

**BIOETHICS: A COMPREHENSIVE, GLOBAL, CURRENT, RETROSPECTIVE AND
PROSPECTIVE APPROACH TO HUMAN BEHAVIOR IN MEDICINE AND OTHER
LIFE SCIENCES.**

**LA BIOÉTICA: UN ENFOQUE -INTEGRAL, MUNDIAL, ACTUAL,
RETROSPECTIVO Y PROSPECTIVO- DE LA CONDUCTA HUMANA EN LA
MEDICINA Y OTRAS CIENCIAS DE LA VIDA.**

March 2025

Bioethics 2025

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Autor: Libro elaborado por diversos autores. La autoría de cada artículo se menciona en su respectiva sección.]

Coordinación editorial: Dr. José María Simón Castellví

Maquetación y elaboración epub: Ignasi Navarro

Imagen de portada: Generada por Gemini

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Primera edición: Marzo 2025

Publicado por: Dr. José María Simón Castellví

Contacto: simoncastellvi@gmail.com

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PRESENTATION OF THE VOLUME

Dr. José María Simón Castellví

Bioethics is interdisciplinary, and is at the intersection of multiple fields of knowledge, including medicine, biology, philosophy, sociology, psychology and theology. It also involves economics (e.g., resource distribution), journalism (communication), etc. Its objective is to examine the ethical implications of scientific and technological advances by reflecting on human conduct and the inherent dignity of each person. In this presentation, I will give some notes on the complexity and relevance of bioethics, its most basic foundations, its impact on critical decisions and its role in the search for the common good; without losing sight of the reality that evil accompanies us almost always.

Bioethics plays a crucial role in the way we understand and manage human life in the context of medical and scientific advances. Studying human behavior from an interdisciplinary perspective allows us to value the intrinsic greatness of each person and to face ethical dilemmas with a critical and compassionate eye.

Through the study and practice of bioethics we can contribute to a future in which scientific advances are used for good, always recognizing the valuable life of each human being, each second of life, and the necessary respect for the dignity that we all deserve. In these lines I have presented an introductory overview of bioethics, highlighting the importance of approaching this discipline with a committed and conscious view of the complexity of the human condition, and the imperative to resist the tendency to evil, always guided by the desire to do good.

The authors who have contributed to the appearance of this book, from different languages, disciplines and specialties, cover the entire bioethical spectrum. I know them all and appreciate them. It is true that most of them are doctors, but also humanists. I believed that with the contribution of these renowned professionals we would have an exact x-ray of how the discipline of bioethics stands today, in this jubilee year of 2025, in the world. And also where the challenges and problems come from, and how we can face the future with confidence despite the difficulties.

PRESENTACIÓN DEL VOLUMEN

Dr. José María Simón Castellví



Académico numerario de la Real Academia Europea de Doctores (RAED), licenciado y graduado en Medicina y Cirugía por la Universidad de Barcelona. Especialista MIR en Oftalmología. Posee un doctorado de Investigación en Oftalmología (UB). Miembro de la Clínica Oftalmológica Simón. Miembro de la Sociedad Española de Oftalmología. Académico numerario de L'Institut Medicofarmacèutic de Catalunya. Académico correspondiente por premio de la Reial Acadèmia de Medicina de Catalunya.

Es autor de numerosas publicaciones científicas y humanísticas. Presidente emérito de la Federación Internacional de Asociaciones Médicas Católicas (FIAMC, 2006-2014). Fue miembro del Consejo Pontificio de Salud. Siempre ha sido un apasionado de la divulgación médica y científica. Lleva más de treinta años ejerciendo la Oftalmología. Ha organizado diversos congresos internacionales de médicos. Es patrono de varias fundaciones. “Goodwill ambassador” de Arkansas. Embajador de “Thankyoudoctor”. Es Comendador de la Orden Pontificia de San Gregorio Magno. Casado con la maravillosa Pilar. Tres hijos. Habla seis lenguas.

Introducción

La bioética es interdisciplinaria, se encuentra en la intersección de múltiples campos del conocimiento, incluyendo de lleno especialmente a la medicina, la biología, la filosofía, la sociología, la psicología y la teología. También involucra a la economía (v.g., la distribución de los recursos), el periodismo (comunicar), etc. Su objetivo es examinar las implicaciones éticas de los avances científicos y tecnológicos reflexionando sobre la conducta humana y la dignidad inherente a cada persona. En esta presentación, daré algunos apuntes sobre la complejidad y relevancia de la bioética, sus fundamentos más básicos, su impacto en decisiones críticas y su papel en la búsqueda del bien común; sin perder de vista la realidad de que el mal nos acompaña casi siempre.

Fundamentos de la Bioética

La bioética se fundamenta, a mi juicio, en la comprensión de que cada ser humano posee un valor intrínseco, independientemente de sus circunstancias biológicas, psicológicas, familiares, espirituales o sociales. Este mérito es una fuente de dignidad que debe ser respetada en todas las decisiones que involucran a la vida humana. El estudio de la bioética implica analizar no solo los aspectos médicos de la atención sanitaria, sino también las demás dimensiones que influyen en la salud y el bienestar de la persona.

Su interdisciplinariedad

La bioética abarca una amplia gama de disciplinas que enriquecen su enfoque. La medicina aporta conocimientos sobre el funcionamiento del cuerpo humano y las muchas y diversas patologías que pueden afectar el desarrollo de las actividades de una persona y de la colectividad. La psicología ofrece una comprensión sobre el comportamiento humano y los procesos de toma de decisiones, mientras que la sociología examina cómo las estructuras sociales influyen en la salud y el acceso a servicios médicos. Por su parte, la teología invita a la reflexión sobre los valores éticos en relación con la divinidad y el hondo significado de la vida sobre esta tierra. La biología nos ayuda a entender la naturaleza sana y a respetar sus tiempos, algo especialmente importante en los ritmos mensuales de fertilidad e infertilidad de la mujer joven.

La bioética, palabra que ha triunfado por su sencillez y claridad, inhabita en parte en la deontología médica, en la moral médica (o sanitaria en general), en la biojurídica.

La conducta humana en la medicina y las ciencias de la vida

La bioética estudia las decisiones médicas desde una perspectiva ética, considerando no solo la eficacia de las intervenciones sanitarias, sino también las consecuencias morales de dichas decisiones. Esto incluye el análisis de temas controvertidos tales como el aborto, la eutanasia (y su primo hermano, el suicidio asistido), la experimentación con seres humanos, la reproducción artificial el transhumanismo o la manipulación genética. Cada uno de estos temas plantea dilemas éticos significativos que requieren un equilibrio entre la libertad y la responsabilidad, así como la consideración de la voluntad del individuo y el respeto por su dignidad.

Hay que tener en cuenta que los profesionales sanitarios no siempre pueden sustituir a los protagonistas de algunos actos. Ello es especialmente cierto en la transmisión de la vida humana por parte de los esposos. Se les puede ayudar pero no de les debe sustituir.

En un sentido, la bioética se podría asimilar a la energía nuclear: se trata de cosas muy delicadas con posibilidades de ser utilizadas para tratar tumores pero también para fabricar armas terriblemente destructivas. Puede servir para defender argumentalmente la

vida de todo no nacido, a la vez que algunos la utilizan para justificar la licitud del aborto por nacimiento parcial.

Bioética y avances tecnológicos

Los avances técnicos en medicina y biotecnología han generado debates intensos dentro de la bioética. Con cada nuevo descubrimiento se amplían las posibilidades de tratamiento y cura, pero también se presentan nuevos desafíos éticos. La posibilidad de modificar genéticamente a los seres humanos, por ejemplo, abre un abanico de preguntas sobre la naturaleza de la humanidad, el concepto de normalidad y las implicaciones de “crear” diseños humanos.

La vida en la Tierra es de ADN dextrógiro (nucleótidos dextrógiros) y proteínas levóginas (sus componentes aminoácidos son levógiros). Los compuestos levógiros proyectan su sombra estereoquímicamente a la izquierda, hacen girar el plano de la luz polarizada a la izquierda o contra las agujas del reloj. Hay quienes piden que se detengan las investigaciones para desarrollar formas de vida especulares, gérmenes con moléculas especulares, parecidas a las de los vivientes actuales, pero con un cambio especular.

A pesar de ser muy parecidos a los actuales, los nuevos gérmenes podrían quizá despistar a nuestras defensas inmunitarias o invalidar en general la eficacia de los antibióticos y producir pandemias catastróficas. De hecho, por motivos distintos, ya tenemos problemas (morbimortalidad) con la creciente resistencia a los antibióticos en todo el mundo. En oftalmología, por ejemplo, estamos volviendo a tratamientos con clorhexidina, yodo o agua oxigenada para curar algunas infecciones.

La biotecnología permite ya producir gérmenes "raros", con sus potenciales peligros militares. Y en unos pocos años se podrían diseñar formas de vida con aminoácidos y nucleóticos especulares. Nuestros anticuerpos podrían no encajar bien con (contra) las mismas debido a que no han sido reconocidas nunca por nuestro sistema inmunitario. El riesgo de pandemias humanas, ataque a nuestros cultivos actuales o al ganado podría ser elevado. La bioética también se ocupa de los animales y de las plantas.

Es cierto que tanto el organismo humano como el resto de la naturaleza (y la misma ciencia) disponemos de otras defensas, quizá no tan específicas pero que podrían funcionar en estos casos. O que la biotecnología nos podría permitir producir gérmenes más resistentes a la contaminación o con posibilidades de degradar plásticos u otros detritus. Pero el riesgo existe y hay que afrontarlo.

Es fundamental abordar estas cuestiones con gratitud hacia los logros del pasado, estudiando minuciosamente todos los recovecos de la bioética. La historia de la medicina

está llena de descubrimientos que han transformado el devenir de la vida humana y, al mismo tiempo, nos recuerdan la necesidad de guiar nuestras acciones con criterios éticos. En algunas ocasiones, la bioética recomendará premios, multas o castigos. No es exactamente su función principal, pero el ser humano necesita estímulos positivos y negativos para que su actuación en este mundo sea lo más correcta posible.

Así mismo, es muy importante el aspecto de la comunicación: los profesionales debemos capacitarnos para advertir y asesorar a individuos concretos o a la sociedad de todo lo que necesiten saber sobre los avances científicos que les atañen. Con información veraz, huyendo de paternalismos, populismos o *fake news*. Y corrigiendo los errores propios o ajenos cuando ello sea necesario (*errare humanum est*).

El valor inherente del ser humano

Una idea central en la bioética es el reconocimiento del valor inherente de cada individuo. Cada uno vale por sí mismo. Desde la concepción hasta la muerte natural, cada persona tiene derecho a ser tratada con dignidad y respeto. Este concepto está profundamente arraigado en varias tradiciones filosóficas y religiosas, y representa un pilar fundamental en la lucha por los derechos humanos y por los derechos de Dios (que los tiene, a pesar de su discreción, como Creador, Mantenedor y Salvador). La libre voluntad y la capacidad de tomar decisiones, aunque sean limitadas, confieren a cada ser humano una dignidad que debe ser valorada y protegida frente a cualquier forma de deshumanización.

El mal como realidad constante

A pesar de los avances y el deseo de muchos de hacer el bien, el mal es una constante en la experiencia humana. Este fenómeno puede manifestarse de diversas formas, desde acciones individuales perjudiciales hasta injusticias estructurales en sistemas de salud. La bioética debe enfrentar esta realidad con honestidad, reconociendo que el mal puede influir en decisiones que afecten vidas humanas. Sin embargo, la clave es no dejarse llevar por esa oscuridad, sino esforzarse por encontrar la luz y las ayudas en medio de la adversidad.

Un ejemplo del mal lo tenemos en el abuso de las sedaciones terminales en tantos hospitales occidentales – a veces con la fecha y la hora de la muerte programadas- que incluso se hacen pasar por “cuidados paliativos”. Las sedaciones se deberían proponer para el confort del paciente, para mitigar sus síntomas y no con la dosis e intención de que fallezca. En pacientes muy frágiles la muerte puede sobrevenir. Pero debemos tener claro que no es lo mismo morir “que te provoquen la muerte” que morir.

Mirar hacia el futuro con confianza

Afrontar el futuro en el ámbito de la bioética significa mantener una actitud proactiva y constructiva. Implica comprender que la bioética no se limita a reaccionar ante situaciones problemáticas, sino que también puede anticipar y guiar el desarrollo de nuevas tecnologías y prácticas en medicina. La educación en bioética es esencial para preparar a las futuras generaciones de profesionales de la salud y responsables de políticas, para que ejerzan su labor con un sentido profundo de ética y compromiso social.

La bioética puede ayudar a formar la opinión público-científica y a transformar para bien sus hábitos de conducta (*ethos*).

Algunos apuntes finales

En conclusión, la bioética desempeña un papel crucial en la forma en que entendemos y gestionamos la vida humana en el contexto de los avances médicos y científicos. Estudiar la conducta humana desde una perspectiva interdisciplinaria nos permite valorar la grandeza intrínseca de cada persona y afrontar los dilemas éticos con una mirada crítica y compasiva. A través del estudio y la práctica de la bioética podemos contribuir a un futuro en el que los avances científicos se utilicen para el bien, reconociendo siempre la valiosa vida de cada ser humano, de cada uno de sus segundos de vida, y el necesario respeto hacia la dignidad que merecemos todos.

En estas líneas he presentado un panorama introductorio sobre la bioética, resaltando la importancia de abordar esta disciplina con una mirada comprometida y consciente de la complejidad de la condición humana, y del imperativo de resistir la tendencia al mal, guiados siempre por el deseo de hacer el bien.

Los autores que han contribuido a la aparición de este libro, de diferentes lenguas, disciplinas y especialidades, cubren todo el espectro bioético. Los conozco a todos y los aprecio. Es cierto que la mayoría son médicos, pero también humanistas. He creído que con la aportación de estos reconocidos profesionales tendríamos una radiografía exacta de cómo se halla hoy, en este año jubilar de 2025, la disciplina de la bioética en el mundo. Y también de dónde vienen los retos y los problemas, y de cómo podemos afrontar el futuro con confianza a pesar de los pesares.

BIOÉTHIQUE 2025. TEMPS ET ESPACE À CONQUÉRIR !

Bernard Ars, M.D., Ph.D.



Accueil - Bernard Ars, M.D., Ph.D.

Mot apparu dans le monde médical, au courant des années 1970, s'ajoutant à plusieurs termes déjà utilisés : déontologie, éthique, morale, l'expression « bioéthique » signifie à l'époque, une réflexion éthique sur la vie Humaine. La notion d'Humanisme y est implicite. Une anthropologie, une vision de l'Homme, la supporte.

Plus spécifiquement, l'Humanisme judéo-chrétien désigne une pensée soulignant le rôle central et le caractère transcendant de la personne humaine dans le temps et dans l'espace. N'étant pas réductrice ici au plan strictement biologique, le propre de l'homme est vu également en fonction de sa destinée.

Le champ de réflexion de la bioéthique se concentre sur la vie et la mort, la santé et la maladie, la qualité de vie et la souffrance, champ bouleversé par les développements bio-médicaux et leurs applications.

Dans le monde **anglo-saxon**, la bioéthique consiste en une réflexion éthique orientée vers le domaine bio-médical, privilégiant l'être humain, mais y incluant aussi les animaux et les végétaux principalement dans leur rapport à l'être humain. La bioéthique entend questionner même la recherche scientifique sur tout le vivant.

Dans le monde **francophone**, jusqu'à récemment, l'aspect « bio » de la bioéthique a été réduit à l'être humain et à la bio-médecine.

Au cours du temps, l'aspect « bio » implique un être humain qu'un faisceau de connaissances et de pratiques techno-scientifiques et médicales permet d'associer à du vivant non-humain, à du vivant artificiellement agencé ou à des dispositifs techniques divers.

Les frontières entre les diverses formes de vie s'estompent, celles entre le vivant et l'inerte s'effacent également.

La vie n'est plus définie par une matière spécifique, mais par des caractéristiques qui varient selon le point de vue des disciplines scientifiques : l'organisation de la matière, le processus, la souplesse d'adaptation, la fonctionnalité, la reproduction avec variation, l'activité métabolique d'échanges, la complexité moléculaire ... etc.

Le travail trans-disciplinaire, exprimé par le concept de convergence, s'impose à la recherche scientifique (1).

L'estompement de la frontière entre le vivant et l'inerte accorde à la technique et à la « machine » une place de plus en plus importante. La bioéthique, restreinte à l'être humain, a déjà dû prendre en considération les appareillages utilisés dans les soins médicaux (l'implant cochléaire, le respirateur, le « pacemaker », ...). Elle a aussi réfléchi aux effets de recherches menées sur des atomes et des molécules qui peuvent affecter n'importe quel être vivant de manière involontaire (contact avec des nanoparticules présentes dans l'air) ou volontaire (soins médicaux, usage militaire, ...). Cette évolution du contenu du préfixe « bio » contraint la bioéthique à ouvrir le cercle du vivant au non vivant (aux éléments physico-chimiques, aux dispositifs électroniques ...). Les questions éthiques associées à ces possibilités techno-scientifiques actuelles valent tant pour les individus humains et les êtres vivants que pour les sociétés et les espèces, ou encore les cultures et la diversité des modes d'existence des vivants non-humains.

Dans ce contexte évolutif, l'anthropologie Humaniste voit apparaître son contraire, l'idéologie trans-humaniste, carrefour de l'individualisme et du bio-capitalisme. Le trans-humanisme désigne à la fois un mouvement philosophique et une mouvance culturelle, de rayonnement mondial, qui affirment qu'il est possible et souhaitable de transformer fondamentalement la condition humaine, par la science et la technique, et uniquement par elles, tout en visant à intensifier, à augmenter les capacités physiques, psychiques, intellectuelles, cognitives et émotionnelles, de l'être humain actuel, considéré comme un stade transitoire et rudimentaire d'un processus évolutif. Sa double techno-prophétie consiste, d'une part, à viser un être « a-mortel », c'est à dire allonger indéfiniment la vie sans en faire disparaître le terme et d'autre part, à faire advenir une nouvelle espèce « trans-humaniste », par la fusion entre l'homme et la machine, « cybernetic organism », ou cyborg ; ainsi que par la gestion, voire la manipulation, de notre programme génétique ; et le transfert de personnalité dans des robots, via l'intelligence artificielle (2)(3).

A travers le développement de technologies NBIC : Nanotechnologies (études et manipulations des structures de la taille du nanomètre comme les atomes), Biotechnologies (études et modifications des êtres vivants, génomique et génie génétique), technologies de l'Information, stockage et échange de flux d'informations via l'informatique et les télécoms, Cloud compute) et Cognitives (descriptions et modélisation des fonctionnements de la pensée des êtres vivants ou non, comme l'Intelligence Artificielle ou IA), le trans-humanisme vise à dépasser toutes les limites humaines, y compris et surtout celle du TEMPS.

Le grand ennemi de cette idéologie trans-humaniste devient alors le passage du TEMPS. La nature humaine se situerait à l'intersection de l'humain et de la « machine », machine qui ne s'inscrit pas dans le TEMPS ou qui d'une certaine manière cherche à échapper à l'effet de la temporalité.

Le corps serait habitable dans un monde physique et matériel et co-existerait avec des environnements digitalisés et façonnés par la réalité virtuelle. Le TEMPS y serait comme aboli. Dans cette perspective, j'ai pris comme référence et fait mien l'excellent travail de Laetitia Pouliquen (4) « I.A. : Maître du temps - Vers une éternité connectée ? ».

De la sorte, un corps humain augmenté devrait être sans âge, avoir un sexe interchangeable, des gènes remplaçables, avec une mise à jour constante et un dispositif de correction des erreurs, une intelligence de 100 quadrillions de synapses, une conscience aux points de vue multiples, insensible aux dangers de l'environnement, à l'optimisme turbo-chargé, se recyclant et purifiant ses déchets, selon Natasha Vita-More (5).

C'est ici que le champ de réflexion et d'action de la bioéthique 2025 s'oppose à l'idéologie trans humaniste pour affirmer que les techno-sciences sont au service de l'Humain, être dans le TEMPS et dans l'espace.

Le trans-humanisme prive l'être humain de la vie biologique, de la relation à autrui, ainsi que de son humanité par son exigence de performance immédiate, au détriment de la persévérance sur le temps long et de l'activité contributive non-économique.

Privation de la vie biologique.

Pour le trans-humanisme, il convient de sortir le vivant de la cyclicité des processus naturels, au cours du temps ; des bio-rythmes.

L'ingénierie génétique reproduit des cycles artificiels et modifie le vivant en vue de sa longévité : organismes et plantes, embryons, génétiquement modifiés, EGM et OGM, clonage.

Le problème de ce rapport au temps réside dans l'effet domino du contrôle du temps, autrement dit, dans la disparition irréversible de la biodiversité.

La technique CRISP-Cas9, méthode de manipulation génétique, précise et peu coûteuse, surnommée « les ciseaux génétiques », développée dans les années 2012, permet de traiter les maladies surtout uni- génétiques.

Cependant, notre compréhension des interactions complexes entre les gènes, leur expression et l'environnement de la personne, ce qu'on appelle l'épi-génétique, est très limitée. Les cibles génétiques à réparer, à modifier sont difficilement identifiables et le faire peut causer des modifications épi-génétiques et aussi des désordres génétiques graves, avec des conséquences indélébiles et irréparables sur les générations à venir.

En 2019, He Jiankui, bio-physicien chinois, « crée » deux bébés humains-filles-dont le gène CCR5 a été modifié pour les rendre résistantes aux virus du SIDA dont les parents étaient porteurs. En 2013, le premier embryon chimérique, être humain-cochon, voit le jour à l'issue de recherches américaines, espagnoles et japonaises.

En 2021, ces mêmes scientifiques annonçaient avoir « créé » les premiers embryons de singe contenant des cellules humaines en vue de pallier la pénurie d'organes issus de dons en créant des organes humains sans limite tels des pièces détachées.

Des techniques existantes de clonage peuvent soit donner naissance à deux embryons ayant le même patrimoine génétique, par scission de l'embryon ; soit à un embryon ayant le même patrimoine génétique qu'une personne en vie. C'est de ce clonage qu'il convient de discuter, qu'il soit un clone conçu pour soigner l'autre ou un clone reproductif, soit un clone conçu pour lui même. « Se dédoubler » permettrait de gagner du temps (l'un fait ceci et l'autre fait cela) et de promouvoir une forme d'immortalité (un complètement autre et un complètement même met le temps en pause sur le plan des changements de génération).

L'université de Paris-Saclay (6) en a évalué les risques éthiques : « L'individu cloné serait obtenu non pas pour lui-même mais comme clone d'un individu existant. Il y aurait donc des risques d'aliénation de cet individu, de crise identitaire. Il se sentirait instrumentalisé. Selon de nombreux scientifiques, le clonage reproductif constitue une atteinte à la dignité humaine ». Remonter dans le temps cellulaire est devenu possible. La reprogrammation cellulaire s'affine. En 2022, naissaient deux jumeaux issus de la congélation d'embryons en 1992, aux États-Unis, donc trente ans auparavant !

En 2023, des chercheurs japonais (Murakami) annoncent la production d'ovocytes à partir de cellules souches embryonnaires provenant de souris mâles. Cette main-mise sur le

vivant pose la question du respect de l'intégrité et de la dignité de l'humain qui ne peut en aucun cas être considéré comme un pur objet.

Les technologies NBIC questionnent fondamentalement notre conception du temps.

Peut-on s'affranchir des générations ?

Peut-on créer des clones sans passé, ni présent, ni futur ?

Rappelons que l'une des deux techno-prophéties de l'idéologie trans-humaniste est l'a-mortalité. Pourtant, le « privilège » de mourir nous différencie des machines.

La mort n'est pas une panne technique ! Elle fait partie de la vie et permet même l'humanisation de notre monde, en nous incitant à la relation avec les autres, avec l'Autre, et au sacré. Ce qui est en jeu dans et autour de la mort a toujours été crucial pour les créatures humaines dès l'origine de l'Homme.

Face à la personne vieillissante et approchant de la mort, que nous serons tous, se pose la question de la longévité : Guérir-**Réparer**-Soigner versus **Transformer**-Augmenter ? (3). Sommes-nous dans l'accompagnement du vieillissement (aider, caresser, rassurer) et de la prise en compte de ses maladies (prothèses-implants auditifs, en cas de presbycusis sévère, rétine électronique en cas de dégénérescence maculaire liée à l'âge; implants cérébraux, en cas de troubles sévères de la mémoire; exosquelette robotisé en cas de mobilité réduite ou altérée) ou sommes nous dans une vision augmentative des capacités corporelles de l'être Humain (fusion homme-machine, re-programmation cellulaire, transfert de personnalité dans des robots) ? La vision trans-humaniste anime l'industrie florissante du rajeunissement. Il serait bon de réfléchir au respect que d'autres cultures ont pour leurs Anciens, en Afrique par exemple, pour inspirer une attitude ouverte aux richesses de chaque âge de la vie !

La techno-logisation actuelle de la procréation permet de se reproduire uniquement quand on veut, parce qu'on le veut et comme on le veut.

L'horloge biologique féminine est mise sur pause. Or, le rapport au temps de la femme est différent de celui des hommes, spécifiquement du fait de sa fertilité et de sa maternité qui en découle. L'a-temporalité imposée à la femme est une atteinte grave à sa dignité.

La vie est dominée et rendue dépendante, par les techno-sciences : fécondation choisie et provoquée par la sélection et la modification du génome, gestation dans l'utérus artificiel, « sortie » du monde physique par l'euthanasie pour rejoindre un monde virtuel par le téléchargement de la conscience.

La neuro-augmentation contribue également à nous faire sortir du temps.

La suppression du sommeil est en cours de procédure, non seulement à cause des addictions mais surtout car c'est une perte d'efficacité et de productivité humaines. Il n'est plus désirable car c'est un temps de mort à soi même. Le repos hebdomadaire disparaît. L'humain hybridé ou cyborg travaille ou s'amuse autant qu'il le désire, sans contrainte. Les commerces sont ouverts 24 heures sur 24 tous les jours de l'année. Exit les rythmes circadiens ! Les rythmes infradiens (cycle semaille/moisson, par exemple) et les rythmes supradiens (cycles reproductifs mensuels, par exemple) sont déjà évacués.

Le cyborg - « cybernetic organism » - a encore besoin de la concentration et de la mémoire cérébrale, avec ou sans implant.

Sans interface homme-machine, les substances chimiques (methylphenidate, modafinil, ritaline, et autres « viagra ») se développent très rapidement.

Les interfaces Cerveau-Machine, avec implant cérébral ou non, sont déjà très utilisés en médecine réparatrice.

Le Conseil de l'Europe rappelait en 2020 qu'« accéder aux processus neuronaux qui sous-tendent la pensée consciente, c'est accéder à un niveau du soi qui, par définition, ne peut être consciemment ni filtré ni dissimulé. Cela risque d'entraîner une profonde violation de la vie privée et de la dignité humaine et pourrait même subvertir le libre-arbitre et porter atteinte au dernier refuge de la liberté : la pensée » (7).

Perte de la relation.

Nous n'avons jamais eu autant d'outils de productivité relationnelle : téléphone GSM, réseaux sociaux, IA générative qui devraient contribuer à libérer du temps pour faciliter la relation en « mode réel ». Et pour autant, nous vivons en mode « **zapping** », celui-ci consiste à passer d'un objet à un autre, d'une personne à l'autre, d'une activité à une autre sans jamais approfondir et se donner « le temps » et « du temps » : zapping virtuel, zapping conjugal et générationnel, zapping sexuel et reproductif, zapping professionnel, zapping de l'autorité,... (4).

Zapping virtuel:

Le numérique, de par l'expérience extra-corporelle qu'il nous fait vivre, occasionne une perte de la relation aux autres. De plus en plus de gens connectés sont en fait prisonniers de leurs bulles numériques, enfermés dans des univers narcissiques.

Les méthodes de manipulations sensorielles des I.A., de la réalité virtuelle et des réseaux sociaux ; ainsi que de conditionnements comportementaux, reposant sur des techniques subliminales, sont déstabilisantes pour l'équilibre psychique normal.

Les écrans « virtualisent » et dépersonnalisent les relations aux autres, notamment par l'interposition d' « une machine » entre l'autre et l'exercice de nos cinq sens. Ils accélèrent, précipitent même les relations. Ils permettent de plus une diffusion massive des sites pornographiques détruisant la relation psychique heureuse, rythmée par la nature, entre deux personnes. La vitesse de diffusion engendre aussi la propagation et l'incitation de la violence : appel à la haine, harcèlement qui brisent les relations entre les personnes.

Les méthodes d'apprentissage en ligne permettent certes un gain de temps grâce à l'élimination des déplacements physiques. Néanmoins, ils réduisent considérablement l'impact de nos cinq sens, à l'exception peut-être de l'acuité visuelle. Seul le sens gustatif échappe pour l'instant à la digitalisation. Mais qu'en est-il alors de l'apport de la relation étudiant-enseignant à la maturation de l'Humain ? L'éducation passe par une véritable relation, où le corps et les sens ont une importance capitale.

Les jeux vidéo ou gaming peuvent d'une part améliorer la mémoire, la planification stratégique et les capacités psycho-motrices, profitables à la maîtrise corporelle, sensorielle et cognitive pour des métiers tels que la chirurgie et le contrôle aérien. Ils peuvent d'autre part provoquer une confusion entre le virtuel et le réel, compromettant le rapport au **temps** et à l'espace. L'addiction aux écrans éloigne l'Humain du passage du **temps** dans l'espace réel. Cette perte de la relation à l'autre, dans la « vraie vie » est la source des nombreuses pathologies psychiatriques actuelles, particulièrement chez nos adolescents.

Zapping anthropologique :

Les « Digital Natives » semblent avoir **inversé** la pyramide de Maslow : besoins physiologiques, de sécurité, d'appartenance, d'estime, et enfin d'accomplissement.

Zapping physiologique :

Notre vie, en mode « bref-bref », est constituée d'une succession ininterrompue de connexions et d'activités numériques ayant un impact sur le sommeil, l'alimentation et la sexualité. Notons que la connexion est le lien entre deux objets génériques, tandis que la relation est le lien entre deux sujets humains.

Dans le zapping jour-nuit, le **sommeil** est mis à mal. Les neurosciences nous démontrent que l'hyper-connexion nuit gravement au sommeil, rythme chronobiologique fondamental. Pour les trans-humanistes, le sommeil est une perte de temps.

Pour les Digital Natives : on picore en consultant son smartphone, on **déjeune** à sa table de travail en télétravail.

Le zapping **sexuel** est sollicité par les réseaux sociaux de mise en relation sexuelle ou amoureuse, adultérine ou pas.

Zapping relationnel.

Parler de relation, C'est parler non seulement d'un lien générique entre deux personnes humaines, mais aussi inclure dans ce lien toute la charge émotionnelle, sentimentale et pleine d'empathie qui se développe entre les deux sujets, laquelle est déterminée par leur expérience personnelle, via leurs cinq sens, et qui évolue continuellement en fonction de nouvelles expériences. L'expression est essentiellement le langage. Or, l'I.A. s'est fait Verbe. Or le langage (formel, algorithmique ...) ne peut jamais être confondu avec la parole qui est vivante, innovante, singulière, étrangère aux règles formelles de destruction ...

Le zapping **conjugal** se caractérise par la multiplication des possibilités en matière de genre, de modes de vie commune, de nombre de partenaires. La relation longue est devenue très difficile dans le monde technologique du mode « bref-bref ».

Existe également le zapping **générationnel**. Quand un enfant est conçu par gestation pour autrui ou par utérus artificiel, celui-ci n'ayant pas bénéficié des relations intra-utérines entre le corps et la psyché de sa mère, cet enfant ne peut reconnaître en elle le modèle fondateur de l'altérité.

La bio-augmentation de l'enfant, ainsi que la multiplication des mères et des pères, rendent l'histoire familiale impossible à retracer. Or les enfants ont besoin de savoir d'où ils viennent pour construire leur propre histoire et s'inscrire dans la chaîne de la vie.

De plus, les générations ne vivent plus ensemble : maisons de retraite, chute de la natalité, colocation, co-working, ...

Avec l'idéologie trans-humaniste, il y aura les augmentés et les autres ... un réel zapping de l'**autorité** !

Quant au zapping **professionnel**, les jeunes accordent la priorité à l'autonomie et à l'équilibre vie personnelle/vie professionnelle. Ils n'hésitent pas à changer souvent de job, même si cette instabilité permanente peut se révéler désastreuse pour les enfants, pour le couple ... **Le summum trans-humaniste repose sur la sortie de l'espace-temps sans mort et sans éternité.** Mais ceci relève d'une imposture car tel l'humain qui rêverait de sortir dans l'espace sous scaphandre, s'auto-détruit du fait même de cette sortie.

Le tout-digital éradique ce quelque chose qui dépasse l'humain et ce pourquoi il est « inscrit » dans le temps. C'est le zapping **transcendental**.

Perspectives :

Après avoir constaté les causes de **perte de notre conception au temps** due à la technique et à l'idéologie trans-humaniste, la **bio-éthique 2025** est invitée à défendre un réel « dé-technicisé » - dé-techniciser le travail, les arts et les loisirs, par le plein exercice de nos cinq sens !, - à refuser la technicisation de la pro-création, l'anthropomorphisme de l'intelligence artificielle et de la robotique, à bâtir de saines relations pour s'inscrire dans le temps naturel et ses rythmes, à rechercher la liberté intérieure à l'aide de la Nature, par un cheminement aux sources de la Vie et ainsi contrer le désordre intérieur et mondial.

Les rythmes du temps qui ne sont rien d'autre qu'une répétition perpétuelle, créent un espace de sécurité pour nous, humains. Sans eux, nous disparaissions !

Réaffirmer la continuité historique et culturelle de notre humanité fortifie l'encadrement éthique du service proposé par les technologies NBIC, en nous encourageant à habiter le temps.

Les quatorze « communs » , décrits par Simone Weil, dans « Les besoins de l'âme » (8), constituent les balises nécessaires à notre bioéthique 2025. Il faut retrouver une éthique fondée sur le respect de la corporéité de l'humain. Or le corps s'inscrit dans l'espace et la matière, mais le propre du corps vivant est précisément qu'il s'inscrit aussi dans une durée qui lui est propre. Tirer sur la fleur pour la faire grandir plus vite revient à la déraciner. Trafiquer les rythmes du corps revient à détruire ce qui fait tout son sens : la durée de son histoire. L'éthique doit se fonder sur le sens de l'histoire, ce qui implique aussi une attention à la richesse de chaque âge de la vie. La négation de l'historicité, de la profondeur et de la densité de la durée est une atteinte à la dignité, c'est à dire au propre de l'Humain.

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BIOÉTICA 2025. ¡TIEMPO Y ESPACIO POR CONQUISTAR!



Dr. Bernard Ars, Ph.D.

[Accueil - Bernard Ars, M.D., Ph.D.](#)

Palabra que aparece en el mundo médico durante los años 70, sumándose a varios términos ya utilizados: deontología, ética, moral, la expresión “bioética” significaba en aquella época una reflexión ética sobre la vida Humana. La noción de Humanismo está implícita en ello. Una antropología, una visión del Hombre, la sustenta.

Más específicamente, el Humanismo judeocristiano se refiere a un pensamiento que enfatiza el papel central y el carácter trascendente de la persona humana en el tiempo y el espacio.

Sin querer reducirnos aquí al nivel estrictamente biológico, la naturaleza específica del hombre también se ve en términos de su destino.

El campo de reflexión de la bioética se centra en la vida y la muerte, la salud y la enfermedad, la calidad de vida y el sufrimiento, un campo trastocado por los desarrollos biomédicos y sus aplicaciones.

En el mundo anglosajón, la bioética consiste en una reflexión ética orientada al ámbito biomédico, privilegiando el ser humano, pero incluyendo también a los animales y a las plantas principalmente en su relación con el ser humano. La bioética pretende cuestionar incluso la investigación científica sobre todos los seres vivos.

En el mundo francófono, hasta hace poco, el aspecto “bio” de la bioética se reducía al ser humano y a la biomedicina.

Con el tiempo, el aspecto “bio” implica un ser humano al que un conjunto de conocimientos y prácticas tecno científicas y médicas permite asociar con seres vivos no humanos, seres vivos dispuestos artificialmente o diversos dispositivos técnicos.

Las fronteras entre las diversas formas de vida se están desdibujando, así como las que separan lo vivo de lo inerte.

La vida ya no se define por una materia específica, sino por características que varían según el punto de vista de las disciplinas científicas: la organización de la materia, el proceso, la flexibilidad de adaptación, la funcionalidad, la reproducción con variación, la actividad metabólica de los intercambios, la complejidad molecular... etc.

El trabajo transdisciplinario, expresado por el concepto de convergencia, se impone a la investigación científica (1).

La difuminación de la frontera entre lo vivo y lo inerte otorga a la tecnología y a la “máquina” un lugar cada vez más importante. La bioética, restringida al ser humano, ya ha tenido que tomar en consideración los dispositivos utilizados en la atención médica (implantes cocleares, respiradores, marcapasos, etc.). También consideró los efectos de las investigaciones realizadas sobre átomos y moléculas que pueden afectar a cualquier ser vivo de forma involuntaria (contacto con nano-partículas presentes en el aire) o voluntaria (atención médica, uso militar, etc.). Esta evolución del contenido del prefijo “bio” obliga a la bioética a abrir el círculo de lo vivo a lo no vivo (a los elementos fisicoquímicos, a los dispositivos electrónicos, etc.).

Las cuestiones éticas asociadas a estas posibilidades tecno científicas actuales se aplican tanto a los individuos humanos y a los seres vivos como a las sociedades y a las especies, o incluso a las culturas y a la diversidad de modos de existencia de los seres vivos no humanos.

En este contexto evolutivo, la antropología Humanista ve surgir su contrario, la ideología trans humanista, encrucijada del individualismo y el bio-capitalismo.

El trans-humanismo se refiere a un movimiento filosófico y a un movimiento cultural, de influencia mundial, que afirman que es posible y deseable transformar fundamentalmente la condición humana, a través de la ciencia y la tecnología, y sólo a través de ellas, al tiempo que pretenden intensificar, aumentar las capacidades físicas, psicológicas, intelectuales, cognitivas y emocionales del ser humano actual, considerado como una etapa transitoria y rudimentaria de un proceso evolutivo. Su doble tecno-profecía consiste, por una parte, en aspirar a un ser "a-mortal", es decir, prolongar indefinidamente la vida sin hacer desaparecer su término y, por otra parte, en hacer surgir una nueva especie "trans-humanista", mediante la fusión entre el hombre y la máquina, "organismo cibernético", o cyborg; así como a través de la gestión, incluso manipulación, de nuestro

programa genético; y la transferencia de personalidad a los robots, a través de la inteligencia artificial (2)(3).

A través del desarrollo de las tecnologías NBIC: Nanotecnologías (estudios y manipulaciones de estructuras de tamaño nanométrico como los átomos), Biotecnologías (estudios y modificaciones de seres vivos, genómica e ingeniería genética), Tecnologías de la información, (almacenamiento e intercambio de flujos de información vía computadoras y telecomunicaciones, *Cloud computing*) y Tecnologías cognitivas (descripciones y modelización del funcionamiento del pensamiento de seres vivos o no vivos, como la Inteligencia Artificial o IA), el trans-humanismo pretende superar todos los límites humanos, incluido especialmente el del TIEMPO.

El gran enemigo de esta ideología trans-humanista se convierte entonces en el paso del TIEMPO.

La naturaleza humana se situaría en la intersección de lo humano y la “máquina”, una máquina que no cabe en el TIEMPO o que de cierta manera busca escapar al efecto de la temporalidad.

El cuerpo sería habitable en un mundo físico y material y coexistiría con entornos digitalizados moldeados por la realidad virtual. Allí el TIEMPO sería abolido.

En esta perspectiva, tomé como referencia e hice mío el excelente trabajo de Laetitia Pouliquen (4) “I.A.: Maestro del tiempo - ¿Hacia una eternidad conectada? ”.

De esta manera, un cuerpo humano aumentado debería ser eterno, tener sexo intercambiable, genes reemplazables, con constante actualización y corrección de errores, una inteligencia de 100 cuatrillones de sinapsis, una conciencia con múltiples puntos de vista, insensible a los peligros ambientales, con un optimismo turboalimentado, reciclando y purificando sus desechos, según Natasha Vita-More (5).

Es aquí donde el campo de reflexión y acción de la bioética 2025 se opone a la ideología trans humanista para afirmar que las tecno ciencias están al servicio del Humano, del ser en el TIEMPO y en el espacio.

El trans-humanismo priva a los seres humanos de la vida biológica, de las relaciones con los demás, así como de su humanidad a través de su exigencia de rendimiento inmediato, en detrimento de la perseverancia a largo plazo y de la actividad contributiva no económica.

Privación de la vida biológica.

Para el trans-humanismo, conviene sacar lo vivo de la ciclicidad de los procesos naturales, a lo largo del tiempo; de los biorritmos.

La ingeniería genética reproduce ciclos artificiales y modifica los seres vivos con vistas a su longevidad: organismos y plantas, embriones, genéticamente modificados, EGM y OGM, clonación.

El problema de esta relación con el tiempo radica en el efecto dominó del control del tiempo, es decir, en la desaparición irreversible de la biodiversidad.

La técnica CRISP-Cas9, método de manipulación genética preciso y económico, apodado “tijeras genéticas”, desarrollado en la década de 2012, permite tratar principalmente enfermedades unigenéticas.

Sin embargo, nuestra comprensión de las complejas interacciones entre los genes, su expresión y el entorno de la persona, lo que llamamos epigenética, es muy limitada.

Las dianas genéticas a reparar o modificar son difíciles de identificar y hacerlo puede provocar modificaciones epigenéticas y también graves trastornos genéticos, con consecuencias indelebles e irreparables para las generaciones futuras.

En 2019, He Jiankui, un biofísico chino, “creó” dos bebés-niñas cuyo gen CCR5 había sido modificado para hacerlas resistentes a los virus del SIDA que portaban sus padres.

En 2013 se creó el primer embrión quimérico (humano-cerdo) tras investigaciones estadounidenses, españolas y japonesas.

En 2021, estos mismos científicos anunciaron haber “creado” los primeros embriones de mono con células humanas para superar la escasez de órganos donados creando órganos humanos ilimitados como piezas de repuesto.

Las técnicas de clonación existentes pueden dar lugar a dos embriones con el mismo patrimonio genético, dividiendo el embrión; ya sea a un embrión que tenga el mismo patrimonio genético que una persona viva. Es esta clonación la que debe discutirse, ya sea un clon diseñado para curar a otros o un clon reproductivo, o sea un clon diseñado para sí mismo. La “división” ahorraría tiempo (uno hace esto y el otro hace aquello) y promovería una forma de inmortalidad (una persona completamente diferente y una persona completamente la misma pone el tiempo en suspenso en términos de cambios generacionales).

La Universidad de París-Saclay (6) ha evaluado los riesgos éticos: “El individuo clonado no se obtendría para sí mismo, sino como clon de un individuo existente. Habría pues riesgos de alienación de este individuo, de crisis de identidad. Se sentiría instrumentalizado. Según muchos científicos, la clonación reproductiva constituye un atentado a la dignidad humana”.

Retroceder en el tiempo celular se ha hecho posible. La reprogramación celular se está volviendo más refinada.

En 2022 nacieron gemelos fruto de la congelación de embriones en 1992, en Estados Unidos. ¡Hace treinta años!

En 2023, investigadores japoneses (Murakami) anunciaron la producción de ovocitos a partir de células madre embrionarias de ratones machos. Este control sobre los vivos plantea la cuestión del respeto a la integridad y a la dignidad del ser humano, que en ningún caso puede ser considerado como un puro objeto.

Las tecnologías NBIC cuestionan fundamentalmente nuestro concepto del tiempo.

¿Podemos liberarnos de las generaciones?

¿Es posible crear clones sin pasado, ni presente, ni futuro?

Recordemos que una de las dos tecno-profecías de la ideología trans-humanista es la a-mortalidad. Sin embargo, el “privilegio” de morir nos distingue de las máquinas.

¡La muerte no es un fallo técnico! Es parte de la vida y permite incluso humanizar nuestro mundo, al animarnos a relacionarnos con los demás, con el Otro y con lo sagrado. Lo que está en juego en y alrededor de la muerte siempre ha sido crucial para las criaturas humanas desde el origen del Hombre.

Frente a la persona envejeciendo y acercándose a la muerte, en la que todos nos convertiremos, surge la cuestión de la longevidad: ¿Curar-**Reparar**-Cuidar versus **Transformar**-Aumentar? (3).

¿Acompañamos en el envejecimiento (ayudando, acariciando, tranquilizando) y teniendo en cuenta sus enfermedades (prótesis-implantes auditivos, en caso de presbiacusia severa, retina electrónica en caso de degeneración macular asociada a la edad; implantes cerebrales, en caso de trastornos severos de la memoria; exoesqueleto robótico en caso de movilidad reducida o alterada) o estamos en una visión aumentativa de las capacidades corporales del ser Humano (fusión hombre-máquina, reprogramación celular, transferencia de personalidad a robots)?

La visión trans-humanista impulsa la próspera industria del rejuvenecimiento. Sería bueno reflexionar sobre el respeto que otras culturas tienen por sus mayores, en África, por ejemplo, para inspirar una actitud abierta a las riquezas de cada edad de la vida.

La actual tecnologización de la procreación nos permite reproducirnos sólo cuando queremos, porque queremos y como queremos.

El reloj biológico femenino se pone en pausa. Sin embargo, la relación de las mujeres con el tiempo es diferente a la de los hombres, específicamente por su fertilidad y la

maternidad que de ella se deriva. La atemporalidad impuesta a las mujeres es un grave atentado a su dignidad.

La vida está dominada y hecha dependiente por las tecno-ciencias: fecundación elegida y provocada por la selección y modificación del genoma, gestación en útero artificial, “salida” del mundo físico por eutanasia para ingresar a un mundo virtual por descarga de conciencia.

La neuro-aumentación también nos ayuda a salir del tiempo.

La supresión del sueño está en marcha, no sólo debido a las adicciones, sino más importante aún, porque supone una pérdida de eficiencia y productividad humana. Ya no es deseable porque es tiempo de muerte para uno mismo. El descanso semanal desaparece. El humano hibridado o cyborg trabaja o juega tanto como quiere, sin restricciones. Las tiendas están abiertas las 24 horas del día, todos los días del año. ¡Salgan de los ritmos circadianos! Los ritmos infradianos (ciclo siembra/cosecha, por ejemplo) y los ritmos supradianos (ciclos reproductivos mensuales, por ejemplo) ya están evacuados.

El cyborg –“organismo cibernético”– todavía necesita concentración y memoria cerebral, con o si implante.

Sin una interfaz hombre-máquina, las sustancias químicas (metilfenidato, modafinilo, ritalina y otros "viagra") se desarrollan muy rápidamente.

Las interfaces Cerebro-Máquina, con o sin implantes cerebrales, ya se utilizan ampliamente en la medicina restaurativa.

El Consejo de Europa recordó en 2020 que “acceder a los procesos neuronales que subyacen al pensamiento consciente significa acceder a un nivel del yo que, por definición, no puede filtrarse ni ocultarse conscientemente. "Esto supone un riesgo de profunda violación de la privacidad y de la dignidad humana y podría incluso subvertir el libre albedrío y socavar el último refugio de la libertad: el pensamiento" (7).

Pérdida de relación.

Nunca hemos tenido tantas herramientas de productividad relacional: telefonía GSM, redes sociales, IA generativa que deberían ayudar a liberar tiempo para facilitar la relación en “modo real”. Y, sin embargo, vivimos en modo “**zapping**”, que consiste en pasar de un objeto a otro, de una persona a otra, de una actividad a otra sin profundizar nunca y sin darnos “el tiempo” y “algo de tiempo”: zapping virtual, zapping marital y generacional, zapping sexual y reproductivo, zapping profesional, zapping de autoridad, etc. (4).

Zapping virtual:

La tecnología digital, a través de la experiencia extra-corporal que nos brinda, provoca una pérdida de relaciones con los demás. Cada vez más personas conectadas son, de hecho, prisioneras de sus burbujas digitales, encerradas en universos narcisistas.

Métodos de manipulación sensorial de IA, realidad virtual y redes sociales; así como el condicionamiento de la conducta, basado en técnicas subliminales, son desestabilizadores para el equilibrio psicológico normal.

Las pantallas “virtualizan” y despersonalizan las relaciones con los demás, en particular interponiendo “una máquina” entre el otro y el ejercicio de nuestros cinco sentidos. Aceleran, incluso precipitan, las relaciones. Permiten también la difusión masiva de sitios pornográficos, destruyendo la feliz relación psicológica, marcada por la naturaleza, entre dos personas. La velocidad de difusión genera también la propagación e incitación a la violencia: llamamientos al odio, acoso que rompe las relaciones entre las personas.

Los métodos de aprendizaje en línea ciertamente ahorran tiempo al eliminar los viajes físicos. Sin embargo, reducen significativamente el impacto de nuestros cinco sentidos, con la posible excepción de la agudeza visual. Hasta ahora sólo el sentido del gusto ha escapado a la digitalización. Pero ¿qué pasa con la contribución de la relación alumno-maestro a la maduración del Ser Humano? La educación implica una relación real, donde el cuerpo y los sentidos tienen una importancia capital.

Los videojuegos o juegos pueden, por un lado, mejorar la memoria, la planificación estratégica y las habilidades psicomotoras, lo que resulta beneficioso para el control corporal, sensorial y cognitivo en profesiones como la cirugía o el control del tráfico aéreo. También pueden causar confusión entre lo virtual y lo real, comprometiendo la relación con el **tiempo** y el espacio.

La adicción a las pantallas aleja a los humanos del paso del **tiempo** en el espacio real.

Esta pérdida de la relación con los demás, en la “vida real”, es la fuente de muchas patologías psiquiátricas actuales, particularmente entre nuestros adolescentes.

Zapping antropológico:

Los “nativos digitales” parecen haber **invertido** la pirámide de Maslow: necesidades fisiológicas, seguridad, pertenencia, estima y, finalmente, logro.

Zapping fisiológico:

Nuestra vida, en modo corto-corto, se compone de una sucesión ininterrumpida de conexiones y actividades digitales que inciden en el sueño, la alimentación y la sexualidad.

Nótese que la conexión es el vínculo entre dos objetos genéricos, mientras que la relación es el vínculo entre dos sujetos humanos.

En el zapping día-noche el **sueño** se ve comprometido. La neurociencia nos muestra que la hiper conexión perjudica gravemente el sueño, ritmo cronobiológico fundamental.

Para los trans-humanistas, dormir es una pérdida de tiempo.

Para los nativos digitales: picoteamos mientras consultamos nuestro smartphone, **almorzamos** en nuestro escritorio mientras teletrabajamos.

El zapping **sexual** es fomentado por las redes sociales para relaciones sexuales o románticas, adúlteras o no.

Relación zapping.

Hablar de relación es hablar no sólo de un vínculo genérico entre dos personas humanas, sino también incluir en este vínculo toda la carga emotiva, sentimental y llena de empatía que se desarrolla entre los dos sujetos, que está determinada por su experiencia personal, a través de sus cinco sentidos, y que evoluciona continuamente en función de nuevas experiencias. La expresión es esencialmente lenguaje. Sin embargo, la IA se convirtió en Palabra. Pero el lenguaje (formal, algorítmico, etc.) nunca puede confundirse con el habla, que es viva, innovadora, singular, ajena a las reglas formales de la destrucción...

El zapping **marital** se caracteriza por la multiplicación de posibilidades en términos de género, de modos de vida en común, del número de parejas. Las relaciones a largo plazo se han vuelto muy difíciles en el mundo tecnológico del modo “corto-corto”.

También existe un cambio **generacional**. Cuando un niño es concebido mediante gestación subrogada o mediante un útero artificial, sin haberse beneficiado de las relaciones intrauterinas entre el cuerpo y la psique de su madre, este niño no puede reconocer en ella el modelo fundador de la alteridad.

La bio-aumentación del niño, así como la multiplicación de madres y padres, hace imposible rastrear la historia familiar. Pero los niños necesitan saber de dónde vienen para poder construir su propia historia y inscribirse en la cadena de la vida.

Además, las generaciones ya no viven juntas: residencias de ancianos, caída de la natalidad, viviendas compartidas, coworking, etc.

Con la ideología trans-humanista, habrá los aumentados y los otros... ¡un verdadero zapping de **autoridad!**

En cuanto al zapping **profesional**, los jóvenes dan prioridad a la autonomía y al equilibrio entre vida personal y vida profesional. No dudan en cambiar de trabajo a menudo, aunque esta inestabilidad permanente puede resultar desastrosa para los hijos, para la pareja...

El pináculo trans-humanista se basa en la salida del espacio-tiempo sin muerte y sin eternidad. Pero esto es una impostura porque, como un ser humano que sueña con salir al espacio con un traje espacial, se autodestruye por el mismo hecho de esta salida.

Lo totalmente digital erradica aquello que va más allá de lo humano y lo que está “inscrito” en el tiempo. Esto es zapping **trascendental**.

Perspectivas:

Después de haber señalado las causas de la **pérdida de nuestra concepción del tiempo** debido a la tecnología y a la ideología trans-humanista, la **bioética 2025** está invitada a defender una verdadera "destecnización" - destecnificar el trabajo, las artes y el ocio, ¡mediante el pleno ejercicio de nuestros cinco sentidos!, - rechazar la tecnificación de la procreación, el antropomorfismo de la inteligencia artificial y la robótica, construir relaciones sanas para ser parte del tiempo natural y sus ritmos, buscar la libertad interior con la ayuda de la Naturaleza, mediante un viaje a las fuentes de la Vida y contrarrestar así el desorden interior y global.

Los ritmos del tiempo, que no son más que una repetición perpetua, crean un espacio de seguridad para nosotros los humanos. ¡Sin ellos, desaparecemos!

Reafirmar la continuidad histórica y cultural de nuestra humanidad fortalece el marco ético del servicio que ofrecen las tecnologías NBIC, animándonos a habitar el tiempo.

Los catorce “comunes”, descritos por Simone Weil en “Las necesidades del alma” (8), constituyen los hitos necesarios para nuestra bioética en 2025. Debemos redescubrir una ética basada en el respeto de la corporeidad de los humanos. Ahora bien, el cuerpo está inscrito en el espacio y en la materia, pero la característica del cuerpo vivo es precisamente la de estar también inscrito en una duración que le es específica.

Tirar de la flor para que crezca más rápido es lo mismo que arrancarla. Alterar los ritmos del cuerpo significa destruir aquello que le da su pleno sentido: la duración de su historia. La ética debe basarse en el sentido de la historia, lo que implica también la atención a la riqueza de cada época de la vida.

La negación de la historicidad, de la profundidad y de la densidad de la duración es un ataque a la dignidad, es decir a la naturaleza misma de lo Humano.

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BIOETHICS 2025. TIME AND SPACE TO CONQUER!

Bernard Ars, M.D., Ph.D..



<https://arsbernard.com/>

A term that emerged in the medical field during the 1970s, alongside several already established concepts such as deontology, ethics, and morality, the word "bioethics" originally referred to an ethical reflection on human life. The notion of Humanism is implicit in it, supported by an anthropology and a vision of mankind.

More specifically, Judeo-Christian Humanism refers to a philosophy that emphasizes the central role and transcendent nature of the human person in time and space.

Not strictly limited to the biological aspect, the essence of mankind is also considered in relation to its destiny.

The field of bioethical reflection focuses on life and death, health and illness, quality of life, and suffering—an area profoundly impacted by biomedical advances and their applications.

In the Anglo-Saxon world, bioethics is an ethical reflection centered on the biomedical domain, primarily prioritizing the human being but also including animals and plants, particularly in their relationship to humanity. Bioethics even seeks to question scientific research on all living entities.

In the French speaking world, until recently, the "bio" aspect of bioethics was limited to human beings and medicine.

Over time, however, the "bio" aspect has come to encompass a human being whose connection to non-human life, artificially arranged life, or various technical devices is enabled by an array of techno-scientific and medical knowledge and practices.

The boundaries between different forms of life are becoming blurred, and the distinction between the living and the inanimate is also fading.

Life is no longer defined by a specific material but by characteristics that vary according to the perspective of different scientific disciplines: the organization of matter, processes, adaptability, functionality, reproduction with variation, metabolic exchange activity, molecular complexity, and so on.

Interdisciplinary work, expressed through the concept of convergence, has become essential in scientific research.

As the boundary between the living and the inanimate blurs, technology and the "machine" are taking on an increasingly significant role. Bioethics, traditionally limited to human beings, has already had to consider the medical devices used in healthcare (such as cochlear implants, ventilators, and pacemakers). It has also examined the effects of research conducted on atoms and molecules, which may impact any living being either involuntarily (e.g., exposure to airborne nanoparticles) or voluntarily (e.g., medical treatments, military applications). This evolving definition of the prefix "bio" compels bioethics to extend its scope beyond living organisms to include non-living elements such as physico-chemical components and electronic devices.

The ethical questions associated with these current techno-scientific possibilities apply not only to individual human beings and living organisms but also to societies, species, cultures, and the diverse modes of existence of non-human life forms.

In this evolving context, Humanist anthropology is now confronted with its antithesis: the transhumanist ideology, a crossroads of individualism and bio-capitalism.

Transhumanism refers both to a philosophical movement and a cultural trend with global influence, asserting that it is both possible and desirable to fundamentally transform the human condition through - and only through - science and technology. Its goal is to enhance and augment the physical, psychological, intellectual, cognitive, and emotional capabilities of the present-day human being, who is seen as merely a transitional and rudimentary stage in an evolutionary process.

Transhumanism is driven by a dual techno-prophecy: on the one hand, the pursuit of an "a-mortal" being—that is, extending life indefinitely without eliminating death itself; and on the other hand, the emergence of a new "transhumanist" species through the fusion of humans and machines, resulting in a "cybernetic organism" or cyborg. This transformation also involves the management - or even manipulation - of our genetic program and the transfer of human personality into robots via artificial intelligence.

Through the development of NBIC technologies - Nanotechnologies (the study and manipulation of nanometer-scale structures such as atoms), Biotechnologies (the study

and modification of living organisms, genomics, and genetic engineering), Information Technologies (the storage and exchange of data through computing and telecommunications, including cloud computing), and Cognitive Sciences (the description and modeling of thought processes in both living and non-living entities, such as Artificial Intelligence or AI) - transhumanism seeks to transcend all human limitations, including, and above all, that of TIME.

The passage of TIME thus becomes the great enemy of transhumanist ideology.

Human nature, in this vision, would exist at the intersection of humanity and the "machine" - a machine that does not exist within TIME or, in some way, seeks to escape the effects of temporality.

The human body would be inhabitable in a physical and material world while coexisting with digitalized environments shaped by virtual reality, where TIME would effectively be abolished.

From this perspective, I have taken as a reference and embraced the excellent work of Laetitia Pouliquen, I.A.: *Maître du temps - Vers une éternité connectée ?* (AI: Master of Time - Towards a Connected Eternity?).

Thus, an enhanced human body would be ageless, with an interchangeable sex, replaceable genes, continuous updates, and an error correction system. It would possess intelligence equivalent to 100 quadrillion synapses, a consciousness with multiple viewpoints, immunity to environmental dangers, turbo-charged optimism, and the ability to recycle and purify its own waste, according to Natasha Vita-More.

It is at this point that the field of reflection and action in Bioethics 2025 stands in opposition to the transhumanist ideology, affirming that techno-sciences must serve Humanity—an entity that exists within TIME and space.

Transhumanism deprives the human being of biological life, of relationships with others, and ultimately of its humanity by imposing an immediate demand for performance, at the expense of long-term perseverance and non-economic, contributive activities.

Deprivation of Biological Life

For the transhumanism, the goal is to remove living beings from the cyclic nature of natural processes over time - from biological rhythms.

Genetic engineering replicates artificial cycles and modifies living organisms to extend their longevity: genetically modified organisms (GMOs), genetically modified embryos (GMEs), cloned organisms and plants.

The problem with this relationship to time lies in the domino effect of controlling time—namely, in the irreversible loss of biodiversity.

The CRISPR-Cas9 technique, a precise and inexpensive method of genetic manipulation, often referred to as "genetic scissors," was developed in 2012 and enables the treatment of primarily monogenic diseases.

However, our understanding of the complex interactions between genes, their expression, and a person's environment - what is known as epigenetics - is still very limited.

Genetic targets for repair or modification are difficult to identify, and such interventions can cause epigenetic alterations as well as serious genetic disorders, with unpredictable, irreversible and indelible consequences for future generations.

In 2019, the Chinese biophysicist He Jiankui "created" two baby girls whose CCR5 gene was modified to make them resistant to HIV, as their parents were carriers of the virus.

In 2013, the first chimeric embryo—a human-pig hybrid—was developed through research conducted in the United States, Spain, and Japan.

In 2021, these same scientists announced that they had "created" the first monkey embryos containing human cells, with the aim of addressing shortages of organ donation by growing unlimited human organs like interchangeable spare parts.

Existing cloning techniques can either produce two embryos with the same genetic makeup by splitting an embryo or generate an embryo identical to a living person. This type of cloning warrants discussion, whether it involves a clone created to heal another individual, a reproductive clone, or a clone created for its own sake.

"Duplicating oneself" could allow for a gain in time (one entity performing one task while the other does another) and promote a form of immortality - where a completely different yet entirely identical being effectively puts time on pause with respect to generational changes.

The University of Paris-Saclay has assessed the ethical risks associated with cloning:

"The cloned individual would not exist for themselves but as the replica of an already existing individual. This could result in alienation, an identity crisis, and a sense of being instrumentalized. According to many scientists, reproductive cloning constitutes a violation of human dignity."

Rewinding cellular time has become possible, as cellular reprogramming continues to advance.

In 2022, two twins were born in the United States from embryos that had been frozen in 1992 - thirty years earlier!

In 2023, Japanese researchers (Murakami) announced the production of oocytes from embryonic stem cells derived from male mice.

This increasing control over life itself raises critical questions about the respect for human integrity and dignity - human beings cannot, under any circumstances, be reduced to mere objects.

NBIC Technologies and the Questioning of Time

NBIC technologies fundamentally challenge our conception of time.

Can we break free from the constraints of generations?

Can we create clones without a past, present, or future?

Let us recall that one of the two techno-prophecies of transhumanist ideology is a-mortality, the indefinite extension of life without eliminating death itself.

And yet, the privilege of mortality is what differentiates us from machines.

Death is not a technical failure. It is an intrinsic part of life, a process that enables the humanization of our world by compelling us to engage with others, with the Other, and with the sacred. Throughout human history, what is at stake in and around death has always been of profound significance.

As we all inevitably face aging and approach death, the question of longevity arises: Healing-Repairing-Caring versus Transforming-Augmenting?

Are we embracing the process of aging by providing support, comfort, and care - addressing age-related conditions through medical solutions such as hearing implants for severe presbycusis, electronic retinas for macular degeneration, brain implants for severe memory disorders, or robotic exoskeletons for reduced or impaired mobility?

Or are we instead pursuing an augmentation-driven vision of the human body - integrating human-machine fusion, cellular reprogramming, and personality transfers into robotic entities?

The transhumanist vision fuels the booming anti-aging industry. It would be wise to reflect on the respect that other cultures, such as those in Africa, have for their elders - offering an opportunity to embrace the unique value of every stage of life.

The Technologization of Procreation and the Escape from Time

The current technologization of procreation allows reproduction to occur only when, because, and how one desires.

The female biological clock is effectively put on pause. However, a woman's relationship to time differs from that of men, particularly due to her fertility and the motherhood that

stems from it. The imposition of atemporality on women represents a severe violation of their dignity

Life itself is increasingly dominated and made dependent on techno-sciences: reproduction is dictated by chosen and induced fertilization through genetic selection and modification, gestation takes place in artificial wombs, and physical existence can be "exited" through euthanasia, allowing one to transition into a virtual world via consciousness uploading.

Neuro-Augmentation and the Disruption of Natural Rhythms

Neuro-augmentation also contributes to this escape from time.

The elimination of sleep is already in progress—not only due to addictions but primarily because it is perceived as a loss of human efficiency and productivity. Sleep is no longer desirable, as it is seen as a form of temporary death. Weekly rest is disappearing. The hybridized human—or cyborg—works or entertains themselves as much as they desire, without limitation. Shops remain open 24/7, every day of the year. Circadian rhythms have been abolished. Infradian rhythms (such as the sowing/harvesting cycle) and supradian rhythms (such as monthly reproductive cycles) have already been discarded.

The cyborg - the cybernetic organism - still requires concentration and memory, whether with or without implants.

Without a human-machine interface, the rapid development of chemical substances such as methylphenidate, modafinil, Ritalin, and other "Viagra-like" drugs offers artificial cognitive and physical enhancement.

Brain-Machine Interfaces (BMIs) - whether with cerebral implants or not - are already widely used in restorative medicine.

In 2020, the Council of Europe issued a warning:

"Gaining access to the neural processes underlying conscious thought means accessing a level of the self that, by definition, cannot be consciously filtered or concealed. This risks causing a profound violation of privacy and human dignity and could even subvert free will, thereby threatening the last refuge of liberty: thought itself."

Loss of Human Connection

We have never had so many tools designed to enhance relational productivity - mobile phones, social networks, and generative AI - all intended to free up time and facilitate "real-world" relationships. And yet, we live in a state of perpetual "zapping", constantly jumping from one object to another, one person to another, and one activity to another, without ever truly engaging or taking the time to develop depth in our interactions. This

manifests in virtual zapping, marital and generational zapping, sexual and reproductive zapping, professional zapping, and even a breakdown of authority.

Virtual Zapping

The digital experience, by offering an out-of-body sense of interaction, leads to a loss of real human connection. Increasingly, hyper-connected individuals are trapped within their own digital bubbles, locked into narcissistic virtual worlds.

AI-driven sensory manipulation, virtual reality, and behavioral conditioning through subliminal techniques destabilize psychological balance.

Screens "virtualize" and depersonalize human relationships by inserting a machine between individuals and their sensory experiences. They accelerate and even short-circuit relationships, eliminating the natural rhythms that allow them to flourish.

Furthermore, the massive proliferation of pornographic content distorts natural and psychologically fulfilling relationships between partners, replacing them with instant gratification disconnected from reality. The speed of digital diffusion also fuels violence - through hate speech, harassment, and cyberbullying - which fractures relationships rather than fostering connection.

Online learning may offer a time-saving advantage by eliminating physical travel, yet it severely reduces the role of the five senses, except for visual perception. For now, only the sense of taste remains untouched by digitization. But what happens to the fundamental teacher-student relationship, which is crucial to human maturation? True education is built on genuine relationships, where the body and senses play an essential role.

Video games can, on the one hand, enhance memory, strategic planning, and psychomotor skills, making them valuable for professions such as surgery and air traffic control. On the other hand, they blur the lines between virtual and real, disrupting our perception of time and space.

Screen addiction alienates humans from experiencing time in the real world. The resulting loss of connection in "real life" is at the root of many contemporary psychiatric disorders, particularly among adolescents.

Anthropological Zapping

The Digital Natives seem to have inverted Maslow's hierarchy of needs, prioritizing self-actualization over basic physiological, safety, belonging, and esteem needs.

Physiological Zapping

Life today, lived in "quick-swipe mode", is a never-ending sequence of digital interactions and activities, disrupting sleep, nutrition, and sexuality.

It is crucial to distinguish between connection, which links two generic objects, and relationship, which links two human beings.

In the day-night zapping cycle, sleep is severely impacted. Neurophysiological research confirms that hyperconnectivity significantly disrupts sleep - a fundamental biological rhythm.

For transhumanists, sleep is merely a waste of time.

For Digital Natives, multitasking dominates daily life - snacking while scrolling through a smartphone, eating lunch at a work desk while telecommuting.

Sexual **zapping** is facilitated by dating and hookup apps, promoting fleeting encounters, whether casual, extramarital, or otherwise.

Relational Zapping

To speak of relationship is not merely to describe a generic link between two human beings, but to encompass the emotional, sentimental, and empathetic charge that develops between them. This connection is shaped by their personal experiences - engaged through their five senses - and continuously evolves with new encounters.

Expression is, above all, language. But AI has now become "the Word." However, language - in its formal, algorithmic form - can never be confused with speech, which is alive, innovative, singular, and beyond the rigid constraints of computational rules.

Marital and Generational Zapping

Marital zapping is characterized by the proliferation of choices regarding gender identity, forms of cohabitation, and the number of partners. Long-term relationships have become increasingly difficult in a technological world dominated by "quick-swipe mode."

Generational zapping is also at play. When a child is conceived through surrogacy or artificial wombs, they miss out on the intrauterine relationship that traditionally develops between the body and psyche of the mother. As a result, they struggle to recognize her as the foundational model of otherness.

The bio-enhancement of children, along with the multiplication of parental figures, makes family history impossible to trace. And yet, children need to know where they come from in order to construct their personal narrative and situate themselves within the continuum of life.

Additionally, generations no longer live together: retirement homes, declining birth rates, shared housing, co-working spaces - all signs of a fragmented society.

Under transhumanist ideology, there will be the enhanced and the non-enhanced - leading to a profound disruption of authority.

Professional Zapping and the Transhumanist Illusion

In the workplace, professional zapping is increasingly common. Young people prioritize autonomy and work-life balance, frequently switching jobs. However, this permanent instability can have devastating consequences - for children, for relationships, and for society as a whole.

At its peak, transhumanism envisions an escape from space and time, without death and without eternity. Yet, this is an illusion - akin to a human dreaming of traveling into deep space without a spacesuit, ultimately self-destructing in the very attempt.

In an all-digital world, something transcendent - something that surpasses the human condition and gives meaning to our existence within time - is erased.

This is transcendental zapping.

Perspectives

After identifying the causes behind the loss of our conception of time - driven by technology and transhumanist ideology - Bioethics 2025 must take a stand in defense of a truly "de-technologized" world.

This means de-technologizing work, art, and leisure - reclaiming the full use of our five senses! It also means rejecting the technologization of procreation, the anthropomorphization of artificial intelligence and robotics, and the erosion of natural human relationships. Instead, we must reintegrate ourselves into natural time and its rhythms, seeking inner freedom through Nature, returning to the origins of Life, and countering both internal and global disorder.

The rhythms of time, which are nothing more than a perpetual repetition, create a space of security for us as human beings. Without them, we cease to exist.

Reaffirming the historical and cultural continuity of our humanity strengthens the ethical framework within which NBIC technologies should operate, encouraging us to inhabit time rather than escape it.

The fourteen "commons" described by Simone Weil in "Les besoins de l'âme" (The Needs of the Soul) serve as essential guideposts for Bioethics 2025.

We must reclaim an ethics founded on respect for the human body. While the body exists within space and matter, its defining characteristic as a living entity is that it also exists within its own unique temporal duration.

To pull on a flower in an attempt to make it grow faster is to uproot it. To manipulate the body's natural rhythms is to destroy what gives it meaning: the duration of its history.

Ethics must be grounded in a sense of history, which includes recognizing the richness of every stage of life.

The denial of history, depth, and the density of time is an attack on dignity - and therefore, an attack on what it means to be human.

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EL SUFRIMIENTO COMPARTIDO EN LA FAMILIA: UN CAMINO ESPIRITUAL PARA SANTO TOMÁS

Padre Simón Asumu Abeso Angué

Pedagogo

Guinea Ecuatorial



Resumen:

Este artículo explora el concepto del sufrimiento compartido en la familia desde la perspectiva de Santo Tomás de Aquino, destacando su relevancia para el crecimiento espiritual. A través del análisis de las enseñanzas de Santo Tomás, se examina cómo el sufrimiento, cuando es enfrentado con fe y solidaridad, puede fortalecer los lazos afectivos y espirituales dentro de la familia. Se discuten las dimensiones emocionales, espirituales, sociales, físicas y psicológicas del sufrimiento compartido, y se presentan ejemplos históricos y contemporáneos de familias que han encontrado consuelo y fortaleza en su fe común y en el apoyo mutuo. El artículo también compara el impacto del sufrimiento compartido con otras virtudes, como la caridad y la empatía, y ofrece aplicaciones prácticas para las familias modernas. En última instancia, se argumenta que el sufrimiento compartido puede ser un camino hacia el crecimiento espiritual y la unidad familiar.

Palabras-clave: Sufrimiento compartido, crecimiento espiritual, Santo Tomás de Aquino, unidad familiar, solidaridad.

Abstract:

This article explores the concept of shared suffering within the family from the perspective of Saint Thomas Aquinas, highlighting its relevance for spiritual growth. Through the analysis of Saint Thomas's teachings, it examines how suffering, when faced with faith and solidarity, can strengthen emotional and spiritual bonds within the family. The emotional, spiritual, social, physical, and psychological dimensions of shared suffering are discussed, along with historical and contemporary examples of families who have found comfort and strength in their common faith and mutual support. The article also compares the impact of shared suffering with other virtues, such as charity and empathy, and offers practical applications for modern families. Ultimately, it argues that shared suffering can be a path to spiritual growth and family unity.

Keywords: Shared suffering, spiritual growth, Saint Thomas Aquinas, family unity, solidarity.

Introducción

De qué Queremos Hablar

Queremos afirmar que el sufrimiento compartido en la familia es un tema de gran relevancia y profundidad, especialmente en el contexto de las enseñanzas de Santo Tomás de Aquino. En un mundo cada vez más interconectado y globalizado, las familias enfrentan una variedad de desafíos que pueden generar sufrimiento y estrés. Estos desafíos incluyen problemas económicos, enfermedades, conflictos interpersonales y crisis sociales. En este contexto, el sufrimiento compartido en la familia se convierte en una oportunidad para fortalecer los lazos familiares y promover el crecimiento espiritual, es decir, ocasión para unirse a Dios a través del prójimo.

Santo Tomás de Aquino, filósofo y teólogo más influyente de la historia, ofrece una perspectiva única, aunque no sistemática, sobre el sufrimiento y la caridad en el contexto familiar. Según él, el sufrimiento es una experiencia negativa que repeler, pero también viene a convertirse en un camino hacia el crecimiento espiritual por medio de la caridad. Al enfrentar el sufrimiento juntos, los miembros de la familia van a desarrollar una mayor empatía, compasión y comprensión mutua. Esto no solo fortalece los lazos familiares, sino que también promueve un ambiente de apoyo y crecimiento espiritual que propicia el encuentro con Dios.

En el contexto actual, donde las familias a menudo se enfrentan a la presión de mantener un equilibrio entre el trabajo, la educación y las responsabilidades personales, el sufrimiento compartido resulta una fuente de fortaleza y resiliencia. Las enseñanzas de Santo Tomás sobre la caridad y el sufrimiento proporcionan una guía valiosa para las

familias que buscan enfrentar estos desafíos de manera conjunta. La caridad, entendida como el amor desinteresado hacia los demás, es una virtud fundamental que puede ayudar a las familias a superar el sufrimiento y a encontrar significado y propósito en medio de las dificultades.

Además, el sufrimiento compartido en la familia puede tener un impacto positivo en la salud mental y emocional de sus miembros. Numerosos estudios han demostrado que el apoyo social y emocional dentro de la familia puede reducir el estrés, la ansiedad y la depresión. Al compartir el sufrimiento, los miembros de la familia se sienten más conectados y apoyados, lo cual contribuye a su bienestar general. Las enseñanzas de Santo Tomás sobre la importancia de la caridad y el apoyo mutuo son especialmente relevantes en este contexto, ya que proporcionan una base sólida para la construcción de relaciones familiares saludables y resilientes.

En definitiva, para nosotros el sufrimiento compartido en la familia es un tema de gran relevancia en el contexto actual. Las enseñanzas de Santo Tomás de Aquino ofrecen una perspectiva valiosa sobre cómo enfrentar dicha experiencia humana de manera conjunta y cómo la caridad puede ser una fuente de fortaleza y crecimiento espiritual. En un mundo lleno de desafíos y dificultades, el sufrimiento compartido en la familia se convierte en una oportunidad para fortalecer los lazos familiares, promover la empatía y la compasión, y encontrar significado y propósito en medio de las adversidades. Las familias que adoptan estas enseñanzas desarrollan en gran medida una mayor resiliencia y bienestar, que les permite enfrentar los desafíos de la vida con una actitud positiva y esperanzadora.

Quién Fue Santo Tomás de Aquino

Santo Tomás de Aquino, nacido en 1225 en el castillo de Roccasecca, cerca de Aquino, en el Reino de Sicilia (actual Italia), es uno de los filósofos y teólogos más influyentes de la historia. Perteneciente a una familia noble, fue el menor de ocho hijos. Desde temprana edad, mostró un gran interés por el conocimiento y la espiritualidad, que lo llevó a ingresar en la abadía benedictina de Montecassino a los cinco años, donde comenzó su educación formal.

A los catorce, Tomás fue enviado a la Universidad de Nápoles, donde estudió artes liberales y se familiarizó con las obras de Aristóteles. Fue en Nápoles donde conoció a los frailes dominicos y decidió unirse a la Orden de Predicadores, también conocida como los dominicos, en contra de los deseos de su familia. Esta decisión marcó el comienzo de su vida religiosa y académica.

En 1245, Tomás se trasladó a París para estudiar teología bajo la tutela de Alberto Magno (1200- 1280), uno de los más grandes eruditos de la época. Bajo la guía de Alberto, Tomás desarrolló su pensamiento filosófico y teológico, integrando las enseñanzas de Aristóteles con la doctrina cristiana. Esta síntesis de fe y razón se convirtió en una característica distintiva de su obra.

Después de completar sus estudios en París, Tomás enseñó en varias universidades europeas, incluyendo París, Colonia y Roma. Durante su carrera académica, escribió numerosas obras, siendo la más famosa la "Suma Teológica", una obra monumental que aborda casi todos los aspectos de la teología cristiana. En esta obra, Tomás expone sus ideas sobre la existencia de Dios, la moralidad, la naturaleza humana y la relación entre la fe y la razón.

Tomás de Aquino también es conocido por su enfoque en la ética y la moralidad. Desarrolló una teoría ética basada en la ley natural, que sostiene que los principios morales son inherentes a la naturaleza humana y pueden ser descubiertos a través de la razón. Esta teoría ha tenido una influencia duradera en la filosofía moral y sigue siendo relevante en el debate ético contemporáneo.

Además de su trabajo académico, Tomás de Aquino fue un hombre de profunda espiritualidad. Su devoción a la oración y la contemplación se refleja en sus escritos místicos y en su amor por la Eucaristía. Fue canonizado como santo por la Iglesia Católica en 1323 y declarado Doctor de la Iglesia en 1567, en reconocimiento a su contribución a la teología y la filosofía cristiana.

Santo Tomás de Aquino falleció el 7 de marzo de 1274 en la abadía de Fossanova, mientras se dirigía al Concilio de Lyon. Su legado perdura hasta el día de hoy, y sus enseñanzas continúan siendo estudiadas y veneradas en todo el mundo. Su enfoque en la integración de la fe y la razón, así como su énfasis en

la caridad y la moralidad, siguen siendo una fuente de inspiración para aquellos que buscan comprender y vivir de acuerdo con los principios cristianos.

Qué Importancia tiene el Sufrimiento Compartido en la Familia según Santo Tomás

El sufrimiento compartido en la familia es un tema que podemos deducir de las enseñanzas de Santo Tomás de Aquino. Su visión del sufrimiento se puede entresacar de su concepto del mal como ausencia de bien. En este sentido, para él, el sufrimiento no solo es una experiencia negativa inevitable, sino que también se revela como una oportunidad para el despertar espiritual, el crecimiento personal y la caridad, siempre que seamos capaces de descubrir la compañía de alguien con mayúscula. Según Santo Tomás,

el sufrimiento puede ser un medio para fortalecer los lazos familiares y promover un ambiente de apoyo y comprensión mutua. Veamos por qué vías.

El Sufrimiento como Camino hacia el Encuentro: la caridad

Para Santo Tomás, la caridad es la virtud teologal más importante, y el sufrimiento compartido en la familia es una manifestación práctica de esta virtud. La caridad, entendida como el amor desinteresado de Dios hacia nosotros y de nosotros hacia los demás, por amor a Dios, se fortalece cuando los miembros de la familia enfrentan el sufrimiento juntos. Al compartir el sufrimiento, los miembros de la familia desarrollan una mayor empatía y compasión. Esto les permite apoyarse mutuamente y mostrar amor incondicional no por simple filantropía, sino sostenidos por el Altísimo, de quien viene la caridad.

Fortalecimiento de los Lazos Familiares

El sufrimiento compartido también tiene el potencial de fortalecer los lazos familiares. Cuando los miembros de la familia enfrentan dificultades juntos, se crea un sentido de unidad y solidaridad. Esta experiencia compartida ayuda a construir relaciones más profundas y significativas, basadas en la confianza y el apoyo mutuo. Santo Tomás enfatiza la importancia de la comunidad y el apoyo mutuo, y el sufrimiento compartido en la familia es una forma de vivir estos principios en la práctica.

Recuerdo una época difícil en mi familia cuando mi padre enfermó gravemente. Fue un momento de gran sufrimiento para todos nosotros, pero también fue una oportunidad para unirnos más que nunca. Cada día, nos turnábamos para cuidarlo, asegurándonos de que nunca estuviera solo. Mi madre, mis hermanos y yo pasábamos largas horas juntos, compartiendo historias, risas y lágrimas.

A través de esta experiencia, aprendimos a apoyarnos mutuamente de una manera que nunca habíamos hecho antes. La enfermedad de mi padre nos enseñó el verdadero significado de la solidaridad y la importancia de estar presentes para los demás. Aunque fue un tiempo de dolor, también fue un tiempo de crecimiento y fortalecimiento de nuestros lazos familiares.

Santo Tomás tenía razón al enfatizar la importancia de la comunidad y el apoyo mutuo. El sufrimiento compartido en nuestra familia no solo nos ayudó a superar la adversidad, sino que también nos permitió vivir estos principios en la práctica, creando relaciones más profundas y significativas basadas en la confianza y el apoyo mutuo.

Crecimiento Espiritual

El sufrimiento, según Santo Tomás, puede ser un camino hacia el crecimiento espiritual. Al enfrentar el sufrimiento con una actitud de aceptación y confianza en Dios, los miembros de la familia encuentran significado y propósito en medio de las dificultades. Esta perspectiva les permite seguir viendo el sufrimiento como una experiencia negativa, pero sobre todo se abren a una realidad más allá que les une. Es cuando el sufrimiento se convierte en esta oportunidad que cualquiera necesita para crecer espiritualmente y acercarse más a Dios. El sufrimiento compartido en la familia resulta entonces una fuente de fortaleza espiritual, ayudando a los miembros de la familia a desarrollar una fe más profunda y una mayor confianza en la providencia divina.

Apoyo Emocional y Mental

El sufrimiento compartido en la familia también tiene un impacto positivo en la salud emocional y mental de sus miembros. Numerosos estudios han demostrado que el apoyo social y emocional dentro de la familia puede reducir el estrés, la ansiedad y la depresión. Al compartir el sufrimiento, los miembros de la familia se sienten más conectados y apoyados. Esto contribuye a su bienestar general. Las enseñanzas de Santo Tomás sobre la importancia de la caridad y el apoyo mutuo son especialmente relevantes en este contexto, ya que proporcionan una base sólida para la construcción de relaciones familiares saludables y resilientes.

Ejemplos Prácticos

En la práctica, el sufrimiento compartido en la familia puede manifestarse de diversas formas. Por ejemplo, cuando un miembro de la familia enfrenta una enfermedad grave, los demás miembros pueden ofrecer apoyo emocional, cuidar de sus necesidades y rezar juntos por su recuperación. Este acto de compartir el sufrimiento no solo alivia la carga del individuo enfermo, sino que también fortalece los lazos familiares y promueve un ambiente de amor y compasión. En este momento el dolor deja de ser sufrimiento, porque se desplaza la atención. Y podemos comprender aquello de que no es tanto lo que te ocurre en la vida, sino cómo lo interpretamos.

En definitiva, queremos afirmar en este artículo que el sufrimiento compartido en la familia es un tema de gran importancia en las enseñanzas de Santo Tomás de Aquino. Que, al enfrentar el sufrimiento juntos, los miembros de la familia pueden desarrollar una mayor empatía, compasión y comprensión mutua, lo que fortalece los lazos familiares y promueve el crecimiento espiritual. Que las enseñanzas de Santo Tomás sobre la caridad y el sufrimiento proporcionan una guía valiosa para las familias que buscan enfrentar los

desafíos de la vida de manera conjunta y encontrar significado y propósito en medio de las dificultades.

1. Marco Teórico y Conceptual

A continuación, nos referiremos a la base conceptual y filosófica que sustenta el análisis y las ideas presentadas en este artículo. Lo haremos proporcionando la estructura y el contexto necesarios para entender y analizar el tema del sufrimiento compartido en la familia desde la perspectiva de Santo Tomás de Aquino.

1.1. Definición de sufrimiento y caridad según Santo Tomás

Santo Tomás de Aquino, en su obra maestra la "Suma Teológica", lo mismo que en algunas obras académicas y comentarios bíblicos, ofrece una visión profunda y detallada sobre el sufrimiento y la caridad, dos conceptos fundamentales en su filosofía. Para Santo Tomás, el sufrimiento y la caridad están intrínsecamente relacionados y se prestan mutuamente para el crecimiento espiritual del ser humano.

1.1.1. Definición de sufrimiento

El sufrimiento, en Santo Tomás de Aquino, es una experiencia inevitable en la vida humana sólo entendida desde el misterio del mal, que se explica como ausencia del bien que más se visibiliza cuando más ausente. Desde esta perspectiva el sufrimiento puede tener un propósito redentor y transformador. En la "Suma Teológica", Santo Tomás argumenta que el sufrimiento puede ser una consecuencia del pecado original y de las imperfecciones inherentes a la condición humana. Analiza el modo como se causan las cosas directa e indirectamente. De este modo último atribuye al pecado el origen del mal Et hoc modo peccatum primi parentis est causa mortis et omnium huiusmodi defectuum in natura humana, inquantum per peccatum primi parentis sublata est originalis iustitia, per quam non solum inferiores animae vires continebantur sub ratione absque omni deordinatione, sed totum corpus continebatur sub anima absque omni defectu, ut in primo habitum est. Et ideo, subtracta hac originali iustitia per peccatum primi parentis, sicut vulnerata est humana natura quantum ad animam per deordinationem potentiarum, ut supra dictum est; ita etiam est corruptibilis effecta per deordinationem ipsius corporis. Subtractio autem originalis iustitiae habet rationem poenae, sicut etiam subtractio gratiae. Unde etiam mors, et omnes defectus corporales consequentes, sunt quaedam poenae originalis peccati. Et quamvis huiusmodi defectus non sint intenti a peccante, sunt tamen ordinati secundum iustitiam Dei punientis.

(Aquino, 1888, ST, I-II, q. 85, a. 5 c)

Sin embargo, también sostiene que el sufrimiento puede ser una oportunidad para la purificación y el crecimiento espiritual. Según él, el sufrimiento nos permite desarrollar virtudes como la paciencia, la fortaleza y la humildad, y nos acerca más a Dios (ST, II-II, q. 123; 136).

Santo Tomás distingue entre el sufrimiento de origen físico y el sufrimiento de origen espiritual. El sufrimiento

físico se refiere al dolor corporal y las enfermedades, mientras que el sufrimiento espiritual se relaciona con el dolor emocional y psicológico, como la tristeza, la angustia y la desesperación. En este sentido debemos comprender que el sufrimiento se origina como respuesta o reacción al cualquier tipo de dolor y que como tal nosotros tenemos la posibilidad de que el dolor no se transforme en sufrimiento. Por eso ambos tipos de sufrimiento pueden ser utilizados por Dios para nuestro bien espiritual, siempre y cuando los enfrentemos con una actitud de fe y confianza en su providencia (ST, I-II, q. 35).

1.1.2. Definición de caridad

Por su parte la caridad, para Santo Tomás, viene a ser la virtud teologal más elevada y la que nos une directamente con Dios. En la "Suma Teológica", define la caridad como la amistad del hombre con Dios que tiene origen en Dios y se manifiesta en el amor desinteresado hacia los demás.

Non quilibet amor habet rationem amicitiae, sed amor qui est cum benevolentia , quando scilicet sic amamus aliquem ut ei bonum velimus. [...] Sed nec benevolentia sufficit ad rationem amicitiae, sed requiritur quaedam mutua amatio, quia amicus est amico amicus. Talis autem mutua benevolentia fundatur super aliqua communicatione. Cum igitur sit aliqua communicatio hominis ad Deum secundum quod nobis suam beatitudinem communicat, super hac communicatione oportet aliquam amicitiam fundari. De qua quidem communicatione dicitur I ad Cor. I, fidelis Deus, per quem vocati estis in societatem filii eius. Amor autem super hac communicatione fundatus est caritas. Unde manifestum est quod caritas amicitia quaedam est hominis ad Deum. (Aquino, 1888, ST, II-II, q. 23, a. 1 c)

La caridad es, por tanto, una expresión del amor divino que nos impulsa a buscar el bien del prójimo sin esperar nada a cambio. Santo Tomás sostiene que la caridad es la raíz de todas las virtudes y la que las perfecciona. Sin caridad, ninguna otra virtud puede ser verdaderamente perfecta, ya que la caridad es la que nos mueve a actuar por amor a Dios, como fin último, y al prójimo por amor a Dios (ST, II-II, q. 23, a. 8). Además, la caridad

no se limita a actos de generosidad material, sino que también incluye el amor y la compasión hacia los demás, así como el deseo de su bienestar espiritual.

1.1.3. Relación entre sufrimiento y caridad

En la filosofía de Santo Tomás, el sufrimiento y la caridad están estrechamente vinculados. El sufrimiento, cuando se enfrenta con una actitud de caridad, resulta una oportunidad propicia para el crecimiento espiritual que nos une con Dios. Ya que inevitablemente el sufrimiento enciende los mecanismos de la búsqueda interior por medio de las potencias del alma. Es en este sentido que la caridad nos permite ver el sufrimiento de los demás con compasión y nos impulsa a actuar para aliviar su dolor. Al mismo tiempo, el sufrimiento personal, cuando se ofrece a Dios con amor y confianza, puede convertirse en una forma de participar en el sufrimiento redentor de Cristo y de crecer en santidad. Esta participación se fundamenta en el valor universal de la oblación de Cristo.

Christus autem, ex caritate et obedientia patiendo, maius aliquid Deo exhibuit quam exigeret recompensatio totius offensae humani generis. Primo quidem, propter magnitudinem caritatis ex qua patiebatur. Secundo, propter dignitatem vitae suae, quam pro satisfactione ponebat, quae erat vita Dei et hominis. Tertio, propter generalitatem passionis et magnitudinem doloris assumpti, ut supra dictum est. Et ideo passio Christi non solum sufficiens, sed etiam superabundans satisfactio fuit pro peccatis humani generis, secundum illud I Ioan. II, ipse est propitiatio pro peccatis nostris, non pro nostris autem tantum, sed etiam pro totius mundi.

(Aquino, 1888, ST, III, q. 48, a. 2 c)

Este ofrecimiento y participación en los sufrimientos de Cristo es posible porque el cristiano, como tal, es miembro del cuerpo místico de Cristo. Él es quien ha asumido todos nuestros sufrimientos. Ha hecho posible que cada yugo y carga nuestra de cualquier índole sea ligera. Porque él traslada también su victoria en ella y lo lleva él con nosotros. Se trata de que nosotros hagamos más consciente esta unión y vivamos con esperanza confiada y nos sepamos acompañados ahora teniendo en cuenta su presencia sufriente en nosotros.

Santo Tomás también destaca la importancia de la caridad en el contexto familiar. Dice, basándose en la doctrina de San Agustín y Dionisio, que la familia, como núcleo fundamental de la sociedad, es el lugar donde se experimenta el sufrimiento de manera más intensa y compartida. La caridad en la familia se manifiesta en el apoyo mutuo, la empatía y el sacrificio por el bienestar de los demás. Su argumento se fija en el orden de

la naturaleza “Est autem talis ordo naturae ut unumquodque agens naturale per prius magis diffundat suam actionem ad ea quae sunt sibi propinquiora, sicut ignis magis calefacit rem sibi magis propinquam”. Cuando una familia enfrenta el sufrimiento de manera conjunta, se fortalecen los lazos de amor y solidaridad, y se promueve el crecimiento espiritual de todos sus miembros. Por eso sigue afirmando “Sed propinquitatis unius hominis ad alium potest attendi secundum diversa in quibus sibi ad invicem homines communicant, ut consanguinei naturali communicatione, concives in civili, fideles in spirituali, et sic de aliis” (Aquino, 1888, ST, II-II, q. 31, a. 3 c).

1.1.4. Aplicabilidad en el mundo actual

La visión de Santo Tomás sobre el sufrimiento y la caridad sigue siendo relevante en el mundo moderno. En un contexto global marcado por crisis humanitarias, desigualdades sociales y desafíos económicos, la caridad se presenta como una respuesta necesaria y urgente. Las acciones caritativas, ya sea a través de donaciones, voluntariado o la creación de organizaciones no gubernamentales, tienen el poder de transformar vidas y comunidades.

Además, la caridad tiene un impacto positivo en la salud mental y el bienestar emocional de quienes la practican. Varios estudios han demostrado que la participación en actividades caritativas reduce considerablemente los niveles de estrés y ansiedad, y aumenta el sentido de propósito y satisfacción

personal¹ (de Recompensa) Al practicar la caridad, desarrollamos una mayor empatía y comprensión hacia los demás, lo cual enriquece nuestras relaciones interpersonales y fortalece el tejido social.

Por lo tanto, la definición de sufrimiento y caridad según Santo Tomás de Aquino ofrece una guía valiosa para enfrentar el sufrimiento humano con amor y compasión. Al practicar la caridad, no solo aliviamos el dolor de los demás, sino que también promovemos nuestro propio crecimiento espiritual y contribuimos a la construcción de un mundo más equitativo y compasivo.

1.2. La visión de Santo Tomás sobre la familia y su papel en el crecimiento espiritual

Santo Tomás de Aquino, en su obra "Suma Teológica", ofrece una perspectiva profunda y detallada, aunque no sistemática, sobre la familia y su papel en el crecimiento espiritual del ser humano. Para Santo Tomás, la familia es una institución fundamental que proporciona un entorno propicio para el desarrollo de las virtudes y la vida espiritual.

1.2.1. La familia como núcleo de la sociedad

Santo Tomás considera a la familia como el núcleo básico de la sociedad, donde se forman y desarrollan las virtudes esenciales para la vida en comunidad. Según él, la familia, nacida del amor humano está formado por los que son de la misma sangre: “In cultu autem parentum includitur cultus omnium consanguineorum, quia etiam consanguinei ex hoc dicuntur quod ex eisdem parentibus processerunt, ut patet per philosophum, in VIII Ethic.” (ST, II-II, q 101, a 1c) es el primer lugar donde se experimenta el amor, la caridad y el apoyo mutuo, y donde se aprenden los valores fundamentales que guiarán la vida de los individuos (ST, II-II, q. 26, a. 9). La familia, por tanto, no solo es una unidad social, sino también una comunidad espiritual que contribuye al crecimiento y la santificación de sus miembros.

1.2.2. El papel de la caridad en la familia

La caridad, entendida como el amor desinteresado y la compasión hacia los demás, es una virtud central en la filosofía de Santo Tomás. En el contexto familiar, la caridad se manifiesta en el apoyo mutuo, la empatía y el sacrificio por el bienestar de los demás. Santo Tomás sostiene que la caridad es la virtud que nos une a Dios y nos permite amar a nuestro prójimo de manera genuina y desinteresada, incluso al enemigo o al pecador “et hoc modo caritas, quae maxime est amicitia honesti, se extendit ad peccatores, quos ex caritate diligimus propter Deum.” (Aquino, 1888, ST, II-II, q. 23, a. 1, ad-3). En la familia, la caridad

¹ En el ámbito anglófono y español, se destacan varios estudios. Por ejemplo, un estudio publicado por los National Institutes of Health (NIH) (Institutos Nacionales de Salud) el 3 de octubre de 2023 encontró que las actividades caritativas, como el voluntariado, pueden reducir los niveles de cortisol, una hormona asociada con el estrés. En el Journal of Happiness Studies, una investigación con datos de casi 70,000 participantes en el se convierte en el fundamento de las relaciones interpersonales y en la base para enfrentar juntos las dificultades y el sufrimiento.

Reino Unido mostró el 3 de julio de 2020 que las personas que hacían el voluntariado regularmente reportaban una mejor salud mental y mayor satisfacción con la vida. La Mayo Clinic Health System también destacó el 1 de agosto de 2023 que el voluntariado puede reducir la depresión y la ansiedad, especialmente en personas mayores de 65 años, y aumentar los sentimientos positivos y relajados al liberar dopamina. En España, un estudio publicado en la revista Ansiedad y Estrés en su volumen 22 del año 2016 encontró que las actividades artístico-recreativas pueden reducir el estrés percibido y mejorar el bienestar emocional.

1.2.3. El sufrimiento compartido en la familia

Santo Tomás reconoce que, en el seno de la familia, el sufrimiento compartido puede transformarse en una oportunidad para el crecimiento espiritual y la fortaleza emocional. Como hemos afirmado, cuando enfrentamos el sufrimiento con una actitud de caridad y una confianza radical en la victoria de Cristo sobre todo dolor, permitiéndole llevar también nuestras cargas, estas se vuelven ligeras. Así, participamos en el sufrimiento redentor de Cristo y crecemos en santidad a medida que aumentamos nuestra confianza y “dejamos” que Cristo venza y reine en nuestro sufrimiento. (ST, III, q. 48, a. 2).

En este sentido, el sufrimiento compartido en la familia nos enseña la importancia de la humildad y la gratitud. Al reconocer nuestras propias limitaciones y la necesidad de apoyo, desarrollamos una mayor humildad y una apreciación más profunda por la ayuda que recibimos. El milagro se produce con el verbo "dejar", que me permite ponerme en un segundo plano. En este momento, aunque el dolor siga sin resolverse, ya no es mi problema ni mi sufrimiento. He pasado la responsabilidad a Otro y a otros. En definitiva, el secreto está en el acto de saber dejar. Esta actitud nos permite enfrentar el sufrimiento con una perspectiva más positiva y constructiva, transformando el dolor en una oportunidad para el crecimiento espiritual. Crezco en confianza, reconociendo que no soy ni el origen, ni el sostén, ni mucho menos el gerente de mi vida; crezco en humildad y en gratitud. (ST, II-II, q. 31, a. 3). Ya que dispone el alma humana con la actitud más conveniente para esperar en Dios.

1.2.4. La educación en valores y virtudes

Santo Tomás también destaca el papel de la familia en la educación en valores y virtudes. Según él, la familia es el primer lugar donde se enseñan y practican las virtudes teologales y cardinales, como la fe, la esperanza, la caridad, la prudencia, la justicia, la fortaleza y la templanza (ST, II-II, q. 47, a. 1). Los padres despiertan en los hijos estos valores por medio del ejemplo de vida virtuosa directa en la que se rezuma amor y respeto mutuo. En el contexto familiar, no todo comportamiento es aceptable ni susceptible de ser considerado valor o virtud. Es importante distinguir lo que hace que una cosa sea valioso o virtuoso. Para Santo Tomás esto no es sino la vida y una vida en plenitud de felicidad. La educación en valores y virtudes dentro de la familia debe centrarse en la defensa de la vida humana en todas sus etapas. Esto contribuye al crecimiento espiritual de cada individuo y fortalece la cohesión y estabilidad de la familia en su conjunto. Al practicar la caridad y otras virtudes en la vida diaria, los miembros de la familia desarrollan una mayor empatía y comprensión hacia los demás, enriqueciendo

sus relaciones interpersonales y promoviendo un fuerte sentido de comunidad y solidaridad. (ST, II-II, q. 31, a. 3)

Por el contrario, si nos dejamos llevar por la corriente según la cual cualquier cosa puede ser considerado valor o virtud de cualquier manera, en vez de conducirnos a una vida plena de felicidad, nos volverá al egoísmo y al consiguiente decrecimiento espiritual.

