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ON THE REFERENCE TO CATHOLIC ETHICAL THEOLOGY IN
CONTEMPORARY HEALTH POLICY

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Abstract: Reference to theology, and in particular to theological ethics, in health policy in contemporary Romania may seem outdated. Some positions have been defended that tend to marginalize the contribution of theology to health policy ethics or even to rule out any contribution of theology to the implementation of health policies. The questions I aim to answer in this paper are the following: (1) Why has the role of theology (theological ethics) decreased in establishing health policies? (2) Which are the major problems for health policy from the perspective of theological ethics? (3) What is the original contribution that Catholic theological ethics can bring to health policy? In the concluding section of this paper I will present a case study that highlights the analogy (in terms of both usefulness and limitations) between the concept of "therapeutic alliance" and the theological concept of "alliance" (covenant).

Key Words: theological ethics, health policy, alliance, covenant, health/illness, sin.

Reference to theology, and in particular to theological ethics, in health policy in contemporary Romania may seem outdated. Some positions have been defended that tend to marginalize the contribution of theology to health policy ethics or even to rule out any contribution of theology to the implementation of health policies. The questions I aim to answer in this paper are the following: (1) Why has the role of theology (theological ethics) decreased in establishing health policies? (2) Which are the major problems for health policy from the perspective of theological ethics? (3) What is the original contribution that Catholic theological ethics can bring to health policy? In the concluding section of this paper I will present a case study that highlights the analogy (in terms of both usefulness and limitations) between the therapeutic concept of “alliance” and the theological concept of “alliance” (covenant).

Why has the role of theology (theological ethics) decreased in establishing health policies?

a. The first cause is political in nature: given the fact that decisions had to be taken for the entire population, leading to the current legislation in the field, the judicial aspects have taken precedence. The consequences of this situation can be felt at the level of the three key components of medical ethics¹:

- *the relationship between doctor and patient*, which used to be based on trust, has now become mostly contractual
- *the focus of research* has shifted from caring for a person to gaining mastery over the object of research
- *at the level of public health policies*, the concern for the person is increasingly conditioned by bureaucratic aspects.

The judicial jargon itself confirms this state of affairs, as it claims to regulate “the right to health” primarily understood as a right of the patient.

b. The second cause derives from the expectation of “scientificity” for medical ethics. The regulations which govern medical ethics need to meet the criteria of scientificity at three levels: health, risk and intervention. One must admit, on the other hand, that the ideological aspect of the theological discourse in Romania often predominates, which makes difficult any constructive dialogue². This is not, however, the case of Western Catholicism, which in spite of its former position of authority makes every effort to engage in an effective dialogue with medical science.

c. Recent philosophical trends have also contributed to a decrease in the role of theology. The concept of “autonomy”, initially defined by philosophers, is now central to bioethics whether we refer to the autonomy of the individual or to the autonomy of ethics from religion³.

However, Adrian-Paul Iliescu's argument that "the idea that any authoritative ethics needs the absolute authority of God can thus be shown to be unjustified"⁴ is theologically outdated. Already in 1965 the Second Vatican Council (*Gaudium et Spes*, the pastoral Constitution concerning the role of the Church in the modern world) stated:

"Now many of our contemporaries seem to fear that a closer bond between human activity and religion will work against the independence of men, of societies, or of the sciences.

If by the autonomy of earthly affairs we mean that created things and societies themselves enjoy their own laws and values which must be gradually deciphered, put to use, and regulated by men, then it is entirely right to demand that autonomy. Such is not merely required by modern man, but harmonizes also with the will of the Creator. For by the very circumstance of their having been created, all things are endowed with their own stability, truth, goodness, proper laws and order. Man must respect these as he isolates them by the appropriate methods of the individual sciences or arts. Therefore if methodical investigation within every branch of learning is carried out in a genuinely scientific manner and in accord with moral norms, it never truly conflicts with faith, for earthly matters and the concerns of faith derive from the same God. Indeed whoever labours to penetrate the secrets of reality with a humble and steady mind, even though he is unaware of the fact, is nevertheless being led by the hand of God, who holds all things in existence, and gives them their identity. Consequently, we cannot but deplore certain habits of mind, which are sometimes found too among Christians, which do not sufficiently attend to the rightful independence of science and which, from the arguments and controversies they spark, lead many minds to conclude that faith and science are mutually opposed."⁵

I would also like to mention here Pope John Paul II's encyclical, *Fides et Ratio*⁶, which can bring the necessary clarifications in this matter. The problem we face is not so much that of the autonomy of ethics from religion but rather the fact that ethics appears to ignore the theological perspective.

d. Finally, a forth reason why the role of theology has become less prominent can be found in the theological approach itself, which has focused on the significance of medical ethics and has not addressed the specificity of its own discourse, with the consequence that often Christian and non-Christian (especially philosophical) positions seem to overlap. This aspect is characteristic of Western rather than Eastern theology.

