsibility, duties and roles of churches and the pharmaceutical industry in the health care systems of the developing countries and to avoid failure prone developments as early as possible. In this process, controversies should be dealt with openly and seriously and resolved wherever possible. At the same time, the discussions are intended to fill gaps in knowledge and clear up misunderstandings.

For example, as early as 1992 and in a revised version of 1999, a joint position paper on drug supply in developing countries was published which includes proposed solutions for the marketing, packaging and range of products, both for the so-called private market and also the public generic market.

Collaborative projects are being proposed and undertaken; but it must be clearly admitted that some questions still remain unresolved, such as:

– the role of the promotional visit/pharmaceutical representative,

– a sensible range of products and the rational use of medicines, and

– research priorities including the research of new drugs to combat tropical diseases

The most productive experiences have been achieved as joint projects. These include:

– *the development of a minilab®*,[10] for checking the quality of drugs under simple conditions in the field.

Whilst the pharmaceutical industry is primarily interested in the minilab because of its potential to detect counterfeits of their branded products, the principle of thin layer chromatographic examination can also be used to check the ingredients of essential drugs, thereby assisting the discovery of a number of counterfeit drugs in the projects of our partners;

– *the development of a manual or handbook*[11] showing how efficient help can be provided by the industry in the case of disaster relief, i.e. by following the Guidelines for Drug Donations.

The compilation of check lists in which the pharmaceutical companies provide information about, for example, the quality of the donated drugs and their shelf life and possible registrations. In turn, the recipients of the drug aid provide information to the donor about the planned project for which assistance is sought and its rationale in order to justify the need for help.

Comparison and adaptation of differing product information for the same drugs sold in Europe, Africa, Asia or South America.

Often the product information covers more indications when sold in the developing countries than when sold in Europe. Following lengthy discussions, many of these discrepancies have been removed.

The most difficult discussions were related to the assessment of the actual need for individual products – the extent to which they can be classed as irrational. Although there was a commercial interest in continuing to sell these products, a large number have been taken off the market by some pharmaceutical companies and through long, tough negotiations, at least partial success has been achieved.[12]

Further projects such as the support of research in tropical medicine or the drawing up of special agreements through differential pricing of HIV/AIDS drugs are to follow.

Our dialogue in recent years with the VFA has been made more difficult by the frequent mergers between companies within the pharmaceutical industry and the constant changes in our contacts for discussions. In addition, as a result of mergers, some German pharmaceutical companies now have their headquarters in other European cities and have thus left the national program of dialogue. We would welcome if similar dialogues could take place in other industrialized countries between church groups, supplemented by specialist NGOs, and the pharmaceutical industry.

An international network of such dialogues and the resulting exchange of these experiences would certainly be very valuable.

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Managing Director of Action Medeor, the German Medical Aid Organization,§ Germany

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FERNANDO S. ANTEZANA ARANÍBAR

5. Power and Health in National and International Structures

As the title of this paper indicates, this paper seeks to discuss the mechanisms of action that act to sensitise and to direct the various powers that converge in the world of health and health care in order with a view to improving the situation of health in the world, and in particular that of the poorest populations.

Following this approach, the inter-relationship between, and the influence of, the various powers will be briefly discussed (as indeed has already been done at these international conferences over the years) in relation to their nature, objectives and general and particular interests, but also as regards their responsibilities towards society which, in various ways, brings about the existence of these powers. Power cannot exist at a vague level and for this reason social awareness is very important for the very existence of power if one wants power to be lasting and vital.

When one speaks about powers, an identification must also be made of the principles that they are based upon when it comes to the field of health and health care. In this sense, we believe that the principles proclaimed in the constitution of the World Health Organisation (WHO), and which are the same as many Christian principles, should be the universal basis by which to establish equity, social justice, co-operation, solidarity, morality and ethics in the world of health and health care services.

'Health and power' is a fitting subject for debate given that we have before us a very complex, important and indispensable relationship (and thus one that is also characterised by conflict) present in today's globalised and 'economicistic' world. Taking this into consideration, I hope that we all agree on the fact that just as upon health depend both the powers involved with it and their inter-relationship so also health and the health care services can be, and in

a large number of contexts are, sources of power. If it is evident that health is the most valued material gift of the human being, health care services are as a logical consequence the hope of obtaining services involving prevention, treatment and rehabilitation when health is compromised. At the same time, for the conservation and maintenance of health, education, promotion and information with regard to a healthy lifestyle are themselves also equally fundamental.

All of this cannot depend solely upon pure science. There are a notable amount of social, spiritual and social elements which mean that the important medical-scientific and cultural contributions are more effective and efficient. We know notable examples of the power of Christian faith in the processes of the maintenance and above all the recovery of health.

It is here that the above-mentioned universal principles of health should guide a co-ordinated and systematic action both at the level of national structures and even more at the level of international structures. I would like to emphasise at this point that the universal dimension of the Church in her totality means that she is a vary major instrument for the promotion and application of these principles.

The National Level

Three dimensions are useful in visualising the sheer scale of the subject and the possible actions which should be followed in order to improve its effectiveness and range:

The human dimension of social justice, equity, ethics and morals, human rights;

The economic dimension, in particular as regards funding and the way it works, costs, forms of access, mechanisms of social insurance, etc.;

The technological dimension, which refers to a rational or fair use of the health care technologies based upon need and not upon wishes or privileges, as well as their ethical and deontological use.

We should add a fourth dimension in order to complete the survey, that is to say the relationship between the public sector and the private sector, including the fruitful work of non-profit making non-governmental organisations in the field of health and health care.

The three above-mentioned dimensions depend upon the inter-relationship of the various forces and influences of the various powers (interests) which come together in the health care sector. It cannot be doubted, however, that the health care policies of countries or regions determine the general framework of this interaction of the above-mentioned powers. This fact recognises the transcendence of the normative function of the state which is the sole power that can and must carry out these functions, thereby reflecting the national health care policy, its priorities and the parameters to be followed, when the interplay of the interests of other protagonists forms a part of the picture. Otherwise, who will stand guard over the security and the defence of patients? Who, otherwise, could perform the role of being the custodian of equity and morality? Taking into account this basic factor (the normative role of the state), the interests of the other powers become more evident, whether these are academic-scientific, economic, technological, or of other kinds.

Within this survey we should pay especial attention to the role of those who provide health care services, both institutions and people. The role and functions of these institutions and people have expressions of power and in many cases their power has a great weight. In various occasions the privatisation of health care services has certainly led as a consequence to greater efficiency, but it has also led to greater unfairness. This is because the new situation is directly bound up with the ability of sick people or their families to pay. As we all know, the sick person is very vulnerable, wants to have a logical quantity of hope, and is absolutely ready to make any sacrifice for himself or herself or his or her family relatives as regards what he or she sees as a health problem. In a word he or she is vulnerable and for this reason it is the duty of the state and the community to protect and guide the sick or the populations at risk.

In the national context, the power of the state and its responsibility must be established. In this sense what should we do to ensure that these functions in the exercise of power reflect the real needs of the

population? This is the reason why I believe that the direct/indirect participation of the community is of indispensable importance. To this end it is important to identify the mechanisms, the levels and the forms through, at, and in which the decisions of central state power take place. The spread of factors that influence health and illness, above all in relation to lifestyles, can be a primary element in the social organisation of a determined human context. The pluri-sectorial nature of health has been demonstrated, as well as the fact that many factors are involved. In recognising these facts, we can better understand how the various powers which influence health actually act. Education in general and in particular health care education are important conditions in the

improvement of the health care level of a population, with the implementation of ways of living and behaving designed to conserve good health and prevent illness.

With regard to the other powers that influence health and health care services at a national level, we have already had an opportunity to listen to important and useful contributions during the sessions of this conference. I believe that this is connected with the need to achieve co-ordinated action and an indispensable harmonisation of the efforts made by the various protagonists. It would be useful to ask oneself in this reflection whether these protagonists have rather contrasting interests and activities and thus whether they are led by these interests and not necessarily by the common good and the fundamental principles we are discussing, which are also expressed in the most recent document on the mission and principles of the international Federation of Catholic Health Care Institutions.

It is in this situation that the normative and regulatory functions of the state-power are unique and inalienable in providing the guarantee that the community deserves and requires. For this reason, the influence that the community can and must exercise in the drawing up and the application of these norms and regulations is the basis for the fair and efficient development of any health care system. It is the right of the citizens to elect those who administer the resources that are available within a framework of fairness, solidarity, ethics and morality, which in addition should be compatible with the teaching of Christ and the Church. What, therefore, should be our work within the Christian community? First of all, we must put indifference to one side. To think that others must be responsible for animating actions is a passive approach, if not actually negative in character. For this reason, it is important to act with all the means that we have available. First by example and then through the spread and promotion of principles, actions and strategies. There are many groups of people who are keen to take part in the kinds of action mentioned above and who are only waiting for a road which allows them to go forward, without distinctions based on class, guided solely by those principles and directed towards the ends pursued by the community and its priorities.

If we agree that health does not know barriers of race, colour, religion, politics, the economy etc, we will be of one mind also on the universal principle of access for everyone to better health and better health services. I would like to emphasise at this point the important role that NGOs play at a national level, referring later to the international level of these organisations, which are indeed acquiring greater influence in the health care sector in particular and in the social sector in general every day. It is wise to remember once again the distinction between a non-profit making NGO and a profit-making NGO. In the sphere of health and health care this distinction is certainly very important.

The International Level

Health and the control of illnesses, and in particular those that can be transmitted, has always been an important question and of constant concern. It is easily demonstrable that illnesses do not have frontiers, and this is even less the case in the globalised world in which we live. Illnesses known as non-transmittable illnesses are still today illnesses shared by the whole of the world's population because chronic illnesses linked to lifestyle have also become globalised, like, indeed, the mass media, television, and rapid transport. To levels that were unthinkable only a few years ago, digitalisation, electronic communication, e-mail, etc., have brought about different cultures, which are above all different from dominant cultures, and which are not always the healthiest or the most compatible with public health or with a suitable control of

illnesses. For example, previously the problems of nutrition were almost always connected with hunger and malnutrition, and this was something that had disastrous consequences in poor countries. Today, we are especially worried about obesity, over-eating because of an excess of fats, quantitative and qualitative food security, and the presence of fertilisers and pesticides in food products that were previously grown in a totally natural way and in harmony with the ecology and the specific characteristics of the environment.

If to all this we add certain customs and so-called 'modern' habits of living that promote practices that are incompatible with good health, such as smoking, the exaggerated consumption of alcohol, the lack of physical exercise, the concentration of people in commercial centres of vast range, refuse and garbage, the treatment of water etc., the image of the world we live in seems to be that of an individual who has all the factors designed to soon make him or her a chronically and at times incurable ill person.