1.3.5. La familia como escuela de amor y santidad

En esta misma línea, es importante reconocer que, para Santo Tomás, la familia es una escuela de amor y santidad donde se aprende a amar a Dios y al prójimo de manera genuina y desinteresada. En el seno familiar, los individuos tienen la oportunidad de practicar la caridad en su forma más pura, ofreciendo su amor y apoyo sin esperar nada a cambio. Esta práctica de la caridad en el contexto familiar fortalece los lazos de amor y solidaridad, contribuyendo al crecimiento espiritual de todos sus miembros (Aquino, 1888, ST, II-II, q. 23, a. 8).

Dicho crecimiento se puede observar en los miembros de esta familia, ya que, gracias a la fortaleza de sus vínculos, se descubren parte de un lazo mayor y mucho más estable: el vínculo que los une a Dios. Este amor divino no se acaba ni abandona en ninguna dificultad, incluida la muerte. Los miembros de la familia crecen con una estabilidad afectiva propia de quienes no necesitan mendigar amor ni reconocimiento de ningún tipo. Cuando se casen, no estarán exigiendo en la pareja lo que solo Dios puede dar, sino que estarán mucho más preparados para vivir en la familia lo que Dios ha hecho con ellos. En todo caso, es bueno saber que, aunque la familia viva el amor perfecto, el amor de Dios es mucho más estable que el humano.

Esta visión de Santo Tomás sobre la familia y su papel en el crecimiento espiritual sigue siendo mucho más relevante en el mundo moderno. En un contexto global marcado por crisis humanitarias, desigualdades sociales y desafíos económicos, y en que esta misma institución sagrada se ve atacada de diversas maneras y de diversos frentes, la familia se presenta como un refugio de amor y apoyo donde se pueden enfrentar juntos las dificultades y el sufrimiento. La caridad, como virtud central en la filosofía de Santo Tomás, nos sigue ofreciendo una guía para vivir de manera más compasiva y justa, y para promover el bienestar y la santificación de todos los miembros de la familia.

En definitiva, podemos ver también en la visión de Santo Tomás sobre la familia y su papel en el crecimiento espiritual otra guía valiosa que nos permite gestionar el sufrimiento humano con amor y compasión. Al practicar la caridad en el contexto

familiar, aliviamos el dolor de los demás, promovemos nuestro propio crecimiento espiritual y contribuimos a la construcción de un mundo más equitativo y compasivo.

1.3. Comparación con otras filosofías y religiones sobre el sufrimiento y la familia

El sufrimiento y la familia son apreciados en otras muchas filosofías y religiones alrededor del mundo. Aunque cada tradición tiene su propia perspectiva y enfoque, existen puntos en común que nos permiten comprender mejor la importancia del sufrimiento compartido y el papel de la familia en el crecimiento espiritual. A continuación, compararemos la visión de Santo Tomás de Aquino con las perspectivas del islam, el hinduismo y el budismo.

1.3.1. Comparación con el Islam

En el islam, se comparte la visión del sufrimiento como una prueba de fe y una oportunidad para el crecimiento espiritual. Según el Corán, el sufrimiento purifica el alma y acerca a los creyentes a Dios (Esposito, 2002). En cuanto a la familia, en el islam, se trata de una institución sagrada que proporciona apoyo emocional y espiritual a sus miembros. Los musulmanes creen que el sufrimiento compartido en la familia fortalece los lazos de amor y solidaridad, y que la paciencia y la perseverancia en tiempos de dificultad son virtudes altamente valoradas. (Esposito, 2002, p. 105)

La caridad, conocida como Zakat, es uno de los cinco pilares del islam y desempeña una función singular en la manera en que los musulmanes enfrentan el sufrimiento. El término "zakat" proviene del árabe (zakāh), que significa "pureza" o "aquello que purifica" (Esposito, 2002, p. 163). En el contexto del Islam, el zakat es una forma de limpiar y purificar los ingresos y la riqueza, y así obtener la bendición de Dios. Es el tercer pilar del islam y su importancia es indiscutible. El zakat implica dar una parte de los ingresos a los necesitados, con la finalidad de aliviar el sufrimiento de los demás y purificar el alma del donante. De esta manera, se fomenta un sentido singular de comunidad y responsabilidad social.

1.3.2. Comparación con el Hinduismo

En el hinduismo, el sufrimiento es entendido como una parte inevitable de la vida humana, influenciada por el karma y las acciones pasadas. A pesar de ello, también los hindúes creen en el papel del sufrimiento como una oportunidad para aprender y crecer espiritualmente (Flood, 1996). Por su parte la familia, en el hinduismo, se considera como una unidad social fundamental donde se practican y transmiten los valores y las enseñanzas espirituales. (Madan, T. N. 2022 pp. 275-289).

En cuanto a la caridad, conocida como dāna, se trata de una virtud importante en el hinduismo. El término "dāna" proviene del verbo sánscrito "da", que significa "dar". Dāna implica dar generosamente a los demás sin esperar nada a cambio. Existen diferentes tipos de dāna en el hinduismo, cada uno con su propio significado y propósito: Anna Dāna, la donación de alimentos a los hambrientos; Vastra Dāna, la donación de ropa a los necesitados; Vidya Dāna, la donación de conocimiento o educación; Aushadha Dāna, la donación de medicinas a los enfermos; y Abhaya Dāna, la donación de protección o refugio a los desamparados. Dāna se considera una forma de purificar el alma y acumular buen karma (Flood, 1996).

En el contexto familiar, la caridad se manifiesta en el apoyo mutuo y el cuidado de los miembros de la familia, especialmente en tiempos de sufrimiento. Los hindúes creen que el sufrimiento compartido en la familia fortalece los lazos de amor y promueve el crecimiento espiritual de todos sus miembros (Madan, T. N. 2022 p. 296)

1.3.3. Comparación con el Budismo

En el budismo, el sufrimiento también es una parte central de la vida y se considera una de las Cuatro Nobles Verdades. Según el Buda, el sufrimiento es causado por el deseo y el apego. Porque nos mantienen atrapados en un ciclo de insatisfacción y dolor. Cuando deseamos algo y no lo obtenemos, sufrimos. Cuando obtenemos lo que deseamos, pero luego lo perdemos, también sufrimos. Incluso cuando obtenemos lo que deseamos y lo mantenemos, sufrimos porque tememos perderlo o porque eventualmente nos aburriríamos y deseamos algo nuevo. Puede ser superado reconociendo y abandonándolos a través del camino óctuple, que incluye prácticas como la meditación, la ética y la sabiduría (Harvey, 2000, p. 52). La familia, en el budismo, es vista como un entorno donde se pueden practicar estas enseñanzas y desarrollar la compasión y la sabiduría.

La caridad, conocida también aquí como Dana, es una práctica fundamental en el budismo. Dana implica dar generosamente a los demás y se considera una forma de cultivar la compasión y reducir el apego. En el contexto familiar, la caridad se manifiesta en el apoyo mutuo y el cuidado de los miembros de la familia, especialmente en tiempos de sufrimiento. Los budistas creen que el sufrimiento compartido en la familia puede ser una oportunidad para practicar la compasión y el desapego, y para promover el crecimiento espiritual de todos sus miembros (Harvey, 2000, p. 102).

1.3.4. Comparación con la visión de Santo Tomás

La visión de Santo Tomás de Aquino sobre el sufrimiento y la familia comparte varios puntos en común con filosofías y religiones como el islam, el hinduismo y el budismo.

Al igual que estas tradiciones, Santo Tomás ve el sufrimiento como una oportunidad para el crecimiento espiritual y la purificación del alma. En su filosofía, la caridad es una virtud central que nos une a Dios y nos permite amar a nuestro prójimo de manera genuina y desinteresada (Aquino, 1888, ST, II-II, q. 23, a. 1).

Sin embargo, Santo Tomás establece un carácter singular del cristianismo al definir la caridad como un atributo que define a Dios. En su singularidad de ser hombre sufriente, Cristo guarda el privilegio de definir lo que ha de ser la caridad: la explica como amor verdadero porque llega hasta el extremo de compartir la suerte de sus amados, entregando la propia vida al sufrimiento por amor. Es caridad por compasión porque busca el bien de los hombres, salvándoles de las miserias del sufrimiento y, sobre todo, de la miseria del corazón, la miseria espiritual, la más radical como es el pecado. Además, es una caridad vivida con pureza de corazón, sin apegos a amores que no son Dios.

En el contexto familiar, Santo Tomás destaca la importancia del apoyo mutuo, la empatía y el sacrificio por el

bienestar de los demás. Al igual que en el islam, el hinduismo y el budismo, la caridad en la familia se manifiesta en el cuidado y el apoyo de los miembros de la familia, especialmente en tiempos de sufrimiento. Santo Tomás sostiene que el sufrimiento compartido en la familia puede fortalecer los lazos de amor y solidaridad, y promover el crecimiento espiritual de todos sus miembros (, II-II, q. 31, a. 3).

Por tanto, creemos que, aunque existen diferencias en las perspectivas y enfoques de estas filosofías y religiones, todas comparten la idea de que el sufrimiento y la caridad son esencialmente imprescindibles en el crecimiento espiritual y en el fortalecimiento de los lazos familiares. La visión

de Santo Tomás de Aquino sobre el sufrimiento y la familia ofrece una guía valiosa para enfrentar el sufrimiento humano con amor y compasión, y para promover el bienestar y la santificación de todos los miembros de la familia.

2. Dimensiones del Sufrimiento Compartido

En esta oportunidad queremos nos referirnos a los diferentes aspectos y niveles en los que el sufrimiento compartido puede influir y manifestarse en una familia abarcando los aspectos emocionales, sociales y espirituales y mostrando la función que cada una de ellas tiene cuando las personas enfrentan y superan las adversidades.

2.1. Dimensión Emocional

El ser humano tiene la capacidad de experimentar, identificar y gestionar las emociones. Una emoción es una respuesta automática y rápida del cuerpo y la mente a un estímulo

externo o interno. Las emociones son intensas y de corta duración, como el miedo, la alegría o la ira. A veces se confunden con los sentimientos, que son la interpretación consciente y subjetiva de una emoción. Los sentimientos son más duraderos y menos intensos que las emociones, como el amor, la tristeza o la gratitud.

En este sentido, las emociones son la base de los sentimientos. Cuando experimentamos una emoción, nuestro cerebro la procesa y la interpreta, convirtiéndola en un sentimiento. Por ejemplo, sentir miedo (emoción) puede llevar a un sentimiento de inseguridad. Así, las emociones actúan como desencadenantes que, al ser interpretados por nuestra mente, se transforman en sentimientos más complejos y duraderos.

2.1.1. Impacto emocional del sufrimiento compartido en la familia

El sufrimiento compartido en la familia tiene un impacto emocional profundo y multifacético. Cuando los miembros de una familia enfrentan juntos situaciones de dolor y adversidad, se generan dinámicas emocionales complejas que pueden afectar tanto a nivel individual como colectivo. Este sufrimiento compartido puede surgir de diversas fuentes, como enfermedades, crisis económicas, conflictos

interpersonales y pérdidas. A pesar de su dolor, el sufrimiento compartido puede convertirse en una oportunidad para el crecimiento emocional y la fortaleza familiar.

Las afectaciones individuales pueden ser variadas y profundas. Las personas pueden experimentar altos niveles de estrés y ansiedad debido a la incertidumbre y la presión emocional de la situación. También pueden producirse sentimientos de tristeza profunda y desesperanza, lo que puede desencadenar episodios depresivos. En otras ocasiones, algunos individuos pueden sentirse abrumados y optar por aislarse de los demás, lo que puede afectar sus relaciones y su bienestar emocional. La manifestación física de estos sentimientos y emociones muestra la simbiosis entre el cuerpo y la mente, y no tardarán en aparecer problemas de salud física, como dolores de cabeza, problemas digestivos o trastornos del sueño. Incluso puede afectar su autoestima, ya sea fortaleciéndola o debilitándola.

Sin embargo, uno de los impactos emocionales más significativos del sufrimiento compartido es el fortalecimiento de los lazos afectivos entre los miembros de la familia. Al enfrentar juntos las dificultades, los miembros de la familia desarrollan una mayor empatía y comprensión hacia los demás. Esta empatía se manifiesta en el apoyo mutuo y en la disposición para escuchar y consolar a quienes están sufriendo. En "Amoris Laetitia", el Papa Francisco destaca la importancia de la solidaridad y el acompañamiento en la familia, subrayando que "la familia es el lugar donde se aprende a convivir en la

diferencia, a perdonar y a ser perdonado, y donde se experimenta la ayuda mutua" (Francisco, 2016, AL, n. 19ss). Así, las familias que comparten el sufrimiento tienden a desarrollar una mayor cohesión y resiliencia emocional, fortaleciendo su capacidad para enfrentar las adversidades con amor y unidad.

El sufrimiento compartido también puede generar un sentido de propósito y significado en la vida de los individuos. Al enfrentar el dolor y la adversidad, los miembros de la familia pueden encontrar un sentido de propósito en el apoyo y el cuidado de los demás. Este sentido de propósito puede proporcionar una fuente de motivación y fortaleza emocional, ayudando a los individuos a superar las dificultades y a encontrar un sentido de esperanza y optimismo en medio del sufrimiento. Según Moreno (2010, p. 31ss), la resiliencia individual se fortalece a través de estas experiencias compartidas, ya que permiten a las personas desarrollar una mayor capacidad para enfrentar y superar los desafíos de la vida.

Sin embargo, el sufrimiento compartido también puede tener efectos negativos en la salud emocional de los miembros de la familia. El estrés y la ansiedad generados por las situaciones de sufrimiento pueden afectar el bienestar emocional de los individuos, llevando a problemas como la depresión y el agotamiento emocional. Es fundamental que las familias desarrollen estrategias efectivas para manejar el sufrimiento y proporcionar apoyo emocional a quienes lo necesitan. Para Santo Tomás de Aquino, una estrategia saludable es la conciencia de la presencia en la vida familiar de los miembros de la familia junto al que sufre, pero sobre todo la presencia de Dios que sufre con nosotros (ST, II-II, q. 30, a. 1).

2.1.2. Ejemplos de apoyo emocional en situaciones de sufrimiento

El apoyo emocional es una herramienta esencial para enfrentar el sufrimiento compartido en la familia. A continuación, se presentan algunos ejemplos de cómo las familias pueden proporcionar apoyo emocional en situaciones de sufrimiento.

Un primer modo destacable de llevar a cabo el apoyo emocional en la familia es a través de la escucha activa y la empatía. Al escuchar de manera atenta y sin juzgar, los miembros de la familia pueden ofrecer un espacio seguro para que los demás expresen sus sentimientos y emociones. Sin embargo, padres y hermanos mayores autoritarios habitualmente impiden la creación de este ambiente al no cultivar confianza y sembrar miedo en las relaciones. Por otro lado, padres demasiado laxos pueden no tomar las riendas a tiempo debido a una excesiva confianza. En todo caso, un sano equilibrio es conveniente para todos.

La empatía, por su parte, implica ponerse en el lugar del otro y comprender su dolor. Esto fortalece los lazos afectivos y proporciona consuelo emocional al desplazar la atención sobre el dolor (Brown, 2020). Al combinar la escucha activa con la empatía, se crea un entorno familiar donde todos se sienten comprendidos y apoyados, lo que contribuye al bienestar emocional de cada miembro.

De igual manera, la expresión de afecto y cariño es una otra forma poderosa de proporcionar apoyo emocional en situaciones de sufrimiento. Gestos como abrazos, palabras de aliento y muestras de cariño pueden transmitir un sentido de amor y seguridad a quienes están sufriendo. Estos gestos no solo alivian el dolor emocional, sino que también fortalecen los lazos familiares y promueven un sentido de unidad y solidaridad (Johnson, 2018).

Por otra parte, el apoyo emocional también puede manifestarse a través de acciones prácticas y tangibles. Ayudar con las tareas del hogar, cuidar a los niños o proporcionar asistencia financiera son formas de aliviar el estrés y la carga emocional de quienes están sufriendo. Este tipo de apoyo práctico no solo demuestra amor y preocupación, sino que también proporciona un alivio tangible en momentos de dificultad (Smith, 2019).

Así mismo, la comunicación abierta y honesta también es esencial para enfrentar el sufrimiento compartido en la familia. Al fomentar un ambiente donde los miembros de la familia se sientan cómodos para expresar sus sentimientos y preocupaciones, se puede promover una mayor comprensión y apoyo mutuo. La comunicación abierta también permite identificar y abordar problemas emocionales antes de que se conviertan en crisis, lo que contribuye al bienestar emocional de todos los miembros de la familia (Brown, 2020).

También en algunas situaciones, puede ser necesario buscar apoyo externo para manejar el sufrimiento en la familia. La terapia familiar, los grupos de apoyo y los consejeros espirituales pueden proporcionar orientación y recursos adicionales para enfrentar el dolor y la adversidad. Este tipo de apoyo externo puede ser especialmente útil cuando el sufrimiento es prolongado o cuando los miembros de la familia tienen dificultades para manejar sus emociones por sí mismos. En "Amoris Laetitia", el Papa Francisco subraya la importancia de la comunidad parroquial y otras asociaciones, afirmando que la comunidad parroquial es una familia de familias, donde las pequeñas comunidades y los movimientos eclesiales pueden ayudar a las familias a crecer en la fe y en la vida cristiana (AL, 229). Además, destaca que la pastoral familiar debe ser un esfuerzo coordinado y continuo, que involucre a las familias en la vida de la

parroquia y en las asociaciones de familias (AL, 279), recordándonos que la comunidad y el apoyo mutuo son esenciales para enfrentar el sufrimiento y fortalecer la resiliencia emocional.

El impacto emocional del sufrimiento compartido en la familia y los ejemplos de apoyo emocional destacan la importancia de la empatía, la comunicación y el apoyo mutuo en tiempos de dificultad. Sin embargo, el sufrimiento compartido no solo afecta a nivel emocional, sino que también tiene dimensiones sociales que influyen en la dinámica familiar y en la manera en que los miembros de la familia interactúan con su entorno.

2.2. Dimensión Social

La dimensión social del ser humano se refiere a la capacidad y necesidad de interactuar y relacionarse con otros individuos. Estas interacciones son fundamentales para el desarrollo personal y el bienestar emocional, ya que nos ayudan a construir nuestra identidad y a encontrar apoyo en momentos de necesidad. Esta dimensión incluye la capacidad de formar y mantener relaciones con amigos, familiares y compañeros; la habilidad para expresar ideas, emociones y necesidades, así como para escuchar y comprender a los demás; la capacidad de entender y compartir los sentimientos de otros; la necesidad de sentirse parte de un grupo o comunidad; y la habilidad para trabajar en conjunto con otros para alcanzar objetivos comunes.

2.2.1. La caridad y el apoyo social en la familia

En esta dimensión social, la caridad y el apoyo social juegan un papel determinante en la manera en que las familias han de enfrentar el sufrimiento de forma compartida. Por una parte, la caridad, entendida como el amor desinteresado y la compasión hacia los demás, se manifiesta en el apoyo mutuo y en la disposición para ayudar a quienes están sufriendo. En el contexto familiar, esta caridad se convierte en una herramienta esencial para fortalecer los lazos afectivos y promover la solidaridad y la cohesión social.

El apoyo social en la familia se manifiesta de diversas formas, desde el cuidado de los niños y los ancianos hasta la provisión de asistencia financiera y emocional. Este apoyo no solo alivia el sufrimiento de los individuos, sino que también fortalece la estructura familiar y promueve un sentido de comunidad y pertenencia. Según algunos estudios, las familias que practican la caridad y el apoyo social tienden a desarrollar una mayor resiliencia y a enfrentar mejor las crisis y las adversidades. (de los Ríos, p. 24ss)

2.2.2. Casos de sufrimiento compartido en situaciones de crisis sociales El sufrimiento compartido en la familia se ve exacerbado en situaciones de crisis sociales, como desastres naturales, conflictos armados y crisis económicas. En estos contextos, el apoyo

social y la caridad se vuelven aún más necesarias para enfrentar el sufrimiento y promover la recuperación y la resiliencia.

Un ejemplo de sufrimiento compartido en situaciones de crisis sociales es el impacto de los desastres naturales en las familias. Durante eventos como terremotos, huracanes e inundaciones, las familias a menudo enfrentan la pérdida de sus hogares, la separación de sus seres queridos y la incertidumbre sobre el futuro. En estos momentos, el apoyo social y la caridad se manifiestan en la provisión de refugio, alimentos y asistencia médica, así como en el apoyo emocional y psicológico para ayudar a las familias a superar el trauma y la adversidad. (Cernuda Martínez, 2012, p. 21ss)

Otro ejemplo es el sufrimiento compartido en familias afectadas por conflictos armados. En zonas de guerra, las familias a menudo enfrentan la pérdida de seres queridos, el desplazamiento forzado y la violencia. En estos contextos, también la caridad y el apoyo social se manifiestan con casi idénticas previsiones: en la provisión de refugio, alimentos y asistencia médica, así como en el apoyo emocional y psicológico para ayudar a las familias a superar el trauma y la adversidad. En estos casos, Santo Tomás señala que la superación genuina se alcanza cuando se perdona de corazón. Ya que el perdón es la remisión de la ofensa, y esto pertenece a la caridad, que es el amor de Dios y del prójimo (Aquino, 1888, II-II, q. 25, a. 2). De esta forma, se cierran totalmente las heridas y se vive sin rencor.

A raíz de todo ello podemos confirmar que el sufrimiento compartido en la familia tiene un impacto emocional profundo y multifacético. A través del apoyo emocional y la caridad, las familias pueden enfrentar juntos las dificultades y promover el crecimiento emocional y la fortaleza familiar. La dimensión social del sufrimiento compartido destaca la importancia del apoyo mutuo y la solidaridad en tiempos de crisis, y cómo la caridad puede fortalecer los lazos afectivos y promover la cohesión social.

2.3. Dimensión Espiritual

Las ciencias humanas² distinguen varias dimensiones en el ser humano que interactúan entre sí. Primero, está el cuerpo, que representa la dimensión física e incluye todos los aspectos materiales y biológicos de nuestra existencia. Luego, está el alma, que abarca nuestras emociones, pensamientos y voluntad, y es responsable de nuestra vida psíquica y emocional. Según Santo Tomás, el alma es la fuente de la fuerza vital vegetativa, sensitiva y racional que anima al cuerpo, permitiéndonos existir y funcionar. (ST, I, q. 75, a. 1.) Además, se considera que el alma tiene un origen espiritual y divino, lo que nos

permite relacionarnos con lo espiritual, ya que es el Espíritu que vive en el hombre. (ST, I, q. 76, a. 1.)

² Disciplinas como la psicología, la sociología, la antropología, y la filosofía estudian diferentes aspectos de la existencia humana y cómo interactúan entre sí para formar una comprensión holística del ser humano.

Con estas distinciones en mente, debemos entender la dimensión espiritual como la más profunda y trascendental del ser humano. Esta dimensión busca un sentido más allá de lo material y lo físico, conectándonos con lo divino, lo sagrado o lo trascendental. La dimensión espiritual nos impulsa a buscar respuestas a preguntas existenciales, a adoptar valores y virtudes, y a encontrar un propósito y significado en la vida. (ST, I-II, q. 1, a. 8)

2.3.1. El sufrimiento compartido como camino hacia el crecimiento espiritual El sufrimiento compartido en la familia puede ser una experiencia profundamente transformadora que lleva al

crecimiento espiritual de sus miembros. Cuando una familia enfrenta el sufrimiento de manera conjunta, se crea un espacio para la reflexión, la empatía y la compasión. Esto fortalece los lazos espirituales y promueve un sentido de unidad y propósito.

El sufrimiento compartido nos enseña la importancia de la humildad y la dependencia mutua. Al reconocer nuestras propias limitaciones y la necesidad de apoyo, desarrollamos una mayor humildad y una apreciación más profunda por la ayuda que recibimos. Esta actitud nos permite enfrentar el sufrimiento con una perspectiva más positiva y constructiva, transformando el dolor en una oportunidad para el crecimiento espiritual. Como queda señalado, Según Santo Tomás, el sufrimiento, cuando se ofrece a Dios con amor y confianza, puede ser una forma de participar en el sufrimiento redentor de Cristo y

de crecer en santidad (ST, III, q. 48, a. 2).

El sufrimiento compartido puede fortalecer significativamente la fe y la esperanza en la familia. Al enfrentar juntos las dificultades, los miembros de la familia encuentran consuelo y fortaleza en su fe común, especialmente cuando las adversidades superan las capacidades humanas. En estas situaciones, cuando se ha perdido la esperanza en uno mismo y en los demás, el alma se aferra a la esperanza en Dios. La oración y la meditación se convierten en prácticas esenciales para enfrentar el sufrimiento, proporcionando paz y esperanza en medio de la adversidad. La fe y la esperanza no solo ayudan a los individuos a superar el dolor, sino que también fortalecen los lazos espirituales y promueven un sentido de comunidad y solidaridad (ST, II-II, q. 17, a. 1).

2.3.2. Reflexiones sobre la caridad y el crecimiento espiritual en la familia Queremos insistir sobre la caridad, entendida como el amor desinteresado y la compasión hacia los demás. Es una virtud central en la filosofía de Santo Tomás y desempeña un papel preponderante en el crecimiento espiritual de la familia. En el contexto familiar, la caridad se manifiesta en el apoyo mutuo, la empatía y el sacrificio por el bienestar de los demás. Al practicar la caridad, los miembros de la familia alivian el sufrimiento de los demás, y también promueven su propio crecimiento espiritual.

La caridad en la familia se manifiesta de diversas formas. Puede incluir actos de generosidad material, como proporcionar alimentos y refugio a quienes lo necesitan, así como gestos de amor y compasión, como escuchar y consolar a quienes están sufriendo. Estos actos de caridad alivian el dolor emocional y físico, también fortalecen los lazos afectivos y promueven un sentido de unidad y solidaridad (ST, III, q. 31, a. 3).

Además, la caridad en la familia fomenta la gratitud y la humildad. Al reconocer nuestras propias bendiciones y compartirlas con los demás, cultivamos un espíritu de agradecimiento y generosidad. La humildad, por su parte, nos permite actuar sin buscar reconocimiento o recompensa, enfocándonos en el bienestar de los demás. Se necesitan estas virtudes para el desarrollo espiritual, ya que nos ayudan a trascender nuestro ego y a vivir de manera más auténtica y compasiva (ST, II-II, q. 23, a. 8).

El sufrimiento compartido en la familia también puede ser una oportunidad para enseñar y practicar la caridad. Los padres pueden servir como modelos de comportamiento caritativo, mostrando a sus hijos cómo actuar con amor y compasión hacia los demás. Al enseñar a los niños y adolescentes la importancia de

la caridad, los padres promueven el crecimiento espiritual de sus hijos, también fortalecen la cohesión y la estabilidad de la familia como en su conjunto. (Francisco, 2016)

En la era digital, la caridad ha adquirido nuevas formas y posibilidades. Las plataformas de “micro financiación” y las redes sociales han facilitado la recaudación de fondos y la movilización de recursos a una escala sin precedentes. Estas herramientas permiten a las familias contribuir de manera rápida y eficiente a causas que les importan, ampliando el alcance y el impacto de las acciones caritativas. Sin embargo, también es cada vez más necesario garantizar la transparencia y la rendición de cuentas en el uso de estos recursos para maximizar su impacto positivo. (Meredith et al., 2015, p. 197)

El conjunto de estos detalles es el que nos lleva a afirmar que el sufrimiento compartido en la familia puede ser un camino hacia el crecimiento espiritual, proporcionando una oportunidad para desarrollar virtudes como la humildad, la gratitud y la caridad. Ya que

al enfrentar juntos las dificultades, los miembros de la familia encuentran consuelo y fortaleza en su fe común, y promueven un sentido de unidad y solidaridad. La caridad, como virtud central en la filosofía de Santo Tomás, nos ofrece una guía para vivir de manera más compasiva y justa, y para promover el bienestar y la santificación de todos los miembros de la familia.

3. El Sufrimiento Compartido en Diferentes Contextos Familiares El sufrimiento compartido en la familia es una experiencia que puede surgir en diversas etapas y situaciones de la vida. Cada contexto familiar presenta desafíos únicos que afectan la manera en que los miembros de la familia enfrentan y manejan el sufrimiento. A continuación, exploraremos el sufrimiento compartido en tres contextos familiares específicos: familias con niños, familias con adolescentes y familias con ancianos.

3.1. Familias con Niños

La niñez, que va desde el nacimiento hasta los 12 años, es una etapa decisiva en la que las familias se centran en el cuidado, la protección, el desarrollo, la educación, el apoyo emocional, la inculcación de valores, la socialización y la recreación de los niños. Estas características son fundamentales para su crecimiento y bienestar. Veamos el papel de los padres y algunos ejemplos prácticos.

3.1.1. El papel de los padres en enseñar la caridad y el manejo del sufrimiento En las familias con niños, los padres desempeñan una función determinante en la enseñanza de la caridad y el

manejo del sufrimiento. Los niños aprenden a través del ejemplo y la observación, por lo que es fundamental que los padres modelen comportamientos de amor, compasión y generosidad. Al enseñar a los niños la importancia de la caridad, los padres promueven el crecimiento espiritual de sus hijos, también fortalecen la cohesión y la estabilidad de la familia como unidad.

La enseñanza de la caridad puede incluir actividades como el voluntariado en la comunidad, la donación de juguetes y ropa a quienes lo necesitan, y la participación en eventos benéficos. Estas experiencias

ayudan a los niños a desarrollar un sentido de empatía y compasión, y también les enseñan a valorar la importancia de ayudar a los demás y a enfrentar el sufrimiento con una actitud positiva y constructiva. (Fernández et al., 2007, p. 33ss)

3.1.2. Ejemplos de sufrimiento compartido en familias con niños

El sufrimiento compartido en familias con niños puede surgir de diversas fuentes, como enfermedades, problemas económicos y conflictos interpersonales. A continuación, se

presentan algunos ejemplos de cómo las familias pueden enfrentar juntos estas situaciones de sufrimiento.

En primer lugar, cuando un niño o un miembro de la familia enfrenta una enfermedad grave, el sufrimiento compartido puede ser una experiencia profundamente dolorosa. En estos casos, es fundamental que los padres proporcionen apoyo emocional y práctico a sus hijos, ayudándoles a comprender y enfrentar la situación. La comunicación abierta y honesta, la expresión de afecto y cariño, y la búsqueda de apoyo externo, como la terapia familiar, pueden ser herramientas esenciales para manejar el sufrimiento y promover el bienestar emocional de todos los miembros de la familia (Brown, 2020).

En segundo lugar, las dificultades económicas pueden generar un sufrimiento significativo en las familias con niños. En estos casos, es importante que los padres enseñen a sus hijos la importancia de la resiliencia y la solidaridad. Al enfrentar juntos las dificultades económicas, los miembros de la familia pueden desarrollar un sentido de unidad y propósito, y aprender a valorar las bendiciones y recursos que tienen. La caridad, en forma de apoyo mutuo y generosidad, puede ser una herramienta poderosa para aliviar el sufrimiento y fortalecer los lazos familiares (Francisco, 2016, AL n. 187ss).

Para enseñar resiliencia y solidaridad a los niños, los padres deben hablar abiertamente sobre las dificultades económicas y cómo afectan a la familia, explicando la situación de manera adecuada a la edad de los

niños para que comprendan la realidad sin sentirse abrumados. Involucrar a los niños en la planificación del presupuesto familiar y enseñarles a manejar el dinero de manera responsable, como hacer una lista de compras, comparar precios y ahorrar para objetivos específicos, también es fundamental. Asignar tareas y responsabilidades a cada miembro de la familia para que todos contribuyan al bienestar común, como tareas domésticas, cuidado de hermanos menores o ayudar en actividades que generen ingresos adicionales, fomenta la colaboración.

Animar a los niños a expresar gratitud por las cosas que tienen y por el apoyo que reciben de los demás, a través de actividades como llevar un diario de gratitud o compartir momentos de agradecimiento en familia, es esencial. Fomentar el apoyo emocional y la empatía entre los miembros de la familia, escuchando y consolando a quienes están pasando por momentos difíciles, y celebrando juntos los pequeños logros y avances, fortalece los lazos familiares. Involucrar a los niños en actividades de voluntariado o en proyectos comunitarios que ayuden a otros en situaciones similares les enseña la importancia de la solidaridad y la generosidad. Practicar la oración y la meditación en

familia para encontrar consuelo y fortaleza en la fe, recordando que, aunque las dificultades económicas sean desafiantes, la esperanza y la unidad familiar pueden ayudar a superarlas.

Al seguir estos pasos, los padres pueden enseñar a sus hijos la importancia de la resiliencia y la solidaridad, y fortalecer los lazos familiares en tiempos de dificultades económicas. En tercer lugar, los conflictos interpersonales, como las discusiones y desacuerdos entre los miembros de la familia, pueden generar un sufrimiento emocional significativo. En estos casos, es fundamental que los padres enseñen a sus hijos habilidades de comunicación y resolución de conflictos. La caridad, en forma de empatía y comprensión, puede ayudar a los miembros de la familia a superar los conflictos y a fortalecer sus relaciones interpersonales (Francisco, 2016, AL n 293)

3.2. Familias con Adolescentes

La adolescencia es el período que abarca aproximadamente desde los 12 hasta los 18 años. Durante esta etapa, las familias con adolescentes se caracterizan por la búsqueda de independencia, el desarrollo de identidad, los cambios emocionales y físicos, la necesidad de comunicación y apoyo, y el aumento de responsabilidades. Estudiemos cómo se puede vivir el sufrimiento en caridad, con algunos casos de sufrimiento compartido.

3.2.1. La caridad y el sufrimiento en la vida de los adolescentes

En las familias con adolescentes, el sufrimiento compartido también puede surgir de diversas fuentes, como problemas escolares, conflictos con amigos y cambios emocionales. Los adolescentes están en una etapa de desarrollo en la que buscan su identidad y autonomía, lo cual puede generar tensiones y desafíos en la dinámica familiar. En este contexto, la caridad y el apoyo emocional son esenciales para ayudar a los adolescentes a enfrentar el sufrimiento y a desarrollar una mayor resiliencia emocional. La caridad en la vida de los adolescentes puede incluir actividades como el voluntariado, la participación en grupos de apoyo y la práctica de la empatía y la compasión hacia los demás. Estas experiencias no solo ayudan a los adolescentes a desarrollar un sentido de propósito y significado, sino que también fortalecen sus habilidades de comunicación y resolución de conflictos, y promueven un sentido de comunidad y solidaridad (Brown, 2020,).

3.2.2. Casos de sufrimiento compartido en situaciones de crisis adolescentes El sufrimiento compartido en familias con adolescentes puede surgir de diversas situaciones de crisis, como problemas de salud mental, acoso escolar y conflictos familiares. A

continuación, se presentan algunos ejemplos de cómo las familias pueden enfrentar juntos estas situaciones de sufrimiento.

En primer lugar, los problemas de salud mental, como la depresión y la ansiedad, son comunes entre los adolescentes y pueden generar un sufrimiento significativo en la familia. En estos casos, es fundamental que los padres proporcionen apoyo emocional y práctico a sus hijos, ayudándoles a comprender y enfrentar la situación. La comunicación abierta y honesta, la expresión de afecto y

cariño, y la búsqueda de apoyo externo, como la terapia familiar, también aquí pueden ser herramientas esenciales para manejar el sufrimiento y promover el bienestar emocional de todos los miembros de la familia.(Moreno, 2010)

En segundo lugar, el acoso escolar es una experiencia dolorosa que puede generar un sufrimiento significativo en los adolescentes y sus familias. En estos casos, es importante que los padres enseñen a sus hijos habilidades de resiliencia y afrontamiento, y que proporcionen un entorno seguro y de apoyo en el hogar. La caridad, en forma de empatía y comprensión, puede ayudar a los adolescentes a superar el acoso escolar y a fortalecer su autoestima y confianza (Cernuda Martínez, 2012)

En tercer lugar, los conflictos familiares, como las discusiones y desacuerdos entre los miembros de la familia, pueden generar un sufrimiento emocional significativo en los adolescentes. En estos casos, también aquí es fundamental que los padres enseñen a sus hijos habilidades de comunicación y resolución de conflictos. La caridad, en forma de empatía y comprensión, también aquí puede ayudar a los miembros de la familia a superar los conflictos y a fortalecer sus relaciones interpersonales (Brown, 2020).

3.3. Familias con Ancianos

La ancianidad es el período que generalmente abarca desde los 65 años en adelante. Durante esta etapa, las familias con personas mayores se caracterizan por el cuidado y apoyo, la transmisión de sabiduría, la adaptación a cambios, el fomento de la independencia y el enriquecimiento intergeneracional.

3.3.1. El cuidado de los ancianos y el sufrimiento compartido

En las familias con ancianos, el sufrimiento compartido también puede surgir de diversas fuentes, como enfermedades crónicas, pérdida de autonomía y aislamiento social. El cuidado de los ancianos es una responsabilidad que puede generar un sufrimiento emocional y físico significativo para los cuidadores y los miembros de la familia. En este contexto, la caridad y el apoyo

emocional son esenciales para enfrentar el sufrimiento y promover el bienestar de todos los miembros de la familia.

La caridad en el cuidado de los ancianos puede incluir actividades como proporcionar asistencia médica y emocional, ofrecer compañía y apoyo social, y ayudar con las tareas del hogar. Estas acciones van en la línea de aliviar el sufrimiento de los ancianos, fortalecer los lazos familiares y promueven un sentido de unidad y solidaridad (de los Ríos, 2014, p. 24ss)

Estas consideraciones reafirman nuestra convicción de que el sufrimiento compartido en diferentes contextos familiares presenta desafíos únicos que afectan la manera en que los miembros de la familia enfrentan y manejan el sufrimiento. A través del apoyo emocional y la caridad, las familias pueden enfrentar juntos las dificultades y promover el crecimiento emocional y espiritual. La caridad, como virtud central en la filosofía de Santo Tomás, nos ofrece una guía para vivir de manera más compasiva y justa, y para promover el bienestar y la santificación de todos los miembros de la familia.

4. Impacto del Sufrimiento Compartido en el Crecimiento Espiritual

El sufrimiento compartido en la familia puede tener un impacto profundo y transformador en el crecimiento espiritual de sus miembros. Diversas filosofías y religiones han reconocido el valor del sufrimiento como una oportunidad para el desarrollo de virtudes y la profundización de la fe. Este proceso implica varios aspectos.

4.1. El sufrimiento como oportunidad para el crecimiento espiritual Para Santo Tomás de Aquino, el sufrimiento, aunque doloroso, puede ser una oportunidad para el crecimiento espiritual. Tiene un propósito redentor y puede acercarnos más a Dios cuando se enfrenta con fe y confianza (Aquino, 1888, ST, III, q. 48, a. 2). Lo afirma porque el sufrimiento compartido fortalece los lazos espirituales y promueve la unidad y el propósito en la familia, desarrollando empatía y comprensión mutua. Además, genera un sentido de propósito y significado, proporcionando motivación y fortaleza emocional (Moreno, 2010, p. 137).

4.2. Comparación con otras virtudes y su impacto en el crecimiento espiritual familiar

El sufrimiento compartido no es la única experiencia que contribuye al crecimiento espiritual en la familia. Otras virtudes, como la caridad, la empatía, la gratitud y la humildad, también juegan un papel importante.

4.2.1. Caridad

Para Santo Tomás, la caridad es una virtud central para el crecimiento espiritual de la familia. Se manifiesta

en el apoyo mutuo, la empatía y el sacrificio por el bienestar de los demás, aliviando el sufrimiento y promoviendo el crecimiento espiritual (Aquino, 1888, ST, II-II, q. 23, a. 1). La caridad en la familia se manifiesta de diversas formas. Puede incluir actos de generosidad material, como proporcionar alimentos y refugio a quienes lo necesitan, así como gestos de amor y compasión, como escuchar y consolar a quienes están sufriendo. Estos actos de caridad alivian el dolor emocional y físico, también fortalecen los lazos afectivos y promueven un sentido de unidad y solidaridad (ST, III, q. 31, a. 3).

4.2.2. Empatía

La empatía, definida como la capacidad de comprender y compartir los sentimientos de los demás, es una virtud esencial para el crecimiento espiritual. Permite conectar con el sufrimiento de los demás y actuar para aliviar su dolor. En el contexto familiar, la empatía se manifiesta en el apoyo mutuo y en la disposición para escuchar y consolar a quienes están sufriendo. Al desarrollar la empatía, los miembros de la familia fortalecen sus relaciones interpersonales y promueven un sentido de comunidad y solidaridad (Moreno, 2010, p. 159)

4.2.3. Gratitud

La gratitud, definida como el reconocimiento y la apreciación de los aspectos positivos de la vida, es otra virtud que tiene un impacto significativo en el crecimiento espiritual. Nos enseña a valorar las bendiciones y recursos que tenemos y a compartirlos con los demás. En el contexto familiar, la gratitud se manifiesta en el reconocimiento y la apreciación del apoyo y el amor que recibimos de nuestros seres queridos. Al practicar la gratitud, los miembros de la familia desarrollan un espíritu de agradecimiento y generosidad, de modo que se fortalecen los lazos afectivos y también se obtiene un sentido de unidad y solidaridad. (Moreno, 2010, p. 160)

4.2.4. Humildad

La humildad, definida como el reconocimiento de nuestras propias limitaciones y la valoración de las contribuciones de los demás, es una virtud esencial para el crecimiento espiritual. La humildad nos permite actuar sin buscar reconocimiento o recompensa, enfocándonos en el bienestar de los demás. En el contexto familiar, la humildad se manifiesta en el reconocimiento de nuestras propias necesidades y la disposición para recibir y ofrecer ayuda. Al desarrollar la humildad, los miembros de la familia fortalecen

sus relaciones interpersonales y con ella también promueven un sentido de comunidad y solidaridad (Francisco, 2016, AL n 98)

4.3. Ejemplos históricos y contemporáneos

A lo largo de la historia, existen numerosos ejemplos de cómo el sufrimiento compartido ha contribuido al crecimiento espiritual de las familias y las comunidades. A continuación, se presentan algunos ejemplos

históricos y contemporáneos que ilustran el impacto del sufrimiento compartido en el crecimiento espiritual.

4.3.1. Ejemplos históricos

Empezamos con la familia de los mártires cristianos. Durante las persecuciones cristianas en el Imperio Romano, muchas familias cristianas enfrentaron el sufrimiento y la muerte juntos. Estas familias encontraron consuelo y fortaleza en su fe común y en el apoyo mutuo. El sufrimiento compartido no solo fortaleció su fe, sino que también promovió un sentido de unidad y solidaridad entre los cristianos perseguidos (Aquino, 1888, ST, II-II, q. 124, a. 1). Hablamos de familias como la de Perpetua y Felicidad. Perpetua era una joven noble de Cartago, fue arrestada junto con su esclava Felicidad por ser cristianas. A pesar de las súplicas de su padre para que renunciara a su fe, Perpetua se mantuvo firme. Ambas mujeres fueron martirizadas en el año 203 d.C., y su historia es un testimonio de la fortaleza y el consuelo que encontraron en su fe y en el apoyo mutuo. (Senent, 2012, p. 160ss)

En esta misma línea podemos hablar de la familia de los Mártires de Lyon. En el año 177 d.C., un grupo de cristianos en Lyon, incluyendo a familias enteras, fue arrestado y sometido a torturas. Entre ellos estaba Blandina, una esclava que, junto con otros cristianos, mostró una fe inquebrantable. Su sufrimiento compartido y su apoyo mutuo fortalecieron su fe y promovieron un sentido de unidad entre los cristianos perseguidos. (Vizcaíno, 2011)

De esta misma forma se habla de la familia de los Mártires de Nicomedia, conocida en la actualidad como Izmit, se encuentra en Turquía. Durante la persecución de Diocleciano, muchas familias cristianas en Nicomedia fueron arrestadas y ejecutadas. Entre ellos estaba San Adrián, un oficial romano que se convirtió al cristianismo y fue martirizado junto con su esposa Natalia, quien lo apoyó hasta el final.

Su historia refleja cómo el sufrimiento compartido fortaleció su fe y su unidad familiar.

Por último, vamos a referirnos a las familias de los santos. A lo largo de la historia, muchas familias de santos han enfrentado el sufrimiento juntos y han encontrado en él una

oportunidad para el crecimiento espiritual. Mucho más cercanos a nosotros, la familia de Santa Teresa de Lisieux enfrentó numerosas dificultades, incluyendo la muerte prematura de la madre de Teresa. A pesar de estas dificultades, la familia encontró consuelo y fortaleza en su fe común y en el apoyo mutuo, lo que contribuyó al crecimiento espiritual de todos sus miembros (Aquino, 1888, ST II-II, q. 23, a. 8). Para no hablar de otras conocidas como la de Marta, Lázaro y María en Betania; la familia de San Joaquín y Santa Ana, la de San Isidro Labrador y Santa María de la Cabeza, lo mismo que la familia de San Leandro de Sevilla. (Arbiol, 1769)

Estos ejemplos ilustran cómo el sufrimiento compartido y la caridad pueden fortalecer los lazos familiares y contribuir al crecimiento espiritual, tal como lo plantea Santo Tomás de Aquino.

4.3.2. Ejemplos contemporáneos

Aquí también podemos tener una lista interminable. Empezando con familias afectadas por desastres naturales. En tiempos recientes, muchas familias han enfrentado el sufrimiento compartido debido a desastres naturales, como terremotos, huracanes e inundaciones. Estas familias han encontrado consuelo y fortaleza en el apoyo mutuo y en la solidaridad de sus comunidades. El sufrimiento compartido ha fortalecido los lazos afectivos y espirituales de las familias, también ha promovido un sentido de unidad y solidaridad en las comunidades afectadas.(Moreno, 2010, p. 60ss)

Según Martín (2024), el 29 de octubre de 2024, la DANA (Depresión Aislada en Niveles Altos) causó inundaciones devastadoras en la Comunidad Valenciana, afectando a miles de familias. Entre ellas, la familia de Elisabet Gil Martínez, de 38 años, y su madre, Elvira Martínez Alfaro, de 64 años, quienes desaparecieron en Cheste mientras se dirigían a trabajar. Días después, el cuerpo de Elvira fue encontrado, pero Elisabet seguía desaparecida hasta hoy.

El sufrimiento compartido fortaleció los lazos afectivos y espirituales de las familias afectadas y promovió un sentido de unidad y solidaridad en la comunidad. A pesar de las dificultades, las familias encontraron esperanza y optimismo en medio del sufrimiento, demostrando la importancia del apoyo mutuo y la resiliencia en tiempos de crisis³(Monzón; Chaves, 2024).

De igual forma podemos hablar de familias afectadas por conflictos armados. En zonas de guerra, muchas familias han enfrentado el sufrimiento compartido debido a la violencia y el desplazamiento forzado. A pesar de estas dificultades, muchas de ellas han

encontrado consuelo y fortaleza en su fe común y en el apoyo mutuo perdonando a los verdugos. El sufrimiento compartido les ha fortalecido los lazos afectivos y espirituales, también les ha permitido promover un sentido de unidad y solidaridad en las comunidades afectadas (Moreno, 2010, p. 32)

Un ejemplo de perdón en un conflicto armado en África es la historia de Immaculée Ilibagiza durante el genocidio de Ruanda en 1994. Immaculée perdió a la mayoría de su familia, incluidos sus padres y dos hermanos, quienes fueron asesinados por los milicianos hutus. A pesar del inmenso dolor y sufrimiento, Immaculée encontró consuelo y fortaleza en su fe.

Después del genocidio, Immaculée tuvo la oportunidad de enfrentarse a uno de los hombres responsables de la muerte de su familia. En lugar de buscar venganza, decidió perdonarlo. Este acto de perdón no solo le permitió encontrar paz interior, sino que también fortaleció su fe y su espíritu. Immaculée ha

³ Hasta este momento de nuestra redacción varios periódicos nacionales siguen dando la noticia de la desaparición de tres personas. Entre ellas Elisabet. Hablamos de: <https://www.20minutos.es/noticia/5656321/0/cinco-personas-aun-estan-paradero-desconocido-tras-paso-dana/>;

https://www.levante-emv.com/comunitat_valenciana/2024/12/29/desaparecidos-dana-valencia-testimonio-familias-falta-humanidadabandono-nadie-nos-ha-llamado-112978879.html

compartido su historia en su libro "Left to Tell: Discovering God Amidst the Rwandan Holocaust", donde relata cómo el sufrimiento compartido y el perdón transformaron su vida y la de muchos otros. (Ilibagiza, 2014)

5. Aplicaciones Prácticas y Relevancia Actual

Nos referimos a cómo los conceptos y enseñanzas sobre la caridad y el manejo del sufrimiento en la familia para el crecimiento espiritual pueden ser aplicados en la vida cotidiana y cómo son relevantes en el contexto actual.

5.1. Estrategias para fomentar la caridad y el manejo del sufrimiento en la familia

Fomentar la caridad y el manejo del sufrimiento en la familia es parte esencial para crear un ambiente de apoyo y crecimiento espiritual. Algunas estrategias prácticas incluyen en primer lugar una Comunicación Abierta y Honesta que posibilita un ambiente donde todos los miembros de la familia se sientan cómodos compartiendo sus sentimientos y preocupaciones. La comunicación abierta ayuda a identificar y abordar el sufrimiento de manera conjunta. (Moreno, 2010, p. 80)

Este ambiente puede llevar a una segunda estrategia consistente en crear una red de apoyo dentro de la familia donde cada miembro se sienta valorado y comprendido. Esto puede incluir actividades como escuchar activamente, ofrecer palabras de aliento y mostrar empatía (Moreno, 2010, p. 182)

Así como participar en actividades espirituales como la oración, la meditación y la lectura de textos sagrados juntos. Estas prácticas pueden fortalecer la fe y proporcionar consuelo en tiempos de sufrimiento (Francisco, 2016, AL, n 223)

Por otra parte, podemos hablar de involucrarse en actividades de servicio comunitario como familia. Ayudar a los necesitados no solo fomenta la caridad, sino que también proporciona una perspectiva sobre el sufrimiento y la gratitud. (de los Ríos, 2014)

Al fin señalaríamos la actividad de enseñar a los niños y adolescentes sobre la importancia de la caridad y el manejo del sufrimiento a través de historias, ejemplos y discusiones. Esto ayuda a inculcar valores que perdurarán a lo largo de sus vidas (de Recompensa)

5.2. Relevancia del pensamiento de Santo Tomás en el contexto actual El pensamiento de Santo Tomás de Aquino sigue siendo relevante en el contexto actual por varias razones:

En

primer lugar, las enseñanzas de Santo Tomás sobre la ética y la moralidad proporcionan una base sólida para abordar los desafíos éticos contemporáneos. Su énfasis en la caridad y la justicia puede guiar a las familias en la toma de decisiones morales (ST, II-II, q. 23, a. 1).

En segundo lugar, la visión de Santo Tomás sobre el sufrimiento como un camino hacia el crecimiento espiritual es especialmente relevante en tiempos de crisis. Su enfoque en la aceptación y el manejo del sufrimiento puede ayudar a las familias a encontrar significado y propósito en situaciones difíciles (ST, II-II, q. 30, a. 1).

En tercer lugar, Santo Tomás destacó la importancia de la comunidad y el apoyo mutuo. En un mundo cada vez más individualista, sus enseñanzas sobre la interdependencia y la caridad pueden fomentar un sentido de comunidad y solidaridad (ST II-II, q 23 a 1)

Y, en definitiva, la integración de la fe y la razón en el pensamiento de Santo Tomás ofrece un enfoque equilibrado para abordar los problemas contemporáneos. Esto es particularmente útil en un mundo donde la ciencia y la religión a menudo se perciben como opuestas.

5.3. Organizaciones y programas que promueven el apoyo familiar y el manejo del sufrimiento

Existen hoy en día diversas organizaciones y programas que se dedican a apoyar a las familias y a manejar el sufrimiento. Algunos ejemplos incluyen Caritas Internationalis, que es una confederación de organizaciones católicas de ayuda, desarrollo y servicio social que trabaja para apoyar a las familias en situaciones de crisis y sufrimiento (Caritas Internationalis, 2023).

Lo mismo que Catholic Charities, que es una red de organizaciones que proporciona servicios de apoyo a familias necesitadas, incluyendo asesoramiento, asistencia financiera y programas de desarrollo comunitario (Catholic Charities, 2022).

Del mismo modo hablamos de la Family Promise. Una organización que ayuda a las familias sin hogar a encontrar estabilidad y apoyo a través de programas de alojamiento temporal, asesoramiento y capacitación laboral (Family Promise, 2021).

The Compassionate Friends, es una organización que ofrece apoyo a familias que han perdido a un hijo, proporcionando grupos de apoyo, recursos y eventos comunitarios para ayudar a las familias a manejar su dolor y sufrimiento (The Compassionate Friends, 2020).

Habitat for Humanity. Una organización que trabaja para proporcionar viviendas asequibles a familias necesitadas, promoviendo la estabilidad y el bienestar familiar (Habitat for Humanity, 2019).

Todas estas estrategias y organizaciones demuestran en nuestros días cómo el pensamiento de Santo Tomás puede aplicarse de manera práctica en el contexto actual, ofreciendo apoyo y guía a las familias en su camino hacia el crecimiento espiritual y la caridad.

En resumen, el sufrimiento compartido en la familia, según Santo Tomás de Aquino, es un camino hacia el crecimiento espiritual y la caridad. A través de la comunicación abierta, el apoyo emocional mutuo, las prácticas espirituales conjuntas, el servicio a los demás y la educación en valores, las familias pueden fomentar un ambiente de apoyo y crecimiento espiritual.

Conclusión

De qué hemos hablado

Hemos empezado estudiando el Marco Teórico y Conceptual. En él Santo Tomás de Aquino define el sufrimiento como una oportunidad para el crecimiento espiritual y la purificación del alma. Dice que la caridad es una virtud central que nos une a Dios y nos permite amar a nuestro prójimo de manera genuina y desinteresada. Que la familia es un pilar fundamental para el crecimiento espiritual. Que, a través del sufrimiento compartido,

los miembros de la familia pueden fortalecer sus lazos y crecer en santidad. Se compara la visión de Santo Tomás con el islam, el hinduismo y el budismo, destacando similitudes y diferencias en la percepción del sufrimiento y la caridad.

Como Dimensiones del Sufrimiento Compartido hemos hablado del impacto emocional del sufrimiento compartido en la familia. Incluye el apoyo emocional y psicológico que ayuda a superar el trauma y la adversidad. De que la caridad y el apoyo social en la familia se manifiestan en la provisión de refugio, alimentos y asistencia médica, especialmente en situaciones de crisis sociales. Y de que el sufrimiento compartido es visto como un camino hacia el crecimiento espiritual, promoviendo la caridad y la pureza de corazón.

Después hemos pasado hablar del Sufrimiento Compartido en Diferentes Contextos Familiares. En él se ha estudiado el papel de los padres en enseñar la caridad y el manejo del sufrimiento. Ejemplos de sufrimiento compartido en familias con niños destacan la importancia del apoyo mutuo. De que la caridad y el sufrimiento en la vida de los adolescentes se abordan a través de casos de crisis adolescentes y el apoyo familiar. Y de que el cuidado de los ancianos y el sufrimiento compartido se reflejan en la caridad y el crecimiento espiritual en la vejez.

Luego hemos hablado del Impacto del Sufrimiento Compartido en el Crecimiento Espiritual. Se ha analizado cómo el sufrimiento compartido contribuye al crecimiento espiritual, comparándolo con otras virtudes y su impacto en la familia. Y Se presentan ejemplos históricos y contemporáneos que ilustran el impacto del sufrimiento compartido en el crecimiento espiritual.

Al final nos hemos referido a las Aplicaciones Prácticas y Relevancia Actual. Allí se proponen estrategias

prácticas para fomentar la caridad y el manejo del sufrimiento en la familia. Se destaca la relevancia de las enseñanzas de Santo Tomás en el contexto actual y cómo pueden aplicarse en la vida familiar. Y se mencionan organizaciones y programas que promueven el apoyo familiar y el manejo del sufrimiento.

Nuestras Reflexiones Finales sobre la Importancia del Sufrimiento Compartido en la Familia

El sufrimiento compartido en la familia es un tema de profunda relevancia y significado, especialmente en el contexto de las enseñanzas de Santo Tomás de Aquino. A lo largo de este artículo, hemos explorado cómo el sufrimiento compartido puede ser un camino hacia el crecimiento espiritual y la caridad, y cómo las familias pueden implementar estrategias prácticas para manejar el sufrimiento de manera conjunta.

En primer lugar, nos ha parecido importante reconocer que el sufrimiento sea una experiencia universal que afecta a todas las familias en algún momento. Sin embargo, la manera en que las familias enfrentan y manejan el sufrimiento puede marcar una gran diferencia en su bienestar emocional y espiritual. Según Santo Tomás, el sufrimiento compartido no solo fortalece los lazos familiares, sino que también promueve la caridad y el crecimiento espiritual. Al enfrentar el sufrimiento juntos, los miembros de la familia aprenden a apoyarse mutuamente, a mostrar empatía y a desarrollar una mayor comprensión y compasión.

La comunicación abierta y honesta es una de las estrategias clave para manejar el sufrimiento en la familia. Cuando los miembros de la familia se sienten cómodos compartiendo sus sentimientos y preocupaciones, se crea un ambiente de apoyo y comprensión. Esto permite que el sufrimiento sea abordado de manera conjunta, lo que puede aliviar la carga emocional y fortalecer los lazos familiares. Además, el apoyo emocional mutuo es esencial para ayudar a los miembros de la familia a sentirse valorados y comprendidos. Escuchar activamente, ofrecer palabras de aliento y mostrar empatía son formas efectivas de brindar apoyo emocional.

Las prácticas espirituales conjuntas, como la oración, la meditación y la lectura de textos sagrados, también juegan un papel importante en el manejo del sufrimiento. Estas prácticas pueden fortalecer la fe y

proporcionar consuelo en tiempos difíciles. Además, involucrarse en actividades de servicio comunitario como familia no solo fomenta la caridad, sino que también proporciona una perspectiva sobre el sufrimiento y la gratitud. Enseñar a los niños y adolescentes sobre la importancia de la caridad y el manejo del sufrimiento a través de historias, ejemplos y discusiones ayuda a inculcar valores que perdurarán a lo largo de sus vidas.

El pensamiento de Santo Tomás sigue siendo relevante en el contexto actual, proporcionando una base ética y moral para abordar los desafíos contemporáneos. Su enfoque en la interconexión de la comunidad y

la integración de la fe y la razón ofrece un enfoque equilibrado para enfrentar los problemas actuales. En un mundo cada vez más individualista, las enseñanzas de Santo Tomás sobre la interdependencia y la caridad pueden fomentar un sentido de comunidad y solidaridad.

Diversas organizaciones y programas, como Caritas Internationalis, Catholic Charities, Family Promise, The Compassionate Friends y Habitat for Humanity, trabajan para apoyar a las familias en situaciones de

crisis y sufrimiento. Estas organizaciones demuestran cómo las enseñanzas de Santo Tomás pueden aplicarse de manera práctica en la actualidad, ofreciendo apoyo y guía a las familias en su camino hacia el crecimiento espiritual y la caridad.

En conclusión, el sufrimiento compartido en la familia no solo fortalece los lazos familiares, sino que también promueve el crecimiento espiritual y la caridad. Las estrategias y organizaciones mencionadas ofrecen un camino claro para aplicar el pensamiento de Santo Tomás en la vida familiar contemporánea, ayudando a las familias a encontrar significado y propósito en medio del sufrimiento. La importancia del sufrimiento compartido radica en su capacidad para transformar el dolor en una oportunidad para el crecimiento y la unión familiar.

Relevancia y Aplicación del Pensamiento de Santo Tomás en el Crecimiento Espiritual Familiar Hoy en Día

Para afirmar la relevancia y aplicación del pensamiento de Santo Tomás en nuestros días para el crecimiento espiritual en el contexto familiar nos apoyamos en las siguientes convicciones que hemos aprendido.

Las enseñanzas de Santo Tomás de Aquino sobre la ética y la moralidad se basan en la ley natural. La ley natural es la participación de la razón humana en la ley eterna de Dios. Por consiguiente, creemos que las enseñanzas de Santo Tomás de Aquino sobre la ética y la moralidad proporcionan una base sólida para la toma de decisiones morales en la familia.

Por otra parte, si para Santo Tomás la caridad es el amor de Dios sobre todas las cosas y el amor al prójimo por amor a Dios. En el contexto familiar, la caridad se manifiesta en el amor y el apoyo mutuo entre los miembros de la familia. Luego hemos de entender que la caridad sea un pilar fundamental para el crecimiento espiritual en la familia.

Así mismo creemos que el sufrimiento puede ser un camino hacia el crecimiento espiritual si se enfrenta con una actitud de aceptación y confianza en Dios. Ya que el sufrimiento es una experiencia universal que afecta a todas las familias en algún momento. Es por ello por lo que creemos que el sufrimiento compartido en la familia fortalece los lazos familiares y promueve la caridad y el crecimiento espiritual.

Por otra parte, consideramos que las prácticas espirituales conjuntas fortalecen la fe y proporcionan consuelo

en tiempos de sufrimiento. Dichas prácticas espirituales conjuntas incluyen la oración, la meditación y la lectura de textos sagrados. Por lo tanto, las prácticas espirituales conjuntas han de considerarse fundamentales para el crecimiento espiritual familiar.

La razón última la encontramos en que el servicio a los demás es una manifestación práctica de la caridad. Involucrarse en actividades de servicio comunitario como familia fomenta la caridad y proporciona una perspectiva sobre el sufrimiento y la gratitud. En este sentido afirmamos que el servicio a los demás ha de ser una forma efectiva de fomentar el crecimiento espiritual en la familia.

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LA DIMENSIÓN ESPIRITUAL DEL SUFRIMIENTO EN SANTO TOMÁS DE AQUINO

Padre Simón Asumu Abeso Angué

Pedagogo

Guinea Ecuatorial



El sufrimiento es una experiencia universal que atraviesa a todas las personas, independientemente de su origen, cultura o creencias. Frente a él, las reacciones humanas varían: algunos lo perciben como una prueba, otros como un castigo, muchos lo viven con desesperación o resignación, e incluso hay quienes pierden la fe en un Dios bueno y todopoderoso. Santo Tomás de Aquino ofrece una perspectiva distinta, considerando el sufrimiento no solo como una adversidad, sino como una oportunidad para el crecimiento espiritual y la unión con Dios. Según su pensamiento, el sufrimiento puede tener un sentido providencial, actuando como un medio de purificación y crecimiento personal cuando se vive con fe. Esta visión transforma el sufrimiento en un acto redentor y liberador, resaltando las capacidades del alma espiritual, como la inteligencia, la voluntad y la memoria, para enfrentar el dolor con esperanza y propósito.

I. Contexto del Sufrimiento en la Filosofía de Santo Tomás

Santo Tomás de Aquino (1225-1274) vivió en una época de profundos cambios políticos, religiosos y filosóficos. La sociedad medieval estaba organizada en tres estamentos: trabajadores, clérigos y guerreros. La Iglesia ejercía un gran poder, lo que generaba tensiones con los gobernantes civiles. En el plano religioso, surgieron movimientos heréticos como los cátaros y los albigenses, que veían el mundo material como algo maligno y negaban la idea de un Dios único y creador.

Ante estas creencias dualistas y gnósticas, Santo Tomás defendió la fe cristiana ortodoxa. Para él, Dios es el creador y sustentador de todo, y el mal no es una entidad propia, sino la ausencia de bien. En su *Summa Theologiae* (I, q. 48, a. 1; I, q. 49, a. 1), explica que el mal no tiene existencia en sí mismo, sino que se manifiesta como una carencia de perfección en la creación.

En este contexto, Tomás de Aquino reflexionó sobre el sufrimiento, diferenciándolo del dolor. Mientras el dolor es una experiencia física, emocional o psicológica, el sufrimiento posee una dimensión más profunda, afectando al alma y vinculándose con la forma en que la persona percibe y reacciona ante la adversidad. Para Tomás, el sufrimiento implica una interpretación personal del dolor y una respuesta interior a él. En su *Comentario al Libro de Job* (In Job, c. 2, lect. 1), explica que el sufrimiento del justo puede tener un sentido providencial, actuando como un medio de purificación y crecimiento espiritual.

Autores modernos como Mario Alonso Puig han resaltado la importancia de esta distinción al abordar el sufrimiento humano desde una perspectiva holística. En su libro *Reinventarse: Tu segunda oportunidad* (2010), enfatiza que la forma en que interpretamos y reaccionamos ante el dolor influye profundamente en nuestra experiencia de sufrimiento. De manera similar, Fray Nelson Medina destaca que el sufrimiento, cuando se asume con una perspectiva cristiana, no solo fortalece el alma, sino que permite una transformación interior que nos acerca más a la voluntad de Dios (Medina, 2018).

II. Purificación del Alma a Través de sus Potencias

En la filosofía de Santo Tomás, el camino interior del sufrimiento comienza con la purificación de la inteligencia, cuya función es conocer la verdad. Sin embargo, el orgullo lleva al hombre a definir la realidad desde una perspectiva limitada y a culpar a otros por sus problemas. Según Santo Tomás (ST, I, q. 16, a. 1), para alcanzar la verdad es necesario abandonar este orgullo y reconocer las propias limitaciones.

El siguiente paso en la purificación del alma ocurre cuando el sufrimiento cuestiona la voluntad. Esta tiene una relación especial con la inteligencia, de la cual recibe luz para orientarse hacia el bien. No obstante, la voluntad también se ve atraída por los bienes sensibles, lo que puede oscurecer la razón. (ST, I-II, q. 19, a. 1). En ocasiones, el sufrimiento confronta a la persona con

la necesidad de aceptar una voluntad mayor que la propia (ST, I-II, q. 24, a. 3), lo que la lleva a centrarse en el amor que puede dar, en lugar del que puede recibir. Este proceso fomenta la transformación personal antes que la imposición de cambios externos (ST, I-II, q. 28, a. 1).

Finalmente, el sufrimiento culmina con la purificación de la memoria. La persona, al intentar alcanzar el bien absoluto, puede llegar a desesperarse de sí misma y experimentar una sensación de vacío. Sin embargo, según Tomás de Aquino, esta crisis puede resolverse a través de una experiencia de sanación y redención. Solo una mano amiga y desinteresada, como la de Dios, puede redefinir la memoria del ser humano, desde la Creación hasta la Redención (ST, I-II, q. 113, a. 3), permitiendo el perdón y un nuevo comienzo.

Conclusión

La reflexión de Santo Tomás de Aquino sobre el sufrimiento ofrece una perspectiva transformadora. Al comprenderlo como un medio de purificación y crecimiento, se invita a superar la visión del sufrimiento como un obstáculo y a reconocerlo como una oportunidad para la maduración personal. Integrar la dimensión espiritual en el abordaje del sufrimiento no solo permite encontrar sentido en el dolor, sino que también favorece el desarrollo de una actitud resiliente y esperanzadora.

El sufrimiento, lejos de ser una realidad absurda, puede ser un camino hacia una vida más plena y significativa. En lugar de quedar atrapados en el dolor, se nos invita a trascenderlo, descubriendo en él un proceso de transformación interior que nos acerca a la verdad, el bien y el amor.

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LE NUOVE FRONTIERE DELLA CHIRURGIA ROBOTICA E I. A. COME UMANIZZARE LA TECNOLOGIA?

Prof. Franco Balzaretti



Specializzazione in chirurgia d'urgenza e pronto soccorso - Università degli Studi di Pavia

Specializzazione in chirurgia vascolare - Università degli Studi di Milano

- Docente di chirurgia generale Università Cattolica Facoltà: medicina e chirurgia "a. Gemelli"
- Membro titolare del C.M.I.L. (Comité Médical International de Lourdes): dal 2002
- Dal ottobre 2000 a tuttora membro del comitato di redazione della rivista scientifica nazionale Orizzonte Medico ed attualmente condirettore (casa ed. Velar)
- Medico responsabile sanitario dell'Oftal di Vercelli
- Tesoriere nazionale AMCI (Associazione Medici Cattolici Italiani)

Onorificenze: Cavaliere al merito della Repubblica Italiana

Incarichi precedenti

- Direttore responsabile della Day Surgery dell'ASL vc di Vercelli (Ospedali di Vercelli e Borgosesia) dal 2008 al 2024
- Direttore del pronto soccorso ASL vc di Vercelli dal 2003 al 2008
- Vice presidente nazionale vicario dell' AMCI Associazione Medici Cattolici Italiani
- È stato membro della Consulta Nazionale per la Pastorale della Sanità della CEI (Conferenza Episcopale Italiana), per 8 anni dal 22 ottobre 2008 al 2016

Chiamato spesso come relatore per conferenze da università, società scientifiche, ordini professionali, scuole superiori, diocesi e club di service su temi scientifici di chirurgia, angiologia, di bioetica e scienza/fede

Scrivo articoli e pubblicazioni per giornali e riviste scientifiche e di bioetica

Il progresso tecnologico ha portato ad un progressivo distacco tra medico e paziente. Con i mezzi ipertecnologici, oggi a disposizione, l'intuito critico del medico viene spesso esautorato, cedendo il passo alla tecnologia. E si viene così a creare una crescente dicotomia tra medico e paziente, che mette a rischio la relazione umana! E ci domandiamo, quindi, se il concetto di progresso possa essere utopisticamente disgiunto da ogni limite o regola etica, come qualcuno sembra prospettare. Anche perché la medicina si è basata per molti secoli su conoscenza, intuito, sensibilità e umanità.

Ma con i mezzi ipertecnologici, oggi a disposizione, l'intuito scientifico ed umano del medico viene spesso messo in secondo piano. E così i cinque sensi del medico sembrano relegati al mesto ruolo di supporto ai potenti mezzi tecnologico-informatici; sempre più sofisticati e guidati da Intelligenze Artificiali che, sulla base di alcuni algoritmi, possono: formulare diagnosi; proporre terapie adeguate ed infine, proprio grazie alla *Chirurgia Robotica*, hanno assunto anche un ruolo determinante per l'esecuzione di diversi interventi chirurgici. Le principali applicazioni della I. A. in medicina sono:

1. L'EPIDEMIOLOGIA
2. LA DIAGNOSTICA
3. LA CHIRURGIA ROBOTICA

In epidemiologia l'I.A. funziona benissimo, per le ricerche bibliografiche, ed altrettanto nell'assemblare, analizzare ed interpretare quanto emerge nel delicato campo della prevenzione. L'I.A. ci offre inoltre la possibilità di esaminare, con approccio induttivo, un'enorme mole di dati, e questo in tempi molto brevi e fornendo correlazioni di aiuto e informazioni significative: e il tutto a costi molto inferiori.

Il secondo campo è la diagnostica, e soprattutto la diagnostica per immagini. In questo campo gli algoritmi prodotti sono eccellenti. Dovremmo pensare quindi alla intelligenza artificiale (I. A.) in modo positivo, e tuttavia dovremo essere anche molto attenti a vigilare; e guidare il progresso, in modo che possa sempre favorire il bene di ogni singola persona ed, ovviamente, il bene comune. E l'ambito radiologico è indubbiamente uno dei più interessati dalla rivoluzione digitale, ed infatti, ogni anno, si effettuano circa 2 miliardi di radiografie del torace, in tutto il mondo.

Mentre l'algoritmo Sybil, è chiamato come le Sibille dell'antica Grecia, figure femminili, che grazie alla conoscenza divina, potevano prevedere il futuro! Ed infatti questo algoritmo è in grado, analizzando numerose immagini TAC polmonari a bassa dose, di prevedere con largo anticipo, anche di anni, la sede esatta, dove andrà a localizzarsi il tumore e le metastasi.

Ed ecco che questi algoritmi ci aiutano sicuramente a superare il classico scontro tra progressisti e conservatori; e, soprattutto, a limitare le paure sull'uso delle tecnologie avanzate, con i relativi allarmi che vorrebbero frenare la ricerca.

Dovremmo pensare quindi alla intelligenza artificiale (I. A.) in modo positivo, e tuttavia dovremo essere anche molto attenti a vigilare e guidare il progresso, in modo che possa sempre favorire il bene di ogni singola persona e di tutta l'umanità.

Ma, come accennavo prima, da parte di alcuni, si sottolinea anche una grande preoccupazione: che un uso incontrollato delle I. A. possa compromettere la relazione medico/paziente. Stiamo quindi attenti a rispettare sempre i canali diretti di comunicazione, e soprattutto l'alleanza terapeutica tra il paziente e il medico.

Oltretutto, stiamo parlando di una tecnologia sanitaria, l'I. A. applicata alla salute (ricerca, medicina, sanità), necessita pertanto di essere sviluppata attraverso una fase preclinica, clinica pilota e clinica allargata, prima di essere applicata sull'uomo, e dovrà essere, pertanto, sottoposta ad una formale valutazione (*Health Technology Assessment*), comprensiva di tutte le varie implicazioni etiche, legali e sociali

Ed è dunque auspicabile che la validazione di queste tecnologie vada, in un futuro prossimo, a potenziare e integrarsi con le competenze cliniche, diagnostiche e terapeutiche del medico e non a sovrapporsi o, addirittura, a sostituirsi ad esso.

E c'è infine il terzo campo, quello della chirurgia robotica, che noi approfondiremo maggiormente. Il robot aiuta sicuramente la precisione, la micromanipolazione, il rispetto di talune strutture delicate. Come, ad esempio, la tecnica robotica di prostatectomia con *nerve-sparing*, che favorisce la salvaguardia anche dei piccoli rami sensitivi ed inoltre, sempre sotto il controllo umano, migliora notevolmente la radicalità. E, oltretutto, garantisce anche una precoce ripresa della continenza e dell'attività sessuale, con tempi operatori e giornate di degenza molto ridotti.

Detto questo, si deve precisare che l'intelligenza artificiale non potrà mai sostituire l'essere umano, soprattutto in un intervento chirurgico particolarmente complesso: perché la tecnologia va sempre guidata dalla mente umana. I nuovi sistemi di robotica chirurgica saranno in grado di svolgere compiti ripetitivi con maggiore precisione e maggiore

autonomia, consentendo ai chirurghi di concentrarsi sugli aspetti più importanti e delicati.

E questi sistemi offrono infatti:

1. ALTA PRECISIONE
2. ELEVATA SICUREZZA
3. RIDOTTA INVASIVITÀ

“Esse autem chirurgus debet manu strenua, stabili, nec umquam tremula, sive dextra sive sinistra prompta et oculis acribus”. (Il chirurgo deve avere la mano forte, ferma né mai tremante, abile sia con la destra che con la sinistra e con vista acuta.). Così sentenziava Aulo Cornelio Celso (25 a. C. – 45 d. C.), nel suo testo *De Medicina*, e fu quindi profetico. Ed infatti, gli straordinari progressi della chirurgia oggi consentono al chirurgo di operare, con mano fermissima (e ruotabile a 360 gradi), e con una vista perfetta, attraverso a sofisticati monitor; parliamo ovviamente della *chirurgia robotica*, che ci offre diversi vantaggi:

1. Migliore visione e virtualizzazione, con sensazione di totale immersione nel campo operatorio;
2. elevati standard di sicurezza per il paziente;
3. dissezione più precisa e micro-dissezione di altissima qualità;
4. standardizzazione delle tecniche ed equalizzazione, verso l’alto, dei risultati tra i chirurghi;
5. migliore performance clinica;
6. migliore Sicurezza Oncologica;
7. assenza di trazioni incontrollate sui nervi.

Ma la Chirurgia Robotica offre anche notevoli vantaggi per il paziente e la società:

1. incisioni minime con notevole riduzione del dolore post-operatorio;
2. limita perdite di sangue e quindi anche la necessità di trasfusioni;
3. riduce la probabilità di infezioni del sito chirurgico;
4. riduce molto i tempi di recupero e quindi favorisce un più rapido ritorno alla normalità;
5. riduce l’ospedalizzazione con un risparmio non trascurabile dal punto di vista economico.

Per quanto riguarda invece gli svantaggi si possono così riassumere:

1. *Costi elevati del sistema*, e quindi solo con un elevato numero di interventi robotici, si possono ridurre ed ammortizzare significativamente i costi variabili.

2. Mentre fra le difficoltà tecniche c'è, *l'apprendimento*: per rendere il gesto sicuro; per cui il chirurgo deve poter fare molta pratica, e questo non è sempre possibile.
3. *Set up* del robot e sua logistica: problemi durante il settaggio del sistema, dal punto di vista degli errori che si commettono e dei tempi che si impiegano.
4. Problemi legati alla *comunicazione* tra chirurgo che opera e il resto del team chirurgico in sala operatoria, per via della distanza fra primo operatore e resto del team
5. *Safety*: il sistema robotico e la strumentazione possono dare ai chirurghi un falso senso di sicurezza ed essere fuorviati, dal punto di vista della percezione della realtà.

La chirurgia robotica si è evoluta nel corso degli ultimi due decenni. La sua crescente diffusione ha creato alcune perplessità circa i possibili benefici, a fronte di alti costi di acquisizione e gestione. Per cui è stato fatto uno studio con una dettagliata revisione dei risultati delle performance dei Robot da Vinci ed un rapporto di analisi relativo al suo utilizzo in Italia. Per cui sono state identificate e valutate le prove dell'impatto clinico della tecnologia in confronto a quelle della chirurgia laparoscopica e a cielo aperto o tradizionale, mediante una revisione sistematica dei documenti di sintesi disponibili.

E tutto questo ha dato alla chirurgia robotica un importante impulso. Per cui la logica conseguenza è un notevole aumento del mercato. Ed infatti, nel 2020, secondo la società di ricerca Statzon, la dimensione del mercato globale dei robot chirurgici è stata di circa 5,4 miliardi di dollari. Tuttavia le previsioni di mercato nei prossimi 10 anni, secondo il report "A Robotic-Assisted Surgery Review: clinical landscape, commercial arena and future outlook" realizzato da Alira Health, indicano che entro il 2030 si supereranno i 22 miliardi di dollari.

Ed attualmente risultano esserci oltre 150 i sistemi robotici in fase di studio e sviluppo per le diverse indicazioni cliniche, in un mercato dominato sempre più dagli Stati Uniti, sia sul fronte dell'innovazione che dell'accesso, con oltre 580mila procedure eseguite nel 2020.

Mentre l'Italia, con i suoi 115 robot e 25mila interventi eseguiti in media in un anno, si colloca al terzo posto in Europa, dopo Germania e Francia, ed appena prima della Spagna, che si trova infatti al quarto posto. Ma, entro il 2025, si prevede un notevole incremento dell'attività, con oltre 200 piattaforme e circa 50.000 interventi/anno.

Gli ambiti, in cui la chirurgia robotica viene maggiormente utilizzata, sono per il 70% l'urologia, seguita dalla chirurgia generale e la ginecologia. Per cui, come si può intuire

la chirurgia robotica è senza ombra di dubbio una tecnica rivoluzionaria; in quanto si basa infatti su una macchina che, in futuro, potrebbe funzionare anche meglio dell'uomo, essendo in grado di elaborare dati e procedere, anche in modo autonomo, al tavolo operatorio, in base ad un programma specifico.

E quindi, come abbiamo già evidenziato, l'utilizzo dei Robot risulta essere sempre più diffuso in ambito chirurgico. Ma se un braccio robotico va in tilt, e se durante l'intervento qualcosa va storto? E se il paziente subisce un danno: chi ne è il responsabile? Ad oggi non esistono risposte univoche ed esaustive a queste domande. Per cui ci si trova di fronte ad una questione non solo etica, ma anche legale; ed, attualmente, ci sono alcune possibili opzioni:

1. Secondo il principio della responsabilità oggettiva, a rispondere dovrebbe essere il produttore perché è nella posizione migliore per limitare i danni; per poi rivalersi eventualmente sui fornitori.
2. L'altra opzione è di fare delle simulazioni ed accurati test di valutazione dei rischi, prima dell'utilizzo di un robot, e quindi eventuali responsabilità sarebbero condivise da tutti i soggetti interessati.
3. E si deve comunque prevedere una specifica assicurazione obbligatoria.

Oltretutto la chirurgia robotica offre anche la possibilità di tecniche di *telechirurgia*. Cioè di interventi eseguiti con procedure robotiche, azionate da un chirurgo che si trova lontano dal tavolo operatorio; magari anche a migliaia di km di distanza. Oggi la *chirurgia robotica* viene effettuata soprattutto in presenza. Tuttavia, ci sono grandi potenzialità di intervenire a distanza con la *telechirurgia*, come peraltro è già stato fatto e si sta facendo. Ma, come accennavo prima, l'applicazione della chirurgia robotica - e soprattutto la telechirurgia - deve presupporre diverse attenzioni:

1. Una valutazione della proporzionalità benefici/rischi di tipo clinico;
2. una adeguata informazione al paziente e consenso informato;
3. la definizione delle responsabilità per malpractice (del chirurgo, designer, produttore);
4. la formazione dei medici all'uso della robotica nella chirurgia, senza perdere l'attitudine a praticare la chirurgia senza robot;
5. devono essere previste figure di chirurghi robotici affiancate a quelle di chirurghi tradizionali per espletare gli interventi che non beneficiano della tecnologia (o in caso di complicanze).

6. La chirurgia robotica è e deve rimanere un mezzo e non un fine ed il robot di oggi è un puro “ausilio” per il chirurgo, non un suo sostituto.

Molti degli addetti ai lavori sono convinti che arriveremo a effettuare la maggior parte degli interventi di chirurgia generale con il robot. Ma, come si sottolineava prima, rimane il dubbio che i chirurghi del futuro possano non essere all'altezza di convertire un paziente direttamente in sala operatoria, ovvero di sottoporlo a un intervento tradizionale in corso d'opera, per esempio a seguito di una sopraggiunta complicanza e/o in caso di emergenza. Bisogna quindi investire maggiormente nella formazione, nella ricerca e nella sicurezza e proporre degli standard etici e della qualità condivisi. I benefici dell'innovazione e della tecnologia devono essere a vantaggio dei pazienti ed accessibili a tutti; non solo delle industrie e delle multinazionali!

E si stanno quindi sviluppando dei *Training Center* per la formazione dei chirurghi. Con il nuovo Training Center si amplia l'offerta formativa; ed è infatti in grado di offrire un training su modelli anatomici reali, consentendo agli operatori e alle equipe dedicate di effettuare un percorso di apprendimento reale oltre che simulato. In 25 anni di chirurgia robotica, in Italia sono stati formati più di 2.200 chirurghi, più di 800 nel solo 2023. Il nuovo Training Center mira oggi a formare più di 800 professionisti all'anno in corsi specifici, più di 150 entro la fine del 2024

C'è poi il problema del controllo dei dati e della privacy. Ed è proprio per questi motivi che l'Unione Europea il 9 dicembre 2023 approvava una legge ad hoc su: *A. I. ed etica*. E quindi è già in vigore una normativa europea sull'intelligenza artificiale. E l'obiettivo principale della nuova legge è infatti di garantire che lo sviluppo della I. A. non leda:

1. i diritti fondamentali,
2. la democrazia,
3. lo Stato di diritto
4. la sostenibilità ambientale.

Anche perché non esiste (né mai esisterà) una tecnologia che possa dotare una “*macchina intelligente*” di una coscienza e di emozioni, in grado di eguagliare e sostituire l'essere umano. Per cui la robotica sarà la chirurgia del futuro, perché ci consentirà Indiscutibili ed irrinunciabili vantaggi per il paziente, nuove opportunità terapeutiche e nuove speranze; ma determinerà anche nuovi problemi ed inquietudini!

Con la chirurgia robotica il chirurgo potrà sicuramente avere una mano più forte, ferma né mai tremante, abile sia con la destra che con la sinistra e con una vista molto acuta, come auspicava Aulo Cornelio Celso 2000 anni fa. Ma a che prezzo?

“Menti umane in mani meccaniche!” E’ il titolo di uno dei tantissimi articoli sulla chirurgia robotica, ma quale sarà il futuro della *chirurgia robotica* e quali potranno essere i problemi maggiori?

1. Che le A. I. possano decidere autonomamente su un intervento da eseguire e come eseguirlo.
2. Il chirurgo, come si sottolineava prima, dovrà essere sempre in grado di intervenire con le tecniche tradizionali, in caso di complicanze. Ed ora i vari chirurghi sono in grado di farlo. Ma domani avranno ancora la necessaria preparazione ed esperienza?
3. I chirurghi saranno in grado di eseguire procedure anche in zone periferiche e difficilmente raggiungibili, attraverso alla telechirurgia; ma questo comporterà anche una concentrazione dei medici migliori in poche realtà, tecnologicamente avanzate e ricche, peggiorando ancor più la carenza di specialisti qualificati nelle aree periferiche, povere e disagiate.

E proprio per questo occorrerà definire meglio il quadro sociale ed etico-giuridico: e intorno allo stesso tavolo dovrebbero sedere, oltre ai chirurghi anche filosofi, sociologi, teologi, giuristi, legislatori, etc. Sì, proprio perché al centro ci deve essere sempre l’uomo e nessuno deve essere lasciato indietro. Perché ogni uomo è unico, irripetibile ed insostituibile e la sua vita ha quindi un valore inestimabile.

E mi piace infine concludere con una citazione di Papa Francesco (del 23 dicembre 2020): *«L’altro giorno, parlando con alcuni scienziati, si parlava dell’intelligenza artificiale e dei robot... ci sono robot programmati per tutti e per tutto, e questo va avanti. E io dissi loro: “Ma qual è quella cosa che i robot mai potranno fare?”. Loro hanno pensato, hanno fatto delle proposte, ma alla fine sono rimasti d’accordo in una cosa: la tenerezza. Questo i robot non potranno farlo».*

In conclusione, possiamo quindi affermare che è giusto, oserei dire indispensabile, aprirci al progresso ed alle nuove tecnologie, ma le decisioni dovranno essere sempre prese e gestite dall’uomo, dal medico, dal chirurgo.

Si cari amici, perché è a noi medici che l’ammalato affida le proprie ansie, angosce e sofferenze e quindi dobbiamo essere sempre e solo noi a dare una risposta alle loro richieste di aiuto, in una Medicina sì moderna e tecnologica, ma al tempo stesso anche umana e capace di garantire un’adeguata relazione personale tra medico e paziente, in pratica quella tenerezza di cui parla Papa Francesco. Una tenerezza che nessun robot sarà mai capace di dare.

ON BIOETHICS 2025...

Dr. Peter Au-Yeung

BSc MBBS MRCP FRCA

FHKCA FHKAM (Anaesthesiol)



Brief Curriculum Vitae

Peter Au-Yeung was born in Hong Kong and studied there until 1976, when he went to finish his schooling in England. He studied medical sciences and then clinical studies in King's College, London and its medical school, qualifying in 1985. He then spent two years in Wolverhampton and later obtaining the MRCP qualification. Turning back to Anaesthesia, he obtained his FRCS two years later in 1991. He returned to Hong Kong to work in the second half of 1992 to work in the Chinese University of Hong Kong and its teaching hospital. Transferring to Yan Chai Hospital after this, following one of his previous bosses, he worked there till retirement until the present day, doing part time work. Peter has written on a large variety of topics including ethics, wine and music (in the form of programme notes)

Ethics is applied philosophy & therefore bioethics is philosophy applied to problems related to life, living organisms, what we encounter in life etc. I was introduced to medical ethics soon after I started medical school (1980Q1) An esteemed member of the Guild of Catholic Doctors (as it was called then, it is now the Catholic Medical Association of England and Wales (CMA(Eng))) Dr. Peter Doherty (General Practitioner in London south of the River Thames) gave the talk & later wrote the book on it. The publication of the Guild was the Catholic Medical Quarterly & often would contain discussions relating to ethical problems encountered during medical practice. One particularly problematic case was whether the conscientious objection rights of doctors

& nurses could apply to a secretary typing out the referral letters (the Janaway case (1989), it did not)

I returned to my natal city of Hong Kong (HK) in 1992 & initially worked at the Chinese University of Hong Kong (CUHK) & its teaching hospital, the Prince of Wales Hospital (PWH). There was no formal ethics teaching as such but I helped with Catholic students if they have an ethics enquiry. After that I transferred to my current hospital (Yan Chai Hospital(YCH) in Tsuen Wan) where I still work 2 days a week after retirement. I didn't realize what a blessing that turned out to be, as the Diocese of Essen (Germany) built the church next door dedicated to SS Cosmas and Damian (the less famous twin brother patron saints of doctors after St Luke, who were martyred with three other brothers in the fourth Century). Formal teaching of bioethics began in the HK medical schools much later, and subsequently I was asked to write the first chapter and part of the transplant medicine chapter (Ch 10), as the person tasked to write that chapter had pulled out at the last moment. That CUHK textbook (Medical Law and Ethics in Hong Kong) was published in August 2016.

People talk about various approaches to bioethics. But before we venture into that, the term “ethics” came from Aristotle, whose work (The Nicomachean Ethics) gave the topic its name. Deontological approaches are based on the work of Immanuel Kant - Metaphysics of Morals. My German was never going to be good enough to read it on my own, so I depended on the classical translation by the Dominicans. Theories based on consequentialism depends on the end result and the saying made famous by the Chinese leader Deng Xiao Peng (鄧小平) put it most eloquently: it doesn't matter if the cat was white or black, a good cat was one that caught a mouse - 不管這是黑貓或白貓，捉到老鼠的是好貓。

The first philosopher to propose something akin to utilitarianism was also Chinese, Moxi (墨子)! Western utilitarianism came from Jeremy Bentham, whose remains are at University College, London. The best known proponent of this theory is John Stuart Mill (Utilitarianism), whose father James was a friend of Bentham. The best known utilitarian approach to ethics remains the four principles approach, which did not arise from any author of any books but in the Belmont Report (April 1979). Other references included ethics books by J Harris, JF Beauchamp and TL Childress, AR Jonsen et al, A Caplan, HT Engelhardt, Jr amongst others. For transplant ethics, I even borrowed books specifically on the topic including one named “Stakes and Kidneys” - a reference to a famous steak

and kidney filling for pies and puddings in England. (FN1) Many people like to know how law & morals interacted with each other and that was the substance of the Hart-Devlin (FN2) debate of the late 1950s, to attempt to decriminalize homosexuality & prostitution. To avoid scandalizing the ladies on the Wolfenden Commission, they substituted the name of a famous biscuit firm - Huntley & Palmers (the former substituting for homosexuals with the latter substituting for prostitutes) Books were also consulted on various related topics and I remembered that the only reference book I read through was a very thick multi author tome on the concept behind many aspects of law.

Many aspects of bioethics are concerned with life - its beginning, end and also about various topics relating to the family. One topic relevant to the beginning of life is of course how to prevent it from happening. From the early proposals of timing sexual intercourse to avoid fertile periods (the so called Rhythm method, to modern developments resulting in Natural Family Planning (NFP)), things took a dramatic turn soon after the start of the Sexual Revolution by discovering the use of exogenous hormones for birth control, resulting in the various types of oral contraceptive pills. The topic of contraception was dealt with by the Holy See in a number of documents starting with the encyclical *Humanae Vitae* (On Human Life, Pope Paul VI, 1968), followed up the post synodal Apostolic Constitution - *Familiaris Consortio* (The Fellowship of the Family, Pope John Paul II, 1981), which is further reinforced by another post synodal Apostolic Constitution - *Amoris Laetitia* (The Joy of Love, Pope Francis, 2016). The prohibition from using contraception was also promulgated in the encyclical *Casti Connubi* (of chaste wedlock) by Pius XI (1930), with the first of these documents *Arcanum Divinae* (The hidden design of the Divine, Pope Leo XIII, 1880) defined marriage for “the propagation of the human race, but also that the lives of husbands and wives may be made better and happier.” (quote taken from *Arcanum*, but paragraph not otherwise specified).

Although the Rhythm Method was the first of the NFP methods, observations relating to cervical mucus were first reported by John & Evelyn Billing. Observations relating to the amount & viscosity of said mucus and its change with the menstrual cycle, especially around the time of ovulation was noted and these were later refined for use as a practical method of NFP. Another pioneer in NFP and later NaPro technology is Thomas Hilgers, who looked at all the various biomarkers of fertility and matched them initially with hormones levels and later correlated them with ultrasound when that technology became available.

Other issues at the beginning of life included artificial insemination, in vitro fertilization (IVF) and other means of creating an embryo. One of the basic tenets relating to human procreation is that it be closely related to the conjugal act. By collecting ovum or sperm and then reintroducing them into the conception process later, this closeness to the conjugal act is violently disrupted and this makes it utterly unacceptable to the Catholic Church. Besides, IVF is often associated with implanting more embryos than needed and later selective reduction is needed (another form of abortion). Excessive embryos are frozen and their fate is also problematic. Two other documents from the Congregation for the Doctrine of the Faith supplemented the teachings outlined above are: *Donum Vitae* (The gift of life, 1987) and *Dignitas Personae* (The dignity of a person, 2008)

Looking at the end of life, the main topics of contention are euthanasia and assisted suicide. Taking euthanasia first, the problem with “mercy killing” is rather like abortion - once you disrespect life in one type of circumstance, you quickly move onto disrespecting life in many more circumstances. The historical example is the euthanasia of people with disabilities and of undesirables in Nazi Germany, led to such a desensitization for the sanctity or value of life that enabled the Holocaust to take place with the killing of around six million Jews. Catholics believe that we are merely temporary guardians of the life that has been given to us, not its true owner. Hence we do not have full say on what to do when we want to abandon it because of suffering, exhaustion or whatever. As a retired Bishop of the local diocese said to me when I visited him in the wards in Wolverhampton so many years ago, what unused suffering! Suffering is hard on those in whose grip they are under, but we can always divert this into good! This is particularly pertinent to the topic of suicide (assisted or not). The assistance rendered is usually in the form of the prescription and supply of lethal medicines to be taken orally for the purposes of suicide. The main professions involved would be doctors and pharmacists.

Another topic related to the problem of controlling pain with the second problem of how hard everyone should try and keep the dying patient alive. In 1957, a couple of Vatican documents emerged, the first in February on whether pain control which may shorten a patient's life might be allowed. The short answer is yes, but it is not widely known that having rid the dying patient of pain, that person can engage in otherwise painful activities which actually prolong life! The second document released in the last quarter of the same year addresses the question of ordinary and extraordinary means of keeping a patient alive, with the question addressed to Pius XII on whether it is permissible to use a

ventilator on a patient whose prognosis was regarded as hopeless even by his doctors. The terms ordinary and extraordinary are often misunderstood. Ordinary in this context means mandatory (常規) whilst extraordinary means optional (非常規).

Advanced medical directives (預設醫療指示) are also becoming popular these days all around the world. Many of the medical interventions that can be refused in advance are not problematic as they fall in the extraordinary or optional category. However, Catholics are reminded that the provision of food and water by whatever means, even including various types of tube feeding constitute ordinary and mandatory means as food and water are basic human needs for survival and the way it is delivered is irrelevant in considering its morally. Therefore that is not an item that can be refused.

In conclusion, having discussed the various aspects of the philosophy of bioethics, we moved onto a review of the issues surrounding the beginning and end of life, concentrating on contraception and new technologies for creating embryos for the former and euthanasia, technologies for keeping patient alive as well as advanced medical directives for the latter.

(FN1) The commonest transplant performed worldwide is actually a blood transfusion - a transplant of thousands of perishable red blood cells from the donor to an (often) unrelated recipient. In this regard, all of transplant ethics can also be discussed with transfusion in mind, be it selling blood, directed donation, saviour siblings or whatever.

(FN2) HLA Hart is a famous professor of law at Oxford University whilst Lord Patrick Devlin was a retired Law Lord, his last position being Master of the Rolls (President of the Civil Division of the Court of Appeal of England and Wales and Head of Civil Justice). One of his memorable sayings was the description of the ordinary man in the street as “the man on the Clapham omnibus (Clapham being a district in South London and omnibus being the proper version of that means of public transport we call bus) (omnibus means everyone in Latin) Their books are *The Concept of Law* and *The Enforcement of Morals* respectively, with the latter incorporating an expanded argument on the part of Devlin. Another book to help understand this is *Judging Judges* by Simon Lee, which devoted one chapter to this subject.

INTELLIGENZA ARTIFICIALE, SALUTE E SPERANZA NELL'EVOLUZIONE ETICA DELLA "CARE"

Prof. Filippo Maria Boscia



L'irrompere nella medicina tradizionale dell'Intelligenza Artificiale e del Machine Learning (ML) riveste oggi un particolare interesse. Le tecnologie innovative, da un canto sono fonte di nuovi entusiasmi esaltate, ma sempre più spesso sono vissute con qualche preoccupazione. Sono in molti a ritenere che nell'Arte Medica potrebbe entrare in crisi quella magica alleanza medico paziente, che costituisce il fondamento più alto per le relazioni di aiuto ed empatia.

Tutti gli uomini di scienza e i professionisti della salute non demonizzano aprioristicamente l'innovazione e la tecnologia: vogliono però sottolineare che nell'empatia è racchiusa e si ritrova l'essenza valoriale della professione.

Occorre accogliere, sperimentare e verificare con attenzione i mutamenti culturali che intervengono nel fare medicina, tenendo sempre ben presente che il metodo clinico è il motore primario delle professioni sanitarie: Esso non deve mai essere compresso da esigenze aziendalistiche o economicistiche, né mai arretrare sul fronte dell'umano. E' indispensabile e necessario che ogni innovazione sia governata dalla mente umana, affinché l'UMANO NON SIA MAI IGNORATO.

Le innovazioni tecnologiche, che con rapidità evolvono di stagione in stagione e a fatica sono seguite dall'ingegno umano, necessitano di un'ampia apertura mentale, che responsabilmente affronti la critica dei sistemi perché non manchi mai la prudenza, la sapienza e la speranza.

Fermare l'innovazione non è possibile, ma controllarla è necessario! Proprio quando gli entusiasmi sono al massimo le attività di ricerca devono farsi più attive: In esse non devono mai mancare quelle preponderanti attività previsionali che da

sole possono assicurare l'assenza di ogni tipo di rischio e conseguentemente consentire un promettente, sicuro e appropriato utilizzo.

Se da un canto è importante stimolare ogni nuova idea e ogni capacità imprenditoriale, dall'altro occorre porre le basi perché il consenso all'utilizzo sia davvero informato.

Molti dispositivi tecnologici indossabili, ormai sono certificati come dispositivi medici. Gli smart watch sono un esempio di sensori innovativi in grado di espletare, momento per momento, analisi non invasive per la verifica di segnali di orientamento. Sono tanti i dispositivi indossabili utilizzati e gli sviluppi, ben oltre il prevedibile, sono sempre più facilmente accettati.

Occorre ribadire che in ogni percorso di innovazione siamo pellegrini nel cercare di imboccare la strada del massimo bene possibile: possiamo farlo solo se saremo in grado, con umiltà, di dar risposte a dubbi, quesiti e interrogazioni finalizzate ad individuare connessioni di bene, di equità e di etica.

Il progetto uomo e ogni percorso di umanizzazione deve sempre partire da precise interrogazioni etiche.

Parlando quindi di I.A. e di umanizzazione è come se avessimo di fronte la classica moneta a due facce. Ogni medaglia ha il suo rovescio e così ogni tecnica ha il suo rovescio. Questa bipolarità la conosciamo da sempre! E' come un diamante che ha con sé un doppio versante: da un lato splendente, dall'altro tagliente.