Identifying the main ethical problems that health policies have to face

This issue will be approached via examples, starting from the three areas of inquiry envisaged by Paul Ricoeur: the relationship doctor-patient, medical research and public health policy.

a. Nowadays *the relationship doctor-patient* is mostly focused on the correct information given to the latter and his/her self-determination (autonomy). However, this approach does not address the full complexity of the relationship between a doctor and a patient. It is especially insufficient for people who are gravely ill or nearing death, as the following testimony indicates:

“I have yet to live anywhere between one and six months, perhaps a year, but nobody wants to speak about this with me. So I face a thick and empty wall, the only thing that is left for me now [...] I am the embodiment of your own fear, whichever it is, your fear of what we all know we will have to face one day. You quietly sneak into my ward to bring my medication and monitor my blood pressure then, once your work is done, you quickly disappear. Why is that? Because I am a young girl training to become a nurse or because I am aware of your fear, which senses that your fear increases my own? What are you afraid of? After all, I am the one who is dying. Don't run away. Wait [...] All I need to know is that somebody will be here to hold my hand when the time comes. I am afraid. Maybe for you death has become routine; for me, however, it is something new. I have never died before”⁷.

It is obvious that the judicial aspects of medical ethics have failed to meet the needs of this person, whose concern is not her informed consent for one treatment or another but rather her response to anguish and the fear of death. This silent presence that the young woman asks for (“All I need to know is that somebody will be here to hold my hand when the time comes”) is not necessarily an attitude specific to the believer but a gesture of fraternity with the poor par excellence, who undergoes the deepest crisis of life and loses the most precious possession: life itself. For a Christian, this human presence can symbolize the silent presence of the One who never abandons man, not even when incurably ill or confronting death. This presence of God can open the path to sacraments.

b. *Medical research*, more specifically the ethics of research as stipulated by current legislation, protects the patient against possible abuses or dangerous deviations of scientific research. However, while reassuring people about the cost-benefit balance, the ethics of research does not even approach the fundamental issues. Thus, the key focus of medical research should be treating diseases and alleviating human suffering. In fact, however, it is ever expanding knowledge about the human body that is mostly sought: curiosity takes precedence over compassion and care⁸. Given these aspects, I believe that health policy should address the following questions: Which are the criteria according to which one kind of research is chosen over another? Why should we privilege, for example, research into the human genome over improving the health and quality of life of people living in the developing world? As Paul Ricoeur has argued,

“[medical]
science progresses faster, and often further, than
the specific diagnosis pronounced near a patient’s
bed. We must remind its practitioners that the
birthplace of medicine is human suffering, and its
most important role is to provide help to people in
danger.”⁹

In this respect too, jurisprudential ethics shows its limitations, as it protects the patient’s autonomy and rights but fails to approach the meaning of life and of the evolution of humankind.

c. *Public health*. An illness does not only concern a person in his/her individuality but also the population at large, which will be exposed to the consequences of other people being ill (for example, to the risk of contracting a disease in the case of an epidemics). This is why public health is of concern to politicians not only in terms of possible threats but also of the costs involved. I will not refer here to the classic issues concerning public health – e.g. the danger of quantifying people (a fraction of the population) by the bureaucratic apparatus, which regards public health in statistic terms without taking the measure of individual suffering. Instead I will highlight the consequences of the increased lifespan that medical progress has made possible in recent decades. The biological prolongation of life generates problems at the social level through the multiple dependencies it triggers: specialized institutions, trained personnel, experts in the field. If death is a fatality we cannot escape, present-day medicine does have the ability to prolong life. On the one hand, genetic research (the “aging gene”, the expectation to create organs compatible with those in the human body) aims to increase the lifespan; on the other hand, the need for wise resource allocation (in both financial and human terms) is more and more important and urgent. The

difficulty of evading this vicious circle (infinite needs for public health vs. limited resources) highlights a deeper aspect, namely our inability to fully comprehend the concept of finitude.