In this scenario, which seems to be catastrophic, there emerges the international nature of health and illness, with the consequent need for a joint, co-ordinated and coherent international action of all the international protagonists of health, always respecting the principles of equity, solidarity, ethics and multiculturalism.

It seems difficult in today's world to distinguish the national protagonists from the international protagonists in matters relating to health. The governments are the same and the NGOs are the same, especially those that are more influential and those possessing greater resources; academic and scientific institutions penetrate each other and some open up a way which the others have to follow, those that is to say those which have fewer resources available. What, therefore, is the difference between activity at a national level and at an international level when it comes to health? The differences vary both as regards quantity and as regards quality. I will refer to some in order to illustrate this statement. There are at least three categories which may be distinguished:

– There are rich countries, those countries which are the most developed and in the front line of progress, whose power can be appreciated on all the fronts that we have mentioned regarding health and health care, for example systematic and accessible vaccinations;

– there are poor countries, which constitute the majority in population terms as well, who are always the losers and often opt for alliances which are not always the ones that are the most convenient and practicable for them;

– there are some countries which find themselves between these two categories, they are not many in number and although this is not recognised by many people they are the countries which have the disadvantages of both and only some of the advantages of the rich, at times aspiring to what they cannot have and leaving aside that which they could have. They have a series of contrasts which it is very difficult to overcome and potentially they have very major social problems when it comes to the health of their citizens.

With this world scenario, what path, then, should be followed?

There can be no doubt that there exists a very large political component in relation to international action in the sphere of health and health care. This fact is denied in many forums but reality itself demonstrates that policy in health is not necessarily health care policy or policy for health.

We all know that we have to share ideals, principles and objectives if we want a co-ordinated and efficient action based, as has already been rapidly said, on fairness, solidarity, and social justice. For these reasons, we need to ask ourselves if in reality these three (arbitrary) categories of countries are able to harmonise their interests to achieve these principles and ideals. Could health serve as a glue to reduce the existing difference in the world so that there are better health care conditions for a better human production, a better standard of life for the less favoured, and a strengthening of peace?

Clearly, the theoretical and academic answer is positive but practice and experience shows us that this is very difficult if not impossible. Must great tragedies take place to convince us that we are all in the same ship? Frankly, I hope that this is not the case. What, therefore, should we do?

In order to achieve a level of international agreement the urgency of, and need for, participation and action at the level of communities are increasingly evident. This participation can take many forms and occur at different levels and in different contexts. However, there are certain shared aspects which it is worthwhile taking into account if we really want to influence national and international health care structures and the path they take. Here are a number of suggestions:

– know about the government and inter-governmental structures in question, how they are formed, how they are structured, and above all else how they function at both national and international levels (international organisations);

– know about the funding of non-governmental organisations, not only their structures and how they work but also the sources of their funds and their operational mechanisms in countries and/or communities (today it is known that a good part of the funds of the principal non-profit making international NGOs come from governments, which makes their situation *sui generis* in terms of international co-operation);

– an evidently tangible demonstration of existing concerns in matters relating to health, at times as a reflection of greater forms of unfairness and conflicts of interest;

– an open and transparent discussion of the factors that determine health and illness, which to a great extent are outside the control and the influence of the health care sector, for example environmental contamination;

– the raising of the awareness of the whole of the community about the responsibility of every individual towards his or her own health, and towards the environment which surrounds the individual and the community in general (providers and recipients);

– detailed information and knowledge about national and in-

ternational strategies, including priorities for action (lobbying?);

– respect for the socio-cultural spaces of communities, including the concepts and the practice of native or traditional medicine;

– a greater demedicalisation of health, with a suitable inclusion of the notion of the spiritual dimension that exists to health.

These reflections may be useful in launching a debate leading to actions which are really influential in making health and health services a good for the whole of the population, that is to say a universal good. For this reason our conference is very important.

The relationship between power (in its various forms and expressions) and health and health care services has been presented and we have discussed and analysed this subject. I believe that this conference and the invitation that we have received from the President of the Pontifical Council for Health Pastoral Care, Msgr. Javier Lozano Barragán, were not intended to express once again our wishes or our beliefs, but rather to reach practical conclusions and recommendations about what should actually be done in this field. I equally believe that the initiative of the Pontifical Council and its President of reactivating and strengthening the Catholic Federation of Health Care Institutions (AISAC) is a demonstration of how to strengthen co-ordinated, systematic and efficient action in the field of health for the greatest system of health care services existent in the world, that is to say the institutions linked to the Catholic Church, and going beyond for ecumenical action in the field of health as well.

In this uncertain future that we are living at the dawn of the twenty-first century, I believe that decisive, co-ordinated, involved and participatory action in the field of health and the prevention of illness is a necessity and is a further element in the construction of a greater understanding between human beings and intercultural dialogue, the practice of social injustice and solidarity for long-lasting peace inspired by Christian teachings.

Dr. FERNANDO S. ANTEZANA ARANÍBAR,
Former Vice-Director General of the World Health Organisation.

EDUARDO R. MONDINO

6. What Should be Done in Relation to the Policy of States in Latin America

I would like first of all to express my gratitude at the fact that this opportunity has been offered to me to present at this prestigious international conference the opinion of the Ombudsman of Argentina on the subject of this meeting, in order to contribute to an analysis of the right to health, and the relationships of power connected with its implementation, in the light of the Magisterium of the Church.

At the same time I would like to present the view of Latin America on the validity of this primary human right, which has been consecrated by all the international conventions and the national Constitutions of our countries, but which remains highly vulnerable at the level of realities and wounded in terms of its validity.

In this sense, for the Ombudsman of the Republic of Argentina, by constitutional mandate, because of how this mandate is exercised, and by personal conviction, *the right to health is an essential and primary human right.*

By human right we mean 'a moral, integral and universal right that all men, of any place and any epoch, must have, and which nobody may be deprived of... In definitive terms, it is a right that belongs to every human being because of the mere fact of being a man...'

It in this context of interpretation and with a meaning of this importance and depth that we understand the concept of 'right to health'.

In more specific terms, the preamble to the Constitution of the World Health Organisation declares as follows:

First, that the enjoyment of the highest possible level of health is one of the fundamental rights of each and every human being, and *second,* that governments are responsible for the health of their peoples and that this responsibility can be implemented only through the adoption of suitable health care and social measures.

It is here, first of all, that we establish the inseparable link between 'human rights' and the 'right to health', and we understand that this link is of such profundity that one cannot think of one being implemented without the other being implemented as well.

For this reason, we do not accept citizens being seen as the 'consumers or users' of health care services. This is because they have the right to the protection of their health as a social good and as a primary human right.

Secondly, so-called 'access to health', which is intimately correlated to the previous right and which is to be located within the responsibility of the state, is a social right and a 'social good' whose implementation must be guaranteed by the state.

This guarantee on the part of the state, in the exercise of its inescapable functions, transcends the jurisdictional aspects of things because a 'human right has no frontiers' as well as the sectoral aspects because this very guarantee goes beyond the sector (whatever it may be: public, private or social security) that provides the various health care services.

Our Reality

An analysis of Latin-American realities in this sphere, which is certainly the same as other so-called 'emerging', 'marginal' or 'developing' countries, allows us to assess the role of the state in the exercise of this guarantee and to identify where and in what ways it has failed.

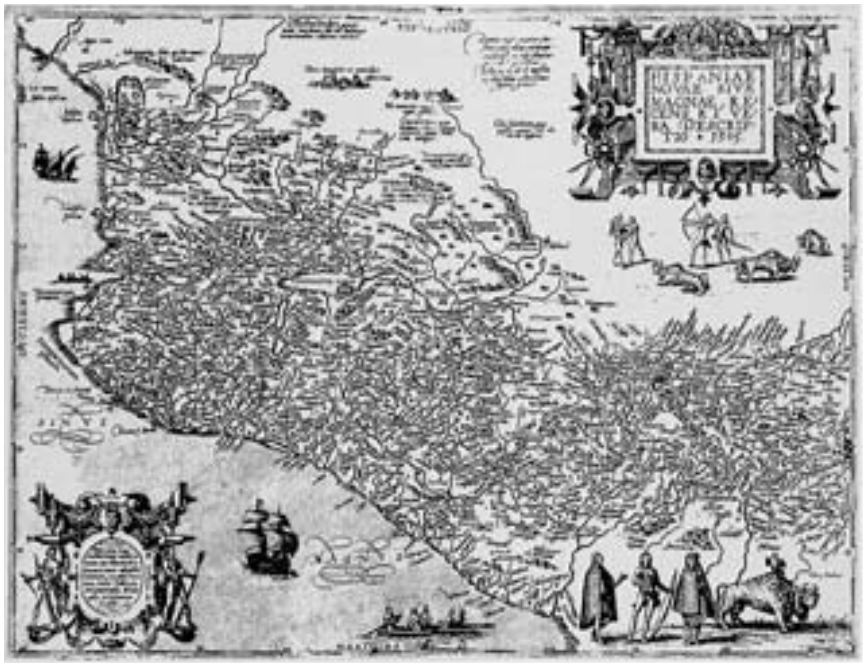
In general, we can state that over recent decades Latin-American countries have experienced deep structural changes in the economic and social fields as a result of the so-called processes of the 'reform of the state', of the privatisation of services which were traditionally seen as being 'public' in nature, and of the concentration of wealth, with the logic of, and a predictable inequality in, the distribution of the incomes that are generated.

These processes have not been accompanied by suitable policies of social defence.

This failure and this lack of precision, which are certainly variable because such variability is implicit in the very idea of these processes, have generated negative effects in a population which has not been adequately helped in facing up to and managing these consequences.

The consequence of these overall processes have been special and contextual policies that have been implemented in every country. For this reason, one should not forget the role of the so-called 'adaptation plans' which were advised by multilateral credit organisations as a condition for access to new sources of finance.

These contingency plans, which were of an eminently 'fiscalist' character, have struck at a general level the implementation of social and health care programmes – in particular to meet 'economicistic' criteria – whose objectives have not always coincided with the needs of the populations involved and as is always the case have afflicted those who have fewer resources.



The various reform programmes of the state and their consequent 'plans of fiscal adaptation' have given rise to a massive paradox because the objective proclaimed by these public policies has always been the development of a model in which social and health care services are the principal activities of the state.

It was assumed that beginning with schemes of privatisation and the adaptation of government structures it was possible to achieve the 'ideal of a neo-liberal state' which was dedicated almost exclusively to being concerned with security, health, education and justice services.

However, without discussing the role that has been attributed to the state, the objectives proclaimed have been very far from being reached.

A crude idea of achieving economic returns have inspired and accompanied the implementation of such reforms, whose negative consequences have soon been felt, and in matters relating to health care it is today easy to observe a real 'state of poverty as regards public health'.