Abbiamo fatto la medesima esperienza anche con il nucleare e oggi abbiamo con l'I.A. anche da esaminare due versanti, due facce: l'una di bene e l'altra di male.

Anche i modernissimi droni, ne siamo a conoscenza, possono servire per consegnare merci a domicilio o per bombardare residenze o sedi istituzionali.

Di fronte alle macchine cibernetiche automatiche (Machine Learning) e di fronte all'intelligenza aumentata, che oggi viaggia verso il riconoscimento automatico dei profili facciali e delle emozioni, nel tentativo di imitare al massimo qualità propriamente umane, occorre riflettere e prendere atto che le MACCHINE non sono altro che magazzini di conoscenza, archivi storici non critici, strutture che includono sistemi efficienti ed intelligenti, ma **mai** cognitivi.

Personalmente stento ad accettare la definizione di Intelligenza Artificiale, ormai in uso: L'Intelligenza è un processo mentale umano, di struttura cerebrale evoluta, capace di inventare, costruire macchine speciali, organizzarle, renderle utilizzabili, sempre con la consapevolezza che la macchina non potrà mai avere prestazioni sensoriali o coltivare il *senso dell'intelligere*.

Le macchine mancano di saggezza: da freddi combinatori capiscono solo quel che in loro è stato immesso e impostato, non vanno oltre.

Sono sciocche, non sagge, non ragionano oltre, non capiscono.

Assemblano dati, archiviano e possono mescolare quanto archiviato.

Non elaborano la conoscenza, ma semplicemente la immagazzinano.

Non hanno valore intrinseco di ricerca della verità, pur essendo state create in equilibrio con la natura.

Le macchine sono in grado di agire più automaticamente che autonomamente.

In sintesi, forniscono funzioni per quel che in loro è stato impostato.

Da medico sono particolarmente attento alle relazioni, ai sentimenti e su questo profilo nessuna macchina ci potrà aiutare.

Presso il Dipartimento di informatica dell'università degli Studi di Bari, diretto dal Prof. Lanubile, stanno lavorando sulla interdisciplinarietà dell'informatica, con specifico riferimento sia al riconoscimento facciale (cosa già esistente negli aeroporti) ma anche al riconoscimento delle emozioni.

In un recente incontro alla precisa domanda: "Potrà una macchina essere in grado di riconoscere le emozioni?" il Prof. Lanubile ha risposto che il riconoscimento automatico delle emozioni certamente sarà reso possibile dall'I.A.: lo sarà quando avremo programmato un algoritmo che, emulando in toto un essere umano, sarà in grado di rappresentare *emozioni, capacità di visione, capacità del parlato, capacità del ragionamento*.

Per il riconoscimento delle emozioni già oggi esistono elaborati modelli, cosiddetti circonflessi, in grado di rappresentare la piacevolezza dello spirito o la spiacevolezza di situazioni inattese.

Oggi dimensioni orizzontali e ortogonali riescono a mappare una rete di emozioni che possono dare esprimibilità in 6 diversi volti: Sistemi esperti sono in grado di esplicitare l'apprendimento di molteplici mimiche.

Oggi il riconoscimento delle emozioni già attuabile ed è metodo ben consolidato, abituato ad interpretare espressioni emozionali facciali.

Altrettanto consolidato è il riconoscimento dal parlato, tanto che sono disponibili già in commercio programmi dedicati.

Sono stati messi a punto sensori di base per il riconoscimento delle emozioni e questi, meticcianti con E4 sensor, potrebbero rilevare e manifestare tanti segnali emozionali, incluso il dolore o la gioia.

Un'azienda fondata a Boston si chiama **“Empatica”**. Questa costruisce dispositivi indossabili principalmente utilizzati per il riconoscimento precoce di epilessia, proprio al suo esordio di crisi.

Caschetti indossabili sono stati sviluppati per cogliere condizioni emotive particolari, capaci di catalogare, addestrare modelli e capire particolari stati emotivi.

Va evidenziato che l'I.A., basata sull'apprendimento automatico delle emozioni, funziona già oggi molto bene ma nel futuro, così riferiscono gli scienziati, avendo sempre più dati a disposizione, ogni funzione renderà il meglio possibile.

Forse dobbiamo crederci, anche se, personalmente conoscendo la singolarità delle persone, penso che sarà davvero difficile interpretare come dal vivo le singole molteplici emozioni.

Non voglio essere scettico rispetto all'innovazione, ma sono fermamente convinto che il senso dell'intellighere, nel suo complesso, sarà difficilmente emulabile nel tecnologico.

Ho amato per oltre 60 anni la Medicina dei 5 sensi+1, conosco bene le endorfine e le loro azioni/reazioni, le ho sempre definite fulmini a ciel sereno, capaci di percorrere in milionesimo di secondo le circonvoluzioni cerebrali. Ho imparato anche la rivoluzionaria evoluzione del pensiero, della mente umana, che dalla logica delle intuizioni è passata a sposare l'analogico e capisco bene che per nulla e per nessun motivo al mondo dovremmo trascurare l'importanza dei sensi, dello sguardo (vista), dell'ascolto (udito), del tocco (tatto), del gusto e dell'olfatto: i sensi realizzano in contesti di alta unicità relazioni empatiche e su questi profili non vorrei mai che le risposte umane siano affidate a programmi informatici, anche se questi possono facilitarci per la massima rapidità che hanno nell'elaborare tutte le risposte da dare.

Papa Francesco in una locuzione ai Vescovi li aveva esortati ad essere Pastori nella comunità dei credenti e ad essere così vicini alle loro creature da avere indosso l'odore delle pecore. Parafrasando questa frase, da medici, noi dovremmo avere addosso l'odore dei malati perché quel fastidioso impatto della sofferenza ci serve per essere nutriti nella com-passione, facendoci spiritualmente gustare anche il più amaro dei calici.

Questo è il fare sensoriale della Medicina che mi ha guidato nei miei 60 anni di professione e dal quale non vorrei mai allontanarmi. Non credo che la tecnologia e l'I.A. potranno abbracciare in toto queste frontiere della com-prensione.

Con molta modestia mi permetto di segnalare la bellezza, la tenerezza e il pathos di quel meraviglioso “metodo clinico” del chinarsi (Klineo) che non ha mai conosciuto crisi, ma

che non ha per fortuna mai incontrato un codice a barre o un codice alfanumerico, pur se imposto dalla globalizzazione.

Interrogiamoci sul perché una scienza, altamente umana, vera Arte, senta oggi l'esigenza di essere oggi riumanizzata. Probabilmente con molto presapochismo l'abbiamo progressivamente disumanizzata.

Mi riferisco alla Medicina della conoscenza, della coscienza e della sapienza, che oggi ha perso il fervore e il calore dell'umano.

Occorre un meticcio culturale che non disperda queste esperienze culturali e morali nell'accogliere con saggezza le positive applicazioni e utilità di una tecnologia cibernetica.

Senza mai essere disillusi affrontiamo con gioia e con positività prospettica l'Intelligenza Artificiale che certamente può:

- Migliorare i servizi di diagnosi e cura
- Per la sua infinita ed inesauribile capacità di immagazzinare dati e profili personali avrà memoria sempre più aumentata e attitudine ad elaborare statistiche sanitarie e a costruire personali e complessi fascicoli sanitari.
- Nella digitalizzazione dei dati, elaborando risposte rapide, efficaci ed immediate, assemblerà anche le notizie più variegata, anche quelle meno aggregabili, che risulteranno indispensabili per interpretare e leggere la globalità anamnestica e la singolarità delle persone. Le applicazioni digitali sanitarie saranno indispensabili nell'applicare molteplici opzioni in telemedicina, teleconsulti, chirurgia robotica a distanza, aprendo orizzonti di altre mirabili e salutari opportunità.
- Anche in termini di miglioramento dell'offerta sanitaria avremo certamente vantaggi per una migliore e più opportuna organizzazione sanitaria.
- In positivo, grazie alla tecnologia, potremo in futuro fruire di un migliore sviluppo umano e prevedere sapienti cooperazioni e integrazioni nel mondo.
- Forse dovremmo raccomandare a tutti l'indispensabile necessità di porre la persona sempre al centro per far partire da questa centralità tutti i raggi operativi, assemblando in un unicum etica: diritti umani, visione empatica, vita personale, professionale, sociale e familiare, costellazioni di un universo da mai denegare.
- Forse però, nel futuro dovremo saper evitare la bulimia dei mezzi informatici per evitare al contempo l'anoressia dei fini.

Ma ora mi sia permessa una raccomandazione:

L'arte medica non sia mai oscurata da leggi di mercato!

Se vanno in crisi funzioni, quali l'affettività, l'accompagnamento, le competenze scientifiche, morali, spirituali e sociali, sicuramente possono vaporizzarsi e smarrirsi quegli essenziali canoni di beneficiabilità e di umanità, connessi al fare medicina.

Credo che questi suggerimenti siano essenziali per essere ben aderenti al tecnologico, ma mai subirlo. Francamente non so se fino ad ora abbiamo percorso strade sbagliate... ma come dice un antico detto *"Sbagliando si impara"*.

Questo assunto proverbiale ci stimola comunque a ripartire col piede giusto, muovendo dall'apprendimento dell'errore per evitare di cadere nel suo paradosso. Apprendere dall'errore è cosa buona e positiva. E' segno di umiltà e di grandezza ma soprattutto di grande responsabilità.

E' proprio su questi punti che va ridiscussa ogni deriva di Medicina tecnologica frettolosa, del tempo minimo, della "sveglia al collo" della catena di montaggio aziendalistica, oggi divenuta un "mantra".

La Medicina che diventa frettolosa, anche per movimentare il tecnologico o per dare spazio a compiti meramente burocratici, importanti per altri fini, è un errore madornale! Va ridiscussa! Non possiamo perseverare in errori già compiuti e dobbiamo smettere di sbagliare!

Ridiscutiamo con sapienza i compiti di una medicina della persona riaffermando l'insostituibile e l'essenziale umanesimo. Solo allora le scienze mediche potranno trarre massimi benefici dai sistemi di I.A., di digitalizzazione, di innovazione tecnologica.

In tal senso, l'intelligenza artificiale sarà costruito positivo per la nostra vita e probabilmente allora dovremo inseguirla e considerarla, non strumento antagonista, ma strumento amplificatore e facilitatore.

Mi auguro che la presente riflessione possa incardinarsi in tutte le problematiche bioetiche connesse alla *care*, senza mai trascurare la riflessione giuridica sempre più imposta dalla tecnologia avanzata.

Vorrei che la presente riflessione si incardinasse anche in una utile discussione riguardante le problematiche bioetiche connesse ed emergenti, ma anche su tutte le ricadute giuridiche che le tecnologie avanzate ripropongono in modo diverso.

Nel contesto dell'Associazione Medici Cattolici Italiani abbiamo molto discusso sull'Intelligenza Artificiale. Siamo stati in tanti a non temerla e ad accoglierla tra le più rappresentative e affascinanti innovazioni proposte dallo sviluppo tecnologico.

Nell'approfondire i vari campi di applicazione dell'Intelligenza Artificiale (sociale, lavorativo, industriale, militare, di polizia, di sorveglianza, della comunicazione, ecc.), di cui è disponibile una vasta letteratura in proposito, abbiamo sollecitato due aspetti che sottolineano alcune raccomandazioni del Comitato Nazionale di Bioetica espresse nel parere del 20 maggio 2020: "Il termine 'intelligenza', coerentemente con il termine inglese 'intelligence', non designa qualità propriamente umane conferite alle macchine, ma descrive funzioni che rendono alcuni comportamenti delle macchine simili a quelli di un essere umano".

In ogni caso, senza voler entrare nell'esame delle caratteristiche tecniche delle varie tecnologie o anche dei robot (con il corpo, senza il corpo, "stupido", "intelligente", che svolge automazione o macchina autonoma non necessariamente antropomorfa, ecc.), desideriamo sottolineare la necessità di disporre nel nostro ordinamento professionale la revisione del Codice deontologico dei medici (ultima edizione 2014). In tal senso abbiamo sollecitato anche la FNOMCeO ad attuare necessari ed ineludibili approfondimenti per disporre conseguenti decisioni.

E' proprio opportuno oggi affrontare i molti quesiti riguardanti il ripristino di un umanesimo nella società digitale e riflettere su tutti i campi della Medicina, nei quali gli algoritmi dell'intelligenza artificiale potranno dare più rapide risposte rispetto a quelle umane e nelle quali l'utilità dei sistemi appare stratosferica.

Che la digitalizzazione sanitaria risulti indispensabile in tanti campi nessuno più lo nega, anzi in molti la rivendicano per una migliore ri/organizzazione dell'assistenza sanitaria, nei progetti di continuità terapeutica ospedale-territorio, in telemedicina, per consulenze mediche a distanza (teleconsulto), ma anche per le tante emergenze connesse all'aumento della popolazione anziana e delle patologie croniche degenerative e ancor più in Oncologia;

Tra le tante applicazioni ed utilità v'è lo studio delle malattie genetiche, la medicina di precisione, la medicina personalizzata, la medicina predittiva proattiva, la sperimentazione clinica sui farmaci, l'imaging diagnostico, la robotica, le chirurgie, ma anche altri ampi settori, laddove viene consentito di intervenire anche a distanza.

Indubbi sono i vantaggi, maggiore la precisione, minore l'invasività.

Senza dubbio dovremmo pensare alla intelligenza artificiale in modo proattivo. Vigilare e guidare il progresso in modo che possa essere realtà di crescita positiva per l'umanità è cosa positiva.

Grandi sono ormai le possibilità tecnologiche offerte ai medici e anche accolte in modo entusiastico. Da parte di alcuni si sottolinea la preoccupazione che un uso incontrollato possa danneggiare la relazione con il malato.

Occorre a questo proposito che non prevalga la tecnocrazia, l'“algocrazia” e il “potere degli algoritmi”.

Se c'è prudenza, sapienza, umiltà e grande preparazione professionale e spiccati profili etici e morali, sicuramente non sarà tolto mai tra paziente e medico quel canale diretto di comunicazione e di alleanza, così come la possibilità di provare reciproci sentimenti di compassione e di sostegno nel superare crisi umane e complesse, quali quelle che aprono la prospettiva anche della morte.

Se il medico, si libera grazie all'intelligenza artificiale di una parte importante del suo lavoro burocratico, amministrativo e gestionale, nei percorsi diagnostico-terapeutici, troverà più tempo per la relazione colloquiale con il malato.

A tutti noi pare che in questo senso trovi grande applicazione l'auspicio fortemente voluto da Papa Francesco e riferito allo “Sviluppo umano integrale”.

Sono proprio le parole del Papa che ci inducono a sottolineare alcuni punti:

- A chi propone di ignorare l'umano diciamo che la Medicina non può permettersi di commettere questo grave errore abbracciando il solo tecnologicamente avanzato che da solo appare scarno e disumano.
- A nostro parere difficilmente l'intelligenza artificiale potrà sostituire l'essere umano in operazioni chirurgiche complesse: ribadiamo che la tecnologia va guidata dalla mente umana.
- Difficile battere l'umano in termini di creatività! Non è possibile pretendere dall'I.A. di prendere delle decisioni per rispondere a situazioni impreviste nel modo più appropriato possibile: solo la mente umana lo può fare.
- Malgrado l'accuratezza raggiunta dall'I.A. nell'assistenza sanitaria routinaria, rileviamo che molte sono le limitazioni che la rendono inapplicabile in percorsi di cura complessi e pluridisciplinari.
- Rileviamo che all'I.A. non sono affidabili capacità empatiche; l'I.A. non può interpretare e comunicare emozioni; non può sostituire l'ideazione e l'intuizione dell'essere umano, né può avvalersi di quelle facoltà, ampie e articolate, che conducono a scelte pro attive e vincenti.

In sintesi riemerge il ruolo dell'umano, come assolutamente indispensabile per orientare il cammino della tecnoscienza: Il dinamismo della tecnica potrà nella società 5.0 svolgersi in modo ottimale solo sotto la guida dell'umano.

Dobbiamo stare molto attenti ad escludere dai percorsi di diagnosi e cura il massimo caposaldo della Medicina che è l'umanizzazione.

L'umanizzazione va oltre la corporeità e include la spiritualità in una sintesi non frantumabile.

La Medicina è arte profondamente umana che percorre contesti umani con finalità olistiche.

Queste funzioni della Medicina non sono assolutamente sostituibili perché toccano al pari corporeità e spiritualità.

CONCLUSIONI

Non per ideologia, ma per reale esigenza umana, queste considerazioni vanno sottolineate oggi in contesti definiti post-moderni e post-umani nei quali occorrerà lavorare per ridefinire l'umano, per ridefinire le strutture profonde del sentire comune che ci sono necessarie per ricomporre la saggia visione della nostra vita, quella che ci sta a cuore e che dovremmo custodire e promuovere.

Noi medici dovremmo stare attenti affinché la clinica non sia soffocata e prevaricata dalla tecnologia. Occorre abbattere l'esaltazione assoluta del tecnologico, ma anche quella autoreferenziale del "secondo me" e aprirsi a necessarie integrazioni. La Medicina del consulto si apra al "Secondo noi", si apra alla collegialità e si sviluppi in Medicina di precisione, in Medicina sartoriale (tailored medicine) che veda la persona al centro.

Questo è il momento più opportuno per abbattere quelle posizioni che hanno condotto alla crisi dell'umano e hanno determinato ricadute inumane, assolutamente non tollerabili: tra questi la tendenza ad ignorare l'umano e ad agire secondo filiere tecnologiche.

Nell'attuale percorso giubilare indetto da Papa Francesco ed intensamente dedicato alla speranza, mi sia permesso di ricordare un pronunciamento contenuto nel capolavoro teologico di Paolo, Lettera ai Romani (Rm 5,5)

Spes non confundit, la speranza non delude.

E' questo l'esordio della bolla di indizione dell'attuale Giubileo Ordinario, che alla presenza del Santo Padre il 9 maggio u.s. è stata letta e resa pubblica.

Cogliendo questa felice occasione è forse opportuno che un medico cattolico si proietti nella dimensione del suo Spirito cercando di calare questo pronunciamento di Paolo nell'ambito della vita personale, professionale e sociale.

Il medico nell'esercizio della sua arte deve essere capace di dare risposte abili, *respons e abilitas* sono la radice latina della respons-abilità.

La responsabilità in medicina non è quella più temuta, cioè quella medico-legale! Essa responsabilità ha un valore assai più ampio e non deve mai mancare.

Respons abilitas significa risposta, abilità, competenza, empatia e tanto altro, affinché si esalti quella C di Cattolico contenuta nel logo dell'AMCI e nel distintivo che portiamo.

Allora, assumere la propria responsabilità significa difendere responsabilmente la vita di ogni persona sempre, dagli *albori della singamia/cariogamia del nascere al tramonto naturale*, riaffermare *la serietà della coscienza e della responsabilità* degli operatori, operare e servire il malato in tutte le fasi di sofferenza, fragilità e disabilità, farlo con acutezza, vigile attenzione, trasparenza, dedizione personale, forza e concentrazione perché l'andare incontro alle tribolazioni umane sia efficace risposta al dramma/tragedia della sofferenza umana. Questo andare incontro non manchi mai e si associ sempre a quella necessaria profondità che caratterizza l'incontro dell'uomo con l'uomo, dell'io con l'altro.

Il buon Samaritano è icona emblematica di una speranza che salva (SPE SALVI).

Rimane sempre un mistero l'universale esperienza del male e della sofferenza, ma noi saremo sempre più aiutati a penetrare questo mistero quanto più da uomini sapremo essere accanto e vivere la profondità etica e morale di questo nostro impegno professionale.

Desidero concludere con un augurio:

Illuminati dalla fede sempre, anche all'interno di sistemi di insufficienza ed inadeguatezza delle strutture di assistenza, con o senza intelligenza aumentata, con o senza intelligenza artificiale, con o senza machine learning, le nostre azioni siano sempre in grado di abitare il futuro dell'uomo con dignità, responsabilità, carisma e carità cristiana.

L'UMANO PROCREARE CAMBIA VOLTO SE TRAVOLTO DA TECNOLOGIE AVANZATE. DA DONO SI TRASFORMA IN DIRITTO E PRETESA

di Filippo M. Boscia



- Professore Universitario di ruolo sin dal 1980 – Titolare emerito della Cattedra di Fisiopatologia della Riproduzione Umana e di Bioetica c/o Facoltà Medica dell'Università degli Studi di Bari.
- Direttore di Dipartimento per la Salute della Donna e la Tutela del Nascituro
- Presidente Emerito della Società Italiana per la Bioetica e i Comitati Etici (SIBCE), oggi Presidente Onorario.
- Accademico di Storia della Medicina e delle Arti Sanitarie.
- Past President Nazionale dell'A.M.C.I. (Associazione Medici Cattolici Italiani).
- Consultore Pontificio e della Conferenza Episcopale Italiana (CEI).
- Autore di oltre 300 pubblicazioni scientifiche su riviste nazionali ed internazionali.
- Editor di 20 volumi di Ginecologia, Ostetricia, Andrologia e Bioetica.

La dirompente innovazione tecnologica che inonda le cronache contemporanee, riguarda tutti gli ambiti, stimola riflessioni sulla modernità del fare e delle azioni, riceve spesso consensi e positivi commenti, ma anche consistenti dissensi. Spesso ci si fa esperti della materia, si parla, si commenta, si giudica senza essersi documentati abbastanza! Ma accade che, in mancanza di precise conoscenze, può venire a mancare quella ineludibile sapienza utile a non far confliggere fra loro tecnologia e bioetica.

Condurre una riflessione su quanto sinteticamente espresso nel titolo è oggi esigenza irrinunciabile nel puntuale tentativo di rispondere a tantissimi interrogativi etici.

Occorre prendere consapevolezza che la “*procreazione*” umana, transitando attraverso la tecnologica “*riproduzione*”, sta pian pianino esitando nella deprecata “*produzione umana*”, settore innovativo di una filiera produttiva economica.

La nostra epoca post moderna, mirabilmente definita da Bauman “società liquida”, tra mutamenti sociali e culturali, pervasa da un’economia di mercato che ha già dimenticato del tutto l’etica, si appalesa, per così dire “drogata”, priva di riferimenti valoriali.

Questo mio contributo vuole avere l’ambizione di reintrodurre, in un dialogo franco e senza equivoci, l’onestà ridefinizione semantica di un linguaggio di verità che reca in sé l’obbligo di sfuggire alle trappole dei pregiudizi, delle ideologie virali, delle intolleranze, delle anarchie o delle radicali opposizioni, per ricercare quell’equilibrato e necessario bilanciamento tra nuovi diritti, etica ed ineludibili doveri.

Il principale obiettivo è quello di far chiarezza nel buio intenso di un’era politica, influenzata da domini autoritari che, utilizzando linguaggi pieni di camuffamenti e di definizioni edulcorate, giungono a denegare verità assolute.

L’insidioso lessico dell’antilingua persegue progetti tendenti a cosificare tutto e tutti, persino madri o padri, ormai senza più nomi e volti, posti alla ricerca di vite embrionarie, anch’esse cosificate come veri oggetti di possesso e non più soggetti/persone.

La “procreatica”, nuova scienza del nascere, con molta rapidità ha presto trasformato il *nascere* oggi in business aziendali e già propone un nuovo lessico e un nuovo campionario/catalogo che parla di contratti e comodati d’uso, di committenti, contraenti, prestatori o venditori di gameti, di donatori/donatrici – venditori/venditrici di spermatozoi ed ovocellule! Non mancano offerte locative di utero, strutture di ectogenesi, gravidanze per contratto o, si fa per dire “in comodato d’uso”, proponendo adesione a cooperative riproduttive a composizione variabile, gestante accettante “**dede**”, donatrice/venditrice di ovociti “**dona**”, ecc.

In questo melange ritroviamo genitorialità condivise, genitori contrattuali, genitori/genitrici che accolgono nuove figure a loro assolutamente estranee, nemmeno più coincidenti con le figure dei genitori genetici, né con i possessori di gameti, magari di diverse etnie, abitanti in stati lontani.

Parliamo di esportazioni o importazioni di gameti maschili e femminili, ossia di gameti freschi o congelati, cataloghiamo e selezioniamo embrioni freschi e congelati, assegnando quel bollino blu o rosso che sia, così come accade nelle accreditate filiere mercatali, che garantiscono il prodotto.

Si evince che la struttura antropologica della famiglia (madre-padre-figlio) non è più di moda e potrà ulteriormente evolversi in legami innovativi, che, includendo figure surrogate, ma anche gravidanze surrogate per garantire la consegna di un figlio perfetto come da ordinazione.

Non importa se questo figlio commissionato incontrerà figure genitoriali diverse, viste e non viste, comunque multiple e senza obbligo di fedeltà, ma pur trascrivibili su documenti ufficiali con codice alfanumerico o codice a barre, genitore da 1 a 6 o anche di più.

Il triste mercato dell'umano cresce fino a costituire quella che con un linguaggio addolcito e politicamente corretto, viene definita "famiglia allargata per gestazione donativa", famiglia colorata, arcobaleno, mista, polivalente.

Tante eufemistiche definizioni spesso occultano vere e proprie nuove schiavitù, in risposta a fantasiosi desideri che, rivendicati come diritti assoluti, sono solo *delitti* o pretestuosi *capricci*.

I recenti fatti di cronaca raccontano di nuovi modelli di surroga, ove genitori contrattuali si mescolano come metalli in un unico crogiolo, con genitori committenti, genitori genetici, genitori portatori, genitori affidatari, genitori d'adozione ecc.

Su questa e tante altre specifiche questioni abbiamo l'obbligo morale e direi anche sociale di rispondere.

Questo obbligo è ancor più accentuato dal fatto che le tecniche di riproduzione assistita sono giunte oggi a delocalizzare nel mondo le varie fasi della gravidanza, anzi oggi sono in sperimentazione innovative macchine e complessi sistemi, quali quelli di ectogenesi, definiti anche *placenta artificiale*.

Non è fantascienza, ma siamo nel pieno di quella cosiddetta filiera riproduttiva preposta a controllare e regolamentare ogni sperimentazione per migliorare la qualità del prodotto e le maggiori percentuali di successo.

I confini delle tecniche non hanno limiti, ma noi sosteniamo che i confini della genitorialità non possono essere allargati a piacimento. Non dovremmo mai discutere su quanti padri e quante madri siano necessari per la costruzione di una vita, ma dovremmo dire "Nati da un padre uomo e da una madre donna" e non nati artificialmente da multipli soggetti denominati poi genitore 1, 2,3,4,5,6 ecc.

Quante madri? (Genetica, fenotipica, portatrice, culturale, di adozione, di allevamento)

Quanti padri? Idem con piccole variazioni ininfluenti. Quanti e quali genitori? Quante e quali famiglie? Quanti i diritti di famiglia? Quali risposte ai contemporanei quesiti?

Quali risposte alle possibili domande dei figli del futuro?

E i nuovi nati? Per loro riserviamo una interrogazione permanente che riguarda il loro futuro e le loro dinamiche psico-affettive e comportamentali.

Anche loro avranno da interrogarsi: Chi sono? Da dove provengo? Dove vado? Con chi vado? Con quali garanzie di fedeltà, di amore, di affetti? Con quali e quanti genitori? Quali i modelli genitoriali da seguire?

Cultura e natura sono realtà alleate o contrapposte? Cosa seguirò da grande: la mia natura o la mia cultura? Riceverò messaggi divaricanti schizofrenici o messaggi equilibrati? Questa è certo un'iniziale anticipazione riferita a pratiche ormai d'uso corrente planetario che affidiamo non solo alla nostra coscienza, ma anche al nostro equilibrio, alle norme del diritto internazionale e alle sue fonti.

Anche le economie planetarie sono in crisi ed anch'esse non collimano più con il rispetto della vita e della salute del pianeta, né con il rispetto dell'uomo.

Forse c'è da chiedersi molte cose sui diritti umani! Forse occorre operare una distinzione tra desideri e diritti, tra capricci e diritti.

Quanto descritto è già realtà! E per molti versi ha già operato una mutazione globale che cambiato il volto della procreazione umana, diventata riproduzione/produzione, forse disumana.

Si avverte un ulteriore pericolo in riferimento alla delocalizzazione temporo-spaziale delle fasi della riproduzione umana alla ricerca del migliore modo, migliore tempo e del migliore luogo per iniziare il processo del nascere, ma anche in riferimento al dove, al con chi e per chi nascere.

Per questo abbiamo l'obbligo di sottolineare e definire la nuova armonia del nascere.

Scardinato del tutto è il noto detto "di mamma ce n'è una sola" perché ormai non possiamo essere più sicuri di quante possano essere le figure genitoriali che entrano in gioco all'interno di un processo procreativo soprattutto nelle molteplici fasi della surroga (maternità surrogata).

Descriviamo oggi un nuovo volto disumano del nascere mentre continuiamo a trascrivere e registrare i tanti e complessi contratti schiavistici stipulati nel mondo (inclusa la clausola "soddisfatti o rimborsati").

Per questo abbiamo l'obbligo di sottolineare e definire la nuova armonia del nascere.

Alcune annotazioni vanno obbligatoriamente descritte:

- La prima riguarda la natura, il mistero e lo splendore dell'evento nascita e questa, a mio parere, costituisce il principale motivo di questa riflessione.

- La seconda è quella legata al ricorso all'utero in affitto da parte di chi, coltivando un'unione omosessuale, acquista, utilizza o recluta madri surrogate, spesso povere e senza potere, al solo scopo di promuovere la cosiddetta "*riproduzione per altri*" (eufemistica definizione che occulta vere e proprie schiavitù).
- La terza sottolineatura è che, come avviene in epoche di dominio autoritario, molti cittadini e/o giornalisti sono obbligati ad un linguaggio "politicamente corretto", usato in particolar modo dai notiziari del servizio pubblico radiotelevisivo, ma anche da molta carta stampata. Avviene che si realizzi così, attraverso i mass media un impressionante camuffamento della dura realtà, la più ampia cosificazione delle madri e dei padri che, come già detto, restano senza nome, senza volto, esecutori/esecutrici di contratti padronali.

Anche alcuni politici sono stati diretti o indiretti protagonisti: da "compratori" di ovociti di una donna, subappaltando il corpo di un'altra donna, madre in fitto, fattrice/produttrice di un figlio biologico, hanno assistito al parto di quest'ultima, rivendicando omosessuale genitorialità, senza consenso del nato, legalmente legittimata all'estero e politicamente accettata in Italia.

Tutto ciò si è svolto in un mortificante silenzio, in aperta e palese violazione di una legge anti-schiavista, chiaramente emanata e poco rispettata nella costumanza del nostro Paese. Il triste e ben radicato dell'umano cresce e ha ingressi da destra e da sinistra! E smettiamola di chiamarli «diritti»! Basta! Ritorniamo ai valori! E ad alta voce reclamiamoli senza scantonamenti di sorta.

Siamo qui per condurre responsabilmente un dialogo, affinché la più grande forza al mondo sia fondata sulla pratica dialogica del bene, nel tentativo di sfuggire alle tante trappole ideologiche del modernismo, dell'intolleranza, di apodittiche opposizioni a quello che la natura ha costruito e migliorato sin dalle origini.

Siamo qui per guardare con fiducia e attenzione agli sviluppi della scienza e lo facciamo senza alcuna demonizzazione, ma senza mai disgiungerci dall'assoluto rispetto per la dignità della vita, rispetto che per me e per tantissimi altri è esigenza prioritaria ed ineludibile.

Da studioso di Fisiopatologia della procreazione umana sono sempre stato dalla parte di chi non ha voce, dei concepiti e per questo desidero concludere questo mio intervento, soffermandomi a descrivere il miracolo della vita che ogni semplice mamma dona al nascituro, al concepito, nel rispetto del naturale percorso fisiologico.

Nella procreazione secondo natura, ogni madre dona sé stessa al concepito: Dona il nido di accoglienza nel momento massimo della sua fragilità, dona ogni necessaria armonica complementarità, realizza quella generatività che vede la madre fecondata, splendida e generosa genitrice, aprirsi alla vita, nel nome del padre e nel nome della madre e, senza egoismi, nel nome del figlio, che si proietta da piccolo tra i piccoli nel mondo.

Nella gravi-danza si svolge davvero una “danza”! Sì, davvero, si celebra una danza in quello splendido nido che è l’utero destinato a trasformarsi presto in quella grande ma piccola discoteca di vita, ricca di tepore, di dondolio climatizzato, vera culla, oltre che nido, per una *Gravi-danza* meravigliosa; danza della vita nella discoteca più piccola del mondo, ove la luce giunge per transilluminazione, ove l’umidità e le *acque madri* consentono una nuotata salutare in penombra, alimentando la piccola SPA (Salus per Aquam), scrigno di acqua, confort di ospitalità e nutrizione, luogo di acquagyn, ove fruscii, sibili, soffi, fremiti, onde e vibrazioni, intersecano lo scorrere di una benefica circolazione, mediata da un cuore che è un tamburo battente, sottofondo di intense e felpate melodie.

Al ritmo dell’infrenabile batteria del tamtam del cuore e al ritmo di un respiro pacato, a volte affannoso e della vibrazione vocale delle parole della madre si realizza un dondolio, una ginnastica primordiale nella prima palestra della vita.

Nella piccola SPA/palestra il calore costante e mitigato di una splendida primavera dà tutela e garanzia all’amabile fatica dell’incontro tra natura e vita, tra scienza e vita. Questo ambiente, dolcissimo, bellissimo e confortevolissimo, certamente influenza l’espressione del DNA dell’embrione, le sue endorfine, il suo primordiale imprinting psico-dinamico, che interconnette le evolutive emozioni con la preziosa interattività materna.

Durante la gravidanza, il feto vive **non in una cassaforte**, ma in un nido multisensoriale fatto di mille e più stimoli, di mille e più sollecitudini positive: dal gusto per i cibi che mangia la mamma e che, elaborati, gli giungono come gradite molecole, alla voce della mamma che arriva forte, distinta e sempre riconoscibile (il feto certamente riconosce quella voce dopo la nascita) agli ormoni prodotti dalla mamma, alle endorfine dello stress e della gioia, del dolore e della speranza. Tutto questo viene trasmesso al feto influenzando nell’epoca prenatale le sue risposte. Il feto prima di nascere riconosce la sua mamma, conosce i suoi modi particolari, le sue sollecitudini, le sue delicatezze, pur senza vederla ne assapora le caratteristiche, i profumi, odori e gusti. Alla nascita rielabora queste stesse sensazioni e sa ben riconoscere la strada verso il seno materno, riaffermando

l'etologico gusto di quel nettare che è il latte della propria mamma, riconoscendo tutta la ricca sensorialità, superlativo miracolo per la sua rassicurazione.

Succede tutto questo se la sua esperienza gestazionale avviene in un utero mercenario? E se avviene cosa accade nell'acuto e definitivo distacco al nascere?

Cosa succede in gravidanza se la mamma presta l'utero?

Cosa succede se la società prende congedo da ogni principio di natura, diventando preda di poteri globalizzati occulti, privi di riferimenti valoriali?

Nessuno lo sa, nemmeno noi ricercatori lo sappiamo... ma possiamo immaginarlo, traendo così le opportune conclusioni.

Riflettiamo per un attimo: passare la gravidanza nella pancia di una persona che non è quella che ti ha concepito, ma che nemmeno sarà la tua mamma... solleva o no inevitabili dubbi, anche etici? Pone o non pone delle domande dal punto di vista dei futuri accadimenti? L'azione posta in essere sarà tutta indifferente al futuro del bambino?

In realtà non lo sappiamo ancora perché gli *uteri in affitto* sono cosa recente e i bambini nati in questo modo sono ancora troppo pochi e ancora piccoli per evidenziare radici di bene o radicamenti traumatici. Qualche considerazione va fatta.

Il senso di commozione e felicità che la madre naturale emana dopo il parto è immensamente profondo. La madre respira il respiro del figlio!

E' una sensazione di dolcezza e calore che pervade il corpo e lo appaga totalmente.

E' qualcosa che sta a cavallo tra un'emozione e un sentimento, vera sensazione inconsapevole che ha a che fare con tutti i 5 sensi +1.

La vista di un essere piccolo, l'ascolto del vagito o di un lamento, l'odore del liquido amniotico che bagna i capelli e che li rende umidi, caramellati, quasi fissati.

La carezza così sublime che percepisce quella tenera umana creatura, calda, morbida, soffice, accarezzabile non ha pari nell'umana esistenza. Un bocciolo che miracolosamente si schiude...

Quel quadro di "eccelso apostolato" di una mamma con il suo bambino in braccio, piccolo indifeso, roseo, paffuto, a volte sì, anche scarno con manine e piedini talvolta freddi, è il quadro dell'amore perfetto, della maternità.

La modernità, avendo reso complesso il mondo ha amplificato gli spazi sociali, ma ha anche ridotto gli spazi etici delle responsabilità-

Credo che oggi sia grande delitto scalfire, profanare, distruggere l'icona della tenerezza materna: smorzare la reale incidenza del sorriso, delle emozioni e delle contemporanee

dolcezza, segno indelebile di tutte le ombre, i colori, i pensieri, i sentimenti primordiali di mamma e bambino non è lecito.

La tenerezza non si impara, la si vive come processo evolutivo vitale, come dimensione profonda e difficile da conquistare.

E' un lungo cammino che si percorre a partire da ogni singola fase della gravidanza e che occupa la vita intera. Tutti siamo chiamati a coltivare oggi la difficile riconciliazione, anche quando reale è l'impossibilità di conciliare l'unità interiore con le molteplici occupazioni che la vita attuale ci riserva.

La gestazione di una vita è il maggior prodigio mai scritto che travolge ogni costume e legge, che narra di una storia bellissima, avventurosa e che descrive la limpidezza di un viaggio di fede e di speranza, di disponibilità, di sacrificio, di bontà che esplicita la meraviglia di una storia misteriosa e sacra: uno scrigno prezioso si schiude nel grembo di una madre improntando di verità tutta la lunga storia dell'Universo e dell'umanità, ossia tutta la storia che dal nido iniziale si proietta nell'incantevole volo della vita.

RESTORING THE SOUL OF MEDICINE: REVIVING CHRISTOCENTRIC HEALTHCARE IN A VALUE-DRIVEN WORLD

Dr. Paul Braaton



About the Author

Dr. Paul Braaton is a highly respected orthopedic surgeon who has dedicated more than two decades to private practice in Modesto, California. Throughout his career, he has assumed numerous leadership roles at the local, state, national and international levels, advocating for ethical standards in orthopedics and promoting practices that prioritize patient well-being.

Currently serving as the chair of his hospital's peer review committee, Dr. Braaton undertakes the critical task of reviewing and objectively evaluating multiple clinical cases. Under his leadership, the committee ensures that the quality of patient care meets or exceeds established benchmarks, and that any deviations or shortfalls are promptly identified and addressed. This commitment to high standards has made Dr. Braaton especially attentive to the principles of value-based healthcare—he recognizes that suboptimal care can not only undermine patient outcomes but also contribute to preventable morbidity and mortality.

While Dr. Braaton acknowledges and appreciates the many positive aspects of value-based care—particularly its potential to enhance patient outcomes, quality, and safety—he also believes that focusing exclusively on value metrics without a guiding mission can lead to the compartmentalization and commoditization of both patients and physicians. In his view, when healthcare systems lose sight of their fundamental mission, they risk dehumanizing care through narrowly defined roles and processes aimed solely at efficiency. His paper critiques the trend of divorcing value-based care from its essential,

mission-driven ethos, urging healthcare professionals and organizations to remember that the true purpose of medicine is to serve the patient holistically, combining evidence-based practice with compassion and ethical responsibility, while also honoring the metaphysical and integral nature of the human person as body and soul.

Introduction

In an era where healthcare is increasingly defined by economic metrics and efficiency models, the very soul of medicine stands at risk. Value-Based Healthcare (VBHC), once heralded as a solution to rising costs and fragmented care, has gradually overshadowed the foundational mission that once guided healing professions—serving the whole person with compassion, dignity, and selfless love. (Georges, 2023) This shift has quietly but profoundly distanced modern healthcare from its deeply Catholic roots, where care for the sick was understood as an act of mercy and a direct service to Christ Himself. (Shannon, 2008) What was once a vocation driven by mission has become a system governed by profit margins, performance metrics, and cost containment, leaving both patients and providers spiritually unfulfilled and ethically compromised. (Groenewoud, Westert, & Kremer, 2019)

This paper will examine how the rise of value-based healthcare and its economic frameworks have displaced Catholic mission-driven care, eroding the integrity and depth that once defined the healing arts. (Corbett, 2016) It will argue for a return to Christocentric healthcare—a model where the dignity of every human person is honored, where care transcends metrics, and where healing is both a physical and spiritual endeavor. (Karches, 2023) This call is not merely for reform but for a transformative renewal of the healthcare landscape in the United States and beyond, restoring medicine to its true purpose: to love, to serve, and to heal in the image of Christ, the Divine Physician.

Background of Western Healthcare Systems

Modern Western healthcare is deeply rooted in Christian principles, most notably exemplified during the Plague of Cyprian around 260 AD. In stark contrast to their pagan counterparts who fled the infected cities, Christians remained behind to care for the sick and dying, regardless of religious affiliation. Their willingness to risk illness and death in service to others embodied a profound commitment to compassion and self-sacrifice, reflecting their belief in the sanctity of life and the promise of eternal salvation. This courageous response not only alleviated suffering but also laid the foundation for the

Christian mission of healing that continues to influence healthcare today. (Flexsenhar, 2020)

The Plague of Cyprian was named after the Bishop of Carthage St. Cyprian. This plague most likely involved smallpox and measles and lasted nearly 20 years. The sacrificial way Christians responded to this plague was one reason that Christianity grew so rapidly within the Roman Empire. Recognizing the transient nature of temporal reality and the supreme importance of eternal salvation, Christians selflessly devoted themselves to serving others, understanding that in doing so, they were serving Christ their Savior and affirming their faith in the resurrection and everlasting life. (Bisesi, 2021)

During this time, local churches organized efforts to provide food, water, and basic nursing care to the plague victims, which was extended to both Christians and non-Christians. This is the origin of Christian healthcare, consecrated in the mission of Christ Jesus, the Divine Physician. (Just, 2020)

The Rise and Failure of Value-Based Healthcare (VBHC)

Modern Value-Based Healthcare

The selfless, Christ-centered care that defined the origins of Western healthcare stands in stark contrast to the modern **Value-Based Healthcare System (VBHS)**, introduced in the 1990s. VBHS was designed to control rising healthcare costs by shifting the focus from volume to value—rewarding providers for *efficiency* and *measurable quality* outcomes rather than the number of procedures performed. This model, championed by Porter and Teisberg (Porter & Teisberg, 2006), was developed with goal of bending the cost curve while replacing the traditional fee-for-service approach, which often prioritized quantity of care over patient well-being. Over time, VBHC has been woven into global healthcare policy through major reforms such as the United States Affordable Care Act of 2010 (Lewis, 2022), initiatives by the World Health Organization, and widespread adoption of value-based purchasing programs across Europe and Asia. *The goal has always been to shift the payment model from one of quantity of service to some performance metric—however this has remained elusive, difficult, if not impossible to achieve. The timeline for implementation has continually been pushed forward whereas today the target implementation date is 2030.* (Werner & Emanuel, 2021)

The rise of the Value-Based Healthcare System marks one of the most significant shifts in the history of Western medicine, yet this transformation has garnered little attention from Catholic bioethicists—likely dismissed as a matter of economics rather than ethics. However, I contend that many of today’s most pressing bioethical debates stem

directly from this profound realignment of healthcare economics, policy and, more importantly, its underlying mission.

Economic Model Focused on Cost

Value based healthcare operates on a fundamental economic value where the value (v) is defined as the sum of quality (q) and patient experience divided by cost. *In reality the majority of time, patient experience is forgotten or left out of the equation. Most often the equation is $V = Q/C$.* (Porter & Teisberg, 2006) Further the questions arise: who defines quality? Is it subjective or objective or combination thereof?

Quality in value-based healthcare is frequently assessed through patient satisfaction surveys and a combination of subjective and limited objective data (Altsech, 2012). While these measures provide valuable insights, they may not fully capture the multifaceted nature of patient well-being and more fundamentally the metaphysical complexity of the human person. Functional measures and evidence-based metrics often fail to account for the individual experiences and emotional states of patients (Berenson & Kaye, 2013). For example, a hospital might prioritize early discharges to free up beds and reduce expenses, even if a patient feels rushed, inadequately informed, and sent home without proper support. (Siu, 2023) On paper, this practice may appear to reflect efficient care and rapid recovery—measurable indicators of quality—but in reality, the patient might rate the quality of care as poor.

Because quality metrics are difficult to define and are frequently subjective, cost and efficiency naturally become the dominant forces driving healthcare decisions. Originally designed to curb rising healthcare expenses and promote financial sustainability, VBHC has failed to achieve these goals. Instead, healthcare costs have accelerated under this model, making the U.S. healthcare system increasingly unsustainable. If value-based care was intended to save money, it's not getting the job done (CMS.gov, 2023).

In value-based model, cost efficiency dictates decision making. Strict budget controls and inflexible resource allocation often prioritize finances over what truly serves patient's best interests. If patients are intended to be happier under VBHC, this has not been demonstrated. In fact the frustration with healthcare among the public is at an all time high.

Ethical and Structural Failures in VBHC

Evidence-Based Practice Challenges

The reliance on evidence-based practices is a cornerstone of modern healthcare. However, the lag between emerging evidence and its implementation in clinical practice can hinder the delivery of the most current and effective treatments. This delay compromises patient care quality, as providers may rely on outdated protocols that do not reflect the latest advancements in medical science (Feinstein & Horwitz, 1997).

Catholic teaching affirms that every human person is both body and soul, created in God's image and likeness. While evidence-based medicine is a powerful tool for understanding the physical dimension, it cannot capture the full mystery of our spiritual nature. In ***the Western traditional hierarchy of knowledge, theology ranks highest by contemplating God; philosophy follows as the framework of reason; mathematics provides certainty in structure; and the empirical sciences, including medicine, operate within observable realities.***

Though valuable, the empirical sciences remain prone to human biases, manipulation, or fraud—especially when financial or political interests are involved. Recognizing these limits helps safeguard against reducing the patient to a mere data point. A striking example of this is the ***opioid crisis fueled by Purdue Pharma***. The company aggressively marketed OxyContin as a safe, non-addictive painkiller, deliberately downplaying and manipulating scientific research to minimize the drug's addictive risks. They funded studies, misrepresented data, and influenced healthcare providers to prescribe opioids liberally, leading to widespread addiction and countless deaths. This catastrophic misuse of science for profit exposed the devastating consequences of divorcing empirical research from ethical accountability (Chow, 2019).

Modern society has created a false idol regarding the scientific method as the ultimate pathway to truth. While it remains a powerful tool for discovery and innovation, it is not immune to the pitfalls of human error, subjective bias, or even outright fraud. ***In the realm of medicine, this emphasis on the scientific method has led to the perception that our vocation is now purely a science—something definitive, exact, and absolute. Yet, this is a reductionist view that overlooks the enduring art of medical practice.***

The scientific method, at its core, is neither inherently good nor bad. It is a structured process—a tool—that guides our attempts to understand the physical universe with ever-increasing depth and accuracy. As such, it remains neutral; its moral value depends on how people choose to use it. Ideally, it is meant to be self-correcting: hypotheses are formulated, experiments are conducted, data is collected, and conclusions are drawn

based on observed evidence. When this method is followed with integrity, it allows humanity to uncover consistent principles of the natural world.

However, the integrity of the scientific method can be undermined when it is manipulated to serve political, personal, or financial interests rather than a genuine pursuit of knowledge. In such cases, research may be designed or presented not to reveal facts, but to achieve a predetermined outcome that bolsters some self-serving agenda. What then happens is no longer a true scientific endeavor but rather a distorted misuse of a method that should remain impartial. The moment the scientific process is twisted to suit a particular narrative, it loses its chief strength: the commitment to objectivity and reliability.

This kind of manipulation contributes significantly to public distrust. When individuals see examples—whether real or rumored—of “science” being exploited for profit, wielded as a political tool, or molded to enhance personal reputation, they have every reason to feel skeptical about new findings or public statements labeled as “scientific.” Unfortunately, that skepticism can extend well beyond the specific misdeeds, casting a shadow of doubt over many scientific discoveries that are, in fact, thoroughly researched and genuinely valid. This erosion of trust complicates the communication between scientists and the broader society.

Ultimately, the public must have confidence that scientists and investigators are motivated by a sincere commitment to uncovering and sharing truth. When scientific findings are presented transparently, subjected to rigorous peer review, and remain open to scrutiny and replication by other researchers, they foster a spirit of mutual trust between the scientific community and society at large. Such trust is crucial if people are to accept new discoveries and integrate them into policy decisions or daily life.

In essence, the scientific method itself is a powerful means of discovery, but it requires honesty, transparency, and an ethical commitment to evidence-based conclusions. When those conditions are met, science can continue to expand human knowledge and enhance our collective understanding of the physical universe. The “buy-in” to scientific evidence depends on this pact between researchers and the public, a pact that must be nurtured through honest practices and clear communication—so that people recognize science not as a tool of manipulation, but as a reliable and trustworthy process providing deeper understanding of the physical universe (Hegde & Sampa, 2015).

Medicine, in reality, is just as much an art as it is a science. While intellectual rigor, evidence-based practice, and systematic inquiry are indispensable, the ability to connect

with patients on an emotional level is often crucial to therapeutic success. Emotional intelligence—sensitivity, empathy, effective communication, and the capacity to perceive and respond to patients’ mental and emotional states—can dramatically influence patient outcomes. By honing these interpersonal skills, physicians not only diagnose and treat conditions but also help foster holistic healing and wellness.

Recognizing the interplay of both art and science in medicine keeps us grounded in our true calling: to treat each patient as a unique human person rather than diseases alone.

Indeed, scientific breakthroughs can guide therapy, but compassion, understanding, and the human touch ultimately shape the healing journey. By restoring emotional intelligence to its rightful place alongside intellectual rigor, we reaffirm our vocation as physicians and uphold the humanity at the heart of medicine.

By placing evidence-based medicine within a holistic view of the human person and under the guidance of faith and reason, we uphold human dignity. This integration fosters a wiser, more compassionate approach to healing, uniting the best of scientific discovery with reverence for the body-soul unity God has bestowed on each of us.

Vertical Integration and Mergers

Initially, proponents of Value-Based Healthcare (VBHC) believed that vertical integration would enhance value, improve quality, and lower costs. By consolidating multiple stages of healthcare delivery—hospitals, physician groups, insurance providers, and ancillary services—into a single organizational structure, the goal was to streamline operations and achieve cost savings through economies of scale. In theory, this model promised seamless coordination and improved patient outcomes.

In reality, however, ***vertical integration has produced the opposite effect. Rather than encouraging competition and driving down costs, it has concentrated market power in the hands of massive healthcare conglomerates. The surge in mergers and acquisitions has allowed these systems to dominate regional markets, negotiate inflated prices with insurers, and prioritize financial expansion. As competition dwindles, patients face higher costs and increasingly impersonal, standardized treatment.*** (Wainer, 2024)

The healthcare industry has witnessed a surge in mergers and acquisitions (M&A), driven by the pursuit of greater market share and cost efficiencies. However, these consolidations often bring together entities with differing missions and operational philosophies. ***The resultant organizations may struggle to maintain a cohesive mission, leading to conflicts and a dilution of original values.*** This also leads to higher costs by reducing competition through increased market share. (Cutler & Morton, 2013)

This consolidation has affected physicians as well. Their livelihoods now hinge on remaining in good standing with corporate employers, creating ethical conflicts when institutional policies clash with their moral convictions, such as with cases involving contraception, sterilization procedures, in vitro fertilization, abortion, or so-called gender affirming care (Wardle, 1993).

While taking into account the adage "No margin, no mission," financial viability has overtaken the mission to heal, reducing healthcare to a corporate enterprise. Administrators and CEOs—especially within physician groups, hospitals, insurance companies, and pharmaceutical firms—have become more powerful than the physicians and patients they are meant to serve. In for-profit models, their primary allegiance is to shareholders and boards, not to human well-being (Gondi & Song, 2019). Even non-profit organizations and health care systems—entities that were traditionally guided by altruistic or service-oriented missions—now find themselves placing greater emphasis on so-called “value-based care.” This model, intended to measure and reward outcomes rather than volume, was originally introduced to align financial incentives with patient health outcomes. Yet in many cases, it has come to overshadow the core missions that once defined these organizations. Instead of remaining steadfast in their commitment to broad-based community service, preventive care, or health equity initiatives, some institutions have allowed the benchmarks and metrics tied to “value-based care” to become the primary lens through which priorities and decisions are made. As a result, patient services, resource allocation, and even leadership structures increasingly revolve around meeting these value-based directives. Where once the focus might have been primarily on accessible, compassionate care regardless of reimbursement rates, the drive for high-value metrics can create unintended consequences—narrowing the scope of services or favoring programs that promise better financial returns. In this way, value-based care has effectively superseded many institutions’ original missions, shifting organizational goals from community-driven mandates to those shaped by performance metrics and fiscal considerations. This shift in priorities has fueled a projected shortage of 450,000 physicians in the United States, even as the ranks of non-clinical administrators swell with disillusioned and exhausted former physicians. Healthcare’s mission is suffocating under both corporate and individual greed—a predictable result of a system that sold its soul for profit and now lives by, *“No margin, no mercy!”* ***Thus, we have the emergence of the powerful medical industrial complex that often acts in its own self-interest without regard to patient or physician.***

Standardization through Best Practices

Standardization in healthcare relies on uniform protocols and procedures to ensure consistency and reliability in patient care. While these standardized best practices can improve efficiency and minimize errors at times, they often come at the expense of flexibility and creativity. This rigid, one-size-fits-all approach stifles innovation and prevents healthcare providers from tailoring treatments to the distinct needs of each patient. This pattern is evident in several areas of healthcare: the management of chronic pain and opioid prescriptions, particularly for cancer survivors or individuals with severe nerve damage who may legitimately require higher doses (Ziegler, 2015); the routine use of birth control to address various women's health concerns without investigating underlying causes; the prescribing of gender-affirming interventions—such as puberty blockers, cross-sex hormones, and surgeries—without thoroughly exploring mental health conditions, past trauma, or social factors; and the widespread reliance on antidepressants as a first-line treatment for mental health issues (Settle, 1998), often without recommending alternatives like therapy, counseling, community support, lifestyle changes, or spiritual guidance.

Transactional Relationships and Commoditization

Prioritizing profit has reduced patient-provider interactions to mere transactions, stripping away the compassionate and spiritual dimensions of care. **Patients are seen as data points, and providers as interchangeable assets—an approach that violates intrinsic human dignity and erodes healthcare's ethical foundation.** (Pellegrino, 1999)

Corporate interests, political pressures, and financial motives increasingly shape how those transactions unfold, sometimes with remarkable ineptitude—an alarming reality made undeniably clear during the COVID-19 pandemic, which revealed how easily sacred ethical obligations can be cast aside. Governmental overreach and corporate influence suppressed legitimate scientific debate, silencing alternative perspectives on prevention, treatment, and public health strategies (Elisha, Guetzkow, & Shir-Raz, 2024). Decisions were often made to protect political interests and financial gains rather than prioritize public health and patient well-being. Policies shifted rapidly without transparent justification, obliterating public trust and sowing confusion. Pharmaceutical companies rushed vaccine development and distribution while dismissing or fear mongering affordable treatment alternatives (Orient, 2024). Media outlets and tech companies censored dissenting voices from medical experts, further limiting informed decision-making and patient consent (Niemic, 2020). This combination of political control and

corporate profit-seeking exposed how easily ethical responsibility can be consumed by corruption, leading to widespread mistrust, public harm, and a fragmented, chaotic healthcare response during a global crisis.

In the end, we were left with a profound sense of uncertainty—one that gave rise to a variety of conspiracy theories and made the general public increasingly wary of any proposed vaccination program. The lingering suspicion that the public might be subject to manipulation severely eroded trust in medical recommendations, prompting widespread hesitation. Over time, this wariness fueled misinformation, leaving communities torn between official health advice and skepticism shaped by doubt and rumor. Restoring confidence in vaccination efforts will require transparent communication, accessible education, and a commitment to engaging communities in meaningful dialogue, all of which are essential steps toward rebuilding the public's trust in scientific and medical guidance.

Value-based healthcare, while aimed at efficiency and cost-effectiveness, risks reducing the sacred work of medicine to mere quality metrics and financial returns based on a mathematical equation, where value and quality are not easily defined. When it operates independently of a mission-based framework—***one that recognizes every human person is created in the image and likeness of God***—it undermines the dignity, protection, and care for everyone involved but particularly the vulnerable as Catholic Social Teaching insists upon. ***In a hyper-sexualized culture, this secular reductionism denies the transcendent and metaphysical reality, shifting focus from the marvelous gift of life and the dignity of the human person to purely material considerations and personal self-gratification.***

Such an approach mirrors the biblical Tower of Babel, as described in Genesis 11:1-9, where people built lofty structures devoid of reliance on the divine. ***By pursuing “quality” and “value” on secular terms alone, medicine can breed confusion leading to the chaos of relativism, eventually eroding clear ethical principles through the denial of moral absolutes.*** At the 2005 conclave before his election, Pope Benedict XVI cautioned that ignoring moral absolutes leads to a ***“dictatorship of relativism,”*** where debate is stifled and ideals give way to power and profit. This is evident in the medical-industrial complex, where cultural and societal pressures, national and geopolitical interests, insurers, pharmaceutical companies, pharmaceutical intermediaries, hospital systems and physician groups drive care models that value financial gains and political expediency over the common good.

When healthcare models prioritize profit over people, it becomes easier for society to accept even more extreme forms of commoditization. This mentality is tragically evident in industries where human life is explicitly bought and sold—such as commercial surrogacy, where women’s reproductive capabilities are reduced to market commodities (Arneson, 1992), and in the horrific realm of human organ trafficking, where vulnerable individuals are exploited, and organs are harvested for the highest bidder (Kassim, 2013). These practices reflect the dangerous consequence of reducing human beings to mere economic value. ***Healthcare must resist commoditization at every level, reaffirming the intrinsic dignity of each unique and non-repeatable human person made in the image and likeness of God.***

Narrowing of Physician Roles

Physicians functioning mainly as specialized interventionists or technocrats have limited time to learn about a patient’s background, social context, and personal concerns. This fragmented structure undercuts comprehensive care, leaving critical needs unaddressed and deteriorating the physician-patient relationship. A clear example of this fragmented care model is seen in orthopedic surgery, particularly in joint replacement procedures. A patient undergoing a knee replacement may briefly meet the orthopedic surgeon during the initial consultation and then again on the day of surgery. Post-operative care is often delegated to physician assistants, physical therapists, or hospitalists, with little to no direct follow-up from the surgeon. If complications arise—such as persistent pain or signs of infection—the lack of consistent oversight can delay proper intervention (Eggins & Slade, 2015). ***This disjointed process not only risks the patient’s physical recovery but also erodes trust, leaving the patient feeling like a case number rather than a whole person in need of comprehensive care. Likewise, this diminishes the physician to mere technocrat of no other value than the specific intervention he or she can perform.***

Shift in Expectations

Under the value-based model, ***patients primarily expect acceptable clinical outcomes rather than comprehensive, holistic care. Physicians, in turn, focus on achieving these outcomes efficiently, often at the expense of building meaningful relationships.*** This transactional dynamic diminishes the role of empathy and personalized attention in patient care

System-Level Pressures and Physician Burnout

Mounting financial pressures and persistent workforce shortages have driven the healthcare system toward hyper-specialization in the name of efficiency. While this approach may streamline certain processes, it often fragments care, undermining long-term patient satisfaction and compromising health outcomes. Physicians confined to narrow roles become increasingly isolated within the system. The relentless pressure to prioritize efficiency over connection leaves many doctors feeling disillusioned and emotionally drained, fueling the widespread burnout that plagues the healthcare profession today. *When physicians are now expected to see patients every 10-15 minutes to meet productivity targets, they begin to feel like assembly line workers rather than healers, unable to provide the truly thoughtful care they once envisioned* (Neprash, et al., 2023). Patients deserve informed, continuous care guided by beneficence, non-maleficence, autonomy, and justice. Limited face-to-face time can compromise thorough decision-making, honest communication and informed consent about risks, benefits, and alternatives.

The commoditization inherent in the value-based model also undermines the inherent dignity of both patients and healthcare providers. Treating individuals as mere commodities negates their intrinsic value, leading to a dehumanized approach to healthcare that conflicts with ethical and moral principles (Haque & Waytz, 2012). Further, this dehumanization is the number one reason for the rapid increase in physician suicide—no mission, no vocation, no purpose, just servitude.

Impact on Physician-Patient Relationship

Medicine has historically been a profession built upon the relationship between doctor and patient—a relational model that affirms patient dignity, fosters trust, and enables collaborative decision-making. By limiting interaction to a few minutes before a procedure and outsourcing follow-up, *we risk reducing the physician-patient encounter to a transaction*, where the patient becomes more like a “consumer” and the physician a “service provider”. *This diminishes or altogether eliminates the transcendent dimension of healing, where Christ the Divine Physician encounters the patient acting through the heart, soul, mind, and body via the hands of the physician—an integral aspect of whole person care. Likewise, the physician encounters the Christ the suffering servant uniquely in each patient. This unique personalized encounter and exchange can have a profound impact on both physician and patient.*

Summary

Value Based Healthcare, by denying the metaphysical, is reductionist in nature and fails to embrace the mystery of both the patient and the physician as human persons. *Gone is the divine vocation of the physician and the centuries old covenant relationship with the patient, being replaced at best by a limited contractual relationship. This can be likened to the covenant relation of a married couple vs the transactional relationship of a prostitute. Yet we wonder why physicians are so profoundly unhappy and the physician shortage grows ever larger.*

The Mission-Driven Alternative: Christocentric Healthcare

Patient Centered Care

Patient-centered care is a healthcare approach that emphasizes the individual needs, preferences, and values of patients, ensuring they are active participants in their own care. It involves open communication, empathy, and collaboration between patients, their families, and the clinical team, with a focus on treating each person holistically rather than just addressing symptoms or diagnoses. By respecting patients' perspectives and personal circumstances, patient-centered care promotes trust, shared decision-making, and improved outcomes, ultimately fostering a more supportive and dignified healthcare experience (Lusk & Fater, 2013).

While patient-centered care rightly upholds the dignity, individuality, and unique needs of each person, it risks distortion in today's culture of radical autonomy and moral relativism. In a society where personal freedom is often elevated above all else, patients may seek procedures—such as abortion, sterilization, or genital mutilation—that not only conflict with the moral convictions of Catholic healthcare providers but fundamentally oppose the Church's teachings on the sanctity and integrity of the human person (Haas, 1993).

From a Catholic perspective, this overreach of autonomy echoes the original temptation in the Garden of Eden: the desire to be “like God,” defining good and evil on one's own terms (Genesis 3:5). Rejecting objective moral truths places human will in direct opposition to God's creative wisdom and loving authority. *Catholic moral theology affirms that the dignity of every human being—created in the image and likeness of God—and the sanctity of life are not matters of personal preference or subjective opinion but unchanging truths that must guide all care.*

The Need for Christ-Centered Care

It is crucial for Catholic healthcare professionals to underscore a *Christ-centered* (often called “Christocentric”) approach to care, rather than simply a patient-centered model

devoid of moral anchors. **Christ-centered care understands that while each patient's autonomy and personal context are important, they must be integrated within an objective framework informed by Catholic moral teaching and guided by the Gospel.**

Sacredness of Life

The Catholic Church resolutely maintains that every human life, from conception to natural death, is a sacred gift that must never be harmed, violated, or destroyed. Practices such as abortion and euthanasia mount an assault against this fundamental truth (Opara, 2024). *A Christ-centered model of care rejects malevolent social ideologies that redefine "healthcare" in ways that deny the sacredness of life.*

Integrity of Human Person

The Magisterium of the Catholic Church *affirms the unity and integrity of the human person, body and soul.* The body is not a mere vessel to be mutilated at will but a divinely bestowed God-given identity, woven with the soul to live out God's intended purpose. *Sterilization and invasive gender surgeries do more than alter physical form; they fracture the harmony between body and soul, reflect a broader cultural rejection of God's design for human flourishing, and undermine the moral fabric that sustains society* (Arnold, 2024).

When these procedures are promoted by healthcare systems, governments, or corporations—especially through coercive practices or financial incentives—it becomes a violation of justice and human rights. For example, in his 2021 book *The Real Anthony Fauci: Bill Gates, Big Pharma, and the Global War on Democracy and Public Health*, Robert F. Kennedy Jr. alleges that Bill Gates has promoted sterilization through vaccination programs in Africa (Kennedy, 2021). While the World Health Organization (WHO) and “fact-checkers” have dismissed these claims (AFP South Africa, 2024), no legal action has been taken against Kennedy for making them. Additionally, reports have surfaced about the presence of hCG—a hormone linked to infertility—in WHO-distributed tetanus vaccines in Kenya (Oller, et al., 2017). Such practices reflect coercive population control strategies that disregard the inherent dignity and autonomy of the human person, compromise the sanctity of life, violate the trust and consent of vulnerable populations, and should be resoundingly rejected by Catholic healthcare providers.

A Christ-centered model of healthcare includes in its scope the whole person, recognizing that authentic healing requires care for the physical, emotional, social, and spiritual dimensions of life. This approach seeks not merely to treat symptoms but to restore well-

being in a way that reflects God's design and affirms the patient's dignity. ***This is not just a model—it is a mission. A mission to heal not only bodies but souls, to restore not just health but the integrity of the human person.***

Witness to Hope in Suffering

Catholic spirituality embraces the redemptive power of suffering when united with Christ's sacrifice. Pain and hardship hold deeper meaning beyond physical discomfort. ***Rather than viewing suffering as purely negative, it can be seen as an opportunity for spiritual formation, prayerful contemplation, and interior strength through grace*** (Pope John Paul II, 1984). ***This perspective offers patients a greater sense of purpose—whether in supporting loved ones, advancing medical understanding, or deepening empathy. Ultimately, it becomes a path to draw hope and strength from Christ, guiding them toward the authentic good of the whole person. This is precisely why Christ's cross is the symbol of Christian hope.***

Catholic physicians are called to ground their practice in a Christ-centered mission, recognizing God as the Author of life and moral truth. Within this sacred framework, ***healing becomes an intimate encounter with Christ the Divine Physician*** (Catholic Church, 1997). ***Acting through the hands of the caregiver, Christ ministers to the patient's body, mind, heart and soul. Simultaneously, the physician meets Christ in the suffering patient—Christ the Suffering Servant—elevates both patient and caregiver through the redemptive love of Christ. In this sacred exchange, suffering is not meaningless but becomes a powerful witness to hope—a path through which healing transcends the physical and resonates through eternity.***

Anchored in Faith: Conscience and Moral Duty

Healthcare providers have a moral obligation to act in accordance with a well-formed conscience, in harmony with the Magisterium and Sacred Tradition. This duty may entail conscientious objection when asked to perform or participate in procedures that gravely conflict with the Church's moral teachings (Catholic Church, 1997). At the same time, it is important to show compassion and respect for every patient, walking with them in their suffering or confusion, and gently bearing witness to truth in a manner that reflects Christ's love.

This commitment to Catholic excellence is most powerfully exemplified by generations of consecrated religious sisters who were the backbone of Catholic healthcare, embodying the Church's mission through tireless service, compassionate care, and unwavering devotion. Their presence was not merely symbolic; it was foundational. ***These women of***

faith nurtured the sick, comforted the dying, and safeguarded the moral integrity of Catholic hospitals, grounding their work in prayer and the love of Christ (Bougaud & Brady, 2022).

Today, their waning presence is deeply felt. Vocations to religious life have dwindled, leaving a void in moral and spiritual leadership (Lingier & Vandewiele, 2021). ***Without these guiding figures, Catholic healthcare institutions struggle to maintain the same cohesive commitment to Church teachings.*** Laypeople, though dedicated, often lack the necessary formation, generally have not taken the evangelical councils of poverty, chastity and obedience and thus lack the same evangelical zeal and dedication to mission that once defined the work of religious sisters. **This gap widens as more lay administrators, often non-Catholic and products of value-based healthcare systems, rise to leadership, prioritizing financial margins over the Church's mission of healing and compassion. Over time, this shift erodes the Catholic identity of healthcare organizations, diminishing the sense of moral duty and conscience essential to carrying out the Church's teachings—to serve Christ in every patient.**

Restoring Christocentric Care

Catholic teaching affirms that every human person is a providential masterpiece created in the image and likeness of God, with body and soul interwoven to bear witness to His divine plan. This truth transcends the grasp of evidence-based medicine, which, while essential for understanding physical health, cannot penetrate the profound mystery of the human person. Theology, philosophy, mathematics, and the empirical sciences each illuminate unique dimensions of human understanding—spiritual, logical, structural, and observable realities. Theology reigns at the summit of knowledge because it contemplates the divine, offering ultimate meaning, moral order, and purpose within the vastness of existence. Philosophy follows closely, establishing the framework of reason and ethical grounding essential for human judgment. Mathematics extends this logic into precise language, unveiling the universe's intricate patterns and structure. Empirical science plays a vital role by allowing humanity to investigate and master the material world through observation, experimentation, and the scientific method. It has driven medical breakthroughs, technological advances, and expanded human understanding of the natural world.

Yet, despite its immense value, empirical science is not immune to distortion. Its reliance on data and interpretation makes it vulnerable to manipulation, especially when financial gain or political power is at stake. For example, In June 2024, an investigation by the

United States Department of Justice uncovered a significant case of fraudulent medical research involving Cassava Sciences' experimental Alzheimer's drug, Simufilam. The DOJ charged Hoau-Yan Wang, an advisor to Cassava, with falsifying research results that misrepresented the drug's effectiveness (Dyer, 2024). Less than a month later, Remi Barbier—president, CEO, and chairman of Cassava's board—abruptly resigned, along with his wife, Lindsay Burns, who served as the company's senior vice president and was Wang's co-author (Manalac, 2024).

In September 2024, the U.S. Securities and Exchange Commission followed suit by filing fraud charges against Cassava, Barbier, Burns, and Wang. While none of the parties admitted to any wrongdoing, they reached a settlement with the SEC—pending court approval—that imposed fines of \$40 million on Cassava, \$175,000 on Barbier, \$85,000 on Burns, and \$50,000 on Wang (Jewett, 2024). In a further blow to the company, results from a Stage 3 trial published in November 2024 failed to show any clinical benefit from Simufilam, forcing Cassava to discontinue its development (Cassava, 2024).

Taken together, these events underscore deep concerns over the integrity of pharmaceutical research and highlight the dangers of unchecked industry practices—an alarming reminder of how quickly scientific ***misconduct can erode public trust and jeopardize patient welfare.***

Such manipulation underscores why healthcare cannot rely solely on evidence-based, empirical science. ***Medicine must be informed by the full spectrum of human knowledge—including theology and philosophy—which safeguards moral truth and honors the dignity of the human person. Without this balance, science can be twisted into a tool for exploitation rather than healing. Only when guided by truth and virtue can all branches of knowledge work together to care for the vulnerable and restore trust in the healing professions.***

Catholic healthcare must urgently reclaim its Christ-centered mission—a mission rooted in the Gospel and the healing ministry of Christ. This approach honors the sacred unity of body and soul and calls physicians to their divine duty: to protect the dignity of every person with steadfast moral conviction. By restoring this foundation, Catholic caregivers become faithful stewards of life, bridging scientific rigor with divine wisdom. Only through this renewal can healthcare truly uphold both the sanctity of life and the integrity of its mission.

Healing through Christ

Catholic healthcare arises, at its most profound level, from a recognition that sickness and death can be traced back to the sin of our first parents, Adam and Eve, and the subsequent fall of humanity (Catholic Church, 1997). In the Christian view, this fall has deeply wounded the descendants of Adam, leaving all of humanity in a state of brokenness and in need of a Redeemer. *Yet, amid this brokenness, there also abides a bedrock conviction that God has an immeasurable, intoxicating love for us—love that preceded our existence, and love that will ultimately redeem.*

It is God, in His infinite goodness, who **first loved us**, calling us out of sin into the light of divine life (1 John 4:19). In response, we are beckoned to love Him in return, to cast aside false idols, and to cherish Him above all else (Deuteronomy 6:5). **He must become our first love**, the one who captivates our hearts and orients our very being. **Indeed, we are asked to love Him more than we love ourselves or even our own lives, for in that surrender we find true freedom and incomparable joy.**

From this primordial foundation—God’s love for us and our willing response—flows the mission of the Mystical Body of Christ, the Church. In this spiritual family, we are enabled to embrace the entire world, stretching out our hands to those in need. We learn to set aside our self-interest and even risk our own lives to serve the most vulnerable. *Love, then, is not merely an emotion; it becomes the animating force that empowers us to meet the world’s brokenness with compassionate care, even amid great personal cost.*

It is imperative for Catholic physicians, healthcare providers, clinics, and hospitals to recognize that the profound reality of God’s relentless love undergirds every aspect of their vocation. Our sacred ministry of mercy and healing flows directly from this vertical relationship with God. **We are not mere social workers.** Rather, we are a tangible reflection of His abiding love for humanity. This love, steadfast and unrelenting, reaches into every suffering heart, calling us not only to treat physical ailments but to witness to the deeper hope offered by Christ the Divine Physician through His suffering, death, and resurrection. *Indeed, without this essential vertical component—our direct communion with God—Catholic healthcare simply does not exist. It is our relationship with Christ and, through Him, the Divine life of the Trinity that shapes our mission, informs our practice, and draws us ever more deeply into the unifying work of caring for the whole person, body and soul.*

This sentiment is beautifully expressed in a passage from *The Dialogue* of Catherine of Siena:

“O immeasurable Love!

*Everything that Thou hast done for us
 Thou hast done for love and for our redemption.
 For love didst Thou hide Thee in the prison of the womb;
 for love wast Thou born amid utmost poverty;
 for love didst Thou labor;
 for love didst Thou suffer the most shameful death upon the Cross.
 And all this Thou didst that Thou mightest redeem lost humankind.
 We see thereby that Thou art indeed inebriated with love—
 Thou, who art the Fullness of all Good!”*

(Catherine of Siena, 1378/2008)

In the end, the love of God is not just a notion or a sentiment. It is a **transformative power** that calls each one of us to respond wholeheartedly—to see Christ in our brothers and sisters, especially the poor and vulnerable, and to serve them with the same unconditional love we have received. This is the radical exchange of love that lies at the heart of the Christian mystery: *God loves us, and in that love, He redeems the world through our hands and hearts, for “We are ambassadors for Christ, since God is making his appeal through us” (2 Corinthians 5:20).*

Eucharist is the Center and Summit of Catholic Healthcare

One might wonder about the true center or the most essential component of a Catholic hospital. While certain institutions distinguish themselves by excellence in neurointerventional radiology, cardiac interventions, or trauma care, there is a singular, unifying reality that underpins them all: the chapel. *With the Eucharist present day and night, the chapel serves as the hospital’s very heartbeat* (United States Conference of Catholic Bishops, 2018). *Until this fact is fully embraced by Catholic healthcare administrators, Catholic physicians, and non-Catholic professionals who serve in these institutions, the mission of Catholic healthcare will never be achieved.*

Moreover, the Eucharist is what separates and distinguishes Catholic hospitals from other Christian hospital systems, for the *Eucharist is the center and summit of the Catholic Faith* (Accardi, 2021). As Padre Pio famously stated, *“It would be easier for the world to exist without the sun than without the Holy Mass”* (Ruffin, 1982). *Indeed, the chapel—where Christ is tangibly present—is not simply the most important, but the indispensable core of Catholic healthcare. Without it, Catholic healthcare in its truest sense cannot exist.*

With the influx of non-Catholic administrators and staff—and even nominal Catholics—into Catholic health care systems, the crucial role of the Eucharist can easily become obscured or even forgotten. Traditionally, Catholic hospitals have been firmly rooted in the faith’s sacramental life, with the Eucharist recognized not only as the source and summit of Christian life but also as a powerful sign of hope and spiritual healing for patients and staff alike (Gumbleton, 2010). ***Yet as these institutions grow more diverse in both leadership and frontline caregivers, there is a risk that the Catholic identity—and particularly, the Eucharistic focus—becomes diluted or is lost entirely.***

Maintaining Catholic Identity

Preserving Catholic identity within emergent healthcare organizations has become increasingly challenging due to several interrelated factors. One major issue arises from the acquisition of physician groups that perform procedures such as sterilization and in vitro fertilization, which directly conflict with Catholic Ethical and Religious Directives (United States Conference of Catholic Bishops, 2018). ***Integrating these groups into larger, more diverse organizations often leads to compromises that dilute the mission-driven focus essential to Catholic healthcare.*** Additionally, the absence of consecrated religious, primarily sisters, who have historically been the backbone of Catholic health services, exacerbates the problem. With fewer religious vocations, it becomes difficult to find laypeople who are equally committed to upholding Catholic values with the same dedication as the religious sisters of the past.

Moreover, the increasing reliance on lay administrators, many of whom are non-Catholic, who are typically educated within a value-based healthcare system, poses another significant challenge. These administrators may prioritize financial margins and operational efficiencies over the organization’s Catholic mission, leading to a gradual erosion of Catholic identity. This shift is further compounded by the absence of consecrated religious who once provided moral and spiritual guidance to staff, leaving a leadership void that can result in a loss of direction and cohesion around Catholic principles. ***Consequently, efforts to maintain Catholic identity within these larger organizations often fall short, as the foundational elements that once supported a faith-based mission are weakened or overlooked.***

Ethical and Religious Directives: Section 6, “Collaborative Arrangements With Other Healthcare Organizations and Providers”

Section 6 of the United States Catholic Conference of Bishops Ethical and Religious Directives for Catholic Health Services (ERDs) governs how Catholic institutions

collaborate with non-Catholic entities while preserving Catholic identity. During my time on the Catholic Medical Association board, I served on a committee that provided comments on the revision of this section, alongside representatives from Catholic hospital systems and other Church advisers. Although we sought to craft rules and regulations that would help Catholic institutions maintain their core values in partnerships, the process highlighted the tension between preserving mission and meeting the demands of a value-based system. ***We saw how legal and financial considerations often led Catholic institutions to forge only enough separation to claim a semblance of Catholic identity, rather than fully living out the boundless love that characterizes true Catholic health care.***

I have since come to believe that no matter how carefully the documents are updated or how precisely collaboration structures are drawn, Catholic health care fundamentally depends on a vertical relationship with Christ and a spirit of self-giving love for the patient. ***True Catholic health care cannot be reduced to financial concerns— “no margin, no mission”—but must instead flow from a conversion of heart rooted solidly in the theological virtues of faith, hope and charity. Ultimately, Catholic institutions will only blossom if they embrace Christ’s healing ministry wholeheartedly, offering care not out of obligation or efficiency but as an encounter of transformative love.***

An example of difficulties and tensions such mergers cause can be seen in 2013, when SSM Health (Sisters of St Mary), a Catholic health system, merged with a non-Catholic chain. In the process, it integrated physician groups that performed procedures like sterilization and in vitro fertilization, which directly conflicted with Catholic ethical teachings. The merger was an example of a larger trend where Catholic hospitals, facing financial pressures and the need to stay competitive, accommodated secular practices within their institutions. This merger led to debates within the Catholic community about how much compromise could be allowed. While SSM Health maintained its Catholic identity in name, secular practices won out in terms of operational influence and the incorporation of services, which are still being practiced there today (Jones, 2017).

Religious Orders’ Role in Mission Driven Healthcare

Order of Malta

The origins of the Sovereign Military Hospital Order of St. John of Jerusalem of Rhodes and of Malta trace back to the founding of the Hospital of St. John in Jerusalem (Order of Malta, 2021). Although the exact date of its establishment remains uncertain, historical evidence suggests that it existed before the First Crusade. It was Blessed Gerard—later

recognized as the founder of the Order of Hospitallers—who oversaw the hospital in its early days. Under his leadership, the hospital’s charitable activities grew rapidly, and the institution gradually evolved into a religious Order around the year 1099, coinciding with the Crusader conquest of Jerusalem.

By around 1080, it is believed that the hospital was already welcoming pilgrims and caring for the sick within its walls. Remarkably, the quality of the hospital’s care was so high that it could rival modern standards. Records suggest that up to 2,000 people a day might have received aid. The hospital’s remarkable devotion to poverty, simplicity, and service presaged many values later associated with Franciscan spirituality, illustrating that its mission was deeply rooted in humility and compassion for those most in need.

Initially, the hospital was under the administration of Benedictine monks from a nearby abbey, and these monks became the earliest members of the nascent Order when the hospital gained independence from its monastic origins early in the 12th century. Blessed Gerard, esteemed as both the hospital’s superior and the future Grand Master of the Order, was famously devoted to what he called the **“holy poor.”** His reputation for tireless and unconventional service drew a wide network of benefactors who helped the institution flourish.

Over time, the group tending to the hospital adopted a formal rule of life and a distinctive mission. Their guiding principle is often rendered as ***Tuitio Fidei et Obsequium Pauperum*** meaning “To Defend (and Nurture) the Faith and Serve the Poor (Malta, 2021).” This motto has remained central throughout the centuries. From the outset, the hospital admitted the sick irrespective of their religious or cultural origins. Such inclusivity set a groundbreaking precedent for medical care in the medieval world.

The Grand Master of the Order continues to hold the title of ***Custos Pauperum***, or *Custodian of the Poor*, reflecting the Hospitallers’ fundamental commitment to charitable service (Order of Malta, 2021). ***Within the Order, brothers were considered the “serfs of the poor,” instructed to dress humbly, lest they give the impression that they placed themselves above those they served.*** Beyond caring for the sick, Hospitallers also took responsibility for burying those who had no family or means, underscoring their holistic dedication to human dignity at all stages of life.

Central to the hospital’s philosophy was the conviction that the poor—men, women, and children—embodied Christ and were therefore deserving of the most excellent care available. The staff understood that many illnesses could improve if patients were kept

clean, warm, fed, and given adequate rest and calm. This patient-centered approach laid a foundation for principles of nursing still prized today.

Upon arrival, Christian patients were encouraged to make a confession and receive communion—practices that reinforced the spiritual dimension of healing in medieval Christian tradition. Communion was also offered each Sunday to those who wished to receive it, underscoring the importance of spiritual sustenance in concert with physical care.

The hospital itself was divided into eleven distinct wards, each blessed with holy water to maintain an atmosphere of reverence and sanctity. Women were treated in separate wards, administered by female attendants, reflecting the hospital's awareness of personal dignity and modesty. Impressively, there was even a dedicated obstetric ward for expectant mothers, an advanced concept for its time. Newborns were bathed immediately, and wet nurses were on hand for those mothers who could not nurse due to illness or poverty.

Operationally, each ward was overseen by a brother responsible for the welfare of the patients, assisted by a dozen servants whose tasks included changing linens, delivering nourishment, and ensuring a hygienic environment. These measures, combined with the fraternal commitment to humility, embodied the hospital's essential devotion to universal compassion—a legacy that has profoundly shaped the Order of Hospitallers throughout history and endures in its modern works of charity and healing.

This philosophy and mission is now known as the Order of Malta had a profound impact on the development of subsequent hospitals throughout Western Europe, which helps explain the institution's widespread renown in its time. (Order of Malta, 2021)

"**Tuitio Fidei et Obsequium Pauperum** remains the central Motto of the Order. Paraphrasing Fra' Emmanuel Rousseau, Grand Commander of the Order of Malta, this motto can be likened to two legs of a stool. We are called to be both contemplative and conquering, just as we need two legs to walk. To be effective Knights and Dames in the Order of Malta, we must have both. Without Christ at the center, our work with the poor lacks depth and meaning. But with our charism, our relationship with Christ must be expressed through direct, hands-on service to the poor and vulnerable.

Order of the Ministers of the Sick (in Latin: Ordo Clericorum Regularium Ministrantium Infirmis, AKA Camillians:

The Order of the Ministers of the Sick, or Camillians, formally recognized by Pope Gregory XIV in 1591, owes its origins to the extraordinary life and vision of ***St. Camillus***

de Lellis (1550–1614). Camillus had a turbulent childhood and troubled life as a soldier and gambler, along with chronic illnesses that brought him into contact with Roman hospitals as both patient and servant (The Editors of Encyclopaedia Britannica, 2024). In order to become a Capuchin Franciscan friar, he reformed his path and entered as a novice but was dismissed because of his leg ulcer. He eventually became a priest, devoting himself to Christ and the care of the sick. He established a religious order of priests and brothers known as “Ordo Clericorum Regularium Ministrantium Infirmis” (M.I.).

Guided by their motto “*Caritas Christi Urget Nos*”, “*the Love of Christ Urges Us*” the Camillians are known for service to the sick even at the risk of their own lives (Ministers of the Infirm, 2013). ***The charism of St. Camillus is the service and pastoral care of the sick, based on Christ’s own love and compassion for the most vulnerable. Members are called to see the face of Christ in the suffering and to treat each patient with dignity, care, and holistic respect for both body and soul.***

During plagues and epidemics, they risked—and often sacrificed—their lives to aid the afflicted, while also extending their mission to victims of hunger, war, and natural disasters, laying the foundation for modern humanitarian efforts. Today the Camillians extend their ministry to hospitals, nursing homes, hospices, prisons, and any place where suffering exists. Camillians unite professional expertise with pastoral compassion, serving as hospital chaplains, nurses, therapists, and counselors. This community continues to be a living testament to the presence of God in the world today, embodying St. Camillus’s enduring ideal: “*The poor and the sick are the heart of God. By serving them, we serve Jesus the Christ.*”

Mother Cabrini and the Missionary Sisters of the Sacred Heart of Jesus

“With God all things are possible.” – Mother Cabrini

Mother Frances Xavier Cabrini was born on July 15, 1850, in Sant’Angelo Lodigiano, located in the Lombardy region of what was then the Austrian Empire. Although her frail health and repeated rejections by other religious orders could have deterred her from religious life, she remained undaunted. In 1880, she founded her own congregation, the Missionary Sisters of the Sacred Heart of Jesus, in Codogno, Italy—then a modest town of about 15,000 inhabitants. Despite being constantly discouraged from pursuing missionary work abroad, her determination ultimately carried her to the United States on March 31, 1889, at the age of 38. She arrived in New York City and, through unwavering faith and perseverance, went on to establish more than 67 institutions—such as

orphanages, schools, and hospitals—across the United States, South America, and Asia by the time of her death in 1917 (DiGiovanni, 1991)

Central to Mother Cabrini's strength were the theological virtues of faith, hope, and charity, all deeply rooted in her devotion to the Sacred Heart of Jesus. She once proclaimed, *"The heart of Jesus does not cease to love His creatures; they are always dear to Him. He loves them tenderly and receives them with infinite mercy."* She also emphasized the necessity of unceasing prayer, recognizing that the salvation of humankind *"does not depend on material success, nor on sciences that could cloud the intellect. Neither does it depend on arms or human industries, but on Jesus alone."* Moreover, Mother Cabrini believed *"Love, today's principal virtue, cannot be true if it does not express itself in good works for the poor"* (Di Donato, 2011)."

Had she clung to the mindset of "no margin, no mission," Mother Cabrini's remarkable legacy never would have materialized. Instead, she placed her complete trust in God's abundant grace. She became a powerful agent of charity among immigrants and the most vulnerable, *trusting that God, rather than human limitation, ultimately determines what is possible. Her life exemplifies how Catholic organizations, such as hospitals, clinics, physician groups and associations are called to place their hope in God first, before relying on their own administrative talents.* Too often, we constrain God's plans through limited vision and short-sightedness—but Mother Cabrini did just the opposite. *"With God all things are possible."* – Mother Cabrini. *By wholeheartedly entrusting her work to God, she built a charitable network so extensive and impactful that, by some accounts, it rivaled the financial empire of the Rockefellers of her era.* Her story stands as a testament to what can be achieved when faith in divine providence is placed above all else.

Decline of the Religious Order, the Presence of Religious Orders Healthcare, Catastrophic for Mission-Driven Healthcare

The gradual decline in the visible presence of religious orders within the healthcare ministry has proven catastrophic for the preservation of the Catholic mission. In times past, consecrated men and women devoted their lives to their Christian vows, committed to the love of Jesus Christ and the Sacred Heart of Jesus—not for profit or material gain. Today, fewer vowed religious remain to carry on this mission, which has been replaced by a heightened focus on margins, budgets, and secular priorities. *This shift has eroded the centrality of the Eucharist and the devotion to Christ's love that once animated Catholic hospitals. Above all, it has weakened the very mission that stands at the heart*

of Catholic healthcare: *the salvation of souls through the healing hands on ministry of Christ.*

Without the living testimony of religious sisters and brothers, many Catholic hospitals have taken on characteristics that hardly distinguish them from secular institutions (Liss, 2024). In losing daily witnesses to Christ's compassion and self-sacrificial service, the healthcare ministry has drifted from its original calling to care for the physical and spiritual well-being of patients. The Eucharist, once a focal point in Catholic hospitals, is no longer the lifeblood of these institutions, and with that loss comes a fading reverence for the sacredness of life and the eternal destiny of each person seeking care.

Now more than ever, there is a pressing need for a renewed interest in religious orders, especially those dedicated to healthcare. *Their humble example and steadfast commitment to holiness can set a new standard of excellence that places Christ, not profit, at the center of healing. In this new millennium, such a resurgence would help reignite the passion for mission-driven healthcare.* Every prayer and every effort toward restoring and strengthening these communities will help reorient Catholic institutions to their true purpose.

One bright sign in this landscape is the Sovereign Order of Malta—a lay religious order that seems uniquely poised for expansion. Its focus on caring for the poor and vulnerable resonates with the core of Catholic social teaching and stands as a powerful reminder that faith can transform the practice of medicine. Just as this lay order grows, other religious communities, too, can experience restoration and renewal, ensuring that the ministry of healthcare remains profoundly shaped by a commitment to Christ and His love for humanity. Through prayer and deliberate action, we may yet see Catholic healthcare flourish with a renewed sense of mission and a clear focus on the salvation of souls.

Reclaiming the Physician's Vocation

Love as the Vocation of the Physician

If our primary vocation as physicians is to love, then our focus must place love before all other things. We are not merely technocrats equipped to perform procedures; we are human persons, each created in the image and likeness of God and each endowed with unique abilities and talents. *As St. Thomas Aquinas teaches, "To love is to will the good of another" (Aquinas, 1270/2017). Building upon the foundational principle of St. Ignatius, we remember that the purpose of life is "to know, love, and serve God," and ultimately be united with Him for all eternity* (St. Ignatius of Loyola, 1524/2015).

With this in mind, our goal is the salvation of humanity, including our own—hence, the salvation of our patients as well as ourselves. This is what it truly means to love. ***Therefore, our love must be Christocentric, guiding patients to discover their true identity in Christ rather than an alternative self-fabricated identity that the secular world may promote, one that inevitably leads to chaos and destruction.***

We are called to meet our patients where they are, guiding them to Christ-centered growth and journeying with them toward eternal salvation. This entails being people of authentic encounter: ***we must see, hear, and acknowledge our patients, recognizing the face of Christ in each one of them.*** We must see not only with our eyes but also with our hearts and listen not only with our ears but also with our hearts. ***When we honor each patient as a human person, we acknowledge Christ in both the other and in ourselves, embracing the profound metaphysical dimension of an encounter between two human beings through Christ.***

This is our vocation as physicians. It is a calling that should bring great comfort to those serving in mission fields where resources are often scarce and the usual range of medical procedures may not be available. The fundamental mission remains the same: to love and to encounter patients as children of God.

Recently, I asked **Charles Wirth, KM**—a former CEO of Sutter Gould Foundation (a large physician group in Northern California) and a current board member of the Order of Malta Free Clinic in Oakland—how I could help, given that the clinic does not have a surgical facility. The Oakland clinic serves several thousand patients a year, all of whom have limited or no resources and no insurance. I posed the question: “I can see your patients, but what if they need surgery or other procedures?” His response illuminated the true nature of our calling: ***“That is not the primary purpose of the clinic, nor the reason you are there. You are there to encounter the person.”***

This insight applies not only in Oakland but in every mission field where resources may be constrained. No matter where we serve, our vocation to love remains paramount. ***By placing love at the forefront, we recognize that our essential task—as much as caring for physical ailments—is to guide souls toward the fullness of life in Christ.***

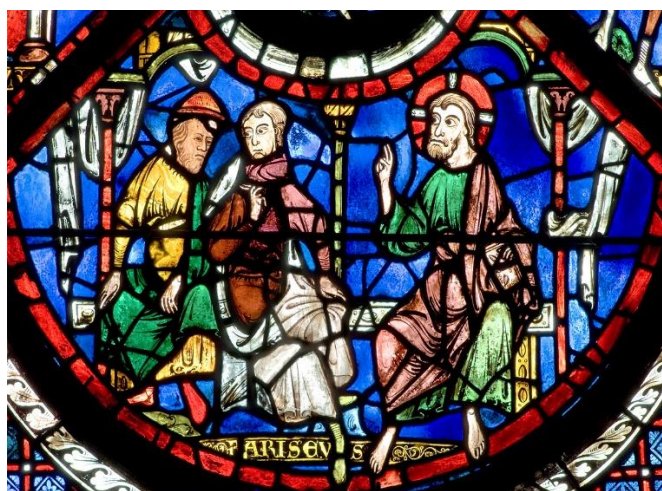
Finally, recognize that the vocation to love as a physician transcends the minimalistic standard of the Hippocratic Oath, which merely enjoins practitioners to do no harm. This calling to love places far greater demands on the physician’s heart, inspiring not just competence and thoroughness, but also a limitless compassion that shapes every interaction. The difference is not one of degree, but of kind: a minimalistic standard

asks us to refrain from harm, while a maximalist directive compels us to seek the utmost good in all we do. By embracing this boundless commitment, physicians become healers in the truest sense—guided by empathy, ever vigilant in protecting the dignity of their patients, and unyielding in their dedication to the well-being of each person entrusted to their care.

The Good Samaritan as a Model for Care

The parable of the Good Samaritan was recently brought forth in the reflections of Fra Emmanuel Rousseau, Grand Commander of the Order of Malta and head archivist of the Cathedral Notre-Dame-des-Chartes in Chartres, France, who noticed a strong connection between the Good Samaritan and the mission of the Order. This parable offers invaluable insights for all Catholic physicians and healthcare providers.

In the parable of the Good Samaritan (Luke 10:30-37), Jesus describes a man traveling from Jerusalem to Jericho who is attacked by thieves, beaten, and left half-dead. While a priest and a Levite pass by without helping, a Samaritan stops, binds his wounds with oil and wine, places him on his own animal, takes him to an inn, and pays for his care. Jesus concludes by teaching that true neighborliness is shown through mercy and calls His followers to "go and do likewise."



This narrative is beautifully depicted in a stained-glass window at the Cathedral of Chartres, where Christ is shown gazing intently at both the Good Samaritan and the victim. Christ can be seen as the Divine Physician, the Good Samaritan as the caregiver, and the victim as the patient. This imagery underscores the holistic nature of healthcare, where every individual—whether caregiver or patient—is heard, seen, acknowledged, valued, and loved in the eyes of Christ.

In his reflection, Fra Rousseau recounted an enlightening encounter with Pope Benedict XVI, who encouraged him as newly consecrated Fra to contemplate the stained-glass

window depicting the Good Samaritan. Though Fra Rousseau PhD and served as the Cathedral's head archivist, he confessed that he had not yet examined the image. When he later met Pope Benedict XVI again, the Pope promptly asked about his observations. Without hesitation, Fra Rousseau replied that the Good Samaritan, the victim, and Christ all shared the same face.

Later in my reflection as a physician and healthcare provider, this revelation held profound significance: Christ as the physician, the Good Samaritan as the caregiver and advocate, and the victim as the patient illustrate the interconnected roles within the divine narrative of healthcare.

Physicians often perceive themselves solely through a professional lens—as authoritative, educated figures respected within their communities, towering above their patients while serving them. This is a very limited short-lived reductionist view of oneself. However, the parable reminds us that physicians and other healthcare professionals are also whole persons who will one day experience vulnerability and require care. Just as the Good Samaritan serves the victim, healthcare professionals are called to serve their patients and caregivers with empathy and compassion, *recognizing that they too will someday find themselves in the vulnerable role of caregiver and/or patient. These later two roles are not a diminishment but rather a completion of our identity as a human person. Albeit they often represent a more essential part of identity than the limited temporal identity as physician serving others.* In a culture where physician suicide is endemic, having an identity that is rooted in the whole person as envisioned by Christ in this parable, outside professional acumen alone is important for physician wellness.

This perspective aligns with St. John Paul II the Great's assertion that *"it is Christ who reveals man to himself"* (John Paul II, 1979), emphasizing that our true identity is rooted in being made in the image and likeness of God. In an era defined by identity politics and the pursuit of personal autonomy, the stained-glass image offers a striking contrast, emphasizing that true self-identity and self-worth are rooted in the triune life of the Trinity. As St. John Paul II the Great reminds us, *we are called to be persons of being, not merely of having.*

Moreover, the image calls us to see the whole person: the professional, which is temporary; caregiver, which can often be frustrating and demanding; and patient, who experiences vulnerability. This holistic view is reinforced by the biblical principle found in 2 Corinthians 12:10, where St. Paul writes, "When I am weak, then I am strong." This

emphasizes that our greatest strength often emerges from our vulnerabilities and weakness.

Additionally, the imagery reflects the truth found in John 3:14-15: “And as Moses lifted up the serpent in the wilderness, so must the Son of Man be lifted up, that whoever believes in him may have eternal life.” This passage underscores that it is the patient, in their greatest vulnerability, enters the most efficacious time in their life by offering their suffering alongside Christ’s. *Therefore, the patient not only receives care but also becomes essential to the healing process of the entire mystical body of Christ—particularly the caregiver and physician—by offering his or her suffering in union with Christ on the cross.*

Therefore, every human encounter particularly in the healthcare setting embraces mystery. The mystery of the human person: each encounter with another individual is an encounter with someone made in the image and likeness of God, embodying the presence of Christ within them. *It is through such encounters that patients, caregivers and physicians discover their own identity rooted in Christ and His Triune life. The value-based healthcare model separated from the metaphysical, overlooks this truth, ignoring that our true identity is rooted in Christ. Anything else is an illusion and a temptation to fall back into the original sin of Adam and Eve in the Garden of Eden.*

St. Padre Pio’s Legacy: Love is the Vocation of the Physician

Padre Pio opened the House for the Relief of Suffering on May 5, 1956, as the culmination of his life’s work, embodying his conviction that faith and science are deeply interconnected (Ruffin, 1982). He described the hospital as *“a temple of prayer and science, where the human race can gain a deeper understanding of itself and God.”* He urged that *“there be no sorrow that is not comfort, no tears that are not dried, no despair that is not relieved. May our dear ones who are suffering see in us, their brothers and in this home, a genuine sign of God’s love.”* He emphasized the harmony of faith and medicine, saying, *“Here science and faith will join hands to bring healing in the name of the Lord. We must always remember that true science does not stand against faith but helps us to understand God’s marvel in creation.”*

Padre Pio saw the physician’s work as sacred, stating, *“The physician’s vocation is a ministry of love. Into your hands, you hold not only the wounds of the body but also the suffering of souls. By healing and comforting, you reflect God’s own mercy for his children.”* He believed healing was not only about curing illness but also about bringing

spiritual solace, urging that “***no one leave this house without the smile of hope, without feeling that the burden of suffering has been shared with the hearts of full charity.***”

From these words, we see that the primary vocation of the physician is not only to provide excellent medical care, but also to serve the entire person—body, mind, heart, and soul—while offering compassion and relief from suffering. Even when our ability to medically intervene for the patient is limited, we can still strive to comfort and support our patients, ***our vocation becomes, above all, a vocation to love.*** This should be particularly comforting to those on medical mission where resources are limited.