References to theological ethics in health policy

Among the specialists currently involved in developing and implementing health policy in Romania, there are voices that are willing to allow only a marginal contribution from theological discourse. It is true that, for a long time in the past, theology was regarded as “the queen of science” and the Catholic Church tended to validate its conclusions in an authoritarian manner:

“Church had been legally given almost full control over all matters pertaining to birth, marriage, and death”, one progressed towards the situation of the modern society, where the competences of the Church were gradually transferred to the state, ending up with the “individual’s emancipation and a liberalization of family and matrimonial relations.”¹⁰

However, the advent of modernity brought significant changes. Far from being in a position of authority, contemporary theological discourse finds itself increasingly isolated¹¹ or even excluded altogether:

“Using the provisions of the Strategy as a starting point, one may establish expert committees made up of professionals, representatives of professional associations and non-governmental organizations active in the field, philosophers, sociologists, psychologists, ethic management specialists, and other specialists in applied ethics. Intentionally, theologians are not included here, despite their concerns with bioethics.”¹²

It is more than surprising that such a position has been defended. First, it remains unclear which arguments allegedly support it. One understands that, given the specific target of their work (mental health), psychologists should be found in a panel of experts on health policy. Sociologists too, as they can measure the changes in health status and quality of life. However, one is rather mystified as to the reason why philosophers should be granted a place in such an “expert committee” while theologians are excluded. With particular reference to specialists in ethics, it remains unclear why philosophy should be preferred to theology. Naturally there are differences between the manners in which the two pursue their respective inquiries. However, ignoring the theological

approach amounts to a deliberate deprivation of a necessary critical perspective. Our humanity would thus be deprived of its spiritual component (both at the level of the individual and of society). Theology can enrich the public understanding of the issues involved in health policy. Moreover, thinking of action from the perspective of the institutions that implement it is a task that demands both a philosophical and a theological approach. Such being the case, it is difficult to comprehend why the contribution of theology (“the Church”, “the clergy”) is regarded as legitimate and welcome for the implementation of programmes for the development of human resources¹³, but the expertise of moral theologians is deemed unnecessary:

”They may find their well defined role in the debates on the specific implementation of sector policies, but not in the process of the creation of these policies. At the level of ethics institutionalization, of the general strategies targeting the construction of a model of social responsibility and public action that should provide an ethical base for an adequate, ethical and efficient resource allocation in the public health system, religious expertise is not necessary.”¹⁴

The very originality of theological reflection¹⁵ should not prevent it from bringing its contribution to the development and implementation of health policy.

a. The first element of originality that theology can contribute to its dialogue with science is anthropological in nature, regarding the human being. Questioning any scientific approach that considers people unilaterally, the Christian perspective opposes to the fashionable notion of “health capital” the belief that “health is the strength of being human”¹⁶. Far from being one commodity among others, health concerns the whole of the person. Moreover, Christianity does not envisage health in the context of an ideal anthropology (as it is often the case in our Western cultures) but of an anthropology grounded in vulnerability: Jesus Christ on the Cross¹⁷. There is a strong connection between anthropology, Christology and soteriology. The link between anthropology and Christology can be found in the New Testament beginning from the Old Testament description of the creation of man in the image of God (Genesis 1, 27), a theme later found in the reference to Jesus Christ as *Imago Dei* (2 Corinthians 4, 4; Colossians 1, 15) according to whom and towards whom all reality was created (1 Corinthians 8, 6; Colossians 1, 16s). However, to understand anthropology beginning from Christology severed from soteriology would be to think of Jesus Christ as only a true and perfect man, sent by God to make manifest the mystery of man and the world and

to indicate to us the appropriate way of being human. If such were the case, claiming to talk about salvation would be a mere word play. If Jesus were only a human being, all he could bring us would be the human, with everything it involves: limitation and uncertainty.

Jesus Christ crucified, the frail and wounded man, has always been the reference for Christians. The contemplation of Christ enables us to regard with different eyes the sick and the disabled. Christian anthropology clarifies and provides guidance for the manner in which sensitive issues should be dealt with in bioethics (e.g. Alzheimer's disease) and in health policies (e.g. human vulnerability).

b. Another field where theological thinking can contribute an element of originality is that of justice. For example, theological ethics opens a new perspective on the matter of resources and resource allocation by first inquiring into the nature of resources (what resources are we talking about?). The approach proposed by theologians – which emphasizes solidarity, the free gift, the gift of the self – has found an echo in the work of Richard M. Titmuss. With reference to blood donation, Titmuss argues in favour of the free donation, the gift made to a stranger without expectation of a reward (financial, moral or of other kind)¹⁸. Naturally, such arguments have been contested by some economists on the grounds that market economy provides the best form of exchange for all goods. Titmuss has indicated, however, the perverse effect of the market economy in the case of blood donation. Firstly the blood is usually collected from the poorest people (who most need the money paid for donations) but it is often used for the benefit of the rich peoples (the inverse “trickle-down” effect). Secondly, and more importantly, Titmuss' study shows that blood donation is more efficient in a system based on altruism than in one that favours the logic of market economy both in qualitative terms (paid donors are more likely to lie about their health status than volunteer donors) and quantitative terms (waste).