This doctrine, converted into a 'state policy' in matters relating to health, has had a further deleterious effect because it has also meant the transformation of a *social good* into a commodity subject to the rules of supply and demand and extraneous to every question bound up with the purposes of the state.

In such circumstances, states are excluded from the role of being protectors in matters relating to health, and leave the population to the mercy of the workings of the market.

The failure to provide remedies to such injustices further accentuates the present-day social differences which result from abandonment or from an unsuitable way of

approaching the traditional pillars of every health care system such as 'prevention' or 'primary care'. And this situation is getting worse because of the lack of sufficient and dignified sources of work for people.

To summarise, the evident results are: social exclusion aggravated by structural unemployment.

For this reason, those efforts must be made which are required to overturn these social imbalances, without, however, ignoring the appeals of its victims, and which are needed to create the conditions which can invert the marginalisation which has already been established within the social fabric of our peoples.

To complete this brief diagnosis, I would like to discuss certain data relating to the health care sector of the Republic of Argentina.

According to the report for the year 2000 of the Pan-American Health Organisation, Argentina has undergone a strong inversion in trends relating to health – from 600 to 800 dollars per inhabitant each year. This represents between 8% and 9% of GDP and places the country at the summit of the scale of Latin American countries which spend the most on health and health care.

Reading this report one can observe the abundance and the high qualifications of the human resources, the suitable supply of education, the existent capacity in terms of buildings and the number of hospital beds. But the report also states that 'with these valuable resources the results of the health service are not satisfactory nor at the level they should be...'

Reference is made to the presence of major regional differences and indicators of inequality with regard to access or the use of resources since these vary a great deal according to the social sector or the region of the country involved.

Furthermore, the report makes clear that 45% of total expenditure in the health care field is met by families, with a growing gap between high and low income groups as regards access to this service.

Lastly, it is estimated that about 38% of the population has only partial coverage under the public health service, a percentage that will certainly grow if the high levels of unemployment increase. This is because this development involves the automatic migration of the part of the afflicted population from the solidly-based system of social work to that of the public sector.

This reality is not natural to Argentina but a reflection and a consequence of the conditions that have just been described, but it should be pointed out that the situation is certainly similar in other countries.

It reflects a great attempt to achieve an annual inversion of the system and, very often, suitable overall indicators of the human resources and materials applied to the health care sector. But as a final result what is obtained is: inequality in the treatment of social groups and also within a single group, unequal geographical coverage, and the absence of the public service in meeting the needs of those excluded by the privatisation of services and by the structural corruption of the systems of social security.

In definitive terms, the inefficient application of scarce public resources and the primacy of criteria of economic returns in approaching the service imply a lack of protection of, and the social exclusion of, growing sections of the population.

The New Role of the State

In this context it is clear that society wants a state that is present and which intervenes because of its responsibility to maintain the social entity that defines it.

No inhabitant of any nation expects or believes the state to be absent. On the contrary, people expect and want the state to concentrate its efforts on the implementation of the principles on which are based the needs for its existence.

For this reason, in the contemporary historical context and with the new challenges of defending the dignity of man, today we must speak once again about the role of the state as regards its essential tasks and purpose and the resultant objectives at the level of political action.

Over the last decade we have witnessed a shift from a the 'welfare state', with functions that at times suffocate the freedom and development of the individual, to a 'neo-liberal state' with the delegation of functions to the market which harms social security and equity.

An analysis of this process of change enables us to reassess the social doctrine of the Church as regards the validity of the principle of subsidiarity as a criterion for the definition of the role of the state. This is a principle which must be understood without bad totalitarian habits with regard to the allocation to the state of functions which can be carried out by individuals, and without liberal or neo-liberal approaches which leave the social order in the hands of the market, forget about man, and weaken every regulating and control mechanism.

We can draw from papal encyclicals the principle of the subsidiarity of the state as a force which harmoniously links freedom, security and social justice in the exercise of its functions.

In an overall interpretation of this principle, the state must not carry out those functions which can be carried out by single individuals or by social entities which are lower down the social scale. But when these lesser entities are not able to carry them out or are not interested in doing so (for example because they are not remunerative), the state must take on the task of defending its essential purpose.

In acting in this way the state must not forget that the social organism wants the individual to be treated as a *citizen* and not as a *'customer or user'* of a system which provides services. And this is especially the case when one is dealing with the health of the population.

In expressing this last essential requirement I am aware that I am entering the subject of the *'crisis of the concepts of citizen and citizenship'*.

The concept of 'citizen does not stop at its legal-political definition but acquires meaning in its daily exercise, in its reality, and in its ideals', as I said at the last congress of the International Institute of Ombudsmen held in Durban in South Africa in November 2000. And I went on: 'the lack of a connection between the theoretical bases of citizenship and the practical ways of its expression is brought out in the realities of the democracies of Latin America when one compares the differences in terms of access of citizens to the enjoyment of goods and objective and subjective rights'. 'Citizens who are unable to obtain work, who remain culturally and socially below the threshold of economic, health care, and educational survival, and even lack their own representation, clearly call into question not only their condition as citizens but also the meaning of their human rights'.

With these words I want to point out the challenges we are faced with when we speak about the new role of the state and it being an agent of inequity, with a view to ensuring access to so-called 'social goods' and the full validity of human rights.

The Role of the Ombudsman

In this context, by mandate of the national Constitution (which was reformed in 1994), the Ombudsman has to engage in the 'defence and protection of human rights and other rights, the guarantees and the interests defended by the Constitution and law, regarding facts, acts or omissions of the government, and the control of the exercise of the public administrative functions'.

This mission of the Ombudsman, within the context of human rights and the sphere of their implementation, involves the on-going task of *avoiding every form of discrimination and not allowing new forms of human and social exclusion.* If he does not do this, his prestige and his credibility will be compromised at a legal, political and moral level.

In this task the appeal of the citizen to our institution plays a fundamental role. This is because his or her voice stimulates the collective conscience and stops needs from remaining in the wilderness.

In this sense, we mean that the Ombudsman, as the recipient of this appeal, is able to demonstrate the consequences of those models of development whose first point of reference is not man, and at the same time to provide data on situations to the administrative power, which is responsible in the final reckoning for the elaboration of public policies.

On the one hand, this is because the Ombudsman is an open door for daily and on-going contact with the individual, who is indeed the final destination point of every policy of the state. As a result of this task the Ombudsman engages in an on-going and up-dated diagnosis of the final results of the action of the state. On the other hand, this is because the Ombudsman engages in a control of the public administrative functions, and does this because of his final purpose – the defence and the protection of human rights, all human rights and the human rights of all people.

The Ombudsman, therefore, as a defender and promoter of human rights, is an effective assessor of the effectiveness of the achievement or otherwise of the tasks of the state.

The outcome of these tasks is translated into recommendations and reports that the Ombudsman presents each year to the legislature of the nation.

On a reading and an analysis of these recommendations by the legislature of the state depends the impact of the contribution of the Ombudsman to the process of the drawing up of public policies.

But nothing, not even their total rejection, invalidates these tasks because their validity is based upon the appeal of the real citizen who turns to the Ombudsman because he or she feels that his or her rights have been damaged.

A Contribution

Within the framework of the role of the Ombudsman as the

person who contributes to the drawing up of public policies for the health care sector, I would like to submit to this conference for its consideration a number of concepts contained in the 'Charter of Ljublijana' of 1996 of the World Health Organisation, which, together with the contribution of our modest experience in this field, could be principles that could be employed to direct a necessary process of change in this area.

To simplify, I will summarise these concepts in the form of recommendations to be presented to the administrative power of the state:

First: invest in the capacity of the health care service by ensuring respect for the principle of universality of access and the geographic coverage of every national area.

Second: supervise matters so that the reform of the health service takes place beginning with a deep reflection on the factors that condition its evolution and a rigorous analysis of the scenarios of its future development.

Third: go beyond the mechanical, one-dimensional and voluntaryistic modes of drawing up policies and understand the change in social systems by adopting a dynamic and interactive approach.

Four: support the idea that change in the system must be based upon the citizen and guarantee a real taking on of responsibil-

ity by the various actors involved in the working of that system.

Five: adopt forms of balanced development of the system by taking advantage of the greatest number of efforts of co-ordination and by creating the conditions for a gradual evolution in the medium and long terms, without neglecting rigour and the wisdom of action in the short term.

In this way we can work to establish principles of equity in the drawing up of public policies: geographical fairness – in order to reduce the inequalities in terms of health care between countries and regions; socio-economic fairness – in order to avoid inequalities between equals; and health care fairness in the treatment of the various groups at risk.

Conclusion

In order to be clear about my participation as an institution which is concerned with the defence of the citizenry summed up in the phrase 'Ombudsman', I would like to finish my paper by expounding in the form of an epistemological proposal a short theory of the system of the relationships between the state, power and health, the central subject of this international conference:

– The state as an organisation subject to the common good and the generator of the common good.

– Power as an instrument of ability to do things which is given legitimately but which becomes legitimate only if it acts to guarantee a balance of equality within society, without forms of coercion or omission, and this for the sake of the common good.

– Health is a right natural to human nature which does not have any need to be classified or described, specifically because it is nature. St. Augustine said in philosophical vein: God forgives because He is the merciful Father; men sometimes forgive; nature does not forgive because it is nature.

There is, therefore, the benchmark of the human right to health, and as a result the system of the relationships between the state, power and health, and at the same time the conditioning relationship of the defender of this right, the Ombudsman, who first of all and prior to any dialectic or imprecise or forced legislation is essentially the Ombudsman of human beings, *in their human nature.*

In our institution we have wanted the theme of our objective to be: 'making all human rights credible'. The first, that of human nature, of all men and the whole man.

So that the above-mentioned theory functions the system of relationships I have referred to is face to face with a crossroads, the most conflict-ridden that there is in people's relationship with each other: *the meaning of power.* Because power, which is often veiled as Max Weber makes clear in his book 'On the Theory of the Social Sciences', 'is the ability to compel or coerce someone so that this person, although he would prefer not to do so, does your will because of your position of strength'.

We all know what power is. The world is full of powerful people who have distorted it by violating human rights. This also happens in the policies, the approaches and the omissions of the sphere of health and health care.

As a result, power, to be valid, must base its exercise on the achievement of the common good in meaningful social and collective policies in favour of life from conception until death.

For this reason, the universality of the authority that comes from God, the author of the total life of everything and which is total for everything, is the beginning and the end of physical, spiritual, moral and intellectual health.

Health is thus a totality, beyond the definition offered by the World Health Organisation and of any shallow expressions to be found in human or fallible Constitutions.

This assumes, as a consequence, within the context of the theory that I have wanted to offer to this meeting, a definition for Ombudsmen of a framework-context towards equity in the equality of equals: their role as defenders of human rights and within the system of relationships between the state, power and health in favour of human nature.