Stigmata is for Everyone

On Friday, September 20, 2024—during the jubilee year celebrating the beatification of Padre Pio in 1999—I stood meditating before the very crucifix where St. Padre Pio received the stigmata, the miraculous appearance of wounds on his hands, feet, and side, marks resembling the suffering of Christ’s crucifixion. It was 106 years after the stigmata first appeared on Padre Pio on Friday September 20, 1918—wounds he bore for exactly 50 years until his death on September 20, 1968. I gazed upon the crucifix, struck by the sacred mystery it bore witness to. ***While St. Padre Pio uniquely bore the external stigmata, we, too, are called to receive the stigmata of Christ—if not in our flesh, then in our hearts. We are called to bear Christ’s wounds, so that through them, we may embrace the sorrows and needs of the world.***

Interestingly, St. Padre Pio himself spoke of his greatest suffering coming not from the marks on his hands and feet, but from a deep bruise on his shoulder. It was there, on his back, that he felt the crushing weight of the cross bearing down upon him. In our modern context, this hidden wound can symbolize the burdens we shoulder in our daily responsibilities—whether it is the unrelenting Electronic Health Record (EHR) demands, the financial and ethical challenges of a medical practice, or the moral dilemmas that arise from providing complex patient care or most importantly the compassionate and empathic care we provide our patients. ***Like Simon of Cyrene, we are asked not only to meet patients where they are, but to join their suffering with our own, to walk alongside them and help bear the weight of their crosses.***



A powerful depiction of this call to embrace suffering stands in St. Padre Pio's hometown of Pietrelcina: **Timothy Schmalz's** statue, *"I Embrace You"*. Donated by the Padre Pio Foundation of the United States, the statue portrays Padre Pio beneath the cross, leaning into the burden of humanity, embracing the world's suffering in silent intercession. The redemptive love flowing from Christ's sacrifice is channeled through Padre Pio and extended to the world through his life, actions, and intercession. ***This is a perfect model for modern health care: we receive grace from Christ's wounds and extend it outward through our service, allowing it to guide us as we offer hope to those who suffer.***

In those moments when our vocation feels overwhelming—such as caring for a homeless individual grappling with polysubstance abuse, mental illness, and complex orthopedic injuries, as I often do as an orthopedic surgeon, where gratitude is scarce and belligerence sometimes overshadows the hours of surgical skill and effort invested—this image serves as a powerful reminder of our mission. ***As Catholic physicians, we are called to bear the internal stigmata of Christ: to unite our work and sacrifices to His passion, and in so doing, to embrace the world's misery through the power of those holy wounds which pour out His love to humanity. This sacred duty must animate our approach to every patient, mark the mission of Catholic health care, and guide all of our charitable and missionary endeavors, whether they are local or across the globe.***

Ultimately, the stigmata is for everyone—not only for those who physically bear the signs but for all who choose to serve as Catholic physicians. ***May this vision of medicine and healing provide a hope to sustain us in our challenging moments, reminding us that by sharing in the wounds of Christ, we can truly embrace the world.***

Call to Action: Renewing Mission-Driven Healthcare

The Role of St John the Baptist in Healthcare

Finally, it is worth noting that Padre Pio's hospital, the *Casa Sollievo della Sofferenza* (House for the Relief of Suffering), is located in San Giovanni Rotondo. The name "San Giovanni" refers to St. John the Baptist, who came before Christ to prepare the way for Him.

The Order of Malta, historically known as the Knights Hospitaller of St John of Jerusalem, established its first hospital in Jerusalem under the patronage of St. John (Order of Malta, 2021). From these earliest beginnings, St. John the Baptist has been recognized as the Order's spiritual protector and guiding force. More than a mere patron, he served as a foundational figure in the evolution of Western health care, as the Knights' pioneering efforts to treat pilgrims and the poor would inspire similar institutions across Europe.

It is particularly noteworthy that both St. Camillus de Lellis and Padre Pio discovered their calling to serve the sick while at the same Franciscan monastery in San Giovanni Rotondo. Their shared experience highlights the enduring influence of St. John the Baptist's example: humility, unwavering faith, and compassionate service. In many ways, St. John the Baptist's life provides a blueprint for all who dedicate themselves to healing—emphasizing selfless care for others as a reflection of divine love.

Reflecting on this legacy, we are reminded of the vital role that St. John the Baptist has played not only in shaping the ethos of the Knights Hospitaller but also in inspiring the broader Christian tradition of service to the infirm. By looking to his life, we gain insight into the virtues of steadfast commitment, perseverance in faith, and deep compassion—essential qualities in the ongoing mission to heal and comfort those in need.

St. John the Baptist exemplifies the mystery of encountering Jesus through Mary. At the Annunciation when Mary, the ark of the New Covenant, learned that her cousin Elizabeth was with child in her old age, she went with haste to the hill country. In that encounter, Elizabeth immediately recognized Mary as the Mother of God, as the unborn John the Baptist leapt with joy in her womb, consecrating John while still in the womb. It was John, the forerunner who was the first to recognize Christ. ***This encounter serves as a powerful reminder of Mary's role in bringing Christ to the world and preparing hearts to receive Him. From that moment, John was entrusted with a mission.*** Only three months later, Zechariah his father would exclaim of him:

"You, my child, shall be called the prophet of the Most High,

*for you will go before the Lord to prepare his way,
to give his people knowledge of salvation
by the forgiveness of their sins.
In the tender compassion of our God,
the dawn from on high shall break upon us
to shine on those who dwell in darkness and the shadow of death,
and to guide our feet into the way of peace.” (Luke 1:76–79)*

Throughout his life, Saint John the Baptist encountered God in remarkable ways: from his joyful leap in the womb at the presence of Christ, to witnessing the Triune God revealed at the Jordan—the moment of Christ’s second Epiphany. His public ministry was highly acclaimed. Yet when he finally beheld Christ, he proclaimed with humble conviction: ***“He must increase; I must decrease.” (John 3:30) This is command for all Christians but particularly the Catholic physician, who is called to die to self through the service of our patients so that Christ may rise within us.***

In an era dominated by value-based healthcare—often reduced to aggrandized self-interest at the expense of human dignity—John the Baptist’s words, “He must increase; I must decrease,” are more vital than ever. ***“I MUST DECREASE AND HE MUST INCREASE”*** must guide Catholic healthcare into the new millennium, ensuring mission remains central, compassion eclipses profit, and human dignity is upheld in every decision.

We might ask, though, when was Saint John’s finest moment, the moment that fulfilled his mission? Was it not in the depths of Herod’s dungeon, where he spent long hours isolated, shrouded in darkness, and possibly even touched by doubt? In that place of loneliness, he persevered in faith until his martyrdom. ***This final testimony, forged in suffering, was every bit as crucial to his mission as his earlier public ministry. Indeed, it offered an unmistakable witness to the truth and brought his life’s purpose to completion. Today, it stands as a powerful symbol of hope for physicians, caregivers, patients, and all who face illness, isolation, vulnerability, or self-doubt.***

To Jesus Through Mary

At the foot of the Cross, in one of His final acts before His death, Jesus entrusted His mother Mary to the care of His beloved disciple, St. John the Evangelist, and commissioned her as the spiritual mother of the whole world. ***It is through Mary that we learn to love others with the heart of Christ.*** Indeed, the mission set before us is impossible without her aid, for we are all burdened by our weaknesses, failures, and sins.

Yet within the arms of her immaculate heart, Mary makes our journey not only possible but fruitful. She is the surest means to loving others with the Heart of Christ. As our loving mother, she gently reminds us, “do whatever He tells you”. (John 2:5)

She will also be our guide in renewing Catholic health care. We find ourselves in a true battle—a battle for the heart and soul of Catholic health care and more importantly for the very identity of the human person. ***Just as in the historic Battle of Lepanto, where Christian forces attributed their miraculous victory to the intercession of the Virgin Mary*** (Brookes, 2011), ***our “flagship” today, like theris, should carry the image of Our Lady of Guadalupe—the pregnant Virgin Mary of mixed heritage, the Ark of the Covenant—who brings Christ into our midst.*** At Lepanto, the Christian fleet carried the miraculous image of Our Lady of Guadalupe as their guiding emblem, symbolizing her role as a protector and source of strength. In the same way, she stands as our image of victory and the guiding force that helps us share Christ’s heart with the entire world. ***Through her intercession and guidance, we can transform humanity’s destiny, one person at a time.***

CONCLUSION

Healthcare, at its core, is meant to be a sacred act of service, yet value-based systems, burdened by rising costs and fragmented priorities, have strayed from their noble purpose. The promise of equity and compassion has given way to a focus on profit and technical metrics, reducing the sacred art of caregiving to a sterile transaction. ***It is time to reawaken the divine mission of healing, where faith, hope, and charity are not peripheral virtues but the very foundation of every encounter with the sick and vulnerable.***

True healing begins when we see each patient not merely as a body to be fixed but as a person created in the image and likeness of God. ***This requires a transformation—not simply of our systems, but of our hearts—toward a Christocentric vision of care. We are called to imitate Christ the Healer, who touched the leper, consoled the brokenhearted, and restored the dignity of the marginalized. To truly encounter our patients is to meet Christ in them, embracing their suffering as an opportunity to reveal God’s mercy and love.***

Let us reject the reduction of healthcare to numbers and efficiency and instead rediscover the transcendent purpose of medicine: to love as Christ loves. ***By integrating science with faith, evidence with compassion, and skill with humility, we honor the divine gift of life, and recognize the intrinsic dignity of every human person as a unity of body and soul***

created in the image and likeness of God. Though the challenges before us are great, we must not despair. **In every act of care, we are reminded of Christ's victory over suffering and death, and through Him, we find the strength to transform this broken system into one that reflects the eternal truth of God's love.**

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RISKS INVOLVED IN RETINAL GENE THERAPY – BIOETHICAL CONSIDERATIONS

Jelena Bućan*, **Kajo Bućan***



Jelena Bućan, Research Assistant at University Department of Forensic Sciences Split,
univ.mag.rel.int. / mag.educ.philol.angl. et ital.



prof. Kajo Bućan, MD, PhD, ophthalmologist, president of Retinal Section of Croatian Ophthalmological Society; regular member Croatian Academy of Medical Sciences, former president of the Croatian Catholic Medical Society - Split branch.

***both authors contributed equally** to the final draft of the manuscript

Address for correspondence:

Jelena Bućan

University Department for Forensic Sciences

Address: Ruđera Boškovića 33, 21000 Split

Phone: +385 21 510 180

e-mail: jelena8994@gmail.com

Key words: retinal inherited diseases, gene therapy, bioethics

1. Introduction

Retinal gene therapy could be described as a revolutionary therapeutic approach whose aim is to treat inherited retinal disorders, a group of genetic diseases that can lead to vision loss and blindness. This innovative therapy aims to deliver genes that are missing or defective, directly into the cells of the retina, with the goal of restoring or preventing further vision loss.

The concept of gene therapy for retinal disorders emerged in the late 1980s and early 1990s, with the development of viral vectors capable of delivering genes to specific cells. This led to the first clinical trials in the late 1990s, focusing on Leber's congenital amaurosis (LCA), a severe form of inherited retinal dystrophy. Since then, the field has witnessed significant progress, with several gene therapies gaining regulatory approval for specific retinal disorders.

Retinal gene therapy has shown promising results in preclinical studies and clinical trials, with some patients experiencing significant improvements in vision. However, it's crucial to understand that this therapy is not a cure for all retinal disorders. While it holds immense potential, there are inherent risks associated with gene therapy, and its effectiveness can vary depending on the specific genetic mutation, disease severity, and individual patient factors.

2. Discussion

2.1. Ethical considerations in gene therapy

Gene therapy raises significant ethical concerns such as the difference between the 'good' and 'bad' usage of the technologies, how to distinguish between the characteristics that are considered normal from those which are believed to be a disorder, the concern whether gene therapy's high cost will possibly limit its availability to the wealthy as well as if human beings should be able to employ gene therapy to improve basic human qualities like height, intelligence, and athletic ability (National Institutes of Health, 2022). On the one hand, the therapy could prevent future generations from dealing with a specific genetic disorder but, on the other, it carries several potential risks, among them being the unpredictability of the development of fetus or other unknown long-term negative effects (National Institutes of Health, 2022). In that sense, it is essential to emphasize the importance of informed consent, ensuring patient autonomy, and addressing potential unintended consequences (National Institutes of Health, 2022).

Furthermore, there are some other ethical considerations in gene editing, encompassing principles such as respect for human dignity, beneficence, non-maleficence, autonomy, and justice (Ethics Centre, n.d.). While respecting autonomy demands informed consent and patient empowerment, beneficence suggests that treatment should benefit the patient. Furthermore, non-maleficence emphasizes reducing possible harm whereas justice requires equitable access to treatment and fair distribution of resources (Beauchamp & Childress, 2019). These principles emphasize the importance of meticulously evaluating the potential advantages and disadvantages, prioritizing patient welfare, and guaranteeing equitable access to treatment.

2.2. Overview of Retinal Disorders Targeted by Gene Therapy

Gene therapy is being intensively researched for a variety of inherited retinal degenerations, which are distinguished by progressive loss of photoreceptor cells in the retina. Inherited retinal diseases (IRDs) are hereditary abnormalities affecting the retina (Cepko & Vandenberghe, 2013). These illnesses can result in visual loss at any age, and there is presently no cure. Gene therapy can effectively treat IRDs caused by single gene mutations. IRDs being researched for gene therapy include Leber's congenital amaurosis (LCA), retinitis pigmentosa (RP), and choroideremia. (Cepko & Vandenberghe, 2013). When it comes to the mentioned IRDs, studies have suggested that gene therapy can enhance visual acuity and function for some patients (Bainbridge et al., 2015, 2008; Maguire et al., 2008). Clinical investigations indicate that gene therapy can improve visual acuity and quality of life for patients with inherited retinal diseases. In a landmark trial, patients with LCA who received gene therapy reported considerable improvements in their ability to navigate and do daily chores (Bainbridge et al., 2015). Nuzbrokh et al. (2020) found that treating patients with RP resulted in enhanced visual function and reduced disease progression.

While gene therapy is primarily focused on inherited disorders, research is exploring its potential for treating certain acquired retinal diseases, such as: Age-related macular degeneration (AMD) Diabetic retinopathy, Retinopathy of prematurity (ROP). These disorders affect the retina as a result of aging, underlying medical conditions, or other factors.

Age-related macular degeneration (AMD) is the most common cause of visual loss in adults over 50. AMD causes macular degeneration, resulting in impaired vision, blind patches, and difficulty seeing faces. Gene therapy, as a potential treatment for AMD, aims to induce the creation of new blood vessels and protect retina cells from damage

(Campochiaro, 2017). While there are no authorized gene therapies for AMD, researchers are exploring gene-based techniques to address the fundamental causes of the complex illness.

Moreover, diabetes retinopathy is a condition that affects the blood vessels of the retina and can cause vision loss by injuring blood vessels, resulting in leakage, edema, and the creation of aberrant blood vessels. Research on gene therapy for diabetic retinopathy shows promise in restoring damaged blood vessels, reducing inflammation, and protecting retinal cells (Barraza-Flores & Pacione, 2020).

2.3. Mechanism of Action in Retinal Gene Therapy

Retinal gene therapy works by delivering therapeutic genes to specific cells in the retina, with the goal of correcting genetic abnormalities that cause various retinal illnesses. This entails inserting a functional copy of the faulty gene or using gene-editing techniques to change an existing gene (Khparde et al., 2024). The delivery strategy is typically via viral vectors, namely adeno-associated viruses (AAVs), which are engineered to transport the therapeutic gene and safely integrate into the host cell's genome (Khparde et al., 2024).

The viral vector is carefully chosen based on its tropism (ability to target certain cells), effectiveness of gene transfer, and safety profile (Khparde et al., 2024). Following delivery, the vector infects target cells and releases the therapeutic gene. This gene then expresses the encoded protein, which may restore or improve the function of the missing protein implicated in the illness process (Khparde et al., 2024). In cases of gene editing, the therapeutic gene is intended to directly fix the genetic flaw, resulting in long-term or permanent correction.

Leber congenital amaurosis (LCA) is a group of hereditary (usually autosomal recessive) retinal degenerative diseases. LCA is the second most common group of inherited retinal dystrophies after retinitis pigmentosa with at least 29 genotypes have been identified. In December 2017, the US Food and Drug Administration (FDA) approved the first-ever gene therapy drug for the eye (voretigene neparvovec-rzyl) for the treatment of LCA with a biallelic RPE65 mutation. RPE65 mutation accounts for only 10% of patients with LCA. This gene encodes an enzyme necessary for the formation of retinal photopigment, which is required for vision. Creating a visual stimulus is a series of enzymatic reactions between the retinal pigment epithelium (RPE) and the neurosensory retina to metabolize dietary vitamin A into 11-cis retinal to generate photopigment. By delivering a

functioning copy of the RPE65 gene using AAV vectors, gene therapy hopes to restore normal retinal photopigment production, perhaps restoring vision in people with LCA.

2.4. Potential Benefits of Retinal Gene Therapy

The major goal of retinal gene therapy is to restore or improve eyesight in patients with inherited retinal disorders. By providing functioning genes, gene therapy has the ability to cure the underlying genetic abnormality, resulting in better light sensitivity, visual acuity, and general visual function.

In rare circumstances, retinal gene therapy can reduce or even stop the progression of retinal disorders, thereby preventing additional vision loss and delaying the need for more intrusive therapies like transplantation. Gene therapy may postpone blindness development and prolong functional eyesight in people with these illnesses. Cai, Conley and Naash (2017) discovered that gene therapy significantly delayed the progression of retinal degeneration in a mouse model of RP. Therefore, gene therapy has the potential to provide long-term or even permanent benefits, potentially eliminating the need for regular or ongoing treatments. Restoring or preserving vision for people with inherited retinal diseases can significantly improve their quality of life. Patients who have lost their sight may struggle with daily duties, social relationships, and overall wellbeing. Gene therapy can improve independence and social integration, allowing for more active participation in life. According to Askou et al. (2019), patients who underwent gene therapy for RP experienced improved quality of life, including increased independence and emotional well-being.

Although the prospective advantages of retinal gene therapy are encouraging, significant bioethical issues must be considered. Informed consent is essential, guaranteeing that patients comprehend the dangers and advantages of treatment, particularly considering the possibility of long-term repercussions. Guaranteeing fair access to this new medication for all patients, irrespective of their socioeconomic status, is essential. Long-term safety concerns, including immunological responses, off-target effects, and unintentional germline changes, must be closely monitored and addressed.

2.5. Risks of Retinal Gene Therapy

The dangers of retinal gene therapy are roughly classified into two categories: those related to the delivery vector and those connected to the therapeutic gene itself. Viruses and other delivery vectors are utilized to convey therapeutic genes into target cells. These vectors can elicit immunological reactions, perhaps resulting in inflammation or rejection of the therapy. Smith et al. (2020) investigated immunological reactivity in patients

following retinal gene therapy. Many individuals showed inflammation and immune cell infiltration in the treated area. These reactions were associated with both the viral vector and the therapeutic gene product. Furthermore, there is a risk of insertional mutagenesis, in which the vector enters the host's DNA in an unexpected position, altering normal gene function or triggering cancer. Jones (2018) examined many incidences of insertional mutagenesis related to gene therapy trials. To reduce the danger of insertional mutagenesis, the study recommends carefully identifying target genes, delivering accurate vectors, and monitoring patients for long-term effects.

The therapeutic gene itself has significant dangers. It may not perform as intended or may possibly have negative consequences. For example, the gene may be expressed at an unsuitable level or in the incorrect cell type. Furthermore, there is risk that the therapeutic gene will not be stably integrated into the genome and may be lost over time which could result in a loss of therapeutic benefit or necessitate additional treatments. Controlling the expression of therapeutic genes once supplied to target cells is a significant difficulty in retinal gene therapy. To obtain the desired therapeutic effect, the gene must be expressed at the appropriate level and duration to avoid negative outcomes. Brown & Chen (2019) investigated ways for controlling gene expression in retinal gene therapy. The study explored the use of promoters, enhancers, and other regulatory elements to optimize gene expression and reduce the danger of overexpression or under expression. The researchers emphasized the importance of choosing promoters with tissue specificity and adequate expression levels in target cells. Gene silencing technologies, including RNA interference (RNAi), can target specific transcripts and control gene expression. They also explored using inducible technologies to control gene expression, allowing for tailored therapy and minimizing off-target consequences (Brown & Chen, 2019).

There are several potential risks associated with retinal gene therapy. These risks include inflammation, immune responses, retinal detachment, and unintended gene integration into the genome (Drag et al., 2023). When it comes to retinal gene therapy, it is also crucial to stress the importance of careful patient selection, monitoring for potential adverse effects, the need for ongoing research to optimize safety profiles and minimize the risk of complications (Drag et al., 2017). The latter emphasizes the crucial need for long-term follow-up to assess the long-term safety and efficacy of these therapies.

2.6. Immune System Response Risks

Retinal gene therapy can elicit immune responses that can be harmful to the eye and potentially lead to treatment failure. The delivery vector, such as a viral vector, can trigger the immune system, leading to inflammation, rejection of the therapy, or even blindness. The introduction of foreign genetic material can trigger an inflammatory response, leading to swelling, redness, and damage to the eye tissue. Also, the body may develop antibodies against the viral vector or the therapeutic gene itself, rendering future treatments ineffective or even harmful. Furthermore, immune cells, such as T-cells, may target and destroy cells that have been genetically modified, leading to loss of therapeutic effect. In order to mitigate these risks, strategies like immunosuppressive therapies, vector modifications, and patient selection are employed.

One major worry with gene therapy is the likelihood of unintended genetic alterations, in which the therapeutic gene integrates into the genome in an unanticipated region. This can result in the disruption of key genes, potentially creating new or worsening health issues. The insertion of the therapeutic gene in the incorrect site may activate or disrupt neighboring genes, resulting in unforeseen outcomes. Researchers and physicians are looking into ways to reduce the danger of unintentional genetic modifications. This includes employing vectors with a lower propensity for random integration, creating more precise gene-editing procedures, and performing extensive genomic analysis before and after therapy.

2.7. Off-Target Effects Risks

Off-target effects occur when the gene therapy vector, intended to deliver the therapeutic gene to specific retinal cells, inadvertently affects other cells or tissues in the body. This can lead to unintended consequences, potentially causing adverse reactions or even long-term health problems. Off-target effects can alter normal gene expression and encourage tumor growth (Schaefer et al., 2016). Miller et al. (2021) investigated the dispersion of viral vectors used in retinal gene therapy. The study discovered that most vectors targeted the retina, although a tiny fraction were also found in other tissues. Therefore, optimizing vector design and delivery strategies can reduce the possibility of undesired tissue transduction.

Moreover, these effects might arise due to the vector's interaction with other genes or cellular processes, leading to alterations in gene expression or protein production. For instance, if the vector inadvertently targets a gene involved in immune regulation, it could lead to immune dysregulation, resulting in autoimmune disorders or increased susceptibility to infections.

The size, stability, mode of administration, and dispersion of the vector in the eye can all impact the therapy's effectiveness and safety. Davis and Roberts (2021) investigated various vector delivery strategies in retinal gene therapy. They compared the benefits and drawbacks of several delivery methods, including subretinal injection, intravitreal injection, and gene delivery using nanoparticles. According to Davis and Roberts (2021), viral vectors, particularly AAVs, are the most promising delivery vehicles for retinal gene therapy. AAVs exhibit excellent transduction efficiency, long-term expression, and a favorable safety profile. However, AAVs have limitations such as immunological responses, limited vector capacity, and the risk of off-target consequences (Davis & Roberts, 2021). Researchers suggest using non-viral vectors like lipid and polymeric nanoparticles for improved biocompatibility and lower immunogenicity. Finally, they also reviewed genome editing technologies like CRISPR-Cas9, which have the potential for precise gene changes and targeted therapies (Davis & Roberts, 2021).

2.8. Dose-Dependent Toxicity Risks

Retinal gene therapy, like any other therapeutic intervention, carries the inherent risk of dose-dependent toxicity. This refers to the potential for adverse effects to increase in severity or frequency as the dosage of the therapeutic agent, in this case, the gene vector, is increased. This toxicity can manifest in various ways, ranging from mild side effects to severe complications, potentially jeopardizing the patient's vision or even overall health. One key aspect of dose-dependent toxicity is the balance between achieving therapeutic efficacy and minimizing adverse events. While higher doses may lead to more robust gene expression and therapeutic benefits, they also increase the risk of off-target effects, immune responses, and even vector-associated toxicity. This delicate balance necessitates careful dose optimization strategies during clinical trials, involving meticulous monitoring of patient responses and adjusting the dosage accordingly.

The clinical consequences of dose-dependent toxicity can be serious. High doses might lead to visual loss or worsen existing retinal impairment (Trapani et al., 2019). This demands precise dose adjustment and close monitoring during clinical trials. Mitigation measures include employing vectors with decreased immunogenicity, optimizing gene delivery techniques, and controlling transgene expression levels.

Furthermore, the nature and severity of dose-dependent toxicity can vary significantly depending on the specific gene vector employed, the target gene, and the route of administration. For instance, certain viral vectors, particularly adeno-associated viruses (AAVs), have been associated with dose-dependent toxicity, with higher doses increasing

the risk of inflammation and immune reactions within the retina. These factors underscore the need for rigorous preclinical studies to assess the safety profile of gene therapy vectors across a range of dosages and to identify potential dose-limiting toxicities.

2.9. Long-Term Safety Concerns

While the initial clinical trials of retinal gene therapy have shown promising results, long-term safety concerns remain a critical area of focus. The potential for unanticipated side effects, especially over extended periods, necessitates ongoing monitoring and research. One concern is the persistence of the therapeutic gene and its potential to induce unforeseen changes in the eye over time. Also, while initial studies have concentrated on short-term outcomes, the long-term impact of gene therapy on the natural course of age-related changes in the eye needs thorough investigation.

Johnson et al. (2023) examined the long-term safety of retinal gene therapy in patients who had received treatment several years prior. The study found that most patients had persistent eyesight improvements, although a small number reported delayed problems such as retinal inflammation and scarring. A key concern is the possibility of delayed or chronic immune responses. While initial immune reactions may be minimized by careful vector design and administration, the long-term effects of repeated exposure to the therapeutic gene or its products remain unclear. There is also the possibility of unforeseen interactions between the therapeutic gene and other genes in the eye, leading to unpredictable consequences. The long-term impact of the therapeutic gene on other tissues, especially the nervous system, which is closely interconnected with the eye, is another aspect requiring careful consideration.

Nguyen & Lee (2022) wrote about the ethical dilemmas of conducting clinical trials on retinal gene therapy. They underline the importance of pre-clinical safety assessments, patient-practitioner communication, and follow-up patient monitoring that all enhance the moral conduct of these trials. Informed consent is amongst the most important parts of ethical research and clinical work – it ensures patients understand the risks, the benefits, as well as any other possible treatment options or any other parallel clinical experiments that may be instituted (Macwan et al., 2021). With respect to the retinal gene therapy, informed consent is even more remarkable as technology and its consequences are advancing with time.

Given that patient autonomy is of the utmost importance, it is imperative that individuals are given the ability to make intelligent decisions when it comes to their own healthcare. Such a disposition calls for well-structured and comprehensive explanations regarding

the mechanics of gene therapy at a level that the specific patient can easily understand. It is crucial that the information addresses not only the short-term risks and rewards, but the side effects, the likelihood of other diseases, as well as the unpredictability of the treatment's long-term safety and effectiveness.

Of note here, in this context, is the fact that ethical aspects are wider than the first consent for participation. These are the aspects that touch on the interaction during the clinical trials themselves. Patients have to be informed of new risks and advancements in evidence, which could alter the treatment protocols. Such communication builds strong relationships and ensures that the patient continues to actively participate in decision-making regarding their health.

The ethical issue of equitable means to retinal gene therapy should be a priority by all parties involved as it relates to the wealth or geographical barriers people face. Efforts to rectify the underlying issue will be complex and involve things such as: the need to create new and better pricing strategies for gene therapy that take long term economic health costs into account, getting both private and public insurance agencies to cover it, implement public-private ventures that foster the use of gene therapies in more economically disadvantaged areas, and prioritizing the research for cheaper techniques of manufacturing the therapy as well as improving the delivery methods.

In order to resolve the technology's high costs of development, manufacture and administration, it will be essential to propose new models that can facilitate so that an imbalance does not arise between those people who have access to the treatment and those who do not.

Additionally, barriers to accessibility are not only financial but also topographic, such as the presence or absence of trained health service providers and specialized medical diagnostics and treatment centers. Eliminating these barriers requires coordinated action on the part of the government, healthcare institutions, and patients' associations, as well as researchers, in order to make sure that the potential of gene therapy is useful to every person who needs it without taking into consideration their background or circumstances.

2.10. Germline Modifications and Future Generations

Retinal gene therapy brings up significant ethical issues, particularly concerning germline modifications and the question of heritability. While current methods typically focus on somatic cells, there's always a risk of unintended germline changes. If a therapeutic gene were to integrate into the germline, it could potentially be passed down through

generations, altering the genetic makeup of future individuals. The ethical ramifications of such inheritance are intricate and warrant careful consideration.

A primary concern is the possibility of unforeseen effects on future generations. While gene therapy aims to treat diseases, it could also lead to unintended genetic changes that might have harmful consequences for offspring. This raises important questions about the rights of unborn individuals to inherit a genetic makeup that may have been modified without their consent. Informed consent, a fundamental principle of ethical research, becomes particularly challenging when addressing the rights of those who have yet to be born.

Another ethical dilemma arises with the possibility of designer babies. Germline modifications could potentially be used to enhance certain traits, raising concerns about genetic inequality and the risk of social stratification based on preferred genetic attributes. These issues underscore the necessity for strong ethical guidelines and regulatory oversight to prevent the misuse of germline gene therapy for non-medical purposes.

2.11. Disability Rights and Identity

Retinal gene therapy brings up important questions regarding disability rights and identity. While the potential to restore sight is enticing, we must consider how this technology could affect the experiences and identities of those with visual impairments. Some people believe that restoring sight might diminish a part of a person's identity, especially for those who have lived with blindness or low vision. Conversely, others argue that regaining sight could be empowering, enabling individuals to engage more fully in society. This ethical dilemma requires us to strike a balance between honoring individual autonomy and ensuring that decisions about gene therapy are made with a deep understanding of how it might influence identity and self-image.

Additionally, it's vital to acknowledge that blindness or low vision can be integral to a person's cultural and social identity, and changing this aspect of their lives could have significant consequences. Engaging with the disability community is essential to ensure that their views and concerns are considered in the development and implementation of retinal gene therapy. This means providing individuals with visual impairments access to accurate and impartial information about the technology and its potential effects, empowering them to make informed choices about whether to pursue therapy.

3. Conclusion

Retinal gene therapy marks a major advancement in treating both inherited and acquired retinal diseases, with the promise of restoring vision through targeted genetic

interventions. While preclinical and clinical studies have shown remarkable results, this therapy also presents various bioethical and safety challenges that require a comprehensive and collaborative approach.

One of the key bioethical issues is ensuring equitable access to the therapy, as its high costs may limit availability to those with greater financial means. Additionally, the long-term safety of gene therapy is still uncertain, considering the risks of immune reactions, unintended genetic changes, and potential dose-dependent toxicity. A particularly delicate ethical issue involves the risk of germline mutations, which could have effects that span generations, as well as the implications of therapy on personal identity and societal views of individuals with disabilities.

Although retinal gene therapy has the potential to revolutionize ophthalmic care, its broader application must be supported by well-regulated protocols, ongoing patient monitoring, and ethically sound clinical guidelines. Future research should aim to enhance the safety profile of the therapy, create accessible funding models, and develop clear bioethical standards to ensure the responsible and equitable use of this groundbreaking technology.

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REPERCUSIÓN DEL DIVORCIO EN NIÑOS Y ADOLESCENTES

Joaquín Callabed



No existe acto humano más digno que cuidar la salud de los niños

Pierre Royer

Nacido 07/11/1946 en Biescas (Huesca).

Licenciado en Medicina Universidad de Zaragoza con sobresaliente 1971.

Especialista en Pediatría y Puericultura Universitat de Barcelona. Prof. Dr. Manuel Cruz (1973-1975). Fundador del Instituto Pediátrico Callabed 1975-2017.

Inspector Médico de Carrera 1976.

Postgrado de Pediatría Social ASPRE-PARÍS con el Profesor Roger Salbreux. (1998-1999). Cuatro “Stages” de pediatría psicosocial.

Fundador del Club de Pediatría Social. (Asociación de Pediatras, Pedagogos y Psicólogos.) Coordinador de 22 congresos (1996- 2015)

Doctor en Medicina y Cirugía, Excelente Cum Laude, Universidad de Barcelona. 2005.

Magister Universitario en Bioética, en 2008-2009 Universidad Complutense de Madrid.

Académico Correspondiente, por elección de la Real Academia de Medicina de Zaragoza.

Académico Correspondiente por elección de la Reial Acadèmia de Medicina de Catalunya

Socio Numerario del Club International de Pédiatrie Sociale de París.

Miembro de Honor del Consejo Superior Europeo de Doctores y Doctores Honoris Causa.

Académico Numerario Electo de la Real Academia Europea de Doctores.

Pertenece a 12 sociedades científicas nacionales e internacionales.

Director y coordinador de 57 congresos de su especialidad.

Autor de 58 comunicaciones y ponencias en congresos nacionales e internacionales.

Representante español en la Encuesta Europea de Prevención de Accidentes. Luxemburgo 1996.

Autor y coautor de 23 libros de Pediatría.

Como escritor humanista es autor de 7 libros de literatura y ensayo.

Ha pronunciado 250 conferencias y publicado más de 300 artículos.

Académico Correspondiente, por elección, de la Real Academia de Nobles y Bellas Artes de San Luís de Zaragoza.

Socio de Honor de la Sociedad Española de Medicina Psicosomática.

Académico Correspondiente de la Academia de Ciencias Odontológicas de España.

Académico Correspondiente de la Reial Acadèmia de Farmacia de Catalunya.

Puntos esenciales

En las últimas décadas se observa que el número de divorcios es importante. El divorcio de los padres oficializa la ruptura de la pareja y de la familia, lugar privilegiado de intercambios y de protección de los hijos. El divorcio o, mejor, la separación conyugal, aunque doloroso, es necesario en algunos casos en los que la convivencia familiar resulta insostenible. Esta situación puede afectar a los hijos que es el motivo principal de este trabajo.

Aspectos que vamos a considerar en el proceso de divorcio

1. Información a la familia de la dimensión del divorcio y de los riesgos para los hijos. Características deseables de la interacción familiar y desarrollo del niño, así como los factores de vulnerabilidad y protección en el proceso de divorcio. Toda esta información puede darse en el contexto de una entrevista que debe reunir unas condiciones determinadas.

2. Detección precoz e identificación de los factores de riesgo en el divorcio valorando las distintas etapas del desarrollo cognitivo y emocional es decir características o comportamientos asociados a un riesgo más o menos elevado.

3. Orientación terapéutica interviniendo sobre los factores de riesgo modificables ya sea suprimiendo un factor de riesgo o reforzando un factor protector. Facilitando la resiliencia del niño y de la familia o derivando a servicios de salud mental

El divorcio constituye en la actualidad el motivo más frecuente de separación de los hijos de los padres. Es una de las circunstancias más dolorosas que pueden surgir en la vida del niño y puede tener claras repercusiones en el futuro como adolescente y adulto

El divorcio implica un proceso de cambios emocionales y sociales que se extienden durante varios años. Los cambios vitales que preceden y se derivan del divorcio ocuparán

muchos años de la vida del niño y adolescente. El divorcio no puede entenderse como un acontecimiento limitado en el tiempo sino como un largo proceso en el que se recorren varias etapas; una etapa previa de *desavenencias* y conflictos maritales; una etapa de *recrudescimiento* de estos conflictos coincidiendo con el comienzo de los trámites legales del divorcio y una tercera de *efectos a medio y largo plazo* que pueden afectar a todos los miembros que constituyen la familia.

Este esfuerzo debemos dirigirlo de un modo personalizado a cada niño. La capacidad de cada niño es muy variable. No debemos etiquetar ni predecir. Todo niño es un sujeto único, irrepetible, que siente, observa, retiene y comprende de un modo personal. El abordaje ideal es desde el equipo pluridisciplinario. El niño tiene unos ritmos propios que no son los de los adultos (Bourrillon).

La pediatría Social entendida como el estado de espíritu que consiste en desarrollar una visión global del niño y su entorno con las influencias sociales del entorno y familiares sobre la salud del niño a nivel de la población y del sujeto está plenamente insertada en la problemática de la repercusión del divorcio en el niño. El pediatra es un invitado de primera fila a este drama de la familia.

I DEFINICIÓN DEL PROBLEMA E INFORMACIÓN A LA FAMILIA DE LOS RIESGOS DEL DIVORCIO

El hecho de que millones de personas compartan los mismos vicios no convierte esos vicios en virtudes; el hecho de que compartan muchos errores no convierte estos en verdades; y el hecho de que millones de personas padezcan las mismas formas de patología mental no les convierte en cuerdos

Erich Fromm

A Introducción

En los años 1970-1980, se consideraba al divorcio como un indicio de que las parejas infelices no se sentían obligadas a permanecer unidas. Se interpretaba como un signo de evolución social más que un indicio de desorganización social.

Las hipótesis se conocen por los resultados y durante la década de los 80 del pasado siglo se comenzaron a mostrar los efectos negativos del divorcio sobre todo en niños. (Amato y Keith, 1993). Informaron que los hijos de familias con un solo padre tenían más problemas en la escuela, mayores posibilidades de conductas delictivas, abuso de sustancias nocivas y sufrían mayores tasas de depresión

Estudios epidemiológicos recientes nos aportan estos datos:

En España 33.000 parejas se divorciaron en el primer semestre del año 2008 lo que supone 365 rupturas al día y un descenso de 4.500 matrimonios rotos al igual período de 2007. En la mayoría de los casos las parejas lograron acordar el divorcio (18.888) y su separación (1.399) mientras que 11.816 matrimonios no llegaron a ponerse de acuerdo.

La Comunidad Autónoma con más divorcios y separaciones fue Cataluña (6311) seguida por Andalucía (6.305) y después Madrid (4.814) y Valencia (4.272). Mas lejos se sitúan Galicia (1.955), Canarias (1.955); País vasco (1.369); Castilla y León (954); Castilla-La Mancha (941), Aragón (802); Murcia (693), Asturias (649), Baleares (616), Cantabria (401), Extremadura (369), Navarra (361) y La Rioja (142).

El primer divorcio de los padres no es raro que se siga de un segundo. Si la tasa de separaciones en el primer matrimonio es de 30-40 % en muchos países occidentales, en los segundos matrimonios esta cifra asciende a un 60%.

El complejo problema del divorcio impone una mirada multidisciplinaria donde la pediatría, la sociología, la psicología, la biología y la bioética tienen un espacio compartido.

El *enfoque social* visto desde la sociología, ha postulado el relativismo conceptual de definir el problema en función de la tolerancia social hacia determinados aspectos de la conducta individual o grupal. Es evidente que la necesidad asistencial aparece a menudo definida primero por la sociedad y con posterioridad el profesional lleva a cabo una redefinición del cuadro.

Desde el punto de vista *psicológico*, el caso se plantea en función del sufrimiento mental del individuo, que abarca desde el malestar subjetivo hasta el desarrollo y adopción de la conducta frente a la enfermedad y la utilización de servicios.

Bajo el punto de vista *biológico*, el motivo sería un sustrato biológico demostrable. (Joseph)

Bajo el punto de vista bioética se buscará la decisión más prudente para el presente y el futuro de los hijos.

Una articulación adecuada de estos puntos de vista es básica para establecer una asistencia médico-sanitaria integral.

El principal objetivo de este trabajo será cuidar al niño en todo el proceso de divorcio, que puede finalizar siguiendo en el hogar de uno de los padres o en un hogar de acogida o internamiento.

Nuestro esfuerzo va guiado a prevenir esta situación con una adecuada información de los riesgos que pueden derivarse. En segundo lugar, debemos hacer un seguimiento con

detección precoz de problemas de desarrollo. Finalmente, debemos realizar o facilitar una intervención terapéutica si las circunstancias lo requieren.

Necesitamos una mayor cultura del divorcio, entendiendo por cultura el depósito de las transformaciones que el ser humano hace sobre el medio donde vive.

B. Interacción familiar y desarrollo normal del niño

La familia representa en la sociedad occidental el medio natural donde el niño vive y ocupa un lugar central en su desarrollo emocional, cognitivo y social. La familia es el más importante agente de socialización.

La representación del lactante y del niño ha cambiado paulatinamente en nuestra sociedad. Del *niño objeto* que se beneficia esencialmente de cuidados corporales, hemos pasado al niño “sujeto” activo e interactivo con su entorno.

La teoría del apego es un modelo útil para comprender la evolución de los niños en el contexto de las relaciones familiares. Las ideas de Bowlby (1988) han producido un fuerte impacto y permitido comprender el efecto de las relaciones iniciales con las que se establecen posteriormente. La teoría del apego asegura que la relación que un niño establece con su madre, o cuidador, es fundamental para el desarrollo de relaciones futuras y la investigación confirma que cuanto más segura sea la relación inicial con el cuidador, más capaz será el niño de explorar el mundo que lo rodea sabiendo que tiene “un lugar seguro” donde regresar.

Las conductas de búsqueda de las figuras de apoyo aumentan con la movilidad (6-7 meses) y comienza a mostrar signos de apego selectivo cuando protesta por la separación y manifiesta temor ante los extraños (8-12 meses). En realidad, casi todas las conductas de apego se incrementan en situaciones estresantes o de miedo.

El apego entre madre e hijo está influido por las condiciones de proximidad. Por esta peculiaridad muchos hospitales fomentan el contacto entre madre y bebé desde el nacimiento. La mirada de la madre es el primer espejo del bebé. Algunas investigaciones indican que las conductas de apego de las madres, al menos inicialmente, son prácticamente idénticas a las de los padres, aunque pasados algunos meses desarrollan roles característicos (Parke y Tinsley,1981)El padre puede ayudar a mitigar “la preocupación primaria” de la madre y favorecer el desarrollo de conductas de interacción con personas desconocidas y reducir las manifestaciones de angustia con personas extrañas

Para que los padres faciliten a los niños una base segura desde la que pueden desarrollarse emocional y socialmente, tienen que:

Entender que los deseos de proximidad, atención y receptividad de los niños no son malos, exigentes o irracionales, sino una expresión evolutiva de sus necesidades. Cuanto más se rechacen o dejen de satisfacerse esas necesidades, mayor será la demanda que acabará expresándose en forma de síntomas físicos o psicológicos.

Reconocer que el origen más corriente de los enfados de los niños es la frustración de su deseo de amor y atención y, por regla general, su miedo refleja incertidumbre acerca si los padres seguirán prestándole atención.

La familia contribuye al desarrollo emocional a través de la calidad de la interacción afectiva entre sus miembros proporcionando un clima emocional adecuado que permite las expresiones de afecto y apoyo mutuo.

La familia aporta estímulos adecuados para el aprendizaje imprescindibles para el desarrollo cognitivo normal.

La familia transmite al niño valores culturales socialmente aceptados como pautas de conducta social apropiadas. Esta transmisión se hace mediante el pronunciamiento verbal de los padres y a través de las conductas paternas (“La palabra conmueve pero el ejemplo arrastra”, decía Confucio). El mundo de la escuela y el de los amigos tienen también un importante significado en el proceso de transmisión y adquisición de valores (Cyrulnik)

C. Factores de vulnerabilidad y protectores en el proceso de divorcio

1. Factores que favorecen la vulnerabilidad (Anthony):

- Clase económica desfavorecida con necesidades básicas poco desarrolladas como alojamiento, alimentación, educación, cuidados sanitarios.
- Psicopatología por parte de los padres
- Conflictividad importante previa al divorcio
- Carácter repentino del divorcio
- Múltiples cambios en el medio familiar
- Conflictividad entre los padres después de la separación
- Problemas legales
- Ausencia física o emocional de uno de los padres

2. Consecuencias del divorcio de los padres:

- . Mayor riesgo de problemas conductuales, conductas antisociales, agresividad, delincuencia y otros acontecimientos antisociales y psicosomáticos como enuresis.
- . Se desenvuelven peor en la escuela y alcanzan menos logros académicos
- . Tienen más posibilidad de ingresos hospitalarios a causa de accidentes y pueden tener más problemas de salud en general

. Hay más posibilidades de abandono prematuro de la escuela y del hogar. Se describen como sexualmente más activos con todos los riesgos que esta actividad supone.

. Tienden a manifestar más síntomas depresivos, y tendencia a fumar, beber y a consumir otras drogas durante la adolescencia y la edad adulta.

. Algunos niños pueden tomar distancia con el hogar y apasionarse por una actividad extraescolar (deporte, ocio, música, dibujo y pintura). Otros tienen tendencia a huir de la realidad en una especie de sueño diurno sobre el tema de la unión de los padres y tienen problemas en la integración social, afectivo e incluso somáticos.

Existen chivos expiatorios (*boucs émissaires*) que cristalizan la agresividad de los padres: maltrato, revivencias, rechazos y balas de cañón, utilizados por los padres para castigarse mutuamente.

El pronóstico es peor en determinados casos: el sexo masculino, cuando hay escasas capacidades intelectuales, temperamento difícil, anomalías cromosómicas, historia de enfermedad crónica, trastorno de la comunicación, institucionalización prolongada, graves daños cerebrales, complicaciones perinatales, retraso del desarrollo, historia de abusos o negligencia (Brasselet-Raynaud).

No quiere decir que el divorcio sea la causa subyacente en todos estos casos ya que la complejidad de los factores antes, durante y después del divorcio indica que es un proceso más que un único acontecimiento, lo cual merece un análisis detenido e individualizado.

Aunque un factor de riesgo incrementa la probabilidad de una determinada consecuencia negativa, eso no significa que toda persona que lo experimente sufra el efecto perverso.

Los profesionales solo eligen por lo general niños con problemas por lo que puede existir un sesgo de profesionalismo, ya que no se dispone de una perspectiva adecuada que incluya a los padres de niños divorciados que no precisan asistencia.

3. Factores protectores

La vida familiar no debe acabar con el divorcio, aunque este modifique sensiblemente su configuración.

Los mismos padres deben tener que confiar en su forma de vida familiar para que los hijos no se sientan en desventaja.

Algunos factores familiares que contribuyen a la **resiliencia** de los niños son:

-Los niños necesitan explicaciones. Necesitan entender que, aunque sus padres no puedan vivir juntos, siguen interesándose y responsabilizándose por ellos. Una explicación les ayudará a superar la idea de que ellos hayan sido los responsables de la ruptura (Gorell Barnes y Dowling, 1977).

- Ausencia de discordia o escasa conflictividad entre los padres
- Cambios mínimos en la organización y funcionamiento de la familia, domicilio, escuela
- Mantenimiento de la relación con el padre ausente

Mantener una relación normalizada a pesar de las interferencias emocionales

- Apoyo económico y emocional a los hijos por parte de ambos padres
- Apoyo de otros miembros de la familia, así como profesores del colegio y amigos
- Ausencia de juicios negativos de un padre acerca de otro en presencia de los hijos
- Cuidar el bienestar psicológico del padre o madre que tienen la custodia. La mejor o peor adaptación de los padres tiene una influencia significativa en los hijos
- Disponibilidad de apoyo para las madres que estén sola
- Controles de salud regulares con vigilancia del desarrollo, maduración y conducta.
- Experiencias escolares positivas. Capacidad de planificación. Eventos neutralizantes
- Es conveniente supervisar la sociabilidad, signos depresivos o signos de malos tratos.

La función del pediatra puede ser muy importante en el seguimiento de la evolución del divorcio:

-A nivel individual tienen mejor pronóstico los niños de temperamento fácil, que se impliquen en juegos e iniciativas, que tengan buena relación con sus iguales, que hayan tenido apego seguro en la infancia, capacidades intelectuales altas buen rendimiento escolar autoimagen positiva, buenas relaciones con los hermanos, presencia de un confidente en su vida.

Si la prevención primaria es importante en muchas facetas de la pediatría aquí también puede ser útil. El divorcio es una epidemia con alta prevalencia y virulencia en la salud infantil y precisa por tanto la prevención primaria

D. La entrevista a los padres antes del divorcio

La entrevista a los padres que están en fase de preparación del divorcio por parte del pediatra y que así lo han manifestado al profesional sanitario que merece su confianza y que quizá conoce la historia de los padres y de los hijos puede ser muy útil. En mi experiencia personal he podido evitar algunas separaciones bien tras una charla detenida o bien derivando a los padres a un psiquiatra de confianza y familiarizado con estos temas. Es muy difícil que en el tiempo normal de una visita pueda profundizarse en todas las variables que inciden en un posible divorcio. Es necesario encontrar el tiempo necesario y el lugar apropiado para que las posibilidades de éxito aumenten (Callabed).

Toda entrevista que precise un enfoque biológico y psico-social precisa tiempo, motivación y técnica.

Las causas de una **mala entrevista** pueden ser:

- Tiempo insuficiente de entrevista
 - Enfoque directo para ganar tiempo, olvidando que antes es preciso escuchar. “La palabra es plata, pero el silencio es oro”.
 - Poco interés y escasa motivación por el tema por parte del profesional
 - Actitudes negativas preconcebidas hacia los problemas psicológicos y sociales que esta circunstancia supondrá en el niño de un modo irremediable, sin individualizar cada caso
- Una **buena entrevista** valorando aspectos psicológicos y sociales supone tener en cuenta este guión:

- Buen contacto visual con los pacientes
- Disponer del tiempo suficiente. Pueden ser precisas varias sesiones
- Dar información positiva. Describir sin juzgar. Hablar solo de lo necesario.
- No leer la historia clínica durante la entrevista
- Estilo empático y próximo de comunicación. La empatía se relaciona con la comprensión, el respeto y las necesidades específicas del paciente. La discreción, la modestia y situarse en las necesidades de los pacientes facilita la empatía.
- Ser sensible a los datos verbales de la entrevista. Recordemos que consultar y confiar son dos verbos diferentes.
- Hacer pocas preguntas de la historia previa
- Clarificar las quejas ordenadamente. Preparar un plan para aclararlas. Hay que canalizar la fuerza emocional a veces dispersa de este tipo de entrevistas. Recordemos que mientras existe conflicto hay posibilidades de solucionarlo.
- Ayudar a la pareja a dar posibles soluciones para la situación que atraviesan. Hacer diagnósticos positivos y negativos.
- Repetir y comprobar el impacto de nuestros mensajes en los pacientes

En algunas ocasiones la función del pediatra será suscitar preguntas más que dar respuestas

- Intentar llegar a un acuerdo con las decisiones tomadas.
- Respeto, compasión y prudencia, como normas éticas necesarias cuando tratamos con el dolor humano
- Información escrita de los temas que deseamos comunicar en la entrevista.(“Si lo oigo lo olvido, si lo leo lo recuerdo, si lo hago lo aprendo” dice, Confucio).

Como comunicar la decisión a los hijos

Cuando la decisión del divorcio ya es firme y nos solicitan ayuda para decírselo al niño, se podemos optar por estas explicaciones que deben adaptarse a la edad y desarrollo del niño.

- Los padres nunca le faltarán y estarán pendientes de él
- Está todo pensado para que no le falte nada. Es un acuerdo mutuo entre los padres
- No tiene la culpa de la separación
- Seguirá teniendo espacio propio para sus necesidades y deseos
- Respuesta a todas las preguntas que surjan, procurando que no sea una fiesta ni un éxito para nadie.

Hay que ofrecer apoyo a los padres. Se les exige que tomen decisiones importantes respecto a su futuro y el de sus hijos cuando ellos mismos se encuentran en plena confusión emocional y llenos de incertidumbres. Este apoyo permitirá ayudar a sus hijos durante la transición de una familia a otra.

Debemos observar y sugerir quien es la persona más idónea para vivir con el niño.

No es función del pediatra judicializar ni psiquiatrizar, ni medicalizar a un niño. Es un momento para escuchar, respetar las decisiones de la familia y acompañarles. Para orientarles en este delicado momento de su vida. Conseguir, si es posible una alianza terapéutica.

Los padres deben conocer los sistemas de apoyo que les ofrece la comunidad donde viven: Sistemas de Salud, Servicios especializados con psicólogos, Psiquiatra, Psicoterapeutas, Maestros y Profesores coordinadores de necesidades especiales, Servicios Sociales, Tribunales de Justicia, Defensor de los derechos del niño, Asociaciones afines.

Los trastornos más evidentes del funcionamiento individual tanto en niños como adultos, suele encontrarse en los dos años posteriores al divorcio.

Después del divorcio

Los niños que han presenciado conflictos de los padres de elevada intensidad pueden experimentar un amplio conjunto de dificultades emocionales y conductuales. La adaptación futura guarda relación con el modo como los padres llevan adelante el proceso de divorcio.

- Regular las visitas periódicas y establecer matices de fiestas, vacaciones, etc.*
- Procurar evitar discusiones en presencia del niño, o que haga de mensajero*
- Respetar los sentimientos hacia cada padre*
- Si un progenitor está ausente, pensar en la necesidad de un adulto que le sustituya*
- Observar periódicamente el impacto, y seguir la vinculación con las nuevas familias*

Si se ha creado una buena relación con los padres y desean seguir comentando las incidencias del divorcio se pueden hacer estas preguntas

¿Se le ha dado al niño alguna explicación de las razones de la ruptura?

¿Está organizado de forma periódica el contacto con el padre que vive fuera de casa?

¿Hay conflictos o violencias en las relaciones entre los padres?

¿Los padres son capaces de comunicarse directamente o lo hacen a través de los hijos?

¿Pueden los padres poner en primer lugar las necesidades del hijo?

¿Están implicadas las nuevas parejas de los padres en el cuidado de los hijos?

E. Una reflexión bioética en el divorcio

La bioética tiene un espacio en el proceso de divorcio ya que es el intento de analizar racionalmente los deberes que como individuos y como miembros de la comunidad humana tenemos con nosotros mismos y con los demás en lo relativo a la vida biológica, salud, enfermedad y puede abrir caminos nuevos en el planteamiento del divorcio

La reflexión bioética en pediatría social debe tener en cuenta las especificidades del niño en tanto que ser en desarrollo en una familia que precisa una atención especial y tiene que proteger a quienes la vida hace frágiles o hiere (Noël D.)

La bioética se apoya en el *principio de autonomía* que es un signo de respeto a la persona. Toda persona debe ser tratada como agente autónomo. Las personas con autonomía disminuida tienen el derecho de ser protegidas. Todo discapacitado tiene muchas capacidades;

El principio de beneficencia asocia el deber de hacer el bien al paciente, de pensar en lo mejor para el interés del paciente; *El principio de no maleficencia*, el deseo de mejorar la condición de las personas enfermas puede ser causa de sufrimiento y se resumen en la frase latina “*Primum non nocere*” (D’abord ne pas nuire) y el de *Justicia o equidad*, por el que todas las personas deben ser tratadas de la misma forma, ofreciendo el mismo servicio a cada paciente, sean los que sean sus recursos financieros.

La ética o estudio de las costumbres y hábitos humanos no trata de valores sino de deberes. El deber es la realización de los valores. La ética no busca lo justo busca lo óptimo.

Las circunstancias que debate la ética son numerosas y las decisiones difíciles (Gracia).

Una reflexión ética puede ser propuesta a los padres. Cuando las personas se hayan dominadas por la angustia o emociones inconscientes no deliberan las decisiones que toman, sino que lo hacen de un modo reflejo, automático, pulsional. Solo quien es capaz

de controlar los sentimientos de miedo y angustia puede tener la entereza y presencia de espíritu que exige la deliberación moral. La virtud suele estar en el término medio.

El análisis de los casos debe constar siempre de unos pasos previos que son los siguientes:

Presentación del caso por la persona responsable

Identificación de los problemas morales que presenta

Identificación de los valores en conflicto

Identificación de los cursos extremos de acción

Búsqueda de cursos intermedios

Análisis del curso de acción óptimo

Decisión final

Comprobación de la consistencia de la decisión tomada sometiéndola a la prueba de la *legalidad* ¿es legal esta decisión? A la de *publicidad* ¿estarías dispuesto a defenderla públicamente? y a la de *consistencia temporal* ¿tomarías la misma decisión caso de esperar algunas horas o algunos días?

La deliberación es el proceso de ponderación de los factores que intervienen en un acto o situación concreta a fin de buscar su solución óptima o cuando esto no es posible la menos lesiva.

II DETECCIÓN PRECOZ DE ALTERACIONES QUE PUEDE PRODUCIR EL DIVORCIO

“Nada existe más elevado, más fuerte y más sano y más útil para el porvenir en la vida que el buen recuerdo de la infancia y de la casa materna. Un bello recuerdo, un santo recuerdo, conservado en la infancia, representa posiblemente la mejor educación”.

Dostoievski. *Los muchachos*

Algunos síntomas que suelen repetirse en los niños de padres divorciados son:

- Agresividad aumentada en el domicilio y en la escuela
- Abatimiento, aislamiento. Pierden amigos e interés por la escuela
- Cambio de hábitos en las comidas. Anorexia
- Alteraciones del sueño (pesadillas, terrores nocturnos)
- Dificultades escolares
- Trastornos psicossomáticos (cefaleas, dolores abdominales, enuresis, encopresis, etc)
- Enferman con más frecuencia. Consultan más al pediatra.

Cualquier niño puede presentar estos cuadros sin que sus padres estén divorciados, pero en el divorcio pueden estar aumentados.

A. Necesidades básicas de un niño, que pueden orientar a sus padres en el proceso de divorcio

1. Hasta 1 año

- protección contra peligros físicos como caídas, quemaduras atragantamientos
- alimentación y atenciones de salud. Observación del desarrollo psicomotor
- La proximidad de un adulto que pueda comprender las señales que emite y que responda a las mismas
- objetos para mirar, tocar, escuchar, oler, gustar
- ocasiones para explorar el mundo
- estimulación adecuada, con vista a la adquisición del lenguaje y las adquisiciones que tenga menos desarrolladas como sedestación y bipedestación (Gosselin J, Amiel-Tison C).

2. De 1-3 años

- protección contra peligros físicos. Los accidentes son una causa importante de morbilidad y mortalidad infantil en esta franja de edad
 - atención para adquirir nuevas capacidades motrices y nuevas aptitudes para expresarse -
 - posibilidades de adquirir una cierta autonomía
 - ayuda para aprender a dominarse y comportarse de un modo responsable.
- Es buen momento de creación de hábitos y control de esfínteres
- ocasiones para empezar a aprender y equivocarse por sí mismo
 - ocasiones de jugar con todo tipo de objetos.

3. De 3-6 años

- ocasiones de desarrollar buenas aptitudes motrices
- estímulos para adquirir el mecanismo del lenguaje por la palabra, la lectura y el canto
- actividades que les inspiren un sentimiento positivo del dominio de la situación
- ocasiones de aprender a cooperar, ayudar y compartir
- una experiencia del pre-aprendizaje de la lecto-escritura

El divorcio repercute evidentemente en los esquemas familiares, por cuanto la familia contribuye al desarrollo emocional, a los aprendizajes y a establecer pautas de conducta social. Todas estas funciones pueden quedar alteradas.

Respecto a la repercusión directa en los hijos, son frecuentes los estados de ansiedad y depresión, afectación de aprendizajes y afectación de la adaptación social, con frecuentes trastornos de la conducta social. En algunos casos, la separación puede llevar a la privación social.

Esta información, facilitada a los padres, preferentemente por escrito puede ser útil para observar, actuar o preguntar a los profesionales sobre la evolución del hijo. Niño familia y pediatra deben ser tres ruedas que giren sincrónicamente.

B. Acontecimientos vitales en la vida del niño

La posible relación entre circunstancias ambientales estresantes y patología se comprobó que disminuyen las defensas inmunológicas del organismo y facilitan la expresión de genes hasta entonces silenciosos con la subsecuente aparición de enfermedades (Mardomingo).

Desde el punto de vista médico y psíquico es importante estudiar el tipo de acontecimientos vitales que tienen un mayor carácter patógeno, que individuos son más vulnerables, que circunstancias del medio familiar y social deberían modificarse, que relación tienen con la edad del niño o joven y que situaciones o circunstancias son factores de protección.

Los acontecimientos vitales se definen como aquellas situaciones que generan un cierto grado de estrés y por tanto exigen de la persona que las sufre un proceso de adaptación. Se supone que a mayor cantidad de estrés y mayor vulnerabilidad individual mayor riesgo de patología. En las tablas representan dos escalas de acontecimientos vitales para niños y adolescentes adaptadas a la población española.

Los acontecimientos vitales que se refieren a la familia y a la escuela tienen un especial interés en niños y adolescentes

Los acontecimientos familiares y escolares se agrupan en cuatro categorías

Pérdida y separación

Acontecimientos relacionados con la interacción familiar

Acontecimientos escolares

Acontecimientos que indican un cambio de situación

Es evidente que a relación entre acontecimientos vitales y patología no es unidireccional y un acontecimiento vital concreto no produce una patología determinada. Los factores genéticos y la las características de la personalidad del individuo son fundamentales. No obstante, es el ambiente el responsable último en ciertos casos de que los genes se expresen y de que el individuo tenga una enfermedad determinada

<i>Escala de acontecimientos vitales (6 a 11 años)</i>	<i>Puntuación</i>
1. Muerte de uno de los padres	90
2. Separación de los padres y vivir con otras personas o instituciones	90
3. Abuso sexual del menor	88

4. Abandono del hogar de uno de los padres	82
5. Alcoholismo del padre o de la madre	79
6. Muerte de un hermano	79
7. Divorcio de los padres	77
8. Toxicomanía de un miembro de la familia	75
9. Condena a prisión de un padre durante un año	67
10. Enfermedad grave del niño con necesidad de hospitalización	65
11. Enfermedad psiquiátrica de uno de los padres	64
12. Enfermedad grave paterna que requiera hospitalización	61
13. Descubrimiento de ser un niño adoptado	60
14. Nuevo matrimonio de uno de los padres	55
15. Deficiente rendimiento escolar durante un curso	54
16. Aumento de discusiones <i>con</i> los padres	54
17. Muerte de un amigo íntimo o un familiar	53
18. Aumento de las discusiones <i>entre</i> los padres	52
19. Cambio de colegio	51
20. Enfermedad grave de hermano con tratamiento hospitalario	50
21. Cambio de la popularidad del niño entre los amigos	49
22. Nacimiento de un hermano	47
23. Muerte de un abuelo	47
24. Abandono del hogar de un hermano o una hermana	46
25. Incorporación de la madre al trabajo a tiempo completo	46
26. Suspensión de la escolaridad	45
27. Problemas con un profesor o una materia escolar	45
28. Cambio del nivel económico de los padres	44
29. Comienzo de la escolarización	42
30. Pena de prisión inferior a 30 días para uno de los padres	42
31. Pérdida de trabajo de uno de los padres	42
32. Cambio de trabajo del padre con aumento del tiempo de ausencia del hogar	39
33. Excelente éxito personal	38
34. Aumento de las discusiones con los hermanos	36
35. Traslado a un domicilio nuevo	35
36. Embarazo de una hermana soltera	33
37. Incorporación de un tercer adulto a la familia	31

Escala de acontecimientos vitales (12-18 años)

1. Muerte de uno de los padres	91
2. Abuso sexual del menor	91
3. Alcoholismo del padre o de la madre	80
4. Muerte de un familiar	51
5. Divorcio de los padres	83
6. Toxicomanía de un miembro de la familia	65
7. Condena a prisión de uno de los padres	80
8. Enfermedad grave del adolescente	77
9. Enfermedad psiquiátrica de uno de los padres	71
10. Enfermedad grave de uno de los miembros de la familia	60
11. Deficiente rendimiento escolar a lo largo de un año	56
12. Aumento de las discusiones con los padres	61
13. Muerte de un amigo íntimo	72
14. Aumento de discusiones entre los padres	62
15. Cambio de colegio	45
16. Nacimiento de un hermano	48
17. Abandono del hogar de un hermano	46
18. Suspensión de la escolaridad	51
19. Problemas con un profesor	48
20. Cambio del nivel económico de los padres	46
21. Pérdida de trabajo de uno de los padres	52
22. Aumento del tiempo de ausencia de uno de los padres	45
23. Excelente éxito personal	46
24. Aumento de discusiones con los hermanos	37
25. Traslado a un domicilio nuevo	32
26. Embarazo de una hermana soltera	40
27. Descenso del número de discusiones entre los padres	31
28. Descenso del número de discusiones con los padres	29
29. Descenso del número de discusiones con los hermanos	26
30. Enfermedad o lesión grave de un amigo íntimo	57
31. Nuevo trabajo del padre	27
32. Embarazo de la novia (hombres)	76
33. Quedarse embarazada (mujeres)	90

34. Nuevo novio o novia	52
35. Suspender un curso	60
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2. Estrés y adaptación

El estrés es uno de los factores etiopatogénicos de un conjunto de enfermedades tradicionalmente denominadas psicósomáticas. Son enfermedades ligadas al estilo de vida moderno que se han llamado enfermedades del progreso. Han sido estudiadas por Claude Bernard, Walter Canon y Hans Selye. Claude Bernard consideraba que la fisiología tenía como misión “buscar la verdad con calma y confianza” y como objetivo “establecerla de modo imperecedero” (Mardomingo).

Hans Selye estudió la respuesta del organismo ante estímulos estresantes de carácter crónico que lo mismo podían ser de tipo infeccioso o tóxico, que emocional o traumático. En todos los casos se produce un conjunto de reacciones fisiológicas que tienen como finalidad responder al nuevo reto a la nueva situación de forma eficaz y restablecer el equilibrio interno en el concepto de Canon de la homeostasis.

Este conjunto de reacciones fue denominado por Selye “Síndrome general de adaptación” (Selye 1956) y consta de tres fases: una de alarma, una segunda de defensa o compensación y una tercera de agotamiento. Durante la fase de alarma se producen una serie de cambios neuroendocrinos y vegetativos que van desde la hipotensión y la hipotermia a la descarga de noradrenalina y corticosteroides. La fase de defensa que viene a continuación supone a puesta en marcha de un conjunto de mecanismos de adaptación y compensación con particular participación del sistema límbico y de las glándulas suprarrenales. Cuando la adaptación que se exige al organismo es excesiva y la situación

traumática y estresante resulta intolerable se produce una tercera fase de agotamiento o descompensación que dará lugar a la enfermedad psicosomática.

De acuerdo con Selye el organismo responde a los más variados agentes estresantes con una sucesión regular de mecanismos de adaptación fisiológicos que en determinadas circunstancias son insuficientes. Unas veces las circunstancias ambientales estresantes son demasiado intensas y perturbadoras, otras se mantienen durante tanto tiempo que exigen un esfuerzo de adaptación excesivo, surgiendo la enfermedad psicosomática.

El esfuerzo de adaptación puede guardar relación con un organismo especialmente vulnerable por razones genéticas o por experiencias estresantes previas. En este caso el riesgo de manifestación es mayor. Circunstancias estresantes intensas y mantenidas facilitarán la aparición de enfermedades psicosomáticas.

3. Respuesta de los hijos según la edad a nivel cognitivo y emocional

Ya hemos indicado en el apartado 2 las necesidades básicas del niño de 0-6 años. La información escrita a los padres es de gran utilidad en todas las consultas y también en la de padres que han padecido un divorcio. Niño, familia y pediatra deben ser tres ruedas que giren sincrónicamente.

Las escalas siempre son orientativas y sirven, sobre todo, para trabajar en equipo, y en este sentido son muy útiles. El aspecto observacional es fundamental para aproximarnos al diagnóstico. No debemos confundir detección precoz con pronóstico prematuro, que puede etiquetar al paciente. El desarrollo no es únicamente una serie de etapas delimitadas. Hay fases de aparente estancamiento y otras más explosivas. Cada etapa representa un proceso de adaptación a una situación nueva y no solo la culminación de un proceso biológico. A nivel orientativo podemos citar unas respuestas que se dan en un número elevado de niños.

a. Respuesta de 3 a 5 años

La respuesta será proporcional en cada niño al impacto, la duración la especial vulnerabilidad y la existencia de experiencias previas

Nivel cognitivo

- Considera el divorcio como separación física
- Cree que es temporal
- Confunde los intercambios afectivos de cada una de las figuras paternas
- Piensa que ha podido ser el culpable

Nivel emocional

- Trastornos del sueño, pesadillas, dificultades para ir a la cama

- Renuncia a ir a la escuela
- Aturdimiento, perplejidad
- irritabilidad con episodios de llanto
- Agresividad con padres y hermanos
- Culpabilidad

Si estos aspectos se abordan de forma sensible y tranquilizadora es posible que se reduzcan o desaparezcan. No obstante, a veces resulta muy difícil para los padres conciliar sus sentimientos con la aceptación de que los hijos están experimentando un profundo sentimiento de pérdida y necesitan recibir ayuda con el fin de superar este momento difícil de su vida.

A los 5 años los niños demuestran un gran interés por el mundo que les rodea y tienen un gran interés por descubrir y aprender cosas. Sin embargo, la capacidad del niño de recibir y procesar nuevos estímulos, de comprender y dar sentido a las experiencias estará determinada por la sensación de bienestar emocional que refuerce su capacidad de aprender. Los niños que se sienten queridos es decir que han tenido una vivencia de entorno seguro, en el que han recibido aprobación, amor y seguridad, se sentirán más libres para explorar nuevas relaciones en el contexto escolar Considerarán a los maestros como adultos benévolos, capaces de fomentar los sentimientos, así como de fijar límites que hagan seguro el mundo nuevo. El contexto social se ampliará y el patio de recreo será un laboratorio para que los niños experimenten estableciendo nuevas relaciones, respetando turnos, ganando y perdiendo y todas las posibilidades que conducen al establecimiento de una identidad dentro del grupo de iguales.

En cambio, el niño en cuyo entorno haya primado el descuido, la crítica y el menosprecio tendrá grandes dificultades para confiar en los adultos y en los iguales y abordará el nuevo contexto con precaución, ansiedad e incluso agresividad con el fin de prevenir cualquier ataque contra él mismo. Hará falta mucho tiempo y esfuerzo como bien saben los maestros, para que un niño ansioso e inseguro comience a confiar de los demás en medida suficiente para sentirse capaz de aprender de ellos

b. Respuesta de 6 a 8 años

Situación cognitiva

- Comprende la finalidad del divorcio
- Capta los efectos físicos y psíquicos de los conflictos paternos
- Puede pensar que su conducta tiene impacto en las decisiones de los padres

Respuesta emocional

- Apenado
- Temor a la desorganización
- Añoranza por la marcha de uno de los padres
- Inhibición o agresión hacia el padre
- Angustia en el hogar materno
- Fantasías de responsabilidad y reconciliación
- Conflicto de lealtades

c. Respuesta de 9 a 12 años

Situación cognitiva

- Comprende psicológicamente los motivos del divorcio
- Aprecia las razones de cada padre en el divorcio.
- No se autoculpabiliza
- Piensa que el fin de los conflictos será un beneficio para él

Respuesta emocional

- Inicialmente bien defendido-Intentos de dominarse por juego y actividad-Ansiedad-Somatizaciones
- Se alinea con una de las figuras paternas

d. Respuesta de 12 a 18 años

Situación cognitiva

12-14 años

Observa la complejidad de la comunicación en la familia y las contradicciones entre lo que se dice y lo que se hace-Acepta respuestas negativas a sus demandas

15-18 años

- Entiende el divorcio como incompatibilidad de los padres y cree que es una decisión madura
- Separa conflictos de los padres de sus características personales

Respuesta emocional

- Cambio en las relaciones con los padres
- Depresión e intentos autolíticos
- Preocupación por el futuro matrimonio que podría terminar como el de sus padres
- Ansiedad
- Depresión y sus posibles evoluciones
- Agresividad
- Hipermadurez moral

-Conflictos de lealtades, cambios en la participación familiar

Las niñas de padres divorciados presentan menores problemas que los varones. Sin embargo, las mujeres de edad adulta tienen una mayor dificultad de relacionarse con los hombres.

El tipo de trastornos que acompañan y siguen al divorcio, junto a las características previas de personalidad del niño tienen en muchos casos un valor pronóstico respecto de la evolución posterior. Los trastornos afectivos en las niñas y los trastornos de comportamiento en los niños se correlacionan con lo que sucede hasta 8 o 10 años después.

Podemos sospechar la aparición de una depresión ante la existencia de 5 ó más de los siguientes síntomas:

Humor deprimido, pérdida de interés, pérdida o ganancia de más del 5% de peso en un mes, insomnio o hipersomnia, agitación o inhibición psicomotriz observable, pérdida de energía y fatigabilidad, sentimientos de culpa o inutilidad, disminución de la capacidad de concentración, ideas de muerte o suicidio. Estos síntomas deben mantenerse durante dos semanas.

Estudiando los factores etiopatogénicos implicados en la psicopatología se llega a la conclusión que el factor patógeno por excelencia es la conflictividad entre los padres sobre todo si tiene efecto prolongado y se acompaña de aislamiento social de la familia que impide la actuación de mediadores del conflicto. También es importante los cambios que suceden tras la sentencia judicial que puede suponer cambio de domicilio colegio, amigos etc.

III Orientación terapéutica

De mi vida de niño siempre quedaron rincones de melancolía pero también entré en la vida del hombre listo para la lucha. La vida sigue.

Dickens. Oliver Twist

No todos los niños de padres divorciados van a necesitar una ayuda especial, ni debemos etiquetarlos y diagnosticarlos por esta circunstancia. Tenemos tendencia a hablar únicamente de casos problemáticos y perder la perspectiva global de todos los niños que atraviesan este proceso. Recordemos que hasta en los casos de niños maltratados luego son padres aceptables y no al revés. Evitemos predicciones futuras. Es importante llegar a un diagnóstico preciso: médico, social, psicológico, cultural y humano. El diagnóstico que se aplica a los niños se aplica igualmente a sus padres (TITRAN).

A. La resiliencia

La resiliencia es un espacio terapéutico relativamente nuevo que merece ser considerado en el tema del divorcio ya que puede ayudar en algunos aspectos a las personas afectadas. No se conocen contraindicaciones.

Vaninstendael la define como la capacidad de una persona (niño, padre) o de un sistema social (familia, comunidad), para desarrollarse bien en condiciones difíciles, y hacerlo de un modo socialmente aceptable. No debe sustituir a la política social sino ser para ella fuente de inspiración y en ocasiones instrumento orientador.

La resiliencia o posibilidad de lucha se desarrolla a través de la interacción entre el niño y su entorno y necesita ser potenciada según la cultura del entorno. La resiliencia elimina el determinismo. El divorcio puede ser un desencadenante de situaciones que pueden favorecerse estimulando la resiliencia.

Aspectos favorecedores de la resiliencia:

Ayuda y aceptación de la persona El niño necesita una persona con quien tenga un vínculo fuerte y constructivo (progenitor, educador, amigo, adulto significativo).

La base es la aceptación incondicional del niño como persona, que no implica la aceptación de la conducta.

Favorecer la autoestima. La autoestima es el valor positivo por el que una persona se reconoce como individuo de forma global, así como en cada uno de los aspectos de la vida. La autoestima necesita que otro te estime, lo cual supone respetar al prójimo y negarse a convertirlo en objeto. Toda persona tiene una historia singular. Todos debemos ser tratados como personas irrepetibles y peculiares. Todos llevamos dentro “las semillas de la grandeza” que esperan los cuidados de un jardinero para germinar debidamente (Callabed).

Expectativas de futuro

Reglas claras y poco numerosas.

Lenguaje valorizante facilitando la expresión de las emociones y procurando que aumente continuamente su léxico, ya que “el lenguaje es el vestido del alma”. Instruir mejor que aleccionar.

Aportar conocimientos y también valores. Debe escuchar que si elige un trabajo que le gusta no trabajará ningún día de su vida.

-Resaltar las cualidades positivas que mucha gente puede pasar por alto porque están escondidas bajo una forma de ser inaceptable.

Competencias cognitivas.

Unas características del carácter que permitan superar eficazmente los problemas.

Las experiencias de eficacia personal, las cuales generan confianza en sí mismo y una imagen positiva de sí mismo.(Vanistendael S, Lecomte J).

Facilitar que gestione sus conflictos. Un error no es un fracaso y lleva una lección escondida.

Correcciones razonadas. Crítica constructiva. Escuchar y tener en cuenta al niño

-Resaltar las cualidades positivas que mucha gente puede pasar por alto porque están escondidas bajo una forma de ser inaceptable.

Conocer los límites.

Circunstancias que pueden ser negativas:

-Disciplina férrea

-Crítica destructiva-

-Patrones de calidad inalcanzables

-Ironía amarga

-Para destruir nada mejor que quitar la esperanza

-Pronósticos negativos prematuros

También es necesario saber que el joven o el niño debe sentir que su actitud puede cambiar el curso de las cosas, aunque sea una pequeña cosa. Debe sentir que el centro del control está dentro de él.

En algunos casos, podemos hablar con los niños de padres divorciados y orientarles, de acuerdo con el padre, la madre o ambos, con estas sugerencias:

-Hay que saber adaptarse. En la vida habrá otras experiencias de adaptación.

-Hay que tener expectativas de nuevas relaciones, que pueden mejorar la situación.

-Intentar superar la cólera hacia algún padre, si llega el caso.

El respaldo social en el divorcio es importante y una persona o una familia pueden recibir apoyo ya en la vida cotidiana, ya en situaciones de crisis en formas de servicios prestados, financieras, administrativas, afectivas. El aislamiento y la soledad están a menudo en la raíz de comportamientos anormales y conductas inadaptadas

B: Derivación a Salud Mental

Si el pediatra ha detectado signos de alerta puede ser necesario que sea atendido por un equipo de salud mental integrado por psiquiatras infantiles, psicólogos, enfermeras psiquiátricas, trabajadores sociales, educadores y pediatras. El equipo de salud mental debe detectar los trastornos de adaptación social, escolar o familiar, y también los trastornos de ansiedad y cognitivos, las psicosis, el autismo, los estados deficitarios

severos, y las malas condiciones familiares especialmente los casos de maltrato y de carencia afectiva. En algunos casos será preciso derivarlos a servicios más especializados. Puede ser útil la aplicación de un protocolo específico de abordaje de los trastornos de ansiedad de separación (Pedreira):

¿Ha presentado el niño alguno de los siguientes problemas en los últimos 6 meses?

1. Temor irreal de que algo serio puede pasarle a él/ella o a sus padres cuando se separen.
2. Rechazo persistente a la hora de ir al colegio y a las actividades extraescolares, alegando que quiere permanecer con los padres en casa. Si es afirmativo: ¿es muy frecuente? ¿hasta cuánto?
3. Remoloneo persistente o cierta oposición a la hora de ir a dormir sin que alguno de los padres esté presente o bien persistente oposición a dormir fuera de casa.
4. Miedo a estar solo en casa o en una habitación separado/a de sus padres.
5. Pesadillas repetidas sobre separaciones (por ejemplo, perderse en el bosque).
6. Síntomas corporales como cefaleas o dolores abdominales en las fechas de escuela
7. Excesivas manifestaciones de estrés y malestar cuando los padres se ausentan (niños/as mayores de 6 años).
8. Irritabilidad, nerviosismo, temor y dificultad para jugar o concentrarse cuando no están los padres.

Evaluación diagnóstica

4 ó más respuestas afirmativas.

-NO: diagnóstico negativo

-SÍ: veremos dos aspectos

- a) Si existen otras afecciones emocionales de base, ansiedad o fobias, u otras afecciones orgánicas de base, se deben abordar.
- b) Si no existen estas otras afecciones comentadas, el diagnóstico es de trastorno de ansiedad de separación continuado.

-Derivar a la Unidad de Salud Mental Infantil para el abordaje psicoterapéutico, en caso de :

-Persistencia de síntomas tras 6 semanas de los pasos anteriores.

-Dificultad de hacer que los padres aporten su colaboración.

-Empeoramiento de las relaciones intrafamiliares

-Empeoramiento de las relaciones con maestros y/o profesionales sanitarios

-En general, no prescribir ninguna medicación de entrada.

-ser conscientes de que algunas enfermedades solo precisan una estabilización.

Toda *intervención terapéutica* debe considerar estos puntos:

-Establecimiento de un correcto diagnóstico

-Proponer unos resultados lógicos y alcanzables

-Terapéuticas y recursos convenientes

-Evaluación de resultados, que pueden suponer nuevos replanteamientos por no haber conseguido nuestro objetivo.

IV CONSIDERACIONES FINALES

Punto 1

Es necesaria la creación de servicios y programas de apoyo y asesoramiento a padres que desean separarse encaminados a disminuir la conflictividad en el hogar y en las relaciones de pareja. Los padres necesitan ayuda a la hora de tomar muchas decisiones difíciles en esta etapa, así como a la hora de adaptarse a los cambios en la relación con los hijos que la separación impone.

Punto 2.

No debemos considerar a un niño de padres divorciados como “un caso clínico” pero si prestar una atención especial a los factores de riesgo propios de su edad y a la especial vulnerabilidad de los niños de padres divorciados.

Punto 3

Dentro de las líneas terapéuticas, la resiliencia puede ser muy útil en determinados casos y grupos de población.

Aunque muchos niños de padres divorciados no precisan ninguna atención especial, en algunos casos la atención y el tratamiento precoz de los problemas emocionales y de conducta de los hijos es una medida preventiva de trastornos psiquiátricos más relevantes en la edad adulta.

Desde la perspectiva de los derechos del niño merece la pena plantearse el tema de la competencia para ser padre y madre

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SMOKING: A GLOBAL HEALTH ISSUE - PAST, PRESENT, AND FUTURE

Prof. José R. Calvo MD, PhD

President of the Institute for International Cooperation of the Royal European Academy of Doctors



Abstract:

Smoking is one of the leading preventable causes of death worldwide, responsible for over 8 million annual deaths, according to the World Health Organization (WHO). Despite global efforts to reduce its prevalence, tobacco consumption remains a critical challenge, especially in developing countries. This article analyzes the historical evolution of smoking, its current impact, including the rise of a new form of tobacco consumption gaining popularity - vaping and its effect on minors - and future strategies to combat this epidemic.

1. Introduction

A significant proportion of preventable deaths, diseases, and disabilities worldwide can be attributed to tobacco use. Since the 1960s, this message has been reaching the public with increasing intensity. However, the habit of smoking remains relatively widespread, so progress must continue to reduce the avoidable suffering caused by this product.

The addictive nature of tobacco, which lies in the pharmacological effects of nicotine on the central nervous system, explains the difficulties many smokers experience in quitting. Therefore, priority prevention strategies must focus on the factors that promote the initiation of smoking in adolescents. The tobacco industry, aware of this reality, has

traditionally concentrated its promotional efforts on capturing young addicts, their main customers, as they will then be loyal customers for decades to the product in general and especially to the brand with which they start. Today, once the enormous national and international legislative pressures have increasingly cornered their capacities for action and promotion, they have found new ways to sell this product and continue with one of the most lucrative businesses that have existed in the world.

Among the factors that promote the initiation of smoking is the perception of many adolescents that smoking is normal adult behavior. Due to this perception, smoking takes on a symbolic character in the maturation process of many young people. It is evident that the industry has exacerbated this perception with its promotional strategies until increasingly restrictive legislative norms have made this task difficult for them.

Another important problem is that which affects passive consumers of tobacco smoke smoked by others. With the overwhelming scientific confirmation that passive smoking has negative health effects, the prohibition of smoking in public spaces becomes a necessity, and it is for this reason that governments and international organizations have been increasingly advocating for restrictive policies on the public use of tobacco (Calvo 2011).

2. Origins and Expansion of Tobacco Consumption

The tobacco plant originates in South America 8,000 years ago. It is estimated that its consumption began between 5000 and 3000 BC in Mesoamerica and South America, where it was used for ceremonial and medicinal purposes (Calvo 1997).

The known data on daily life in America before Christopher Columbus demonstrate that the habit of inhaling the smoke from tobacco leaves existed there from remote times.

The data presented by Fray Bartolomé de las Casas in his "Historia de Indias" and by other authors of that time report that the Indians participated in ceremonies where large bonfires were lit. In them, they burned tobacco leaves and inhaled the smoke, inhaling it through the nose through cylinders made of rolled tobacco leaves.

Smoking tobacco in those civilizations obeyed various reasons:

- Religious. Maya engravings from the time show priests smoking and the Jaguar God with a cigar or tubular pipe. Tobacco was used as a vehicle in divination rituals, as to interrogate the spirit (which according to Maya beliefs lived in the right calf), the leg was rubbed with saliva obtained by chewing tobacco. If the calf muscles moved, it indicated an affirmative response. Apart from the magical powers that tobacco provided them, they entered a state of mystical ecstasy with wonderful visions (Chapa and Rico, 1990).

- Social. Tobacco was also used as a ceremonial element in large celebrations and to seal war alliances.

- Health. In some peoples, it was believed that disease was produced by evil spirits that inhabited the sick person and that tobacco smoke expelled them. They considered that smoke had great therapeutic properties for the respiratory system. The Aztecs used tobacco as an almost universal medicine used against asthma, fever, convulsions, wounds produced by animal bites, for digestive or intestinal problems, and skin and eye diseases. They also chewed tobacco to combat fatigue, toothaches, and labor pains. Women who acted as midwives kept dried tobacco leaves inside a gourd (Soustelle, 1977).

The first colonizers who saw the plant and its use were Rodrigo de Jerez, a sailor who went on the caravel *La Niña*, and Luis de Torres, a converted Jew, who according to documents of the time went as an "interpreter," as he mastered several Oriental languages and supposedly it was to the East where they were heading.

As Fray Bartolomé de las Casas relates in the "Historia de Indias, on November 4, 1492, the two adventurers were sent by the Admiral "12 leagues further north" and there they found a tribe of natives, the Arapahos, who among other customs used to dry a leaf of a plant which they then rolled and set on fire, inhaling the smoke that came from the combustion. When they told Admiral Columbus of their discovery, he renounced it and forbade them to use what was "proper to savages" (Calvo 1997).

But Rodrigo de Jerez ignored the prohibition and thus became the first European smoker and later addicted to this substance, which also cost him jail upon his return, denounced by his own wife to the Inquisition because "her husband was bewitched because he released smoke through his nostrils" (Calvo 1997).

Probably the massive introduction, as well as the description of the new plant in Spain, was due to the friar Romano Pané, companion of Columbus on his second voyage, who in 1497 sent a report to Charles V detailing the medicinal virtues of tobacco (Borio, 2001). However, the first complete description of the plant would be made in 1535 by Gonzalo Fernández de Oviedo, governor of Santo Domingo. But it is Philip II's chamber physician, Francisco Hernández Boncalo, who in 1558 officially introduces the plant to Spain (Pardell, Salto Sallerras, 1996); (Borio, 2001); (Davey, 2003).

In 1568, the Franciscan friar of the Angoulême convent who accompanied the Portuguese expeditions to Brazil, André Thevet, makes the first description of the use of tobacco, called "petum" among the Brazilian "tupi" natives and affirms that tobacco is useful for "cleaning the superfluous humor of the brain" (Borio, 2001).

Juan de Cárdenas, in his work "Problems and Marvelous Secrets of the Indies" dedicates a chapter to: "Why coca and tobacco, being brought in the mouth, give strength and sustenance to the body".

Juan de Castro, a Cordovan writer who wrote a monograph on tobacco, argued in its favor that tobacco was useful because (Calvo, 1997):

- a. It calms the spirit.
- b. It restrains carnal appetites.
- c. It predisposes minds to go on missions.

Other Spanish authors such as Juan Fragoso or Cristóbal Hayo would join this chorus of praise for the plant, which will not cease to make its voice heard during the following centuries throughout the world.

By the end of that century, tobacco had reached all corners of the world, due to Italian, English, and Portuguese sailors taking it to the East, Asia, and Africa. Wars, especially the Thirty Years' War, spread tobacco throughout half of Europe, including Russia (Pardell, Saltó and Salleras; 1996).

Initially, tobacco was known both in Europe and in the rest of the world for its medicinal virtues, attributing to it the following properties:

- Virtues of green tobacco: for headaches, stiffness of the neck, chest ailments, stomach pains, chilblains, animal bites, etc.
- Virtues of dry leaf tobacco: as a purgative, for stomach pains.
- Virtues of powdered tobacco: as a hypnotic, to sharpen the senses and memory, and for stone disease.
- Virtues of rancid tobacco smoke: for headache and stomach pain, for digestion, against asthma, to eliminate nausea, vomiting, kidney ailments, sores, etc.

A German doctor, Dr. Michael Bernhard Valentini, describes in 1571 in the work "Polychresta exótica" the medicinal use of the plant through enemas that are magnificent for curing "colic, nephritis, hysteria hernia, and dysentery" (Borio, 2001).

The first great step for the diffusion of tobacco throughout the world was the acceptance by the nobility and the Courts of Europe.

The second great step for its introduction was the curative properties attributed to tobacco, which came to be recognized in 1587 as a "panacea herb", and which according to Nicolas Monardes, court physician and author of a book on things brought from our West Indies, cured up to 36 different diseases including headache, cough or meteorism (Borio, 2001).

During the 17th century, tobacco became a key commercial product for the American colonies.

Given this, it is not surprising that it was the Queen of France, Catherine de Medici, one of the first to try its virtues since she suffered from migraine headaches and to combat this ailment her ambassador in Lisbon, Jean Nicot, recommended the powder of tobacco leaves that she had to inhale through the nose. She became accustomed to consuming it and that habit spread rapidly among the nobles of the French court. Nicot's defense of the curative properties of the plant meant that when Linnaeus established the botanical nomenclature, the genus of this plant was given the name *Nicotiana* (Calvo, 1997; Díaz, 2002).

With the arrival of the 17th century, the conception that had been held of tobacco until then began to change and it began to be prohibited. This was punished with very harsh penalties: (Calvo, López and López; 1998; Bello, 2001; Becoña and Vázquez, 1998; Ribeiro, 2002; Becoña, Palomares and García, 1996; Díaz, 2002).

King James I banned tobacco consumption in England in 1613. He also prohibited its cultivation because agricultural lands should only be for food crops. Later, the king changed his mind when he encountered financial difficulties. As a way to resolve them, he granted two merchants the exclusive rights to import tobacco. In turn, they had to pay him taxes on profits. This generated that, seeing business possibilities, other merchants began to introduce contraband tobacco.

In 1586 a work is published in Germany "De plantis epitome utilisima" in which tobacco is described as a "violent herb" (Borio, 2001).

In Spain, the Inquisition made it clear, from the aforementioned episode of Rodrigo de Jerez, that only Satan could confer on man the faculty of expelling smoke through the nose and mouth. In this way, the Church could accuse a smoker of pacting with the devil, which in those years was equivalent to being burned at the stake.

Since then, therefore, a long history would begin that has not ceased to be characterized by the appearance of opposing positions, everywhere and at any time.

The most active opposition to the habit of smoking continued to be, for many years, that of the Catholic Church, perhaps because of the reputation that tobacco brought from the New World of being an aphrodisiac and abortive substance, or because it was not uncommon for priests to smoke during mass, with the consequent bad example for the congregation.

Pope Urban VII published a bull stating that priests who took snuff while saying mass would be excommunicated "ipso facto incurrendi". Such a papal bull had an argument that was at least picturesque if we compare it with those used, not long before, to explain its virtues.

The bull declared the consumption of tobacco illicit because:

- a. It induces hallucinations.
- b. It disturbs family harmony.
- c. It gives rise to aberrant practices.

Subsequently, Pope Urban VIII promulgated excommunication for those who smoked within sacred precincts or in places close to the dioceses.

Such initial prohibition referred to the Diocese of Seville, where the first large tobacco factory was established. Subsequently, it was extended to the entire Catholic world. (Calvo 1997).

Popes Innocent X and Innocent XII also publish respective bulls, with penalties of excommunication for smokers.

All this was later abolished by Pope Benedict XIII, who nullified the prohibitions and who in 1724 decided to accept "dry drunkenness", the name by which the habit of smoking was then known (Escohotado, 1998).

However, not everything was good news for smokers. From early times, tobacco also aroused aversion, hatred, and cruelty towards its users.

In the Lüneberg region (Germany), the act of smoking, inhaling, or chewing tobacco was punishable by death in the late 17th century.

In the 17th century, the Sultan of Constantinople Murad IV punished smokers with decapitation, dismemberment, or mutilation of feet and hands.

In 1606 the University of Cambridge promulgated two decrees that prohibited students and other members of the faculty from excessive drinking and tobacco consumption.

In 1650 both the possession and consumption of tobacco were prohibited in the regions that today correspond to Bavaria, Saxony, and Zürich.

In Russia, Tsar Michael Fedorovich Romanov (17th century), ordered that smokers should be tortured until they confessed the name of their supplier, cutting off the nose of both, castrating them, or deporting them to Siberia.

In the year 1640, during the reign of the last Ming, it was decreed in China that all individuals caught smoking or trafficking tobacco would be decapitated.

The Shah of Persia also decrees the death penalty for consumers of this product.

Tsar Alexis Mikhailovich reaffirms his predecessor's decree and orders that any smoker continue to be tortured until he declares from whom he received the drug, keeping the mutilation of the nose in force.

In Saxony, Transylvania, Bern, Saint Gall, the Netherlands, and Sweden the custom is illegal, with measures of varying severity.

In the 19th and early 20th centuries, tobacco consumption by women and children was considered unacceptable. In most developed countries, it was considered vulgar, inappropriate, and even immoral for women to smoke, and in several countries, anti-smoking campaigns were often led by women or women's organizations.

Of all of them, the figure of Lucy Page Gastón stood out greatly in the USA, a furious activist who became an uncomfortable character for the country's leaders since she founded an association called "League in favor of temperance" with which she mercilessly flagellated smokers, to whom she attributed the cause of all the evils of society, and legislators who did not follow her abolitionist slogans.

Her diatribes against tobacco manufacturers for using promotional cards with faces of distinguished athletes of those times were famous. Mrs. Gastón died in 1924, paradoxically of laryngeal cancer, and already at that time the North American tobacco industry sold 73 billion units of cigarettes. (Calvo 1997)

But these attitudes soon begin to change with the emancipation of women and their access to academic training, even though the first women who dared to smoke in public in the early 19th century were prostitutes known as "lorettes" because they were located near the church of Our Lady of Loreto in Paris (Borio, 2001).

All these moralizing efforts against the new custom of smoking crashed against the stubbornness of people in continuing to enjoy the new pleasure that the discovery of the New World had provided them.

The invention of the cigarette rolling machine in 1881 marked a milestone by allowing mass and accessible production of the product, and even though studies began to emerge at the end of the 19th century that linked tobacco consumption with serious diseases, the two world wars boosted its popularity by being distributed among soldiers as part of their rations and that continued with enormous force until almost the beginning of the 21st century where finally, the governments of 192 countries under the auspices of the World Health Organization, decided to sign the "Framework Convention on Tobacco Control", which laid the first international legislative basis to end this social, economic and health scourge.

3. The Taxation of Tobacco

As we have already said, tobacco became a prized asset for obtaining resources and went from being prohibited to being "tariffed" when countries discovered that it was an element of mass consumption that could provide significant benefits and a succulent source of income for the public treasury via taxes.

Spain was the first country to tax tobacco imports around 1611, when there were already rationalized plantations in Santo Domingo and Cuba, with the Cortes deciding in 1623 that the Public Treasury would take charge of the commercialization of tobacco works, thus establishing one of the oldest monopolies. The income from this monopoly was basically destined for public and social works.

Thus, the tobacco revenue served to finance the construction works of the National Library of Madrid and the publication of the first Dictionary of the Spanish Language by the Royal Spanish Academy in 1723.

Similarly, while one pope demonized and excommunicated smokers, another pope, Alexander VII, seeing the financial possibilities offered by tobacco, established the first tax on tobacco use in the world in 1660, even before the excommunication of smokers was lifted. This action was completed by Pope Benedict XII in 1779, establishing the first pontifical tobacco factory and commissioning nuns from several Roman convents to produce cigarettes (Borio, 2001).

Countries that followed Spain and the Vatican in terms of tobacco taxation were Portugal (1664), Austria (1670), and France (1674).

King Philip III decreed in 1606 that tobacco could only be cultivated in Cuba, Santo Domingo, Venezuela, and Puerto Rico, and punished the sale of seeds to foreigners with the death penalty.

In 1614, the same monarch proclaimed Seville as the world capital of tobacco, established the first large tobacco factory, and ordered that all products harvested in the domains of the empire be transferred to Seville for control, manufacture, and subsequent export (Borio, 2001).

4. Forms of consumption

Tobacco has been consumed throughout history in different ways (Laguerre, 1999). When the conquistadors arrived in America, they discovered that the Indians used it either by throwing seeds of the plant into a bonfire and inhaling the smoke, or by rolling the dried leaf and setting it on fire. In the case of slaves, they tirelessly chewed a mixture of tobacco

leaves with powdered clam shells with the aim of reviving themselves and not feeling hunger or thirst, as a means of resisting the work pressure to which they were subjected. In the 17th century, it was consumed pressed in the form of tablets. It was mainly chewing tobacco in poor environments and among sailors (a custom that persists in some Asian countries).

The English, however, seem to have been more attracted to the pleasures of tobacco than to its medicinal virtues. In England, aristocrats and the bourgeoisie smoked it in pipes. Cigars began to appear in England around 1814.

Precisely when taxes were lowered, many relegated their snuff boxes to oblivion, giving way to cigars. Queen Victoria abhorred it in all its forms, and the Duke of Wellington published ordinances to repress such a custom in the army, as it was, they who, during the Crimean War, imported the fashion of cigars to their country after copying it from the Egyptian and Turkish army.

Another form of tobacco consumption is the pipe. As a smoking instrument, the pipe is very old, already used by barbarians in ancient Rome. It is believed that Portuguese sailors brought the habit of pipe smoking to Europe, where it became popular among fishermen and then among peasants, although it is attributed to an English corsair, Sir Walter Ralleigh, its current form and the popularity it achieved in England under the reign of Elizabeth I.

In France, a new form of use developed, nasal intake, which became a privilege as tobacco was an expensive commodity, fashionable among the aristocracy and high bourgeoisie, and among ladies. Nasal intake was considered a socially refined custom. This powdered tobacco mixed with clove and other aromatic essences was kept in a luxurious snuffbox and was used by depositing a small amount of tobacco powder, call “rape” on the hollow left by the thumb when extended and raised. It was inhaled in a quick and elegant manner, being known as snuff. Soon this more aristocratic method of taking tobacco spread among the distinguished society of Western Europe.

Tobacco powder from Seville gained international renown thanks to being finely chopped and exquisitely flavored with orange blossom water.

Until the last century, powdered tobacco was consumed in Galicia and among certain religious communities.

Regarding cigars, it should be said that they receive this name because they are made only with tobacco leaves, without additives or more wrapping than the plant's own leaves.

They have been consumed since the 17th century and for centuries have been the paradigm of elegance and sophistication for those who smoke them. Their rise is due to Ferdinand VII, a great cigar smoker who granted full freedom of cultivation and processing of tobacco to Cuba.

Since the early 19th century, major Cuban brands enter Spain, then generalizing the consumption of tobacco in the form of cigars and taking the name of “Havanos”. There seems to be very important evidence regarding the cigarette rolled with paper being a Spanish invention. There are documents from the late 16th century that show that finely chopped tobacco is rolled in a very soft paper. Therefore, the invention of the so-called smoking paper seems attributable to the Spanish.