The debate initiated by Richard M. Titmuss has moved beyond blood donation, and brought up once more the issue of the relationship between volunteering and interest. Titmuss' stance against liberalism is obvious, as he argues for political decisions that favour free donation, outside the constraints of the market economy. In other words, Titmuss refuses the logic of exchange in this particular field. Since he published his study, debates over blood donation have become increasingly complex¹⁹, but it was Titmuss who highlighted the idea that donation (as gift) could be the result of creating the social circumstances that encouraged it: “The social forms that altruism and generosity can take are not the direct result of an impulse to give; we must consider the very institutional circumstances in which such an impulse can be manifested”²⁰. Concerning resource allocation, theological ethics interrogates the relationship between the free gift and the logic of market exchange. Far from excluding the latter, it

reflects on the manner in which a fair relationship between the two can be found, so that both can survive.

Another aspect that involves the concept of justice is the access to medical services. Ethical issues are generated by the fact that the Romanian state currently encourages liberal policies which tend to transfer the burden of responsibility for health on the individual rather than the state, with the consequence that the population will have unequal access to medical services²¹. Moreover, this will lead to a weakening (or even breaking) of social ties, and the people who are most vulnerable – economically, socially, or culturally – will be abandoned. In addition, one must take into account the fact that the argument over responsibility for medical services, much discussed in Romania, has been pursued in the context of a number of scandals that have reflected negatively on the medical system (malpractice, inadequate management of resources, embezzlement of funds, misguided health policies).

Theologians, as well as philosophers who come close to a Christian position (Ricoeur, Levinas, Jonas) link the concept of responsibility to those of frailty and vulnerability. Theology reflects with special intensity on one's relationship with the wounded and the suffering, on one's readiness to be available for any person who suffers so that a relationship can be established (also) through recognition of our common humanity (as people created in the image of God). The essential link that creates this shared identity is not only Christ in His glory but also the suffering Christ. Vulnerability is a feature of both the doctor and the patient, the roles can be reversed. From this perspective, theology interrogates the meaning of the desire to be healthy for individuals but also for the political powers.

If I have emphasized an anthropological perspective in the first part of this paper, I would now like to focus on an ethical issue that connects the concept of therapeutic alliance to the theological concept of alliance (covenant).

The concept of therapeutic alliance and the theological concept of alliance (covenant). A case study

My interest in this case study has been triggered by the thought-provoking connection it occasions between the medical and the theological discourse, in particular the manner in which the alliance (covenant) of God and His people can shed a clarifying ethical light on the alliance between doctor and patient. To this purpose I will closely follow P. Ricoeur's "Les trois niveaux du jugement médical"²² and Dominique Jacquemin's "Le concept d'alliance à l'épreuve de la relation de soins"²³ in order to define the two concepts. I will then refer to the type of logic specific to each of these two alliances. Finally, a conceptual analysis of the distinctions (and possible confusions) between the medical and the theological discourse will establish the limits of this analogy.

The concept of therapeutic alliance

The concept of therapeutic alliance as defined by P. Ricoeur aims to circumscribe the correct form of the relationship between patient and doctor:

“It is a relationship between two people, the one who suffers, describes his pain and asks for help from a health expert, and the other who is qualified, has the know-how, provides help. A pact grounded in trust is established between the two: the patient believes that the doctor can and wants to cure him, or at least to treat him, the doctor expects the patient to contribute to his own recovery.”²⁴

Prudential judgment underlies this alliance grounded in *trust* which is characterized by the two people’s commitment against illness and *suffering*. A *promise* animates the prudential judgment, through the hoped for recovery or at least through the medical services provided (which involve both the *doctor’s* and the *patient’s commitment* and mutual responsibility).

The theological concept of alliance (covenant)

The theological concept of alliance²⁵ in the Old Testament, as described by Dominique Jacquemin, emphasizes the contractual aspect of the covenant: “God chooses a partner and establishes a contract which entitles to a right associated with a promise”²⁶. It is worth remembering here that the laws take second place in the Bible, as compared with the narrative texts of the origins. It is not accidental that the first book of the Bible is the Genesis and the first commandment is this promise that sets in motion: “The Lord said to Abram: “Go forth from the land of your kinsfolk and from your father's house to a land that I will show you. “I will make of you a great nation, and I will bless you; I will make your name great, so that you will be a blessing.” (Genesis12,1-2)”. God takes the initiative of choosing the people of Israel; the latter is asked to respond. The alliance (covenant) is not regarded as a mere “bilateral pact” but involves a personal relationship, the gift of freedom and the promise that God makes to His people. The law represents a manner of living the covenant, but also a response as it allows a greater liberty: that of accepting or refusing the covenant. The New Testament opens a novel perspective concerning the alliance, which is now understood as fulfillment: “that is, in a fundamental progressive continuity, which necessarily involves breaks at certain points [...], but the establishment of a covenant that is truly new, founded on a new base, Christ's personal sacrificial offering (cf Hebrews 9,14-15)”²⁷.