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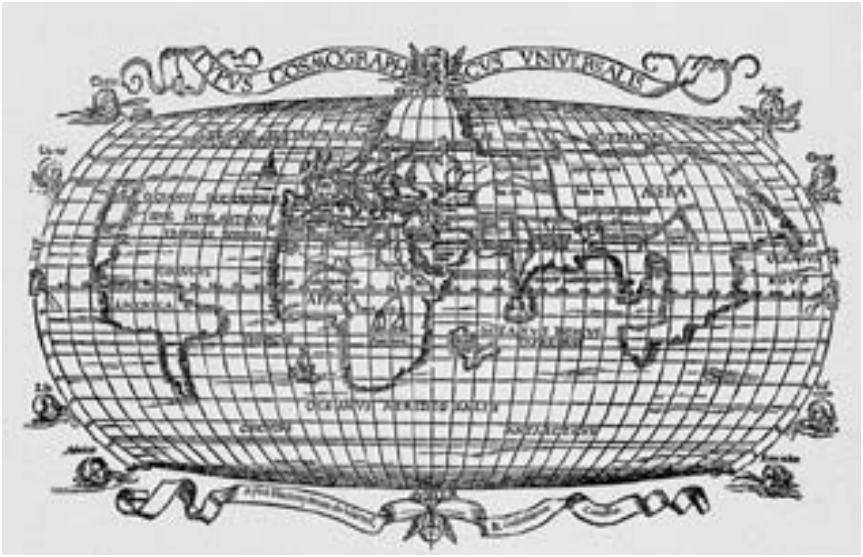
LUCIANO SANDRIN

7. Educating in Relationships among all the Subjects of Care

1. Ongoing Training



One of the *reasons* for the present-day malaise (and consequent burnout) which affects in a special way those who work in the health care world is the perceived and experienced gap between the requests to which they are subjected every day and the (technical and relational) resources that they have available. The 'expectations' about the professional capacities of those who work in a health care context are often greater than their *real abilities*.[1]

In analysing the requests to which he or she is called upon to respond, assessing their meaning and importance, seeing if they should really be met, and establishing priorities, the health care professional can realise that his or her training is inadequate both at the level of *contents* and at the level of *ability*, but also, and above all else, as regards the *approach* he or she should adopt in entering work and managing it in a 'healthy' way for himself or herself and for the patients that have to be treated. If learning about all this takes place first of all during the *training curriculum*, that is to say when people go to school and prepare the ground for a specific profession, this must, however, continue through training that accompanies the therapeutic activity and is suited to the requirements that precisely in the health care world can change (and even change rapidly).

To object that 'practice is more important than grammar' can lead one off one's path: the relationship with the sick person and those who suffer is too sensitive a matter to be left to chance and learnt through 'trial and error', and the quality of life and the health of people certainly gain more if *action* is illuminated and constantly directed by up-dated *knowledge* both in the technical and the relational sphere. *Training*, in order to be suited to new needs, must be on-going because it is the place where experience is addressed, problems examined, crisis thought about, new kinds of measures planned, and consequent strategies drawn up. If knowledge illuminates and renews our action, it is implementation that asks questions about, provokes, vitalises, and makes 'historical' our knowledge, especially in those professions such as the health care profession which involve a relationship of help and care which is never completely predictable and able to be placed in a 'category'.

But the kind of training that is chosen, that is to say the *knowledge* that must guide our *knowing how to do things* in a suitable way in the health care world, cannot depart from a number of fundamental anthropological questions: who is the partner of our relationship? What is he or she asking for when he or she asks to be treated and healed? What kind of relationship must we form with him or her in order to respond in an effective way to his or her request for health? And lastly: what anthropological model underlies and directs our relationship of care?

To what models, for example, do we refer in shaping our relationship of care? To military models (we fight an illness and the sick person is the field of battle), sporting models (one can only win or lose a match and the sick person is the trophy of the victory or the sign of defeat), technological models (linked to the efficiency of the instruments available, not always valuable forms of help but too often our substitutes and our masters), economic models (there are those who provide a service, those who receive it, and the accounts do not always balance)

or political models (it is a place where we express a service to the community or where we establish ourselves to manage power)? Or is it the case, without demonising all this, that our relationship of care has a richer anthropological model which underlies it and in the not only theoretical but also practical recognition of a relational reciprocity invites us to be respectful of the richness of the person who asks for care and to be 'critical' of our (at times reductive and poor) way of engaging in a relationship?

Training that is mere cosmetic lifting designed to sell the product of health cannot escape these questions and fail to pay attention to the changes which are underway in the health care world. It is not my intention to make a complete analysis of all of this but only to propose certain reflections which are useful as regards our subject.

2. The Rediscovery of the Subject

There is no contradiction between a criticism of an 'ideology of technology' (of hegemony in the health care world as well and its insensitivity towards the worries and suffering of the sick person and those who are next to him or her) and a recognition of its importance in improving care and treatment. 'There is no contradiction given that every technical form of intervention is immersed in a context of a radical inter-subjectivity and a psychological and human atmosphere which enable the patient to feel around him or her not cold applications of technological categories but human presences able to listen and to engage in assistance and treatment at one and the same time', capable that is to say of *ad-sistere* (to be near) and *therapeuein* (to serve and to treat).[2]

Therapy and assistance cannot be such if not within relationships in which the human dignity of the sick person is fully recognised at all the moments and contexts of the process of care. The health care environment and the relationship of care are often criticised for having a lack of 'humanity'. This is a view which applies, however, not only in cases of 'bad health care' but also to a certain way of engaging in a relationship with people who suffer and which calls into the picture the *vision of the person* which is at the basis of a *training that 'is revealed' in the process of care and treatment* where, for example, the use of medicines and technology, both at the level of exploration and intervention, end up very often by making the recognition of the sick person as a subject, and relational concern with him or her as a person, 'non-functional' (if not actually disturbing).

In the new socio-health care context 'in which on the one hand the person lives out the fascination of modern technology applied to medicine, and on the other perceives malaise, both because of the impersonality of the procedures, especially at a hospital level and the level of specialist medicine, and in relation to the experience of disorientation linked to the sectorialisation of measures which results from the dominion of the concept of competence which at the most is concerned about physical pain but is very rarely concerned about the subjective conditions of well-being/ill-being and thus of suffering, once again the *need for subjectivity* has emerged in a very evident way'.[3]

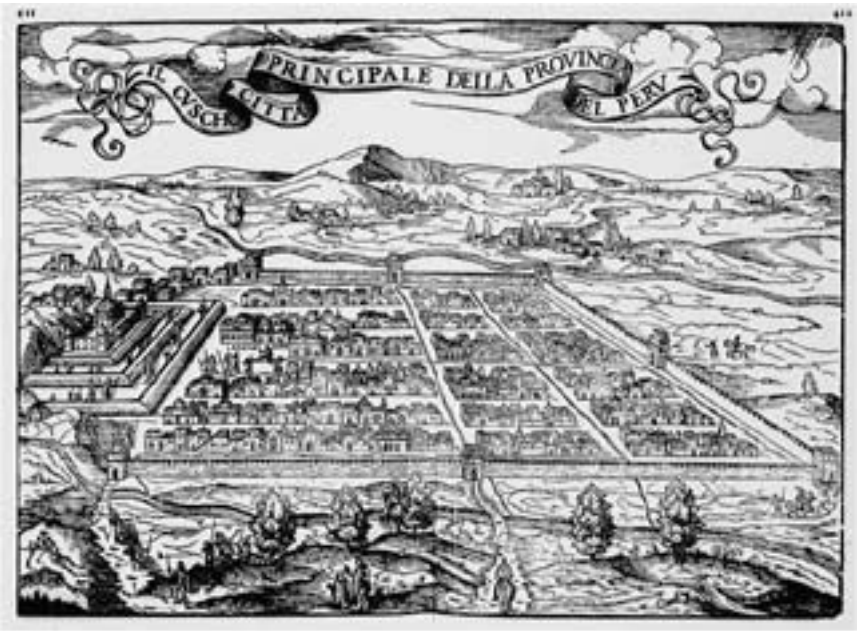
The sick person often experiences at first hand a *fragmentation* involving being looked at and taken care of by various health care workers, each from their own point of view, without due respect for the patient as a whole. From the relationship of care he or she receives, as in a mirror, a fragmented and partial image. For the *response of care* to give again unity to the subject who asks for it and narrative continuity to a biography interrupted by the illness, there is a need in the therapeutic relationship as well for a rediscovery of the model of an *alliance*, for a pact in which the two partners take each other seriously in the entirety of their personalities as well as the implicit experience to which both the request for care and the answer to it refer: not only the *entirety of the sick person but also that of the individual who looks after that sick person.*

One can give the name 'therapeutic alliance' to the relationship between a sick person and the person who treats him or her when such a relationship is understood in its most radically existential dimension: within an experience of illness a request for care arises, and a competent subject promises to provide help. Illness is not a mere alteration of a part of the organism and the therapeutic endeavour does not end its role in an organ which must be made to work, in an enemy virus which has to be combated, in something that can be totally objectivised. The *request for treatment and care*, the call for help that the suffering person makes to those who are near him or her, is full of an expectation which is wider than the mere technical service: 'it is a search, that is to say, by the suffering person for his or her own true identity, for what has really gone in the drama of illness, for what he or she in the final analysis is really looking for when asking for health, and finally what name God, who has allowed this malady, really deserves'. To answer the expectations of the sick person cannot, therefore, be reduced to the mere offer of technical services. The request for care and treatment is a request by the person who suffers for his or her recognition as a person, for a form of health that technical measures, on their own, can never fully satisfy'.[4]

But this care for the sick person as a subject must go beyond 'declarations of intent' and can find an expressive place in the therapeutic relationship only if it is learnt and made its own along the whole of the training curriculum.

In his motu proprio *Dolentium hominum*, John Paul II reminds us that in her service to the sick and her approach to the mystery of suffering 'the Church is guided by a precise conception of the human person and his destiny in the plan of God', and when considering illness and suffering he adds that these 'are not experiences that regard only the physical substratum of man but man in his entirety and

in his somatic-spiritual unity'. The human person must therefore be understood as a *global unity*. Man is an integral reality, a complex and articulated expression of several dimensions which may be distinguished but not separated: the somatic dimension, the psychic dimension, the relational dimension, and the spiritual dimension. And all this has profound implications for the relationship with the sick person (at a medical, nursing, psychological, technical and pastoral level) and for the kind of training that must make people capable of *re*-cognising



the global unity of the sick person, even through a specialist (and thus duly partial) approach which concentrates on one of these dimensions.