Although the hand-rolled cigarette was initially very successful, sales were suspended two years later because having to roll one's own cigarette produced a loss of working hours that companies did not want to tolerate.

The first reference to mass consumption of tobacco took place during the war between Turkey and Egypt in 1832, during which a Turkish grenade destroyed the pipes of Egyptian soldiers, who then came up with the idea of filling their rifle cartridges with chopped tobacco, thus creating the first cigarette. The word cigarette is another point of discussion among historians since, while the French attribute it to a Gallic word ("sigarrette"), the Spanish, and specifically the Dictionary of the Royal Spanish Academy, places its etymology in a term from the Mayan language ("siyar"), from which it claims, the term cigar and later cigarettes was derived.

Once massive campaigns against tobacco began to significantly impact the bottom lines of tobacco companies, they began to allocate huge amounts of resources to research new ways of delivering nicotine, which is the real basis of their business, and they found it in the electronic cigarette. Indeed in recent years, electronic cigarettes or vaping devices have gained popularity as an alternative to traditional tobacco as we will have the opportunity to analyze later.

5. Propagation of the smoking habit in the world

Many authors consider that there are many milestones that have led to the spread of tobacco as a mass consumption product. (Calvo, 1997; Díaz, 2002)

At first, cigars were rolled by hand. This work was performed by young women, who could roll up to five cigarettes per minute. Allen & Ginter, owners of a tobacco company, offered at that time up to \$75,000 to anyone who could invent a machine that would automate the process.

This happened in 1880, thanks to a young engineering student named James Albert Bonsack. Initially, the machine produced 400 cigarettes/hour and worked 24 hours, while the people in charge of manual production produced between 200 and 300 cigarettes in an hour and their workday did not exceed 12 hours.

Of the fifty tobacco companies that existed at that time, the machine was tested by all of them, but they decided that the cost was very high from an investment point of view. It was the entrepreneur James Washington Duke who buys it and manages with his aggressive marketing philosophy to corner a good part of the incipient cigarette market. This allowed him to have lower production costs than his competitors and therefore lower prices. Together with his sons, he opens a small factory that launches the first automated cigarette pack on the market called "The Duke of Durham". This company grew so much that only 9 years after its birth, they were producing 2 million cigarettes a day.

Sales in 1889 reached \$4 million. This led them to buy, merge or absorb 250 small companies, becoming in less than two decades the most important tobacco company in the U.S. under the name of American Tobacco Company.

This monopoly was maintained until 1911, when the Supreme Court of the United States decided to apply the antitrust law and forced the fragmentation of the company into several smaller ones and the limitation on the possession of shares of a single company by a single owner. This did not substantially modify the ATC's business because thanks to legal tricks they were buying small packages of shares of the companies that were emerging and thus weaving a legal framework between them that persists today.

One of the beneficiaries of this fragmentation was the farmer Richard Joshua Reynolds, who, under the protection of that law, founded a small company in South Carolina in the city of Winston-Salem.

The American Tobacco Company signed cooperation agreements with this company and began doing business overseas. Over the years it came to create a multinational corporation called "Consolidated Tobacco Co".

In London, another family business begins to flourish. The name of its owner was Philip Morris. This company became a supplier to the English Royal House and launched a tobacco with the name of the Prince of Wales at that time, Prince Albert. This tobacco was made from hand-rolled Turkish tobacco.

When Philip died, his widow decided to transfer the business to his brother Leopold, who, seeing so much success, decided to open two new stores, one on Poland Street and another on Malborough Street. Entrepreneur Duke had established business relationships with

them and advertised in the United States a British tobacco that "is a luxury for your lips and prevents irritations of tongue and throat".

The disorderly life that Leopold led brought him to ruin and the company had to be sold to a businessman named William Curtis Thompson, who cleaned up the company and created a small corporation in the United States. This launches different brands in the North American market, including one specially designed for women with the name of Marlborough which initially had no success.

At that same time, safety matches appeared which also facilitated the extension of the habit.

In 1909 the Germans invented the gasoline lighter, an event that increased tobacco consumption.

During World War I, sending cigarettes to soldiers was considered patriotic, which put an end to the anti-smoking campaigns organized.

It also contributed to the spread of cigarettes the idea that tobacco produced a feeling of relaxation and served to keep soldiers occupied.

This period therefore corresponds to the significant incorporation of women into the world of tobacco. Women began to smoke in public as a sign of emancipation and equality. Women not only worked like men, but also adopted their behaviors. Smoking cigarettes becomes a pleasant social custom practiced assiduously by men and more daring women. Smoking then becomes a fashion very much in line with the mentality and lifestyle of the "roaring twenties".

The first filter cigarette appeared in 1949. Although companies never acknowledged it, today it is known that the filter appeared as a response to the public, concerned about health damage.

The advertising campaigns of tobacco companies, the production, sale and consumption of tobacco skyrocket, increasing the number of smokers progressively in all Western countries. In the 1950s, the sale of filter cigarettes increased considerably. In 1959 filter brands represented only 12% of sales. In 1969, due to strong advertising campaigns, it rose to 78% and in 1989 it represented 98%.

In addition, certain behavior models of famous personalities led the population to adopt the same behavior, with the consequent increase in consumption and sales. In the 1940s and 1950s, the American film industry was the biggest advertising springboard for tobacco companies. There are many actors and actresses who appear in the most

successful films, some with the cigarette in the corner of their lips and others with seductive attitudes, becoming models to be imitated by generations of adolescents.

Despite the popularity that tobacco consumption had reached in the United States, once the first scientific evidence of health damage became known, authorities in some states began to enact restrictive laws on the sale and consumption. The big companies responded by selling rolling paper and chopped tobacco separately since only the sale of cigarettes had been prohibited.

In states where the sale was prohibited but not the consumption of tobacco, they chose to give away cigarettes and only charged for the price of matches, which were sold jointly and inseparably from cigarettes.

6. Global impact of smoking

Smoking remains the leading preventable cause of death worldwide.

Tobacco kills more than 8 million people each year, most of them in low- and middle-income countries. Indonesia, for example, is home to approximately 64.9 million smokers, making it the third country with the highest number of smokers in the world after China and India.

And there are more interesting data: 912,000 million USD is the money generated worldwide by the tobacco business... more than double the state budget of Spain.

100 million people died in all the wars of the 20th century and 100 million, in the same 20th century, died from tobacco.

11 million cigarettes are sold on the planet every minute.

1300 million people smoke.

And so, we could continue offering data, about an incontrovertible reality, "smoking kills". This slogan has become an omnipresent warning on cigarette packs and in public health campaigns around the world. This direct and forceful message seeks to raise awareness about the serious health risks associated with tobacco consumption. Despite scientific evidence and regulatory efforts, smoking remains one of the leading preventable causes of disease and premature death globally. (Calvo 2024)

Tobacco not only affects active smokers, but also those around them, exposing them to secondhand smoke, which is also enormously harmful. Tobacco-related diseases include various types of cancer, heart disease, respiratory problems and general health deterioration. The slogan "smoking kills" tries to be a constant reminder of these consequences, acting as a deterrent to reduce the number of smokers and, therefore, tobacco-related diseases and deaths.

Additionally, this message has been a catalyst for stricter policies regarding tobacco regulation, including restrictions on advertising and sale of tobacco products, as well as the implementation of smoke-free spaces. Although the path to a smoke-free society is complex and challenging, the impact of these policies has proven to be significant in reducing smoking rates and improving public health. The slogan "smoking kills" remains a crucial component in the fight against smoking, reminding us of the importance of making healthy decisions for ourselves and for future generations.

7. Tobacco consumption and its impact on health

That tobacco causes health damage is a truth that no one objects to today, not even the industry itself, which after years of denying it has ended up acknowledging that tobacco is a cause of diseases and that is why currently their efforts are focused, paradoxically and for obviously lucrative reasons, on demonizing the consumption of traditional cigarettes, discouraging their use, and passing the baton to their new element of financial gain which is the aforementioned electronic cigarette.

The late recognition of the risks of tobacco may be due to several reasons:

- The delay of more than twenty years between the beginning of intoxication and the appearance of complications.
- The increase in life expectancy, which leaves enough time for these complications to develop.
- Above all, the much more harmful nature of cigarettes compared to other forms of tobacco consumption and their exponential spread for a century, which has contributed to trivializing it.
- The industry's own efforts to deny the evidence that they themselves possessed and fraudulently concealed from public opinion for many years.
- Historically, it is known that the massive spread of tobacco consumption in Europe and the world occurred more easily because the risks could not be documented until a relatively recent date. The first known antecedents of medical opinions related to the harm caused by tobacco come from the 18th century in which doctors John Hill and Percivall Pott described, based on the observational method, the association between tobacco consumption and some types of cancer.

In 1914 Yamagawa and Ichikawa demonstrated the carcinogenic nature of some hydrocarbons present in the composition of cigarette smoke.

In 1949, a prestigious North American epidemiologist who worked for Johns Hopkins University, Raymond Pearl, determined that there is a possible cause-effect relationship

between cigarette consumption and lung cancer, but that report never came to light and only had limited dissemination in the academic field because no media outlet wanted to publish anything against the all-powerful tobacco industry.

- The first serious scientific evidence that appears in the medical literature dates from 1954, the year in which an epidemiological study carried out by Sir Richard Doll and Austin Hill in England was published, demonstrating a clear correlation between tobacco consumption and lung cancer in a study carried out on more than 4,000 British doctors whom they followed for years until documenting this irrefutable statistical association. (Calvo 2024)

- The Royal College of Physicians and Surgeons of England established a committee in 1959 to examine existing data on tobacco and health. This committee reviewed the scientific literature of the time and considered all possible explanations that had been given about the relationships between tobacco consumption and cancer. They also reviewed relevant data on other associated pathologies.

From this work, the Royal College published a report dated May 7, 1962, presented at a press conference by its president Sir Robert Platt, and whose most important conclusions were (Royal College 1962):

1. The benefits of the smoking habit are entirely social and psychological. They may help some people avoid obesity. There is no reason to suppose that smoking prevents any kind of neurosis.

2. Cigarette smoking is a clear cause of lung cancer and bronchitis and probably contributes to the development of coronary heart disease and other less common diseases. It is also responsible for delaying the healing of gastric and duodenal ulcers.

3. The risk of smoking in the population has been calculated from mortality rates in relation to their smoking habit among British doctors. The probability of dying in the next 10 years for a 35-year-old man who is a heavy smoker is 1 in 23, while a non-smoker of the same age has a risk of 1 in 90. Only 15% (1 in 6) of men at this age who are non-smokers will die before age 65, increasing to 33% in those who are heavy smokers, although not all of this difference in life expectancy can be attributed to smoking. From there, criticism from the scientific community towards tobacco begins to increase (Pardell, Saltó, Salleras 1996), since even before Doll and Hill, in the 1930s, Dr. Alton Oschener began to seriously study the problem of tobacco, making it clear the association that existed between smoking and lung cancer (Calvo 1997). Although his data did not allow inferring a cause-effect relationship that had the necessary statistical power to be

able to draw valid conclusions, it did provide a significant indication of the damage that the product caused to health (Calvo, 1997).

In 1964, the First Report of the Surgeon General of the United States, Dr. D. Luther L. Terry, (U.S. Public Health Service. 1964) comes to light, in which it is demonstrated that tobacco consumption is the main preventable cause of death in the world and that nicotine has a high addictive capacity. His final recommendation is categorical in stating that "the health risk is so significant that it requires the adoption of immediate preventive actions". That report, which has periodically been followed by others that monographically deal exhaustively with issues related to tobacco and its damage to health, represents the starting point for researchers from around the world to be permanently documenting different aspects of this problem that has become one of the most studied in the scientific literature, with more than 80,000 papers published to date (Calvo, 1997).

Tobacco consumption is an important public health problem, not only because of its magnitude but also because of the health consequences it entails, as well as the high economic and social costs it generates. Smoking, in addition to being a habit, is a form of drug dependence. Nicotine is the active principle of tobacco; it is an addictive drug and as such has the characteristics of other drugs:

- Tolerance.
- Physical dependence.
- Psychological dependence.

And to these dependencies are added two other dependencies, added and almost exclusive to cigarettes, social dependence and gestural dependence.

Numerous studies have documented the relationship that exists between tobacco use and more than 30 additional diseases, such as cardiovascular disease, chronic obstructive pulmonary disease, cancer of the mouth, esophagus, throat, urinary bladder, cervix, pancreas and in children exposed to maternal smoking, low birth weight and sudden infant death syndrome.

8. Components of tobacco smoke

Each cigarette is a small factory of chemical substances and produces an average of 250 cubic centimeters of smoke.

Factors that determine the composition of tobacco smoke.

- * The nature of the tobacco itself is one of them.
- * Drying, subsequent treatment and the incorporation of additives can vary the composition of the smoke.

* The intensity of the combustion system depends on the diameter of the cigarette and the porosity of the paper, with more porous paper, the combustion is more complete and therefore the production of carbon monoxide is lower.

* When the smoke passes through the cigarette, the first element to consider is the tobacco itself, this self-infiltration mechanism largely explains the increase in the intensity of the flavor as the cigarette burns.

* Ventilation allows the smoke to be diluted, it depends on the porosity of the paper and especially on the perforations in the mouthpiece.

* Decreasing the diameter of the cigarette.

* Modifying its length.

* Using tobaccos with greater filling capacity.

* Varying the expansion technique to give the tobacco more volume after drying.

It is important to note that tobacco:

* Does not contain tars or carbon monoxide (CO), these components appear because of combustion.

* The paper by itself is not the dangerous element of the cigarette.

* The cigar is more dangerous, because it has no filter. The same happens with hand-rolled cigarettes. (US DHHS (1990)).

When a cigarette is lit, the tobacco burns, producing smoke, like any other plant; that smoke contains carbon monoxide (CO) and tars, which are a mixture of various substances produced in the combustion of tobacco. Smoke production results from the incomplete combustion of tobacco; in a cigarette, that combustion is complete only at the lit end, where the amount of oxygen (O₂) is sufficient and the temperature reaches 1,600° C (Molimard, 1996).

Tobacco smoke is an aerosol, formed by substances in liquid state, dispersed in very small droplets suspended in a mixture of gases. When tobacco is smoked, three currents are formed (Henningfield, 1995):

1- The primary (or main) current is produced during the smoker's puffs. In the pipe, these are spaced, and the smoke is usually not swallowed. In cigarettes, the smoke is inhaled, penetrating deeply, to the pulmonary alveoli.

2.- The secondary (or lateral) current is formed by the smoke released between puffs.

For a cigarette, the duration of the emission of the secondary current is much more important than that of the primary current (20 to 30 seconds of active puffs out of a total of about 10 minutes). This secondary current significantly contaminates the environment.

Its content of toxic products is much higher than that of the primary current. Smokers who breathe the contaminated air for a long time thus recover a large part of the harmful effects of the smoke, and the same happens with non-smokers.

3- The tertiary current is constituted by the smoke exhaled by the smoker. The smoker of light cigars exhales the puff of smoke later.

When analyzing tobacco smoke, two different phases are distinguished:

1- Gas phase. It is the smoke content that passes through a filter.

2- Particle phase. It is the content that does not pass, being retained in the filter.

Cigarette smoke contains about 4,722 chemical substances, several of which are very toxic to humans. More than 40 of these substances have been shown to be carcinogenic. These can be divided into four large groups (WHO, 2008):

a) Nitrosamines. They are the most dangerous.

b) Aldehydes. They are formed when sugars and cellulose are burned.

c) Polycyclic aromatic hydrocarbons.

d) Heavy metals. Such as cadmium and arsenic, toxic to multiple organs. They come from fertilizers. They damage cells and DNA.

These components act in various ways:

- Directly damaging cellular DNA, which can lead to the development of cancer.
- Causing chronic inflammation in various organs.
- Altering the functioning of the immune system.
- Causing oxidative stress throughout the body.
- Affecting blood coagulation and increasing the risk of thrombosis.

Of all these substances, there are three that deserve special attention because they are responsible for the different pathologies.

Nicotine, Tar and carbon monoxide

A) Nicotine is the predominant toxic alkaloid of tobacco. It is synthesized in the root of the plant and from there it reaches the green leaves through the sap. Nicotine represents the main psychoactive substance responsible for the addictive nature of the smoking habit. It produces more addiction than alcohol, heroin and cocaine.

Different types of tobacco have different amounts of nicotine. The nicotine content varies according to the process used to dry the leaves. Nicotine enters the body "suspended" in tar particles. Cigarette smoke is acidic and is better absorbed in the lungs, while pipe smoke is alkaline and is better absorbed by the oral mucosa. Nicotine has the following characteristics (Calvo, López y López, 1998):

a) It is the most characteristic component of tobacco and the ultimate responsible for addiction. It is a highly toxic plant alkaloid, name derived from its alkaline properties, which functions as a stimulant in low doses, but also as a depressant in high doses.

b) Nicotine is a liquid, oily, colorless and intensely alkaline substance, which acquires a brownish coloration when it comes into contact with air.

c) After inhalation of tobacco smoke, nicotine is carried in small tar particles and is rapidly absorbed through the skin, oral mucosa and respiratory tract. The speed of absorption depends on the pH of the medium. In the mouth and skin, the pH is predominantly basic, so when smoking pipes and cigars, which are alkaline in nature, absorption occurs mostly in the mouth; while in the respiratory tract the pH is acidic, so when smoking cigarettes, which are acidic in nature, rapid absorption of nicotine is facilitated predominantly in the lung.

d) It is this substance that causes addiction. Nicotine meets the criteria to be considered a drug because it produces dependence and withdrawal syndrome when withdrawn. Nicotine addiction is considered a true drug dependence.

For Alonso (2002), nicotine meets all the criteria that a substance must present to be considered psychoactive, for the following reasons:

1- More prolonged consumption over time or in greater quantity than initially planned.

2- Existence of desire or repeated attempts to abandon consumption:

More than 90% of smokers want to quit smoking.

3- Daily use of a lot of time in processes related to the consumption of the substance.

4- Limitation of activities or relationships to maintain consumption.

5- Maintenance of substance consumption despite the existence of alterations due to it.

6- Progressive appearance of tolerance, with the associated need to increase the dose to maintain the effects; disappearance of certain effects with sustained consumption, so that the first consumptions produce nausea, dizziness, unpleasant taste, palpitations, etc. These symptoms are a consequence of generalized nicotinic activation, and disappear as the individual consumes cigarettes regularly, possibly due to a partial inactivation of the brain specific receptors.

7- Appearance of a withdrawal syndrome when there is no consumption of the substance or when it is less and/or consumption is maintained to prevent the appearance of the syndrome.

People, (De la Peña 2002), rapidly develop a physical dependence on nicotine because:

1- Nicotine is eliminated from the body in about two hours. Therefore, the smoker is forced to supply nicotine to their neurons quite a few times a day. If this does not happen, the nervous system is responsible for demanding its dose with increasing intensity, until the obsession to take a puff prevents them from thinking about anything else.

2- The amount of nicotine that an organism consumes tends to be constant. The average smoker smokes 17 cigarettes a day and the average time between one cigarette and another is 58 minutes.

3- Nicotine inhaled by the lungs reaches the brain faster than if it were intravenous. It only takes 7 seconds to reach the brain.

Smoking light or low-nicotine cigarettes forces you to take more and deeper puffs. The purpose of this is to obtain more doses of nicotine.

4- Cigars may seem more harmless. But nicotine is absorbed through the mouth mucosa and through the lungs, and they also have a lot of tar. A small cigar can have the nicotine of 5 cigarettes and a cigar up to the same amount as a pack of cigarettes.

5- The last third of the cigarette, next to the filter, acts as another filter for the combustion of the tip and center. When you finish a cigarette, the toxicity of the smoke reaches its maximum degree. This part of the cigarette, known as the "condensation zone", causes greater problems than the rest.

6- In situations of stress, nervousness or anxiety, the body may need more nicotine. The action of adrenaline "burns" nicotine earlier and the body asks for a higher dose of tobacco.

7- You smoke non-stop when you drink alcohol. Alcohol produces bronchodilation and then, nicotine "escapes" earlier from the body, asking us for more.

For all this, we see that smoking is not a vice, nor a way to distract oneself, nor a reflex act, nor a bad habit, nor a custom, nor a whim, nor a pastime: smoking is a drug addiction. Nicotine passes into the blood through the cells of the mouth, bronchi and lung. Then it accumulates in the hypothalamus and other brain structures. In the end, the body eliminates it, metabolically modified, through urine and sweat. In the case of breastfeeding women, nicotine appears dissolved in breast milk. From the time a nicotine particle enters the body until it leaves, three- or four-days pass (Calvo, López y López, 1998).

In pure and concentrated form, nicotine is extraordinarily toxic (Calvo, López y López 1998) in such a way that:

* A drop of pure nicotine would kill a bird.

- * Three drops would kill a dog.
- * Eight drops would kill a horse.
- * In humans, the toxic dose is between 10 and 20 mg.
- * The lethal dose is between 0.5 and 1 mg per kilo of weight, which is equivalent to a total dose of 40 to 60 mg.

95% of the nicotine inhaled reaches the lungs. From there it passes into the blood and reaches the various organs in just 10-19 seconds. The half-life of nicotine in the body (time it takes for the blood concentration to decrease by half) is 2 hours (Benowitz, 1991). The body processes nicotine and produces inactive substances. Among them, the most important is cotinine, which can be measured in saliva, blood and urine and serves to verify if someone has stopped smoking. The action of nicotine occurs almost immediately after being absorbed, as it reaches the brain in approximately 7 seconds. The two areas of the brain where there is a greater number of nicotinic receptors are the mesolimbic system and the "locus coeruleus".

Each dose of nicotine increases the release of the neurotransmitter "dopamine" in the mesolimbic system. This produces pleasure, joy and increased alertness. This mechanism of action is like that of cocaine or heroin. The effect dissipates after a few minutes, making the smoker want to continue smoking to repeat the pleasurable effects. In the locus coeruleus, nicotine releases the neurotransmitter "norepinephrine" which produces an increase in alertness, concentration and memory. It also decreases appetite (Calvo, 1997). According to the same source of information, continuous exposure to nicotine increases the number of nicotinic receptors in the brain by 2 to 3 times. The greater the number, the greater the amount of nicotine needed to make them react and calm the need to smoke again. This is called "tolerance".

During the night, nicotine in the blood decreases; and therefore, upon waking withdrawal symptoms occur. The first cigarette is the one that produces the greatest feeling of relaxation because it calms that prolonged deprivation. The time that elapses between waking up and the first cigarette is a good indicator of the severity of the addiction. Each smoker develops an "ideal" concentration of nicotine that must be kept constant throughout the day so that the adverse effects of nicotine withdrawal are not felt.

B) Tars. Of the more than 4,000 chemical substances found in tobacco smoke, at least twenty have demonstrated carcinogenic effects. These substances are contained,

fundamentally, in the tars of the particle phase of tobacco smoke (Spanish Society of Pneumology and Thoracic Surgery, SEPAR 2002).

Tar has many characteristics. Ribeiro (2002) enumerates them as follows:

- Tar is an unctuous substance, dark in color, with a strong odor and bitter taste. This component of smoke is extremely harmful to health. Its strong relationship with the appearance of malignant tumors, such as lung cancer, has been proven. It also affects all organs of the person, as it transports various toxic and carcinogenic substances through the bloodstream. It decreases the smoker's olfactory capacity; then, it reaches the lungs and stays there, forming a layer that hinders oxygen absorption and causes coughing.
- Respiratory cilia lose part of their ability to move and begin to have difficulties performing their lung cleaning function. Therefore, the smoker tends to cough and may develop bronchitis and even emphysema. Smoking is responsible for 90 percent of lung cancer cases.
- Tar appears from the mixture of different substances after the combustion of cigarette paper and to a lesser degree, after the combustion of tobacco.

The amount of tar in tobacco and its toxicity depends fundamentally on the curing of the leaf. Tar contents vary depending on the actual contents of the various existing tobacco leaves (Calvo, López y López, 1998). These contents would be:

- * Low tar contents would be between 0 and 10 mg of tar per cigarette.
- * Medium content between 11 and 29 mg of tar per cigarette.
- * High content from 29 mg of tar per cigarette.
- * In the 1960s, the first light cigarettes appeared, with lower tar content. At that time, quantities above 20 milligrams per cigarette were normal. From January 1, 1993, the maximum rate was 15 milligrams per cigarette, reduced to 12 milligrams from January 1, 1998.

C) Carbon monoxide. Hemoglobin is the protein in red blood cells responsible for carrying oxygen (O₂) to tissues. Carbon monoxide (CO) is 250 times more affine to hemoglobin than oxygen (O₂). When carbon monoxide binds to hemoglobin forming carboxyhemoglobin, it takes away the place of oxygen. The following example clarifies the above; normal air has a concentration of 1-30 carbon monoxide particles per million. With these concentrations, the carboxyhemoglobin content in blood is 1-2%. When smoking 5-20 cigarettes per day, the carboxyhemoglobin content increases to 4-7%; and when smoking more than 25, it increases to 8-15% (U.S. Public Health Service. Smoking and Health. (1964).

Carbon monoxide has the following characteristics:

- It is a toxic, odorless, colorless, tasteless and non-irritating gas that is mainly formed by the combustion of tobacco and cigarette paper. It forms part of 5% of the total cigarette gases and is only absorbed if the smoke is inhaled.
- When inhaled through the lungs, it combines with blood hemoglobin producing carboxyhemoglobin, a substance that displaces oxygen from red blood cells, thus preventing the supply of oxygen to the body and reducing the amount of hemoglobin available to transport oxygen, thereby delaying the absorption of oxygen by tissues.
- Hemoglobin, when binding with carbon monoxide, not only reduces the oxygen uptake capacity but also delays tissue absorption, causing the body to react by producing more red blood cells; however, even though the increased number of cells is responsible for this transport, tissue oxygenation continues to be hindered by the presence of carbon monoxide in the blood. The result is thickening of the blood, which can induce, in genetically predisposed individuals, coagulation disorders, such as thrombosis, embolisms, etc. (Calvo 1997).

The concentration of carbon monoxide in tobacco smoke depends on (Jiménez, et al 1995):

- * The type of product used. Cigarettes release more carbon monoxide than cigars.
- * Temperature.
- * Speed of combustion.
- * Degree of atmospheric pollution.

The smoker exposes their alveoli to an amount of 400 ppm (parts per million) of carbon monoxide in each inhalation.

Carbon monoxide has the following main characteristics, (Sánchez, l. 1991):

- Carbon monoxide reaches the blood, and then forms carboxyhemoglobin. The red blood cell, which has the mission of carrying oxygen to the cells, then finds itself as if its cargo had been changed. Instead of oxygen, it carries monoxide. The cells are not oxygenated enough, and then fatigue appears along with everything that comes with lack of oxygenation. A non-smoker has approximately 2% carboxyhemoglobin, and a regular smoker has up to 14%. The toxic, almost lethal dose is around 18%.
- Tobacco smoke contains between twenty thousand and sixty thousand ppm (parts per million) of carbon monoxide, while the combustion gases of an automobile contain thirty thousand to eighty thousand ppm. A study conducted in London among traffic police, drivers, and workers exposed to high concentrations of carbon monoxide concluded that

in non-smokers the level of carboxyhemoglobin was 1.5 percent, while in smokers it was 10% (Ribeiro, 2002).

Carbon monoxide is characterized by the following:

- It is found in cigarette smoke at a concentration 400 times higher than the maximum accepted in industrial environments.
- It occupies the place of oxygen, which causes one to breathe more rapidly, forcing the heart to pump harder to provide the body with sufficient oxygen.
- The smoker's lungs are continuously exposed to cigarette smoke. A smoker of 30 cigarettes a day lights one every half hour and takes between 4 and 10 minutes to consume it.
- The smoker spends about 4 hours a day inhaling carbon monoxide.

9. Health problems caused by tobacco

Cigarettes are the cause of death for one in two regular smokers, and approximately half a billion people currently alive (8% of the world's population) could die from tobacco if they continue to smoke.

Despite this pandemic, tobacco consumption is increasing in many countries, especially in Asia, Southern and Eastern Europe. A key factor affecting public awareness of the health dangers of tobacco use is the time (between three and four decades) from when the prevalence of tobacco consumption reaches its greatest dimension and when tobacco-related mortality reaches its peak (López, Collishaw and Piha, 1994).

Although, as we have seen, tobacco use has been known for centuries, various changes in recent years have modified its consumption and the consequences derived from it.

General health effects

Tobacco consumption affects virtually all organs of the body and is responsible for a wide range of diseases:

a) Cardiovascular diseases

- Hypertension
- Coronary heart disease (angina or myocardial infarction)
- Cerebrovascular accidents (thrombosis, hemorrhages or embolisms)

Smoking significantly increases the risk of developing these conditions, being responsible for approximately 30% of all coronary heart diseases.

b) Respiratory diseases

- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic bronchitis

- Pulmonary emphysema
- Asthma
- Pneumonia and other respiratory infections

c) Cancer

Smoking is associated with multiple types of cancer, including:

- Lung cancer (95% of cases)
- Laryngeal cancer
- Mouth and throat cancer
- Esophageal cancer
- Bladder cancer
- Kidney cancer
- Myeloid leukemia
- Liver cancer
- Pancreatic cancer

d) Effects on the digestive system

- Gastrointestinal ulcer
- Chronic gastritis
- Crohn's disease
- Colorectal cancer

e) Effects on the reproductive system

- Sexual impotence in men
- Decreased fertility in both sexes
- Complications during pregnancy and childbirth

f) other effects

- Osteoporosis
- Seropositive rheumatoid arthritis
- Age-related macular degeneration
- Cataracts
- Premature skin aging

10. Epidemiology of tobacco consumption

Spain continues to be one of the European countries with the highest prevalence of smoking. The four smoking-related diseases that cause the highest number of deaths are ischemic heart disease, bronchopulmonary cancer, chronic obstructive pulmonary disease, and acute cerebrovascular accident.

According to the European Health Survey in Spain for the year 2020 (INE.es 2020), 16.4% of women and 23.3% of men smoke daily. The highest percentage in men corresponds to the age group of 25 to 34 years, and in women to the group of 45 to 54 years. The population that smokes daily is concentrated in the ages of 25 to 64 years, with percentages around 30% in men and 20% in women. From the age of 65, the daily smoking population decreases, although to a greater extent for women.

2.1% of women and 2.6% of men declare themselves occasional smokers. The highest percentage corresponds to men in the age group of 25 to 34 years (3.9%) and to women in the group of 15 to 24 years (3.9%).

16.7% of women and 27.6% of men declare themselves ex-smokers. The age group of 55 to 64 years concentrates the highest percentage in women (27.5%) and that of 75 to 84 years in men (51.8%).

64.8% of women and 46.4% of men have never smoked. The highest percentages in women correspond to the age group of 85 years and over (95.6%) and in men to that of 15 to 24 years (73.9%).

Exposure to tobacco smoke

87.5% of women and 85.3% of men have never or almost never been exposed to tobacco smoke in enclosed spaces, according to the European Health Survey in Spain 2020. The population aged 65 and over is the least exposed (95.1% of women and 92.9% of men).

In the age group of 15 to 24 years, 10.2% of men and 9.4% of women were exposed to tobacco smoke in enclosed spaces every day.

The effects that tobacco has on the health of passive smokers have been the subject of numerous studies. Their results have been modifying the perception of the scientific world, as it has been proven that environmental tobacco smoke increases the risk of lung cancer, problems during pregnancy, childbirth, etc. In children, environmental tobacco smoke is the cause of an increase in the risk of respiratory tract infections and a decrease in respiratory function, as well as an increase in the number and severity of asthma episodes.

11. Advertising and its influence on consumption among young people

a) Marketing strategies of the tobacco industry

As we have already mentioned, the tobacco industry has historically used sophisticated marketing strategies to attract new consumers, especially young people. Some of these strategies include:

- Association with sporting and cultural events

- Sponsorship of celebrities and influential figures
- Attractive design of packages and products
- Advertising at points of sale
- Digital and social media marketing

b) Impact on young people

Young people are particularly vulnerable to tobacco marketing tactics due to several factors:

- Susceptibility to peer pressure
- Desire for experimentation and rebellion
- Search for identity and belonging
- Limited perception of long-term risks

Studies have shown that exposure to tobacco advertising significantly increases the likelihood of young people starting to smoke.

c) Advertising regulations and bans

In response to evidence of the impact of advertising on tobacco consumption, many countries have implemented restrictions or total bans on tobacco product advertising. These measures include:

- Ban on advertisements on television, radio and print media
- Restrictions on event sponsorship
- Regulations on packaging and labeling of tobacco products
- Ban on product display at points of sale

d) new challenges: digital marketing and social networks

Despite restrictions, the tobacco industry has found new ways to reach young people, mainly through digital platforms and social networks. This presents new challenges for regulators and public health advocates.

12. Challenges in developing countries

The impact of smoking is disproportionate in regions such as Asia and Africa, where more than 80% of global tobacco production is concentrated. China and India are key examples:

- China: It is the world's largest producer and consumer of tobacco. Although smoking rates have decreased slightly (from 26.6% in 2018 to 24.1% in 2022), total sales continue to increase due to economic policies that prioritize tax revenues over public health. The lack of strict national anti-smoking legislation aggravates the problem.

- India: Second largest tobacco producer in the world, faces unique challenges due to the widespread consumption of traditional products such as bidis and kreteks. These products are cheaper but equally harmful, making efforts to reduce their use difficult.

13. Role of the Tobacco Industry. Past, Present and Future in their strategies

In many countries, tobacco industries still exert a strong political influence that hinders the implementation of effective policies.

Indeed, the role of tobacco companies from their beginnings to the present has experienced a dramatic evolution, both in developed countries and in those that are in the development phase and that have been especially vulnerable to the policies of this industry, marked by the constant adaptation of their strategies and messages from their early days to the current era, as they have been modifying their tactics to maintain their business in the face of growing evidence about the harms of tobacco that, as we already mentioned, began to materialize with reliable data in the 1950s of the last century.

1. Beginnings and expansion (1900s-1950s)

1.1 Initial promotion

- Tobacco companies initially promoted tobacco as a product beneficial to health.
- Slogans such as "More doctors smoke Camel" (R.J. Reynolds) were used to give medical credibility to the habit.
- Smoking was associated with glamour, sophistication and social success.

1.2 Innovative marketing strategies

- They hired models to smoke in public, normalizing the habit, especially among women.
- They sponsored radio programs and later television to increase the visibility of their brands.
- They used product placement techniques in Hollywood movies, associating tobacco with stardom.

1.3 Expansion of the female market

- They launched campaigns specifically aimed at women, such as Lucky Strike's "Reach for a Lucky instead of a sweet".
- They presented cigarettes as a symbol of female emancipation and weight control.

1.4 Leveraging historical events

- During world wars, they distributed cigarettes for free to soldiers, creating a generation of loyal smokers.
- They associated smoking with patriotism and support for the troops.

2. Era of denial (1950s-1990s)

2.1 Response to early scientific studies

- When in 1950, Ernst Wynder and Evarts Graham published a study linking smoking with lung cancer, tobacco companies responded by creating the Tobacco Industry Research Committee (TIRC) in 1954 to sow doubts about these findings. (Calvo 1997)

2.2 Boycott and disinformation tactics

- They funded biased studies to counter scientific evidence on the harms of tobacco.
- They used "mercenary" scientists to testify in favor of the industry in courts and before the US Congress.
- They implemented public relations campaigns to discredit anti-tobacco researchers and activists.

2.3 Manipulation of science

- They suppressed internal research that confirmed the risks of tobacco.
- They created seemingly independent research institutes to generate favorable studies.
- They infiltrated scientific organizations to influence their positions on tobacco.

2.4 Legal tactics and lobbying

- They employed teams of lawyers to delay and obstruct litigation against the industry.
- They pressured politicians and officials to avoid strict regulations.
- They used threats of litigation to intimidate media outlets that wanted to publish unfavorable information.

2.5 Manipulation of public opinion

- They launched massive advertising campaigns to counter growing public awareness about the risks of tobacco.
- They promoted the idea that smoking was a "personal choice" to deflect responsibility from the industry.

3. Adaptation to restrictions (1990s-2000s)

3.1 Response to advertising bans

- They developed indirect advertising strategies, such as sponsoring sporting and cultural events.
- They used branding on products unrelated to tobacco to maintain the visibility of their brands.

3.2 Focus on youth markets

- Despite publicly denying that they targeted minors, internally they developed strategies to capture young smokers.

- They created campaigns like R.J. Reynolds' "Joe Camel", which were attractive to teenagers and played with their emotions by associating their products with consumer items and objects of desire.

3.3 International expansion

- Faced with growing restrictions in developed countries, they intensified their efforts in emerging markets with laxer regulations.
- They used trade agreements and diplomatic pressure to open new markets.

3.4 Regulatory obstruction tactics

- They legally challenged tobacco control laws in multiple countries.
- They funded front groups to oppose smoke-free policies.

3.5 Development of "safer" products

- They introduced "light" and "low tar" cigarettes, although internally they knew they did not significantly reduce health risks.

4. Current era (2010s-present)

4.1 Diversification towards alternative products

- They invested heavily in the development and promotion of electronic cigarettes and heated tobacco products.
- They presented these products as "less harmful" alternatives to traditional tobacco.

4.2 Adoption of a "harm reduction" discourse

- They changed their narrative to implicitly acknowledge the harms of tobacco by promoting "safer" alternatives.
- They used the concept of harm reduction to argue against strict regulations of new products.

4.3 Digital marketing strategies

- They took advantage of social networks and online platforms to promote their products, especially among young people.
- They used influencers and content marketing to circumvent traditional advertising restrictions.

4.4 Focus on low- and middle-income country markets

- They intensified their efforts in Africa, Asia and Latin America, where regulations are weaker.
- They used corporate social responsibility tactics to improve their image in these markets.

4.5 Lobby and litigation against plain packaging

- They aggressively opposed plain packaging laws in several countries, arguing violations of intellectual property rights.

4.6 Investment in cannabis and other industries

- Some tobacco companies have begun investing in the cannabis industry, anticipating possible wider legalization.
- They diversified their portfolios by investing in sectors unrelated to tobacco.

4.7 Adaptation to the COVID-19 pandemic

- They took advantage of the health crisis to promote their alternative products as "less risky" in the context of a respiratory disease.
- They donated funds and medical equipment in several countries, to improve their public image.

5. Vaping: a new frontier in nicotine consumption and the current industry strategy to continue with its lucrative business.

5.1 What is vaping? (Calvo 2024)

Vaping refers to the act of inhaling and exhaling the aerosol, often called vapor, produced by an electronic cigarette or similar device. These devices heat a liquid (e-liquid) that usually contains nicotine, propylene glycol, glycerin, and flavorings.

5.2 Differences between vaping and electronic cigarettes

Although often used interchangeably, there are some differences between vaporizers and electronic cigarettes:

5.2.1 Electronic cigarettes

- Designed to mimic the experience of smoking conventional cigarettes
- Generally smaller and lighter
- Usually have a battery, a mouthpiece, and an atomizer
- Primarily designed to vaporize liquids with nicotine

5.2.2 Vaporizers

- Tend to be larger and more customizable
- Can have cylindrical, rectangular, or modular shapes
- Offer more options for temperature and power control
- Can be used to vaporize a wider variety of substances, including nicotine-free liquids, herbs, and oils

5.3 Popularity and usage trends

Vaping has rapidly gained popularity, especially among young people and young adults. Factors contributing to this trend include:

- Perception that it is less harmful than smoking traditional cigarettes
- Variety of attractive flavors
- Modern and technological design of the devices
- Aggressive marketing on social networks and other digital media

5.4 Health risks associated with vaping

Although vaping is often promoted as a safer alternative to traditional tobacco, emerging research suggests it is not without risks:

5.4.1 Nicotine exposure

- Highly addictive
- Can affect brain development in adolescents and young adults
- Increases the risk of cardiovascular diseases

5.4.2 Exposure to potentially harmful chemicals

- Propylene glycol and vegetable glycerin: can form toxic compounds when heated
- Flavorings: some may be safe to ingest but not to inhale
- Heavy metals: can be released from device components

5.4.3 Respiratory effects

- Irritation of the respiratory tract
- Possible long-term lung damage
- Cases of acute lung injury associated with the use of electronic cigarettes

5.4.4 Explosion and fire risks

- Reported cases of devices exploding or catching fire, causing injuries or death.

5.5 Impact of vaping on youth and adolescents

The increase in vaping among young people is particularly concerning:

- Increasing usage rates: In many countries, the use of electronic cigarettes among adolescents has surpassed the use of traditional cigarettes.
- Gateway: Concern that vaping may lead to the use of other tobacco products.
- Effects on brain development: Nicotine exposure during adolescence can affect attention, learning, and propensity for addiction.

5.6 Regulation of vaping

The regulation of vaping varies significantly between countries:

- Some countries have completely banned vaping products.
- Others have implemented restrictions on sale, advertising, and use in public spaces.
- Many countries are struggling to keep up with the rapid evolution of these products.

5.7 Debate on the role of vaping in smoking cessation

There is an ongoing debate about whether vaping can be an effective tool for quitting smoking:

- Some studies suggest it may help smokers quit traditional tobacco.
- Others argue that it may perpetuate nicotine addiction and potentially lead to dual use of electronic and traditional cigarettes.

14. Effective treatment of cigarette addiction

1. Understanding nicotine addiction

Tobacco addiction is complex and involves physical, psychological, and social factors:

- Physical dependence: Nicotine alters brain chemistry, creating a physical need.
- Psychological habit: Smoking is associated with certain activities, moods, or social situations.
- Social factors: The social environment can reinforce or discourage the smoking habit.

2. Pharmacological approaches

a. Nicotine Replacement Therapy (NRT)

- Patches, gums, lozenges, inhalers, or nasal sprays containing nicotine.
- Help control withdrawal symptoms.

b. Non-nicotine medications

- Bupropion: Antidepressant that reduces the desire to smoke.
- Varenicline: Acts on nicotine receptors in the brain.
- Cytisine: Acts as a partial agonist of nicotine receptors in the brain.

3. Behavioral and psychological approaches

a. Cognitive-behavioral therapy (CBT): Helps identify and change thought patterns and behaviors associated with smoking.

b. Motivational interviewing: Patient-centered technique to increase motivation to quit smoking.

c. Mindfulness and stress reduction techniques: Can help manage emotional triggers for smoking.

d. Comprehensive cessation programs

The most effective programs usually combine pharmacological and behavioral approaches:

- Individual or group counseling
- Telephone or online support
- Regular follow-up and adjustment of the treatment plan

e. new technologies and innovative approaches

Mobile applications: Offer real-time tracking, motivation, and support.

Social networks and online communities: Provide peer support and accountability.

Virtual reality: Being explored to help manage cravings and trigger situations.

f. Relapse prevention

- Identification of triggers and development of coping strategies.
- Planning for high-risk situations.
- Ongoing long-term support.

g. Special considerations for specific populations

1. Adolescents and young adults: Approaches tailored to their unique needs and usage patterns.
2. Pregnant women: Specialized interventions due to additional risks to the fetus.
3. People with psychiatric comorbidities: Integrated treatment that addresses both addiction and mental health.

15. Future Perspectives: Global Strategies to Combat Smoking

1. WHO Framework Convention on Tobacco Control (FCTC) (WHO 2005)

The FCTC is the first international public health treaty, and it came into force in 2005:

- Establishes global standards for tobacco control.
- Covers areas such as advertising, taxes, packaging, and exposure to secondhand smoke.
- Has been ratified by over 190 countries.

2. WHO MPOWER measures (WHO 2008)

The WHO has developed a set of measures known as MPOWER to help implement the FCTC:

- Monitor tobacco use and prevention policies
- Protect people from tobacco smoke
- Offer help to quit tobacco use
- Warn about the dangers of tobacco
- Enforce bans on tobacco advertising, promotion and sponsorship
- Raise taxes on tobacco

3. Smoke-free policies

- Implementation of smoking bans in public places and workplaces.
- Reduction of exposure to secondhand smoke.
- Change in social norms regarding smoking.

4. Increase in taxes and prices

- Considered one of the most effective measures to reduce consumption.
 - Particularly effective among youth and low-income populations.
 - Challenges: smuggling and illicit tobacco products.
5. Plain packaging and graphic warnings
 - Elimination of attractive branding elements on cigarette packages.
 - Inclusion of graphic warnings about health risks.
 - Growing evidence of its effectiveness in reducing the attractiveness of tobacco.
 6. Comprehensive bans on advertising, promotion, and sponsorship
 - Restriction of all forms of tobacco marketing.
 - Facing challenges in regulating digital and social media marketing.
 7. Public education and awareness campaigns
 - Use of mass media to inform about the risks of smoking.
 - Campaigns targeted at specific populations (youth, pregnant women, etc.).
 8. Support for economic diversification in tobacco-producing countries
 - Programs to help farmers transition to alternative crops.
 - Challenges: resistance from the tobacco industry and economic dependence.
 9. Regulation of new nicotine products
 - Development of regulatory frameworks for e-cigarettes and heated tobacco products.
 - Balancing harm reduction potential with prevention of youth use.
 10. International collaboration and sharing of best practices
 - Exchange of information and strategies between countries.
 - Support for low- and middle-income countries in implementing tobacco control measures.
 11. Combating tobacco industry interference
 - Recognizing and countering industry tactics to undermine tobacco control policies.
 - Need for transparency and policies to prevent conflicts of interest.
 12. New forms of nicotine consumption
 - Regulation of emerging products such as e-cigarettes and heated tobacco.
 - Balancing harm reduction with prevention of use among non-smokers.
 - Urgent need to establish strict international regulations to control e-cigarettes and protect minors. This includes banning attractive flavors and restricting advertising campaigns targeting youth.
 13. Inequalities in tobacco consumption
 - Concentration of smoking in vulnerable and low-income populations.

- Need for culturally adapted approaches targeting specific groups.

14. Illicit trade in tobacco products

- Challenges in implementing the Protocol to Eliminate Illicit Trade in Tobacco Products.
- International cooperation to address smuggling and counterfeiting.

15. Sustainability of tobacco control programs

- Ensuring long-term funding for tobacco control initiatives.
- Integration of tobacco control into broader sustainable development goals.

16. Focus on developing countries

In regions like Asia and Africa, it is crucial to implement policies adapted to their socioeconomic contexts.

17. Technological innovations

The use of mobile applications for smoking cessation or advanced medical devices could play an important role in reducing dependence.

18. Adaptation to a changing nicotine landscape

Evolution of consumer preferences and new nicotine delivery technologies. Need for continued research on long-term effects of new products.

19. Addressing smoking in the context of other public health crises

Integration of tobacco control in the response to pandemics and other health emergencies. Recognition of smoking as a risk factor for multiple health conditions.

20. Promoting alternative crops for tobacco-dependent farmers and strengthening educational campaigns focused on rural communities.

21. Increasing tobacco taxes.

22. Strengthening international cooperation

Enhancing collaboration between countries to share best practices, research findings, and policy strategies is crucial for global tobacco control efforts.

23. Addressing tobacco industry interference

Developing and implementing policies to prevent tobacco industry influence on public health policies, in line with Article 5.3 of the WHO FCTC.

24. Promoting tobacco-free finance

Encouraging financial institutions and investors to divest from tobacco companies and invest in sustainable, health-promoting industries.

25. Integrating tobacco control into broader health and development agendas

Linking tobacco control efforts with other global health priorities, such as non-communicable disease prevention and sustainable development goals.

26. Enhancing cessation support

Expanding access to evidence-based smoking cessation services, including behavioral support and pharmacotherapy, through healthcare systems and community-based programs.

27. Addressing emerging products

Developing comprehensive regulatory frameworks for novel and emerging nicotine and tobacco products, balancing potential harm reduction with youth protection.

28. Strengthening surveillance and monitoring

Improving data collection and analysis systems to track tobacco use trends, industry tactics, and policy effectiveness.

29. Promoting smoke-free environments

Expanding and enforcing smoke-free policies in public spaces, workplaces, and multi-unit housing to protect non-smokers and denormalize smoking.

30. Leveraging technology for tobacco control

Utilizing digital health interventions, artificial intelligence, and big data analytics to enhance tobacco control efforts and smoking cessation support.

These strategies, combined with ongoing efforts and adaptations to address emerging challenges, will be crucial in the continued fight against the global tobacco epidemic.

16. Bioethical analysis of the tobacco phenomenon

The bioethical analysis of tobacco consumption, the role of tobacco companies, and governments is a complex issue that involves multiple ethical principles and public health considerations.

Smoker's autonomy

The principle of autonomy is fundamental in bioethics, but in the case of smoking, it is compromised by several factors:

1. Habit initiation: Most smokers begin in adolescence, when their capacity for autonomous decision-making is not yet fully developed. Young people are influenced by social pressure, advertising, and environment, which questions the true autonomy of this initial decision.
2. Addiction: Once nicotine dependence is established, the smoker's autonomy is drastically reduced. Addiction compromises the ability to make truly free decisions about tobacco use.
3. Information and informed consent: Although there is now extensive information about the risks of tobacco, as we have seen throughout this article, tobacco companies concealed

and manipulated this information. This raises doubts about whether smokers, especially those of previous generations, could exercise real informed consent and therefore make informed decisions based on the information provided to them.

Beneficence and non-maleficence

These bioethical principles are clearly affected in the context of smoking:

1. Health damage: Tobacco causes serious harm to the smoker's health, violating the principle of non-maleficence. Diseases associated with smoking, such as cancer, COPD, and cardiovascular diseases, represent clear harm to the individual.
2. Passive smoking: Secondhand smoke affects non-smokers, including children, pregnant women, and the unborn, which represents an additional violation of the principle of non-maleficence.
3. Responsibility of health professionals: Healthcare professionals have an ethical obligation to promote health and prevent diseases, which includes addressing smoking in their patients.

Justice and equity

The principle of justice in bioethics is challenged by several aspects of smoking:

1. Health inequalities: Smoking disproportionately affects lower socioeconomic groups, exacerbating health inequalities.
2. Costs to the health system: The treatment of tobacco-related diseases poses a significant burden on health systems, raising issues of distributive justice in the allocation of health resources.
3. Tobacco control policies: Measures such as tax increases may have an unequal impact on different socioeconomic groups.

Role of tobacco companies

The actions of the tobacco industry raise serious ethical dilemmas and have generated debates in recent years:

1. Manipulation of science: Tobacco companies have funded studies to deny the dangers of tobacco, undermining the integrity of scientific research.
2. Misleading marketing: The promotion of "light" or "low tar" cigarettes has been a deceptive strategy that has led consumers to erroneously believe in a lower risk.
3. Targeting vulnerable populations: The industry has directed its marketing efforts towards young people and developing countries, exploiting the vulnerability of these populations and continues to do so in markets where they are still allowed to act without restrictions.

4. Interference in public policies: Tobacco companies have tried to influence tobacco control policies, prioritizing their economic interests over public health.

Government responsibility

Governments face ethical challenges in their approach to smoking:

1. Balance between individual freedom and protection of public health: Tobacco control policies must balance respect for individual autonomy with the obligation to protect public health.

2. Regulation of new products: The emergence of electronic cigarettes and heated tobacco products poses new ethical dilemmas about their regulation and potential use in harm reduction strategies.

3. Conflict of interest: Some governments obtain significant revenue from tobacco taxes, which can create a conflict of interest in implementing control policies.

4. International responsibility: Governments have the ethical and moral obligation to implement the tobacco control measures agreed internationally in the WHO Framework Convention on Tobacco Control.

Harm reduction

The harm reduction approach in smoking poses complex ethical considerations:

1. Electronic cigarettes: Although they may represent a less harmful alternative for current smokers, their promotion could normalize nicotine consumption and attract new users, especially young people, and we still do not know their true long-term effects on consumers' health.

2. Risk balance: Governments and health professionals must balance the potential for harm reduction for current smokers with the risk of initiating non-smokers.

3. Public information: There is an ethical challenge in how to communicate the relative risks of different nicotine products without promoting their use among non-smokers.

Therefore, we believe that, from a bioethical perspective, addressing smoking requires a multifaceted approach that considers individual autonomy, protection of public health, social justice, and the responsibility of the different actors involved. A balance is needed between respecting individual decisions and protecting the population from the harms of tobacco, especially the most vulnerable. Transparency in research, effective regulation of the tobacco industry, and evidence-based public policies are fundamental to ethically address this global health problem.

17. Conclusion

Smoking remains one of the greatest public health challenges worldwide. Despite significant advances in tobacco control in recent decades, millions of people continue to die each year due to tobacco use and exposure to secondhand smoke. The emergence of new products such as electronic cigarettes presents additional challenges, especially regarding their use among young people.

Future success in the fight against smoking will depend on a comprehensive approach that combines effective policies, public education, support for quitting smoking, and innovative regulation. International collaboration, ongoing research, and adaptability to a changing landscape of nicotine consumption will be crucial.

While the goal of a tobacco-free world may seem distant, each step towards reducing tobacco consumption represents a significant victory for global public health. The sustained commitment of governments, health organizations, communities, and individuals will be essential to continue progressing in this important cause, and bioethical considerations must always be present in the various actions that the various actors involved must take.

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UNA VISIÓN BIOÉTICA FRENTE A FUTURAS PANDEMIAS

Dra. M. de los ANGELES CALVO TORRAS



Licenciada y doctora en Veterinaria por la Universidad Complutense de Madrid; y Licenciada i doctora en Farmacia per la Universitat de Barcelona. Diplomada en Sanidad y especialista en Microbiología y Parasitología.

Catedrática de Sanidad Animal en la Universidad Autònoma de Barcelona. Actualmente profesora emèrita. Ha publicado más de 280 trabajos de investigación y ha colaborado en la redacción de capítulos de libros de Micología y de Microbiología, así como en libros de Ciencia, en general. Ha dirigido más de una treintena de tesis doctorales i ha recibido 14 premios por su labor investigadora o docente, entre los que destaca el Premio *One Health* otorgado por el Colegio Oficial de Veterinarios de Barcelona y el “Premio Mujer del año, de salud animal y veterinaria 2024”

Acadèmica numeraria de la Reial Acadèmia de Medicina de Catalunya, de la Reial Acadèmia Europea de Doctors, de la Real Academia de Doctores de España, de la Acadèmia de Ciències Veterinàries de Catalunya, de la que es Presidenta y de la Reial Acadèmia de Farmàcia de Catalunya.

Asimismo es académica correspondiente de la Real Academia de Medicina de España, de la Academia de Ciencias, Ingenierías y Humanidades de Lanzarote, de la Academia Nacional de Medicina de Méjico, de la Academia Nacional de Veterinaria de Méjico, de la Academia de Farmacia de Brasil y miembro del Institut Mèdic-Farmacèutic, de la Sociedad Argentina de Veterinaria, de la Asociación Catalana de Ciències de la Alimentación, filial del Institut d'Estudis Catalans, de la Cofradía Internacional de

Investigadores de Toledo y de la Cofradía de la Verge de l'Olivera de Barcelona y de diversas Sociedades científicas relacionadas con su ámbito de investigación.

Fue miembro del Comité Científico de Nutrición Animal (SCAN), siendo experta de la Comisión Europea. Asimismo, fue vicedecana y decana de la Facultad de Veterinaria de la UAB y es miembro del Consell Assessor de la Salut Pública Catalana, entre otros méritos. Forma parte de la Comisión *One Health* del Consell de Col·legis Veterinaris de Catalunya, actuando de portavoz.

INTRODUCCIÓN

La pandemia ocasionada por el SARS-CoV-2 ha puesto en evidencia la situación de los sistemas de salud tanto a nivel nacional como internacional y por tanto, el nivel de preparación, planificación, coordinación y prevención de los diferentes países frente a una situación que implica una alta demanda asistencial. El sistema asistencial de sanidad, sin duda, quedó desbordado al no disponer de un protocolo para intentar hacer frente a la pandemia, implicando que los recursos para cada hospital, residencia de tercera edad, centro de salud, comunidad autónoma, tuvieran que decidirse sin una orientación bioética definida. Ante la magnitud de la pandemia y su evolución incontrolada, se hizo imprescindible una toma de decisiones de forma rápida para intentar hacer frente cuanto antes a un enemigo común.

Aunque las pandemias forman parte de la historia de la humanidad, debemos considerarlas como episodios excepcionales que generan graves situaciones de desequilibrio, no solo a nivel sanitario sino también a nivel económico y social. Requieren respuestas urgentes y extraordinarias, que pueden llegar a poner en riesgo los recursos disponibles. Debe recordarse que cuando se manifiesta una crisis, no deben modificarse los valores éticos y por ello, resulta imprescindible, plantear un debate y alcanzar unas conclusiones que cuente con el consenso de todos los implicados.

La capacidad de respuesta efectiva de los países frente a la pandemia de Coronavirus fue muy variada, dependiendo de las circunstancias de cada localización. Unos países disponían de sistemas de salud bien organizados y con una correcta dotación, que les permitía garantizar a su población unos niveles aceptables de protección a la vida y a la salud, otros contaron con una cobertura sanitaria, completamente insuficiente que no les permitió cubrir las necesidades de todos los ciudadanos y en consecuencia no fueron capaces de afrontar la grave problemática sanitaria.

La pandemia del COVID-19, puso en evidencia que estos procesos no discriminan por situación socioeconómica, política, cultural, de género, edad o discapacidad ni por zona

geográfica. La crisis generada por la pandemia de la COVID-19 puso a prueba, sin duda a la humanidad en su conjunto, a todas las sociedades, a los servicios sanitarios y en consecuencia a la economía a nivel mundial. Los países, cuyos gobernantes, no reconocieron la importancia y gravedad del problema desde su primer momento, y por tanto no aplicaron de forma rápida un sistema de planificación, tuvieron un índice de contagio muy elevado y una mayor tasa de morbilidad y mortalidad, mucho más elevada que los que aplicaron de forma más rápida los sistemas de control y planificación frente a la pandemia.

BIOÉTICA Y PANDEMIAS

La OMS define a la bioética como: “una actividad analítica basada en principios y criterios éticos que pretende orientar la práctica en el ámbito de la salud”.

El debate sobre los principios de la bioética se inició en el año 1974, tras la constitución de la Comisión Nacional para la Protección de los Sujetos Humanos de Investigación Biomédica y del Comportamiento en el Congreso de los Estados Unidos. Su finalidad era identificar los principios éticos básicos que deben regir la investigación con seres humanos en la medicina y las ciencias de la conducta. En 1978 se publicó, el denominado: Informe Belmont, en el que se diferenciaban tres principios éticos básicos: respeto por las personas, beneficencia y justicia. El «Informe Belmont» se refiere a la ética en el ámbito de la investigación clínica, y más concretamente en la experimentación con seres humanos. Posteriormente, Beauchamp y Childress, en su libro “Principios de ética biomédica”, publicado en 1979, replantearon los principios éticos, citados, con el fin de que también puedan ser aplicados a la ética asistencial y en consecuencia se consideraron cuatro principios: autonomía, no maleficencia, beneficencia y justicia.

Autonomía

Se respeta la autonomía del paciente cuando se le reconoce el derecho a mantener puntos de vista, a poder elegir y a realizar acciones basadas en sus valores y creencias. El respeto por la autonomía del paciente obliga a los profesionales a revelar información, a asegurar la comprensión y la voluntariedad y a potenciar la participación del paciente en la toma de decisiones.

No-maleficencia

El principio de no-maleficencia hace referencia a la obligación de no causar daño intencionadamente. Este principio ya se define en la máxima clásica *primum non nocere* («lo primero no dañar»). Y también en el juramento Hipocrático podemos leer: «si es para su daño (...) lo impediré».

Beneficencia

Consiste en prevenir el daño, eliminar el daño o hacer el bien a otros. Frente a la no-maleficencia que se caracteriza por la ausencia de acción, la beneficencia incluye siempre la acción. Beauchamp y Childress distinguen dos tipos de beneficencia: la beneficencia positiva y la utilidad. La beneficencia positiva implica la obtención de beneficios, por el contrario, la utilidad determina un balance entre los beneficios y los daños.

La beneficencia es todo tipo de acción que tiene por finalidad el bien de otros, pero cuando Beauchamp y Childress hablan del principio de beneficencia, no se refieren a todos los actos realizados para hacer el bien, sino sólo a aquellos actos que son una exigencia ética en el ámbito de la medicina. Según estos autores, antes de realizar un tratamiento sobre un paciente, estamos obligados a hacer un balance de sus beneficios y riesgos.

Justicia

Las diferencias en la capacidad de acceso a la salud y el incremento de los costes han determinado que se establezca un debate sobre justicia social en todo lo referente al derecho a la salud y a los cuidados para mantenerla y/o recuperarla.

En este sentido, cabe considerar el concepto de justicia distributiva que, según estos autores, se refiere a “la distribución imparcial, equitativa y apropiada en la sociedad, determinada por normas justificadas que estructuran los términos de la cooperación social”. Sin duda, son varias las instituciones públicas y privadas implicadas, incluyendo al Gobierno y al sistema sanitario.

La bioética debe tenerse en cuenta en la preparación de las crisis sanitarias, ya que es imprescindible evaluar las políticas públicas que deben ponerse en práctica, así como las consecuencias que ello implicaría o en su caso proponer alternativas.

Cuando se consideran las medidas a aplicar en salud pública se deben evaluar los cambios legales y éticos que pueden derivarse de su establecimiento y se debe revisar si pueden interferir con los derechos cada individuo, entre los que podemos considerar: limitar el movimiento; aplicar una cuarentena y aislamiento; cerrar los centros educativos, comercios y lugares públicos; limitar la privacidad en relación con los contactos con los pacientes o decidir cómo se lleva a cabo la asignación de recursos a pacientes que requieren tratamiento y no pueden hacer frente al mismo, entre otros.

En una pandemia, las decisiones médicas sobre cada uno de los pacientes dependen, sin duda de los objetivos de salud pública. La actuación del clínico debe centrarse en el bienestar de la comunidad y ello hace imprescindible establecer un debate entre las partes implicadas sobre qué principios éticos deben tenerse en cuenta para alcanzar la toma de

decisiones lo más correcta posible. Consideramos que, frente a una situación de crisis sanitaria, es imprescindible establecer un proceso abierto, transparente y participativo en el tanto la sociedad científica como la civil estén implicadas y así se pueda preparar un plan actuación frente a pandemias o crisis sanitarias, en general.

Sin duda los dilemas éticos y la toma de decisiones en la práctica clínica cotidiana son habituales, y se agravan con las crisis sanitarias. Frente a posible crisis sanitarias y/o pandemias, es imprescindible una reflexión bioética en la asignación de recursos con la premisa que toda persona, independientemente de su edad o estado funcional, tiene dignidad y merece recibir la atención médica y cuidados necesarios.

LOS PRINCIPIOS DE LA BIOÉTICA DEL CONSEJO DE EUROPA

En Europa hay una gran diversidad de culturas que se muestra en las diferencias existentes entre las instituciones de los diversos países, los modelos de pensamiento, y los modelos de trabajo. Sin embargo, la diversidad de las tradiciones políticas, jurídicas y profesionales no son un obstáculo para su armonización dentro de la Unión Europea. «Para alcanzar una armonización sobre los principios éticos que deben regir en los países individuales, hay ya una manera institucional de proceder del Consejo de Europa, así como contribuciones de parte del Parlamento Europeo». Jacob Dahl Rendtorff y Peter Kemp, afirman tras la realización de proyecto EU-Biomed II, que aglutinó a investigadores de diversos países europeos, que la persona es un centro de la bioética, y afirman que los principios éticos básicos de Europa en Bioética, en el marco de la solidaridad y la responsabilidad, son los siguientes: 1) autonomía, 2) dignidad humana, 3) integridad y 4) vulnerabilidad.

CONCLUSIONES

La toma de decisiones desde el punto de vista de la bioética, en ámbitos de salud, son habituales, y se complican frente a una crisis sanitaria de cualquier índole o ante una pandemia, en particular. Es, por tanto, imprescindible una reflexión bioética, ante la asignación de recurso, partiendo siempre de la base que toda persona, independientemente de su edad o estado funcional, tiene dignidad y merece recibir la atención médica y los cuidados necesarios.

Antes de la pandemia ocasionada por el Coronavirus, la bioética se centró fundamentalmente en los principios éticos asistenciales, en la ética clínica y en la ética de la investigación. Frente a posibles nuevas pandemias, debemos considerar una bioética global y social, a partir de la que se considere tanto el bien personal como el bien general.

Debe tenerse en cuenta una visión holística de la bioética, dado que: 1.- las políticas financieras, económicas, laborales, de educación y de salud pública influyen en las conductas civiles y en el comportamiento del ser humano y 2.- la salud se ve claramente afectada por el comportamiento de la sociedad y el desconocimiento de los derechos y deberes civiles.

Por todo ello, es imprescindible considerar el concepto de salud, como el equilibrio social, cultural y mental de una población, no solo la ausencia de enfermedad y para lograrlo, aplicar los principios de la bioética en todo momento y en particular en momentos de crisis o de pandemias es imprescindible.

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ABORTION IS NOT PART OF HEALTH CARE

Bogdan Chazan



Professor, obstetrician and gynecologist. In the past head of the Clinical Department of Obstetrics and Gynecology at the National Research Institute of Mother and Child in Warsaw, Poland, and national consultant in obstetrics and gynecology.

A member of the Board of MaterCare International (MCI), the Catholic professional organization supporting mothers and children in Kenya, Rwanda, Uganda and Christian professionals all over the world. Representative of MaterCare International at the Forum International of the Catholic inspired organizations.

Deputy Head of the Polish Society of Catholic Physicians, Deputy President of the European Federation of Catholic Medical Associations.

Author and editor of handbooks and chapters. His scientific interest covers the subjects of perinatology, public health and bioethics.

1. Introduction

Tens of millions of children die every year around the world as a result of abortion. In many societies, the killing of children in the womb of their mothers is not only permissible, but even promoted. We sometimes wonder how it is possible that where for centuries abortion was considered a crime, today it is considered a human right and a normal medical procedure in the care of human health. Postmodern philosophy, the Cultural Revolution, one of its offshoots - the sexual revolution and feminist movements - led to the erosion of Christianity's influence on public morality. Starting in the 1960s, acceptance of abortion in Western societies steadily increased. Although the invention of the ultrasonography exposed lies denying the humanity of children in the womb, the media controlled by liberal circles did not allow this truth to be propagated.

Both the law and the rules of medical care for women make it easier in Western countries to access the procedure of killing a child before it is born. More important than the child's life is the personal comfort of the parents, pleasure and the hedonistic, unreflexive desire to enjoy life without resulting consequences.

Modern medical knowledge provides a lot of information about the adverse effects of abortion on the physical and mental health of mothers. Many studies indicate that abortion can cause immediate, sometimes life-threatening complications for mothers. It has been proven that performing them can lead to fertility disorders, premature births, and breast cancer in the future.

There are also mental health disorders, chronic depression, suicide attempts¹. The reproductive health of women across the population deteriorates, as well as the quality of health and life of future generations. An entire society is losing out because state spending on women's health care is increased. The number of births decreases, demographic indicators deteriorate, the efficiency of pension systems is compromised. Despite so many harmful consequences for physical, mental, social and spiritual health, abortion is considered in Western countries part of health care, saving human health and life.

The far-reaching goal of promoting abortion is to change the human person, to destroy the traditional value system. Citizens are meant to be incapable of recognizing right and wrong. It is to make them insensitive, burdened with remorse for having had numerous abortions, thoughtless, abandoned, easy to manage. In other words, it is to spread the civilization of death in the world.

With regard to the medical community, these actions are taken to remove from their representatives any scruples, any sensitivity to the sanctity of human life, to the voice of their own conscience. Doctors, nurses and midwives are supposed to be ready to perform every task, exhausted by higher emotions, burnt-out, frightened, disciplined, without own opinion, indifferent to the beauty of motherhood and the dignity of the life of the unborn child. Medical staff, accustomed to taking the lives of unborn children on a daily basis, will unfortunately not be motivated to endure enormous physical and mental effort and devote time to effectively save the lives of patients in other wards of the hospital. The consequences of the mass introduction of abortion in hospitals as a common medical procedure will therefore be borne by all, current and future patients.

¹ Pike G. Abortion and women's health. Society for the Protection of Unborn Children, 2017.

The vast majority of abortions are for convenience, no medical reason rather than life-threatening situations. The problem is most often the mother's lack of acceptance for the presence of another person, her child. This is a question of a social, spiritual but not a medical nature². But they are the gynecologists who are supposed to make decisions about performing abortions for non-medical reasons. Do they have the appropriate competence? They don't have the proper legal or sociological background but they are expected to issue and execute death sentences as part of medical care over the health and lives of patients. Abortion has a toxic effect on societies because it is related to the essence of humanity, the natural law, the principles of religion, it hurts the sense of justice and decency, destroys sensitivity to threats to life, and by arousing anger, outrage and hatred it destroys social peace, divides society and families.

2. Efforts to popularize abortion and improve its image. Is abortion a medical procedure?

Supporters of widespread abortion in most Western countries, including Poland, have faced the difficult task of justifying the validity or even necessity of abortion, perversely motivated by women's health needs. Contrary to the obvious facts, they are not called mothers during pregnancy.

In order to improve the image of this procedure in the society, it was decreed that it should be treated as a part of health care, a normal medical procedure. Moreover, the procedure that takes the life of an unborn child was declared as necessary to save health and life. It was included in routine medical procedures in the care of maternal and child health, which are guaranteed by the state under the universal social insurance system.

Contrary to the facts, abortion is presented as a procedure to remove the suffering of children who have been diagnosed with a disease or developmental defect before birth. The method of removing these suffering is special because it proposes to remove the suffering along with the suffering child.

As a result, in Poland, every obstetric and gynaecological unit, regardless of its place in the reference system or subspecialty, must have in its contract with the National Health Fund an obligation to perform abortions for reasons that take into account the law, as a guaranteed medical procedure. It does not matter the traditions of the hospital, the views of the majority of the medical staff employed or the person of the hospital's patron (for

² Harrison Donna J.:What is and is not an abortion? The 12th MaterCare International Rome Conference, Rome September 2024.

example, the Holy Family or John Paul II). Everyone is to be equally "dipped" in the lethal abortion procedure. No hospital can be exempt from it, no one can feel better.

3. Definition of abortion

We are witnessing manipulation of the definition of abortion. Such an agreed definition of procedures surrounding the end of pregnancy is important in discussions among women's health providers, policymakers, journalists and lawyers. The definition of each procedure should specify precisely its intentions and purpose.

Medline Plus reports a definition of abortion in 2024 as: "Medical procedure to end a pregnancy." According to the broader definition of ACOG (The American College of Obstetricians and Gynecologists), induced abortion is an intervention to end a pregnancy so that it does not result in a live birth. The physician performing the procedure should be sure that the baby does not survive the separation³.

A similar definition is found in the Merriam Webster Dictionary: It is the termination of a pregnancy after, accompanied by, resulting in, or closely followed by the death of the embryo or fetus⁴. So according to those definitions the purpose of abortion is to kill the child.

Dr Donna Harrison, an obstetrician – gynecologist, the previous president of the American Association of Pro – Life Obstetricians and Gynecologists (AAPLOG) proposes another definition of abortion: „Abortion is defined as any drug, device or procedure used to terminate a pregnancy for the primary purpose of ensuring the death of the human being in utero before, during, or in the process of separation of the mother and her embryo or fetus” . The abortion is defined in a similar way at the AAPLOG practice guideline N 10, August 2022 „Concluding pregnancy aethically”⁵

The definition of abortion as a procedure directly aimed at depriving the life of the child, as the deliberate killing of an innocent human being and intentional feticide was presented by St. John Paul II. John Paul II, in his Encyclical "Evangelium Vitae," (62). „I declare that direct abortion, that is, abortion willed as an end or as a means, always constitutes a grave moral disorder, since it is the deliberate killing of an innocent human being” .

4. Abortion as a “medical procedure to save the life of the mother”

³ acog.org/womens-health/faqs/induced-abortion

⁴ <https://www.merriam-webster.com/dictionary/abortion>.

⁵ <https://aaplog.org/wp-content/uploads/2022/10/PG-10-Concluding-Pregnancy-Ethically.pdf>.

Care of many medical conditions such as missed miscarriage, septic miscarriage and life-threatening maternal conditions are often cited as abortions. According to ACOG, "Induced abortion is an essential component of women's health care. women need abortion in certain cases to avoid death" - or that certain complications or conditions "may be so severe that abortion is the only measure to preserve a woman's health or save her life." ⁶ This statement contradicts to same extent the earlier definition given by the same institution of abortion as a procedure whose purpose is to deprive the life of the child.

These arguments are deliberate overcutting to distract from the clear purpose of elective abortion, which is to make sure the baby dies, no matter what gestational age. They aim to portray abortion as a life-saving medical procedure, which in reality it is not.

In these situations many medical experts call abortion irrelevant. According to them abortion, defined as the purposeful ending of an unborn child's life, is never medically necessary. ⁷

Medical or surgical procedures carried out in a situation of danger to the health or life of the expectant mother as separating the child from the mother (induction of labour or performing cesarean section), are not abortions, because they are not specifically designed to end the life of the human being.

Dublin Declaration (issued 2012) regarding no reason to carry out abortion to save mother's life says that: „As experienced practitioners and researchers in obstetrics and gynaecology, we affirm that direct abortion – the purposeful destruction of the unborn child – is not medically necessary to save the life of a woman. We confirm that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women. We uphold that there is a fundamental difference between abortion, and necessary medical treatments that are carried out to save the life of the mother, even if such treatment results in the loss of life of her unborn child”⁸.

Authors associated with the pro-abortion agenda described the Declaration as a part of an ideologically driven attempt to influence national debates, create confusion and competing truth claims.⁹ In certain circumstances, where the danger to life is undoubted, like septic miscarriage, heavy cases of hemorrhage during pregnancy or severe

⁶ <https://www.acog.org/advocacy/facts-are-important/abortion-is-healthcare>

⁷ <https://www.catholicnewsagency.com/news/251941/ectopic-pregnancies-miscarriage-abortion-never-necessary-these-doctors-say>.

⁸ <https://www.dublindeclaration.com/>

⁹ Morgan M.M., The Dublin Declaration on Maternal Health Care and Anti – Abortion Activism. Health Hum. Rights, 2017, 19 (1), 41 – 53.

preeclampsia, chorioamnionitis, and HELLP syndrome lifesaving treatment that involves the mother and child' should be performed. Mother's life is a guarantee of the unborn child's survival if the child is unable to live outside her organism.

If a physician does not separate mother and fetus, the mother and her baby will both die soon child. Separations done after viability are done to maximize the chances that both mother and child will live. Physician will make every effort to save the life of a preterm baby where possible. The death of the pre-viable child is foreseen but not desired.

It must be stressed that the death of a child as a result of medical intervention does not in itself save the life of the mother but rather is a tragic unavoidable consequence. If a doctor could save her child, he would do so. It must also be made clear that killing her fetus (intentional feticide) is not a mother's life saving treatment. Elective induced abortion or direct abortion has nothing to do with saving a woman's life,

These two types of intervention should be distinguished from each other and not mixed, consciously or unconsciously. The first is a medical procedure that is part of health and life care, while the second is prenatal homicide, dangerous to the physical and mental health of the mother and sometimes her life.

In the years since the US Supreme Court's decision reversing Roe v. Wade a number of misinformations regarding abortion have made. Dr Kim Hardey said that doctors are still free to protect the lives of their patients, because elective abortion has never qualified as living – saving medical care.¹⁰ Dr Joseph Meaney published recently at The National Catholic Bioethic Centre the paper entitled: „A false charge against Catholic Health Care”. He says that ”Catholic health care principles mean striving to save both patients if possible, saving only one if only that can be achieved and never directly killing a patient in any case” and that „it is vital to keep in mind that direct abortion is not a medical treatment” .¹¹

On September 2012 there was in Poland a death of a mother with a septic miscarriage in the 22nd week of pregnancy. 30-year-old patient was admitted to a hospital because of a loss of amniotic fluid. The patient was given an antibiotic but died as a result of septic shock. According to the liberal media, the doctors were afraid to undertake medical intervention due to the fear of being held legally liable for having an abortion ("freezing" law effect). This was due to the changes in the abortion law, following the verdict of the

¹⁰ https://www.nola.com/opinions/article_b86f18d0-4ef7-11ed-b845-a735f44c49a6.html?mode=comments

¹¹ <https://www.ncbcenter.org/messages-from-presidents/a-false-charge-against-catholic-health-care>

Polish Constitutional Tribunal from October 22, 2020 which ruled that abortion because of a disease or developmental fault of the fetus ("eugenic abortion") is against the Constitution. Medical documentation was analysed by the court. The lawyers concluded that medical personnel taking care of the patient did not act correctly. The medical personnel did not diagnose the threat to the mother's life, and did not undertake proper actions, compliant with the common medical knowledge and the law. Lack of early detection of emerging sepsis caused a threat to mother's life.

Induction of miscarriage could have saved the mother's lives. Such a procedure must not be considered as an abortion, as the separation of the child from the mother would not have been intended to kill the child. In the aftermath of the death of the mother there was a lot of manipulation in the media, social turmoil, mass women's protests on the streets. There have been calls for a change in abortion law in Poland to make abortion more permissible. A similar clinical case caused protests in Ireland a few years ago and led to a change in abortion law. This has not happened in Poland. Abortion has been presented in a way that misleads the public as a life-saving procedure.

And in this case, the mother could have been saved not by abortion but by treating the patient according to medical standards. Contrary to the opinion of the protesters, it must be stated that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women. As a rule, a child's disease does not pose a threat to the mother's physical health.

Misrepresentation of the mother's life-saving procedure of separating the child from the mother, as an abortion subject to abortion law may result in the perception that doctors will be afraid to make reasonable clinical decisions in urgent cases.

5. Abortion as a medical procedure to „treat” mental and psychological problems of mothers during pregnancy.

In 2020, Poland's Constitutional Court banned abortion due to a disease or developmental defect of the child. The number of legal abortions taking place in Poland decreased by 90% in 2021 following this decision.¹² According to the opinion spread by liberal circles the new law threatens mother's mental health, as ban on eugenic abortion is supposed to be a torture for the mother, disruption her private life

The European Parliament condemned new Poland's abortion law, calling it a "de facto ban of abortion." Since changing this situation through a parliamentary act is impossible

¹² <https://www.catholicnewsagency.com/news/251949/poland-reduces-legal-abortions-90-percent-court-eliminates-exception-fetal-defects..>

due to the division of seats in the Parliament, the government has proposed a surrogate solution - abortion will be performed due to the mother's distress caused by the diagnosed disease or malformation of the unborn child.

Announced on 30/08/2024 The "Guidelines on Existing Legislation on Access to Abortion Procedure" attempt to circumvent existing legislation and repeal the constitutional guarantee of the right to birth of a human being conceived in the womb. They are contrary to the Code of Medical Ethics. They are to apply to all hospitals and, under the pretext of saving the health of women, to allow abortions due to psychiatric reasons regardless of the stage of the pregnancy. The guidelines recommend performing abortions not only in cases of stress caused by the child's illness, but in all situations when a pregnant woman is experiencing discomfort for any reason confirmed by a psychiatrist. It is known that information about conceiving a child is often the cause of fears, which quickly pass.

Gynaecologists are concerned that following the guidelines will result in birth following abortion of live full term or preterm children. The question is what to do with a live baby born after abortion? A national consultant who suggested that they should be transferred given neonatal intensive care if needed and then put up for adoption has been sacked by the Health Minister.

The practice in the West of intracardiac injecting a baby with potassium chloride to prevent a live birth has vivid references in Poland to World War II, when in concentration camps the Germans used this method to murder prisoners (St. Maximilian Kolbe).

There is pressure on gynaecologists, who are responsible for the health of the mother and her child, to perform an abortion immediately after showing them a certificate issued by a psychiatrist during a one-off, perhaps remote, visit. There seems to be a legitimate view that the promoted solutions are tantamount to abortion on demand, because the poor mental state of the mother during pregnancy can often be caused by difficult living conditions and personal situation. Abortion, defined as a strictly medical procedure, is to be used to solve problems of a non-medical nature

The Minister threatens gynaecologists that their attempts to seek the opinion of another doctor or to convene a consultation will end in being charged with restricting women's access to the state-guaranteed abortion procedure, while the woman's individual health situation may even impose this obligation on them. Draconian penalties are imposed on hospitals where doctors do not agree to perform abortions under these rules. The authorities of the Polish Psychiatric Society claim in Pilate's gesture that the psychiatrist

does not make the decision to terminate the pregnancy, that he is merely a consultant. They do not accept that the certificate he issues is in fact a death sentence for the child. A psychiatrist who gives a death sentence to a child will also burden his conscience with a high probability of serious health consequences of abortion in the mother

From the information available in the public sphere, it appears that in certificates issued by psychiatrists very often the diagnoses of 'adjustment disorders' in the mother were issued, which are so painful that they make continuation of pregnancy simply impossible. Meanwhile these are psychological states that occur in the life of every human being, and also appear in the course of the physiological pregnancy.

A psychiatrist's diagnosis that the pregnancy poses a risk to the mental health of the mother should be the basis for starting therapy to improve her mental state. Performing an abortion will make it worse. It is not the refusal of abortion but the abortion itself that constitutes risk to the mental health of the mother - depression, suicide attempts. There is an administrative pressure to modify strictly medical decisions concerning the health and lives of patients. This is the result of recognizing abortion as a medical procedure, in fact deadly and life-threatening.

Will the 'Guidelines' achieve their goal of increasing the number of abortions in Poland? Much depends on doctors, gynecologists and psychiatrists, their fidelity to the medical profession, their sense of responsibility and common decency.

6. Conclusions

I. Abortion cannot be treated as a medical procedure, as a method of treating obstetric complications. Directly killing the baby, because that is what abortion is, will not save a seriously ill mother.

II. Abortion is not a treatment for the psychological disorders that often accompany pregnant women.

III. Medical care facilities providing care during pregnancy should follow medical procedures aimed at preventing and treating illness and reducing suffering. Killing unborn children does not meet these criteria.

PROFESSIONAL AND ETHICAL CHALLENGES DURING THE COVID-19 PANDEMIC

Prof. Rok Čivljak, MD, PhD

University of Zagreb School of Medicine

Dr. Fran Mihaljević University Hospital for Infectious Diseases, Zagreb

The Croatian Catholic Medical Society, President

Mirogojska 8, 10000 Zagreb, Croatia

1. Introduction

The history of mankind is marked by numerous infectious diseases causing significant morbidity and mortality, including a great suffering. During the numerous epidemics, that sometimes escalated into pandemics, many people would fall ill at the same time, often with significant lethality, as has also been the case during the current COVID-19 pandemic. Owing to the specifics of caring for COVID-19 patients, the need for isolating the sick and dying, as well as limiting contact with them, healthcare workers found themselves confronting numerous medical, social and ethical challenges. Sometimes patients have been unjustifiably isolated from the society, without the possibility of contacting their loved ones, which has generated additional suffering and pain. Additionally, in order to prevent infection of a large number of people, possibly leading to the collapse of the healthcare system, very strict social isolation measures were introduced outside the healthcare institutions limiting freedom of social contacts. Besides professional medical care, millions of sick and dying patients also needed comfort, compassion and companionship that was an additional burden for healthcare workers.¹³ Western medicine, guided by the absolutized ideal of health and victory over death, predominantly oriented to a particular morphological, physiological and technological approach to diagnostics and treatment, has distanced itself from the human person missing to recognize the needs arising from the mental state of the sick and dying. We found ourselves facing the challenge of redefining the role of healthcare workers, even reviving the paradigm of holistic medicine that we have neglected over time. Therefore,

¹³ Čivljak R. Compassion in some medical disciplines: Infectious diseases and compassion. In: Defilippis V, van Ittersum FJ, Scardicchio AC, editors. Challenges of competence and compassion in contemporary medicine. Acta of the Symposium of the European Federation of Catholic Medical Associations (FEAMC); 2022 May 27–29; Assisi, Italy. Bari: Paginaria; 2023. p. 123–134.

the experience of the COVID-19 pandemic was an opportunity to restore medicine to its fundamental and original meaning by incorporating compassion into health care – caring for human being, not only his/her disease.¹⁴

2. COVID-19 pandemic timeline

In mid-December of 2019, a pneumonia outbreak erupted in China resulting in COVID-19 pandemic caused by SARS-CoV-2 with more than 777 million people fallen ill so far, of whom more than 7 million have died.¹⁵ Just try to imagine how many families lost their grandfathers and grandmothers, children lost their parents, brothers their sisters, and how many among the dead were our friends, colleagues, neighbors...

The COVID-19 epidemic caught the entire society, healthcare systems and healthcare workers unprepared. When a newly discovered disease started spreading in China, few people thought it would soon appear in Europe, and nearly no one considered the possibility of a pandemic of the magnitude that occurred during the past five years. What few predicted happened: an infectious disease changed social and economic relations, in a certain way, humanity as a whole, by penetrating into every pore of society.¹⁶

At the beginning of the pandemic, when we thought that nothing worse could happen, a natural disaster occurred in Croatia: on March 22, 2020, the citizens of Zagreb were awakened by an earthquake. In addition to extensive property damage, several hospitals had to be evacuated, including the University Hospital for Infectious Diseases where patients with COVID-19 were being treated. Let us recall the scene around our hospital, where the old and young, personnel and patients, SARS-CoV-2-positive and negative, were scattered on the grass and the parking lot, shivering from the cold and fear, asking for help from each other, and remembering His words: *Eli! Eli! Lama azavtani!* (My God, my God, why hast Thou forsaken me?). Unfortunately, another earthquake in the vicinity of Zagreb occurred several months later, with even greater property damage and more human victims, including psychological consequences that are still being revealed. This additional misfortune jeopardized the safety of all, especially the most vulnerable members of our society: children, the elderly and the sick. What was the role of health professionals at that time? We were expected to stay level-headed, muster all our strength,

¹⁴ Čivljak R. Can the compassion of health professionals save Western medicine: what can we learn from the COVID-19 pandemic? Glasnik HKLD. 2022;32(3):15–22.

¹⁵ World Health Organization. WHO COVID-19 dashboard [Internet]. [Accessed March 13, 2025]. Available at <https://data.who.int/dashboards/covid19/cases>

¹⁶ Čivljak R, Markotić A, Kuzman I. The third coronavirus epidemic in the third millennium: what's next? Croat Med J. 2020;61(1):1–4.

knowledge and skills, and provide our patients with the best possible, and sometimes impossible, level of care.¹⁷

On March 11, 2020, after more than 118,000 cases in 114 countries and 4,291 deaths, the World Health Organization declared COVID-19 a pandemic. At the beginning of the pandemic, emphasis was placed on primary prevention including containment and management of the spread of SARS-CoV-2 outbreaks through the use of non-pharmaceutical interventions that addressed different modes of transmission. Secondary prevention focused on early detection, rapid response and containment measures to limit the spread of virus once it has emerged and before it escalates into a full-blown pandemic. Tertiary prevention of pandemic aimed to mitigate long-term consequences, reduce morbidity and mortality, and promote recovery and resilience within affected communities.¹⁸

Many countries enforced lockdowns of varying stringency in response to the pandemic. Some included total movement control while others enforced restrictions based on time. Schools, universities and colleges closed either on a nationwide or local basis in 63 countries, affecting approximately 47% of the world's student population. The pandemic has led to the adoption of particular hygienic behaviors (e.g., wearing masks, washing hands) and discouraged certain daily practices (e.g., leaving home, shaking hands). Amid the worldwide lockdown and transition to online learning, students were most satisfied with the support provided by teaching staff and their universities' public relations. However, they were mainly concerned about their future professional career and studies, experiencing significant anxiety and frustration. Students with certain socio-demographic characteristics (male, part-time, first-level, applied sciences, a lower living standard, from Africa or Asia) were significantly less satisfied with their academic life during the pandemic, while female, full-time, first-level students and students faced with financial problems were more affected in terms of their emotional life and personal circumstances.¹⁹

The COVID-19 pandemic has made a significant impact on various supply chains. Initially, extreme shortages emerged in the personal protective equipment for healthcare

¹⁷ Čivljak R, Markotić A, Capak K. Earthquake in the time of COVID-19: The story from Croatia (CroVID-20). *J Glob Health*. 2020;10:010349.

¹⁸ Cilloniz C, Pericas JM, Čivljak R. Future perspectives: preventing the next pandemic. In: Chalmers JD, Cilloniz C, Cao B, editors. *COVID-19: An Update (ERS Monograph)*. Sheffield: European Respiratory Society; 2024. p. 300–320.

¹⁹ Aristovnik A, Keržič D, Ravšelj D, Tomaževič N, Umek L. Impacts of the COVID-19 Pandemic on life of higher education students: A global perspective. *Sustainability*. 2020;12(20):8438.

workers, diagnostic testing, equipment and staffing to provide care to seriously ill patients, and basic consumer goods disrupted by panic buying. These shortages left healthcare and frontline workers dangerously ill-equipped to care for COVID-19 patients, due to limited access to all supplies, including gloves, medical masks, respirators, goggles, face shields, gowns, and aprons. Although shortages of personal protective equipment were found in most countries, no significant impact on infection rate was found among healthcare workers.²⁰

Due to the rapid increase in the number of patients and deaths, and the inability to find appropriate specific treatment, the process of licensing new drugs and vaccines against COVID-19 has been accelerated, although already existing advanced technology has been used. At the very beginning of the pandemic, three medications – chloroquine phosphate, hydroxychloroquine sulfate, and remdesivir – have been granted emergency use authorization for the treatment of COVID-19.²¹ However, while subsequent research showed that the first two drugs were ineffective, remdesivir was the first one to receive approval for use in adult and pediatric patients for the treatment of patients with severe disease requiring hospitalization.²²

Soon after, emergency use authorization was issued for the first COVID-19 vaccines that met the high standards for safety, effectiveness, and manufacturing quality required of an approved product.²³ As a messenger RNA (mRNA) vaccines, based on novel platforms with previously unregulated aspects of manufacturing, some serious concerns about the safety and effectiveness raised in the public, especially if such vaccine derived mRNA can be reverse transcribed into DNA with a risk of insertion into the human genome. New DNA insertion into the human genome would be a serious concern if it happens on the level of stem cells of the reproductive system. Although such suspicions have not been confirmed, actions like silencing dissenting voices, coupled with policy decisions often reliant on assumptions rather than robust experimental data, may have inadvertently

²⁰ Kroneman M, Williams GA, Winkelmann J, Spreeuwenberg P, Davidovics K, Groenewegen PP. Personal protective equipment for healthcare workers during COVID-19: Developing and applying a questionnaire and assessing associations between infection rates and shortages across 19 countries. *Health Policy*. 2024;146:105097.

²¹ Ison MG, Wolfe C, Boucher HW. Emergency use authorization of remdesivir: The need for a transparent distribution process. *JAMA*. 2020;323(23):2365–2366.

²² US Food and Drug Administration (FDA). FDA news release: FDA approves first treatment for COVID-19 [Internet]. [Accessed March 13, 2025]. Available at <https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-covid-19>

²³ US Food and Drug Administration (FDA). FDA news release: FDA approves first COVID-19 vaccine [Internet]. [Accessed March 13, 2025]. Available at <https://www.fda.gov/news-events/press-announcements/fda-approves-first-covid-19-vaccine>

undermined both science and public confidence. To rebuild trust, it is crucial to return to the fundamental principles of scientific inquiry.²⁴

3. COVID-19 and maternity

Since the onset of the COVID-19 pandemic, the consequent lockdown and other social changes brought about by the pandemic, the question of the possible impact on women's health and maternity immediately arose. In addition, particularly severe cases of COVID-19 were observed in young and previously healthy women during their pregnancy with numerous and various unfavorable outcomes for both the mother and child. Therefore, many questions have arisen, such as: if SARS-CoV-2 affects the pregnancy of an individual pregnant woman; if COVID-19 pandemic generally affects the fertility and birth rate of the population; are there indications for the increased protection of women against the SARS-CoV-2 with the aim of protecting motherhood and future generations; what about the possible impact of certain medicines and vaccines against SARS-CoV-2 on the outcome of pregnancy and the health of the offspring.²⁵

In most women during and following pregnancy, the clinical feature of COVID-19 is similar to those in non-pregnant women, with some minor exceptions. Approximately 70-80% women who become infected with SARS-CoV-2 during pregnancy will develop asymptomatic infection, and the majority of those who do become symptomatic will only ever experience mild to moderate symptoms. However, natural physiological adaptation to pregnancy results in changes to the immune and respiratory systems, cardiovascular function, and coagulation, which may in turn affect the progression of COVID-19. It has been shown that pregnant women have a higher incidence of severe COVID-19, as well as the need for admission to the intensive care unit (ICU) and mechanical ventilation, and death, than infected non-pregnant women of the same age.^{26,27}

²⁴ Igyártó BZ, Qin Z. The mRNA-LNP vaccines - the good, the bad and the ugly? *Front Immunol.* 2024;15:1336906.

²⁵ Čivljak R. COVID-19 and maternity. *Glasnik HKLD.* 2022;32(4):31–39.

²⁶ Collin J, Byström E, Carnahan A, Ahrne M. Public Health Agency of Sweden's brief report: Pregnant and postpartum women with severe acute respiratory syndrome coronavirus 2 infection in intensive care in Sweden. *Acta Obstet Gynecol Scand.* 2020;99(7):819–822.

²⁷ Chinn J, Sedighim S, Kirby KA, Hohmann S, Hameed AB, Jolley J, et al. Characteristics and outcomes of women with COVID-19 giving birth at US academic centers during the COVID-19 pandemic. *JAMA Netw Open.* 2021;4(8):e2120456.

SARS-CoV-2 infection among pregnant women and women in labor is associated with a higher risk of maternal mortality or morbidity caused by obstetric complications.^{28,29} In a US retrospective study among 14,000 women, pregnant women infected with SARS-CoV-2 had a significantly higher incidence of a composite outcome of maternal death or serious morbidity related to hypertensive disorders of pregnancy, postpartum hemorrhage, or non-COVID infections compared to uninfected pregnant women. The risk of complications was higher in pregnant women with severe COVID-19.³⁰

Unfortunately, the incidence rates of SARS-CoV-2 infection in pregnant women, as well as health outcomes for mothers and children, have been shown to vary significantly across the world, depending on economic and underlying social differences. A study conducted in Italy showed that pregnant women with COVID-19 were more likely to be <35 years of age, foreign women, unemployed, or living with an unemployed partner.³¹ The highest infection rates were observed in Latin America and the Caribbean and in lower-middle-income countries. Lower-middle-income countries had significantly higher rates of maternal mortality, ICU admissions, and stillbirths compared to high-income countries.³² When all the psychological and social effects of the COVID-19 pandemic are added to the usual vulnerability of women during and following pregnancy, an increase in the negative psychosocial effects of the pandemic was to be expected. During the pandemic, an increase in depression and anxiety was observed in women following pregnancy, highlighting the need for increased screening and interventions for the prevention of peripartum mood disorders and anxiety. In women who gave birth during the pandemic, the average incidence of depression and anxiety was significantly higher compared to

²⁸ Badr DA, Mattern J, Carlin A, Cordier AG, Maillart E, El Hachem L, et al. Are clinical outcomes worse for pregnant women at ≥ 20 weeks' gestation infected with coronavirus disease 2019? A multicenter case-control study with propensity score matching. *Am J Obstet Gynecol*. 2020;223(5):764–768.

²⁹ Lokken EM, Huebner EM, Taylor GG, Hendrickson S, Vanderhoeven J, Kachikis A, et al. Disease severity, pregnancy outcomes, and maternal deaths among pregnant patients with severe acute respiratory syndrome coronavirus 2 infection in Washington State. *Am J Obstet Gynecol*. 2021;225(1):77.e1–77.e14.

³⁰ Metz TD, Clifton RG, Hughes BL, Sandoval GJ, Grobman WA, Saade GR, et al. Association of SARS-CoV-2 infection with serious maternal morbidity and mortality from obstetric complications. *JAMA*. 2022;327(8):748–759.

³¹ D'Ambrosi F, Iurlaro E, Tassis B, Di Maso M, Erra R, Cetera GE, et al. Sociodemographic characteristics of pregnant women tested positive for COVID-19 admitted to a referral center in Northern Italy during lockdown period. *J Obstet Gynaecol Res*. 2021;47(5):1751–1756.

³² Sheikh J, Lawson H, Allotey J, Yap M, Balaji R, Kew T i sur. Global variations in the burden of SARS-CoV-2 infection and its outcomes in pregnant women by geographical region and country's income status: a meta-analysis. *BMJ Glob Health*. 2022;7(11):e010060.

women who gave birth before the pandemic.³³ A higher proportion of women with psychosocial problems arising in connection with pregnancy and childbirth during the pandemic was associated with the introduction of social distancing measures. In a study conducted in the United Kingdom in mid-2020, as many as 11.4% of women developed depression in the first three months after giving birth, and 18.4% developed anxiety. However, using the Edinburgh Postnatal Depression Scale and the Spielberger State-Trait Anxiety Inventory, even 43% of women had clinically significant postpartum depression, and even 61% had clinically significant anxiety.³⁴

The COVID-19 pandemic has also negatively impacted female fertility and birth rates. Nine months after the pandemic began, birth rates have begun to decline in many developed countries. In Italy, birth rates fell by more than 21% in December 2020 compared to the previous year.³⁵ In the United States, the largest decline in birth rates was among those living in higher socioeconomic status.³⁶ Study investigating the impact of the first wave of the pandemic on birth rates in 24 European countries showed that 10 months after the onset of the pandemic (and the first lockdown), an average decrease in the number of live births of 14% was observed compared to 2018 and 2019. The only variable associated with this phenomenon was the duration of the lockdown, while the factor that influenced the reduction of this unwanted effect was a higher national income per capita. Although the number of births rebounded in the following months in many countries, it seems that in most countries it failed to compensate the previous decline in birth rates. The negative demographic impact of the pandemic was all the greater as the mortality rate increased at the same time which resulted in a further decline in the natural increase rate.³⁷

³³ Zhang CXW, Okeke JC, Levitan RD, Murphy KE, Foshay K, Lye SJ i sur. Evaluating depression and anxiety throughout pregnancy and after birth: impact of the COVID-19 pandemic. *Am J Obstet Gynecol MFM*. 2022;4(3):100605.

³⁴ Fallon V, Davies SM, Silverio SA, Jackson L, De Pascalis L, Harrold JA. Psychosocial experiences of postnatal women during the COVID-19 pandemic. A UK-wide study of prevalence rates and risk factors for clinically relevant depression and anxiety. *J Psychiatr Res*. 2021;136:157–166.

³⁵ Kearney MS, Levine P. The coming COVID-19 baby bust: Update. 2020 December 17 [Accessed March 04, 2025]. Available at <https://www.brookings.edu/blog/up-front/2020/12/17/the-coming-covid-19-baby-bust-update/>

³⁶ Silverman ME, Sami TJ, Kangwa TS, Burgos L, Stern TA. Socioeconomic disparity in birth rates during the COVID-19 pandemic in New York City. *J Womens Health (Larchmt)*. 2022;31(8):1113–1119.

³⁷ Pomar L, Favre G, de Labrusse C, Contier A, Boulvain M, Baud D. Impact of the first wave of the COVID-19 pandemic on birth rates in Europe: a time series analysis in 24 countries. *Hum Reprod*. 2022;37(12):2921–2931.