The specific rationality of the two types of alliance

Narrative rationality. To illustrate this kind of rationality, I will refer to Psalm 22 (21), a psalm of lament that expresses the feelings of the sick or the bereaved. Claus Westermann describes the structure of lament, whose elements are: “1. invocation/asking for help; 2. lament (involving three entities: God/myself/my enemies) – see Psalms 79 (78), 1-3; 13 (12), 1-2; 3. testimony of faith (introduced by an adversative *waw*); 4. supplication; 5. certitude that one’s prayer has been heard; 6. double wish for a divine intervention against and in favour of; 7. promise of future praise; 8. praise of God”²⁸. Through invocation, the lament affects both man and God; in a similar manner, the patient’s suffering demands the doctor’s attention.

In the therapeutic alliance, the patient

“expresses his suffering in the form of a lamentation with a double dimension: descriptive (a certain symptom) and narrative (a person’s life story). Lamentation then leads to soliciting something (a cure and, who knows, perhaps health or even, at the back of one’s mind, eternal life) and soliciting from somebody (the appeal to a certain doctor)”²⁹.

Joining Paul Ricoeur, we could wonder – by way of analogy – whether in the current context of health policies increasingly influenced by contractual medicine, “the suffering man of today can still express his lament in the form of an invocation”³⁰. The distinction between the pact of medical care and the contract of medical services is significant in this respect³¹.

Argumentative rationality. As it should be fulfilled through love, the law can only be understood in this double perspective: of the commandments and of love. This type of rationality functions as well at the level of the therapeutic alliance where “neither the strict laws (regulations, deontology, legislation, protocols) nor compassion is sufficient”³² when taken in isolation. A proper relationship involving medical services cannot remain at the level of protocols but must also take into account the suffering of the person who is in a position to ask for help.

Critical rationality. In the New Testament the law becomes the law of love, which fulfills the old law in that it allows a greater freedom with respect to the law (Matthew 5, 17-18) but also radicalizes³³ it (the law is no longer external but has become internalized). The passage from the Old to the New Testament equally occasions an evolution from the negative expression of the law (“Thou shalt not kill!”) to its positive formulation (“Love Me!” or “I want you to live”), from passivity to action. Thus, a

person is now in a constant state of tension between keeping the law external and internalizing it, aiming at surpassing one's limitations with the help of the Holy Spirit and moving beyond the interdictions of the law towards the "extra mile" one is willing to walk in a spirit of love.

An analogy with the therapeutic alliance would enable avoidance of the situation when laws, protocols and regulations become an end in themselves whereas, in fact, their purpose is only to facilitate the true meeting of two people and allow us to live creatively³⁴.

Limits of the analogy between the therapeutic alliance and the theological concept of alliance

There are a number of common elements which the therapeutic alliance shares with the theological concept of alliance and which can expand our understanding of the former: the suffering, the promise, the trust, the law, the commitment. However, a rigorous conceptual analysis has to be performed so that confusion derived from unwarranted mixture of discourse will be avoided.

The analogy between suffering (illness) and sin. Several scholars have drawn attention to the analogy between public health and religious morals³⁵, regarding the former as a new form of morality or as a substitute for religious control. Some have described the new "secular morality" that underlies contemporary health policy in terms of the principles of traditional Jewish-Christian morality. If Christian morality functions according to the pattern: sin, punishment, redemption (salvation), public health morality follows the pattern: illness (or addiction), sanction, health³⁶.

When confronted with the absurdity of suffering, people will often find themselves guilty and responsible for their condition, thus associating suffering with the consequences of sin. A Biblical example is that of the healing of the man born blind (John 9, 1-3), when Jesus warns against too hastily associating blindness with sin (committed by the blind man himself or by his parents). There are, however, other Biblical references in which a connection is established between sin and illness³⁷.

It is important that a distinction should be made between culpability and sin: the former is a reality internal to the self, the latter is a theological concept that refers to a person's relationship with God³⁸. It is also important to distinguish between physical evil and moral evil (sin). If the former is a consequence of our condition as mortal beings, a denial of our desire to be omnipotent, the latter is a result of our freedom, a confirmation of our desire to be omnipotent³⁹.

The analogy between the alliance doctor – patient and the alliance (covenant) of God with His people. The analogy between doctor – patient and God – His people should be understood in metaphorical terms.