In the experience of *crisis* of illness, the person who suffers is called to rediscover his or her *global unity*, albeit in the differentiated emergence of his or her dimensions, to understand his or her self-transcendence, or rather his or her incessant search for meaning which leads him or her to go out of himself or herself in order to go beyond the present condition, to conceive his or her existence as being dialogical and relational within a project of alliance with God and with those who in taking care not only of his or her illness but of him or her as a sick person welcome the voices of hope in his or her invocation of care and manage his or her self-entrusting to them with competence and discretion.[5] It is the case that on by no means few occasions this entrusting gives rise to a paternalistic (and thus 'infantalising') relationship if not actually to a relationship of power. If in speaking about a therapeutic alliance, reference is being made to the biblical model of a covenant one has to be careful, not least so as not to identify the health care worker after a certain fashion with God, and the sick person with the people to whom God offered his covenant: in the *therapeutic alliance between the health care worker and the sick person* each of the two partners is an image in different ways of God and his people, of Christ the Samaritan and Christ the sick person.

When a person falls sick and enters an institution of care and treatment, he or she entrusts himself or herself to other people and places his or her own life and autonomy in their hands. The risk being run is that the various health care workers make themselves the 'lords of life', eliminating his or her autonomy and making him or her increasingly dependent at the psychological and functional levels as well. To help, to heal, or even only to treat and rehabilitate means to accept the *entrusting* of the person in difficulty, experiencing it as *temporary* and *limited* even when for various motives it tends to endure over time. It also means defending the life of the patient, above all the *dignity and quality of his or her life*, being careful not to hide satisfaction with something with roots elsewhere behind 'the good of the patient', for example often unconscious desires for control and power.

In illness and disability the situation of dependence and the ability to be autonomous experiences constant fluctuations; in addition, the need to be protected is not always absolute and defined once and for all.[6] If the therapeutic relationship has to be respectful of the 'subjectivity' of the patient and concerned with the maintenance of a good quality of life, then the fundamental principle is the recognition of the patient's *autonomy* which always remains '*possible*', even in the presence of a dependence which continues.[7]

The sick person is extremely 'vulnerable', already wounded by his or her illness and pain but made even more fragile by inadequate relational modalities: the 'wounds' of the person who treats the sick person, his or her unrecognised *in*-consistencies, his or her worries, his or her conflicts that are not resolved, and his or her relational *in*-competencies run the risk of also expressing themselves in more or less concealed forms of control, violence and power.[8] As Heidegger wrote, 'taking care of can in a certain way free others from 'care', by taking their place in providing care, by *occupying* their position. This taking care means for other people that the taking care which is specifically theirs is taken on. Other people thus become expelled from their positions, demoted, to receive *de facto* or from others, in a way that is already ready and available, that which was taken care of, and as a result they become totally exempt. In this form of taking care other people can be transformed into dependents and the dominated, even though the dominion is tacit and dissimulated. This taking care, as a replacement of others in taking 'care', greatly conditions people's

co-existence and concerns for the main part taking care of the usable. Opposed to this is that possibility of taking care, which, rather than putting oneself in the place of others, pre-supposes them in their being able to be existential being, not in order to take 'Care' away from them but to insert them authentically in it. This form of taking care of people, which is essentially concerned with authentic care, that is to say the existence of others and not *something* that they take care of, helps other people to become aware and to be *free for* their own care.[9]

3. Subjects in a Relationship

Reflections on the image of the 'wounded healer' are also of interest here: a special archetype of the healer and the patient does not exist because they are the aspects of the same archetype which can be expressed by both the partners in the relationship. The relationship of treatment and care is health-inducing only when the health care worker does not become identified rigidly with the 'healer' and sees that he or she is wounded, and because of this able to 'shake with the sufferings of others', with undue forms of identification, reawakening in the patient *his or her* strength of healing.[10]

In the therapeutic relationship, however, it is important to be careful about not 'objectifying' either of the two partners of the relationship. In the search for the reconstruction of an identity that is put into crisis by illness the person asks for help from the person by whom he or she is cared for and treated. But if he or she 'reduces' (and impoverishes) his or her identity within a role, or allows himself or herself to be represented or replaced by technology, he or she cannot grasp (or cannot but deny) this need for identification of the sick person, forcing him or her to remain within a role – the *role of the sick person* – through which (alone) he or she knows how to establish and maintain a relationship. The relationship of the health care worker with the sick person thus becomes nothing else but a relationship between figures (between masks), between roles that have a functional relationship, and not a relationship between persons. Only by accepting the request for identification made by the sick person can the health care worker discover, or rediscover, the wealth of his or her own identity, and only in this way can his or her answer of care can express the rich anthropological model of the carer that the Gospel

entrusts to us in the person of the Christ, the Good Samaritan.

A well-structured humanistic training, however, must not be reduced to the acquisition of relational techniques to convince the sick person to accept care and treatment and engage in compliance. It must, rather, help in enabling a person *to be within a relationship*, to be careful about the experiential and communicative wholeness of the sick person (which is also valuable for a more accurate diagnosis because it is more attentive to the symbolic and communication aspects of the symptoms) without flights but also without illusions. The caring person is the principal medicine or drug and he or she is a medicine or drug who develops his or her therapeutic force through the relationship.

The healing of a person through the stages of the illness 'means that one must listen not only to what strives to be listened to (often one is dealing with an organisation of symptoms which are a shield for the real cause of the malady, preventing the person from engaging in changes at a deep level) but also and above all else to that which has been 'excommunicated', that is to say withdrawn from communication. One can, in other words, use one's own skill in healing to 'distance' what is really important'[11] but which can reawaken in the health care worker the *difficult to manage*, and thus removed, *interior world*.

The use of technology can also respond in those who are providing care and treatment to this need for defence. From this comes a therapeutic regime characterised by the neglect of everything that can lead the sick person to the centre of things, his or her history, his or her problems, his or her emotions, that is to say all the experiential aspects in the relationship of care. This is rarely intentional but automatically leads to the result that (even more than the stress induced by the illness) it is the stress induced by the hospital and by the relationship of care and treatment which enter the picture as a pathogenic factor in the experience of the illness.

We need, if we want to improve the relationship of care and treatment, to revise (at the level of the training curriculum to begin with)

the therapeutic model of reference, passing from a model *centred around the illness* which becomes easily centred around the *medical doctor, the nurse or the institution* to a model *centred around the sick person*. In medicine centred around the patient the relationship becomes a moment of the process of care and treatment whose protagonist is the sick person, ready to grasp the meanings that he or she gives to the illness, the *feelings* generated by it, the *expectations* and *wishes* with which the medical doctor and the health care institutions are turned to, the family, social and cultural context to which the sick person belongs.[12]

And this takes place only within an *empathetic* relationship within which the health care worker is able to shift the focus of the attention from himself or herself (from his or her own mental categories and emotions) to the sick person and his or her experience, grasping also what is implied in his or her communications, his or her request for care and treatment, and his or her pain: a message in code that is not always deciphered and to which one responds all too often in a merely technical way without first deciphering the meaning that it has for that person, the place that it has in his or her life and the life of his or her family.[13]

An integral anthropological vision of the person (and a training that takes this into account) helps us to read his or her illness as a break in an equilibrium which although it has its matrix at a somatic level affects the person in his or her entirety and the various dimensions in which this is expressed. Ethical reflection and the kind of training that it brings about must, therefore, increasingly be concerned with the defence and the promotion of the life and the health of the person throughout the course of his or her existence, and when weak or sick during the whole of the course of treatment so that *all that care respects the sick person*, his or her dignity, his or her subjectivity, his or her rights and duties, and first and foremost that of being an active partner in the process of care and treatment. And thus, above all else, the therapeutic relationship does give rise to varying levels of 'hidden' forms of control and power.

If the use of technology and drugs and medicines takes the place of the relationship this impoverishes not only the sick person but also those caring for that sick person. *The rediscovery of the subject* applies not only to the sick person but also to those who care for him or her and cannot but influence the training models that are proposed.

4. Shared Relationships

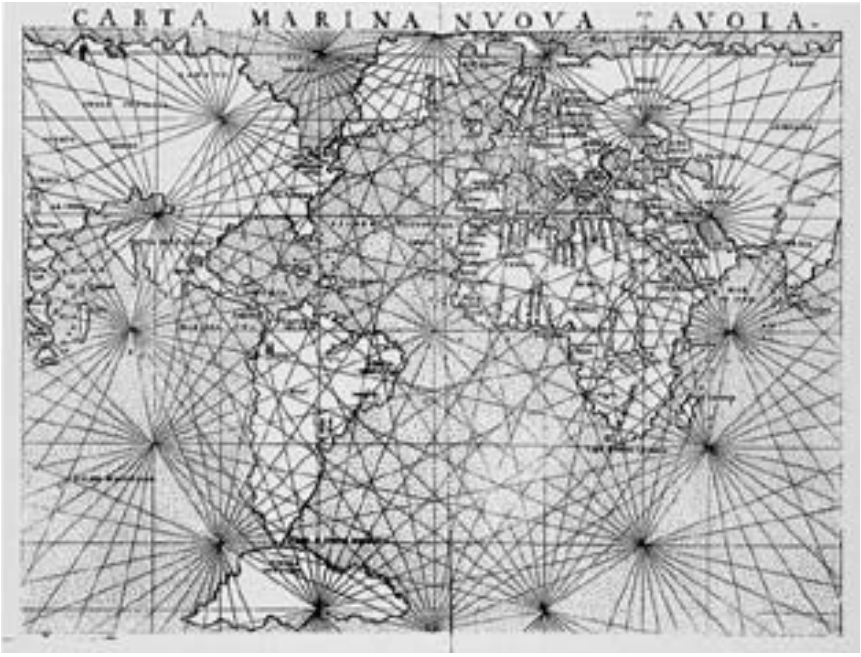
Despite new definitions and declarations in relation to health, a real cultural change both in health care spheres and in the broader social world has yet come about. Too often the various dimensions that make it up are seen as being separate, at the most bordering each other, perhaps only to be counted together, but they are not seen as being inter-acting in a dynamic equilibrium where the subject is called (and helped if need be) to gradually find his or her *point of balance*. And this is the case not only in the practice of treatment and care but above all in the training that must prepare the way for that practice.[14]

And yet it must be clear that it is not possible for an individual health care worker to respond to the deep and weighty requests for healing on the part of the sick person, to engage in a therapeutic alliance that does not disappoint him or her, or that does not give rise to a paternalistic relationship or a relationship of power, if not by (of necessity) engaging in an alliance with all those who are responsible for the patient (whose integral health is of importance to them), sharing skills and sensitivity, accepting that we are all *pieces of the same therapeutic mosaic*, without wanting our own vision and form of professional intervention to manage or dominate the process of care and treatment. Illness, like health, affects the person as a whole and thus they are connected to a *great alliance* of factors. Therapy, too, must be the fruit of a successful mosaic of *professional knowledge and skills*. Only together do the various health care workers achieve suitable and adequate therapy. Only together do they become a therapeutic and health-inducing community in which the sick person, at the centre of different knowledge-based approaches and various professional relationships, is cared for and treated in his or her entirety, in all the dimensions in which his or her health has entered a state of crisis.[15]

In a new anthropological model of health and care, *collaboration* between the various health care workers cannot be the fruit of 'benevolence' or mere friendship but a precise *ethical duty* (and thus find suitable spaces of training) if we want to respond to the entirety of the request of the sick person and the depth of his or her need for care and treatment, healing and health. In order to continue to be concerned with the various aspects of the request for care and treatment on the part of the sick person (and of those who are near the patient) and to be able in order to respond to it, 'to *collaborate*', we need a training which is from many points of view *new* and makes people able to grasp the entirety of the sick person behind his or her partial expressions and to dialogue in a respectful way with all the other health care

professions, '*sharing*' knowledge and relationships with the various protagonists of care and treatment.