Although vertical transmission of SARS-CoV-2 itself, as well as a direct prenatal effect of SARS-CoV-2 on the child during pregnancy, has rarely been confirmed,³⁸ SARS-CoV-2 is not regularly found in the placenta³⁹ nor it may be transmitted to infants by breastfeeding⁴⁰. However, maternal immune activation during pregnancy could negatively affect the development of the child, including altered offspring neurodevelopment, as has been confirmed in the case of other prenatal infections. Namely, recent research shows that infection with the SARS-CoV-2 during pregnancy also causes immune activation of the mother, placenta and fetus, which could ultimately result not only in undesirable effects on the pregnant woman but also in neurodevelopmental consequences for the offspring. Children born to mothers who experienced such immune activation during pregnancy are at increased risk of various diseases and conditions, such as attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, anxiety, depression, cognitive disorders, learning disabilities, and even schizophrenia.⁴¹ Therefore, it is necessary to monitor other possible long-term effects of COVID-19 on children conceived, born, and raised during the pandemic, as there is a possibility that such long-term effects may also occur in the case of SARS-CoV-2 infection.

Considering all the previously mentioned possible effects of SARS-CoV-2 infection, COVID-19, and the entire pandemic on women during and following pregnancy, as well as the possible short-term and long-term negative impacts on children born to mothers who have contracted COVID-19, it is essential to implement all necessary preventive measures to prevent severe forms of COVID-19 during pregnancy and after childbirth, as this also prevents possible adverse effects on children. In the first waves of the pandemic, when a larger proportion of the population was uninfected and immunologically naive to SARS-CoV-2 infection, mandatory mask-wearing and limiting access to health facilities for pregnant women and women in labor were necessary to reduce the risk of acquiring the infection. However, with the advent of the first vaccines against SARS-CoV-2, we have obtained a safe and effective measure to prevent the occurrence of infection, and

³⁸ Jeganathan K, Paul AB. Vertical transmission of SARS-CoV-2: A systematic review. *Obstet Med.* 2022;15(2):91–98.

³⁹ Mourad M, Jacob T, Sadovsky E, Bejerano S, Simone GS, Bagalkot TR, et al. Placental response to maternal SARS-CoV-2 infection. *Sci Rep.* 2021;11(1):14390.

⁴⁰ Chambers C, Krogstad P, Bertrand K, Contreras D, Tobin NH, Bode L, et al. Evaluation for SARS-CoV-2 in breast milk from 18 infected women. *JAMA.* 2020;324(13):1347–1348.

⁴¹ Shook LL, Sullivan EL, Lo JO, Perlis RH, Edlow AG. COVID-19 in pregnancy: implications for fetal brain development. *Trends Mol Med.* 2022;28(4):319–330.

more importantly, to prevent the progression to severe COVID-19 requiring hospitalization and ICU treatment. Vaccination reduces the risk of developing COVID-19 and reduces the severity of the disease if the infection does occur, and all available data indicate the safety of the use of currently available vaccines against SARS-CoV-2 before, during and after pregnancy.⁴²

Prevention and treatment of COVID-19 in pregnant and postpartum women do not differ significantly from that in non-pregnant individuals. However, it is recommended that pregnant women be treated in institutions that are competent in providing specialized multidisciplinary care that includes appropriate monitoring of both mother and child. It is important to emphasize that pregnant and breastfeeding women should not be denied some forms of prevention (including vaccination) or treatment due to hypothetical suspicion of possible adverse effects.⁴³⁴⁴⁴⁵⁴⁶ Compared to placebo, most of the SARS-CoV-2 vaccines approved by the FDA and EMA have reduced the risk of symptomatic infection in clinical studies, such as BNT162b2 (BioNtech/Fosun Pharma/Pfizer) by 97.8%, mRNA-1273 (ModernaTx) by 93.2%, ChAdOx1 (Oxford/AstraZeneca) by 70.2%, Ad26.COV2.S (Janssen) by 66.9%, while for some there is high-certainty evidence that they reduce the risk of severe or critically ill disease. There is little or no difference in the occurrence of serious adverse events between most vaccines and placebo.⁴⁷

However, post-marketing safety monitoring of vaccines has shown that they cause some side effects that were not detected in clinical studies, such as myocarditis, pericarditis, vaccine-induced thrombotic thrombocytopenia or Guillain-Barré syndrome.⁴⁸ However,

⁴² Graña C, Ghosn L, Evrenoglou T, Jarde A, Minozzi S, Bergman H, et al. Efficacy and safety of COVID-19 vaccines. *Cochrane Database Syst Rev.* 2022;12(12):CD015477.

⁴³ Centers for Disease Control and Prevention. Consideration for inpatient obstetric healthcare settings [Internet]. [Accessed December 22, 2022]. Available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html>

⁴⁴ The American College of Obstetricians and Gynecologists. COVID-19 FAQs for obstetrician-gynecologists, obstetrics [Internet]. [Accessed December 22, 2022]. Available at <https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics>

⁴⁵ Society for Maternal-Fetal Medicine. Publications & Clinical Guidance [Internet]. [Accessed December 22, 2022]. Available at <https://www.smfm.org/covidclinical>

⁴⁶ National Institutes of Health. COVID-19 Treatment Guidelines Panel. Coronavirus disease 2019 (COVID-19) treatment guidelines [Internet]. [Accessed December 18, 2022]. Available at <https://files.covid19treatmentguidelines.nih.gov/guidelines/covid19treatmentguidelines.pdf>

⁴⁷ Graña C, Ghosn L, Evrenoglou T, Jarde A, Minozzi S, Bergman H, et al. Efficacy and safety of COVID-19 vaccines. *Cochrane Database Syst Rev.* 2022;12(12):CD015477.

⁴⁸ Centers for Disease Control and Prevention. Selected adverse events reported after COVID-19 vaccination [Internet]. [Accessed January 18, 2023]. Available at <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html>

the use of vaccines against COVID-19 has also raised some controversies resulting in vaccine hesitancy, partly due to unfounded claims that vaccines can adversely affect the reproductive health of women and future generations, and partly due to their moral unacceptability because some of them are produced using human cell cultures obtained from aborted fetuses.⁴⁹ A review on the ethical aspects of vaccination and their relationship to the doctrine of the Catholic Church has been published in which all examples of vaccines and the moral justification of their use are clearly argued.⁵⁰ Namely, back in 2005, the Pontifical Academy for Life declared itself in favor of the use of the aforementioned vaccines, explaining that the use of these vaccines is morally permissible if there is no formal participation in evil, that is personal consent, if there are no alternative vaccines, and if their non-use could cause a serious risk to the health of children and the entire population.⁵¹ The Congregation for the Doctrine of the Faith also took the same position on COVID-19 vaccines, emphasizing that vaccination must be voluntary, and to those who do not vaccinate, it conveyed the importance of responsible behavior and implementing all other forms of prevention.⁵²

Research has shown that maternity restrictions during pregnancy and childbirth at the beginning of the pandemic have also negatively affected the experiences of fathers in several ways. The exclusion of fathers (e.g. during prenatal care and childbirth) produced feelings of isolation and a sense of loss, the inability to create an initial bond between father and child, and the absence and lack of closeness of the husband/father also had a detrimental effect on the mental health of pregnant women and mothers. However, the new living conditions during the pandemic, especially working from home, increased the presence of fathers in the first months of a child's life and subsequently provided an opportunity to build a more intensive parental relationship for fathers and a closer long-term connection between father and child, compared to pre-pandemic conditions.⁵³

⁴⁹ Domazet-Lošo T. mRNA Vaccines: why is the biology of retroposition ignored? *Genes* (Basel). 2022;13(5):719.

⁵⁰ Richter D. Ethical aspects of immunization. In: Duncan LT, editor. *Advances in health and disease*. Volume 42. New York, USA: Nova Science Publishers, Inc.; 2021. p. 53–104.

⁵¹ Pontifical Academy for Life Statement of 2005. 2019. Moral reflections on vaccines prepared from cells derived from aborted human foetuses. *The Linacre Quarterly*. 2019;86(2–3):182–187. [Accessed March 5, 2025]. Available at

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6699053/pdf/10.1177_0024363919855896.pdf

⁵² Congregazione per la Dottrina della Fede. Nota sulla moralità dell'uso di alcuni vaccini anti-COVID-19 (21/12/2020.) [Internet]. [Accessed March 5, 2025]. Available at

https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20201221_nota-vaccini-anticovid_it.html

⁵³ Andrews K, Ayers S, Williams LR. The experience of fathers during the COVID-19 UK maternity care restrictions. *Midwifery*. 2022;113:103434.

The impact of the COVID-19 pandemic on the health of the population will last for a very long time, and according to some predictions, it could be felt well into the 22nd century.⁵⁴ Both the infection caused by the SARS-CoV-2, as well as some epidemic-prevention measures, have had a negative impact on the health of the population, especially mothers and children. It is expected that some of these impacts will also affect child development, including early childhood, puberty and adolescence. Therefore, a comprehensive review of the effects of COVID-19 and the pandemic, as well as the long-term effects on children conceived, born and raised during the pandemic, is important for understanding and possibly mitigating the adverse effects.

4. COVID-19 and compassion

Compassion is not just an understanding of a person's needs and suffering but also something more. Compassion motivates people to do their best to alleviate the physical, mental, or emotional pain of others and themselves. However, compassion does not just involve "feeling for the other" but also the desire to alleviate the suffering of others. And among healthcare professionals, this includes not only medical treatment, but also offering oneself to others as brothers, like the Good Samaritan, and ultimately, like Jesus Christ himself (*Christus Medicus*).⁵⁵

Can compassion help in the treatment of patients, but also help healthcare professionals themselves? Research in this area is growing rapidly in recent years, thanks to magnetic resonance imaging and other high-tech methods in order to "understand the brain to understand the mind".⁵⁶ Medical care that includes compassion is associated with greater patient compliance and better treatment outcomes. Compassion has a positive effect on healthcare workers, as it affects the lower incidence of burnout and greater satisfaction among them. Therefore, some medical schools have implemented programs for studying compassion in their curricula, either as core or elective courses. Compassion should be a virtue that we learn in medical school, just as we learn how to perform a thorough physical examination.⁵⁷

⁵⁴ Mentis AA, Paltoglou G, Demakakos P, Ahmed F, Chrousos GP. Could COVID-19's aftermath on children's health be felt into the 22nd century? *Children (Basel)*. 2022;9(4):482.

⁵⁵ Čivljak R. Can the compassion of health professionals save Western medicine: what can we learn from the COVID-19 pandemic? *Glasnik HKLD*. 2022;32(3):15–22.

⁵⁶ Weiner S. Can compassion help heal patients — and providers? 2019 Nov 19 [Accessed March 6, 2025]. Available at <https://www.aamc.org/news-insights/can-compassion-help-heal-patients-and-providers>

⁵⁷ Patel S, Pelletier-Bui A, Smith S, Roberts MB, Kilgannon H, Trzeciak S, et al. Curricula for empathy and compassion training in medical education: A systematic review. *PLoS One*. 2019;14(8):e0221412.

In the midst of the COVID-19 pandemic, the European Federation of Catholic Medical Associations (FEAMC) organized a conference "The challenges of competence and compassion in contemporary medicine" in Assisi, Italy. At the conclusion of the Conference, Prof. Msgr. Jacque Suaudeau, ecclesiastical assistant of the FEAMC, emphasized the importance of holding the conference and its title precisely at the time of the pandemic. "The very title given to the Assisi symposium is significant. If compassion is the virtue and the way forward for the Christian doctor today, in order to move away from technical and impersonal medicine "for the disease" and find the way back to medicine "for the patient", professional competence is an integral part of compassion. There is no true compassion if there is no professional competence." Pope Francis says it very well: "In today's hurry, amidst a thousand errands and constant worries, we are losing the ability to be moved and to feel compassion, because we exhaust this return to the heart". Between these two opposing tendencies – the illusory dream of transhumanism and the reality of the scarcity of means – the Christian doctor must make his way in the service of patients in imitation of Jesus himself. A key virtue for him is compassion, compassion for the sick person, compassion for the patient's family, despite all obstacles. For the Church, this goal of compassion in the medical field should become a pastoral priority.⁵⁸

5. COVID-19 and healthcare workers

Only human is aware that he shares the same ultimate fate with all living things – *All of life has a beginning and end!* This human orientation towards death has dramatically come to the fore during this pandemic. In this pandemic, death does not happen by chance since many people die, including people close to us. Therefore, COVID-19 has confronted us with the realization that we are disposable, mortal. People have become aware that they are an “endangered species”, although the technological and scientific progress of medicine has instilled in them a belief in indestructibility, almost immortality.⁵⁹ At the beginning of the pandemic, the dignity of dying was also called into question. A person often died alone, sometimes without a dignified farewell to what had been his body until recently, which was sometimes not even dressed but “packed” in a bag. There was no

⁵⁸ Defilippis V, van Ittersum FJ, Scardicchio AC, editors. Challenges of competence and compassion in contemporary medicine. Acta of the Symposium of the European Federation of Catholic Medical Associations (FEAMC); 2022 May 27–29; Assisi, Italy. Bari: Paginaria; 2023.

⁵⁹ Šestak I, Čivljak R. Phenomenology of the effects of COVID-19 and a review of two year experience in Croatia. In: Koprek I, editor. The pandemic, economy and business ethics. Zagreb: University of Zagreb Faculty of Philosophy and Religious Studies / Center for Business Ethics; 2023.

dignified funeral either, but everything took place only in the circle of a few closest people who themselves lived in fear of the virus catching them too. Both the farewell and the mourning process in the pandemic were deprived of their natural course and noble psychological medicine. Despite the progress of science and technology, providing adequate health care to life-threatening patients suffering from infectious diseases requires an additional dimension: an ethical approach that goes beyond mere science, professional competence and technical skills.⁶⁰

However, not only during the COVID-19 pandemic, but also during previous pandemics, many healthcare workers have been shown to suffer from various forms of stress related to working with more demanding patients, occupational exposure to infection in the workplace, infection-related stigma, or the many challenges associated with the physical, mental, and social condition of patients. It is therefore necessary to increase institutional support for healthcare workers and develop training programs to improve their skills in addressing these challenges, leading a healthy lifestyle, and developing self-compassion. The same could apply to healthcare workers during the COVID-19 pandemic.⁶¹

During previous epidemics, such as the recent one in Africa caused by the Ebola virus, healthcare workers did not hesitate to provide health care to the sick even at the cost of their own lives. Then, and during the COVID-19 pandemic, providing high-level healthcare, such as intensive care, meant exposing healthcare workers to efforts and self-denials that could have resulted in endangering their own lives. This opened up new questions about determining the boundaries of the professional and the moral. Healthcare workers in these situations had a double obligation: to provide patients with maximum healthcare for the purpose of recovery and survival, while at the same time preventing the transmission of infection to themselves and others (other healthcare workers, members of their families, the wider environment in which they moved).⁶²

During the COVID-19 pandemic, entire families fell ill: grandparents, fathers and mothers, brothers and sisters, husbands and wives, and even children. Sometimes, several members of the same family died in just a few days, which must have left a mark on the

⁶⁰ Čivljak R. Can the compassion of health professionals save Western medicine: what can we learn from the COVID-19 pandemic? *Glasnik HKLD*. 2022;32(3):15–22.

⁶¹ Tong H, Zhou Y, Li X, Qiao S, Shen Z, Yang X, et al. Stress coping strategies and their perceived effectiveness among HIV/AIDS healthcare providers in China: a qualitative study. *Psychol Health Med*. 2022;27(4):937–947.

⁶² Petrosillo N, Čivljak R. Ebola virus disease: A lesson in science and ethics. In: Koporc Z, editor. *Ethics and integrity in health and life sciences research Vol 4*. Bingley, UK: Emerald Publishing Limited; 2018, p. 33–45.

healthcare workers who cared for them. In the solitude of hospital isolation, patients were often infused with spiritual strength by physicians and nurses – sometimes the only ones with whom the patients had the opportunity to communicate – which gave an unexpected new dimension to the profession of healthcare worker.

Even religiosity itself has been put to the test during the COVID-19 pandemic. Namely, spiritual activities that believers carry out with priests in the auspices of sacred spaces (liturgical celebrations, baptisms, confessions, communions, confirmations, pilgrimages, weddings and funerals) came into question with the declaration of a lockdown due to which joint worship, gatherings, mass celebrations were interrupted. Even more drastic was the deprivation of access to the sacraments of those who were in greatest need: the sick and the dying, especially those who were separated from their loved ones in isolation units in hospitals and faced COVID-19 and death straight in the eye. The sick rightly asked themselves: where are those clergymen, hospital chaplains?⁶³

During the pandemic, the Church used modern media channels to broadcast sermons and liturgical celebrations. These broadcasts kept the spiritual community of believers together. However, problems remained with the sacraments of confession, the Eucharist and the anointing of the sick, and the understanding of priestly life during the pandemic. Prof. Ivan Bodrožić, clergyman of the Croatian Catholic Medical Society, published a practical monograph on the pandemic and its consequences, a theological-spiritual analysis of the situation in the Church and its activities during the pandemic in Croatia. In three chapters – *Confession as a victim of the COVID-19 pandemic*, *The Eucharist as a victim of the COVID-19 pandemic* and *The Priest as a victim of the COVID-19 disease* – he presented the problems related to the activities of the Church during the pandemic. His thoughts on the crucial meaning of the Eucharist will certainly bear fruit in the future.⁶⁴

At a time when healthcare workers were expected to make up for all the shortcomings of epidemiological measures, etiological treatment, and poorly planned dynamics of vaccination coverage, and when they were the only hope for patients from whom help (and even compassion) was expected – from whom should healthcare workers expect even the slightest dose of compassion: from employers, bosses, colleagues, family

⁶³ Šestak I, Čivljak R. Phenomenology of the effects of COVID-19 and a review of two year experience in Croatia. In: Koprek I, editor. The pandemic, economy and business ethics. Zagreb: University of Zagreb Faculty of Philosophy and Religious Studies / Center for Business Ethics; 2023.

⁶⁴ Bodrožić I. The Church in Vortex of COVID-19 Pandemic. Split: Crkva u svijetu; 2021.

members, society and the public, or from the patients themselves? Therefore, under the influence of overexertion from excessive work, an extraordinary lifestyle and selfless giving, healthcare workers themselves have become in need of compassion. These extraordinary demands on healthcare workers have become particularly evident during the COVID-19 pandemic. Healthcare workers sometimes require emergency assistance when confronting such challenges. Therefore, *Code Lavender*, so-named for lavender's calming effects, has been launched to support healthcare workers in crisis situations. The support protocol can be activated at any time for healthcare workers, patients and members of their families by a single phone call. Support is achieved through physical presence, thereby demonstrating an interest in helping, warm beverages and snacks, all the way to individual or team conversations, supplemental psychological and/or pharmaceutical therapy, or even prayers and spiritual assistance. Intervention can be performed by a trained individual or often by an entire multidisciplinary team, which includes a social worker, psychologist, member of the clergy and other trained personnel. The specific manner of implementing such intervention can vary from institution to institution but the fundamental principle is the same: providing immediate and holistic care at moments of increased stress or emotional need while fostering a culture of care and support focused on the well-being of healthcare workers. In some institutions, permanent interdisciplinary *Code Lavender Teams* have already become integral components of a coordinated form of spiritual, emotional and psychological support for healthcare workers, often involving priests and hospital chaplains as essential team members who provide holistic care not only to patients but also to medical personnel. Perhaps the introduction of *Code Lavender Teams* could raise awareness of the psychological and spiritual needs of the healthcare workers in the healthcare system, enhance the role of the clergy and promote an interdisciplinary holistic approach to caring for the needs of healthcare workers.⁶⁵

6. Lesson for the future

The experience of the COVID-19 pandemic was an emergency during which healthcare professionals found themselves facing numerous professional and ethical challenges. Although it was difficult to respond to all these challenges, and many questions still remain unanswered, perhaps the pandemic was supposed to consolidate Catholic doctors in promoting a holistic, integrative approach to medicine, while incorporating compassion

⁶⁵ Čivljak R. Is the time ripe for the introduction of the Code Lavender in Croatia? *Glasnik HKLD* 2023;33(4):19–24.

into health care, in order to return medicine to its true original meaning – caring for the person, not just for their illness. This could restore the lost trust of patients in Western medicine, and by scientifically-based integration of compassion into technologically advanced methods of practicing modern medicine, improve today's medical practice – improve patient care and treatment outcomes, while at the same time increasing patient satisfaction and trust.

On the occasion of the 30th World Day of the Sick, on February 11, 2022, Pope Francis published a message entitled “Be merciful, even as your Father is merciful” (Lk 6:36), which encourages us, above all, to turn our gaze towards God, who is “rich in mercy” (Eph 2:4), who always watches over his children with a father’s love, even when they turn away from him. “When individuals experience frailty and suffering in their own flesh as a result of illness, their hearts become heavy, fear spreads, uncertainties multiply, and questions about the meaning of what is happening in their lives become all the more urgent. How can we forget, in this regard, all those patients who, during this time of pandemic spent the last part of their earthly life in solitude, in an intensive care unit, assisted by generous healthcare workers, yet far from their loved ones and the most important people in their lives? This helps us to see how important is the presence at our side of witnesses to God’s charity, who, following the example of Jesus, the very mercy of the Father, pour the balm of consolation and the wine of hope on the wounds of the sick.”⁶⁶

On 8th December, 2020, on the 150th anniversary of the proclamation of St. Joseph as Patron of the Universal Church, the Holy See published an Apostolic Letter of Pope Francis entitled *Patris Corde* (With a Father’s Heart).⁶⁷ The background to the Apostolic Letter was the COVID-19 pandemic, which, as Pope Francis writes, has helped us to understand the importance of ordinary people, people often overlooked, daily demonstrate the virtue of patience, offer hope in others and encourage responsibility. Pope Francis’s letter *Patris corde* seems to speak of healthcare workers: a multitude of humble and self-denying people who first chose the arduous and demanding path of becoming a

⁶⁶ Pope Francis. Message of his holiness pope Francis for the thirtieth world day of the sick. February 11, 2022 [Internet]. [Accessed March 14, 2025]. Available at https://www.vatican.va/content/francesco/en/messages/sick/documents/20211210_30-giornata-malato.html

⁶⁷ Pope Francis. Apostolic Letter *Patris corde*. December 8, 2020 [Internet]. [Accessed March 14, 2025]. Available at https://www.vatican.va/content/francesco/en/apost_letters/documents/papa-francesco-lettera-ap_20201208_patris-corde.html

physician, nurse, pharmacist or dentist, because the studies for these professions are the most demanding and time-consuming, and then to study for the rest of their lives, because pursuing these professions inevitably requires lifelong learning, and ultimately serving humanity in its most difficult moments: illness, hardship, suffering and death. Moreover, healthcare workers often have to be in contact with the entire family of their patient, listen to their stories, offer them advice, a warm word, and paternal care. The healthcare workers become like a father, like Saint Joseph, the one on whom the survival of the entire family depends.

Patients need physician who are both professional and compassionate. These qualities are important for providing appropriate care to patients with infectious diseases, but also in general. Moreover, a physician cannot act alone. A physician needs other to provide satisfactory care, but also to remain healthy, satisfied, and professional. Therefore, interdisciplinary teams are what medicine should strive for in the future. And along with the physician, the nurse, and other healthcare personnel, a clergyman – spiritual assistant, should definitely be part of that team because he understands the spiritual needs of the patient, but also of the healthcare professionals.

BEAUTY THAT SAVES: ETHICS AND AESTHETICS

Antonia Covarrubias Noé



Born in Santiago de Chile, 1972. Studied Economics and Administration at the Pontificia Universidad Católica de Santiago. After some years, she began her studies of art and architecture at the Finis Terrae University in Santiago de Chile, finalizing with a postgraduate course of interior design at Rome (2003-2005) in the Istituto Europeo di Design. She developed her artistic career with solo and collective exhibitions, mainly in Rome during the following years, while she worked as the secretary of Fiamc at the Vatican (2007-2008). Married with three children, she recently studied a Master in History of Architecture at Birkberk University, London, where she is currently living. Her main exhibitions include, "Guardando L'Oriente" at the Primo Municipio (Rome 2006), "Deshojando el Sur_ India" (with the Embassy of India in Chile, at the Museo Lord Cochrane, Valparaíso 2011), biennale Manifesta (Palermo 2018), "Contemplazione" with the Embassy of Chile in Italy (2020) and others.

In his encyclical *Dilexit nos*⁶⁸, the Holy Father speaks of the heart as the place of encounter with God, with Christ, where our human feelings unite with God's divine Love. There we experience comfort, closeness, and tenderness—encompassing us if we allow ourselves to be so embraced. He shows us that mercy is greater than justice, and that beauty surpasses contemplative reason. In this way, God enlightens us, brings us joy,

⁶⁸ Encyclical Letter *Dilexit nos* of the Holy Father Francis on the Human and Divine Love of the Heart of Jesus Christ, Oct 24, 2024.

elevates our spirit, and helps us transcend ourselves. Through beauty, art plays a fundamental role in the life of each person and society, orienting us toward a higher good in an unexpected and marvelous way. It also heals our wounds through the joy that imparts an inexplicable sense of satisfaction, something we discover when we come face to face with something—or someone—we recognize as truly beautiful.

Art in its fullest sense—expressed through music, painting, sculpture, poetry, or architecture—has been deeply affected by rationalist and deconstructionist influences for centuries. It is not uncommon in art classrooms to find a purely subjective definition of beauty, with some declaring the concept outdated or obsolete, and others viewing it as a luxury not accessible to those who suffer. Consequently, art often becomes a utilitarian object serving political or social messages, evaluated mostly on how “current” or “practical” it might be. Alternatively, some voices claim that only “classical” or “realistic” language can be deemed genuinely beautiful, dismissing modern and contemporary expressions altogether.

Yet when one truly seeks beauty, art and its ultimate purpose go far beyond the particular language or form employed. Classical works were not always flawless, and not all contemporary art is “ugly.” So where is the key? Artists and philosophers have spent centuries searching for an answer—a quest in which spirituality and religion hold crucial insights.

The Gothic and the Search for Light

Looking at specific eras in art history, it was perhaps during the Gothic age (reaching its height in the 12th and 13th centuries) that the desire for spiritual union and contemplation through human endeavor was most intensely felt. Originating in France and spreading especially across northern Europe, Gothic builders devised groundbreaking construction techniques to create sublime spaces in which to worship God. These efforts integrated significant philosophical ideas, such as the theory of light and color. The Franciscans who arrived in England, for instance, frequently drew on St. Augustine and St. Anselm to guide them in building and beautifying churches and abbeys, with the aim of glorifying God in tangible form.

St. Augustine of Hippo (ca. 351–430) taught that God is the Light illuminating Truth (a concept later developed by St. Thomas Aquinas), underscoring that eternal truths become visible to human reason only through God’s light—always leaving an infinite distance between humanity and its Creator. St. Anselm of Canterbury (ca. 1033–1109) reaffirmed that one must believe in order to understand, and that God must dwell first in the mind to

comprehend reality. Hence, faith was indispensable in this pursuit of happiness through created things—and beauty, in turn, was pivotal in this search, for it made us happy in God. Such happiness can uplift the soul and even the body, effectively “saving” us and redeeming reality.



Saint Peterborough Cathedral, England, photo courtesy of the author.

Robert Grosseteste (ca. 1168–1253) mysticism of light was famously expressed in the stained-glass windows of Lincoln Cathedral. Around the same era, Hildegard of Bingen (ca. 1098–1179) described the “shadow of the Living Light,” reminding us that our frail humanity cannot fully perceive the divine Epiphany but only an “eclipsed” reflection of its radiant grandeur. Meanwhile, the Cistercians led by St. Bernard (ca. 1090–1153) championed a more austere mystical beauty, opting for simpler lines and fewer decorations so as not to overwhelm, thereby fostering more profound encounters with God’s light. Their debate with Abbot Suger (ca. 1081–1151), who lavishly remodelled the Abbey of Saint-Denis, concluded with Suger promising St. Bernard that his community’s lifestyle would be as austere as that of the Cistercians.

The intellectual riches of the Gothic world shifted with the Renaissance and Baroque eras, in a dynamic tug of war over how much to focus on human feelings and aspirations. The question of defining beauty remained open, but when Claude Perrault translated Vitruvius’s *Treatise* in 1671, under the Royal Academy of Architecture, rationalism firmly took root. Perrault identified two ways of understanding art—“positive” and

“arbitrary”—and thereby set the stage for functionalism. Sir Roger Scruton, in *The Symbolic Order*, sums up these seismic changes in aesthetic thought:

“...aesthetics, conceived as a systematic branch of philosophy, is an invention of the eighteenth century. It owes its life to Shaftesbury, its name to Baumgarten, its subject-matter to Burke and Batteux, and its intellectual eminence to Kant. ... In Schiller’s *Letters on Aesthetic Education*, the newly discovered faculty of aesthetic judgment is given the sacred task that was once laid on the shoulders of religion ... In Hegel’s *Lectures on Aesthetics* art is presented as the successor to religion, an all-embracing form of consciousness in which the truth of the world, at a certain point of spiritual development, is most perfectly distilled.”⁶⁹

Meanwhile, Europe retained a powerful communal memory of the great Gothic cathedrals, built collectively with anonymous craftsmanship, where each participant felt they had a share in that monument to the glory of God. Later eras attempted to recover this sense of unity and redemption through art—visible in England’s Gothic Revival of the 18th and 19th centuries, with architects like Augustus Pugin, notable religious conversions, and John Ruskin’s *The Seven Lamps of Architecture* (1849). Ruskin championed a moral approach to design that connected the perception of forms and materials with tangible social and spiritual benefits. By the century’s close, William Morris and the Arts and Crafts movement aimed to return art-making to the people, letting everyone create beauty in workshops and trades inspired by nature.

This “Gothic mysticism” also resonated in the turbulent modern era. Against corruption and spiritual emptiness, Modernist architects—many affiliated with the Bauhaus school—debated the place of spirituality in the arts. Their 1919 manifesto, featuring Lyonel Feininger’s woodcut of a Gothic cathedral on its cover, highlighted an aspiration that transcended mere functionality. Walter Gropius (ca. 1883–1969) often declared that only a religious mindset could foster good art, while the socialist Adolf Behne wrote in 1919:

“It seems to me the most important thing is to build an ideal house of God—not one limited to a particular denomination, but a religious work. Without the reawakening of religiosity we cannot move forward.”⁷⁰

⁶⁹ The Symbolic Order, Roger Scruton, Chapter 3, page 22.

⁷⁰ Alexander Nagel, *Medieval Modern*, chapter 18, page 242.



Eltham Palace interior, 1930's art deco, Bromley, London. Photo courtesy of the author.

From Rationalism to Edith Stein

This drive to rescue society through architecture found a champion in Le Corbusier (ca. 1887–1965), who sought to design entire cities as a means of redeeming people through well-designed urban spaces. He tried to totally decipher the language of beauty through lines, harmony, and mathematics, expanding on Leonardo da Vinci's Vitruvian idea of proportion. Meanwhile, under communist ideologies, rationalist approaches to architecture and housing gained traction. Buildings were expected to prioritize function and materials over aesthetics; people, it was thought, did not need beauty as urgently as they needed shelter. Thus, art and beauty were left to poetry and other forms of expression that followed very different paths to achieve happiness: through hedonism or politics, they sought an answer to fulfil the soul. Around 1930, the Czech architect and poet Karol Teige (ca. 1900-1951) presented in Moscow his proposal of "Minimum Dwelling", where buildings would be communal, and in order for women to have their independence, children would live in shared spaces overseen by designated caregivers.



Barbican Centre, 1982, City of London.

Brutalist architecture style, photo courtesy of the author.

Movements such as Art Nouveau and German Expressionism, however, introduced new ideas about emotional life and art, with Wilhelm Worringer (ca. 1881–1965) emphasizing *Einfühlung* (“empathy”) as a way to understand how our feelings mold and reflect artistic creations. His exploration of organic and inorganic forms encouraged a variety of new artistic expressions, including abstraction.

Against this backdrop, Edith Stein’s work offered a fresh perspective on how we appreciate beauty, distinguishing objective and subjective dimensions while affirming the decisive role of feeling. In her *Science of the Cross* (1950), Stein situates the object (the work of art or a landscape) in relation to the person (the subjective aspect)—evoking Plato’s allegory of the cave, where we strive to see truth and beauty yet never fully grasp their entirety. In *Finite and Eternal Being*, she further describes our ascending movement toward God, a spiritual journey in which beauty can serve as a guiding light.



Land's End, Cornwall, England.

Important tourist landscape, photo courtesy of the author.

If rightly ordered, beauty and art help us transcend our daily reality and glimpse God's presence. If they are missing or distorted, however, we move in the opposite direction. Ugliness—like evil—manifests in unmistakable ways: no one would call a war-ravaged city “beautiful,” and many would readily agree that certain natural landscapes *are* beautiful. While most of life exists in the nuanced space between these extremes, our emotional life remains strongly affected by our surroundings; we naturally seek out pleasing, uplifting places to restore our spirit. Indeed, beauty has that “mysterious something” going beyond our natural order—an otherworldly reward that astonishes us when we experience it. Pope Benedict XVI observed that artists often realize their finished work transcends them, penetrating the soul and conveying a deeper redemption. Here, suffering and sacrifice can also enter the scene, as Christians place them at the foot of the Cross: Christ's redemptive act becomes the pinnacle of transcendence and spiritual ecstasy.

“A first awareness that beauty has to do with pain is undoubtedly present even in the Greek world. ... Plato views the encounter with beauty as that healthy emotional shock that causes a person to leave himself behind, to be ‘inspired’ ... Memory and longing induce the search, and beauty tears us away from everyday comfort. It makes us suffer. ... The arrow of longing strikes a person, wounds him, and thereby gives him wings, raising him on high.”⁷¹

⁷¹ Joseph Ratzinger, Speech for the Meeting of Rimini with Communion and Liberation, 2002.

Today, in a rapidly shifting world that often relegates beauty to a secondary role, we can draw inspiration from these converging strands—Gothic mysticism, rationalist innovation, and modern attempts to unite the spiritual with the everyday. As you pause to reflect on the art, architecture, or music around you, consider how each expression might serve as a bridge between the material and the sacred. In experiencing genuine beauty—whether in a soaring cathedral or a humble, heartfelt creation—you open yourself to something greater than mere utility or fleeting pleasure. You allow yourself to be “wounded” in the best sense: stirred by longing, uplifted with hope, and reminded that in seeking beauty, you are ultimately seeking the Truth that redeems and gives life.

LE RÔLE DE LA FAMILLE ET DE LA MORALE DANS LA SOCIÉTÉ

Gábor Fejérdy



Je suis né en 1951 à Budapest (Hongrie) et j'ai terminé mes études en 1975 à la faculté de médecine de l'université médicale Semmelweis, où j'ai obtenu un diplôme de médecine générale, puis je me suis spécialisé en orthopédie et en chirurgie traumatologique. J'ai travaillé dans le service de traumatologie orthopédique du principal hôpital de Budapest jusqu'en 1993. J'ai pu réaliser la première replantation réussie d'une main en 1989.

Après le changement de politique, ma femme et moi avons créé une fondation pour améliorer l'accès au traitement des patients souffrant de troubles musculo-squelettiques dans les zones rurales (Kismaros). Depuis lors, cette fondation gère la clinique médicale cistercienne de Kismaros. J'ai été et je suis toujours le directeur médical de cette institution depuis 1993.

Je me suis mariée en 1975 et nous avons eu cinq enfants. Les deux fils aînés se sont mariés, le troisième est prêtre catholique depuis 20 ans, notre fille aînée s'est mariée et notre plus jeune est moine au monastère cistercien de Kismaros, moine à vœux perpétuels depuis 15 ans. Nous avons onze petits-enfants.

Depuis 1991, j'ai été président de l'association Saint-Luc des médecins catholiques hongrois pendant douze ans.

Depuis 1988, je suis oblat du monastère cistercien de Kismaros, où je me suis engagé avec mon épouse.

La protection de la nature est aujourd'hui une préoccupation majeure dans le monde entier. Le réchauffement du climat et les catastrophes naturelles ont choqué de nombreuses personnes, et la responsabilité de l'humanité et de la société dans ces changements est de plus en plus pointée du doigt. Des tentatives ont été faites dans le monde entier pour trouver les causes de ces évolutions et inverser ces tendances. Mais peut-être devrions-

nous nous poser la question d'une relation entre ces évolutions et le comportement, la morale des familles, la plus petite communauté de la société. La vision d'une surpopulation mondiale, le développement inégal de sa population, la réduction drastique de la population dans certaines régions et son augmentation dans d'autres, peuvent provoquer des perturbations sociales et économiques. Dans le même temps, la croissance de la population mondiale devrait s'arrêter ou diminuer au tournant du siècle.

Les lois de la nature comprennent non seulement les lois directes de la science, mais aussi les lois morales. De même que les lois élaborées par les hommes dans la société sont conçues dans un certain but, pour régler, pour protéger, les lois de la nature et de la morale sont conçues pour régler, pour protéger le monde, la nature et l'homme. Le fait d'obéir aux lois, de les respecter, permet en général de vivre en sécurité. Respecter la loi, vivre selon elle, c'est surtout une aide à la vie. Par exemple, le code de la route est là pour protéger la vie et les biens. De la même manière, le respect des lois morales permet de vivre en toute sécurité. Les lois morales sont globales et s'appliquent non seulement à l'individu, mais aussi à la communauté et, en tant que plus petite communauté, à la famille. Si nous ignorons les lois qui ne dépendent pas de nous (la nature, la morale), nous en subissons immédiatement les conséquences. Par exemple, si quelqu'un ignore la loi de la gravité et la loi de la chute libre, et enjambe la balustrade d'un balcon d'un immeuble élevé, il risque de subir des blessures graves ou mortelles à la suite de son acte.

Parfois, ce n'est qu'après une longue période, des années ou des décennies, que nous constatons que nous avons ignoré ces lois, comme l'histoire du monde l'a prouvé à maintes reprises, en développant des situations catastrophiques de plus ou moins grande ampleur. Si les progrès scientifiques et techniques dans la compréhension du monde physique et vivant ont connu un développement exponentiel, il n'en est pas de même du développement moral de l'homme, au niveau tant individuel que communautaire, qui se révèle presque incapable de relever les nouveaux défis.

L'individu et la communauté, qui sont les deux faces d'une même médaille, ne peuvent exister l'un sans l'autre. La famille (et sa structure naturelle : homme, femme, enfant) est la plus petite unité qui représente et réalise la communauté dans le monde, dans la création.

La famille est une communauté spéciale, une communauté d'amour entre l'homme et la femme (puis l'enfant), une communauté qui est la base de la continuité physique, spirituelle et mentale de la vie, en termes d'aujourd'hui, de la réalisation du caractère

durable de la vie. C'est un grand honneur d'être non seulement partie prenante de la création, mais aussi collaborateur.

La famille est une forme de vie librement consentie par les individus - où l'homme et la femme, créés en tant qu'homme et femme, tout en conservant leurs différences physiques (corporelles) et spirituelles (mentales), sont capables de s'unir et de ne faire qu'un. Ils y parviennent lorsqu'ils s'efforcent de vivre la voie du triple amour, c'est-à-dire l'harmonie de l'amour de Dieu, de l'amour du prochain (des autres personnes) et de l'amour de soi. Mais cela n'est possible que lorsque l'homme et la femme, les époux, s'acceptent mutuellement, se donnent l'un à l'autre avec respect et dignité, et que leur amour est orienté vers un amour central commun, enraciné dans l'amour de Dieu.

C'était le cas dans les siècles précédents, mais aujourd'hui l'importance de la famille est de plus en plus remise en question. Le large éventail des possibilités techniques, la connaissance croissante et de plus en plus précise des lois biologiques permettent à l'homme d'influencer, de modifier et, dans certains cas, de déformer les fonctions naturelles et physiologiques, et lui donnent les moyens de le faire.

Tant que les possibilités physiques et mentales sont adaptées aux lois de la nature, elles peuvent être adoptées et utilisées avec une grande joie. Cependant, il n'est pas rare que nous soyons confrontés à des informations erronées et à des résultats scientifiques incertains, ou encore à l'ignorance. D'autres fois, les questions matérielles, les idées fausses ou les valeurs erronées déforment la réalité. Cette distorsion est encore exacerbée par tout ce qui, à notre époque, nous coupe de la réalité. À la crise des valeurs s'ajoute une crise de crédibilité. Cette situation crée inévitablement de l'incertitude dans le monde des générations futures et une confusion identitaire.

Avec l'augmentation de la vitesse et des possibilités de transport, les distances spatiales ont été réduites et, avec l'utilisation du web, les informations vraies et fausses sont indistinctement et presque instantanément accessibles. Ainsi, la connaissance (souvent superficielle) et le mélange de différents courants intellectuels (matérialisme, libéralisme, etc.) et de cultures constituent un terreau supplémentaire pour l'incertitude, qui en est la conséquence

„une conception théorique et pratique erronée de l'indépendance des conjoints entre eux; de graves ambiguïtés à propos du rapport d'autorité entre parents et enfants; des difficultés concrètes à transmettre les valeurs, comme bien des familles l'expérimentent; le nombre croissant des divorces; la plaie de l'avortement; le recours sans cesse plus

fréquent à la stérilisation; l'installation d'une mentalité vraiment et proprement contraceptive. » (Familiaris Consortio)

La communication entre les personnes se fait de plus en plus par des moyens techniques, même au sein de la famille, car le temps dont disposent les membres de la famille pour se rencontrer face à face a progressivement diminué. Le foyer, qui est censé être un lieu de repos et de convivialité, est remplacé par la maison, qui n'est qu'un lieu, un toit.

Dès la petite enfance, les enfants sont placés en institutions, l'école maternelle est obligatoire dans la plupart des endroits, puis l'école, le sport, la musique, occupent les plus grands. Le temps de travail des parents s'est accru, il y a donc rarement une table partagée, un repas partagé, qui jouerait un rôle majeur dans la transmission des valeurs, des normes morales, des comportements et de l'expression d'un service mutuel.

De plus en plus de personnes, à la recherche de leur propre place - en raison de l'influence de l'environnement externe décrit ci-dessus - ont le sentiment d'être quelqu'un lorsqu'elles « se réalisent ». Par conséquent, la carrière professionnelle devient d'une importance primordiale, car elle donne un sentiment d'appartenance et d'identité. Ce sentiment est encore renforcé par l'attrait de l'argent et le sentiment que les possessions matérielles peuvent tout faire. Avec l'attitude consumériste, encouragée par les médias et le commerce, il est facile de se débarrasser des choses, de remplacer ce qui ne nous sert plus. La loyauté, l'attachement dans le bon sens du terme, sont donc considérés comme inutiles, et cela s'applique non seulement aux objets, mais aussi au conjoint. Par intérêt personnel, souvent associé à la recherche du confort, l'individu considère son partenaire, les membres de sa famille, comme des rivaux.

Une famille le devient réellement avec l'arrivée d'un enfant, ou de plusieurs enfants. Parfois, les couples mariés considèrent la procréation comme un obstacle dans leur vie et n'hésitent pas à recourir à des solutions immorales comme l'avortement. D'autres fois, ils veulent compenser l'absence d'enfant à tout prix, en choisissant (de même) des méthodes qui sont aussi paradoxalement opposées à la vie, comme par exemple, l'insémination artificielle.

Il est naturel qu'au sein des couples, l'égoïsme (carrière), la possessivité (besoin d'argent, besoin d'enfants), le confort (être servi et ne pas être dérangé), conduisent à des conflits, voire à de la violence (tous les jours). Dans un tel environnement familial, les valeurs et la morale des enfants sont déformées par l'exemple donné, elles ne se développent pas sainement et les lois morales sont relativisées. Un tel exemple corrompt davantage la génération suivante, entraînant une crise morale et sociale de plus en plus grave, ce qui

conduit finalement à des problèmes démographiques et économiques pour les nations et le monde.

Tout comme nous devons trouver des solutions aux changements pathologiques de la nature provoqués par l'homme, nous devons également trouver des solutions aux défis qui se posent de plus en plus dans la société et dans la famille. Ce n'est pas impossible si nous trouvons un moyen d'adapter les lois de la nature et de la morale à notre époque, de les interpréter et de les appliquer d'une manière compréhensible et appropriée.

Le respect des lois de la nature est également important pour les familles, compte tenu de la différence naturelle fondamentale entre l'homme et la femme, qui n'est pas seulement une différence physique, mais aussi une différence précieuse dans la manifestation de la vie.

Les lois inscrites dans le cœur de l'homme depuis des milliers d'années, comme les dix commandements de l'Ancien Testament, concernent directement l'homme, quelle que soit sa religion ou sa croyance : respect, sainteté de vie, pureté de la sexualité, droit aux biens matériels qui assurent la subsistance, pureté et vérité dans la communication, pureté dans le mariage, vie selon les vrais sentiments, pensées et désirs (cf. Ex 20) (Mt 5).

Nous trouvons dans *Familiaris Consortio* l'exhortation suivante :

„Il est donc nécessaire que tous reprennent conscience du primat des valeurs morales: elles sont celles de la personne humaine comme telle. La compréhension du sens ultime de la vie et de ses valeurs fondamentales est le grand défi qui s'impose aujourd'hui en vue du renouvellement de la société. Seul le sentiment du primat de ces valeurs permet d'utiliser les immenses possibilités mises par la science dans les mains de l'homme de manière à promouvoir vraiment la personne humaine dans sa vérité tout entière, dans sa liberté et dans sa dignité. La science est appelée à s'unir à la sagesse.”

C'est un grand défi et une tâche pour les familles et la société que d'éduquer les générations suivantes selon ces valeurs morales. Un rôle important à cet égard est joué par la préparation et la vie authentique des hommes et des femmes en tant que communauté familiale, afin qu'en tant que petite communauté, ils puissent transmettre la stabilité morale qui constituera la base d'une réponse adéquate aux défis des temps à venir. «Les parents, parce qu'ils ont donné la vie à leurs enfants, ont la très grave obligation de les élever et, à ce titre, ils doivent être reconnus comme leurs premiers et principaux éducateurs. Le rôle éducatif des parents est d'une telle importance que, en cas de défaillance de leur part, il peut difficilement être suppléé. C'est aux parents, en effet, de créer une atmosphère familiale, animée par l'amour et le respect envers Dieu et les

hommes, telle qu'elle favorise l'éducation totale, personnelle et sociale, de leurs enfants. La famille est donc la première école des vertus sociales dont aucune société ne peut se passer» (Concile Vatican II)

Il incombe à la société, à la communauté dans son ensemble, de fournir le cadre économique, social et spirituel nécessaire pour aider les familles. Il revient à la famille, en tant que plus petite cellule de la société, de construire celle-ci au service de la vie.

„La situation historique dans laquelle vit la famille se présente donc comme un mélange d'ombres et de lumières. Ce mélange montre que l'histoire n'est pas simplement un progrès nécessaire vers le mieux, mais un avènement de la liberté, et plus encore un combat entre libertés qui s'opposent, c'est-à-dire, selon l'expression bien connue de saint Augustin, un conflit entre deux amours: l'amour de Dieu, poussé jusqu'au mépris de soi; l'amour de soi, poussé jusqu'au mépris de Dieu(16). Il s'ensuit que seule l'éducation de l'amour enracinée dans la foi peut conduire à acquérir la capacité d'interpréter les «signes des temps», qui sont l'expression historique de ce double amour. «(*Familiaris Consortio*) C'est le début de la lutte contre les tendances morales pathologiques et nuisibles et de la construction d'une véritable vie durable.

LIMITACIÓN DE LA NATALIDAD Y ABORTO

Javier Garralda Alonso.



Economista y teólogo

Introducción

Pueden parecer dos temas dispares, pero lo son menos si consideramos que ambos son un ataque a la vida: uno, la limitación de natalidad, ataque de corte ideológico que pretende que no nazcan niños por motivos diversos; y otro, el aborto provocado, que suprime al ser humano concebido, con una u otra excusa.

En cuanto al primero, podemos afirmar que en casi todo el mundo asistimos a un invierno demográfico: En muchos países no se alcanza la tasa de reposición de la población y mueren más personas que las que nacen. Se dice que pronto será muy difícil mantener las pensiones de nuestros mayores. Y, en vez de optar por políticas que alienten la natalidad, se extiende una niebla perniciosa que intenta dar razones económicas a la limitación de la natalidad.

Por desgracia, de modo acrítico, no faltan voces que defienden una nueva vigencia de la fracasada y pesimista teoría de Malthus, que con un análisis objetivo veremos que es falsa: No es cierto que la población no pueda crecer por falta de alimentos. Y veremos cómo en una economía en crecimiento, la mejora del nivel de vida medio por persona, resulta compatible con el incremento de la población. Además, cabe esperar que las dotes innovadoras de nosotros los humanos puedan lograr un crecimiento respetuoso con el medio ambiente y la salvaguarda de la naturaleza.

En cuanto al segundo, la deriva antinatalista recurre a un medio de control de natalidad salvaje. Hay países con niveles de natalidad mucho más bajos que la tasa de reposición de la población, que al menos la alcanzarían si no se produjeran abortos. Y este carácter salvaje al que aludimos se demuestra cuando constatamos con la biología en mano, como no puede ser de otro modo, que el aborto es suprimir la vida de un ser humano distinto de la madre gestante, un ser único e irrepetible al que no se permite nacer. Aparte de la

víctima física, el niño concebido, existe además una víctima moral, la madre que aborta, que arrastrará trauma y remordimientos. Otra víctima físico-moral es Dios mismo. Mas no se debe desesperar porque la misericordia del Señor no tiene límites para quien se arrepiente sinceramente.

Limitación de la natalidad. Teoría de Thomas R. Malthus y su desmentido.

Razones económicas

Fue el economista inglés Thomas R. Malthus quien, a finales del siglo XVIII, popularizó la idea de que los frutos de la tierra crecerían a menor ritmo que el aumento de la población.

Según Malthus la producción de alimentos crecería en progresión aritmética (2, 4, 6, 8, 10, 12) mientras que la población lo haría en progresión geométrica (2, 4, 8, 16, 32, 64). Y cada nuevo trabajador en la tierra agrícola produciría menos (a partir de cierto momento), supuesto que permaneciera constante el factor tierra, hasta llegar al momento en que el nuevo trabajador agrario no produciría prácticamente nada más, y los nuevos nacidos no podrían producir lo necesario para subsistir, por lo que morirían de hambre. Y esta mortandad se encargaría (simplificando el argumento) de mantener la población estancada, sin que pudiera crecer por falta de alimentos.

Pero en el año 2007 la población mundial llegó a más de 6000 millones de personas. Y se constata su crecimiento en los siguientes años: En 2024 alcanzó los 8200 millones. Y ha crecido desde 1958 en 2000 millones. Se prevé que sólo en el año 2080 comenzaría a declinar (?). De modo que, gráficamente, se estima que la población era seis veces mayor en 2007 que la de la época de Malthus (finales del siglo XVIII). Si hubiera sido cierta su teoría, este meteórico crecimiento de la población sencillamente no hubiera sido posible. Por falta material o física de alimentos para subsistir. Y eso que apenas crecen las nuevas tierras cultivables...

Y para que este espectacular aumento de la población sea posible es preciso que la producción por nuevo trabajador agrícola sea constante o creciente. Más aún si se tiene en cuenta que disminuye el porcentaje de trabajadores dedicado al sector agrario. Esta afirmación puede suscitar perplejidad o extrañeza: ¿no es acaso cierto que si el resto de factores productivos, la tierra, permanecen constantes, la nueva unidad de factor trabajo, el nuevo trabajador, producirá – a partir de cierto punto – cada vez menos?

Pero la respuesta es que sólo aparentemente permanece fijo el factor tierra, ya que incorpora de año en año un capital biotecnológico mayor y así será cada vez más fértil. Y éste es un aspecto que Malthus ni tan solo consideró. Pero que en los últimos decenios es

algo patente: nuevas semillas con rendimientos muy superiores, irrigación más eficaz, antiparasitarios, abonos mejores, maquinaria agrícola que multiplica la eficacia del trabajador, cultivos transgénicos, etc. De modo que ya resulta creíble que la producción por nuevo trabajador sea o constante o creciente.

Y ello viene confirmado en el solvente libro de Amartya Sen y Jean Drèze, “Hunger and Political Action”, Oxford 1989, Cuadro 2.3. Según sus datos, la producción de alimentos por persona, per cápita, aumenta a medida que pasan los años. Así, la producción de alimentos por persona creció un 2% en el conjunto de países desarrollados y en un 5% en el conjunto de países pobres, en desarrollo, a lo largo de cinco años (crecimiento de la media de 1986-8 sobre la media de 1981-3). O según otros datos, a lo largo de diez años, creció un 3% en el conjunto de países desarrollados y en un 11% en el conjunto de los países en desarrollo, o pobres (media de 1986-8 sobre media 1976-8). Es decir que, incluso en el conjunto de los países pobres creció la producción de alimentos por persona. Se exceptúan algunos países en guerra.

Y ello significa que, si un trabajador de la tierra produce cada vez más alimentos, entonces a medida que aumenta la población mejorará el nivel de vida medio en el aspecto alimentario: tocará a más alimentos por persona. Puede suceder, sin embargo, que, debido a una distribución injusta de los alimentos, incluso en el interior de los países pobres, haya sectores de la población que padezcan hambre crónica o aguda, pero en cifras globales hay alimentos para todos y la providencia no falta, aunque el misterio de la libertad humana, que el Señor respeta y no modifica por sus inescrutables designios, la maldad de los hombres, puede frustrar que todos vivan desahogadamente.

En verdad, largos decenios han contemplado, al menos en Occidente, cómo incremento de la población y mejora del nivel de vida medio han coexistido. Y ello es más claro aún para el sector industrial, en que resulta más evidente que la incorporación de capital multiplica lo producido por trabajador. Y la idea simplista de que “cuantos más seamos a menos tocará a cada uno” sólo se podría referir a una situación de estancamiento, sin incremento de producción. Y es que, con rendimientos crecientes, por incorporación de capital tecnológico, cada vez tocará a más a cada uno.

Pero algunos economistas agoreros repiten el error de Malthus y auguran que para el año 2050 no habrá suficientes alimentos para una población creciente y no consideran que el mismo Malthus hizo un presagio pesimista desmentido por los hechos, ya que le parecía impensable que la tierra aumentara su fertilidad como sucede por la incorporación de capital tecnológico, como demuestra la multiplicación por más de 6 de la población

mundial desde su época, a finales del siglo XVIII. Y estos pesimistas de nuestro tiempo piensan que es increíble que la inventiva humana propicie un progreso tecnológico adicional.

Otros profetas de desgracias, que pueden ocasionar una catástrofe humanitaria, serían aquéllos que sostienen que no tenemos que aspirar al crecimiento de la economía o que incluso preconizan su decrecimiento, basándose en la peregrina idea de que el crecimiento perturbaría el medio ambiente y al resto de seres vivos que no son el hombre. También aquí asistimos a un pesimismo sobre la capacidad humana, su inventiva y creatividad, para armonizar y hacer compatibles crecimiento y respeto y cuidado, o incluso mimo, de la naturaleza.

Razones de Fe

Frente a este pesimismo, que en el caso de Malthus ha resultado desmentido por los hechos, ¿qué nos dice la Fe? Respecto a la escasez de alimentos el Evangelio pregunta (Mt 6, 25-34): “... ¿No es la vida más que el alimento? ...” Y viene a decir que Dios, quien nos ha dado la vida, con mayor razón no dejará de procurarnos el alimento. Y respecto a la incompatibilidad entre desarrollo y respeto al medio ambiente, nos dice la Biblia (Gn 2, 15) que Dios encomendó al hombre, aún inocente, el cuidado del jardín del Paraíso “para que lo cultivase y cuidase”. Si el Señor pide además del cultivo del jardín su cuidado, es que fertilidad de la tierra, con el trabajo humano, y su cuidado son compatibles, pues Dios no mandará algo sin proporcionar al hombre los medios para realizarlo.

El aborto. O cómo el concebido es distinto individuo humano que la gestante.

Medio de control de natalidad de hecho

En países en que el número de defunciones es mayor que el de nacimientos, el aborto actúa como medio de control de natalidad supletorio o de hecho. Por ejemplo, en España el número de nacimientos en el año 2023 fue sólo de 322.075 y el de defunciones alcanzó 433.163. Mientras que el de abortos “voluntarios” fue de 103.097. De modo que, si no se produjeran abortos provocados, la cifra de nacimientos, prácticamente igualaría a la de defunciones, con lo que la población se mantendría constante, alcanzando al menos la tasa de reposición.

Razones biológicas que muestran que el concebido es distinto ser humano que la gestante

Apuntemos que el aborto es, de hecho, un medio de control de natalidad, que resulta particularmente salvaje y cruel, pues consiste en la eliminación de un ser humano distinto de la madre gestante:

Para justificar el aborto se aduce que el concebido es parte del cuerpo de la gestante. La propia Kamala Harris, candidata demócrata a la presidencia de los Estados Unidos y acérrima abortista, con toda claridad afirmaba que la mujer tiene derecho a hacer lo que quiera con su propio cuerpo, dando por verdad que el feto forma parte del cuerpo de la embarazada.

Ciertamente el concebido está alojado en el cuerpo de la madre. Pero un dedo de la madre tiene en sus células impreso el ADN de la madre. En cambio, el ADN del concebido es característico y diferente del de la madre y del del padre. Su código genético, su carnet biológico, es distinto y diferenciado, mostrando así que no se confunde con el organismo de la gestante. Y si está alojado en el cuerpo de la madre, ello no le da derecho a ésta a matarlo, como si se tratara de sacarse una muela. Por el hecho de alojar a un viajero no se está facultado para eliminarlo. El buen sentimiento natural de la mujer le inclina, en cambio, a custodiar al concebido con cariño maternal.

También confirma que el concebido es un ser distinto de la gestante otro hecho biológico: Cuando se produce un embarazo, el organismo de la gestante segrega una sustancia hormonal dirigida a evitar el rechazo del feto, como si de un cuerpo extraño se tratara (rechazo análogo al que suscitaría un trasplante de órgano de otra persona donante). Y ello significa que, en ausencia de dicha secreción hormonal, la embarazada experimentaría un rechazo orgánico a un cuerpo extraño, lo que confirma que el feto no es el propio organismo que la madre.

Razones de Fe

Para un creyente, además de la evidencia biológica, y sin desechar la intuición que experimentan muchas mujeres encintas de que lo que late en sus entrañas es su hijo, se dan razones de Fe para concluir que el concebido es persona: tiene ya alma.

En la propia Sagrada Escritura, en el evangelio de San Lucas, pasaje de la Visitación (Lc 1, 39-44) asistimos a la interacción, o diálogo mudo, de dos concebidos aún no nacidos: Jesús concebido en el seno de María y Juan Bautista, concebido en las entrañas de Isabel, a quien la Virgen viene a visitar: “En cuanto he oído tu voz (dice Isabel a María) saltó el niño de alegría en mi seno” (Lc 1, 44). Y Juan contaba con 6 meses de vida (Lc 1, 36-37), mientras que Jesús que fue concebido en la Anunciación contaría sólo con días, pues María tras dicha anunciación fue “con presteza a la montaña...” (Lc 1, 39) a casa de Isabel, a Ain Karen que dista como 3 ó 4 días de camino (M.J. de Ágreda en la antigua revelación privada del siglo XVII, “Mística Ciudad de Dios” nos dice que Jesús tenía 8 días cuando María, con Él en su seno, visitó a Isabel).

Y los entendidos creen que fue esa presencia humana del Niño Dios la que hizo saltar de alegría a Juan y experimentar una santificación precoz (a su padre Zacarías se le había dicho que ese niño “será lleno del Espíritu Santo desde el seno de su madre”) (Lc 1, 15). Y veamos la nota 3 (a Lc 1, 40) en la Biblia Nácar-Colunga: “María lleva en su seno al Santificador de los hombres, el cual hace sentir sus efectos en Isabel y el fruto de su vientre (Juan B.) por una santificación prematura”.

De modo que la persona de Jesús (Dios hecho hombre) actúa y ya está presente a los pocos días de ser concebido y lo mismo cabe decir de la persona de Juan Bautista que se alegra ya existe a los 6 meses de su concepción.

Y esta relación sin palabras entre ambos concebidos aún no nacidos ya nos muestra que ambos actúan o sienten, que ya son personas, que ya tienen alma infundida (Jesús, como verdadero hombre, además de Dios). Por eso eliminar antes de nacer a un concebido es eliminar a una persona.

Y además de la evidencia en la Sagrada Escritura, la santa Tradición abomina del aborto: La Iglesia ha afirmado la malicia moral del aborto desde el siglo I (Catecismo, nº 2271). Y así mismo condena el aborto el Magisterio unánime de la Iglesia y la enseñanza de los Papas, como el último, el Papa Francisco, que ha afirmado en repetidas ocasiones que quien se encarga de realizar un aborto es un sicario (pues mata por dinero). Y el propio Concilio Vaticano II tacha el aborto de “crimen abominable” (Gaudium et spes, 51).

Por todo ello, para no condenar el aborto hay que ir contra la Sagrada Escritura, contra la Tradición, contra el Magisterio autorizado de la Iglesia y contra la infalibilidad de los concilios ecuménicos. Por tanto, los que defienden el aborto se apartan gravemente de la Fe católica.

Perdón del aborto

Cuestión distinta es que las mujeres que hayan caído en ese grave pecado no han de desconfiar de la Misericordia divina, que no tiene límites si están sinceramente arrepentidas. Citemos a Santa Teresa de Calcuta que, tras denunciar el aborto, nos muestra un ejemplo de la misericordia inagotable de Dios para con las mujeres arrepentidas de haberlo cometido: Afirmaba la madre Teresa que el mayor destructor de la paz en el mundo es el aborto. “Si una madre puede matar a su propio hijo, ¿qué podrá impedirnos, a ti y a mí, matarnos recíprocamente?” Pero, a la vez, la madre Teresa acogía con verdadero amor a las mujeres que habían caído en esa locura: “Hace unos días vino a verme una señora y se echó a llorar. Nunca había visto llorar tanto a nadie. Me dijo: “He leído lo que Vd. ha escrito acerca del aborto. Yo he abortado dos veces. ¿Podrá Dios

perdonarme?”. Yo (habla la madre Teresa) le contesté: Desde luego que sí, si es Vd. sincera en su arrepentimiento. Vaya a confesarse y sus pecados quedarán lavados por la absolución que recibirá. Trate sólo de estar segura del disgusto de su corazón. Ella dijo: “Es que no soy católica”. Y yo a ella: Rece según su religión. Yo pediré a Dios que la perdone. Ella entonces hizo un hermoso acto de contrición. Cuando yo terminé de rezar, parecía un ser diferente, totalmente recompuesta. ¡Qué sufrimiento más tremendo tiene que representar darse cuenta de que uno ha dado muerte a su propio hijo!”

Conclusión

Limitación de la natalidad

Frente a la ideología anti-nacimientos pesimista y sin base empírica, constatamos, bien al contrario, que el hecho de que la población mundial se haya multiplicado por más de 6 desde la época en que Malthus formuló su teoría, desmiente ésta, pues, si fuera cierta, ese meteórico incremento no habría sido posible. También las estadísticas nos muestran que el trabajador agrícola produce cada vez más, contra la previsión maltusiana de que cada vez produciría menos. Y si la distribución es justa, hay sobreabundancia de alimentos para una población creciente. Por tanto, la presión antinatalista no tiene razón de ser en general. Aunque a nivel individual y por razones serias, haya que procurar una paternidad responsable que puede espaciar los nacimientos por medios naturales (abstinencia periódica). La continencia periódica es consustancial al matrimonio: por viajes, trabajo, enfermedades, para espaciar los nacimientos de los hijos.

Aborto

En cuanto al ataque físico a la vida, el aborto, constatamos su gravedad al demostrar que el niño concebido es un ser humano distinto y diferenciado de la madre gestante, tanto por razones biológicas o científicas, como por razones de Fe. Pero a pesar de su gravedad no hay que abandonar a las mujeres que han abortado a la desesperación, ya que Dios tiene una misericordia sin límites para quien se arrepiente sinceramente. No es bueno que se entreguen a un suicidio espiritual.

THE ITALIAN WAY TO EUTHANASIA. NOTES FOR A HISTORY

Gian Luigi Gigli



INTRODUCTION

The equivalent in sociology of the slow habituation process to poison, known in medicine as mithridatization, is called "*Overton window*". This is the term used by the American sociologist Joseph P. Overton (1960-2003) to describe the way in which, with the passage of time and under the push of appropriate actions, even very controversial issues can end up being accepted by the social body: It is a question of setting in motion a process that what was first inconceivable, gradually turns only into something extreme, to then become acceptable, therefore reasonable, coming to have the force of law, when it is sufficiently popular and shared.

Italian Radicals were masters in proposing paths of this type, leading the Italian society to add up to the most foreign ideas. In some ways this is part of the physiological dynamic of a democratic society. However, it is a dynamic that, if it does not want to contradict the same foundations of democracy, should stop on the threshold of fundamental rights, which cannot be questioned by the parliamentary majorities of the moment.

Thanks to the action of Radicals and Associations that refer to the radical ideology (primarily the "Luca Coscioni" association and its mentor Marco Cappato), the Overton window has been wide open on euthanasia and the ground has now become fertile for introducing the sweet death in the Italian legal system. If this change has been able to produce itself in a few years, it is "merit" of those who have carried out the long march for the introduction of euthanasia in Italy, a consistent project to demolish the moral resistance and legal obstacles together, using pitiful cases to introduce general principles

in the system. At any legal success, the moral (and political) resistance came out weakened, in a vicious circle.

In the impossibility of reconstructing the whole story, it is necessary to analyze at least some fundamental joints.

THE NODAL POINTS OF A LONG MARCH

1. The judicial controversy and the death of Eluana Englaro.

The first can be identified in the judicial controversy that concerned Eluana Englaro. Despite the Supreme Court of Cassation, in the 2007 ruling on the case, had claimed that “the right to die” or the faculty “to choose death rather than life” do not derive from the Constitution, at the end of a very long battle, it was without any sanction ruled by a court the principle that also in Italy, like in other Countries, a human being could be left to die by subtracting her hydration and nutrition. And this on the basis of an alleged manifestation of will, reported by third parties and with discordant testimonies that could not enter into a discussion expertly brought to the civil and non-criminal justice, although it was a matter that questioned a human life.

2. Law n. 219 of 2017 on Informed Consent and Advance Directives on Treatment (Living will)

The second joint is constituted by the law on advance directives on treatment (ADT). In the name of an alleged absolute right to self-determination, with law 219/2017, each person was allowed to refuse not only cure, but also nutrition and hydration, and to do so not only when they are actually too burdensome for the patient or when they really represent therapies of the specific clinical case, but also when they simply constitute the indispensable supports to every human being, healthy or sick who is, to be able to stay alive.

In 2017, some of the topics considered by 219 (informed consent, shared care planning, refusal of diagnostic and therapeutic obstinacy, attention at the time of therapeutic desistance, palliative medicine) had already become cultural heritage of any good doctor even before the approval of the law, although it was still necessary to work so that they could become increasingly embodied values in professional practice, in the awareness that is within the medical-patient relationship that the solution of difficult cases can be found.

The true and ethically more controversial innovations introduced by 219/2017 are instead: a) in the definition *ex lege* of hydration and nutrition no longer as elementary needs of the person (it does not matter if healthy or sick), but as medical therapies and as such

refusable in any case by the patient, based on the absolutization of the principle of self-determination; b) in the possibility that the refusal can also be requested by those who legally represent the patient or the minor (parent, guardian, support administrator); c) in the provision of continuous deep (terminal) sedation to mask the suffering that dehydration and starvation inevitably produce; d) finally, in the legal approval of advance directives on treatment (ADT).

Already in the course of the parliamentary debate, which saw us strongly engaged, we warned that with L. 219 it would surreptitiously enter our legal system a sort of "right to suicide", albeit limited to death by dehydration and starvation, a right that by analogy could be dangerously extended with jurisprudential interpretations, if only to allow a faster and more "human" death, compared to that consequent to the suspension of vital supports.

The risks of an euthanasic drift due to the law approval on December 22, 2017 had also been announced with reference to what was appearing as a likely conclusion for the trial that met Marco Cappato (investigated after self-denounce since 1 March 2017) for having organized the journey of death of the disk jockey Fabiano Antoniani, died in Switzerland on February 27, 2017.

Political forces and civil society did not want to realize the consequences of the new law. Also part of the Catholic world actively worked for its approval, among them Mario Marazziti, the President of the Health Commission of the Parliament and a prominent member of the Sant'Egidio Community. Others lived in the illusion that limitations in the application of 219/2017 would have come by its jurisprudential application. Punctually, however, the jurisprudence has proceeded to interpret the law in an extensive sense.

3. The (fake) trial for the death of DJ Fabo

This subtitle refers to what happened with the trial involving Marco Cappato, who reported himself for having helped the assisted suicide in Switzerland of Fabiano Antoniani (known as DJ Fabo). It is the third nodal point of this long march.

Despite the orientation against assisted suicide had been reiterated again in 2013, when the Supreme Court did not hesitate to rule that the choice of suicide is: *"a denial of the fundamental principle on which every organized community is based, represented by the respect and promotion of life in all its manifestations,"* a few months after the approval of 219, promptly, the High Court in Milano who had the task of judging Cappato did not hesitate to complain that article 580 of the Criminal Code (which punishes instigation and aiding suicide) *"is contrary to the principles of freedom and self-determination of the*

individual, enshrined in the Constitution and the European Convention on Human Rights, which were recalled and declined in law on the end-of-life no. 219/2017". The Milanese judges relied on law 219/2017 to affirm that with the ATDs the right to suicide by renouncing treatment or life support has been introduced in Italy, legalizing in fact "indirect omission euthanasia", even without recognizing the right to choose the methods of suicide. The fact that a patient cannot choose the methods of suicide, demanding that doctors administer a drug that causes death, "cannot lead to denying the ... freedom of the person to choose when and how to end his or her existence", based on articles 2 and 13 of the Constitution. In the opinion of the Milanese Court, therefore, the same "constitutional principles that inspired, only a few months ago, the formulation and approval of law no. 219/17 must also preside over the exegesis of the rule" under examination for the Cappato trial, i.e. article 580 of the Criminal Code, in the part that sanctions assisted suicide.

Contradicting the many Catholics who, out of naivety or personal interest, had preferred to vote in favor of the DAT, the Court sent the documents of the Cappato trial to the Constitutional Court, so that it could evaluate whether to declare the unconstitutionality of the part of art. 580 of the Criminal Code that concerns assisted suicide.

In the order with which the Court of Assizes of Milan brought the case to the attention of the Constitutional Court, the Milanese judges referred precisely to law 219/17 to argue that what differentiates Swiss assisted suicide from what the law had already permitted in Italy would be only the way in which the aspiring suicide decides to anticipate his end.

4. The interventions of the Constitutional Court

The fourth nodal point is the two-step response of the Constitutional Court to the order of the Milanese High Court.

First, with order no. 207 of 24 October 2018, the Court noted that:

"The criminal legislator cannot be considered inhibited, therefore, from prohibiting conduct that paves the way for suicidal choices, in the name of an abstract conception of individual autonomy that ignores the concrete conditions of hardship or abandonment in which, often, such decisions are conceived. Indeed, it is the duty of the Republic to implement public policies aimed at supporting those who find themselves in similar situations of fragility, thereby removing the obstacles that prevent the full development of the human person".

At the same time, however, it invited to consider "situations that were unimaginable at the time the incriminating rule was introduced, but brought under its sphere of

application by developments in medical science and technology, often capable of snatching patients in extremely compromised conditions from death, but not of restoring their vital functions". In cases, such as that of Fabiano Antoniani, in which the person is "(a) affected by an irreversible pathology and (b) a source of physical or psychological suffering, which he finds absolutely intolerable, who is (c) kept alive by means of life-sustaining treatments, but remains (d) capable of making free and conscious decisions", assisted suicide "may present itself to the patient as the only way out to avoid, in compliance with his own concept of the dignity of the person, an artificial maintenance of life that is no longer wanted and that he has the right to refuse".

The constitutional judges therefore adopted the similarity with what was provided for by law no. 219 of 2017, proposed by the Milanese magistrates (and inspired by the radicals), according to which the sick person has the right to refuse any treatment and the doctor is required to respect his will, noting that, despite this new legislation, the regulatory framework does not allow the doctor to offer the patient treatments capable of hastening his death. *"In this way, the patient is forced to undergo a slower process, hypothetically less corresponding to his vision of the dignity of dying and more burdened with suffering for the people who are dear to him".*

According to the Court, *"the absolute prohibition of assisted suicide ends up limiting the patient's freedom of self-determination in choosing therapies, including those aimed at freeing him from suffering".* For the constitutional judges, *"the assistance of third parties in ending his life can present itself to the patient as the only way out to avoid, in compliance with his own concept of the dignity of the person, an artificial maintenance of life that is no longer wanted and that he has the right to refuse".* After these considerations, the Constitutional Court chose to postpone the decision to the public hearing of 24 September 2019, to allow Parliament *"any appropriate reflection and initiative".* With a heavy and unusual intervention, it invited Parliament to address the end-of-life regulation within a year, threatening its own interpretative intervention otherwise.

One year after its own ordinance 207/2018, the Constitutional Court finally ruled on the Cappato case and in particular on the question of the constitutional illegitimacy of art. 580 of the Criminal Code in the part in which it criminalizes the conduct of assisted suicide, regardless of their contribution to the determination and strengthening of the suicidal intent.

Resuming the content of order no. 207, the Court reiterates that the criminalization of assisted suicide cannot be considered in itself in conflict with the Constitution and that the purpose of art. 580 of the Criminal Code is to protect people, especially the weakest and most vulnerable, who are going through moments of serious difficulty and suffering, avoiding that the decision to take one's life may be subject to interference by others interested in such an outcome.

However, according to the Court, it is possible to identify an area of constitutional non-compliance, limited to cases in which the aspiring suicide is a person "*(a) suffering from an irreversible pathology and (b) a source of physical or psychological suffering, which he finds absolutely intolerable, who is (c) kept alive by means of life-sustaining treatments, but remains (d) capable of making free and informed decisions*". The Court reaffirms that, although Law 219/2017 recognizes the patient's right to refuse or interrupt any health treatment, even if necessary for survival, and the right to access palliative care and pain therapy, the legislation in force does not allow the doctor to make available to the patient, who falls within the conditions indicated, treatments aimed at determining his death, forcing the subject to slower solutions, unacceptable for him and a source of psychological suffering for the people dear to him.

On the basis of these considerations, the Court concludes that "*if the fundamental importance of the value of life does not exclude the obligation to respect the patient's decision to end his or her existence by interrupting health treatments - even when this requires active conduct, at least on a naturalistic level, by third parties - there is no reason why the same value should translate into an absolute obstacle, protected by criminal law, to the acceptance of the patient's request for assistance that can save him or her from the slower progression resulting from the aforementioned interruption of life-support devices*". As regards the risk of pressure or abuse on the most vulnerable persons, the Court notes that it sees no reason why those who are already authorised to forgo life-sustaining treatments cannot decide to end their own existence with the help of third parties, provided that the conditions identified by the Court itself are met.

According to the Court, in the limits of this context, the absolute prohibition of assisted suicide would constrain the patient's freedom of self-determination, deriving from Articles 2, 13 and 32, second paragraph, of the Constitution, imposing a single method for renouncing life.

Article 580 of the Criminal Code is therefore declared unconstitutional insofar as it does not exclude the liability of those who, with the methods provided for by Articles 1 and 2

of Law No. 219/2017, facilitate the execution of the intention of suicide, autonomously and freely formed, of a person who presents the requirements described above, provided that such conditions and the methods of execution have been verified by a public structure of the health service, following the opinion of the territorially competent ethics committee.

However, the Constitutional Court's ruling 242/2019 does not represent the final conclusion. In the ruling, in fact, the Court did not establish any right to suicide, stating instead that *"From art. 2 Cost. - no differently than from art. 2 ECHR - derives the State's duty to protect the life of every individual: not that - diametrically opposed - of recognizing the individual the possibility of obtaining from the State or from third parties assistance in dying"*. The Constitutional Court did not even cancel the crime of assisted suicide, limiting itself to providing for its non-liability if certain conditions are met, including, not least, the patient's dependence on technological life support.

Furthermore, the Constitutional Court, in declaring assisted suicide not punishable, limited to the circumstances indicated by it, clarified in the same ruling that there is no right to be helped to die by the NHS, but rather a right to kill oneself, with the NHS remaining only responsible for ascertaining the conditions for non-liability, the suitability of the drug and more generally the ascertainment of the methods of execution, which must be *"such as to avoid abuse to the detriment of vulnerable people, to guarantee the dignity of the patient and to avoid suffering for the same"* (Constitutional Court no. 242/2019, point 5 Cons. dir.). This is even more true if one considers that, precisely due to the lack of any obligation on the part of the NHS, the Constitutional Court does not provide for any conscientious objection for medical and nursing staff.

In addition, for the Court, the necessary effective offer of palliative care and pain therapy should instead represent *"an absolute priority for health policies"*. *"Otherwise, we would fall into the paradox of not punishing assisted suicide without first ensuring the effectiveness of the right to palliative care"*.

Even with these limitations, the intervention of the Constitutional Court undoubtedly represents an important step forward in the long march towards the recognition of the lawfulness of medically assisted death in the Italian legal system. Without saying it, sentence 242/2019 conveys the idea that there are living conditions that are unworthy of being lived and which are better put an end to (for the moment as a personal choice); it spreads the idea that it is possible to solve the problem of suffering by eliminating the person who suffers; it confuses cure and care, forgetting that life itself is an *"irreversible"*

disease and that “*care*” is always possible and necessary; it contributes to perverting the nature of the medical and nursing profession and the vocation to care of healthcare institutions; it aggravates the current tendency of healthcare institutions to intervene according to criteria of economy and efficiency and not according to criteria of humanity; it encourages those who are in difficulty and feel like a burden to ask to leave the scene; shifts even more towards the individual a society already weakened in its bonds of solidarity; subverts the foundations of the legal system, based on natural rights and *favor vitae*; destabilizes the balance of powers of the state with a very serious invasion of the judicial power in the field of legislative power.

Moreover, other disturbing questions inevitably arise. In fact, as happened with law 219/2017, which through the trial of Marco Cappato led to the ruling of the Constitutional Court, the ruling itself constitutes the starting point for new and more serious developments, inevitable for mere reasons of logic.

It is legitimate to ask, for example, what will happen to those who, in anticipation of not being able to decide, have entrusted the request for assisted suicide to the ATDs? In its ruling, the Court does not contemplate this possibility, referring only to articles 1 and 2 of the 2019, which do not speak of advance directives, but only of informed consent. However, how can the request for assisted suicide, advanced “*now for then*” using the ATDs, be rejected if the law on ATDs allows one to end life with dehydration and malnutrition?

Furthermore, what will happen to those who are not “*aware and autonomous in their choices*”? As with the suspension of hydration and nutrition, will the legal representative decide on the death of severely disabled and demented people (in their “best interest”, obviously)?

Finally, how will we deal with those who, due to their motor limitations, are not even able to action the pump for intravenous injection or to crush between their teeth or swallow the legal cocktail? Will we be able to discriminate against them by denying them that it is someone else who performs the last gesture for them?

Logic is inescapable and leads to active euthanasia, beyond someone's “*merciful*” intentions.

5. The attempt of the abrogative referendum

With the wind in the stern for the climate changed by the unappealable judgments of the Constitutional Court, a further approach to the Euthanasic goal was attempted by its

proponents, following two roads: that of the path in Parliament and that of the use of the urns of the referendum. Different roads, but complementary to each other.

The ambitious and unrealistic referendum project, served in fact only to create pressure on the Parliament for adopting a law to avoid the Far West that would be determined by the regulatory vacuum, produced in case of referendum repeal of the article of the Criminal Code sanctioning the homicide of a consenting person.

The referendum question, in fact, asked to repeal 18 words in the text of article 579 of the penal code, which punishes the murder of the consenting person. "Only" 18 words less, however, from the effect devastating: the murder of the consenting would not have been more prosecuted, unless the killing took place to the detriment of a minor, a person infirm of mind or affected by intellectual disability, or in the event of consent extorted with violence, threat, suggestion or deception.

In the event of a referendum victory of the radicals, the murder of the consenting would not have been more prosecuted, regardless of the patient's clinical conditions (suffering or not, irreversible or not), by the profession of the killing (doctor or not) and by the tool chosen to kill (drug, cushion, bullet or other).

The referendum chisel of the radicals, left to the work, would also have inserted in the law an unacceptable inequality between the crime of murder of the consenting (which would have been liberalized by the referendum) and that, less serious, of help to suicide (made not punishable only at certain conditions by the Constitutional Court).

6. The Unified (consolidated) Text approved by the Chamber of Deputies

From its side, only a year and a half from the approval of Law 219/2017 and in parallel to the referendum process, the Chamber of Deputies found itself to examine seven proposals of bills who aimed all, except one, to introduce medically assisted death in the Italian legal system, providing for "*the non-applicability of articles 575, 579, 580 and 593 of the penal code to the doctors and the other health personnel*" who caused the patient's death, as long as they exist the major age and full awareness of the patient, and if he manifests his will with a written act.

During their discussion, the bills were combined in a single text. The unified text leads the theme to the assisted suicide only, making the reference to the non -applicability of articles 575 and 579 fall (murder of the consenting).

On 14 January 2021, the unified text of the law project on "*medically assisted voluntary death*", speakers the Alfredo Bazoli and Nicola Provence, received an explicit endorsement from Carlo Casalone, Jesuit father, corresponding member of the Pontifical

Academy for Life, in an article published in *Civiltà Cattolica*, the Jesuit magazine directed by Father Antonio Spadaro: *"in the current cultural and social situation, it appears to me not to be excluded that the support to this proposal of law is not in contrast with a responsible pursuit for the possible common good"*.

On February 15, 2022, fortunately the Constitutional Court declared the radical referendum inadmissible, with an inevitable and legally flawless judgment. In fact, if the referendum had been declared admissible and if the radicals had won it, the foundations of the law and of social coexistence itself would have suffered the effects of an earthquake, coming out devastated.

Even when the ability of judgment is undermined by ideology, it is difficult to deny that the referendum question posed by radicals did not concern euthanasia, but the murder of the consenting.

In fact, it came out of the field of disease and medicine, erasing a fundamental concept with a stretch of pen: life, like freedom, is an inalienable good, even for those who want to get rid of it. As it is not legitimate to decide to become a slave to another, so you cannot deliver to others their right to life, however much these choices may be the result of a voluntary decision.

In fact, a written consent would not be enough to exclude that the request to die may have been produced following blackmail, pressure, economic difficulties, psychological subjection, momentary disheartening, depression. All things, these, who have nothing to do with suffering for a disease. Homicides, these, for whose execution a paid killer could have been hired.

But the decriminalization of the murder of the consenting would also have had other consequences. If, in fact, one can dispose of the supreme good of life, what sense would it make the ban on selling one's own organ for transplant purposes, or blood to pay for a debt? How to prevent a life sentenced from asking a cellmate to put an end to his suffering for the deprivation of freedom? If life is no longer sacred, why death penalty should not be admitted, at least for the most heinous crimes?

The above presented are considerations that do not require a particular legal culture. So what was a clearly improper referendum for? It is likely that the objective of the radicals was actually only to exert pressure on the Parliament, so that, to avoid the disruptive effects of the referendum, it approved euthanasic legislation.

Still only a week before the judgment of the Constitutional Court, the Hon. Alfredo Bazoli, speaker of the unified text under discussion in the Chamber of Deputies, did not

hesitate to assert verbatim: *"This law is the only alternative to the drift proposed by the radical referendum, which would like to legalize the murder of the consenting without restrictions"* (Avvenire, 8 February 2022).

A week later, the gun of political blackmail was proved to be a toy gun and the inadmissibility of the referendum made the moral alibi fall, for those Catholic politicians and church men, who had argued that the rapid approval of the law on medically assisted voluntary death should be favored as a minor evil.

Despite the inadmissibility of the referendum, the large majority present in the Chamber of Deputies in favor of medically assisted death managed to approve the unified text on 10 March 2022 and to transmit it to the Senate for its approval.

The text does not even speak of assisted suicide, but of *"medically assisted voluntary death"*. Ambiguity is most likely intentional, so that medical assistance does not turn *"only"* to the suicide, but can also practice actively. In the unified text, the death following medically assisted death is equated to that for natural death, in all respects of the law. It provides for the possibility of resorting to *"medical assistance"* even if the person is affected by *"suffering"* only of a psychological type, provided that they are considered intolerable.

More important, the requirement of an irreversible pathology is enlarged to includes the clinical *"conditions"* of irreversibility, that is, also the chronic situations of infirmity or those of irreversible disabilities (in the sense of permanent), but with which it is possible to coexist for a long time.

If this is added the failure to define what is to be understood for vital supports, it is inevitable to conclude that the approval of this text in the formulation with which it has gone to the Chamber of Deputies would not allow to deny medically assisted death also to the depressed or anorexic that refuse feeding, or to the demented no longer able to feed.

It is also significant the fact that a psychiatric evaluation is not considered mandatory, but it only said that the physician can make use of it while writing the certification (*"report"*). Finally, the bill that has now become known as *"Bazoli"*, from the name of the speaker deputy, presents another fundamental flaw. The Constitutional Court, in fact, asked that the clinical conditions of the applicant and the suicide methods were verified by a public structure of the National Health Service, however providing that for the structures of the NHS there was no obligation to collaborate in suicide. At this stage, the legislator has exactly reversed things. In fact, according to the text, a verification of the NHS structure

would not be required, being sufficient the declaration of the general practitioner or a specialist. Conversely, there is in the bill the possibility for the patient to request that the "suicide" occur in the structures of the National Health Service and that these are in any case obliged to ensure the performance of the procedures provided for by the law, thus including medically assisted death among the essential levels of assistance (LEA) that the NHS has to make accessible all over the country. Hence the need for the bill to recognize the right to conscientious objection. It is evident that in addition to the perversion of the medical profession, the finalities of the health care institutions are in the way subverted. The approval of the "*Bazoli*" text would in fact transform the of solidaristic perspective of public health into a bureaucratic approach, making the medical intervention aimed at procuring the patient's death an ordinary protocol, elevated to the rank of the most noble interventions in medicine.

To temporarily hinder the path of the euthanasic project, the dissolution of the Chambers intervened on 21 July 2022, following the resignation of the Draghi government, which caused the early end of the XVIII legislature, causing consequently the forfeiture of all the legal proposals to the examination of the Parliament, not yet approved.

On the same day of the resumption of parliamentary works with the XIX Legislature (13 October 2022), the Bazoli bill was reappeared (Senate Act n. 104), this time with the name Alfredo Bazoli, become Senator, as the first signature among proponents.

However, the parliamentary majority change, followed in the elections, made much more difficult the coagulation in Parliament of a transversal bipartisan majority in favor of medically assisted death and this bill ended up on a dead track.

7. The introduction of assisted suicide through regional laws

Aware of this political difficulty, the "Luca Coscioni" Association has attempted to promote regional laws aimed at ensuring certainty of exam and execution times of assisted suicide procedures for the cases allowed by the ruling of the Constitutional Court n. 242 of 2019.

In various regions (including Veneto, Friuli Venezia Giulia, Emilia Romagna, Lombardy, Tuscany) proposals of popular initiative have been filed, almost identical among themselves and corresponding to the type model prepared by Marco Cappato for the same "Luca Coscioni" Association. All the proposals also provided a widening of the tasks of the health service, that the Constitutional Court had limited to the verification of the existence of the required requirements and to the surveillance of compliance with the patient's dignity.

It is the attempt to bring suicide back into the organization of health services, which in Italy is competence of the regions. Operating a distortion of perspective of health protection, the Coscioni Association is trying to pass in many regions of Italy the equation of support for suicide to health care, charging the health service of the task of providing spaces, instruments, poison to be injected and medical and nursing staff for assistance, at the expense of the taxpayer, as if suicide would be included among essential levels of assistance (LEA).

Continuing in its aberrant logic, the Cappato bill claims that the expenses are not covered through the identification of specific resources, but by drawing on the same funds used for health in the terminal phase of life, not even it was a palliative care.

The severity of the Cappato bill lies in wanting to transform suicide from a tragic failure, with a limited area of non-punishment for those who help the suicidal person, into a health practice, to be accepted on request, if the patient prefers it to care.

Fortunately, this project was rejected by the same regional councils and censored by the State Attorney because it uses the boundaries of regional healthcare competences, going to invade the exclusive competences of the State in the field of fundamental rights of the person. In fact, it is clear the unconstitutionality of a regional law in subjects, such as the civil and criminal code, which our system rightly reserves for State competences. In fact, a variety of legislation in the different regions would not be admissible on these issues.

8. What should be legally intended as life sustaining treatments

In the meantime, the Constitutional Court has produced a weakening of the conditions that the Court itself had defined in sentence 242/2019 for the decriminalization of medically assisted suicide.

On January 17, 2024, the Court of Florence submitted to the Constitutional Court the case of a patient suffering from multiple sclerosis in conditions of immobility except for a residual ability to use the right arm. The patient did not depend on mechanical supports, he was not subjected to life saving pharmacological therapies, nor did he require particular care interventions. The Florentine judge himself highlighted in the case in question the lack of the requirement of "*dependence on life-sustaining treatments*" provided for by the Constitutional Court. Nonetheless, the judge raised doubts of constitutional legitimacy with reference to art. 3 of the Constitution (for an unreasonable disparity of treatment between substantially identical situations), to articles 2, 13 and 32 co. 2 (for the compression of the freedom of self-determination of the patient in the choice of therapies), and to art. 117 of the Constitution in relation to articles 8 and 14 ECHR

(implying an interference in the right to respect for private and family life that is not functional to the protection of the right to life)

On July 1, 2024, the Constitutional Court, rejected the question of legitimacy raised by the judge of Florence on art. 580 of the Italian Criminal Code, as amended by sentence no. 242/2019 of the same Court. Nevertheless, With sentence no. 135/2024, the Constitutional judges gave a new and wider version of what should be understood for life sustaining treatments, saying that: *"The patient has the fundamental right of refusing any health treatment practiced on his body, regardless of his degree of technical complexity and invasiveness. Therefore, including those procedures that are normally carried out by healthcare personnel, and whose execution certainly requires particular skills subject to specific professional training, but which could be learned from family members or "caregivers" that take charge of the patient's assistance"*.

In addition: *"To the extent that these procedures - such as, to resume some of the examples of which it was discussed during the public hearing, the manual evacuation of the patient's intestine, the insertion of urinary catheters or the aspiration of the mucus from the bronchial ways - they prove to be concretely necessary to ensure the performance of vital functions of the patient, to the point that their omission or interruption would predictably determine the patient's death in a short interval of time, they will certainly have to be considered as vital support treatments, for the purposes of applying the principles stated by sentence no. 242 of 2019"*.

The extension of the potential suicidal audience is evident. It is no longer, as the Court itself has justified in its order 207/2018, a question to respond to *"situations unimaginable at the time when the incriminating rule was introduced, but brought under its application sphere by the developments of medical science and technology, often capable of tearing patients in extremely compromised conditions to death, but not to return them a sufficiency of vital functions"*.

With another slip along the slippery slope that leads to euthanasia, from now on, to request medically assisted suicide, it will no longer be necessary to be connected to any machine, nor subject to invasive practices, becoming sufficient to motivate the request also the need for nursing practices as ancient as the world, such as *"the manual evacuation of the patient's intestine"*.

9. The Tuscany Region approves the "Cappato" Law

The last (for now) stage of the long march of euthanasia in Italy was the approval, on February 11, 2025, by the Tuscany Region (as the first and - for the moment - the only

Italian Region) of proposal of popular initiative known as "*Cappato Law*" which, however, will be challenged by the Government.

This law also passed with the indispensable vote of the Catholic regional councilors elected in the Democratic Party. Upon them the icy comment of the bishop of Pistoia, Mons. Fausto Tardelli, who did not hesitate to call things with their name: "As for Catholics engaged in politics, assuming that they still exist, at least sometimes they should not be afraid to go against current and pay attention not to lend themselves to games, mostly made to maintain power".

If unfortunately, the unconstitutionality of the Tuscan law were excluded, it is clear that with it, giving death would enter the DNA of medicine, while the healthy institutions would be transformed, according to the options, from places of care into places of intentional death.

Recently it has also been learned that in Lombardy, a Region ruled from the center-right coalition, a case of assisted suicide has been realized with the help of the health services, despite the fact that, unlike Tuscany, the attempt to approve a law on the Cappato model had previously failed in Lombardy.

PROSPECTS FOR POLITITIANS

When writing this article, it would seem that in the context of the majority of government that holds Italy, they are maturing reflections in favor of a national law, to prevent the regions from proceeding in a scattered order and that it can even start an internal suicidal tourism, on the type of that existing towards Switzerland.

Unfortunately, it is now late to circumscribe the phenomenon, which could still have been limited to exceptional cases before sentence 135 of 2024 of the Constitutional Court, which widened the concept of vital supports required for the decriminalization of the help to suicide.

However, it might not be late to exclude with a national law the assistance of the health services to suicidal procedures.

The political hesitancy with respect to a legislative intervention is due to the fear that despite its approval, the new law could be dismantled to pieces by the Constitutional Court, in response to requests from courts for specific cases, similarly to what happened for law 40/2004, regulating artificial procreation.

In his speech of September 11, 2019, the then president of the CEI, card. Gualtiero Bassetti expressed an extremely critical, albeit late, evaluation of the law on living will, coming to affirm that "*well before the crime of suicide, parliamentary works should be*

dedicated to a revision of the advance treatment directives, approved with law 219, of December 2017. The provisions contained in that text, in fact, represent the starting point of a law favorable to assisted suicide and euthanasia". According to Cardinal Bassetti *"Law 219 should, in fact, be revised where it includes assisted nutrition and hydration in the list of health treatments, which as such can be withdrawn; in the same line, the circumstances that the law establishes for deep sedation should be clarified and the possibility of exercising the conscientious objection to the norm should be introduced".*

Unfortunately, such clear words were not pronounced in 2017, before the approval of Law no. 219, which was made possible only thanks to support of many Catholic politicians, inspired and blessed by important clergy members.

The truth operation, therefore, cannot ignore a sincere self-criticism of the harmful role played by prominent Catholics or, in the absence of self-criticism, by an indispensable change of the roles of responsibility that they continue to exert.

The battles, in fact, can also be lost, but those concerning crucial themes should at least be fought, if only to avoid that, together with the deep sedation of the patient, the consciousness of the people of God be anesthetized.

When Parliament will have to transform the contents of the Constitutional Court sentence into law, it is likely that it will only be possible to obtain the possibility for doctors to exercise conscientious objection. However, this does not exonerate us from taking a great educational effort, in order to develop a critical thinking in the clergy and among the faithful, of which there is an extreme need.

Together with it, as asked by the President of the Italian Bishops, *"there is the need to strengthen the use of palliative care, whose importance is crucial in offering the necessary relief to the suffering of the patient".* Palliative medicine, accompaniment and solidarity, in fact, are the most effective prevention of therapeutic abandonment, assisted suicide and euthanasia, even if they cannot be separated by correct anthropology. Without this anthropology, there is the risk that palliative medicine includes euthanasic intervention, as already happens in Holland and Belgium.

To facilitate the acceptance of the indispensable changes to the text of the law, it is now necessary that the Catholic world exerts pressure on the many parliamentarians declaring themselves as Catholics, to go beyond party obedience, operating choices not based on the emotion for a difficult and distressing case, but capable of looking at the long-term consequences of legislative acts, especially to the detriment of the most fragile persons.

Unfortunately, it is no longer even a matter of obedience to the party, but of values confusion, if a bill such as n. 104 (under evaluation at the Senate bears the name of a Catholic parliamentarian (Sen. Alfredo Bazoli) and if numerous others, among those who have co-founded it, also declare themselves Catholic.

Their consciences deserve to be re-proposed the careful reading of a recent, fundamental document of the Magisterium. This is the letter "Samaritanus bonus on the care of people in the critical and terminal phases of life" (published by the Congregation for the Doctrine of Faith on 14 July 2020, after approval of Pope Francis) (Link to [Samaritanus bonus](#))

In this fundamental, even if unfortunately neglected document it is verbatim stated:

Euthanasia, therefore, is an intrinsically evil act, in every situation or circumstance. In the past the Church has already affirmed in a definitive way “that euthanasia is a grave violation of the Law of God, since it is the deliberate and morally unacceptable killing of a human person. This doctrine is based upon the natural law and upon the written Word of God, is transmitted by the Church’s Tradition and taught by the ordinary and universal Magisterium. Depending on the circumstances, this practice involves the malice proper to suicide or murder”. Any formal or immediate material cooperation in such an act is a grave sin against human life: “No authority can legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity”. Therefore, euthanasia is an act of homicide that no end can justify and that does not tolerate any form of complicity or active or passive collaboration. Those who approve laws of euthanasia and assisted suicide, therefore, become accomplices of a grave sin that others will execute. They are also guilty of scandal because by such laws they contribute to the distortion of conscience, even among the faithful. (Samaritanus Bonus V,1)

In the face of the legalization of euthanasia or assisted suicide – even when viewed simply as another form of medical assistance – formal or immediate material cooperation must be excluded. Such situations offer specific occasions for Christian witness where “we must obey God rather than men” (Acts 5:29). There is no right to suicide nor to euthanasia: laws exist, not to cause death, but to protect life and to facilitate co-existence among human beings. It is therefore never morally lawful to collaborate with such immoral actions or to imply collusion in word, action or omission. The one authentic right is that the sick person be accompanied and cared for with genuine humanity. (Samaritanus Bonus V,9)

The right to conscientious objection does not mean that Christians reject these laws in virtue of private religious conviction, but by reason of an inalienable right essential to the common good of the whole society. They are in fact laws contrary to natural law because they undermine the very foundations of human dignity and human coexistence rooted in justice. (Samaritanus Bonus V,9)

Those who feel impotent in the face of the tide that advances, it is necessary to provide support in order to resist to the equation of those who would like to reduce us to people incapable of compassion towards those who suffer, urging everyone to work to reduce suffering and not to eliminate the suffering.

The compromise at all costs, in fact, cannot be the mark of politics, the more knowing well that jurisprudential and administrative practice will move the bar further down. Instead, the fracture should be overcome between those who desperately seek mediation without a soul and those who want the opposition for the pleasure of being in contrast with the mainstream. Only in this way can we avoid abandoning the first to the betrayal of values and to deliver the latter to ideologies that do not respect the life of all fragile subjects.

CONCLUSIONS

The dogma of absolute self-determination contains within it an iron logic of development. The final step towards euthanasia, which will make us like Canada, will most likely be written once again by the Constitutional Court, when it will be asked how it is possible to accept the objective discrimination that undoubtedly exists between those who are able to self-administer the lethal drug, although with the help of a health worker and with an injection pump, and those who can't do even that. Without a leap of responsibility (cultural and political) and without a serious educational commitment, in order to meet the needs of these patients it will not be long before we officially open up to euthanasia (technically in fact it would no longer be assisted suicide, but the murder of a consenting person).

In ancient philosophy, with euthanasia, beautiful, quiet and natural death was indicated, accepted with a peaceful spirit as the fulfillment of life. It was something similar to the Christian "good death", the one that takes place in peace with God and with the brothers. Then came the desire for the "beautiful death", as a sudden death, of which not to notice, does not matter if without the possibility of repairing justice and reconciling with God and brothers.

The rejection of pain also came, that medicine had difficulty to soothe, now deprived of any redemption meaning.

Euthanasia began to be invoked with the new meaning of non-painful death, to be achieved by ending the life of a patient with the intention to avoid prolonged suffering over time. In the meantime, the eugenic movement also developed to impose sterilization to those whose reproduction would have added unnecessary burdens to the society in development, because affected by hereditary diseases or because belonging to lower breeds. Speaking of euthanasia and eugenics, there would be many prominent figures to be mentioned, especially in the Anglo-Saxon world, largely belonging to the masonic and esoteric sects present in the upper society and influential in the international context. I mention only the two brothers Huxley, Aldous (author of "The Brave New World") and Julian (biologist and future president of Unesco). I also remember that there were those who prophetically anticipated the project of the atheistic philanthropy that was developing in their times. This is the case of Robert Hugh Benson, author of "*The master of the world*".