In pastoral teachings, spiritual works and the discourses of great theologians⁴⁰ (an example being St. Augustin⁴¹) one often hears references

to Christ as “doctor of the souls”⁴² and “doctor of the bodies”. The arguments are taken from the Bible, which describes physical⁴³ as well as spiritual healings: “Those who are well do not need a physician, but the sick do.” (Matthew 9,12)

Conversely, with reference to medical practice the analogy between medicine and sacerdocy⁴⁴ is drawn both by Christians and by doctors in order to highlight the vocation that is proper to, or should be proper to, the medical profession.

A similarity can be noticed in the dissymmetry that characterizes both alliances. In the relationship between a doctor and a patient, the dissymmetry is given by the professional expertise of the former as compared to the latter. This dissymmetric balance can be redressed by recognition of the doctor’s professionalism as well as gratitude on the part of the patient. Reciprocity, by empathizing with the other person⁴⁵, represents another attitude through which this dissymmetry can be remedied. In the covenant between God and His people (humanity) the dissymmetry derives also from the manner in which the people (humanity) receive God’s proposition and respond to it. In this form of alliance, God’s promise is made for ever in spite of the negative answer from mankind.

The analogy between the promise of health and the promise of salvation. The analogy between the promise of health and the promise of salvation can prejudice both medicine and theology as it is based on a semantic confusion of the two concepts.

In this respect Patrick Verspierenm’s distinction between health and holiness, between the vocation for health and the general vocation of every person for salvation remains essential: “A ‘healthy’ person has not necessarily completed his/her ‘conversion’ [...] Although we must protect and promote life and health, these are not the ultimate values; every person should seek and develop them in order to correspond as well as possible to his/her personal vocation, to which life and health remain subordinate”.⁴⁶ According to Verspierenm, this “duty towards health” is communitarian rather than personal in nature. The appeal to one’s duty towards health goes beyond public campaigns (which target education against, and prevention of, alcohol or drug abuse etc.). Indeed, this appeal aims to raise awareness of the increasing loss of the taste for life in our society, a taste for life which communities should promote and develop as the ultimate purpose of any law is life itself.

The analogy between therapeutic alliance and the theological concept of alliance (covenant) has enabled me to find a common structure, grounded in a narrative, argumentative and critical rationality, as well as common concepts such as suffering, the promise, the law, the commitment. While the theological concept of alliance can indeed shed new ethical light on therapeutic alliance, other pair concepts such as illness/sin, promise of health/promise of salvation etc. have to be

subjected to a rigorous analysis lest an unwarranted mixture of medical and theological discourses should lead to major confusions.

With respect to the partners involved in the two types of alliance, analogies can be found in terms of their dissymmetric roles and their respective responsibilities in the alliance. I will join Dominique Jacquemin in the conclusion that, unlike God, doctors cannot place themselves “in a position of unconditionality that would result in excessive responsibility”⁴⁷.

Conclusions

Although in the past the Catholic Church claimed to have the last word on everything human, and even if some contemporary positions may still sound so, theology is now open to a genuine interdisciplinary dialogue that can lead to a better understanding of the human being in its multiple dimensions. It is an ethical challenge that theology undertakes in the large debate over health policy together with the other disciplines involved in the field. Indeed, theology can enrich ethical approaches, expand the area of ethical inquiry and open new perspectives on health policy.

Notes

¹ Paul Ricœur, *Le juste 2* (Paris: Editions Esprit, 2001) 245-255.

² Mihaela Frunză and Sandu Frunză, “Ethics, Superstition and the Laicization of the Public Sphere”, *Journal for the Study of Religions and Ideologies*, vol. 8, Issue 23 (2009): 30.

³ Adrian-Paul Iliescu, “The Autonomy of Morals. Two Analytic Arguments.” *Journal for the Study of Religions and Ideologies*, vol. 9 Issue 26 (2010): 4.

⁴ Adrian-Paul Iliescu, 3.

⁵ “Pastoral Constitution on the Church in the Modern World *Gaudium et Spes*” &36 *Documents of the II Vatican Council* (1965), http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html.

⁶ John Paul II, “Fides et Ratio” (1998)

http://www.vatican.va/edocs/ENG0216/_INDEX.HTM

⁷ Elisabeth Kubler-Ross, „Rencontre avec les mourants”, *Laenec*, 2 (1974): 10.

⁸ Paul Ricœur, *Le juste 2* (Paris: Editions Esprit, 2001), 247.

⁹ Paul Ricœur, *Le juste 2* (Paris: Editions Esprit, 2001), 248.

¹⁰ Ioan Bolovan and Sorina Paula Bolovan, “From Tradition to Modernisation. The Romanian Family in Transylvania in the Modern Era (1850-1918),” *Transylvanian Review*, vol. 18 (2009): 147; Ioan Bolovan and Sorina Paula Bolovan, “From Tradition to Modernization. Church and the Transylvanian Romanian Family in the Modern Era”, *Journal for the Study of Religions and Ideologies*, vol. 7 Issue 20 (Summer 2008): 107-133.