Taking care of the sick person assumes a capacity to grasp the wealth of his or her request, often to read his or her pain, his or her emotional experiences, his or her relationships, his or her thirst for meanings, and his or her movement towards transcendence, and to implement (because trained to do so) a kind of care and treatment that integrally responds, albeit by various specialised paths, to his or her need for healing. We should, therefore, 'deprivatise' the therapeutic alliance, without taking anything away from the importance (which varies according to the kind and contexts of care and treatment) of certain professional figures.



The *relationship between the health care worker and the sick person* cannot but take place within a wider *relationship between the therapeutic community and the sick person* in which the relationship with the patient is also a relationship with his or her family and with the socio-cultural context in which he or she lives. As Edmund Pelligrino writes: 'the era in which the ethics of various health care workers could be conceived solely in terms of individual transactions with individual patients has passed. The dyadic moral obligations are as important as ever but now they are to be found within institutional and collective contexts'.[16] The response to the good of the patient cannot be the 'monopoly' of an individual professional. And training must also take responsibility for this. The therapeutic alliance must therefore become also an alliance between all those who take care of, and treat, the sick person.

Hipppocrates himself understood how the physical and cultural environment affects health and stated that a democratic society is more health-inducing because it guarantees the dignity of the person.[17] His approach is still of contemporary relevance. The premise of an open society is above all awareness that nobody can possess all the truth on the pathway of human knowledge. This awareness of the partiality of our knowledge makes us open to listening and to the discussion of our positions. *Awareness of our human fallibility* is the engine of scientific and technical progress because it imposes comparison on us in an attempt to solve problems that are always new and is the *liberty* and the *responsibility* that guarantee an open society. If democracy is based upon fallibility, liberty and responsibility, it shares its premises with health which compels us to take up the reins of our contingency in the awareness that we are finite but that we have the responsibility of our own limits.

Health is not a 'state', a given equilibrium, but something that is constantly regained within an internal and external interaction. Educating in health means, therefore, educating in intellectual humility, liberty, and responsibility, not looking for salvation on this earth, the drug or medicine that is able to heal everything, because this would be illusory: *our vision*, precisely because it is human, *is necessarily in perspective* and we must address the various problems that exist by 'engaging in dialogue' with those who have other perspectives, specifically because we are not God and we cannot have the only vision there is. The dignity of holistic medicine is to be found in its noble requirements to treat the whole man, but in the awareness that this is a utopia, a hope and not a certainty, that health is *already* a salvation of a *not yet* that can never be expressed completely on this earth.

To educate in health and its care and treatment is also to educate in the inevitability of illness, a sign of weakness, but also a place of responsibility, the terrain of a personal challenge but also of a challenge to the community, because the struggle against illness should be faced up to with an authentically competitive spirit (in the sense of *cum-petere*, that is to say looking together). For this reason knowledge, which is the basis of a health-inducing care and treatment, cannot be centralised, and at times can also be found even in unsuspected places and voices that are not very authoritative, in the sick person and those who are in loving fashion at the side of the sick person.

Intellectual humility, the *ability to interact* and *responsibility*, which are the bases both of the dynamic of democracy and of the dynamic of health and care and treatment, are the premises of an intellectual and moral character that provide criteria for training, collaboration, and the sharing of the specific skills at the service of those who people who suffer.

Certainly, the *utopian engineers*

of health care who always seek to foresee every problem rather than defeating the possibility of its emergence think that they can bend life to their noble but anxious need for planning. And they often run the risk of manufacturing idols. More realistically, it is important to train *gradualist engineers* who commit their strength and their responsibility in care and concern for the sick person and those who suffer, in the awareness that they will have to face up to new problems every day: professionals who look for healing but who know that it can never be definitive. And they know that they cannot act on their own.

Training *good health care workers* thus means training *masters of contingency*, experts in treating wounds 'together' but also in making good use of them, placing in communion values and projects as members of *moral community* which does not confine itself simply to sharing habits (a form of life acquired by up-bringing and not re-evaluated in a critical sense) but appeals to the *responsibility* of each person: a community that shares *similar modalities of action* because it sets itself *shared ends* and tries to implement the *same values*.

The community has a constant need to be *saved* from the risk of *unhealthy* relationships, from the exploitation of other people, and from dominion, and the universal drug or medicine for this is *dialogue*, given that rational communication is specific to man. And in 'reasoning together' one discusses and establishes criteria and tasks, rights and duties.

Educating in community, in co-responsibility, in living together and in sharing, in dialogue and the reciprocity of relationships, is fundamental because it means educating people to be free and responsible *men*, to be a *mature self* in a relationship to a *you who calls on us* and whom in some cases we have to become responsible for in order not to betray our humanity: ready and willing to walk because aware that the *homeland* has not yet been reached and that the approximations are all contingent. But this *homeland*, although it cannot be objectified, is the engine, the *condicio sine qua non* of our thinking and our acting, which is distant and, paradoxically, near to hand. It is the Augustinian *intimior intimo meo*, the transcendent spirit that lives in us and makes us authentic because it frees us from the empirical and from the banal calling of us constantly to ends beyond this world; it is the *love* that makes us understands differences, and makes us appreciate them positively.

On their training journey the professionals of health are called today to 'rediscover together' the values and the meanings of their own relationship of care and treatment[18] and above all to make their own, through an initial and ongoing training, a 'culture of intersubjectivity', which is only such, in its human foundations as well, if it is a 'culture of humility'.[19]

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Notes

[1] On the subject of 'burnout' see my 'Burnout e lavoro scientifico' (with accompanying bibliography) in G. CINÀ, E. LOCCI and L. SANDRIN, (eds.), *Dizionario di Teologia Pastorale Sanitaria* (Camilliane, Turin, 1997), pp. 157-161. This dictionary is cited hereafter as *DTPS.*

[2] E. BORGNA, *Noi siamo un colloquio. Gli orrizonti di conoscenza e di cura in psichiatria* (Feltrinelli, Milan, 2000, 2nd. edn.), pp. 188-202 (quotation, p. 199).

[3] L. PINKUS, *Senza radici? Identità e processi di trasformazione nell'era tecnologica* (Borla, Rome, 1998), p. 147. The italics are mine. See also S. MARHABA (ed.), *Salute, ben-essere e soggettività. Nuovi orizonti di significato* (McGraw-Hill, Milan, 1999).

[4] P. CATTORINI, 'Alleanza terapeutica', in *DTPS*, pp. 30-37 (quotation, p. 31).

[5] G. CINÀ, 'Antropologia nel mondo della salute', in *DTPS*, pp. 64-78.

[6] P. VERSPIEREN, 'Respecter et promouvoir l'autonomie du malade', *Revue d'ethique et theologie morale "Le Supplément"*, I (1995), 47-60.

[7] Cf. L. DAVEGGIA and L. SANDRIN, *L'autonomia possibile. Attenzioni psicologiche nella riabilitazione del disabile* (Camilliane, Turin, 1996), and L. SANDRIN, 'Autonomia e dipendenza della persona anziana in una prospettiva psicologica', in F. CARETTA, M. PETRINI, and R. BERNABEI (eds.), *La cura della persona anziana. Manuale per gli operatori sanitari*, Vol. II (CEPSAG, Università Cattolica del Sacro Cuore, Rome, 2001), pp. 121-133.

[8] Cf. L. SANDRIN, 'Etica del contenimento', in A. Cester (ed.), *Legare i vecchi* (Edup, Rome, 1995), pp. 57-63, and F. CARETTA, 'L'uso dei mezzi di contenzione: aspetti clinici ed etici', in Caretta *et al., op. cit.*, pp. 145-165 and see also the detailed bibliography.

[9] M. HEIDEGGER, *Essere e tempo* (Longanesi, Milan, 1976) (original German edition 1927), pp. 157-158.

[10] Cf. A. BRUSCO, 'Guaritore ferito', in *DTPS*, pp. 565-568, and A. GUGGENBUHL-CRAIG, *Al di sopra del malato e della malattia. Il potere 'assoluto' del terapeuta* (Raffaello Cortina, Milan, 1987) (original German edition 1983).

[11] S. SPINSANTI, 'L'ascolto nella practica sanitaria. Gli interrogativi fondamentali', in AA.VV., *L'ascolto che guarisce* (Citadella, Assisi, 1989), p. 21.

[12] Cf. E.A. MOJA and E. VEGNI, 'La comunicazione e la relazione fra medico e paziente nella medicina patient centred. The patient centred model in medicine', in A.C. BOSIO and M. CESA-BIANCHI (eds.), *Contributi per la medicina*, special issue of *Recherche di Psicologia*, 4 (1996)-1 (1997), pp. 444-445, and E. A. MOJA and E. VEGNI, *La visita medica centrata sul paziente* (Raffaello Cortina, Milan, 2000). On the psychology of the sick person see L. SANDRIN, 'Psicologia della salute e della malattia', in *DTPS*, and L. SANDRIN, *Compagni di viaggio. Il malato e chi lo cura* (Paoline, Milan, 2000).

[13] Cf. L. SANDRIN, *Come affrontare il dolore. Capire, accettare, interpretare la sofferenza* (Paoline, Milan, 1995). See also N.P. NIELSEN, *Pillole o parole? Relazione verbale e rapporto psicofarmologico* (Cortina, Milan, 1998).

[14] Cf C. BRESCIANI, 'Salute. Approccio storico-culturale', in *DTPS*, pp. 1073-1079, and a critical reading of the definition provided by the World Health Organisation to be found in L. LOZANO BARRAGÁN, *Teologia e medicina* (Dehoniane, Bologna, 2001), pp. 11-20.