It was Nazi Germany, however, that combined euthanasia and eugenics with the elimination of "*lives unworthy of being lived*": mental patients, intellectually disabled persons, Jews, gypsies, homosexuals. And it was for the horror aroused by the Nazis that the euthanasic movement lost ground.

A ground that has been widely reconquered as a side effect of medical progress: today the problem is proposed because medicine allows patients with chronic diseases to live until their old age, while keeping in life patients with prolonged disorders of consciousness and procrastinating the death of the children with malformations who escape to eugenic abortion.

What to do with these lives also considered "*unworthy of being lived*"? What to do if, even among those who are not yet sick, the belief has spread that living with a tube or having lost the memory is equivalent to a condition unworthy of life, compared to which it is better to anticipate death? What to do in the face of the fear of those who simply prefer to remove the burden that their condition impose to others? What to do if, even on a public level, doubts arise about the opportunity to allocate resources for an extension of life, which is deemed futile? It is evident that here it is no longer a matter of physical pain, for controlling which, however, the development of palliative medicine has made great strides.

The battle against the introduction of assisted suicide and euthanasia, even if it were lost, will not be useless if it will force us to reflect on the risks of a man without God, totally master of his destiny. It is only a more fragile and afraid man, without a supreme guarantor and deprived of the pity of his fellow men. A man who to affirm his freedom of decision must deny its root itself, life. A man who proclaims himself independent, while he is dependent on social pressure and propaganda of strong powers, who establish what is good for him.

The story of Covid pandemic has already shown how dangerous it is if someone else should decide to what extent a patient has the right to the respirator and care. However, the decision taken on a clinical basis and taking into account the availability of the devices is certainly more democratic than the suspension of the vital support decided by a judge, by a guardian or a support administrator, on the basis of a fake pity or a negative judgment on the "quality" of life. Still, this is precisely what would inevitably happen to those who cannot decide for themselves, if the right to kill themselves or to be killed in the name of self-determination would pass for those who can decide how to end their lives.

More than death, there is a society to fear that is afraid of life and that decides on its quality and dignity.

It is necessary to go back to repeat today that every life is precious, if only as a teaching and warning for those who are healthy and carefree; to repeat that there are no live is unworthy of being lived, but that everything depends on the eye with which we look at them ("*dignity is in the eye of the beholder*", as H.M. Chochinov said). For this reason, it is necessary to re-propose a kind of medicine made of care, listening and relationship with the person who is alone, who suffers, who does not want to be a burden on others, who would only like to be helped while asking to die. It is this the deeper meaning of palliative care, capable of covering human suffering with the cloak (*pallium*) of the care.

The antithesis to therapeutic obstinacy is not abandonment, nor even less the intentional death, but the solidarity accompaniment.

Those who support social justice and solidarity should be aware of that euthanasia and assisted suicide risk being the opposite of self-determination, becoming only the cost solution for a society that does not want to take charge of the growing number of elderly people suffering from chronic diseases. It is therefore necessary to wonder if, even in Italy, medically assisted death has nothing to do with freedom, but with a wrong reply to need, isolation, despair. If it is not a matter of rights (the right to die), but of duties (the duty to remove the burden represented by those who are more fragile or vulnerable).

They should also wonder what will be the consequences of the breakdown of the relationship of trust that binds the doctor and his patient since the times of Hippocrates. For those who are Christians, finally, it is necessary to return to witness that suffering and death are only the door for the resurrection

When my moment will arrive, I hope that the transition from this life will take place in the arms of Jesus, who with his suffering and dying has opened the doors of the new world, a world fortunately deeply different from that described by Huxley.

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LA VIA ITALIANA VERSO L'EUTANASIA. APPUNTI PER UNA STORIA.

Gian Luigi Gigli

Già Presidente della FIAMC



INTRODUZIONE

L'equivalente in sociologia del processo di lenta assuefazione al veleno, noto in medicina come mitridatizzazione, è denominato “finestra di Overton”. È questo il termine con cui il sociologo americano Joseph P. Overton (1960-2003) descrisse il modo in cui, con il trascorrere del tempo e sotto la spinta di opportune azioni, anche temi molto controversi possono finire per essere accettati dal corpo sociale: si tratta di mettere in moto un processo per cui ciò che era dapprima inconcepibile, pian piano si trasforma solo in qualcosa di estremo, per diventare poi accettabile, quindi ragionevole, arrivando ad avere forza di legge, quando è sufficientemente popolare e condiviso.

I radicali sono stati maestri nel proporre percorsi di questo tipo, portando la società italiana ad assuefarsi alle idee ad essa più estranee. Per certi versi ciò è parte della fisiologica dinamica di una società democratica. Si tratta però di una dinamica che, se non vuole contraddire i fondamenti stessi della democrazia, dovrebbe arrestarsi sulla soglia dei diritti fondamentali, che non possono essere messi in discussione dalle maggioranze parlamentari del momento.

Grazie all'azione dei radicali e delle associazioni che all'ideologia radicale si rifanno (in primis l'Associazione Luca Coscioni e il suo mentore Marco Cappato), la finestra di Overton è stata spalancata sull'eutanasia e il terreno è divenuto ormai fertile per introdurre la dolce morte nell'ordinamento giuridico italiano. Se questo mutamento ha potuto prodursi in pochi anni è “merito” di chi ha portato avanti la lunga marcia per

l'introduzione dell'eutanasia in Italia, un progetto coerente per demolire insieme la resistenza morale e gli ostacoli giuridici, servendosi di casi pietosi per introdurre principi generali nell'ordinamento. Ad ogni successo giuridico, la resistenza morale (e politica) ne è uscita indebolita, in un circolo vizioso.

Nell'impossibilità di ricostruire tutta la storia, occorre analizzarne almeno **alcuni snodi fondamentali**.

I PUNTI NODALI DI UNA LUNGA MARCIA

1. La vicenda giudiziaria e la morte di Eluana Englaro.

Il primo può essere identificato nella vicenda giudiziaria che ha riguardato Eluana Englaro. Malgrado la Suprema Corte di Cassazione, nella sentenza del 2007 sul caso, avesse sostenuto che dalla Costituzione non derivino "il diritto a morire" o la facoltà "di scegliere la morte piuttosto che la vita", al termine di una lunghissima battaglia, poté affermarsi impunemente il principio che anche in Italia un essere umano può essere lasciato morire sottraendogli idratazione e nutrizione. E ciò sulla base di una presunta manifestazione di volontà, riportata da terzi e con testimonianze discordi che non poterono entrare in un procedimento portato sapientemente in sede civilistica e non penale, pur trattandosi di questione che metteva in discussione una vita umana.

2. La Legge 219 del 2017 su Consenso informato e DAT

Il secondo snodo è costituito dalla legge sulle Dichiarazioni Anticipate di Trattamento (DAT). In nome di un preteso diritto assoluto all'autodeterminazione, con la legge 219/2017 si è consentito a ogni persona di rifiutare non solo le cure, ma anche nutrizione e idratazione, e di farlo non solo quando esse sono effettivamente troppo onerose per il paziente o quando si configurano realmente come terapie dello specifico caso clinico, ma anche quando esse costituiscono semplicemente i sostegni indispensabili ad ogni uomo, sano o malato che sia, per poter restare in vita.

Nel 2017, alcuni dei temi sanciti dalla 219 (consenso informato, pianificazione condivisa delle cure, rifiuto dell'accanimento diagnostico e terapeutico, attenzione al momento della desistenza terapeutica, medicina palliativa) erano patrimonio culturale di ogni buon medico già prima dell'approvazione della Legge, anche se era necessario lavorare perché diventassero valori sempre più incarnati nella pratica professionale, nella consapevolezza che è all'interno del rapporto medico-paziente che può essere trovata la soluzione dei casi difficili.

Le novità vere ed eticamente più controverse introdotte dalla 219/2017 stanno invece: a) nell'equiparazione (definita ex lege) di idratazione e nutrizione non più come bisogni

elementari della persona (non importa se sana o malata), bensì come terapie mediche, dunque rifiutabili in ogni caso dal paziente in base alla assolutizzazione del principio di autodeterminazione; b) nella possibilità che il rifiuto possa essere richiesto anche da chi rappresenta legalmente il paziente o il minore (genitore, tutore, amministratore di sostegno); c) nella previsione della sedazione profonda continua (terminale) per mascherare la sofferenza che la disidratazione e la denutrizione inevitabilmente producono; d) infine, nelle dichiarazioni anticipate di trattamento (DAT).

Già nel corso del dibattito parlamentare, che ci vide fortemente impegnati, avvertimmo che con la L. 219 sarebbe entrato surrettiziamente nel nostro ordinamento una sorta di diritto al suicidio, seppur limitato alla morte per disidratazione e denutrizione, un diritto che per analogia avrebbe potuto andare incontro a pericolose estensioni per via giurisprudenziale, se non altro per consentire una morte più rapida e “umana”, rispetto a quella conseguente alla sospensione dei sostegni vitali.

I rischi di una deriva eutanasica del provvedimento erano stati denunciati anche con riferimento a quanto si andava profilando nel processo che vedeva imputato Marco Cappato (indagato dopo autodenuncia dall'1 marzo 2017) per aver organizzato il viaggio della morte verso la Svizzera del DJ Fabo (morto il 27 Febbraio 2017).

Le forze politiche e la società civile non vollero rendersi conto delle conseguenze della nuova legge e anche una parte del mondo cattolico lavorò per la sua approvazione, tra cui lo stesso relatore alla Camera dei Deputati, On. Mario Marazziti della Comunità di Sant'Egidio. Altri si illusero che per la 219 sarebbe stata possibile una limitazione del campo applicativo per via giurisprudenziale. Puntualmente, invece, la giurisprudenza ha provveduto a interpretare la legge in senso estensivo.

3. Il (finto) processo per la morte del DJ Fabo

È quanto si è verificato con la vicenda processuale che ha interessato Marco Cappato, autodenunciatosi per aver aiutato il suicidio assistito di Fabiano Antoniani (conosciuto come il DJ Fabo) in Svizzera. È questo il terzo punto nodale di questa lunga marcia.

Malgrado l'orientamento contrario al suicidio assistito, fosse stato ribadito ancora nel 2013, quando la Suprema Corte non esitava a sentenziare che la scelta del suicidio è «negatrice del principio fondamentale su cui si fonda ogni comunità organizzata e costituito dal rispetto e dalla

promozione della vita in ogni sua manifestazione», a pochi mesi dall'approvazione della 219, puntualmente, i magistrati milanesi che avevano il compito di giudicare Cappato

non esitarono a lamentare che l'articolo 580 del Codice Penale (quello che punisce l'istigazione e l'aiuto al suicidio) «risulta contrario ai principi di libertà e di autodeterminazione dell'individuo, sanciti dalla Costituzione e dalla Convenzione Europea dei Diritti dell'Uomo, che sono stati richiamati e declinati nella legge n. 219/2017 sul fine vita». I giudici milanesi hanno fatto leva proprio sulla legge 219/2017 per affermare che con le DAT è stato introdotto nel nostro Paese il diritto al suicidio da rinuncia alle cure o ai sostegni vitali, legalizzando nei fatti l'«eutanasia indiretta omissiva», pur senza riconoscere il diritto alla scelta delle modalità di suicidio. Il fatto che un paziente non possa scegliere le modalità di suicidio, pretendendo dai medici la somministrazione di un farmaco che procuri la morte, «non può portare a negare la ... libertà della persona di scegliere quando e come porre termine alla propria esistenza», fondata sugli articoli 2 e 13 della Costituzione. Ad avviso della Corte d'Assise milanese, dunque, gli stessi «principi costituzionali che hanno ispirato, solo alcuni mesi fa, la formulazione e l'approvazione della legge n. 219/17 devono presidiare anche l'esegesi della norma» in esame per il processo Cappato, cioè dell'articolo 580 del C.P. nella parte che sanziona l'aiuto al suicidio.

Smentendo i tanti cattolici che per ingenuità o per interesse personale avevano preferito votare a favore delle DAT, la Corte d'Assise trasmise alla Consulta gli atti, del processo Cappato, affinché valutasse se dichiarare l'illegittimità costituzionale della parte dell'art. 580 C.P. che riguarda l'aiuto al suicidio.

Nell'ordinanza con cui la Corte di Assise di Milano ha posto il caso all'attenzione della Corte Costituzionale, i giudici milanesi hanno fatto riferimento proprio alla legge 219/17 per sostenere che ciò che differenzia il suicidio assistito svizzero da quanto già permesso in Italia sarebbero solo la modalità con cui l'aspirante suicida decide di anticipare la sua fine.

4. Gli interventi della Corte Costituzionale

Il quarto snodo è costituito dalla risposta, avvenuta in due tempi, della Corte Costituzionale all'ordinanza della Corte d'Assise Milanese.

Con l'ordinanza n. 207 del 24 ottobre 2018, la Corte rilevava che «Al legislatore penale non può ritenersi inibito, dunque, vietare condotte che spianino la strada a scelte suicide, in nome di una concezione astratta dell'autonomia individuale che ignora le condizioni concrete di disagio o di abbandono nelle quali, spesso, simili decisioni vengono concepite. Anzi, è compito della Repubblica porre in essere politiche pubbliche

volte a sostenere chi versa in simili situazioni di fragilità, rimuovendo, in tal modo, gli ostacoli che impediscano il pieno sviluppo della persona umana».

Allo stesso tempo, però, invitava a considerare «situazioni inimmaginabili all'epoca in cui la norma incriminatrice fu introdotta, ma portate sotto la sua sfera applicativa dagli sviluppi della scienza medica e della tecnologia, spesso capaci di strappare alla morte pazienti in condizioni estremamente compromesse, ma non di restituire loro una sufficienza di funzioni vitali». Nei casi, come quello di Fabiano Antoniani, in cui la persona sia «(a) affetta da una patologia irreversibile e (b) fonte di sofferenze fisiche o psicologiche, che trova assolutamente intollerabili, la quale sia (c) tenuta in vita a mezzo di trattamenti di sostegno vitale, ma resti (d) capace di prendere decisioni libere e consapevoli», l'aiuto al suicidio «può presentarsi al malato

come l'unica via d'uscita per sottrarsi, nel rispetto del proprio concetto di dignità della persona, a un mantenimento artificiale in vita non più voluto e che egli ha il diritto di rifiutare». I giudici costituzionali fecero dunque propria la similitudine con quanto previsto dalla legge n. 219 del 2017, proposta dai magistrati milanesi (e ispirata dai radicali), secondo cui la persona malata ha il diritto di rifiutare qualunque trattamento e il medico è tenuto a rispettare la sua volontà, rilevando che, ciò malgrado, il quadro normativo, non consente al medico offrire al paziente trattamenti in grado di affrettarne la morte. «In tal modo, si costringe il paziente a subire un processo più lento, in ipotesi meno corrispondente alla propria visione della dignità nel morire e più carico di sofferenze per le persone che gli sono care».

Secondo la Corte «il divieto assoluto di aiuto al suicidio finisce per limitare la libertà di autodeterminazione del malato nella scelta delle terapie, comprese quelle finalizzate a liberarlo dalle sofferenze». Per i giudici costituzionali «l'assistenza di terzi nel porre fine alla sua vita può presentarsi al malato come l'unica via d'uscita per sottrarsi, nel rispetto del proprio concetto di dignità della persona, a un mantenimento artificiale in vita non più voluto e che egli ha il diritto di rifiutare». Dopo queste considerazioni, la Corte Costituzionale, sceglieva di rinviare la decisione all'udienza pubblica del 24 settembre 2019, per consentire al Parlamento «ogni opportuna riflessione e iniziativa». Con un pesante ed irrituale intervento, invitava il Parlamento a por mano entro un anno alla disciplina del fine vita, minacciando in caso contrario un proprio intervento per via interpretativa.

A un anno dall'ordinanza 207/2018, la Corte costituzionale si pronuncia infine sul caso Cappato e in particolare sulla questione di illegittimità costituzionale dell'art. 580 c.p.

nella parte in cui incrimina le condotte di aiuto al suicidio, a prescindere dal loro contributo alla determinazione e al rafforzamento del proposito suicidario.

Riprendendo il contenuto dell'ordinanza n. 207, la Corte ribadisce che l'incriminazione dell'aiuto al suicidio non può ritenersi di per sé in contrasto con la Costituzione e che la finalità dell'art. 580 c.p. è di tutelare le persone, soprattutto quelle più deboli e vulnerabili, che attraversano momenti di grave difficoltà e sofferenza, evitando che la decisione di togliersi la vita subiscano possano subire interferenze da parte altri interessati a tale epilogo.

Tuttavia, secondo la Corte, è possibile ravvisare una area di non conformità costituzionale, limitatamente ai casi in cui l'aspirante suicida sia una persona «(a) affetta da una patologia irreversibile e (b) fonte di sofferenze fisiche o psicologiche, che trova assolutamente intollerabili, la quale sia (c) tenuta in vita a mezzo di trattamenti di sostegno vitale, ma resti (d) capace di prendere decisioni libere e consapevoli». La Corte riafferma che, pur essendo riconosciuto al paziente dalla L. 219/2017 il diritto al rifiuto o all'interruzione di qualsiasi trattamento sanitario, anche se necessario alla sopravvivenza, e il diritto all'accesso alle cure palliative e alla terapia del dolore, tuttavia la legislazione in vigore non consente al medico di mettere a disposizione del paziente, che rientri nelle condizioni indicate, trattamenti finalizzati a determinarne la morte, costringendo il soggetto a soluzioni più lente, per lui non accettabili e fonte di sofferenze psicologiche per le persone a lui sono care.

Sulla base di queste considerazioni, la Corte conclude che «se il fondamentale rilievo del valore della vita non esclude l'obbligo di rispettare la decisione del malato di porre fine alla propria esistenza tramite l'interruzione dei trattamenti sanitari – anche quando ciò richieda una condotta attiva, almeno sul piano naturalistico, da parte di terzi – non vi è ragione per la quale il medesimo valore debba tradursi in un ostacolo assoluto, penalmente presidiato, all'accoglimento della richiesta del malato di un aiuto che valga a sottrarlo al decorso più lento conseguente all'anzidetta interruzione dei presidi di sostegno vitale». Quanto al rischio di pressioni o abusi sulle persone più vulnerabili, la Corte rileva di non ravvisare ragioni per cui chi è già autorizzato

a rinunciare a trattamenti di sostegno vitale non possa decidere di porre termine alla propria esistenza con l'aiuto di terzi, purché in presenza delle condizioni dalla Corte stessa identificate. Limitatamente a tale ambito, il divieto assoluto di aiuto al suicidio limiterebbe per la Corte la libertà di autodeterminazione del malato, derivante dagli artt.

2, 13 e 32, secondo comma, Cost., imponendogli un'unica modalità per rinunciare alla vita.

L'art. 580 c.p. è dunque dichiarato incostituzionale nella parte in cui non esclude la punibilità di chi, con le modalità previste dagli artt. 1 e 2 della legge n. 219/2017, agevola l'esecuzione del proposito di suicidio, autonomamente e liberamente formatosi, di una persona che presenti i requisiti sopra descritti, purché che tali condizioni e le modalità di esecuzione siano state verificate da una struttura pubblica del servizio sanitario, previo parere del comitato etico territorialmente competente.

La sentenza 242/2019 della Corte Costituzionale, tuttavia, non rappresenta la conclusione definitiva. Nella sentenza, infatti, la Corte non ha sancito alcun diritto al suicidio, affermando anzi che «Dall'art. 2 Cost. – non diversamente che dall'art. 2 CEDU – discende il dovere dello Stato di tutelare la vita di ogni individuo: non quello – diametralmente opposto – di riconoscere all'individuo la possibilità di ottenere dallo Stato o da terzi un aiuto a morire». La Consulta non ha tanto meno cancellato il reato di aiuto al suicidio, limitandosi a prevederne la non punibilità qualora ricorrano alcune condizioni, tra cui, non ultima, la dipendenza del paziente da sostegni vitali di natura tecnologica.

Di più, la Corte Costituzionale, nel dichiarare non punibile l'aiuto al suicidio, limitatamente alle circostanze da essa indicate, ha chiarito nella stessa sentenza come non esista un diritto ad essere aiutati a morire dal SSN, ma semmai come un diritto a darsi la morte, restando in capo al SSN solo l'accertamento dei presupposti per la non punibilità, quello dell'idoneità del farmaco e più in generale l'accertamento delle modalità di esecuzione, le quali dovranno essere «tali da evitare abusi in danno di persone vulnerabili, da garantire la dignità del paziente e da evitare al medesimo sofferenze» (Corte cost. n. 242/2019, punto 5 Cons. dir.). Ciò è tanto più vero se si considera che, proprio per la mancanza di qualunque obbligo da parte del SSN, la Consulta non prevede alcuna obiezione di coscienza per il personale medico e infermieristico.

Per la Corte poi, la necessaria offerta effettiva di cure palliative e di terapia del dolore dovrebbe rappresentare, invece, «una priorità assoluta per le politiche della sanità». «Si cadrebbe, altrimenti, nel paradosso di non punire l'aiuto al suicidio senza avere prima assicurato l'effettività del diritto alle cure palliative».

Pur con questi limiti, l'intervento della Corte Costituzionale rappresenta indubbiamente un importante passo avanti nella lunga marcia per il riconoscimento della liceità della morte medicalmente assistita nell'ordinamento italiano. Come rilevato da Alberto

Gambino, infatti, la sentenza 242/2019 fa passare senza dirlo l'idea che esistano condizioni di vita indegne di essere vissute e a cui è meglio por fine (per ora come scelta personale); diffonde l'idea che sia possibile risolvere il problema della sofferenza eliminando la persona che soffre; confonde l'inguaribilità con la incurabilità, dimenticando che la vita stessa è una malattia "irreversibile" e che la "cura" è sempre possibile e doverosa; contribuisce a pervertire la natura della professione medica ed infermieristica e la vocazione di cura delle istituzioni sanitarie; aggrava la tendenza in atto delle istituzioni sanitarie a intervenire secondo criteri di economicità ed efficienza e non secondo criteri di umanità; incoraggia quanti sono in difficoltà e si sentono di peso a chiedere di uscire di scena; sposta ancor più verso l'individuo una società già indebolita nei suoi vincoli solidaristici; sovverte i fondamenti dell'ordinamento giuridico, fondato sui diritti naturali e sul favor vitae; destabilizza l'equilibrio dei poteri dello stato con una gravissima invasione del potere giudiziario nel campo del potere legislativo

A tutto ciò si aggiungono inevitabilmente altri inquietanti interrogativi. Infatti, come è accaduto per legge 219/2017, che attraverso il processo a Cappato ha portato alla sentenza della Corte Costituzionale, la sentenza stessa costituisce il punto di partenza per nuovi e più gravi sviluppi, inevitabili per mere ragioni di logica.

È lecito chiedersi, per esempio, cosa accadrà a chi, in previsione di non poter decidere, avrà affidato alle DAT la richiesta di suicidio assistito? Nella sua sentenza, la Corte non contempla questa possibilità, richiamandosi solo agli articoli 1 e 2 della 2019, in cui non si parla di DAT, ma di consenso informato. Come respingerla, tuttavia, la richiesta di suicidio assistito, avanzata "ora per allora" servendosi delle DAT, se la legge sulle DAT consente di porre fine alla vita con la disidratazione e la denutrizione?

Inoltre, cosa potrà accadere a chi non è "consapevole e autonomo nelle sue scelte"? Come per la sospensione della idratazione e nutrizione sarà il legale rappresentante a decidere della morte di gravi disabili e dementi (nel loro "migliore interesse", ovviamente)?

Infine, Come ci regoleremo con chi, per le sue limitazioni motorie, non è in grado neanche di schiacciare tra i denti o deglutire il cocktail legale? Potremo discriminarlo negandogli cioè che sia un altro a compiere per lui l'ultimo gesto?

La logica è ineluttabile e porta all'eutanasia attiva, al di là intenzioni "misericordiose" di qualcuno.

5. Il tentativo di referendum abrogativo

Con il vento in poppa per il clima mutato dalle inappellabili sentenze della Corte Costituzionale, per un ulteriore avvicinamento al traguardo eutanasico, sono state tentate dai suoi fautori due strade: quella del percorso in Parlamento e quella del ricorso alle urne del referendum. Strade diverse, ma tra loro complementari.

Il progetto referendario, ambizioso e velleitario, serviva infatti proprio a creare pressione sul Parlamento, affinché adottando una legge evitasse il far west dell'omicidio del consenziente che si sarebbe determinato per il vuoto normativo prodotto da una eventuale abrogazione referendaria.

Il quesito referendario chiedeva infatti di abrogare 18 parole nel testo dell'articolo 579 del codice penale, che punisce l'omicidio della persona consenziente. "Soltanto" 18 parole in meno, dall'effetto però devastante: l'omicidio del consenziente non sarebbe stato più perseguibile, salvo che l'uccisione avvenisse a danno di un minore, di una persona inferma di mente o ritardata, o in caso di consenso estorto con violenza, minaccia, suggestione o inganno.

In caso di vittoria referendaria dei radicali l'omicidio del consenziente non sarebbe stato più perseguibile, indipendentemente dalle condizioni cliniche del paziente (sofferente o meno, irreversibile o meno), dalla professione dell'uccisore (medico o no) e dallo strumento scelto per uccidere (farmaco, cuscino, proiettile o altro).

Il cesello referendario dei radicali, lasciato all'opera, avrebbe inoltre inserito nel diritto una inaccettabile sperequazione tra il reato di omicidio del consenziente (che sarebbe stato liberalizzato dal referendum) e quello, meno grave, di aiuto al suicidio (non punibile solo a certe condizioni).

6. Il Testo Unico approvato dalla Camera dei Deputati

In parallelo all'iter referendario e a solo un anno e mezzo dall'approvazione della L. 219/2017, la Camera dei Deputati si è trovata dal canto suo ad esaminare alcune proposte di legge (ben sette) che nei fatti miravano tutte, eccetto una, a introdurre la morte medicalmente assistita

nell'ordinamento giuridico italiano, prevedendo "la non applicabilità degli articoli 575, 579, 580 e 593 del codice penale al medico e al personale sanitario" che hanno provocato al morte del paziente, purché sussistano la maggiore età e la piena consapevolezza del paziente, se questi manifesta la sua volontà con atto scritto.

Nel corso della discussione le proposte di Legge sono state abbinate in un testo unico. Il testo unificato riconduce il tema al solo suicidio assistito, facendo cadere il riferimento alla non applicabilità degli articoli 575 e 579 (omicidio del consenziente).

Il testo unificato del progetto di legge sulla “morte volontaria medicalmente assistita”, relatori gli Alfredo Bazoli e Nicola Provenza, riceveva il 14 gennaio 2021 un endorsement esplicito da Carlo Casalone, Padre gesuita, membro corrispondente della Pontificia Accademia per la Vita, in un articolo pubblicato su *Civiltà Cattolica*, la rivista dei gesuiti diretta da Padre Antonio Spadaro: “Nell’attuale situazione culturale e sociale, sembra a chi scrive da non escludersi che il **sostegno a questa proposta di legge non contrasti** con un responsabile **perseguimento del bene comune** possibile”.

In data 15 febbraio 2022, per fortuna la Corte Costituzionale dichiarava inammissibile il referendum radicale, con un giudizio inevitabile e giuridicamente ineccepibile. Infatti, se il referendum fosse stato dichiarato ammissibile e se i radicali lo avessero vinto, le fondamenta del diritto e la convivenza sociale avrebbero subito gli effetti di un terremoto, uscendone devastati.

Anche quando la capacità di giudizio è minata dall’ideologia, è difficile negare che il quesito dei radicali non riguardava l’eutanasia, ma l’omicidio del consenziente.

Usciva infatti dall’ambito della malattia e della medicina, cancellando con un tratto di penna un concetto fondamentale: la vita, al pari della libertà, è un bene inalienabile, anche per chi volesse disfarsene. Come non è lecito decidere di diventare schiavo di un altro, così non si può consegnare ad altri il proprio diritto alla vita, per quanto queste scelte possano essere frutto di una decisione volontaria.

Non basterebbe infatti un consenso scritto ad escludere che la richiesta di morire possa essersi prodotta a seguito di ricatti, pressioni, difficoltà economiche, sudditanza psicologica, momentaneo sconforto, depressione. Tutte cose, queste, che nulla hanno a che fare con la sofferenza per una malattia. Omicidi, questi, per la cui esecuzione avrebbero potuto proporsi anche killer a pagamento.

Ma la depenalizzazione dell’omicidio del consenziente avrebbe avuto anche altre ricadute. Se, infatti, uno può disporre del bene supremo della vita, che senso avrebbe più il divieto di vendere un proprio organo a fini di trapianto, o il proprio sangue per pagarsi un debito? Come impedire poi che un ergastolano possa chiedere a un compagno di cella di mettere fine con la morte alla sua sofferenza per la privazione della libertà? Se poi la vita non è più sacra, perché la pena di morte non dovrebbe essere ammessa, almeno per i delitti più efferati?

Sono considerazioni le nostre che non richiedono particolare cultura giuridica. A cosa serviva dunque un referendum palesemente improponibile? È verosimile che l’obiettivo dei radicali fosse in realtà soltanto quello di esercitare pressione sul

Parlamento, affinché, per evitare gli effetti dirompenti del referendum, approvasse una legislazione eutanasica.

Ancora soltanto una settimana prima della sentenza della Corte costituzionale, l'On. Alfredo Bazoli, relatore del testo unificato in discussione nell'aula di Montecitorio, non esitava ad affermare testualmente: “Questa legge è l'unica alternativa alla deriva proposta dal referendum radicale, che vorrebbe legalizzare senza argini l'omicidio del consenziente” (Avvenire, 8 febbraio 2022).

Una settimana dopo, la pistola del ricatto politico si è rivelata essere una pistola giocattolo e l'inammissibilità del referendum ha fatto veneri meno l'alibi morale, per quanti, politici cattolici

e uomini di chiesa, hanno sostenuto che la rapida approvazione della legge sulla morte volontaria medicalmente assistita andasse favorita come male minore, sollecitando le rette coscienze a ricondurre il testo entro e non oltre i limiti indicati dalla Consulta nella sentenza 242 del 2019 con cui dichiara l'illegittimità costituzionale dell'art. 580 del Codice penale, limitatamente alla parte in cui non esclude la punibilità di chi agevola l'esecuzione del proposito di suicidio in alcune particolari situazioni.

Malgrado ciò, l'ampia maggioranza presente a favore della morte medicalmente assistita nella Camera dei deputati, riusciva ad approvare il 10 marzo 2022 il testo unificato e a trasmetterlo al Senato per la sua approvazione.

Il testo non parla neanche di suicidio assistito, ma di “morte volontaria medicalmente assistita”. L'ambiguità è molto probabilmente intenzionale, affinché l'assistenza medica non si rivolga poi “soltanto” al suicida, ma possa anche esercitarsi in forma attiva. Nel testo unificato, il decesso a seguito di morte medicalmente assistita è equiparato a quello per morte naturale, a tutti gli effetti di legge. Esso prevede la possibilità di far ricorso all'assistenza medica anche se la persona è affetta da “sofferenze” solo di tipo psicologico, purché ritenute intollerabili. Il requisito di una patologia a decorso irreversibile viene allargato a comprende le “condizioni” cliniche di irreversibilità, cioè anche le situazioni croniche di infermità o quelle di disabilità irreversibile (nel senso di permanente), ma con le quali è possibile convivere per lungo tempo. Se a ciò si aggiunge la mancata definizione di cosa sia da intendersi per sostegni vitali, è inevitabile concludere che l'approvazione di questo testo nella formulazione con cui è passato alla Camera dei Deputati non permetterebbe di negare la morte medicalmente assistita anche al depresso o all'anoressico che rifiutino l'alimentazione, o al demente non più in grado di alimentarsi.

Significativo anche il fatto che non è considerata obbligatoria una valutazione psichiatrica, ma si prevede soltanto che il sanitario possa avvalersi di essa nel redigere la sua certificazione (“rapporto”).

Il progetto di Legge divenuto ormai noto come “Bazoli”, dal nome del deputato relatore, presenta infine un’altra fondamentale pecca. La Corte costituzionale, infatti, aveva chiesto che le condizioni cliniche del richiedente e le modalità del suicidio fossero verificate da una struttura pubblica del Servizio sanitario nazionale, prevedendo tuttavia che per le strutture del SSN non ci fosse alcun obbligo di collaborare al suicidio. Il legislatore in questa fase ha esattamente invertito le cose. Infatti, secondo il testo, non sarebbe più richiesto che ci sia una verifica della struttura pubblica, bastando la dichiarazione del medico di base o di uno specialista. Viceversa, si prevede che ci sia la possibilità per il paziente di chiedere che il “suicidio” si verifichi nelle strutture del Servizio sanitario nazionale e che queste siano in ogni caso tenute ad assicurare l’espletamento delle procedure previste dalla legge, quasi si trattasse di livelli essenziali di assistenza (LEA). Di qui la necessità di riconoscere il diritto all’obiezione di coscienza. È evidente che oltre alla perversione della professione medica, vengono in questo modo stravolte le finalità dei luoghi di cura.

L’approvazione del testo “Bazoli” trasformerebbe infatti la prospettiva solidaristica della sanità pubblica in un approccio burocratico, rendendo l’intervento medico diretto a procurare la morte del paziente un protocollo qualsiasi, elevato al rango di più nobili interventi.

A ostacolare temporaneamente il percorso del progetto eutanasico, è intervenuto il 21 luglio 2022 lo scioglimento delle Camere a seguito delle dimissioni del Governo Draghi, che ha provocato la fine anticipata della XVIII legislatura, causando necessariamente la decadenza di tutte le proposte di legge all’esame del parlamento non ancora approvate.

Il giorno stesso della ripresa dei lavori parlamentari con la XIX Legislatura (13 ottobre 2022), il disegno di legge Bazoli è stato ripresentato (stavolta proprio a forma di Alfredo Bazoli, diventato Senatore (Atto Senato n. 104), ma il suo iter è finito su un binario morto.

Il cambio di maggioranza parlamentare, seguito alle elezioni, ha tuttavia reso molto meno scontata la coagulazione in Parlamento di una maggioranza trasversale a favore della morte medicalmente assistita.

7. L’introduzione del suicidio assistito attraverso Leggi Regionali

L'Associazione Luca Coscioni ha tentato di far approvare in sede regionale delle leggi volte a assicurare certezza di tempi di esame e di esecuzione alle pratiche di suicidio assistito consentite dalla sentenza della Corte Costituzionale n. 242 del 2019.

In diverse Regioni (tra cui Veneto, Friuli Venezia Giulia, Emilia Romagna, Lombardia Toscana) sono state depositate proposte di legge di iniziativa popolare, quasi identiche tra loro e corrispondenti al modello tipo predisposto da Marco Cappato per la stessa Associazione Coscioni. Tutte le proposte prevedevano anche che i compiti del servizio sanitario si allargassero, rispetto a

quanto previsto dalla sentenza della Corte Costituzionale (verifica della sussistenza dei requisiti previsti e sorveglianza del rispetto della dignità del paziente).

Si tratta del tentativo di ricondurre il suicidio nell'ambito dell'organizzazione dei servizi sanitari, di competenza, questa sì, delle regioni. Con una distorsione di prospettiva della tutela della salute, l'Associazione Coscioni sta cercando di far passare in molte regioni d'Italia l'equiparazione dell'assistenza al suicidio all'assistenza sanitaria, caricando il Servizio Sanitario del compito di fornire gli spazi, le strumentazioni, il veleno da iniettare e il personale medico e infermieristico per l'assistenza, a spese del contribuente, manco si trattasse di livelli essenziali di assistenza.

Proseguendo nella sua logica aberrante, la proposta di legge Cappato pretende che le spese non siano coperte attraverso l'individuazione di specifiche risorse, ma bensì attingendo agli stessi fondi utilizzati per la salute nella fase terminale della vita, neanche si trattasse di cure palliative.

La gravità della proposta di legge Cappato sta nel voler trasformare il suicidio da tragico fallimento, per l'aiuto al quale ammettere una circoscritta area di non punibilità, in prestazione sanitaria, da accogliere su richiesta, se il paziente la preferisce alle cure.

Tale disegno è stato per fortuna rigettato dagli stessi Consigli regionali e censurato dalla avvocatura dello stato perché esce dai confini delle competenze regionali in materia di sanità, andando a invadere le competenze esclusive dello stato in materia di diritti fondamentali della persona. È palese, infatti, l'incostituzionalità di una legge regionale in materie, come il codice civile e quello penale, che il nostro ordinamento riserva giustamente alle competenze statali. Non sarebbe infatti ammissibile su questi temi una varietà di legislazioni nelle diverse regioni.

8. Cosa debba intendersi per sostegni vitali

Nel frattempo, la Corte Costituzionale ha prodotto un indebolimento delle condizioni per la depenalizzazione dell'assistenza al suicidio medicalmente assistito che la Corte stessa aveva definito nella sentenza 242/2019.

Il 17 gennaio 2024 il Tribunale di Firenze sottoponeva alla Corte il caso di un paziente affetto da sclerosi multipla in condizioni di immobilità eccetto che per una residua capacità di utilizzazione del braccio destro. Il paziente non dipendeva da supporti meccanico, non era sottoposto a terapie farmacologiche salvavita, né richiedeva interventi assistenziali particolari. **Il giudice fiorentino stesso evidenziava nel caso in esame la mancanza del requisito della “dipendenza da trattamenti di sostegno vitale” previsto dalla corte costituzionale.**

Ciononostante, il giudice fiorentino sollevava dubbi di legittimità costituzionale con riferimento all'art. 3 Cost. (per un'irragionevole disparità di trattamento fra situazioni sostanzialmente identiche), agli artt. 2, 13 e 32 co. 2 (per la compressione della libertà di autodeterminazione del malato nella scelta delle terapie), e all'art. 117 Cost. in relazione agli artt. 8 e 14 CEDU (implicando un'interferenza nel diritto al rispetto della vita privata e familiare non funzionale alla tutela del diritto alla vita).

In data 1 luglio 2024, la Corte costituzionale, nel rigettare la questione di legittimità sollevata dal Giudice per le indagini preliminari di Firenze sull'art. 580 c.p., come modificato dalla sentenza n. 242/2019 della stessa Corte, ha però dato una nuova e più ampia versione di ciò che debba intendersi, a parere della Corte per trattamenti di sostegno vitale. **Con la sentenza n. 135/2024** ha affermato, infatti, che: «il paziente ha il diritto fondamentale di rifiutare ogni trattamento sanitario praticato sul proprio corpo, indipendentemente dal suo grado di complessità tecnica e di invasività. Incluse, dunque, quelle procedure che sono normalmente compiute da personale sanitario, e la cui esecuzione richiede certo particolari competenze oggetto di specifica formazione professionale, ma che potrebbero essere apprese da familiari o “caregivers” che si facciano carico dell'assistenza del paziente.»

Ed ancora: «Nella misura in cui tali procedure – quali, per riprendere alcuni degli esempi di cui si è discusso durante l'udienza pubblica, l'evacuazione manuale dell'intestino del paziente, l'inserimento di cateteri urinari o l'aspirazione del muco dalle vie bronchiali – si rivelino in concreto **necessarie ad assicurare l'espletamento di funzioni vitali del paziente, al punto che la loro omissione o interruzione determinerebbe prevedibilmente la morte del paziente in un breve lasso di tempo,**

esse dovranno certamente essere considerate quali trattamenti di sostegno vitale, ai fini dell'applicazione dei principi statuiti dalla sentenza n. 242 del 2019».

L'estensione della potenziale platea suicidaria è evidente. Non si tratta più, come la Corte stessa aveva disposto nella sua ordinanza 207/2018, di rispondere a “situazioni inimmaginabili all'epoca in cui la norma incriminatrice fu introdotta, ma portate sotto la sua sfera applicativa dagli sviluppi della scienza medica e della tecnologia, spesso capaci di strappare alla morte pazienti in condizioni estremamente compromesse, ma non di restituire loro una sufficienza di funzioni vitali”. Con un'altra scivolata lungo il pendio scivoloso che porta all'eutanasia, d'ora in avanti, per richiedere il suicidio medicalmente assistito non sarà più necessario essere collegati ad alcuna macchina, né sottoposti a pratiche invasive, diventando sufficiente a motivare la richiesta anche il bisogno di pratiche infermieristiche antiche come il mondo, come “l'evacuazione manuale dell'intestino del paziente”.

9. La Regione Toscana approva la Legge “Cappato”

L'ultima (per ora) tappa della lunga marcia dell'eutanasia in Italia ha visto, in data 11 febbraio di quest'anno, l'approvazione da parte della Regione Toscana (prima e per ora unica Regione italiana) della Legge fotocopia di iniziativa popolare nota come “Legge Coscioni” che, tuttavia, verrà molto presto impugnata dal Governo.

Anche questa legge è passata con il voto indispensabile dei consiglieri regionali cattolici eletti nel PD. Su di essi il gelido commento del Vescovo di Pistoia, Mons. Fausto Tardelli, che non ha esitato a chiamare le cose con il loro nome: “Quanto ai cattolici impegnati in politica, ammesso che ancora esistano, almeno qualche volta non dovrebbero aver paura di andare contro corrente e porre attenzione a non prestarsi a giochetti, fatti perlopiù per mantenere il potere”.

Se malauguratamente fosse esclusa la incostituzionalità della legge toscana, è evidente che con essa il dare la morte entrerebbe nel DNA della medicina, mentre le istituzioni sanitarie si trasformerebbero, a seconda delle opzioni, da luoghi di cura in luoghi di morte intenzionale.

Di recente si è anche appreso che in Lombardia, regione, retta dal centro-destra, un caso di suicidio assistito è stato portato a termine con l'aiuto del servizio sanitario, nonostante che, a differenza della Toscana, il tentativo di approvare una legge sul modello Cappato fosse in precedenza fallito.

PROSPETTIVE POLITICHE

Al momento di scrivere questo articolo, sembrerebbe che nell'ambito della maggioranza di governo che regge l'Italia stiano maturando riflessioni a favore di una legge nazionale, per evitare che le regioni procedano in ordine sparso e che possa addirittura avviarsi un turismo suicidario interno, sul tipo di quello esistente verso la Svizzera.

Purtroppo è forse tardi per circoscrivere il fenomeno che -forse- avrebbe ancora potuto essere limitato a casi eccezionali prima della sentenza 135 del 2024, con la quale la Corte Costituzionale ha allargato a dismisura il concetto di sostegni vitali in presenza dei quali permettere la depenalizzazione dell'aiuto al suicidio.

Potrebbe invece non essere tardi per escludere con una legge su tutto il territorio nazionale l'assistenza del servizio sanitario alle procedure suicidarie.

Le esitazioni politiche rispetto ad un intervento legislativo sono legate al timore che malgrado la sua approvazione la nuova legge potrebbe essere smantellata a pezzi dalla Corte Costituzionale, in risposta a richieste di tribunali per specifici casi, sul modello di quanto avvenne per la Legge 40/ 2004 che regolamentava la procreazione artificiale.

Nel suo intervento dell'11 settembre 2019, l'allora Presidente della CEI, Card. Gualtiero Bassetti ha espresso una valutazione estremamente critica, seppur tardiva, della legge sul biotestamento, arrivando ad affermare che “ben prima che sul reato di suicidio, i lavori parlamentari dovrebbero essere dedicati a una revisione delle Disposizioni Anticipate di Trattamento, approvate con la legge 219, del dicembre 2017. **Le disposizioni contenute in quel testo, infatti, rappresentano il punto di partenza di una legge favorevole al suicidio assistito e all'eutanasia**”. Secondo il cardinal Bassetti “la legge 219 andrebbe, infatti, rivista laddove comprende la nutrizione e l'idratazione assistite nel novero dei trattamenti sanitari, che in quanto tali possono essere sospesi; così, andrebbero chiarite le circostanze che la legge stabilisce per la sedazione profonda e dovrebbe essere introdotta la possibilità di esercitare l'obiezione di coscienza alla norma”.

La 219/2017, tuttavia, fu possibile solo grazie al sostegno di molti cattolici impegnati in politica, dietro ispirazione e con la benedizione d'importanti prelati. L'operazione verità, dunque, non può prescindere da una sincera autocritica del ruolo nefasto di quella legge sgabello o, in assenza di autocritica, da un indispensabile ricambio dei ruoli di responsabilità.

Le battaglie, infatti, si possono anche perdere, ma quelle riguardanti temi cruciali andrebbero almeno combattute, se non altro per evitare che, insieme alla sedazione profonda del paziente, venga anestetizzata anche la coscienza.

Nel momento in cui il Parlamento dovrà trasformare in legge i contenuti della sentenza della Corte Costituzionale, è probabile che si riuscirà ad ottenere solo la possibilità per i medici di esercitare l'obiezione di coscienza. Ciò non ci esonera tuttavia dall'intraprendere un grande sforzo educativo, per sviluppare nel clero e nei fedeli un pensiero critico di cui si avverte un estremo bisogno.

Insieme ad esso, come ha chiesto il Presidente della CEI “andrebbe, rafforzato il ricorso alle cure palliative, la cui importanza è cruciale nell'offrire il necessario sollievo alla sofferenza del malato”. La medicina palliativa, l'accompagnamento e la solidarietà, infatti, sono la più efficace

prevenzione dell'abbandono terapeutico, del suicidio assistito e dell'eutanasia, anche se non possono essere separati da una corretta antropologia. Senza questa antropologia, la medicina palliativa rischia di comprendere anche l'intervento eutanasico, come già accade in Olanda ed in Belgio.

Affinché le indispensabili modifiche al testo di legge possano essere accolte, è necessario ora che il mondo cattolico eserciti una doverosa pressione sui tanti parlamentari che cattolici si dichiarano, affinché superino l'obbedienza di partito, operando scelte non fondate sull'emotività di una risposta a casi difficili e angoscianti, ma capaci di guardare le conseguenze a lungo termine degli atti legislativi, soprattutto a danno dei più fragili.

Purtroppo, non è più neanche solo questione di obbedienza al partito, ma di confusione valoriale, se un disegno di legge come il n. 104 all'esame del Senato porta il nome di un parlamentare cattolico (il Sen. Alfredo Bazoli) e se numerosi altri, tra coloro che lo hanno co firmato, si dichiarino anch'essi cattolici.

Alle loro coscienze merita di essere riproposta l'attenta lettura di un recente, fondamentale documento del magistero. Si tratta della Lettera “**Samaritanus bonus** sulla cura delle persone nelle fasi critiche e terminali della vita” (pubblicata dalla Congregazione per la Dottrina della Fede il 14 luglio 2020, dopo formale approvazione da parte di Papa Francesco)

www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_it.html

In questo fondamentale, anche se purtroppo trascurato documento si afferma: “L’eutanasia, pertanto, è un atto intrinsecamente malvagio, in qualsiasi occasione o circostanza. La Chiesa in passato ha già affermato in modo definitivo «che l’eutanasia è una grave violazione della Legge di Dio, in quanto uccisione deliberata moralmente inaccettabile di una persona umana. Tale dottrina è fondata sulla legge naturale e sulla Parola di Dio scritta, è trasmessa dalla Tradizione della Chiesa ed insegnata dal Magistero ordinario e universale. Una tale pratica comporta, a seconda delle circostanze, la malizia propria del suicidio o dell’omicidio». Qualsiasi cooperazione formale o materiale immediata ad un tale atto è un peccato grave contro la vita umana: «Nessuna autorità può legittimamente imporlo né permetterlo. Si tratta, infatti, di una violazione della legge divina, di una offesa alla dignità della persona umana, di un crimine contro la vita, di un attentato contro l’umanità». Dunque, l’eutanasia è un atto omicida che nessun fine può legittimare e che non tollera alcuna forma di complicità o collaborazione, attiva o passiva. **Coloro che approvano leggi sull’eutanasia e il suicidio assistito si rendono, pertanto, complici del grave peccato che altri eseguiranno. Costoro sono altresì colpevoli di scandalo perché tali leggi contribuiscono a deformare la coscienza, anche dei fedeli.**(Samaritanus Bonus V,1)

Dinnanzi a leggi che legittimano – sotto qualsiasi forma di assistenza medica – **l’eutanasia o il suicidio assistito, si deve sempre negare qualsiasi cooperazione formale o materiale** immediata. Tali contesti costituiscono un ambito specifico per la testimonianza cristiana, nei quali «bisogna obbedire a Dio piuttosto che agli uomini» (At 5, 29). **Non esiste il diritto al suicidio né quello all’eutanasia: il diritto esiste per tutelare la vita e la co-esistenza tra gli uomini, non per causare la morte. Non è pertanto mai lecito per nessuno collaborare con simili azioni** immorali o lasciar intendere che si possa essere complici con parole, opere od omissioni. **L’unico vero diritto è quello del malato di essere accompagnato e curato con umanità.**

(Samaritanus Bonus V,9)

Il diritto all’obiezione di coscienza non deve farci dimenticare che i cristiani non rifiutano queste leggi in virtù di una convinzione religiosa privata, ma di un diritto fondamentale e inviolabile di ogni persona, essenziale al bene comune di tutta la società. Si tratta, infatti, di leggi contrarie al diritto naturale in quanto minano i fondamenti stessi della dignità umana e di una convivenza improntata a giustizia.

(Samaritanus Bonus V,9)

A quanti invece si sentono ormai impotenti di fronte alla marea che avanza, è necessario fornire sostegno resistere emotivamente all'equazione di chi vorrebbe ridurre a persone incapaci di pietà verso coloro che soffrono, sollecitando tutti a lavorare per ridurre la sofferenza e non per eliminare il sofferente.

Il compromesso a tutti i costi, infatti, non può essere il DNA del cattolicesimo in politica, tanto più sapendo bene che la prassi giurisprudenziale e amministrativa sposterà l'asticella sempre più in basso. Bisognerebbe invece superare la frattura tra chi cerca disperatamente una mediazione senz'anima e chi vuole la contrapposizione fine a sé stessa. Solo così potremo evitare di abbandonare i primi al tradimento dei valori e di consegnare i secondi a ideologie che non rispettano la vita di tutti i soggetti fragili.

CONSIDERAZIONI CONCLUSIVE

Il dogma dell'autodeterminazione assoluta contiene al suo interno una logica di sviluppo ferrea. Il passo definitivo che ci farà diventare come il Canada, lo scriverà con ogni probabilità ancora una volta la Corte Costituzionale, quando le verrà chiesto come possa essere accettata la discriminazione oggettiva che indubbiamente esiste tra chi, seppure con l'aiuto di un sanitario e di una macchina, è in grado di autosomministrarsi il farmaco letale e chi non è in grado di fare neanche ciò.

Senza un soprassalto di responsabilità (culturale e politica) e senza un serio impegno educativo, per venire incontro a questi malati non si tarderà ad aprire all'eutanasia (tecnicamente infatti non si tratterebbe più di aiuto al suicidio, ma di omicidio del consenziente).

Nella filosofia antica, con eutanasia si indicava la morte bella, tranquilla e naturale, accettata con spirito sereno come il compimento della vita. Era qualcosa di molto simile alla "buona morte" cristiana, quella che avviene in pace con Dio e con i fratelli. Poi venne il desiderio della "bella morte", come morte improvvisa, di cui non accorgersi, non importa se senza possibilità di riparare il male fatto e di riconciliarsi con Dio ed i fratelli.

Venne anche il rigetto del dolore, che la medicina faceva fatica a lenire, privato ormai di ogni significato redentivo.

Si incominciò ad auspicare l'eutanasia nella nuova accezione di morte non dolorosa, da realizzare ponendo termine alla vita di un paziente, per evitare sofferenze prolungate nel tempo. Nel frattempo, si sviluppava anche il movimento eugenetico, per imporre la sterilizzazione a coloro che, affetti da malattie ereditarie o perché appartenenti a razze inferiori, riproducendosi avrebbero aggiunto fardelli inutili alla società in sviluppo. A

proposito di eutanasia ed eugenetica, sarebbero molte le figure di spicco da citare, soprattutto nel mondo anglosassone e nelle colonie, in gran parte aderenti alle sette massoniche ed esoteriche presenti nell'alta società ed influenti nel contesto internazionale. Basti menzionare qui i due fratelli Huxley, Aldous (autore de *Il Mondo Nuovo*) e Julian (Biologo e futuro presidente dell'Unesco). Ricordo anche che ci fu chi profeticamente anticipò il progetto che la filantropia atea stava sviluppando. È il caso di Robert Hugh Benson, autore de *"Il padrone del mondo"*.

Fu la Germania nazista, tuttavia, a coniugare eutanasia ed eugenetica con l'eliminazione delle "vite indegne di essere vissute": malati mentali, ritardati, ebrei, zingari, omosessuali. E fu solo per l'orrore suscitato dai nazisti che il movimento eutanastico perse terreno.

Un terreno che è stato ampiamente riguadagnato come effetto collaterale degli sviluppi della medicina: oggi il problema si ripropone perché la medicina consente a pazienti portatori di

malattie croniche di vivere fino ad età avanzata, tiene in vita pazienti con disturbi prolungati di coscienza e riesce a procrastinare la morte dei bambini affetti da malformazioni che sono sfuggiti all'aborto eugenetico.

Cosa fare con queste vite considerate anch'esse "indegne di essere vissute"? Cosa fare se, anche tra coloro che malati ancora non sono, si è diffusa la convinzione che vivere con un sondino o avendo perso la memoria equivalga a una condizione di vita indegna, rispetto alla quale sia meglio anticipare la morte? Cosa fare di fronte alla paura di chi semplicemente preferisce togliere il disturbo per non essere di peso? Cosa fare se, anche a livello pubblico, sorgono dubbi sulla opportunità di allocare risorse per un prolungamento della vita che è ritenuto inutile? È evidente che qui non si tratta più di dolore fisico, rispetto al quale peraltro lo sviluppo della medicina palliativa ha fatto passi da gigante.

La battaglia contro l'introduzione del suicidio assistito e dell'eutanasia, anche se fosse perduta, non sarà inutile se ci costringerà a riflettere sui rischi del velleitarismo prometeico dell'Uomo senza Dio, padrone del suo destino. Si tratta solo di un uomo più fragile e impaurito, privo di un garante supremo e privato della pietà dei suoi simili. Un uomo che per affermare la sua libertà di decisione deve negarne la radice stessa, la vita. Un uomo che si proclama indipendente, mentre è dipendente dalla pressione sociale e dalla propaganda dei poteri forti, che stabiliscono ciò che è bene per lui.

La vicenda della pandemia Covid ha già dimostrato quanto sia pericoloso se qualcun altro debba decidere fino a che punto un paziente abbia diritto al respiratore e alle cure. Tuttavia, la decisione presa su base clinica e tenendo conto delle disponibilità dei mezzi è certamente più democratica della sospensione dei sostegni vitali decisa da un giudice, da un tutore o da un amministratore di sostegno, sulla base di una finta pietà o di un giudizio negativo sulla “qualità” della vita. Eppure, è proprio questo che inevitabilmente accadrebbe a chi non è in grado di decidere da solo, se, per quanti ancora possono decidere, passasse il diritto ad uccidersi o a farsi uccidere in nome dell’autodeterminazione.

Più che la morte, c’è da temere una società che ha paura della vita e che decide sulla sua qualità e dignità.

È necessario tornare a ripetere oggi che ogni vita è preziosa, se non altro come insegnamento e monito per chi è in salute e spensierato. Ripetere che non esistono vite indegne di essere vissute, ma che tutto dipende dallo sguardo con cui le guardiamo (“la dignità è nello sguardo del curante”, H.M. Chochinov).

Per questa regione è necessario ri-proporre un tipo di medicina fatta di cura, ascolto, relazione con la persona che è sola, che soffre, che pensa di essere di peso per gli altri, che è solo alla ricerca di un aiuto mentre chiede di morire. È questo il significato più profondo delle cure palliative, che avvolgono l’umana sofferenza con il mantello (pallium) della cura.

L’antitesi all’accanimento terapeutico non è l’abbandono e tanto meno la morte, ma l’accompagnamento solidale.

Coloro che lottano per la giustizia sociale e la solidarietà dovrebbero essere consci che eutanasia e suicidio assistito rischiano di essere l’opposto dell’autodeterminazione, divenendo solo la soluzione ai costi per una società che non desidera farsi carico del crescente numero di anziani affetti da malattie croniche. Pertanto, è necessario chiedersi se, anche in Italia, la morte medicalmente assistita non abbia nulla a che vedere con la libertà, ma non rappresenti piuttosto una risposta sbagliata al bisogno, all’isolamento, alla disperazione. Chiedersi cioè se non sia tanto questione di diritti (il diritto a morire), quanto piuttosto di doveri (il dovere di togliere il fardello che le persone fragili e vulnerabili rappresentano per la società dell’efficienza produttiva).

Dovrebbero anche interrogarsi sulle conseguenze a lungo termine della rottura del patto di fiducia che lega il medico al suo paziente fin dai tempi di Ippocrate.

Quanti sono cristiani, infine, dovrebbero interrogarsi se non sia giunto il tempo di tornare a testimoniare che la passione e la morte sono solo la porta per la risurrezione. Quando giungerà il mio momento, mi auguro che il passaggio da questa vita avvenga tra le braccia di Gesù, che patendo e morendo ci ha aperto le porte del mondo nuovo, un mondo per fortuna profondamente diverso da quello descritto da Huxley.

MEDICAL AND BIOETHICAL ASPECTS OF GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

Urh Groselj



Assoc. Prof. Urh Groselj, MD, MSc in Bioethics; Specialist pediatrician endocrinologist; Clinical Department of Endocrinology, Diabetes and Metabolic Diseases, University Children's Hospital, UMC Ljubljana; Department of Pediatrics and Department of Medical Ethics, Faculty of Medicine, University of Ljubljana; National Committee for Medical Ethics of Slovenia.

Curriculum – Urh Groselj

Prof. Urh Groselj, PhD, MD, MA, graduated (2007) and received his PhD (2012) from the Faculty of Medicine, University of Ljubljana, and his MA (2008, *summa cum laude*) from the Faculty of Medicine, University of Leuven, Belgium. Since 2014, he has been a specialist paediatrician at the Department of Endocrinology, Diabetes and Metabolism, University Children's Hospital – UMC Ljubljana. Since 2022, he has been an Associate Professor of Paediatrics and an Assistant Professor of Medical Ethics, and a member of both Departments at the Faculty of Medicine of the University of Ljubljana. He was a Fulbright Scholar, and a Visiting Scholar at the School of Medicine, Stanford University, California, USA. Since 2013, he has been a member of the National Medical Ethics Committee of Slovenia and from 2012-2016 a deputy member of the Committee on Bioethics of Council of Europe and currently also a national representative at the UEMS Thematic Federation of Medical Ethics. Since 2024, he has been the Vice President of the Slovenian Heart Foundation. He is a member of the scientific committee of FH Europe, of Eurordis newborn screening working group, a member of EndoERN and from 2024 a

lead representative of MetabERN for Slovenia. He has published over 100 SCI peer-reviewed publications, many of them in the most prominent scientific journals.

Abstract

Gender dysphoria in children and adolescents presents complex medical, psychological, and ethical challenges, particularly as diagnoses have risen sharply in recent years, often among adolescents with co-occurring psychiatric conditions such as depression, anxiety, autism spectrum disorders, and personality disorders. This chapter critically examines the stability of gender dysphoria diagnoses, emphasizing that most prepubertal children with GD do not persist in their dysphoria post-puberty, raising serious concerns about early medical interventions such as puberty blockers and cross-sex hormones, which carry risks of infertility, sexual dysfunction, and irreversible physiological changes. The chapter applies key bioethical principles—autonomy, non-maleficence, beneficence, and justice—to evaluate whether adolescents possess the cognitive maturity to provide informed consent for life-altering treatments, especially given the lack of long-term safety data. Additionally, it addresses the politicization of gender medicine, highlighting the need for evidence-based clinical practice in contrast to ideological approaches. Ethical scrutiny is also applied to the affirmative model of care, questioning its medical justification given the high rates of desistance and the limited understanding of long-term outcomes. The chapter argues for a cautious, multidisciplinary approach that prioritizes comprehensive psychological assessment and psychosocial support before considering irreversible medical interventions. With growing concerns from international reviews, such as The Cass Review (2024) and the ESCAP Statement (2024), this chapter underscores the necessity of scientific rigor, ethical responsibility, and patient-centered care in the treatment of gender-dysphoric youth, ensuring that clinical decisions prioritize well-being, long-term safety, and the avoidance of preventable harm.

Introduction

The term gender dysphoria (sometimes more commonly referred to as 'gender identity disorder'; also referred to in the literature as 'gender incongruence') describes the discrepancy between an individual's biological sex and gender identity, or the psychological distress associated with it. Gender dysphoria can be associated with a strong desire to transition to the gender with which the individual identifies. This may mean a desire to change appearance, to seek medical treatment, even to change documents. In this sense, particularly in the medical context, we also speak of transgenderism, which implies a change of sex or a desire to change sex (Drobnič

Radobuljac et al., 2024). According to the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th edition; APA 2022), gender dysphoria refers to "... *distress that may accompany a discrepancy between one's own experienced or expressed gender and one's assigned gender*" and also requires the presence of "... clinically significant distress or impairment in social, school, or other important areas of functioning"; the DSM-5 lists gender dysphoria as a mental disorder. On the other hand, the most recent version of ICD-11 (International Classification of Diseases, 11th edition; WHO 2018/2019) describes gender non-conformity as a condition '*... characterized by a marked and persistent discrepancy between an individual's experiential sex and assigned sex*'; ICD-11 now lists gender non-conformity as a condition related to sexual health (whereas previous versions of the ICD listed it as a 'mental and behavioral disorder').

A person's biological sex is determined by their genetic characteristics. The English language does have the term "sex" (for biological sex), as opposed to the term "gender" (which is a social and cultural construct describing how individuals understand, express and experience their sex) (Peters et al., 2018). Sex as a biological fact is a scientifically proven and widely accepted phenomenon, one of the most fundamental characteristics of living beings; gender as a social construct is a relatively recent, also controversial, concept or theoretical framework that is contested by many (Kuby, 2015). Gender as a biological fact (sex) could be therefore seen as a scientifically proven phenomenon, but the same cannot be said of sex as a social construct, which is also accepted differently in different cultures and societies, and in different times (gender; also translated here as 'sexual identity', but in legal language in some instances the term 'sexual self-image' is recommended, because it is vernacular and at the same time does not imply the possibility of external imposition (as the term 'identity' can)).

Sex is correctly determined in over 99.95% of newborn babies at birth (or, in most cases, earlier in pregnancy by ultrasound), according to the physical characteristics of the newborn (fetus) (the term "sex assignment", which is also often used in recent times, is thus not a term that is appropriate in terms of meaning and expertise). In very exceptional cases (in our case, a few children a year), the sex at birth remains unclear - these are intersex conditions, which have recently been more frequently referred to as "Disorders/Differences of sex development" (DSD) (Witchel, 2018). The sex characteristics of these persons (e.g. chromosomes, gonads or genitals) do not correspond to the typical (binary) notions of the male or female body (e.g. sex chromosomes, gonads or genitalia). Traditionally, pediatric medical treatment has been reserved almost

exclusively for cases with (congenital) disorders of sex development (intersex conditions), but not for gender identity disorder or gender dysphoria (transgender conditions) (Drobnič Radobuljac et al., 2024). In all the cases where sex at birth is not (completely) clear, interdisciplinary management should be provided, working together with the family to protect the best interests of the child; empathic communication is always needed (Witchel, 2018).

Increased prevalence of gender dysphoria

Until a few decades ago, gender dysphoria was very rare; until this millennium, there has been no significant development of expertise and capacity in this field. Few people sought medical help and intervention in this regard. Until just over ten years ago, the "typical" child with gender dysphoria was a prepubertal male (biological) child, extremely rare in the population (Drobnič Radobuljac et al., 2024). However, as some published scientific research shows, within a relatively short period of time (especially in the last 10-15 years), female (biological) adolescents started to show gender dysphoria, often with a new onset (i.e. these girls had no personal history of gender dysphoria at an earlier, pre-pubertal stage) (Bachmann et al., 2024; Drobnič Radobuljac et al., 2024). Often, gender dysphoria was already present in someone in their friendship or social circle, usually also social media users (Littman, 2018). There have also been reports from several developed countries of an increase of more than 1000% in the prevalence of gender dysphoria in recent years, particularly in the female adolescent demographic (Bachmann et al., 2024; Hilden et al., 2021). The main reason for this increase in the incidence of gender dysphoria in a relatively short period of time cannot be biological, but various other factors (psychological, social) are thought to play a role.

Associated mental health issues

Children and adolescents diagnosed with gender dysphoria have high rates of co-occurring mental disorders (Boyd et al., 2022). A recent study in Germany found that more than 70% of young people diagnosed with gender dysphoria had at least one other psychiatric diagnosis (Bachmann et al., 2024). Comorbid diagnoses included depressive disorder, anxiety disorders, borderline personality disorder, attention deficit/hyperactivity disorder and post-traumatic stress disorder. Autism spectrum disorders are also frequently present. These findings underline the importance of a holistic approach, including in particular clinical psychological and pedopsychiatric treatment for both gender dysphoria and co-occurring mental disorders, as these problems are often closely linked. Such treatment is needed before any transition (Drobnič Radobuljac et al., 2024). According to

the recent Finnish study, suicides remain uncommon events in gender-dysphoric youth, regardless of gender transition status and the results do not suggest that gender transition reduced suicides. The results suggest that the clinical management of gender-dysphoric young people should focus on the management of comorbid psychiatric conditions, which are a well-known risk factor for suicides (Ruuska et al., 2024).

The natural course and stability of diagnosis of gender dysphoria

Symptoms of gender dysphoria at prepubertal ages decrease or even disappear in a considerable percentage of children (most published estimates range from 80–95%). One recent study found that in very few cases (only 2%) does gender dysphoria intensify in young adults if untreated; in all others, it is alleviated or no longer present (Rawee et al., 2024). Most children will thus not remain gender dysphoric after puberty; with regard to sexual orientation, the most likely outcome of childhood gender identity disorder is homosexuality or bisexuality (Wallien et al., 2008). Therefore, any intervention in childhood would seem premature and inappropriate (Cohen-Kettenis et al., 2008). Since most gender dysphoric children will not remain gender dysphoric through adolescence (Wallien & Cohen-Kettenis, 2008), it is recommended that young children do not make a social transition (e.g. different clothing, a different given name, referring to a boy as “her” instead of “him”) (de Vries and Cohen-Kettenis, 2012).

Transition, "confirmation therapy" and medical therapies for gender dysphoria in children and adolescents

Many individuals with gender dysphoria seek various social, legal and medical changes that validate their subjectively experienced gender. Social transition means representing one's preferred gender in a personal setting (e.g. family, friends, workplace, school, etc.) by using different names and pronouns, dress, behavior. This is usually the first step that can lead to legal and/or medical transition. Legal transition means e.g. formal name and/or gender changes in documents. Medical transition can be achieved by prescribing hormones (estrogen or testosterone, depending on the biological characteristics of the person) and/or gender reassignment surgery, including genital (gynecological, urological) and other procedures (e.g. mastectomy, plastic surgery, ear, nose and throat procedures). Medical transition is not allowed for children and adolescents in most of the countries in Europe and elsewhere. Legal transition is very limited as well (Drobnič Radobuljac et al., 2024). Additionally, the WHO has recently indicated that the evidence basis for commencing medical gender reassignment interventions during developmental years is

weak and insufficient, and therefore the forthcoming WHO guidelines will not concern minors (WHO 2024).

Affirmation (or affirmative) therapy is an approach that affirms and supports the adolescent's expressed gender identity. This year, a comprehensive report by pediatrician Hilary Cass and a team of contributing experts ("The Cass Review") was published (Cass 2024), showing that affirmation therapy is not supported by adequate scientific evidence and can have irreversible consequences. The report refutes many of the arguments for invasive and irreversible interventions on children seeking sex reassignment. The report's findings show that many of the studies supporting this therapy are exaggerated or misrepresented. The report warns against social transition of children as this increases the likelihood of further medical interventions. The vast majority of children and adolescents experience gender dysphoria without medical intervention. Children and adolescents are one of the most vulnerable groups, which means that any medical intervention with them is subject to high ethical standards. Any deviation from these standards is a serious ethical concern. Globally, in most of the countries, confirmatory therapy is not practiced or even forbidden in children and adolescents.

Puberty blockers (technically known as GnRH agonists) are reasonably safe drugs that are scientifically indicated, especially for children and adolescents with precocious puberty. In the last 15 years, however, puberty blockers have been used (in some countries frequently) in children and adolescents with gender dysphoria, without a formal professional indication, and the expected benefits of the treatment were overstated, on the premise that delaying puberty gives adolescents time to explore their sexual identity without the pressure of the physical changes associated with biological puberty (Clayton, et al 2022). However, if an adolescent with gender dysphoria is given puberty blockers, his/her development proceeds differently than it would otherwise have done; indeed, in one (admittedly very rare) study from the Netherlands, all adolescents treated with puberty suppressants subsequently went on to hormone therapy (which is clearly inconsistent with the fact that gender dysphoria resolves on its own in most cases by young adulthood) (De Vries et al., 2011). Thus, rather than buying time for children to explore their feelings about gender and weigh risks and benefits of various treatment options, as proponents of puberty suppression have often claimed, now multiple studies demonstrate nearly all children who undergo puberty suppression proceed to cross-sex hormones (Carmichael, et al 2018; Drobnič Radobuljac et al., 2024; Rew et al., 2021). In this way, puberty blockers have encouraged all of them to 'chronicle' their gender

dysphoria. There is currently no method to identify the small proportion of children and adolescents who are expected to persist with gender dysphoria into adulthood. Such treatment outside serious clinical studies are therefore highly controversial as it is a violation of the usual professional and ethical standards in medicine. Recently, several countries have banned the practice - Sweden, Denmark, Finland and the United Kingdom in particular. Western European countries are still developing protocols for clinical studies that could assess the effects of this type of treatment (Cass, 2024; Drobnič Radobuljac et al., 2024; WHO 2024; Rew et al., 2021).

Hormone therapy for gender dysphoria is a medical procedure that uses hormones to stimulate physical characteristics that are consistent with an individual's expressed gender identity (e.g. breast development in biological males, or a deeper voice and hair growth in biological females). It can be a step forward from puberty suppressants. Similarly, to the use of puberty suppressants, there is currently no appropriate professional indication for the use of this therapy in adolescents, no adequate clinical trials, no long-term studies on treatment outcomes and safety. Hormone therapy for gender dysphoria in adolescents has recently been banned outside the research setting by several of the aforementioned countries. Some experts are of the opinion that the consequences of such therapy may include, in particular, an increased risk of cancer of the gonads, an increased risk of cardiovascular disease and a higher incidence of infertility. The physical changes themselves (e.g. deep voice) are mostly irreversible (Cass, 2024; Drobnič Radobuljac et al., 2024; Ludvigsson et al., 2023).

The next step is often surgical transition, in the case of girls, surgical removal of the breast (mastectomy) or, in both sexes, correction of the genitals and/or other parts of the body in the direction of the desired sex characteristics. In some foreign countries, such procedures are carried out on adolescents, which is unacceptable as they are mostly irreversible and often have serious health consequences (e.g. high rates of urinary incontinence, infertility, stress). It is generally believed that an adolescent cannot make such a far-reaching decision (Cass, 2024; Drobnič Radobuljac et al., 2024). By comparison, sterilization (a common consequence of surgical transition) is in itself prohibited in adolescents almost universally.

Regret and detransition

More recently, detransition has gained wider recognition as a process in which an individual who has previously undergone social, legal, or medical gender transition decides to partially or fully discontinue their transition. This may involve a return to

identifying with their sex assigned at birth or adopting a different gender identity altogether. While social and legal transitions can often be reversed, medical interventions such as hormonal treatments and surgical modifications frequently result in irreversible physiological changes, which may complicate detransition and contribute to physical and psychological distress. The prevalence of detransition among adolescents remains unclear, as systematic data collection is limited, and definitions of detransition vary across studies. A survey-based study suggests that detransitioners often cite psychological distress, inadequate pre-transition assessments, social pressures, and changes in gender identity as key factors influencing their decision to revert. Furthermore, accounts from detransitioners indicate that they frequently experience medical complications from previous gender-affirming treatments, including sterility, chronic pain, and metabolic disorders (Littman, et. al., 2024; Vandenbussche, 2021; Jorgensen, 2023; Entwistle, 2021). Beyond medical concerns, sociocultural factors also play a significant role in the detransition experience. Some individuals report experiencing alienation from LGBTQ+ communities and non-acceptance from previously supportive environments, leading to additional emotional distress and identity conflicts. Additionally, online platforms have become a major space for detransitioners to share their experiences, with many detailing regret, lack of informed consent, and insufficient psychological support prior to medical intervention (Vandenbussche, 2021; Jorgensen, 2023; Entwistle, 2021). Given these complexities, further longitudinal research is needed to better understand the long-term outcomes of medical transition, the factors influencing detransition, and the psychological needs of detransitioners (Entwistle, 2021; Drobnič Radobuljac et al., 2024).

Main bioethical issues in the management of children with gender dysphoria

Bioethics, rooted in the principles of autonomy, beneficence, non-maleficence, and justice, serves as the foundation for clinical decision-making. The treatment of gender dysphoria in children and adolescents presents one of the most complex ethical dilemmas in modern medicine, as it involves high-stakes, irreversible interventions on a population with developing cognitive and emotional maturity. Very recently, the Cass Review (Cass 2024) and the ESCAP Statement (Drobnič Radobuljac et al., 2024), in line with some other documents, raise significant concerns about the ethical justification for current treatment models, particularly gender-affirming medical interventions. These reports, along with growing evidence from Sweden, Finland, the UK, and Germany, highlight that the ethical principles governing pediatric medicine are being compromised in the rush to

affirm gender identity without sufficient long-term data (Cass, 2024; Drobnič Radobuljac et al., 2024).

Informed consent and respect for autonomy. One of the most fundamental ethical breaches in pediatric gender medicine is the failure to ensure informed consent. The principle of autonomy dictates that patients must be capable of making informed decisions about their treatment. However, in the case of children and adolescents, there are serious concerns about their ability to provide meaningful consent for lifelong medical interventions. Neuroscientific research confirms that adolescents have an underdeveloped prefrontal cortex, impairing their ability to evaluate long-term consequences, assess risks, and make high-stakes decisions (Gerritse, K., et al., 2018). Current consent processes in pediatric gender medicine are inadequate and misleading, as clinicians often fail to fully explain the experimental nature of treatments and their irreversible effects (Cass, 2024; Drobnič Radobuljac et al., 2024). Furthermore, the affirmative approach assumes that a child's stated gender identity is fixed and should be immediately affirmed with medical intervention. This disregards the fact that many children later desist from their dysphoria (Drescher, et al. 2014). Thus, the practice of allowing minors to consent to irreversible medicalization—despite scientific uncertainty and their underdeveloped decision-making capacity—constitutes a fundamental violation of autonomy and informed consent. Furthermore, the minors should – as a matter of principle - not be permitted to consent to interventions with permanent, poorly studied consequences.

Non-maleficence and the risks of medical harm. The ethical principle of non-maleficence ("do no harm") demands that medical interventions must not inflict avoidable harm. The evidence base for puberty blockers and cross-sex hormones in minors is alarmingly weak, with emerging concerns about serious long-term effects. Puberty blockers have been in many cases misrepresented as harmless and fully reversible, when in reality they disrupt natural development, impair bone density, and may impact cognitive function (Cass, 2024; Drobnič Radobuljac et al., 2024). Furthermore, almost 100% of children who start puberty blockers progress to cross-sex hormones, contradicting the claim that they are a “pause button” function (Drobnič Radobuljac et al., 2024). Adolescents who take cross-sex hormones face lifelong sterility and permanent loss of normal sexual function, a consequence that is minimized or omitted in clinical discussions (Cass 2024). Evidence also suggests that hormonal interventions increase risks for cardiovascular disease, osteoporosis, and metabolic disorders (Bizic, et al., 2018). Thus, the affirmative model disregards non-maleficence by offering poorly

studied, potentially harmful interventions to vulnerable minors. Unproven treatment with significant risk of harm should not be offered to children.

Very convincingly, this notion was elaborated by Jorgensen et al. in a very recent paper arguing that puberty blockers may prevent the right to an open future of children and adolescents (Jorgensen, et al. 2024). Two key - problematic and unproven-by-evidence - assumptions are still prevailing (1) puberty blockers are a low-risk, reversible intervention, and (2) that suppressing puberty will improve physical and psychological outcomes in later life. While the adverse effects of puberty blockade for a short time may be minimal, many children remain on puberty blockers for years, which can lead to harm (e.g., negative effects on bone and brain development, inability to have children of their own, or experience sexual pleasure as adults). There are also significant unknowns associated with interrupting a vital step of human development. Furthermore, puberty suppression is not a reversible, standalone intervention, but instead it triggers a cascade of increasingly invasive medical interventions. Rather than buying time for children to explore their feelings about gender and weigh risks and benefits of various treatment options, as proponents of puberty suppression have often claimed, multiple studies that demonstrate nearly all children who undergo puberty suppression proceed to cross-sex hormones. The authors convincingly conclude that delaying "*medical transition until the child has had the chance to grow and mature into an autonomous adult would be most consistent with the open future principle.*" Finally, the authors note that the same reasoning can be applied to treating youth with cross-sex hormones and surgeries although not the subject of the paper (Jorgensen, et al. 2024).

Beneficence and underlying psychological conditions. The ethical principle of beneficence demands that medical interventions must be in the best interest of the patient. However, emerging research indicates that many children diagnosed with gender dysphoria suffer from co-occurring mental health conditions that are overlooked. The Cass Review (Cass 2024) concludes that individuals with gender dysphoria have disproportionately high rates of depression, anxiety, autism, and histories of trauma—yet these conditions are often ignored in favor of fast-tracking transition. The ESCAP Statement (Drobnič Radobuljac et al., 2024) warns that medical transition is being prioritized over psychotherapy, despite the fact that many gender-questioning children might benefit from psychological support rather than medicalization. By failing to prioritize mental health treatment and instead pushing children towards irreversible medicalization, the gender-affirming model violates beneficence.

Principle of justice. It requires equitable access to care, robust scientific scrutiny, and transparency. However, the field of pediatric gender medicine has been plagued by scientific and ethical failures. The Cass Review (Cass 2024) and NICE (NICE 2021) concluded that no high-quality studies demonstrate the safety or effectiveness of gender-affirming treatments in minors. Furthermore, gender medicine has been heavily politicized, leading to suppression of dissenting views and resistance to scientific scrutiny (Drobnič Radobuljac et al., 2024). Any administering of medical treatments without scientific integrity and proper ethical oversight constitutes a violation of justice. One could even argue, that all pediatric gender medical treatments be paused until rigorous, long-term studies are conducted.

Conclusions

Recently, a significant development in understanding the medical and ethical aspects of gender dysphoria in children and adolescents are witnessed (Cass 2024; Drobnič Radobuljac et al., 2024). Most notably, a comprehensive report by pediatrician Hilary Cass and a team of contributing experts ("The Cass Review") was published (Cass 2024), showing that affirmation therapy is not supported by adequate scientific evidence and can have irreversible consequences. In particular, it is important that child or young person with gender dysphoria receives professional treatment and support as soon as possible, from an experienced clinical psychologist or pedopsychiatrist who has experience in this field and who will be able to liaise with other professionals (Drobnič Radobuljac et al., 2024). We can conclude, that the current approach to the management of gender dysphoria in children and adolescents represents in many cases a profound ethical failure in modern medicine. The violation of core ethical principles—autonomy, non-maleficence, beneficence, and justice—raises serious questions about the legitimacy of current practices. Informed consent is not possible due to cognitive immaturity and lack of reliable evidence; non-maleficence is compromised by offering harmful, poorly studied interventions; beneficence is disregarded as underlying psychiatric issues are ignored; justice is undermined due to lack of scientific rigor and transparency. Given these grave ethical concerns, gender-affirming medical interventions in minors should be halted immediately until robust, long-term research is conducted. Medicine must return to its core ethical commitments: "*Primum non nocere*"—first, do no harm.

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BIOETHICAL ISSUES FROM A PAEDIATRICIAN'S PERSPECTIVE

Dr. Andrej Hrádický



1957 born in Trenčín, Slovakia

1963–1972 primary school, Trenčín, Slovakia

1972–1976 grammar school, Trenčín, Slovakia

1976–1977 nuclear engineering, Czech Technical University, Prague, Czech Republic

1977–1983 medicine, Charles University, Prague, Czech Republic

1983–1984 military service

1984–1990 resident doctor, Paediatric Department, Trenčín Hospital, Slovakia

1990–1993 assistant, 1st Children's Clinic, University Hospital, Bratislava, Slovakia

1994–2004 resident doctor, Neonatal Department, 1st Gynaecological Clinic, University Hospital, Bratislava, Slovakia

2004–2024 doctor, private children's practice, Trenčín, Slovakia

1994–2024 member of the Bioethics Committee of the Slovak Bishops' Conference

Paediatrics is a medical field that, unlike other medical specialties, consists of two equal components: on the one hand, the clinical medicine component, which deals with the diagnostics, therapy, and prevention of diseases in newborns and children, and on the other hand, the sociological-preventive component, which deals with the sociological and societal impact on children and youth (including issues related to laws concerning children and youth, children and youth's health and life protection in its broadest sense, nutrition of children and youth, living conditions of children and youth, education of children and youth, etc.). Both components include many bioethical elements.

The United Nations Convention on the Rights of the Child (UNCRC) was adopted on 20 November 1989 (Article 3, Paragraph 1) and it states:

“In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.”

Although the convention has been adopted by many countries, in many of them, other interests, other “rights”—often quite strange—take precedence over the best interests of the child for ideological reasons. A classic example of not respecting the best interests of the child is an abortion. Is performing an abortion (i.e., killing the child) the best interest of the child, which, according to the UNCRC, should be the primary consideration?

The actual non-compliance, disrespect or distortion of what is in the best interest of the child is, in the overwhelming majority of cases, also an ethical and bioethical issue.

Both of the mentioned components that comprise paediatrics contain a rich array of ethical and bioethical issues. The child itself is usually powerless against its environment and needs protection—parental, societal, medical, and economic.

This comprehensive perspective on the field of paediatrics carries the need and necessity to address other ethical-bioethical questions, on the one hand, in the area of healthcare management and financing, on the other hand, in family policy.

In practical terms, it means, for example, supporting the creation of conditions for gynaecological and paediatric practices that operate in accordance with Catholic ethical values, advocating for health insurance and legislation aligned with Catholic ethical values, etc. The reasons for this are as follows:

Today, the position of doctors and healthcare professionals is rapidly and radically changing due to a complex change in the structure and functioning of healthcare systems. Gradually, what once was a free profession, where doctors made decisions about patients freely according to their best knowledge and conscience, is becoming a profession dependent on various institutions and their regulations and limits. Due to these regulations and limits, doctors and healthcare professionals are often pressured and forced into decisions that are contrary to their ethical and moral principles.

Until the mid-20th century, the medical profession was a free profession, allowing doctors to make independent decisions regarding the diagnosis and treatment of individual patients. It was a direct, non-anonymous doctor-patient relationship in all aspects. Doctors were expected to follow a specific ethical approach, as defined, for example, in the Hippocratic Oath. These ethical principles were also defined in the health legislation.

However, from around the second half of the 20th century, as structures of healthcare management and financing gradually began to form, the free and independent medical decision-making regarding the diagnosis and treatment of individual patients gradually and subtly began to be restricted.

The structures gradually penetrated the direct doctor-patient relationship and increasingly took over the decision-making about patients in an anonymous and indirect manner – decisions no longer based solely on ethical criteria but also on other factors, such as economic, social, age-related criteria, etc. (For example, patients over a certain age are no longer entitled to a specific therapy, or due to age or other reasons, they are no longer entitled to a particular drug, etc.)

Furthermore, these structures of healthcare management and financing gradually began to make decisions that directly contradicted the medical ethics/Hippocratic Oath – such as decisions about the so-called “quality” of human life, assessed based on criteria that were diversely defined and formulated, or decisions about whether and to what extent a health insurance company would invest in the diagnosis and treatment of a particular patient.

These decisions were (and are) made by the mentioned structures anonymously, often based on other than ethical criteria, and doctors and healthcare professionals are pressured in various ways into implementing these decisions.

The mentioned healthcare structures do not make any ethical vows or oaths and often try to adjust the legislation in such a way that their decisions, even though contrary to the medical ethics, adhere to the applicable laws.

This development is very dangerous and can gradually transform certain medical fields and professions in a fundamentally negative manner. It is also necessary to realise that in the organization of healthcare (for example, pharmaceutical policies, vaccination policies, health insurance, robotics, artificial intelligence, telemedicine, etc.), globalization trends are rapidly taking place.

Therefore, it is essential to seek ways and opportunities to implement ethical and moral criteria—with the clear priority of putting the best interest of the patient created in God’s image first—into these processes.

ADVANCE "MIS-DIRECTIVES": EUTHANASIA IN CATHOLIC HOSPITALS IN THE UNITED STATES

George Isajiw MD,KM



Past President, Catholic Medical Association, USA

Past Vice-President, FIAMC

Presented at the World Congress of Catholic Medical Associations in Seoul, Korea on September 3, 2002

The 1980 "Declaration on Euthanasia" by the Sacred Congregation for the Doctrine of the Faith, defines euthanasia as "... an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated".

The traditional distinction between "ordinary" and "extraordinary" treatments is emphasized, indicating that only "ordinary" treatments are obligatory. "Extraordinary treatments", even if risky or excessively burdensome, CAN be used : "—If there are no other sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity."

It is important to note that while "extraordinary" treatments are not obligatory, using them DOES NOT constitute any moral harm to the patient, even if the treatment cannot, in effect, achieve its goal to sustain life or improve health. The Vatican document further states that "... it is also permitted, with the patient's consent, to INTERRUPT these means [treatments], where the results fall short of expectations."

The authors of the Vatican document provide a safeguard against an arbitrary withdrawal of beneficial treatment with the following statement: "... But for such a decision to be made, account will have to be taken of the REASONABLE wishes of the patient and the patient's family, as also of the the ADVICE OF THE DOCTORS WHO ARE SPECIALLY COMPETENT IN THE

MATTER".

It is necessary to make a JUDGMENT that a given treatment does, in fact, meet the criteria of being "extraordinary" in the moral sense. While it is always the PATIENT (or in the case of incompetence, the patient's surrogate) who makes the DECISION whether or not to withdraw treatment, it is the PHYSICIAN who must make the JUDGMENT that a given treatment is, or has become "extraordinary": "...The latter [i.e. the physicians] may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques."

Ordinary treatment can become "extraordinary", depending on the clinical situation: ".... When INEVITABLE death is IMMINENT in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted." Thus, a particular treatment, such as a ventilator, which would be "ordinary" for a reversible pathology such as an infectious pneumonia or reversible congestive heart failure, can become "extraordinary" in the case of irreversible respiratory or heart failure.

It is the doctor who makes the JUDGMENT, and it is the patient who makes the DECISION. One cannot act ethically without the consent of the other. The patient has the right to continue any treatment, even if in the opinion of the physician a given treatment is judged to be "extraordinary". This protection for the patient reaffirms the "Sanctity of Life", and reassures us that no treatment on behalf of sustaining life, even if extraordinary or "useless", should be considered objectively harmful, immoral or unethical.

As we all know, especially in the so-called developed societies such as the United States and Europe, euthanasia is becoming accepted as a way of solving the problem of suffering and advancing age. While this trend is clearly recognized in secular institutions, it is also rearing its "ugly head" in Catholic health care facilities as well. There is a wide-spread attempt to justify both active and passive euthanasia among Catholic ethicists through a false application of the principles of "ordinary" and "extraordinary" means, and the false application of the principle of patient "autonomy".

It has become particularly popular to falsely apply the principles and legal distinctions of so-called "Advanced Directives", or "Living Wills", in order to promote euthanasia.

Unfortunately, because one can "theoretically" rationalize the use of advance directives as

merely a means of expressing the desire to avoid "extraordinary" treatment, the Catholic Church in the United States has endorsed the concept of a "Living Will", which is promoted as a means of expressing legitimate autonomy and legitimate end of life decisions.

I have collected a series of case histories involving my own patients at my Catholic hospital. Most of these cases involve the refusal by the surrogate decision makers to consent to the use of ventilators or feeding tubes under circumstances where this would have been ordinary treatment for a non-terminal patient with a reversible pathology. A typical example is an incompetent patient who has had a stroke with paralysis and dysphagia. The patient needs a long term feeding tube, and is otherwise medically stable. Natural death is NOT imminent. The provision of tube feeding is certainly useful in providing nutrition and hydration and the burden does NOT outweigh the benefit. However, because the patient may have an "advance directive" or "living will" which specifically states that feeding tubes are NOT to be used, the family insists that it is the patient's wish to be allowed to die from dehydration under such circumstances.

An "Advance Directive" has NO significance UNLESS the patient is BOTH incompetent AND in a terminal condition. It is the physician's responsibility to judge whether a terminal condition truly exists. Hospital ethics committees often misrepresent Catholic medical-moral teaching to the family, convincing them that it is they, and ONLY they, who determine what is ordinary or extraordinary. They then advise the family to transfer the patient's care to another physician who will carry out their wishes. A "do not resuscitate" order (in some Catholic institutions it is now ironically termed "allow natural death") is given. Intravenous fluids are discontinued and the patient is given a morphine drip in rapidly increasing doses, resulting in death within 24 to 48 hours thereafter.

Another typical example is a patient who has the diagnosis of incurable cancer, but is not yet terminal, and the prognosis is still reasonably good for an extended period of time, perhaps 6 months to a year, or longer. When such a patient develops an infectious pneumonia or congestive heart failure which are treatable and reversible, but may require a ventilator for a short period of time -- permission for a ventilator is denied by the family. This is often based on the reasoning that if the patient recovers, he or she will have to face suffering and death from the cancer in the future -- and thus it is better to allow death now. Again, the theologian representing the ethics committee concurs with the family's reasoning, and justifies it based on an improper interpretation of the concept of "extraordinary care". Empowered by the opinion of the theologian who often is a Catholic priest or a nun, the family is erroneously led to believe that their decisions are in accordance with the Magisterium.

It is of particular interest to point out that the ethics committee typically condones withdrawal of treatment on the basis of patient autonomy (disregarding the physician's medical opinion as a matter of principle). When the opposite happens – if the family wishes to continue treatment against the advice of the physician, the ethics committee then sides with the physician, attempting to convince the family of the futility of further treatment, and the acceptability of treatment withdrawal. It appears to be the proverbial "one way street", to use an American idiom. "Time for a Formalized Medical Futility Policy" was published in the July-August 2000 issue of "Health Progress", the official journal of the Catholic Health Association of the United States. This organization, like many Catholic hospitals, is independent of the Bishops of the United States. This proposition is excellently critiqued and refuted by Wesley J. Smith under the title "Not-So-Catholic Bioethics" in the winter, 2001 edition of the "Human Life Review", which is an independent pro-life publication. Wesley Smith is also the author of a landmark book, "Culture of Death, the Assault on Medical Ethics in America". Author Smith states: "Futile-care policies directly contradict Catholic moral teaching concerning end-of-life care. Indeed, the Bishops identify 'omissions' that are intended to cause death...as a form of euthanasia, an act unequivocally forbidden by Catholic moral teaching...To get around this snag, the authors equate the treatments in question with the Catholic concept of "extraordinary care..."

This trend towards euthanasia in Catholic institutions reflects a false understanding of Church teaching about the nature of death, and the nature of life after death as well. This is rooted in the heretical rejection of the possibility of suffering AFTER death, thus resulting in the false belief that death represents relief of all suffering. The basis of the Church's strong condemnation of ALL EUTHANASIA is precisely based on the CERTAIN knowledge, through Faith, that death is NOT necessarily the end of all suffering, and that eternal life is NOT inevitably achieved by death. Eternal life requires forgiveness of sins and the atonement for sin (either before or after death), in union with the Redemptive Suffering, Death and Resurrection of Our Lord Jesus Christ. Thus, it is not death which ends suffering, but rather the Mystery of Redemption.

Author Wesley Smith concludes: "Church leaders have been sound in promulgating Catholic doctrine on medical ethics but slow to recognize the threat from within. They must now act swiftly and diligently, to the point, if necessary, of prohibiting renegade institutions from using the word "Catholic" in their names. There is still time to preserve the concept of sanctity of life, with all that that implies. But if the fifth column is not rooted out, its penetration of Catholic institutions will continue, and before we know what happened the new medicine will rule triumphant."

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ESCUCHAR AL PACIENTE: APRENDER A CUIDARLO

Andrés de Juan y María Gloria Simón



Andrés de Juan Ortega es enfermero asistencial en el Hospital Clínic de Barcelona, cuya labor combina de manera paralela con la investigación, pasión que surgió durante los primeros cursos de la carrera cuando comenzó a interesarse por el mundo de los cuidados paliativos y la bioética. A raíz de su interés, organizó y coordinó unas sesiones de bioética mensuales para el grupo joven Bioética SAFOR de la Archidiócesis de Barcelona, junto con otros estudiantes del mundo de la salud, donde invitaban a diversos expertos para promover este campo entre la gente joven. Actualmente está realizando un doctorado en la Universidad de Barcelona sobre gestión de sistemas sanitarios y recursos humanos.



Maria Gloria Simón Codina es estudiante de sexto curso de Medicina en la Universidad Autònoma de Barcelona. Actualmente ejerce sus estudios en la unidad docente del Hospital de la Santa Creu i Sant Pau, donde está realizando sus prácticas clínicas. Ha sido voluntaria en el Cottolengo del Padre Alegre, donde se encargaba del cuidado de pacientes con enfermedades crónicas y terminales, y a partir del cual comenzó a desarrollar un fuerte interés por el ámbito de la bioética y los cuidados paliativos. A raíz de este interés,

organizó y coordinó unas sesiones de bioética para jóvenes a través de la asociación cultural Gausac ubicada en Sant Cugat del Vallés.

Hay mucho que aprender

La doctora en Medicina y Psiquiatría, Elisabeth Kübler-Ross, se vio en un compromiso cuando el catedrático Sydney Margolin, su jefe en el laboratorio de psicofisiología del departamento psiquiátrico de la Universidad de Colorado, la designó para reemplazarle en sus clases teóricas en la Facultad de Medicina, debido a que él debía ausentarse dos semanas. Pronto se sintió abrumada, puesto que el Dr. Margolin tenía fama de buen conferenciante. No obstante, a medida que le daba más vueltas al tema que debía elegir para hablar a los alumnos, Kübler-Ross acabó dando en el clavo tras reparar en aquello que tenían en común los distintos especialistas médicos que irían a escucharla: la muerte. De hecho, en su autobiografía escribía lo siguiente: *“Todos los enfermos y médicos pensaban en ella. La mayoría la temían. Tarde o temprano, todos tendrían que enfrentarse a ella; eso era algo que médicos y enfermos tenían en común, y era probablemente el mayor misterio de la medicina. Y el mayor tabú también”* (1).

Corrían los años 60 en EE. UU., y a pesar de vivir en un país lleno de progreso para la época, tuvo grandes dificultades para encontrar información sobre el tema de la muerte. Además, la Dra. Kübler-Ross, quería darle un enfoque distinto. Entendiéndola mejor, pensaba, los médicos se sentirían menos violentos ante la muerte. Puede que, sencillamente, debieran hablar de cómo es morir.

Así que, a la hoy en día famosa psiquiatra, se le ocurrió llevar a la clase a una chica de 16 años con leucemia, que moriría en poco tiempo. La conferencia fue un “éxito” rotundo. A pesar de atender en ocasiones a pacientes con enfermedades terminales, muchos de los oyentes nunca habían reflexionado sobre lo que era vivir con una enfermedad así. Durante la práctica clínica, sólo pensaban en términos médicos y parámetros analíticos. No se les ocurrían otras preguntas para hacer a los pacientes más allá de las que tenían relación con esos aspectos. Al final de la sesión, el silencio dominaba la sala. Los presentes no podían dejar de pensar qué sentirían si estuvieran en el lugar de esa chica.

Las palabras que les dirigió la psiquiatra al terminar la sesión recogen muy bien el sentimiento general: *“Tal vez ahora no solo vais a saber cómo se siente un moribundo, sino también seréis capaces de tratarlos con compasión, con la misma compasión con la que desearíais que os trataran a vosotros”* (1).

Y el sentimiento que nos puede surgir a nosotros, al pensar en este suceso de hace más de 60 años, puede ser el siguiente: hay muchísimo que aprender sobre la vida escuchando a los moribundos.

Oímos, pero no escuchamos

La anécdota de la Dra. Kübler-Ross puede resultarnos todavía muy actual. Si nos paramos a pensar, los que trabajamos en algún ámbito del mundo sanitario a menudo vamos de aquí para allá, centrados en los aspectos más clínicos de la enfermedad de nuestros pacientes y, con frecuencia, incluso olvidamos sus nombres. Pasan a ser rápidamente “*el paciente de la habitación 9.1*”, “*el de la 13.2*”, o bien “*el del linfoma*” o “*el del sarcoma*”, etc.

Vivimos en una época de velocidad, rapidez, inmediatez, en la que, acostumbrados a obtenerlo prácticamente todo en unos pocos segundos, apenas dejamos espacio para la tranquilidad y el sosiego. Falta tiempo para la reflexión, para la meditación. No escuchamos. O no sabemos escuchar a otros, más allá de nosotros mismos. Oímos, pero no escuchamos. Tampoco a nuestros pacientes.

¿Qué podemos hacer nosotros para calmar la mirada que recibimos de los ojos asustados de un paciente cuando ingresa en un hospital? ¿Cómo podemos procurar que encuentre la acogida que necesita en ese momento de miedo e inseguridad?

¿Qué debemos cambiar para que ese anciano desorientado o ese adolescente que tiene trato por primera vez con “grandes especialistas de la medicina”, puedan expresar lo que sienten, puedan transmitirnos sus preocupaciones?

Debemos tener presente la importancia de escuchar a nuestros pacientes, la importancia de conocer lo que requieren de nosotros. Es posible que aquellos pacientes con enfermedades más avanzadas no nos estén pidiendo que busquemos y empecemos un nuevo tratamiento curativo, sino simplemente que hagamos lo que podamos para paliar su dolor. Quizás, si supiéramos escuchar también a las familias, podríamos tener una mejor visión del conjunto. Tal vez, si nos escucháramos mejor entre los mismos profesionales podríamos ver de manera holística las necesidades que tiene nuestro paciente, y no enfocarnos solamente en nuestra área de especialidad.

La falta de escucha, desgraciadamente, también se respira en ocasiones en Facultades de Enfermería y Medicina. A menudo, centrados únicamente en el diagnóstico clínico y en la curación de la enfermedad, nos olvidamos de transmitir a los alumnos la esencia del cuidado, o la importancia de la calidad de vida.

Nuestro papel como médicos y enfermeros va mucho más allá de encontrar una solución para el problema agudo que trae a una persona a nuestro centro. Parece que tenemos claro que acompañar es un pilar del cuidado al paciente con enfermedad en fase terminal, pero no deberíamos esperar a encontrarnos en ese punto, en ese extremo, para ofrecer a nuestros pacientes algo tan humano como es el acompañamiento en un momento de sufrimiento. Saber cuidar es comprender que la atención a las personas cuando enferman va mucho más allá de tratar la enfermedad. Es cierto que los profesionales, en un ámbito tan acelerado como puede ser un hospital, podemos tener dificultades a la hora de establecer pautas para que los requerimientos médicos de la enfermedad no nos hagan olvidar, o relegar a un segundo plano, el acompañamiento que precisan los pacientes y sus familias.