¹¹ Indeed, the position of the (Catholic) Church concerning marriage (heterosexual, monogamous and for a lifetime) may seem isolated when compared with the secular view on marriage and the legislation pertaining to it (divorce, multiple successive marriages, monoparental families, free unions and the demand for legalization of same-sex 'marriages'). This does not mean, however, that the Church is content to remain isolated; on the contrary, she attempts to reestablish marriage on its sound basis. See Philippe Bordeyne, *Ethique du mariage. La vocation sociale de l'amour* (Paris :Desclée de Brouwer, 2010), 11-17.

¹² Sandu Frunză, "On the Need for a Model of Social Responsibility and Public Action as an Ethical Base for Adequate, Ethical and Efficient Resource Allocation in the Public Health System of Romania," *Revista de cercetare si interventie sociala*, vol. 33 (2011): 186.

¹³ The National Strategy for Public Health, June 2004: 55, 58. <http://www.insp.gov.ro/cnepss/wp-content/themes/PressBlue/pdf/Strategia%20nationala%20de%20sanatate%20publica.pdf>

¹⁴ Sandu Frunză, "On the Need for a Model of Social Responsibility and Public Action as an Ethical Base for Adequate, Ethical and Efficient Resource Allocation in the Public Health System of Romania," *Revista de cercetare si interventie sociala*, vol. 33 (2011): 186.

¹⁵ "The purpose of Christian theology – this manner of thinking and acting which is almost impossible, always inadequate – is to write contemporary history in the light of the Gospel of Jesus Christ. To discern the essence of the Christian Gospel in our own present is to uncover the false visions of the present which affect us", in David Tracy, „La désignation du présent,” *Concilium*, 227 (1990): 73.

¹⁶ Karl Barth, *Dogmatique III*, (Geneve : Labor et Fides, 1965), 39.

¹⁷ If we defend a Christian position, do we not run the risk of becoming isolated? I do not think so because such a position can easily be articulated with those of philosophy and the social sciences. Philosophy, theology and the social sciences are complementary: the human being under its various aspects – body, language, sexuality, finitude etc. – can and should become the object of Christian reflection. Which are, then, the anthropological stakes? I do not believe that Christian anthropology lessens the other approaches (philosophical, psychological or social anthropology etc.) that attempt to understand the human person. All these positions should be regarded as interconnected, according to the principle that a comprehensive understanding of the human is the most appropriate: one approach does not invalidate the others.

¹⁸ Richard Titmuss shows that blood donation is more efficient in a system based on altruism than in one that favours the logic of market economy. In Richard Titmuss, *The Gift Relationship: From Human Blood to Social Policy* (New-York: The New Press, 1997).

¹⁹ Philippe Steiner, "Don de sang et don d'organes : le marché et les marchandises 'fictives'", *Revue française de sociologie*, 42 (2001): 357-374.

²⁰ Philippe Steiner, "Don de sang et don d'organes : le marché et les marchandises 'fictives'", *Revue française de sociologie*, 42 (2001): 369.

²¹ Sandu Frunză, "On the Need for a Model of Social Responsibility and Public Action as an Ethical Base for Adequate, Ethical and Efficient Resource Allocation

in the Public Health System of Romania,” *Revista de cercetare si interventie sociala*, vol. 33 (2011):182.

²² Paul Ricoeur, *Le juste 2* (Paris : Editions Esprit, 2001), 227-243.

²³ Dominique Jaquemin, “Le concept d’alliance à l’épreuve de la relation de soins,” *Revue Francophone de Psycho-Oncologie*, 4 (2005) : 281-284. The article can be found by accessing the site:

<http://www.uclouvain.be/cps/ucl/doc/viespirituelle/documents/Concept-alliance.pdf>

²⁴ Paul Ricoeur, *Le juste 2* (Paris : Editions Esprit, 2001), 246.

²⁵ The Hebrew word *berith*, translated as covenant (alliance), has several slightly different acceptations depending on the Biblical context in which it is used (the Noahic covenant, the Abrahamic covenant, the Mosaic covenant, the covenant in the Deuteronomy or the covenant with Jeremiah): „For the word can also mean more generally “promise”, which is also a parallel with “oath” to express a solemn pledge.” in The Pontifical Biblical Commission, *The Jewish people and their sacred scriptures in the Christian Bible* (Vatican City: Libreria Editrice Vaticana, 2001) &37. See

http://www.vatican.va/roman_curia/congregations/cfaith/pcb_documents/rc_c_on_cfaith_doc_20020212_popolo-ebraico_en.html#1. Jewish Methods of Exegesis

²⁶ Lauret Bernard and Francois Refoulé (ed), *Initiation à la pratique de la théologie. Tome II, Dogmatique 1*, (Paris : Cerf, 1982): 7.