[15] Consulta Nazionale CEI per la Pastorale della Sanità, *Il mosaico terapeutico* (Camilliane, Turin, 1997). For a theological-pastoral examination of the question see L. SANDRIN, 'Chiesa, comunità sanante. Una prospettiva teologico-pastorale', in L. SANDRIN, *Chiesa, comunità sanante. Una prospettiva teologico-pastorale* (Paoline, Milan, 2001).

[16] E. Pelligrino, quoted in G. KHUSHF, 'Organisational Ethics and the Medical Professional: Reappraising Roles and Responsibilities', in D.C. THOMASMA and J.L. KISSEL (eds.), *The Health Care Professional as Friend and Healer. Building on the Work of Edmund D. Pelligrino* (Georgetown University, Washington D.C., 2000), p. 158.

[17] These reflections are the result of a conversation with Palma Sgreccia.

[18] The specialists of this sector are rediscovering the importance of *meanings and values* as an antidote to the specific work stress known as 'burnout' as well. Cf C. CHERNISS, *Beyond Burnout. Helping Teachers, Nurses, Therapists and Lawyers Recover from Stress and Disillusionment* (Routledge, New York and London, 1995), and in particular chapter 14: 'What's Missing? The Quest of Meaning', and C. MASLACH and M. LEITER, *Burnout e organizzazione. Modificare i fattori strutturali della demotivazione al lavoro* (Erikson, Trento, 2000) (original English edition 1997), especially chapter 7 'Promuovere i valori umani', pp. 121-137.

[19] Cf. E. BORGNA, *op. cit.*, pp. 200-201.

EDGAR WIDMER

8. In Relation to Hospitals and Other Health Centres

Speaking of Health, Power and Actions to be promoted in Relation to Hospitals and other Health Centres we will consider the first referral level, Institutions within the so called District Health System.(DHS) The *DHS* is a functional and coherent decentralised health care organisation aiming to implement Primary Health Care for a defined population, with participation of the communities and ensuring responsiveness to the local needs. It consists at least of the community, first line health and first referral Hospital. *Primary Health Care* is defined as the basic curative, preventive and promotional health care services available, accessible, affordable and acceptable for all.[1] The DHS is the nucleus of a National Health System, as the family is the cell of society. Actually the ongoing health policy reforms foster decentralisation, concentrating the main responsibilities to the district health authorities. At this level we find most Church Health Institutions. The challenge is to better integrate them into the DHS by intensifying partnership between Government and Church-bound Services. Considering that about 40 percent of the health services in Sub Saharan Africa belong to the Churches, we realise the enormous potential integration of these NG-Institutions into the DHS have for an optimal overall efficiency of health services. The responsibility for integration lies in the hands of those in power. Since more than 30 years we of Medicus Mundi co-operate with more than 250 Church Hospitals. Sharing with you this experience, we witness important changes concerning "Health and Power at District Level".

1. What do we mean by power ?

We read in the introductory text for this conference that Power means *force joined to intelligence*. May I propose to add to this definition that *Power should be the capacity to generate consensus.* Consensus gives legitimacy to power.

2. Who has power ?

According to law, power is in the hand of the owner of an institution. Power is bound to responsibility and vice versa.

But, what is the LEGAL ENTITY of the institution? Who is the owner? Is it the Bishop, the Diocese, the Parish, a Congregation, a Church-bound Foundation or an Association? Does it belong to the legal entity of the Diocese or has it a SEPARATE LEGAL STATUS?

Most Church-bound hospitals lack a separate legal status. This may hamper transparency and be a cause for difficult relationships with Governments as well as with Donor Institutions. A Church Hospital should have its own governing body, accountable to the owner but not subject to his arbitrary interference. There is a need for greater autonomy and self governance within the different structures and entities of a diocese. It is necessary to clearly define what kind of responsibilities and competences are delegated to them.

An intelligent owner knows that despite having power and responsibility, he is not the only one to determine affairs. He will have to rely on all those who perform the services. Those in charge must be competent in their field, be it the doctors, the different health workers or the administrator. They all have authority and decision making power, always within the limits of the overall interests of the institution as defined in Mission- and Policy Statements An owner will also know that those who procure the money, be it the Government, the users or donors, that they give money usually under specific conditions.

3. What norms and factors determine power ?

a. The vision of the church for its engagement for health:

At global level the vision of the healing ministry[2] is given by Christ himself as described in the Gospel, by the Churches' tradition throughout the centuries and by its Magisterium. We all know the merit of this Pontificate for having for the first time in history created a specific Dicasterium by the Motu Proprio: "Dolentium Hominum". This Dicasterium for Health Pastoral Care among others, co-ordinates the work of International Catholic Health Associations such as the International Federation of Catholic Health Care Institutions. This Federation, last year, gave new directives for the future work. It strongly recommends to stand up against the new tendencies of mercantilism in the world of health, to defend the Not for Profit policy for the benefit of all parts of society, to reinforce the position of Church-bound Institutions by optimal co-ordination among themselves and to support initiatives for a better partnership with Governments.

The Vatican has given full support to an initiative launched by Medicus Mundi International promoting in the World Health Assembly a resolution in favour of: "Contracting NGO' s for Health"

or in other words: "Strengthening Health Service Delivery by Improving Partnership between Public and Private Health Care Providers".[3]

At a local level some Episcopal Conferences together with Catholic Lay Health Professionals have elaborated MISSION STATEMENTS as well as POLICY STATEMENTS. Excellent examples are the statements recently approved in Uganda.[4] All the bishops of the country, the Catholic Medical Bureau in Kampala, the Nuncio and many experts worked on it. The different power structures are described, such as the authority and competence of the owner, the role of the board of governors, the

administration and the medical staff. These statements are aligned to the specific country realities, they consider the ongoing health-sector-reforms and they are aware of the consequences the paradigm-shift Alma Ata brought into the world of health. In 1978 the Alma Ata Declaration on PHC and in 1987 the Harare Conference defining the District Health System have changed the Churches' traditional engagement for the sick. This engagement is now widened towards health promotion, towards the defence of life and the protection of human dignity. Strategies such as PHC and Prevention have become essential. The slogan: "Health for All and Health for the Whole Man" has become a new vision which corresponds widely to the strategies of the World Health Organisation, as confirmed in the Rome meeting in 1997 when discussions were held on: "Church and Health in the World, Expectations and Hopes on the Threshold of the Year 2000".[5]

According to the mentioned global and national vision of the Churches role for health a bishop should be encouraged to formulate a DIOCESAN HEALTH CONCEPT and procure a Diocesan Health Committee out of which he can delegate representatives to the Government Health Committees at district level. Government representatives on the other hand should be invited into the boards of the Church Services, institutionalising a well structured partnership.

b. The policy of the national co-ordinating agencies of church-related health services.

At national level the Church should have one voice. The power of the different hospital owners should be channelled through these national bodies and the Church Health Services should be co-ordinated with clear mandates in those already existing CATHOLIC OR CHRISTIAN MEDICAL BUREAUS

These Co-ordinating Agencies should foster ecumenical and inter-religious co-operation to increase negotiating power in dealing with Government. A strong position may even help in giving a contribution to formulating national health policy.

Health Institutions should only be recognised as CHURCH BOUND on the base of their faithfulness to the Mission- and Policy-Statements and not on the mere grounds of legal ownership by the church.[6]

c. The Institution needs a *concept for a pastoral care in health* which is aware of the paradigm-shift from former pastoral care for the sick towards the broader one for health, for health promotion, a pastoral care also for the health workers, pastoral care actively educating the individual and the community, promoting their responsibility for health and fighting mere consumerism.[7]

d. Church bound institutions have to be inspired by a specific *Christian charism.* Every man should be called by his name in the way Christ is calling us by our name. Charism is not a matter of stereotype friendliness, it is above all love, compassion and respect, love combined with hope and faith being the most important healing factor. The dignity of every man has to be at the centre of our interest, humanism has to dominate technology and science.[8] Those in power set standards by their own attitudes

e. The institution is bound to *ethical standards.* It should have its own Ethical Committee for matters such as the option for the poor, non-discrimination, equity, accessibility, keeping up solidarity, mercy and empathy with the needy.

f. The institution is bound to human rights

The Declaration of Universal Human Rights was formulated in the year 1948. The declaration of Alma Ata, 30 years later, indicates the PHC concept as an important strategy to reach the right for health. Nevertheless in the declaration of human rights some con-

flicts are inborn: demands and needs can be controversial; scientifically sound principals may socially not be acceptable; individual interests and community necessities can be antagonists. The rights of society may precede individual rights. There is a hierarchy of values. Even knowing that every human being has the right to security, to respect for his dignity and the right to health, we have to acknowledge that each one of these elements depends on human solidarity and therefore the economic, cultural and political interests of society have to be protected.[9]

Every country is faced with the problem of money allocation, with the problem of how much to spend on health and how much at what level.

An institution may be confronted with the troubling question: "Who has to die when the means do not allow the survival of all and no one wants to die"? "How can one decide upon priorities within a particular health care system"? "Does the right to health and the intention to heal allow us to neglect our obligation towards God's creation"? Progress in medical research provokes many bio-ethical questions. Human rights are deeply bound to ethical values and faith. is confronted with daily reality. Even trying to take decisions by interdisciplinary discussions, setting ethical standards does not mean to procure acceptance for every feasible new trend. Very delicate discussions are going on and limits, especially in the field of reproductive health, have to be pronounced.[10]

g. Most Private Not For Profit Health Institutions have a public function and should be an integral part of the NATIONAL HEALTH POLICY. They have to adapt their policy according to government legislation, its standard-setting and its basic criteria for employment of personnel. Criteria for equipment, teaching aims, service delivery, transports, supervision, monitoring and money allocation have to be defined.

Transparency and accountability are the main prerogatives for mutual trust. An institutionalised dialogue between government and the private sector is necessary. The improvement of partnership between the two requires a process where step by step one comes to common agreements and memoranda of understanding and finally to legal contracts. Once the World Health Assembly has agreed upon the above mentioned Resolution on: " Strengthening Health Service Delivery by Partnership with NGO-health Care Providers" or: "Contracting NGO' s for Health", this process will be accelerated to the benefit of a better integration of NGO Health Services into the District Health System.[3]

h. The institution has to observe *medical professional directives* such as decisions concerning priority-setting or defining the type of health care. Discussions about optimising care, quality-assurance and rationalisation of services are professional matters. Clerical interference should be avoided. A Jesuit once spoke about the danger of consecrated incompetence.

i. The institution is bound to *social obligation* towards all those working in a hospital. Besides economic aspects, the health workers expect career planing, professional ethics and the satisfaction gained by doing a good job.This helps to avoid brain drain, corruption and demotivation.[11]

j. Financial constraint

First of all, the concept of " Not for Profit " has to be defined. It means that although a Non Governmental Health Care Institution aims at a *balanced budget*, no alien gain is seeked.

Contributors to a *balanced budget* are on the one hand the government, users and donors; on the other hand strict control over spending is just as important, optimal management and administration is required.[12]

The institution needs money for investments, maintenance and running costs including the costs for ongoing training and for capacity building for reforms. Government contributions may vary from country to country. The fact is that the government has the responsibility to guarantee the delivery of health services. Due to structural reforms imposed by the World Bank and by the International Monetary Fund many subsidies have been dramatically reduced. For the sake of fairness, criteria for money-allocation have to be re-discussed for those private institutions recognised and accredited as Not for Profit and of Public Interest.

The users contribute by their fees. These are fixed either by the political authorities or by agreements between the Institutions and the population. Sometimes the fees are established by the institution above.

Balancing budgets by increasing fees often causes a reduction of the utilisation of the services and can lead to the critical point of collapse.

Therefore before fees are increased one has to define the average basic package of health care to be given and then to analyse the real cost-factors. Without evidence based information it is impossible to fix realistic fees. In many places one knows at the end of a year the overall cost of care. That , however, is of limited use. In a study made in Zimbabwe, Medicus Mundi Belgium together with the Ministry of Health and Child Welfare and the Institute of Tropical Medicine, Antwerp,[13] showed how to provide further data: What are the cost data per facility level? What percent of the total health cost goes to the District Hospital and how much to the Dispensaries? How much is spent in the different departments of a hospital? How much is spent on the different compartments of a hospital? How much is spent on the different components of disease specific groups? (malaria – or HIV-patients) Are the consumables used at their best? Who is employed and what is the average salary per hour of work? One can also measure and compare how much time staff members need to deliver one unit of service. Is the staff efficiently deployed and sufficiently motivated? Is the institution, compared with similar private health services, or with public services, competitive? For this purpose MMI published together with WHO, the Guidelines for Hospital Reports,[14] an instrument which allows to compare efficiency be-

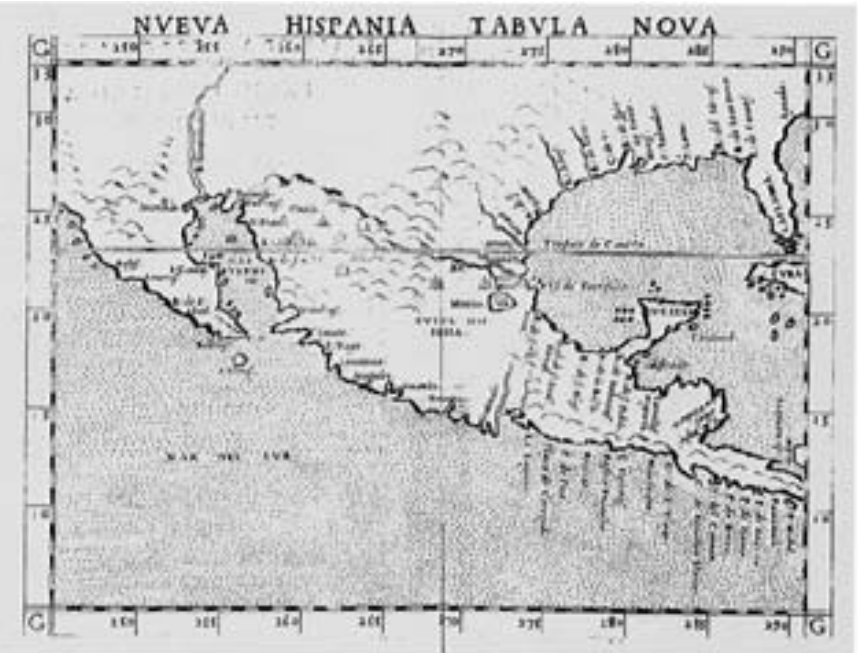
tween different institutions and which helps to analyse the hospital's impact on the improvement of the health status of a given population. These are just some practical examples on how in a differentiated way one can calculate the proper costs and accordingly fix fees or correct eventual mismanagement.

Proper book-keeping, transparent financial reports, clear plans for managerial operation are needed as well as the advice by health economists.

More money not always gives better results A few years ago studies demonstrated that poor institutions may even have better performances than richer ones.[15] Kerala , with a very low income per capita, shows an infant mortality of only 31 per thousand life births. This is forty percent lower than in Punjab which has twice the income of Kerala.

Balancing budgets by creating departments for private patients is another possibility. There are examples where fees for special hotel-like services allow some gain and the mix of "Private for Profit" with "Private Not for Profit" may compensate deficits.

Balancing budgets by collective solidarity introducing insurance systems, as has happened in more advanced countries, may help to reduce individual hardship. Insurance systems can be started by civil initiatives on a small local scale, or on large scale by government.[16]



k. Institutions should ensure the *participation of communities' representatives* in their governing structures and programs. In the understanding that women are a key actor in the promotion of health, particular attention to a balanced participation of women and men in the governing structures of Church health institutions should be offered to secure the formulation of gender sensitive policies.

l. Up to now many *donor governments* have invested their aid directly through NGOs. Many *donor agencies* and *international organisations*, apart from their own money-raising-campaigns, depend on money they administer on behalf of their governments. We are witnessing a change of policy. The so-called Sector-Wide Approach diverts foreign government aid directly into an overall basket administered by the central government, unless the private institution and the local government have come to clear contracts. Institutions must know that such contracts may be the condition for further direct payment by donor countries through NGOs.

The help of *donor agencies* and *international organisations* will greatly depend on whether administrative efficiency and reliability exist. In many cases sustainability may better be reached by offering help in terms of administrative assistance, instead of offering money. The International Federation of Catholic Health Care Institutions (AISAC), in its working-program 2000, therefore has decided to offer training facilities for administrators and health economists in order to strengthen capacities. Health economists should be placed within National Co-ordinating Agencies and serve as experts to the single NGO-Hospital. *donor agencies* and *international organisations* not only offer partnership and advocacy. Due to their development work and partnership with other private Institutions, be it within the same country or in different geographical regions, they can share experiences and offer advice so as to avoid mistakes or indicate successful strategies.

4. Instruments of power

Command, force, fighting, punishment and sanctions have often been connected with power. We have to consider that in imposing the truth by authority, the stronger, not the intelligent, are favoured. Using power by command and force is disruptive and destructive. Another approach may be the dispute, a dispute where convincing each other is the prerogative. This is what Jürgen Habermas describes as: *"Herrschaftsfreier Diskurs", a dispute free of command*. It is a dispute where *Information* has to flow two ways. *Free Dialogue* has to replace blind obedience. *Decisions* have to be taken bottom up and top down and need *consensus*. *Team dynamics* ensure creativity. *Participatory* methods optimise motivation and improve efficiency. Every training should include the teaching on how to reach consensus.

Clear job-descriptions and attribution of responsibilities stimulate initiatives. Well defined targets facilitate the introduction of a monitoring system which allows corrections and improvement of the

performance. Incentives for good accomplishments will keep engagement alive.

We have to avoid the institution becoming an autonomous workshop for one or other stakeholder. I may cite a medical mission sister who 25 year ago in a COR UNUM workshop said: "If we want the health institutions to become devoted to the health of many, the first and essential thing is a *change in mental attitude* on the part of:

1. the doctors who see the hospital as "their" workshop;
2. the nurses who want to use their training only for personal gain;
3. the sick and their relatives who demand the doctor's personal attention for all kind of minor illnesses;
4. the hierarchy and religious, who insist on the "most modern and best" in services regardless of the cost, instead of being content with giving good simple service;
5. the administration of the hospital which wants to keep up with the neighbours in the scramble for the latest in equipment and drugs.

Attitudinal change may still be necessary nowadays.

Assuming responsibility and using power by respecting the above mentioned norms is quite an effort. Only in such a way will an owner become a real *servant* for the well being of individuals and society. The proper understanding of power, the sharing and intelligent channelling of power, are part of a modern process which also includes democratic control (by the church community, diocesan health boards or district authority) over the use of power. There is great hope that in such a way optimal health care services and efficient district health systems can be reached

The world community has never before been aware of an apocalyptic dimension of health crisis as it is today. Therefore since the beginning of the new millennium, the European Union, UN-agencies and the G-8 have been discussing a dozen international initiatives, such as the UN fight against poverty, the WHO fight against AIDS, TBC and malaria and the right to cheaper drugs. But the first and foremost obligation is to ensure access to adequate health care as a basic human right and as a crucial element in the fight against poverty and underdevelopment Even with free drugs, antiretroviral treatment (ART) for AIDS is not possible without solid medical structures. The universal strategy for tuberculosis control, the so-called "Directly Observed Treatment Short-Course" (DOTS) needs "observers". WHO's Roll Back Malaria (RBM) programme calls first of all for a strengthening of health care services.[17]

Once more therefore we have to confirm that the Church, using its power properly, and serving the improvement of district health system Church health institutions, can play a crucial role in the improvement of health, and that is what I wanted to share with you here.

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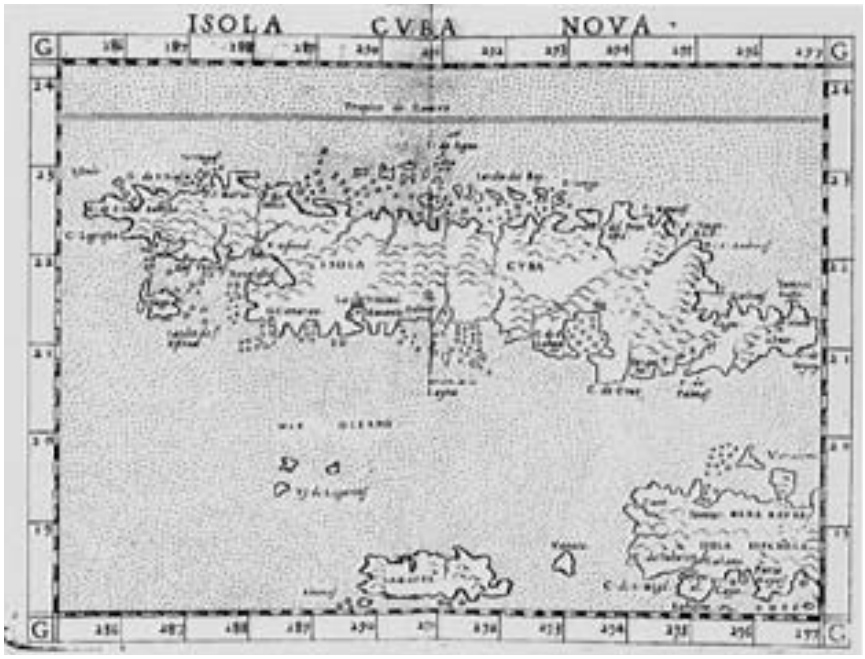

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