²⁷ The Pontifical Biblical Commission, *The Jewish people and their sacred scriptures in the Christian Bible* (Vatican City: Libreria Editrice Vaticana, 2001) &40 and 42. See http://www.vatican.va/roman_curia/congregations/cfaith/pcb_documents/rc_c_on_cfaith_doc_20020212_popolo-ebraico_en.html#1. Jewish Methods of Exegesis

²⁸ Clauss Westermann, *Praise and Lament in the Psalms* (Atlanta: Jon Knox Press, 1981) quoted in André Lacocque and Paul Ricoeur, *Cum să înțelegem Biblia* (Iași: Polirom/Plural Religie, 2002), 210.

²⁹ Paul Ricoeur, *Le juste 2* (Paris : Editions Esprit, 2001), 230.

³⁰ André Lacocque and Paul Ricoeur, *Cum să înțelegem Biblia* (Iași: Polirom/Plural Religie, 2002), 257.

³¹ Paul Ricoeur, *Le juste 2* (Paris : Editions Esprit, 2001), 227-243.

³² Dominique Jacquemin, “Le concept d’alliance à l’épreuve de la relation de soins,” *Revue Francophone de Psycho-Oncologie*, 4 (2005): 281-284

³³ “You have heard that it was said...But I tell you...”

³⁴ Călin Săplăcan, “Legea în teologia morală “ in *Mozaic teologic I*, (Cluj-Napoca: Ed. Viața Creștină, 200), 89-105.

³⁵ “Health tends to replace redemption as the manifestation of a virtuous life. Risk prone behaviour is regarded as outside the category of moral rectitude (Foucault, 1988). A healthy body will give the measure of somebody’s morality (Crawford, 1994) and people will end up attributing moral connotations to their health, fitness and mental balance. Good health will indicate “a secular state of grace” (Leichter, 1997:359) for the achievement of which “zealots of well-being” will engage in an “effort to correct daily habits” (ibid: 360-361) for the benefit of a “chosen people whose lifestyle is kosher” (ibid: 372)” in Raymond Massé, *Ethique et santé publique. Enjeux, valeurs et normativité* (Québec: Presse de l’Université Laval, 2003),18-22.

³⁶ Solomon Katz; „Secular Morality,” in *Morality and health* (New-York/London: Routledge, 1997), 298-299.

³⁷ "According to a widespread belief in the ancient world, there is a strong connection between sin and physical infirmity (Exodus 9,1-12; Psalms 38,2-6; Ezekiel 18,20). In the case of children born with disabilities, some rabbis ascribe the fault to the child's parents, others to the child himself while in the womb." See endnote h) for John 9,2 in *Traduction Oecumenique de la Bible* (Paris, Cerf, 1989).

³⁸ "Sin is the refusal of something that builds a person in the truth, because God's plan is to help all people to reach their full potential as men and women standing on their own [*debout* in the original], as accomplished people, adopted and freed children. Committing a sin is always a dehumanizing gesture. It involves regressing to a stage that prevents a person from developing fully as a human being." In Xavier Thévenot, *Les péchés. Que peut-on en dire ?* (Mulhouse : Salvator , 1983), 72.

³⁹ Xavier Thévenot, *Les péchés. Que peut-on en dire ?* (Mulhouse : Salvator , 1983), 68.

⁴⁰ See *Les pères de l'Eglise face à la science médicale de leur temps*, edited by Véronique Boudon-Millot and Bernard Pouderon (Paris : Beauchesne, 2005).

⁴¹ Marcel Neusch, „Le verbe fait chair, Un grand maître venu du ciel”, *Itinéraires Augustiniens*, 38 (2007),

<http://www.assomption.org/Ressources/ItinerairesAugustiniens/IA35/AugustinMaitreSpirituel.htm>.

⁴² Often the priest, as a representative of Christ, is also called a “doctor of the souls”.

⁴³ The healing of the man born blind, the parable of the good Samaritan, other healings.

⁴⁴ The sacerdocy refers to the position and duties of a priest, but also to his calling (vocation).

⁴⁵ Paul Ricoeur, *Soi-même comme un autre* (Paris: Seuil, 1990). “Oneself as Another” is the title of a book by Paul Ricoeur.

⁴⁶ Patrick Verspieren, „Vie, santé, mort” in *Initiation à la pratique de la théologie. Tome IV. Ethique*, ed. Lauret Bernard and Francois Refoule (Paris: Cerf, 1993), 367-370.

⁴⁷ Dominique Jacquemin, “Le concept d’alliance à l’épreuve de la relation de soins,” *Revue Francophone de Psycho-Oncologie*, 4 (2005): 284.

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