El cuidado siempre está focalizado en las personas y en las acciones que busquen su máximo bienestar, y algunos profesionales que deberían ejercerlo están más centrados en el control de la enfermedad que en el cuidado de la persona que la padece. El fracaso del cuidado en el ámbito asistencial no es la enfermedad o la muerte, sino la falta o escasez de ayuda que ofrecemos a nuestros pacientes frente al sufrimiento. Un sufrimiento que puede ser muy distinto en cada persona. Un sufrimiento que se puede manifestar en forma de dolor físico, pero también en forma de miedo ante el reciente diagnóstico de una patología crónica no terminal como puede ser una diabetes tipo 1 en un adolescente, o en forma de duelo ante la pérdida de un hijo en una mujer embarazada de gemelos.

Ante aquellas personas con enfermedades potencialmente mortales, uno de los recursos que tenemos a nuestra disposición, a través del cual podemos aliviar su sufrimiento, son los cuidados paliativos. Se trata de cuidados que tienen como objetivo evitar o aliviar el sufrimiento y mejorar la calidad de vida. Se pueden ofrecer desde el primer momento en que un paciente es diagnosticado de una enfermedad grave y sufre como consecuencia de esta. Al proporcionarse al mismo tiempo que el resto de los tratamientos para la enfermedad, no hay razón alguna para esperar (2). Parece que hoy en día, estos conceptos tan básicos acerca de los cuidados paliativos son desconocidos por una parte de los profesionales del ámbito sanitario, pues en algunas universidades lo poco que se explica sobre los cuidados paliativos es en referencia a pacientes dependientes que se encuentran en sus últimos días. En dicho contexto, los estudiantes adoptan una concepción errónea de lo que son estos cuidados, quién puede recibirlos y cuándo deberían ofrecerse, lo cual puede comportar consecuencias negativas para aquellas personas susceptibles de recibirlos, a las que los profesionales no se los ofrecen por desconocimiento.

No enfatizamos lo suficiente, quizás, la importancia de paliar el dolor siempre, incluso cuando el tratamiento de elección ya no resulte efectivo. No enseñamos el valor que pueden tener unos buenos cuidados paliativos, no uno o dos días antes de fallecer, sino semanas o meses antes, para que el hablar de la muerte sea parte de una etapa más de nuestra vida. Para que podamos morir bien, y también ayudemos a otros a morir bien, como una etapa natural de la vida.

Un mundo cambiante

Nos encontramos cada vez más con un aumento progresivo de la esperanza de vida de las personas, especialmente en países occidentales. Este aumento de la esperanza de vida, aunque positivo, entraña grandes retos, pues con él han aumentado también las personas que, al llegar a una edad avanzada, acumulan consigo un sinfín de patologías, muchas de ellas crónicas, que con el paso del tiempo y la complejidad asociada de un estadio avanzado dificultan mucho los tratamientos a seguir y el cuidado que los profesionales sanitarios deben proporcionarles en su día a día (3).

A su vez, aunque todavía en un estado incipiente, estamos aprendiendo a convivir con nuevas tecnologías como la inteligencia artificial, que nos están planteando dilemas éticos al presentarnos diferentes maneras de hacer las cosas. El cuidado de los enfermos está cambiando y, de manera inevitable, aquellos que hemos hecho del cuidado del prójimo nuestra profesión, debemos adaptarnos a estos cambios y acoger los beneficios que nos ofrecen, tratando de preservar esa mirada humana que solo se puede dar de una persona a otra.

Este aumento de las tecnologías lleva asociado, como es lógico, un aumento de la hiper especialización. Médicos y enfermeras especialistas se preparan durante años para, con sus conocimientos, poder cuidar y tratar de la mejor forma a sus pacientes. Realizan carreras universitarias de varios años de formación, másteres, residencias y estancias en el extranjero, con tal de llevar los avances más importantes de otros países a sus campos respectivos.

Incluso con todo el progreso de las profesiones sanitarias, al tener los pacientes de hoy en día necesidades más específicas y cuidados más complejos, surge, inevitablemente, la paradoja de los cuidados del siglo XXI, donde a pesar de la hiper especialización y el avance técnico hemos dejado atrás esa mirada de totalidad que tanto deseáramos que tuvieran con nosotros si estuviéramos enfermos y que, quizás, sí que existía hace unos años.

Posiblemente, y volviendo al punto planteado en el apartado inicial de la psiquiatra Kübler-Ross, una buena formación en Cuidados Paliativos es lo que mejor encarnaría esta mirada holística tan necesaria en la actualidad.

Desgraciadamente, hoy por hoy las asignaturas de cuidados paliativos son algo escasas, y la colaboración multidisciplinar que tanto demandan los alumnos es insuficiente en carreras universitarias como Enfermería y Medicina (4).

No se enseña a cuidar a la persona de manera integral y holística. Al llegar a la práctica clínica, como estudiantes o ya graduados, a menudo no somos conscientes de las fases vitales que experimenta el paciente. Nos cuesta ver en profundidad qué otras necesidades humanas, relacionadas o no con su enfermedad, pueden tener en este doloroso proceso durante el cual se encuentran a nuestro cuidado.

Tal vez, si recibiéramos con más insistencia esta formación en los aspectos del final de vida, podríamos ir acompasados al ritmo del paciente, estableciendo junto con él, en cada momento, qué es lo que más le conviene y lo que necesita. Qué es lo que nos pide que hagamos por él.

¿Falta de referentes?

Parece que quedan atrás los tiempos en los que médicos reconocidos como el Dr. Giuseppe Moscati sabían ver que estamos aquí de paso, y que es tan o más importante el cuidado del alma como lo es el cuidado del cuerpo.

Moscati, a principios del siglo XX, tenía una visión integral de lo que debía ser la enseñanza médica, *“que no concebía como una mera transmisión de conocimientos científicos [...]”* sino que *“estimulaba a sus alumnos a que se preocupasen, además del cuerpo, del alma de los enfermos. [...] Sabía que esos momentos, en los que aparentemente el médico ya no tiene nada que hacer, son de hecho, paradójicamente, cuando el médico puede hacer más”*(5).

Fijándonos en personajes como Moscati, Kübler-Ross o tantos otros que han sabido distinguir lo accesorio de lo principal cuando han estado al lado de los enfermos (Jérôme Lejeune, José Gregorio Hernández, Santa Madre Teresa de Calcuta...), los jóvenes de hoy en día también podemos tener presente la manera en que supieron tratar a sus pacientes. De modo que nosotros seamos también ejemplos y referentes para los demás, y sepamos transmitir, como lo hicieron ellos, la esencia del cuidado y esa mirada compasiva que deberíamos tener en el trato diario con nuestros pacientes. Aunque reconozcamos la imposibilidad de curar a alguien de su enfermedad, y que inevitablemente muera al cabo de unos días o meses, no significa esto el final de nuestra participación como enfermeros

o médicos, sino que podemos asegurar el cuidado hasta el final. *“Curar si es posible, cuidar siempre”* afirmó San Juan Pablo II (6).

Nos parece conveniente recordar también aquellas palabras del papa San Pablo VI que fueron tan acertadas en su época como lo son ahora, y que, con una sola frase, resume lo esencial del mensaje que hemos querido transmitir:

“El hombre contemporáneo escucha mejor a quienes dan testimonio que a quienes enseñan (...), o, si escuchan a quienes enseñan, es porque dan testimonio” (7).

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SOBRE LA CONSTITUCIONALIDAD DEL ABORTO EN ESPAÑA.

Javier Junceda



Licenciado en Derecho por la Universidad de Oviedo y Doctor en Derecho por la Universidad de Valladolid. Autor de más de dos centenares de publicaciones. Académico Correspondiente de la Real Academia Española de Jurisprudencia y Legislación y de la Academia Norteamericana de la Lengua Española. Académico de Honor de la Academia Peruana de Derecho y Miembro de la Sociedad Peruana de Derecho Internacional. Académico de Número de la Real Academia Asturiana de Jurisprudencia y Miembro de Número del Real Instituto de Estudios Asturianos. Doctor Honoris Causa en Derecho por seis universidades extranjeras (entre ellas, la Mayor de San Marcos, decana de América), y Profesor Honorario de otras seis. Ha impartido conferencias en España, Bélgica, Brasil, Perú o Estados Unidos. Forma parte de numerosos consejos de redacción de revistas españolas y extranjeras. Columnista habitual en la prensa española, compagina el ejercicio de la abogacía en su propio despacho -Junceda Abogados, fundado en 1994-, con la docencia del derecho en universidades de Madrid, Barcelona y Oviedo, habiendo ejercido como decano en dos de ellas, en una durante dos mandatos. Ha impartido también la docencia en otros centros de Estudio, como la Escuela Judicial Española o distintos Colegios de Abogados. Está acreditado como profesor agregado, contratado doctor y de universidad privada, con sexenio investigador. Ha participado en la elaboración del Diccionario Panhispánico del Español Jurídico, auspiciado por la Real Academia Española y la Asociación de Academias de la Lengua Española, y ha dirigido y escrito el Glosario Jurídico Hispanounidense, para la Academia Norteamericana. Preside la Comisión de Derecho, Economía y Ciencias Sociales del Real Instituto de Estudios Asturianos. Es, desde 2016, vocal de la Comisión de Urbanismo y Ordenación del Territorio del Principado de Asturias, nombrado por el Gobierno entre expertos de

reconocido prestigio. Y, desde 2022, miembro del Consejo Asesor de la Asociación Española de Derecho Urbanístico.

I.

Dos sentencias del Tribunal Constitucional español han puesto de actualidad la regulación del aborto. La primera, la número 44/2023, de 9 de mayo, sobre la Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo. Y la segunda, número 92/2024, de 18 de junio, sobre la Ley Orgánica 1/2023, de 28 de febrero, por la que se modifica la anterior Ley Orgánica. Ambas decisiones cuestan compartirse en estrictos términos jurídicos, como trataré de razonar centrándome en las principales cuestiones polémicas. Adelanto que parte de mi argumentario ha sido puesto de manifiesto, oportunamente, por distintos magistrados del Tribunal en sus votos particulares, que bien merecían a mi modo de ver de haberse llevado al fallo. Ello no ha sido así, desafortunadamente, por diferentes motivos extrajurídicos, entre los que cabría citar una configuración del pleno del Supremo Intérprete constitucional poco alejado del control político y de una deseable exégesis legal neutra.

Aunque existan extremos merecedores de discrepancia aparte de los que expondré -como los relativos al consentimiento informado o la objeción de conciencia-, considero que los que nos ocuparán constituyen el núcleo esencial de ambos fallos, que a mi juicio resultan desacertados y provocan una grave desprotección del *nasciturus*, que como diremos debiera continuar gozando de amparo constitucional no solo por elementales razones jurídicas, sino por su notoria vulnerabilidad e indefensión. Es difícil de creer que, en tiempos en que hasta se modifica la Constitución Española para sustituir el término “disminuido” por “persona con discapacidad”, se permita terminar legalmente con un ser humano en formación, esté en perfecto estado o con padecimientos.

II.

La STC 44/2023 insiste con reiteración en una “interpretación evolutiva” de la norma fundamental (que no hace mención alguna al aborto), para justificar que la Ley Orgánica 2/2010 resulta constitucional, e incluso el “modelo legal” más ajustado a la ley de leyes española en el presente contexto histórico.

Con independencia de que tanto los “modelos legales” como las propias leyes pueden cambiar con el tiempo a resultas de la propia dinámica democrática y social, no parece lo más acertado contemplar como constitucional algo que no está incluido entre los preceptos insertos en la *norma normarum*. Para eso está la reforma constitucional, anclada en el sacrosanto principio democrático en el que asientan nuestros sistemas políticos. Por

más que los norteamericanos hablen de *living constitution*, extendida a otras culturas jurídicas comparadas, esta doctrina no puede sustituir a los mandatos más elementales previstos para la alteración de las constituciones si estas caen en obsolescencia o la sociedad así lo desea con su voto en referéndum.

Además, esta sentencia soslaya una doctrina anterior del mismo Tribunal que ofrecía una mayor protección constitucional al *nasciturus* o “vida humana en formación” (las SSTC 53/1985, 212/1996, 116/1999, ó 66/2022), jurisprudencia sobre la que el legislador concibió precisamente la norma impugnada, sin que se explique ahora satisfactoriamente el cambio de criterio operado por la Corte de garantías. Lejos de eso, no razona por qué se aparta de tales precedentes, sino que incluso consagra nada menos que una especie de derecho fundamental de la mujer al aborto, incompatible por definición con lo sentenciado con anterioridad, toda vez que los derechos de la mujer no pueden ni deben tener primacía absoluta sobre la vida del *nasciturus*, que es también un bien jurídico protegido por el art. 15 Constitución Española.

Esta sentencia de 2023, al reconocer un nuevo derecho fundamental de la mujer “a la autodeterminación respecto de la interrupción del embarazo”, establece, además, un deber de los poderes públicos para garantizar su efectividad. Y lo contrapone al deber de proteger la vida prenatal como bien constitucionalmente protegido por la STC 53/1985. Como es natural, algo así desborda por completo lo reservado a la justicia constitucional, pues lo que se hace es plasmar un nuevo derecho fundamental, algo que solo puede hacer de forma exclusiva el poder constituyente, único capaz de reescribir la *norma normarum* para concebir en ella nuevos derechos fundamentales u ordinarios a través de los oportunos procedimientos de reforma.

Como parece obvio, esta sentencia debiera de haber considerado que el deber de tutelar la vida humana en formación debe cohonestarse con los derechos e intereses legítimos de la mujer embarazada, como declaró oportunamente la STC 53/1985, algo que desgraciadamente no hace.

Por otro lado, desde las tempranas SSTC 4 y 11/1981, el alcance del enjuiciamiento constitucional “no consiste necesariamente en cerrar el paso a las opciones o variantes imponiendo autoritariamente una de ellas”, sino fijar los límites dentro de los cuales puede moverse libremente el legislador y convertir en ley sus opciones políticas, plasmar sus preferencias ideológicas y sus juicios de oportunidad. Una libertad legislativa que deriva de su específica legitimidad democrática, de su naturaleza como representante en cada momento histórico de la soberanía popular (*ex art. 66 CE*).

En las SSTC 215/2016; 191/2016, y 112/2021, se dijo también que “el legislador no ejecuta la Constitución, sino que crea Derecho con libertad dentro del marco que esta ofrece”, de forma tal que “este Tribunal Constitucional no ha de hacer las veces de propio legislador, constriñendo su libertad de disposición allí donde la Constitución no lo haga de manera inequívoca”

Como es natural, al crear un nuevo derecho fundamental al aborto, el Intérprete se aparta de esos justificados precedentes constitucionales, y en lugar de analizar si la opción legislativa sobre el aborto se acomoda o no a la Constitución, y por qué lo hace o no, acaba generando algo jamás concebido por el constituyente. Y explayándose incluso sobre la idoneidad de un modelo legal determinado, sin mención alguna a los preceptos impugnados en concreto en dicho proceso constitucional.

Por otro lado, las discutibles afirmaciones de poderosa carga ideológica en que se funda esta sentencia no logran sin embargo desentrañar las razones por las que la libertad de la mujer precise necesariamente del sacrificio de la vida del *nasciturus*, considerado para esta sentencia una especie de apéndice no deseado o bulto sospechoso del cuerpo de la mujer, valga la expresión, cuando se trata de una vida humana en formación y en total indefensión, además, frente a aquellas acciones orientadas a poner fin a su existencia por la decisión de la madre en cuyo cuerpo se encuentran.

La STC 53/1985 declaró a tales efectos que la vida humana era “un devenir que comienza con la gestación, en el curso de la cual una realidad biológica va tomando corpórea y sensitivamente configuración humana, y que termina en la muerte”. Y en el que “la gestación genera un *tertium* distinto de la madre, aunque alojado en el seno de esta”. Por consiguiente, entre el *nasciturus* y el cuerpo femenino existe una relación de alteridad, de donde debiera haberse seguido una protección dual cuando la existencia del concebido depende todavía de la gestante, pues la dependencia de la madre no convierte al *nasciturus* en una parte suya, como si se tratara de un órgano corporal materno.

En su consecuencia, el concebido es un bien jurídico protegido precisamente por su dimensión humana, de ahí que deba participar de la protección del derecho a la vida (art. 15 CE), algo imposible de alterar convirtiéndolo en materia disponible a voluntad de su madre. Por ello, la vida del *nasciturus* cuenta con un valor constitucionalmente protegido por tratarse de una vida humana en fase de gestación, insusceptible de destrucción. Y ello sin mencionar que la madre no puede reservarse el derecho exclusivo a decidir sobre el concebido, al tratarse de un embrión humano fecundado que porta el ADN de sus dos progenitores.

En relación con el llamado sistema de plazos, esta sentencia consagra que durante determinadas semanas (catorce) el *nasciturus* carezca de protección y que en ese tiempo no exista limitación alguna a la decisión de la mujer, que a su libre arbitrio podrá disponer la destrucción del feto, como si fuera una parte de su cuerpo de la que puede deshacerse a voluntad, sin condicionamiento de ningún tipo y orillando la voluntad de quien ha contribuido con su ADN a la generación del embrión fecundado y cuya legitimación ha declarado el Tribunal Europeo de Derechos Humanos válida a efectos de personarse como víctima de un aborto practicado a su hijo no nacido (asunto *Boso c. Italia*).

Como se plasmó en la STC 53/1985, “los derechos de la mujer no pueden tener primacía absoluta sobre la vida del *nasciturus*, dado que dicha prevalencia supone la desaparición, en todo caso, de un bien no solo constitucionalmente protegido, sino que encarna un valor central del ordenamiento constitucional” (FJ 9). Y en la STC 66/2022. (FJ 6), se insistió en que “el *nasciturus* constituye un bien jurídico cuya protección encuentra fundamento constitucional en el art. 15 CE, en cuanto encarna el valor fundamental de la vida humana, garantizado en dicho precepto constitucional”.

Sin embargo, ambos razonables precedentes constitucionales resultaron desplazados, sin justificación alguna, por esta lamentable decisión de 2023, que no tiene en cuenta que la vida humana en formación merece protección constitucional y que constituye además un derecho fundamental básico, sin el que los demás carecen de sentido. Y no digamos nada en el caso de supuesto de aborto del no nacido por el hecho de padecer una enfermedad extremadamente grave e incurable, que puede ser detectada una vez transcurridas las veintidós semanas de gestación, cuando ya es susceptible de vida independiente.

III.

La segunda sentencia del Tribunal Constitucional español sobre el aborto que centra nuestro interés es la número 92/2024, de 18 de junio.

Con apoyo en la anterior de 2023, concibe al aborto como derecho fundamental de la mujer durante las primeras catorce semanas de gestación, lo que implica el correlativo abandono por el Estado de su obligación de proteger al *nasciturus*, apartándose de la proclamación constitucional de la STC 53/1985, de que es bien jurídico digno de protección conforme al artículo 15 CE.

Con todo, esta decisión va aún más allá de la STC 44/2023, que en cierto modo reconocía que la Ley Orgánica 2/2010, “satisface el deber estatal de protección de la vida prenatal” al dispensar al *nasciturus* una protección “gradual” en atención al desarrollo del embarazo, durante determinadas semanas.

Sin embargo, en la STC 92/2024 se confirma la constitucionalidad de un sistema que durante las primeras catorce semanas de gestación no reconoce al *nasciturus* protección jurídica alguna, apartándose de manera definitiva del parecer de 1985.

Eso supone alejarse diametralmente de los criterios comparados o de instituciones europeas, que han venido rechazando de forma sistemática el reconocimiento de cualquier “derecho al aborto” o fórmula similar (así, Comité de Ministros del Consejo de Europa o Parlamento Europeo, en 2013). Es más: el Tribunal Europeo de Derechos Humanos considera que el art. 8 del Convenio Europeo de Derechos Humanos (CEDH) no puede interpretarse en el sentido que confiera ningún derecho al aborto (STEDH de 16 de diciembre de 2010, asunto *A, B y C c. Irlanda*), ni tan siquiera derecho a practicarlo (asunto *Jean-Jacques c. Bélgica*). En el mismo sentido, en la STEDH de 30 de octubre de 2012, asunto *P. y S. c. Polonia*, el Tribunal declaró que el art. 8 CEDH no se puede interpretar como otorgamiento de ningún derecho al aborto.

A mayores, como con loable claridad expositiva y oportuna justificación esgrime la magistrada Espejel Jorquera en sus autorizados votos particulares a estas sentencias, otros tribunales constitucionales han reconocido el derecho a la vida del embrión humano, como el Tribunal Federal Alemán en su sentencia de 25 de febrero de 1975, al admitir que el derecho a la vida, reconocido en el art. 2 de la Ley Fundamental de Bonn, se extiende a la vida del embrión, “en tanto que interés jurídico independiente”. Con posterioridad, la sentencia del Tribunal Constitucional Federal de 28 de mayo de 1993 indicó que “en el momento así determinado del embarazo, el no nacido es una vida individual que ya no es divisible, que está definida ya en su identidad genética y, por lo tanto, en su singularidad y no intercambiabilidad, que en el proceso de crecimiento y auto-desplegarse (*im Prozeß des Wachsens und Sich-Entfaltens*) se desarrolla no hacia un ser humano sino como un ser humano”.

En fin, la sentencia del Tribunal Supremo de los Estados Unidos de América de 24 de junio de 2022 (caso *Dobbs contra la Organización Jackson para la Salud de las Mujeres*), declaró que el supuesto derecho al aborto no está recogido en la Constitución americana, Ni siquiera se puede amparar en el derecho a la libertad y que tampoco se puede amparar en la cláusula del debido proceso de la decimocuarta Enmienda. Y que en ningún caso el feto puede considerarse como propiedad privativa de la mujer.

Por si fuera poco, esta sentencia del Tribunal Constitucional español que comentamos alcanza hasta avalar la novedosa previsión de que las administraciones educativas tienen que promover una visión de la sexualidad desde la óptica del placer y el deseo. Como

sostiene en su atinado voto discrepante el magistrado Tolosa Triviño, “es difícil negar lo insólito de un precepto legal que impone la visión que debe darse a las relaciones sexuales, pero igualmente insólito resulta que este tribunal se pronuncie sobre esta cuestión, que es totalmente ajena a los valores de la libertad, la igualdad o el respeto a los que se refiere la sentencia”.

La decisión constitucional española que nos ocupa llega al extremo de definir lo que debe entenderse por una visión “saludable y completa de las relaciones sexuales”, lo que sin duda es un exceso de enjuiciamiento constitucional, al suponer un adoctrinamiento incompatible con la doctrina del Tribunal Europeo de Derechos Humanos, que lo prohíben respecto a comportamientos sexuales determinados (STEDH de 7 de diciembre de 1976, asunto *Kjeldsen, Busk Madsen y Pedersen c. Dinamarca*, § 54).

IV.

Por las razones apuntadas, las decisiones sobre el aborto del Tribunal Constitucional español merecen ser calificadas como desacertadas en términos jurídicos, siendo clementes en el juicio. No se alcanza a comprender, salvo que exploremos coyunturas extrajurídicas, que una mayoría de especialistas en derecho no hayan sabido decidir con arreglo a argumentos sólidos y hayan preferido deslizarse por las siempre resbaladizas pendientes sociológicas o políticas. Es imperdonable que así sucediera teniendo en cuenta los formidables aportes técnicos incluidos en los diversos votos disidentes de la sentencia, especialmente los de la magistrada Espejel, unos textos impecables y cargados de elemental razón jurídica y sentido común.

Lo más grave de esta cuestión es que futuras reformas legislativas del aborto en España pueden encontrar en esta doctrina constitucional un severo escollo, salvo que, con base en la misma “interpretación evolutiva” del texto fundamental al que tanto se apela en estas dos sentencias, el propio Tribunal opere un deseable cambio de rumbo en un futuro próximo, otorgando como procede un decisivo amparo al que va a nacer, porque todos, incluidos los magistrados del alto órgano, hemos sido en su día también embriones, titulares por tanto de derechos constitucionales dignos de protección.

ABORTION PILL REVERSAL

Dr Dermot Kearney



Dr Dermot Kearney qualified as a medical doctor from University College Dublin in 1989. After completing General Medical and Specialist Cardiology training in Ireland, he completed a two-year Fellowship in Interventional Cardiology in Leiden and Amsterdam in 2003. Since 2003, he has been working as a Consultant Cardiologist and General Medical Physician in the North-East of England.

He became a member of the Catholic Medical Association (UK) in 2008 and was President of the Association from 2018 until 2021. He has been a member of Council of the CMA (UK) since 2010 and is currently an assistant Vice-President of FEAMC. He is the current FIAMC World Medical Association representative.

In 2020, along with Dr Eileen Reilly, he established the Abortion Pill Reversal service in the UK but was temporarily banned from continuing that service for a nine-month period from May 2021 until February 2022. The APR service resumed in the UK in March 2022 after the General Medical Council investigation concluded there was “no prospect” of finding any evidence to support the allegations of potential professional misconduct that had been fabricated by abortion providers.

Introduction

In many jurisdictions where induced abortion is allowed, the majority of abortions are now carried out by chemical, rather than surgical, means. In England and Wales, drug-induced abortions accounted for 86% of the total number of 252,122 abortions reported in 2022.¹ In Scotland, 99% of 13,758 abortions reported in 2021 were carried out by chemical means.² It is estimated that 63% of induced abortions in the USA in 2023 were induced by drugs.³

The drugs most commonly used to induce abortion are Mifepristone and Misoprostol in combination. This regimen has been used to induce abortion in the UK since 1990, having

been first approved and used in France one year earlier. The drugs received Food and Drug Administration (FDA) approval for induction of abortion in the USA in 2000.

Mifepristone is administered first. In the UK and in the USA, the recommended dose of Mifepristone is 200mg. Higher doses of 600mg are used in some other jurisdictions, most notably in several other European countries. Mifepristone is a specific Progesterone receptor antagonist. By competing for Progesterone receptor sites with natural endogenous Progesterone, it blocks the action of the natural hormone Progesterone that is essential to maintain pregnancy by maintaining the integrity of the endometrium.

One common cause of spontaneous miscarriage in early pregnancy is a low level of natural Progesterone production. By blocking the natural action of Progesterone, the administration of Mifepristone mimics a state of low Progesterone levels or insufficient Progesterone effect and thereby frequently induces miscarriage by interfering with the process of decidualisation, causing shedding of the endometrium to which the developing embryo or fetus is attached. Decidualisation is a process of endometrial cellular morphological and functional change in preparation for, and during, pregnancy.

The second drug, Misoprostol, is taken 24-48 hours after the administration of Mifepristone, in order to complete the intended abortion and emptying of the uterus. It is a Prostaglandin analogue that induces intense contraction of the uterine muscle cells. The recommended dose of Misoprostol for abortion induction in the UK and USA is an initial dose of 800 micrograms with additional doses of 400 micrograms if necessary to complete the abortion.

Some mothers during pregnancy change their minds about continuing with a planned abortion, even after they have taken the first abortion pill, Mifepristone. Even though Mifepristone per se is very effective in inducing miscarriage, there is a window of opportunity whereby sometimes the lethal effect of the drug on the developing child can be prevented and its effect reversed by offering bioidentical Progesterone therapy. This use of Progesterone is known as Abortion Pill Reversal (APR) treatment. Just as Mifepristone can block the natural effects of endogenous Progesterone by competing for Progesterone receptors, similarly exogenously-administered Progesterone can act as the natural antidote to the potentially poisonous effect of Mifepristone by competing for those same receptor sites and allowing the life-saving and pregnancy-maintaining effect of the hormone to continue.

Discussion

There are three possible outcomes for a developing child in utero after the child's mother has taken Mifepristone to induce abortion.

1. The child's mother may continue with the abortion process and take the second abortion-inducing pill, Misoprostol, 24-48 hours later as instructed by the abortion providers. This is the outcome in the vast majority of drug-induced abortions. When both Mifepristone and Misoprostol are effectively administered, there is a 98% chance the baby will be killed by induced abortion.⁴
2. If the child's mother takes Mifepristone, doesn't take Misoprostol but doesn't receive Progesterone rescue therapy, there is still an 80% chance her baby will be killed by abortion.⁴
3. If she takes Mifepristone, doesn't take Misoprostol and promptly receives rescue treatment with Progesterone and continues the rescue treatment, there is a 50-68% chance her baby will survive.^{5,6}

The UK experience is that APR achieves a success rate with successful antagonisation of Mifepristone of 50-55%.⁶ Studies from the USA have demonstrated a possible 64-68% success rate.⁵ Likely explanations for the difference in success rates relates to a greater awareness of the service in the USA and a greater number of APR providers relative to the UK. Rescue treatment is delivered in a more timely manner in the USA. The mean time for administration of the first dose of Progesterone therapy after Mifepristone has already been administered in the UK is 25 hours.⁶ Delivery of Progesterone occurs earlier in the USA. Furthermore, in many US centres, it is possible to obtain immediate or urgent ultrasound examinations to assess whether or not the developing child is still alive after Mifepristone has been administered. This is rarely possible in the UK where treatment is started blindly with the hope that the child may still be alive. In the UK, it can take several days before ultrasound examinations can be arranged. Overall, however, APR therapy more than doubles the chance of a baby surviving after a mother has been administered Mifepristone relative to expectant management alone and receiving no rescue Progesterone therapy.

Success of APR appears to be dependent on a wide variety of factors including the stage of gestation at which the Mifepristone was administered and the delay in the initiation of Progesterone rescue treatment.⁵ The method of Progesterone administration also appears to be an important factor. One large observational study demonstrated higher success rates with oral and intramuscular administration of Progesterone relative to vaginal pessary administration.⁵ It is likely, however, that other factors may be important in determining

success rates such as the general health of the mother and the presence or absence of other medical conditions and concomitant medications, her previous obstetric history, maternal age, maternal body mass index, educational and socio-economic factors.⁶

Since the APR Network programme was established formally in the USA in 2012, more than 6000 babies have been saved by their mothers seeking this service.⁷ Importantly, there is no evidence of any increased risk of congenital defects for those babies that have been saved, despite the early exposure to Mifepristone.⁵ It is apparent that Mifepristone either ends the life of the developing child at an early stage after administration during pregnancy or has no long term effects whatsoever. Furthermore, Progesterone has been used in pregnancy for more than fifty years and is widely recommended for helping to reduce the risk of miscarriage in mothers who are perceived to have an increased risk of miscarriage in early pregnancy. It is also used routinely in in-vitro fertilisation to help maintain pregnancy.⁸ The doses of Progesterone used in APR rescue treatment are similar to the doses used in those other currently-recognised and approved clinical situations.

When a mother wishes to seek help with APR treatment in an attempt to save her baby after regretting that she has taken Mifepristone, she can do so in a variety of ways. She can contact the 24/7 international APR network helpline and the trained nurses will arrange care for her with an APR-providing physician in her area. Alternatively, she may be able to contact a local pregnancy help centre or prolife organisation who can readily find a local APR provider for her. The APR provider, after discussing the treatment in great detail with her and obtaining her fully-informed consent to initiate the protocol, arranges emergency Progesterone treatment for her. The initial dose, administered as soon as possible after Mifepristone, is micronized Progesterone 400mg twice daily for three days followed by 400mg once daily (or 200mg twice daily) for at least a further two weeks. Micronised Progesterone can be administered by oral capsules (Utrogestan in the UK) or vaginal pessaries (Cyclogest in the UK).

In some jurisdictions, intramuscular (IM) Progesterone injection regimens may also be available. One APR protocol using IM injections recommends the use of compounded Progesterone in oil 200mg IM slowly over 2-3 minutes as soon as possible after the ingestion of Mifepristone. followed by 200 mg IM once a day for two more days and continuing 200mg IM on alternate days until day 14 after Mifepristone ingestion. The same IM dose may then be continued twice weekly until the end of the first trimester.

Whichever APR treatment regimen is used, the aim is to help endogenous and exogenous Progesterone molecules compete for Progesterone-binding receptor sites with

Mifepristone molecules, to counteract the potential pharmacological effects of Mifepristone, to preserve pregnancy and to protect the developing child to at least 13 weeks gestation. By the start of the second trimester, the placenta is usually capable of producing sufficient quantities of natural endogenous Progesterone to maintain pregnancy.

While APR may prove effective in preserving pregnancy in more than 50% of cases with initiation and continuation of treatment when commenced within 72 hours of Mifepristone ingestion, as long as heavy bleeding or severe abdominal cramps have not commenced, it is vital to start treatment as soon as possible, ideally within 6 hours of Mifepristone administration. The earlier rescue treatment is commenced, the higher the chances of a successful outcome.^{5,6}

Despite the life-saving effects of APR and the excellent safety record associated with the treatment, there is an unfortunate widespread lack of awareness of the availability and the well-established benefits of the service among the general population. From the very start of the APR service, it has attracted a great deal of opposition, primarily from abortion providers and particularly from staunch promoters of drug-induced abortion using Mifepristone and Misoprostol.⁹

Those opposed to APR, initially claimed that it was very rare for women to change their minds about continuing with abortion after taking Mifepristone. It was later claimed that APR was no more effective than expectant management alone in allowing for continuing pregnancy after ingestion of Mifepristone and before Misoprostol administration.⁹ The term “expectant management” refers to the employment of a conservative or “watch and wait” approach by avoiding the subsequent administration of Misoprostol after initial Mifepristone administration but not attempting to intervene by the use of Progesterone or any other measure designed to prevent or reverse the pharmacological effect of Mifepristone.

When it became clear that these claims of a lack of necessity and a lack of efficacy of APR were without foundation with the increasing evidence of the demand for APR and the impressive real life success rates and the observational data indicating success⁵, a new claim of a potential “danger” of APR was fabricated and propagated by abortion providers.¹⁰

A very small study published in 2020 has been used to support this claim.¹⁰ The “study” was designed by Mitchell Creinin, an abortionist from California and an early outspoken

critic of APR. He was determined to design a “study that can be definitive” to demonstrate once and for all that APR was “junk science”.¹¹

The actual design of this “study” merits assessment. It was described as a “Randomized Controlled Trial” yet it was certainly not controlled. It was decided in advance that only 40 subjects would be required for the trial to demonstrate a superior efficacy of APR over “expectant management” if such a superiority actually existed. With such small numbers, it is quite obvious that this “study” was designed to demonstrate an absence of superiority. In addition, no attempt was made to “control” for any of the relevant factors that may be important in determining whether or not APR may or may not be successful in preserving life, such as maternal age, previous obstetric and general medical history, concomitant medications, BMI, socio-economic factors and even the gestational stage of pregnancy. It was therefore not a Randomised Controlled Trial but rather a poorly-designed randomised Trial.

Despite the poor design, the “study” went ahead. It had been decided to recruit 40 mothers who had taken Mifepristone to induce abortion. From this cohort, 20 would receive oral Progesterone 24 hours later and 20 would receive placebo. None of the 40 would have Misoprostol administered. They would be followed up with ultrasound examinations and blood testing for Progesterone levels up to 15 days after the administration of Mifepristone. If they were still pregnant at that stage, they would be offered surgical abortions.

In total, 12 volunteer mothers were recruited to participate. Of these, 6 were assigned to the APR group receiving oral Progesterone and 6 were assigned to the placebo group. Following randomisation, 2 mothers withdrew from the study within a matter of days and proceeded to undergo complete abortions. One withdrew from each of the two groups. The “study” was discontinued ahead of schedule after these 12 mothers had been recruited. The results from the remaining 10 participants had demonstrated that 4 of the 5 mothers who had received Progesterone after Mifepristone were still pregnant with viable pregnancies at the 15 day mark. Among those who had received placebo (expectant management), only 2 out of 5 were still pregnant. This represented a doubling of the survival rate (80% versus 40%) for babies whose mothers had received APR relative to the survival rate for babies whose mothers did not receive Progesterone rescue therapy. In addition, 2 of the 5 mothers in the placebo group needed emergency hospital attendance due to severe haemorrhage. One of these two required a blood transfusion and the other required emergency surgical intervention. Of the 5 mothers who received Progesterone

therapy, only 1 required an emergency attendance due to heavy bleeding. Following assessment, she was discharged from hospital without the need for any intervention. She did not have a significant reduction in her haemoglobin level and she remained haemodynamically stable. Her Progesterone levels were lower than would have been expected, suggesting a possible issue with compliance or absorption of the oral Progesterone medication in her case.

This small study therefore demonstrated that Progesterone rescue therapy administered 24 hours after Mifepristone was more effective in preserving pregnancy and also reduced the risk of serious maternal haemorrhage when compared to expectant management alone for mothers who wanted to try to save their babies after Mifepristone administration.

Despite this outcome, the authors incredibly concluded that there was no evidence to demonstrate superiority of APR over expectant management and that APR per se might represent an actual danger to women who have taken Mifepristone as it might lead to severe haemorrhage. They stated that the “study” had to be discontinued because of those “safety” concerns. For any neutral observer, however, it should be clear that the reason for stopping the “trial” early was much more likely related to the fact that the authors did not like what was actually demonstrated after only 12 participants had been recruited. The “study” was not supposed to demonstrate that APR was not only more effective but also safer than expectant management alone.

Conclusion

In summary, Abortion Pill Reversal services using Progesterone is now widely available, is safe for both mother and child and is often effective in saving lives. If administered promptly after Mifepristone and continued for at least 2 weeks, APR using Progesterone more than doubles the chance of babies surviving despite exposure to Mifepristone in early pregnancy. There is no increased risk of any congenital malformations for babies who survive. More than 6000 babies (from 2012 to December 2024) whose mothers availed of APR services have already been born.

For those who need help in accessing abortion pill reversal, the Abortion Pill Reversal Network provides worldwide help 24/7 and can be accessed on abortionpillreversal.com

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A CATHOLIC BIOLOGIST IN MEDICINE: HOPE FOR BIOETHICS

Vincent Kemme



Vincent Kemme is a retired biology teacher from the Netherlands, who did additional studies in theology, philosophy and bioethics. He is the founder of the Biofides apostolate for biology, faith and ethics. He is married, father of six children and grandfather of five grandchildren. He lives in Belgium with his wife Ine, who is an occupational therapist. It is an honor for me to contribute to this important book on the ‘state of research ’in bioethics in the Year of Hope, 2025. I do so as a biologist, with a background in secondary education, a degree in biology from the University of Utrecht (the Netherlands) and a somewhat remarkable career both in the field of my faith and that of my work. In this article, I would like to share that career with you, to draw lessons from it for the way in which we think, speak and hopefully also act in bioethics from the perspective of faith.

Biology

What leads someone to study biology? In my case, that was simply the fascination with the phenomenon of “biological life. Growth, adaptation; reproduction; the ability to adequately respond app environmental stimuli, degrees of intelligence that you can increasingly observe in the animal kingdom, species diversity, the workings of plants, animals and the human body: so many things to marvel at and then want to understand better. Life is beautiful, fascinating, awakens our wonder. And with these insights, I saw myself as a secondary school teacher in the Netherlands: enthusing young people, as some excellent biology teachers had done with me.

Faith

By the time I made this life decision, I had left my faith and the Church behind me. I did not yet realize that I was living in one of the most secularized countries in Europe, where church life would go through a serious crisis, after the Second Vatican Council. Everything was in doubt, and the priests of my youth, still the new songs in the national

language, could not captivate me enough to get up in time to attend Mass from the age of 16 on Sundays. I was never an atheist: I called myself “practicing agnostic” and was not at all concerned with questions of faith and church. I was not against it, but neither was I for it. I simply did not know.

Until a classmate whom I continued to meet during my studies told me about the “charismatic movement,” a movement of prayer groups throughout the world, created immediately following the Second Vatican Council, in response - it is believed - to Pope John XXIII's prayer for a “New Pentecost. I let my friend have his way, but I did not follow him: I had more peers who did belong to one or another ‘cult’: I myself did not seek that. But the conversations with my school friend did often concern religion. One day we spoke about ‘how we saw God’. I don't remember what I said, but I vividly remember that at a certain point my friend asked me how I thought God saw *me*. That would cause a total turnaround in my thinking. However, for that to happen, God would have to exist, possess intelligence (have an idea about me) and have time to think about one of the then six billion people on Earth! I was not at all convinced of the first and second; I absolutely could not imagine the third.

Finally, I did go with him once, to a ‘Catholic-charismatic’ eucharistic celebration in the parish of my youth. The priest suggested that I would come three times and then make a decision, knowing that I had not seen the inside of a church for seven years. I thought that was a reasonable proposal. After having ‘survived’ the first two services (the way of singing and praying was very different from what I remembered from the past), I decided to take an evening out on the eve of the third time to see where I stood in terms of philosophy of life. Was I ‘left’, or ‘right’, ‘green’ (which was on the rise in those days), Christian? Catholic? Protestant (the Netherlands is a very Protestant country)? I didn't know.

That evening, I drew an isosceles triangle on a sheet of paper, with God, the world and ‘me’ in the three corners, to organize my thoughts. I reflected on the relationship between the world and God and found, as a biologist, that it was reasonable, plausible, to suspect a creative intelligence, or something of that nature, behind biological reality. There is so much ‘organisation’ in nature, so much ‘order’, ‘intelligence’, ‘purpose’ and ‘beauty’ that I could see myself calling myself a ‘Christian’, or at least ‘religious’. I saw no problem with a possible Christian identity in terms of the relationship between the world and myself. I grew up in a Catholic environment where the emphasis was very much on solidarity, the second commandment, and also on caring for the environment, but hardly

on the vertical dimension of faith, the personal bond with God. I had no problem with that social dimension of the Christian faith, nor with caring for the environment.

The relationship with God

But then it had to be about my relationship with God. I couldn't think of or write anything sensible about it. In the end I decided to do what those 'charismatics' often do: in their prayers, individually or in their prayer groups, just open the Bible anywhere and give God the chance to speak, to communicate something, a word that He wants to say to that person or group at that moment. I took a school edition of the New Testament that I had kept from my bookcase and opened it at random, with the thought: 'If you do exist...'. And I read *'It will lead to your giving testimony. Remember, you are not to prepare your defense beforehand, for I myself shall give you a wisdom in speaking that all your adversaries will be powerless to resist or refute'*, a passage from the Gospel according to Luke, chapter 21, verses 13-15. I could not help but feel personally addressed. I was writing out a kind of testimony of faith or justification, but could not get it right, and then 'Someone' tells you that you should not even try to prepare it because that 'Someone' has 'a wisdom in speaking', where 'my wisdom' had proven to fall short. It was as if 'Someone' had been looking over my shoulder, knew exactly what I was thinking, saw me fail in my attempt to justify my possible belief, and then offered 'His wisdom in speaking' instead. For a moment I thought: isn't this just a coincidence? Or am I imagining things? That evening I heard no voice from heaven, felt no warmth around my heart or other outwardly perceptible manifestations, but I did read this text, which provided a ready-made answer to what I had been contemplating that evening. In the end, I decided that it was more reasonable to believe that God had indeed spoken to me than the opposite. But that had enormous consequences! Imagine, the God of heaven and earth comes to visit you, with something personal to share? It would be overwhelming, wouldn't it? Later, a brother of mine gave me the Confessions of St Augustine as a gift. In part 8, I read the story of Augustine's conversion in a garden in Milan. He had opened a copy of the Epistle to the Romans at a time in his life when he was dealing with major existential questions, and read something that made him decide to live his life as a Christian from then on and to have himself baptized. Of course, I don't want to compare myself to this great church father, but I did think: I am in good company!

Biology, faith, ethics

During my years at university, two students from the traditionally very Calvinist province of Zeeland (not New Zealand, but Zeeland was needed) who studied biology in order to

prove that Darwin was wrong and that the theory of evolution was flawed. Only a literal interpretation of the first chapters of Genesis was acceptable to them, as that was, after all, 'the Word of God'. Between lectures, this naturally provided plenty of material for discussion with the predominantly non-believing students, who only believed in modern science. So the question of the debate between science and faith, more precisely 'evolution and creation', came to my attention. I had to gain clarity on this again, if only for myself.

Another theme was human sexuality. We were in the twilight of the sexual revolution that had taken our country by storm in the sixties. Sex outside of marriage had become an accepted reality. The use of contraceptives was self-evident: after all, you didn't want to conceive a child if you had sexual intercourse with another person. That did not, of course, apply to those who preferred sexual relations with someone of the same sex: no child would come from that. Because sexuality, 'thanks to' contraception, was no longer necessarily linked to fertility, sexual intercourse was also no longer necessarily something that had to take place between persons of different biological sexes. Experiencing sex had become an end in itself. Having children was perhaps something for later, but waiting to have sex until you were ready to have children, whether married or not, had become absurd. Persoonlijk was ik ook meegesleept in deze manier van denken en handelen, waardoor ik in mijn eerste relaties met meisjes niet erg 'katholiek' omging met seksualiteit.

But now I had discovered that God really does exist and it was as if a light had been switched on in my mind! Intuitively, I saw that my sexual behavior was not compatible with God, with Christ. In a long conversation with the aforementioned priest, I came to that conclusion and decided to live in abstinence from then on, until my marriage to my girlfriend at the time. I received God's forgiveness and started a new life. I married her several years later, now forty years ago, and we had six children and, for now, five grandchildren.

Teaching biology

But in this liberal climate, how was I going to teach biology at schools, even Catholic schools, which left the contraception lessons to the biologists and considered it absolutely necessary to prevent teenage pregnancies? I was spared that. In France I had become acquainted with the Emmanuel Community, a community for lay people, priests and consecrated sisters and brothers, recognised by the Church, which in my experience formed the ideal synthesis between 'charismatic renewal' and 'Catholic tradition'.

Thanks to a major sponsor, I was able to help establish this community in the Netherlands and organize numerous apostolic activities, including weekends for young people on subjects such as love and sexuality, and weekends for married couples on their calling to be fruitful in love, biologically and in many other areas.

In the Netherlands I taught for some time at a Catholic private school, and in Brussels at the European Schools. In the Belgian capital I had also studied theology, philosophy and bioethics to feed my thinking in those areas, to further understand the reasonableness of faith, and also the reasonableness of certain ethical positions of the Church.

Eventually, I decided to found the 'Biofides' apostolate in Belgium, a personal think tank for biology and faith and for bioethical issues. It started with attending the Evolution and Creation conference, in the Darwin Year of 2009, organised by the Pontifical Council for Culture. I was then invited to do radio broadcasts for Radio Maria Netherlands (and later also in Belgium). And I was invited by a French-speaking doctor from Brussels to join the board of the Belgian Medical Association Saint-Luke. This association could use some 'reorientation' when it came to medical ethics. Until last year, I served this association, including as editor-in-chief of the trilingual magazine *Acta Medica Catholica*.

When this Brussels doctor and chairman, Prof. Dr. Bernard Ars, one of the authors of this book, was elected president of the World Federation of Catholic Medical Associations (FIAMC), he asked me to support him in that position as his assistant, so that I could suddenly enter into discussions with doctors from all continents about the major issues surrounding faith and medicine: ethical issues, but also spirituality and intellectual development. It was there that I also had the pleasure of getting to know Dr José María Simón Castellví and was invited to speak in various European capitals, not least Rome. With Dr Ars, we organized a Consecration for doctors to the Sacred Heart of Jesus (2019) and a Conference on Transhumanism (2022), both in Rome. Due to personal circumstances, I had to stop these activities in 2014. However, it is an honor for me to be able to report on them here in this writing and to thank God for the road travelled.

Bioethics in the Year of Hope, 2025

What can we take from all of this in our reflection on bioethics in 2015, the Year of Hope? First of all, I would like to emphasize how much faith is much more than personal devotion or belonging to a particular religious culture. Faith is a gift from God that reveals Himself to us to the extent that we are willing to open our hearts and minds to His presence, His self-revelation in our lives. Certainly, our intellect can already lead us to

the conclusion that God exists and is the One who is behind observable reality. But our minds can be clouded by misconceptions, limitations and deformation of our knowledge. We can overcome this through study, but the grace of faith can ignite a light in our minds that enables us to see the greater coherence. Faith is therefore not only a personal conviction, but also a light that illuminates the path, individually and in community. It is the fruit of an encounter with the living God. It is a unique source of light that illuminates all aspects of human existence. It also offers a foundation for hope and direction in life, especially in times of darkness and uncertainty.

Secondly, I wish to emphasize the great importance of a clear vision of the dialogue between faith and reason. Faith and science are not opposites, but complementary paths that together can lead to a deeper understanding of the truth. Faith stimulates a critical attitude and wonder about creation, which can enrich scientific research. Science can protect us from misconceptions in our understanding of God's Word.

Thirdly, I feel it is important to refer to the reasonableness of Christian morality in general and Catholic medical ethics in particular. Christian morality is not just a collection of rules, but an answer to the love of God and a path to true human fulfilment. It is rooted in human dignity and the self-revelation of God. The moral standards taught by the Church are not only based on divine revelation, but also on reason and the moral law of nature, which enables us to distinguish good from evil. This means that the Church's moral guidelines can also be understood logically and rationally. Catholic medical ethics offers a coherent and consistent approach to moral issues in healthcare, and is based on a deep respect for life and human dignity. The conscience of the healthcare provider plays a central role in this: it is the inner voice that helps him recognize and follow moral truths. Care providers should form their conscience through prayer, reflection and study of the moral teachings of the Church. This process helps them to make well-considered and ethically responsible decisions in complex medical situations.

Finally, I would like to draw attention to the witness that Catholic physicians and nurses can bear in the places where they work and provide care. Through his testimony, he can contribute to a new evangelization, not only in the transmission of faith, but also in the concrete experience of that faith through acts of love and care. Caregivers can be an extension of the love of Christ in the world. Caring for the sick and the suffering is an essential part of the Christian calling. In addition to his outstanding professional skills, his faith and compassion make him a reflection of God. The testimony of carers is therefore a way of putting the message of the gospel into practice.

Conclusion

Bioethics in the Year of Hope is a more than topic. Unfortunately, we too often view bioethics in the light, or rather 'the darkness', of the many violations against Christian morality and human dignity that characterize our post-Christian era. Ultimately, this is the bitter fruit of a Western world that has largely abandoned goodbye to God and developed its own ethics that inevitably fail when it comes to the importance of the whole person, body, soul and spirit, and all of humanity. But through personal faith, experienced as a personal bond with God through prayer and the sacraments in the community of the Church, we can be hopeful and contribute to a new 'awakening 'of Cristian values in healthcare. What is needed for this is an unconditional 'yes 'to what God has in store for us, like Mary's 'yes 'to the angel. Through that "yes," God's Spirit can become active in us, making us 'charismatic 'Christians, enlightening our minds, introducing us to the truth, filling us with love and compassion, and making us true witnesses of God's love. Every healthcare professional is called not only to be a believer but also an apostle, and to contribute to the mission that Christ gave to all his baptized: to be a proclaimer of the gospel of life, especially in the periphery of human existence, as a truly Good Samaritan.

POST ABORTION GRIEF

Anne Lastman



**Founder Victims of Abortion Trauma Counselling & Information Services
(Australia)**

1996-

Level 4 Clinical Counsellor

Education

- BA Psych/Supporting Major Rel. Studies. (Edith Cowan Uni. W.A) 1995
- Grad. Dip. Education. Australian Cath Uni. (1998) Vic
- MA Rel. Education Australian Cath Uni. (2000) Vic
- MA Theological Studies Australian Cath Uni. (2002) Vic
- 6 Units of Pastoral Care Cert. (WA)

Post Grad Certificate in Trauma Grief & loss (2 units to complete cancer)

57 hours Trauma studies (as part of ongoing OPD)

Member Australian Counselling Association (Level 4)

Member ACA College of Loss & Grief (Level 3 Specialist Member)

Member Counsellors Victoria (full member).

Member Assoc Psychotherapists & Counselling Assoc. Singapore. 2015-22

Conference Speaker on Post Abortion Grief Matters. & Sexual Abuse

- Speaker Right to Life Conference 1997 -**Melbourne**
- Speaker Women Hurt by Abortion 1998 – **Adelaide**
- Speaker Women's Group **1998 Melbourne**
- Speaker Human Life International 1999 -**Melbourne**
- Speaker Human Life International 2001 -**Brisbane**

- Guest speaker 9 days **Papua New Guinea 2000 as guest of HLI.**
- Speaker Nalag (National Association Loss & Grief) 2002 **Melbourne**
- Speaker Human Life International 2003 **Sydney**
- Speaker Right to Life Meeting (Warrnambool Vic) **2004 Melbourne**
- Speaker Thomas More Summer School 2003 **Melbourne**
- Speaker Prayer Groups, youth groups, ladies' groups. **Melbourne**
- Speaker Knights of Southern Cross 2004 **Melbourne**
- Speaker Family Life International **New Zealand 2005**
- Speaker Family Life International **Alotau Papua New Guinea (2005)**
- Meeting with Pontifical Council for Family 2004 **Rome Re PAS**
- Meeting with Pontifical Council for Health Workers 2004 **Rome re PAS**
- Meeting with Pontifical Council for Life 2004.**Rome re PAS**
- Speaker Conference On Life in **Vanimo Papua New Guinea 2005**
- Presenter Workshop Inter. Conf on Grief in Contemporary Society 2005 **London Kings College**
- Speaker at NALAG Conference (Vic) **Melbourne 2005)**
- Speaker at Family Life International Aust. 2005- **NSW**
- Speaker at Family Life International **Conference NZ Sept 2005.**
- Speaker Guild of St Luke, doctors Assoc 2005 **(Brisbane).**
- Speaker Guild of St Luke Doctors Assoc **Brisbane (2006)**
- Speaker Life Conference, Fatima/Portugal, for HLI, 2006-**Portugal**

Introduction

Abortion in our day has become a word which evokes little response and moves few individuals to respond to the enormity of this modern disaster. It has become so normal that it has appended to it, usages or other meanings (e.g. the flight was aborted) except for what it truly means, that is, the killing of an in-utero infants. This time in our history abortion or has become a woman's right and enshrined in the laws of many nations. This enshrinement is the difficulty with acknowledgement that abortion grief is real and great suffering is experienced as a result of the procedure.

This paper is not a paper about who researched which aspect of abortion, though some who have will be mentioned, it's the writing by a post abortion grief counsellor who has worked with women, counselling them, and assisting them through their regret and

subsequent grief over their decision to abort her child. These are the personal experiences and findings of a counsellor who has worked for 30 years helping to bring peace to those hurting. Doing this work I have found it to be most rewarding. Working with post abortive women I have discovered a grief unlike any other because it touches at the very essence of motherhood and what this means.

Post abortion grief is a contentious issue even though the symptoms of an unnamed grief can be seen in society. Society weeps in pain. It causes great pain to women and leaves in their being a place which remains empty and a destructive search is embarked upon to look for that which is missing in order to fill that empty space. Abortion is not a procedure which is necessary but carried out because of the change in societal understanding of the meaning and sacredness of human life and this loss has made aborting a preborn child easy. According to World Health Organisation over 70 million abortions are performed every year, and this represents over 70,000,000 human beings killed which further means 70,000,000 women and men whose design has been damaged and changed with a substantial number of women suffering a grief which has no name.

Research into abortion indicates aftereffects of a type of complicated grief. Yet pro-abortion voices drown out the tears of those who regret their decision and demand for more gruesome methods for death of infants even up to stage of viability and to full term. Further, demand for more freedoms including government funding for such a procedure. Globally the demand is that nations not only enshrine in law the right of woman to terminate the life of her baby, but the demand for taxpayer funds to be used to pay for her choice, and the insidiousness of advancing the gestational age further to after birth abortion which now has become a reality.

This reality goes on even though research has established that abortion is very painful to infant, harmful to women, with lifelong effects like depression, uncontrolled weeping, unrelenting sadness, substance abuses, sterility, promiscuity, suicide ideation, completed suicide, addictions, self-harm, relationship difficulties, guilt, shame, and inability to look at and hold other babies.

Yet these and other harmful effects are not brought to the attention of society. Intentionally there is a media blackout about the aftereffects of abortion and indeed the very term abortion has even been changed from abortion and its true meaning to the more sanitised termination of pregnancy, “TOP” “curettage” “product of conception” “tissue” cells, and other non-image producing terms. “Baby” has a specific meaning and has a recognised image. All societies know the term “baby” and its image. So, a new

terminology has slowly been developed which camouflages the true meaning of these words.

In past research it was found that abortion will interfere with a woman's preparation and anticipation of the next pregnancy and feels anxiety, fearfulness, and further, the previous abortion interferes with the bonding between mother and her new baby/babies.

Studies have also shown that even though abortion causes psychological sequelae it remains an unvalidated type of grief. A grief which is caused by an intended, accepted, and demanded death, but which still remains whispered about and distasteful. It is and remains a taboo topic and whilst demanded, by radical feminists and pro-abortion women, it's still out of the range of topics for discussion in what we might call "normal" families, friendship circles, groups.

It has been acknowledged that the sudden realisation, (usually through a trigger) that abortion has meant the death of her baby threatens the individual's own idea self-worth. The abortive woman suddenly realises that she feels different than what she expected and the impact of such a realisation complicates her self-permission to grieve. The "intent" in her decision making and action further complicates her regret, pain and desire for recovery. She believes that it was all her fault even though most times it was because of coercion of another in her life, or inconvenience.

One of the most important aspects of grief are the rituals which accompany death, but with abortion, (as with miscarriage) the grief rituals are not available. No body to see and hold and say goodbye to. (similar to suicide) The death of an aborted or miscarried child was not expected but by intention of the mother and at times father. Rituals are certain ceremonies which every society has developed in order to navigate an event or time including the those of the grieving process and slowly disengagement which ensure psychological health. Abortion to date has no official ritual. A ritual with family, friends, community is sign that the one who died and those left behind are not alone.

Rituals are also important because they assist the one bereaved to mourn with others and be supported by them who help her to slowly emerge from darkness and begin to re-enter life, though not the same, or forgetting and breaking bonds, but continuing the bonds with the one who has gone.

An abortive woman, especially when no one knows about her abortion, will not receive the support and sympathy she needs because of her fear, shame, abandonment, and in her pain remains alone, unrecognised as hurting, unacknowledged, and will not have the supporters that other grievers will have. In this isolation, aloneness, horror at her own

action the suicide ideation will begin. Depression will begin, and she will begin to experience thoughts of being with her baby who “needs me.” These thoughts about ending it so all pain goes away and going to be with “my baby” are not words which pro-abortion activists, population control activists supported by the media, want to reach the normal childbearing population. They do not care whether self-harm occurs, or whether a suicide occurs, their intention has been achieved. Abortion to all stages of gestation which has now become a reality.

Abortion trauma and grief do not arouse widespread interest in the mental health of abortive women once the aim has been achieved. The importance is that another milestone in the abortion demand strengthens the agenda of the abortion movement and death culture.

Clinical depression appears to have increased within communities and in studies it was found that women who abort a first pregnancy are at greater risk of developing long term clinical depression leading to other self-harming behaviours, compared to women who carry through with the pregnancy even an unintended pregnancy.

Other researchers who have also studied the effects of abortion have found that long term grief has serious consequences apart from depression to anger-guilt, fear of discovery, preoccupation with dead child, fear of other children, and her own future children whom “God will take from me as my punishment for my abortion” low self-esteem, PTSD symptoms, mood disorders, substance abuse, distrust or incompatible and failed relationships.

It has been argued that controlled and wanted pregnancies will mean that no unwanted child will be battered, abused, neglected, or psychologically abandoned child will be born. Yet the reality is that there is no evidence to support this. However, there is evidence that child abuse is increasing. It has also been found that the types of child abuse have increased and doubled over the past 30-year period. Child abuse is the result of many factors, however one of these factors is poor bonding between mother and infant. The bonding process may be disturbed by a number of factors including the abortion procedure. Abortion unrecognised as factor. Imagery of the past aborted baby haunts her. Thoughts of what might “he/she been like?” and as her new and wanted pregnancy proceeds the memory of the aborted child returns stronger especially following the birth of her child when she has intrusive memories of the other. One client said “every time I breast fed my baby another face superimposed itself over his. I couldn’t feed him anymore” This from a woman with her first child following her abortion.

For many women an abortion may represent the loss of confidence in her ability to experience motherhood. Her belief is that if she could be willing to abort her other child then she wouldn't be suitable as a woman to mother any future baby. Part of self, doubts her ability to be a mother because, "I have been heartless with my first pregnancy."

This fear is one of deep regret and sense of unworthiness and belief that she now cannot be worthy of being able to care for another of her children or see and call herself mother. The degree of support for one who has had the experience of abortion and found it to be a difficult, but is supported by family, friends, spiritual guide, goes some way in assisting healing journey whilst the absence of any support adds substantially to an already traumatised individual. Unvalidated grief (abortion, suicide, euthanasia, lost body, death of same sex partner) is a grief which cannot ever be discussed. It's there but cannot be discussed because of shame and the lack of knowledge of what to say about the situation. Abortive traumatised women live within a societal context which is not necessarily negative but more ambivalent and as such remain part of wounded, secret grieving group, but not recognised as such. This is because their experience (abortion) and subsequent needs are not recognised as those of someone who has been exposed to suffering through her own decision and the intentional nature of the loss, this because abortions are now conceded to be societal norm and the belief that no suffering is attached to it. It's seen as a choice procedure and isn't expected to cause long term effects. The woman has believed the lie that after abortion she may experience a "sadness" for several days or even several weeks but she will return to normal after that time and her reason for the abortion will be gone.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, states that suffering is deeper when there is present the intentional factor and with an abortion there is the intentional factor.

Abortion, a stressor outside of the normal day-to-day experiences, is a contributing factor in the decline in mental health of women, and because of its legality she has found little support and attention, first by family and friends, but also by governments globally and intervention strategies not considered as necessary even though harms to women have been acknowledged and recorded.

Abortion is found not to be a safe procedure either physically, psychologically, emotionally, or spiritually and indeed it appears a dangerous procedure to women, men, children, and society. Encouraging health professionals and those in clinical practice to first inform themselves and where possible informing patients presenting for abortion

information and, referrals about the possibility of abortion grief, is very important, and assistance in the training of health professionals how to be able to see the effects of abortion would go a long way towards helping those who have chosen this path, and be able to help those who are suffering. Whether coerced or intentional the procedure which leads to much pain, must be discussed and considered by those who legislate for abortion for the supposed benefits of society, but mostly women to consider removal of legitimacy given to such procedure. Abortion is demanded by those who have already been born and by those who have no care for women and babies, or the future. It's the demand of women to harm other women. Those who have no care for life. The global governments legitimising of such procedure has done nothing to safeguard their future citizens and their country's future or their country's women. Abortion purveyors, because of the legitimacy accorded to abortion, are able to demand and change laws because the truth of such a procedure have has been hidden within their laws.

The abortion decision is always situation specific, the difficulties experienced at time of unwanted pregnancy will pass but the memory of what has happened will not pass away either in the immediate or in future to end stage. A human person's conscience can become clouded but it is written into her being and cannot change to accommodate changes in societal norms, because conscience is the core of each and every human being. It's the place of dialogue with the Creator and the human being.

The decision once made cannot be reversed, and self-unforgiveness ensures that we have a society of men and women hurting and whose heart is heavy laden and too ashamed to turn for help of one who has said "come to me you who are burdened and heaven laden and I will give you rest" (Mt. 11:28). A canopy of grief seems to overshadow all of us. The random deaths, murders, wars, natural disasters, gender issues, euthanasia and assisted suicide, and to our knowledge hundreds of millions of aborted babies we only know a culture mired with death. Abortion, touted as empowering women, does not do so and indeed disempowers them through their grief. It's instead a disempowerment of large percentage of the human population. It's a procedure which ensures death for the child in 100% of time, though post birth abortion (allowing infant born alive but whose mother demanded abortion for that child left to die unaided) is now finding a slow incursion in society.

Pro-abortion laws have systematically removed any rights that the unborn child has and these laws are now set in opposition to those of the mother, which is what the proponents of abortion have used as their mantra. The unborn child has had removed his/her right to

life even if born alive following a failed abortion, whilst the woman separates herself with words “It’s my body my choice” The previous symphony between mother’s body and her child’s body has lost its harmony.

In conclusion the enormity of the grief and suffering which abortion inflicts cannot ever be truly reflected because society has placed a veil of unbelief before this horror. The veil of unbelief and unreality using many imageless euphemisms preserves and protects society from the knowledge of what is being done. This veil of protection from the truth about abortion has been so successful that governments, medical profession, mental health profession, grief education profession, some denominations of churches, society in general, have now turned their faces away from the story. The term “abortion” evokes very little second thought if indeed any first thought.

However, suffering following abortion is very real, either immediately or in time to come because a woman’s design and psyche cannot forget that she carried in her womb, her body, “Life” and she rejected it that life. Her grief brings before the eyes of the world the message that abortion has meant and means the death of her unborn child and a sorrow which find no place to rest.

ABORTION: A DARKNESS OVER THE LANDS.

Anne Lastman



***Founder Victims of Abortion Trauma Counselling & Information Services (Australia)
1996-***

Level 4 Clinical Counsellor

In our day with the information available on abortion and its aftereffects and grief, it still remains a contentious issue. It's a procedure carried out globally at least with an approximate figure of 73,000,000 pa and it's the single highest contributor to death. It's an emotive subject and demanded by women as a sign of liberation, feminine rebellion, and a sign of the depth of immorality and depravity which has descended on humanity, with woman leading the charge. It's the most common medical procedure carried out. The aftereffects of abortion, though their existence remain contested, I believe have cast a shadow over the land, though there is sufficient evidence with both studies and anecdotal evidence to suggest that post abortion trauma and grief are a reality and not "in my head."

Beginning in early 1980s medical interest began in earnest and the psychological sequelae disturbing and considered to be a type of post-traumatic stress disorder characterised by at times delayed development of symptoms resulting from impacted emotional reactions to the perceived physical and emotional trauma of abortion. Abortion grief, it was found, is not like a more severe form of post-natal depression but more serious, longer lasting, and subsequently affecting of the development of personality.

Whilst in the early stages of interest by the medical and mental health profession the thing most agreed upon was that there was a negative response to abortion, with some women experiencing deeper grief reactions, than others. This abortion grief was also thought to

be similar to the grief experienced due to other foetal loss example miscarriage, and other foetal loss not induced but involuntary.

Through the many studies which were beginning to be carried out, and their outcome, presented for both medical and public consumption, it was found that abortion caused a grief similar to any loss of pregnancy. Whilst the findings of researchers seemed to vary, what was brought to attention was the similarity with the experience of trauma.

Abortion grief is believed to be at times “slow developing” and this central to the problem. It’s the slow development which means that it may take from months to years before certain behavioural symptoms or patterns are identified and related to the past abortion. The grief over time developed and intensified because the abortion was not acknowledged as possible cause and remained a topic out of the realm of possibilities for the cause of the ongoing grief.

The symptoms exhibited with grief which are clearly associated with an abortion, guilt, shame depression, anxiety, diminished self-esteem, self-destructive behaviours, relationship difficulties, ongoing pervasive sadness, substance/alcohol abuse and very much, in my practice, suicide ideation and completed suicides. (“to be with me baby”) increased tendency to violence (especially in males) and later discovered link to breast cancer.

Some indications which further suggest that abortion grief is present, hyper alertness, avoidance of anything natal, avoidance of reproductive matters, emotional shutdown, which is an interesting one because it was explained to me by client (post abortive) that if she permitted herself to feel then the memories, of what she had done and the resultant loss, and what might have been, would re-open and she wouldn’t be able to shut the gate down. The pain would be too much.

Whilst DSM IV has removed abortion as a psychosocial stressor, this does not mean that abortion falls within the “normal” range of daily human experience because the response to abortion, whether acknowledged at the time of the procedure or over time, onset of guilt is a definite factor and further anxiety, depression, regret sense of empty following the abortion also a factors. Abortion, whether for a minority or extensive number in the population, is a traumatic life event and it requires acknowledgement that it did occur and not remain in the category of disenfranchisement. Foetal death, including abortion requires recognition that it happened and the grief treated as a loss experience, even at times a complicated grief experience. Perhaps even understood that abortion has not and

does not empower woman, or liberate her, but the knowledge that in time the abortion may come to be seen by her as the death of the feminine. Her motherhood potential.

The predominant features of post abortion pain and grief appear to be denial and suppression. These two defence mechanisms (Freud, 1920) are put in place, at times prior to the abortion itself or immediately following the procedure. Denial serves to refuse to see and believe that the abortion is anything other than a medical procedure removing “product of conception” (told to patient by clinic nurse) and not the death of a human being (her baby), because this could not be tolerated, and immediately begins the denial of what actually happened and suppression (a very strong defence mechanism) which helps to erase/cover the experience from conscious memory. However, long term denial and suppression may actually serve to create more psychological difficulties because whilst the event is deeply hidden, the permanent or long-term storage of such trauma, without resolution, causes serious psychological behaviours which eventuate including confused life beliefs (it’s my body. Its ok I’m ok. It’s not as baby. It’s tissue)

The genesis and psychological predisposition of the woman pre her abortion, I believe, contributes to the actual outcome. This based on her feelings and attitude at the time of her abortion, indicate the depth of her refusal to heal from her regret. From my experience counselling post abortive women I found that those who were distressed leading to the abortion were more likely to experience severest grief. Further, those who had a moral conflict over the abortion, example, religious beliefs, and if forced to abort because of need or circumstance were more likely to be affected. A deep forgetting was necessary.

As a post abortion grief counsellor with nearly thirty years’ experience in this field I would offer a response to this. Over time, I have counselled many women who did not experience difficulty with reaching the decision to abort or even any difficulty after the abortion. Indeed, they reported that they were relieved that the difficulties associated with being pregnant were resolved and they could return to the life pre-pregnancy. However, in one particular case, the abortion happened 62 years earlier. My client, now 79 years old, said that she found herself pregnant she knew family and society would have been scandalised, so the choice was made to quietly abort and seemingly return to “normal” without the knowledge of anyone. Years later she was watching an American TV program where one of the characters became pregnant and sought advice regarding an abortion. This particular episode acted as a trigger for my client who burst into uncontrollable tears and would not be consoled. The tears, withdrawal, dreams about her

baby “girl” continued for many weeks before she sought help (she was a widow with adult children). Her call to the “crisis” line brought her to me. Her abortion had lain dormant for many years. The trigger resurrected her own experience.

A different case is the woman who came to me (referred by pregnancy centre) because she was experiencing a pregnancy which she was happy about but could not bond with her child. Indeed, she would not even refer to her baby as a “baby” but as “it.” She called the pregnancy centre for support and to try and understand why she couldn’t connect with her in utero infant and in the discussion admitted that prior to this pregnancy she’d had two abortions. Interestingly this lady said to me at our first session “I know I can’t love this baby because I couldn’t love the other two” It appears that since her abortions she had, at a deep level, separated herself from her womb and reproductive system and could not reestablish connection with that part of her body. It further seemed that because her womb had been violently vacated, she felt that no love was left for the womb to accept another child and/or for her to love her new child.

For this particular woman (now married) the meaning of pregnancy had changed. When she had her abortions, she was unmarried and in transient relationships therefore the abortion seemed a necessary part of that state of being, a necessity. However, when she was married and able to be pregnant the meaning of “pregnancy” had not changed with her new state of being happily married and being happily pregnant. She still remained in a state of “I can’t have this baby.”

Perhaps the important thing about the research into this area is that bonding doesn’t occur only when all settings are correct but bonding actually does begin from conception even before the woman knows she’s pregnant. She knows that her body feels different. Acknowledging the bonding and then loss of the same pregnancy, irrespective of method of loss (e.g. miscarriage, abortion) will cause pain, especially if noted as a death experience. Perceiving abortion as an intentional death experience rather than a pregnancy loss ensures that guilt will be stronger, and boundary ambiguity, which is the woman’s psychological attachment to the absent baby will continue at a deeper level and will be more difficult to be resolved and will cause deep psychological distress

The counselling of individuals affected by abortion grief, their fear, anxiety, self-hatred, guilt, presents many challenges because we are dealing with an issue, which is highly emotive. The politics surrounding this issue ensures that confusion will continue to impede acknowledgement and programmes written and made available to counsellors,

medical professionals, mental health professionals. If consensus cannot be reached then health of those who suffer will be further compromised.

However, having said this, it's important to note that research into this issue continues and increase and this will ensure that more and more will be discovered as to why it is that some appear unaffected by their abortion experience (at least temporarily) whilst others become severely traumatised (pre and post abortion) To this end it's imperative that mental health researchers continue this work.

Notwithstanding hopes for future answers, treatment for abortion grief is still in the early stages as counsellors try to understand this type of loss. A problem, which is faced by counsellors, is the societal denial, which accompanies the belief that abortion is a 'non-event.' Its lobbyists, forcibly demand that it's "my body my choice" and with these demands the acceptance of abortion to all gestational ages. Babies born alive because of failed abortions not assisted because the woman had demanded a dead baby and therefore left to die. One could say a modern understanding of offering to Moloch

We have a further issue to contend with and that is that abortion is now considered almost like a badge of "honour" whereas in past societies it was considered a horror. Inconceivable, shameful. However, abortion became "normal" when sexual revolution, contraception, sexual revolution, governments making decisions on matters of intimacy, liberation from past norms, changes of family structures, transient families came into being.

Above all used and abused sexuality led to open and rampant sexuality even in the youngest of women (girls 13 yrs olds on contraception then abortion then became a necessity. Politically, abortion issue a vote winner and gave it strength. This rejection of life mostly by women eventually led to all changes relating to intimacy. Woman rejected her infant, now man wants to conceive and the transgender issue to surface. Refusal of life as God created has led to acceptance of forced demands for life by mechanical and illegitimate means.

Abortion grief counselling is not a six-session relationship but in needs to be a work in stages. First development of trust between therapist and client and then slow retelling of story and commitment from client to want to proceed forward. From then on work begins by breaking of barriers, and defence mechanisms, acceptance of loss and breaking denial which is important and is to be done in stages. First remembering (the most difficult part and painful part). Then acceptance of the loss of someone who was and is important to her.

My own treatment plan, which has been developed over many years, is based on my own experience of personal healing and then being encouraged by my priest “now go and do for others what the Lord has done for you” (and I have tried) continuing to study abortion, its meaning, its pain, and studying consequences of this suffering, loss, grief. Forgiveness and the overarching connection. Love. Love points to error but also to its healing. Love knows no hatred. Only love can show that life is beyond measure. Believing in Merciful forgiveness which is available to all. Over time my counselling model was and is being developed and changes and as I learn more my treatment plan, is modified according to the new understanding of those suffering from this unique kind of grief. Only love can lift the canopy of darkness which now covers the land because the voices of the innocent cry out for mercy and tears of their mothers fall on the earth.

IN DEFENCE OF VOLUNTARY INFORMED CONSENT: AN AUSTRALIAN PERSPECTIVE

Eamonn Mathieson and Deirdre Little



Dr Mathieson graduated from Monash University in 1992. He qualified as a Specialist Anaesthetist in 2002 having completed his training through the Alfred hospital, and the Royal Melbourne Hospital.

Since qualifying Dr Mathieson has worked in both public and private practice. He currently works at the Mercy Hospital for Women and also several private hospitals across Melbourne, including St Vincent's Private, Epworth Richmond, Cabrini Malvern, Western Private, Warringal Private, Glenferrie Private and Peninsula Private Hospital.

His areas of interest include Orthopaedic Surgery, Spinal Surgery, Obstetrics and Gynaecology, General Surgery, Urology, Endoscopy, and Ambulatory surgery.

Dr Mathieson participates in ongoing Professional Development with the Australian and New Zealand College of Anaesthetists and is a member of the Australian Medical Association.

Deirdre Little

I am a General Practitioner working in rural GP obstetrics and family and emergency medicine for 33 years. My commitment has contributed continuous and ongoing service to Bellingen Hospital inpatient care, 24/7 emergency care, intrapartum obstetrics (to 2010) and general practice family medicine. My commitment is grounded in evidence-based medicine.

This chapter is a reflection on the significance of Voluntary Informed Consent for medical interventions in light of the recent experiences and responses to the SARS CoV-2 pandemic.

Although it is written from an Australian perspective its implications are relevant to the universal Church and the international Catholic community.

Voluntary Informed Consent (VIC) for medical interventions and medical research is a foundational principle of medical ethics, is at the heart of good patient-doctor relationships and occupies a central and essential role in the practice of ethical medicine. Its importance is grounded in the recognition of the inherent dignity of the human person and based on an authentic understanding of human freedom which is understood in light of the implications that each human person is made in the image and likeness of God.

These basic principles of Catholic medical ethics need restating and defending in light of the recent global public health response to SARS Cov-2 in which mandates to receive the covid-19 vaccine (and other medical interventions) were enforced in many countries and jurisdictions around the world.

In this chapter we will argue that the use of mandates and coercive force by the state to impose medical interventions is always contrary to the principles of voluntary informed consent and thereby undermines the practice of good medicine, contradicts sound medical ethics and does violence to the inherent dignity of the human person.

We will also argue that the use of coercion and mandates to implement medical interventions is not only contrary to a Catholic vision of medical ethics as stated in Catholic Health Australia's (CHA) Code of Ethical Standards and other Catholic documents but also contravenes the stated positions of leading medical organisations both in Australia and internationally, including the Australian Medical Council's (AMC) Code of Conduct (2018), the National Health and Medical Research Council] (NHMRC) National Statement on Ethical Conduct in Human Research (2018), the Australian Medical Association's (AMA) Code of Ethics 2016, as well as the World Medical Association's International Code of Medical Ethics (WMA).

We will conclude by claiming the general response of many bioethicists advising the Catholic Church during this time of 'global emergency' in response to the SARS Cov-2 pandemic, was suboptimal. We believe an opportunity was missed to clearly articulate Catholic teaching, defend its vision of the human person and support the faithful many of whom had grave concerns about the coercive overreach of the state into their personal and religious lives. This failure, we argue was in part the result of an inadequate

understanding of the technical and clinical aspects of the issues faced at that time and an underestimating of some of the forces at play such as commercial and other business and political interests, the role of media and of institutions less accustomed to research ethics and clinical considerations.

We maintain that a great deal of information was readily available early in the pandemic that may have resulted in a response by the Catholic Church that may have mitigated many of the harms and errors of judgement that are now readily seen in hindsight.

Members of Catholic Medical Associations both in Australia and internationally, with both technical expertise and ethical understanding, were some of the few who attempted to raise concerns about decisions being made and the basis on which they were being made, both from an ethical and technical or clinical perspective, but to little or no avail. This experience highlighted the need for moral philosophers and theologians, as well as bioethicists, to be better appraised of the technical and clinical details upon which they make their ethical judgements which then informs the Church and its Faithful.

We conclude with the recommendation that the leadership of the Catholic Church establish a closer relationship and a more formalised advisory role with FIAMC and its members, who have the technical expertise and are well-formed in their Catholic faith, in order to bridge the apparent gaps between ethical reasoning and technical and clinical knowledge, and better respond to future challenges.

The Ethics of Informed Consent

The requirement of voluntariness and adequate information

The NHMRC states that ethical and informed consent for medical interventions and medical research ‘should be a voluntary choice, and should be based on sufficient information and adequate understanding of both the proposed research [or intervention] and the implications of participation’.⁷² The Australian Medical Council (AMC) endorses the NHMRC’s requirements for informed consent as necessitating ‘a voluntary decision about medical care that is made with knowledge and understanding of the benefits and risks involved’⁷³ adding that ‘good medical practice involves ‘providing information to patients in a way that they can understand before asking for [and obtaining] their informed

⁷² General Requirements for Consent, Chapter 2.2: NHMRC: National Statement on Ethical Conduct in human Research.: <https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018#download> (accessed 27/3/2024)

⁷³ Informed Consent, Section 3.5: Good Medical Practice: A Code of Conduct for Doctors in Australia. Developed by a working party of the Australian Medical Council on behalf of the medical boards of the Australian states and territories. https://www.amc.org.au/images/Final_Code.pdf (Accessed 27/3/2024)

consent...before you undertake any examination, investigation or provide treatment (except in an emergency), or before involving patients in teaching or research'.⁷⁴

These codes and statements of the AMC and the NHMRC on the ethics and requirements of voluntary informed consent for medical interventions complement and reinforce the position statements of both the World Medical Association (WMA) and the Australian Medical Association (AMA).^{75 76 77}

To confirm and reinforce these codes, in 2018 the Australian government supported recommendations from a report by the Senate Affairs References Committee regarding the preparation of guidance material on ensuring effective dialogue medical practitioners and patients for 'effective informed consent processes' which should include, adequate information, treatment options, risks and benefits, the opportunity to ask questions and confirmation of understanding.⁷⁸

More significantly for the organisations responsible for this statement, the ethics of informed consent is also addressed in Catholic Health Australia's Code of Ethical Standards in which the voluntary nature and the requirement of the provision of relevant information of informed consent is clearly articulated, reiterating the concepts put forth in the documents previously cited.

In addition, the CHA Code of Ethical Standards appropriately places health and informed consent in a broader 'context of a life in which things other than one's health also matter' and that 'each person is primarily responsible for making decisions concerning his or her own health.'

The proscription of pressure, coercion and manipulation

⁷⁴ Ibid., Sections 3.5.1 and 3.5.2

⁷⁵ *Declaration of Geneva*. World Medical Association (2017): Physician's pledge: "...The health and well-being of my patient will be my first consideration; **I will respect the autonomy and dignity of my patient**; I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat...." www.wma.net/policies-post/wma-declaration-of-geneva/ (Accessed 27/3/2024)

⁷⁶ *International Code of Medical Ethics*. World Medical Association (2006), Section 13: "In providing medical care, the physician must **respect the dignity, autonomy, and rights of the patient**. The physician must **respect the patient's right to freely accept or refuse care** in keeping with the patient's values and preferences. www.wma.net/policies-post/wma-international-code-of-medical-ethics/

⁷⁷ The Doctor and the Patient. Section 2: AMA Code of Ethics. Revised 2016. See 2.1.5: '**Respect the patient's right to make their own health care decisions**. This includes, **the right to accept, or reject, advice regarding treatments and procedures including life-sustaining treatments**.' And 2.1.6: 'Respect the patient's right to refuse consent or to withdraw their consent.' (Accessed 27/3/2024): <https://www.ama.com.au/articles/code-ethics-2004-editorially-revised-2006-revised-2016>

⁷⁸ Australian Government response to the Senate Affairs References Committee report: Recommendation 6. 10th October 2018. <https://www.tga.gov.au/resources/publication/publications/australian-government-response-senate-community-affairs-references-committee-report#recommendation6>

Coercion, pressure or manipulation to undergo medical interventions or participate in medical research is a violation of human dignity and the proper autonomy of the human person and contravenes fundamental principles of medical ethics and the validity of informed consent. Historically, where this principle has been laid aside, human tragedy has resulted.

CHA's Code of Ethical Standards, in alignment with the ethics informed by the Catholic Faith as articulated in the Catechism Catholic Church,⁷⁹ also proscribes the use of coercion in obtaining informed consent. Such coercion, opposing the principle of voluntary, free and informed consent, is unethical and antithetical to genuine freedom and a violation of the intrinsic dignity of human persons.

Regarding covid vaccination the Australian Catholic Bishops Conference,⁸⁰ in concert with the Vatican's Congregation for the Doctrine of the Faith,⁸¹ state that: "vaccination is not, as a rule, a moral obligation and must be voluntary. No one should be coerced to receive any vaccine."

Importantly, the proscription of coercion in obtaining informed consent is also iterated in position statements of the NHMRC, the AMC, the AMA and the WMA.

Reflecting these principles, **the National Immunization Handbook⁸², states that vaccines** 'must be given voluntarily in the absence of undue pressure, coercion or manipulation.'

Voluntary Informed Consent and the Covid Response

The lack of adequate information

Despite the positions articulated by leading Australian and international medical institutions and organisations regarding the nature, requirements, importance and foundational protections of informed consent,⁸³ those positions were abruptly abandoned during the widespread public health response to the covid pandemic.

Instead, unqualified assurances of 'safe and effective' were often the only information heard by members of the public from health authorities, regarding these novel and incompletely researched vaccines. Concerns about, and requests for, further information

⁷⁹ Catechism of the Catholic Church https://www.vatican.va/archive/ENG0015/_INDEX.HTM

⁸⁰ https://www.catholic.org.au/images/FAQs_and_Guidance_on_COVID-19_Vaccination.pdf

⁸¹

https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20201221_nota-vaccini-anticovid_en.html

⁸² National Immunization Handbook, Australian Government Department of Health and Ageing <https://immunisationhandbook.health.gov.au/contents/vaccination-procedures/preparing-for-vaccination#valid-consent>

⁸³ Ibid., 7,8,9,10,11,12.

in regard to medium- and long-term risks were unanswerable, but were often met with silence and indifference, instead of acknowledgements of the limitations of the existing research.

Troublingly, the directives of AHPRA and the Medical Board of Australia in March 2021⁸⁴ appeared to threaten medical doctors and other healthcare professionals for providing information to patients that could be seen to undermine ‘public health messaging’ or encourage ‘vaccine hesitancy’. This may have further impaired the provision of voluntary informed consent and the ethics of medicine in this country.

This arguably unprecedented directive by AHPRA and the intrusion of government into the patient-doctor relationship may have put at risk the long-standing trust of the community in the medical profession by placing ‘public health messaging’ above individual patients’ concerns and wellbeing, weakening the integrity of informed consent discussions. For example, the recent National Centre for Immunization Research and Surveillance (NCIRS) Coverage Report, now ‘highlights a concerning downward trend in fully vaccinated coverage in children’.⁸⁵ This recent downward trend in confidence in vaccines as well as uptake has been noted globally by UNICEF.^{86 87} The AHPRA directive was not rescinded until November 2023.

Mandatory medical interventions and the use of coercion

Despite the uniform proscription of coercion for medical interventions, as articulated in the various codes of medical ethics, a range of coercive measures was implemented to obtain compliance. It needs to be stated unequivocally that voluntary informed consent cannot be obtained through coercion or by coercive measures. This unethical practice was further compounded by the safety issues and the lack of efficacy in reducing infection or stopping transmission which were known at the time the vaccine mandates were implemented.

⁸⁴ AHPRA Position Statement 9 March 2021 ‘Registered Health Practitioners and students and covid-19 vaccination’. [file:///C:/Users/deird/Downloads/Ahpra---Position-statement---COVID-19-vaccination-position-statement%20\(1\).PDF](file:///C:/Users/deird/Downloads/Ahpra---Position-statement---COVID-19-vaccination-position-statement%20(1).PDF) Superseded.

⁸⁵ Prof Frank Beard Associate Director at NCIRS. *NEWS GP*, 14th December 2023 <https://www1.racgp.org.au/newsgp/clinical/concerning-decline-in-child-vaccination-coverage>

⁸⁶ **New data indicates declining confidence in childhood vaccines of up to 44 percentage points in some countries during the covid-19 pandemic.** 20th April 2023. <https://www.unicef.org/eap/press-releases/new-data-indicates-declining-confidence-childhood-vaccines-44-percentage-points-some>

⁸⁷ Six Explanations for Rising Vaccine Hesitancy. Julian Gillespie and Ramesh Thakur. Brownstone Institute. <https://brownstone.org/articles/six-explanations-for-rising-vaccine-hesitancy/>

Coercive measures included loss of livelihood, loss of the right to work,⁸⁸ financial ruin, exclusion from participation in civil society. This orchestrated campaign was led by government official and senior health authorities and involved the use of behavioural psychological techniques and messaging by ‘nudge units’ and contracted advertisers.^{89 90}

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The campaign included the active vilification of members of the public who were hesitant to receive the covid vaccines due to concerns about unknown and unknowable safety issues as well as those who chose to exercise their autonomy and follow their consciences, based on the evaluation of their individual risk-benefit analysis. Such assessments were often made in the context of responsibilities for others, including the maintenance of ongoing parenting and caregiving roles.

This was a low point in the exercise of civility in this country.

The Disregard of the Precautionary Principle

We contend that the abandonment of ethical informed consent, by the enforcement of mandatory medical interventions as part of the pandemic management response, also contravened the precautionary principle of medical ethics, especially for the young and pregnant, given that medium- and long-term potential harms of a novel biological platform were unavailable at the time of implementing the mandates. Covid vaccines in Australia had been given only Provisional registration.⁹² As such, they remained

⁸⁸ Laborem Exercens, 8: ‘the right to a just wage and to the personal security of the worker and his or her family’
https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_14091981_laborem-exercens.html.

⁸⁹ **The secret ‘nudge’ tactics the government used to you to agree to a lockdown. Daily Mail Australia. 3rd October 2022.**

<https://www.dailymail.co.uk/news/article-11273665/NSW-Government-used-behavioural-insights-unit-guide-peoples-behaviour-covid.html>

⁹⁰ Dai, H., Saccardo, S., Han, M.A. *et al.* Behavioural nudges increase covid-19 vaccinations. *Nature* 597, 404–409 (2021). <https://doi.org/10.1038/s41586-021-03843-2>

⁹¹ **Public health experts launch Melbourne Centre for Behaviour Change. Report:**
<https://www.unimelb.edu.au/newsroom/news/2023/february/public-health-experts-launch-melbourne-centre-for-behaviour-change-to-discuss-challenges>

⁹² ‘TGA provisionally approves Pfizer covid-19 vaccine’, Australian Government, Department of Health, Therapeutic Goods Administration (web Page, 25th January 2021)
<https://www.tga.gov.au/media-release/tga-provisionally-approves-pfizer-covid-19-vaccine>

‘Investigational’⁹³, pending further safety and efficacy research.⁹⁴ The Provisional status of the covid vaccine approval was omitted from the National covid vaccine consent form⁹⁵ The reproductive health of potential parents and their offspring should be particularly safeguarded where the reproductive health and safety outcomes of an intervention are not researched and known. In addition, the sacredness of human life from its beginning confers a profound moral duty to safeguard the health of the developing foetus and his or her future health outcomes, especially in the absence of clinical trial research of reproductive health outcomes.⁹⁶

This is critically relevant to the mandating of covid vaccination for employment to persons of reproductive age. It is pertinent to recall the recent apology by Prime Minister Anthony Albanese and the Australian Parliament to individuals and families affected by the pharmaceutical thalidomide tragedy, described as ‘one of the darkest chapters in Australia’s medical history’.⁹⁷ Prime Minister Albanese further stated: ‘Expectant mothers through no fault of their own were exposed to a drug with devastating effects that were realized too late’. Australia’s Health Minister Mark Butler subsequently added that ‘we must ensure this tragedy is never forgotten’.⁹⁸

The Diminishment of Truthfulness as a Principle of Medical Ethics

We contend that discarding valid informed consent during the pandemic also contravened the principle of Truthfulness in medical ethics, or ‘Truth-telling’ as it is articulated in the CHA’s Code of Ethical Standards.⁹⁹ The unqualified promise of ‘safe and effective’ by health authorities for an only Provisionally Registered vaccine was misleading and manipulative.

⁹³ Council for International Organizations of Medical Sciences. Cumulative Pharmacovigilance glossary Version 1.0 <https://cioms.ch/wp-content/uploads/2021/03/CIOMS-Cumulative-PV-Glossary-v1.0.pdf>

⁹⁴ Little DT, Seman EI, Walsh AL. Covid-19 Vaccination: Guidance for Ethical Informed Consent in a National Context. *Issues in Law and Medicine* Vol 36; no 2 p 127. Fall 2021.

⁹⁵ ‘Consent form for COVID-19 vaccination’. **June 5th 2023**. Australian Government, Department of Health and Ageing.

https://www.cmanews.org/_files/ugd/ff7779_1335299c501f4fcfb4d9c2006755dc5b.pdf

⁹⁶ RANZCOG statement: ‘Given the recency of covid-19 and the paucity of data, particularly in pregnancy, the accuracy of any advice may be rapidly superseded.’ January 2024 <https://ranzocg.edu.au/news/covid-19-vaccination-when-pregnant-or-breastfeeding-and-for-those-planning-pregnancy/>

⁹⁷ Prime Minister Anthony Albanese. Media Release 29th November 2023: National Apology to thalidomide survivors and their families. <https://www.pm.gov.au/media/national-apology-all-australians-impacted-thalidomide-tragedy>

⁹⁸ Ibid.,

⁹⁹ <https://cha.org.au/wp-content/uploads/2021/06/Code-of-ethicsfullcopy.pdf> “1.8 Patients need to be able to rely on their practitioners to communicate truthfully and sensitively with, and to be accessible to, them.”

Given the reports of serious harms and deaths, as well as the lack of efficacy in stopping infections and blocking transmission,^{100 101} (see also Appendix 1) that were known at the time of the mandatory vaccine rollouts, this was a serious breach of Truthfulness or ‘Truth-telling’.

Instead, the dominant guiding ethical theory throughout the covid pandemic appeared to be a form of Consequentialism (an ethical theory inconsistent with Catholic teaching), based on insufficient or inaccurate information, which negatively influenced the integrity of research ethics and analysis and undermined the rights of freedom of speech and freedom of conscience.

The Lack of Respect for the Role of Conscience

In contrast to other nations, Australia explicitly rejected the role of conscience, on religious or other grounds, as a valid exemption to the covid vaccine mandates.

This decision was enforced despite the knowledge that the utilization of aborted foetal cell lines in the production and/or testing of covid vaccines was an ethical concern for many.¹⁰² Vaccine patents reveal utilization of aborted foetal cell lines in the testing of the BNT162b2 Pfizer and NVX-CoV2373 ‘Novavax’; vaccines, and in the production of the AstraZeneca vaccine.^{103 104}

This significant ethical consideration was given little recognition in the mandating of covid vaccines by government and health authorities. With some exceptions, many voices, even within the Church, downplayed the significance of personal discernment and conscience by referencing the remoteness of the material cooperation and instead directed its members to override their consciences in pursuit of the purported ‘greater good’ of the community.

Arguably the most authoritative teaching by the Catholic Church on this issue, *Dignitas Personae* (2008), highlights the moral imperative for governments to find (or make

¹⁰⁰ Singanayagam A, Hakki S, Dunning J et al. Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study. *Lancet Infect Dis*. 2021; (published online Oct 28.) [https://doi.org/10.1016/S1473-3099\(21\)00648-4](https://doi.org/10.1016/S1473-3099(21)00648-4)

¹⁰¹ Franco-Paredes, Carlos. Correspondence, January 2022. Transmissibility of SARS-CoV-2 among fully vaccinated individuals. <https://www.thelancet.com/journals/laninf/article/PIIS1473-30992100768-4/fulltext>

¹⁰² Ibid, 18

¹⁰³ Zimmerman RK Helping patients with ethical concerns about covid-19 vaccines in light of some foetal cell lines used in some COVCID-19 vaccines. *Vaccine*. 2021 Jul 13; 39(31): 4242–4244. Published online 2021 Jun 15. doi: [10.1016/j.vaccine.2021.06.027](https://doi.org/10.1016/j.vaccine.2021.06.027)

¹⁰⁴ Letter to Archbishop from ACMA, CWLA and FLI. Website link

available) ethically acceptable alternatives and re-affirms that no one can be compelled to act against their conscience and receive vaccination.¹⁰⁵

However, the coercion of conscience occurred despite the availability of alternative and ethically manufactured covid vaccines, including Bharat Biotech's Covaxin and Nikolai Petrovsky's COVAX-19. Some of these alternatives were temporarily available in Australia but were subsequently disallowed despite the ethical concerns being raised and written appeals to the TGA and government officials, including Prime Minister Scott Morrison.^{106,107}

The ethical and religiously informed concerns about the utilisation of increasing numbers of aborted foetal cell lines also highlights the fact that breaches of accepted medical ethics in relation to informed consent and the use of coercion, should not be based merely on the predictions and calculations of potential physical health outcomes related to a single disease state, using utilitarian models.

Respect for the integrity of conscience and sincerely held religious beliefs should not be discarded as part of the calculus of public health decision making.

Furthermore, those who have a conscientious objection to covid vaccination retain their entitlement to appropriate medical care and should be offered alternative evidence-based preventative strategies.

The Role of Censorship and Behavioural Psychology

The condemnation and censoring of those who questioned or challenged the ethics of vaccine mandates by government and public health officials, revealed a failure of ethical judgment which further diminished the capacity for freely informed consent.

Leading experts in the fields of public health, epidemiology, virology, immunology, vaccination and infectious disease were threatened, silenced and denounced, if they raised concerns about the pandemic response, undermining the basis of medical science which is founded on dialogue, discussion and the challenging of accepted norms with evidence

¹⁰⁵ Vatican Council II, Declaration on Religious Freedom *Dignitatis humanae*, n. 3: "In all his activity a man is bound to follow his conscience in order that he may come to God, the end and purpose of life. It follows that he is not to be forced to act in a manner contrary to his conscience. Nor, on the other hand, is he to be restrained from acting in accordance with his conscience, especially in matters religious."

¹⁰⁶ **TGA recognises two more covid-19 vaccines not registered in Australia but used widely internationally.**

1 November 2021 <https://www.tga.gov.au/news/media-releases/tga-recognises-two-more-covid-19-vaccines-not-registered-australia-used-widely-internationally>

¹⁰⁷ Private correspondence with the Therapeutic Goods Administration and the Experimental Products Section Medicines Regulation Division | Health Products Regulation Group International Regulatory Branch Australian Government Department of Health

and argument. Such responses were exemplified by, but not limited to, the experiences of the authors of the Great Barrington Declaration.¹⁰⁸

The use of behavioural insight teams or ‘nudge units’ that utilised techniques designed to activate unconscious responses to increase compliance compromises the ethical principle of voluntary and informed consent.

In addition, the weaponization of behavioural psychology to foment fear during the covid pandemic in order to achieve compliance to various covid responses and increase covid vaccine uptake was unethical, antithetical to the integrity of public health medicine and further compromised the capacity for voluntary informed consent.^{109 110 111}

The compliance sought and the techniques used during the covid era was at the expense of social cohesion and welfare, civil discourse and trust in the medical and scientific professions. The societal costs of this approach, borne by many individuals and families, are significant and are still being counted.

Regarding the Justifications for Vaccine Mandates

and the Abandonment of the Ethics of Informed Consent

Mandatory vaccinations were introduced on the understanding they were necessary for the ‘greater good’ of the health of the community by reducing transmission to others who may be vulnerable to the covid illness. Covid vaccines, however, were not designed to stop transmission nor ever tested for their ability to do so. It has subsequently been found that they do not stop transmission.^{112 113}

Therefore, even if the flawed ethical theory of Consequentialism, (ie, the ‘end justifies the means’) which is explicitly rejected by the Catholic Church, was utilised as justification for covid vaccine mandates, and thereby the abandonment of the ethics and

¹⁰⁸ **Murthy, et al. v. Missouri, et al:** <https://nclalegal.org/case/state-of-missouri-ex-rel-schmitt-et-al-v-biden-et-al/>

¹⁰⁹ Stephen Reicher, John Drury; The UK government’s attempt to frighten people into covid protective behaviours was at odds with its scientific advice *BMJ* 2023;380: p652
doi: <https://doi.org/10.1136/bmj.p652>

¹¹⁰ Laura Dodsworth, Gemma Ahearn et al; The Three Rs of Fear Messaging in a Global Pandemic: Recommendations, Ramifications and Remediation. *Clinical Psychology and Psychotherapy*.
<https://doi.org/10.1002/cpp.2972>

¹¹¹ **Laura Dodsworth; Government Advisers Caught Falsely Claiming Never to Have Supported Pandemic Fear Messaging.** <https://dailysceptic.org/2024/04/27/government-advisers-caught-falsely-claiming-never-to-have-supported-pandemic-fear-messaging/> (cited April 28th 2024)

¹¹² Professor Robert Clancy. The Mechanics and Efficacy of covid Vaccines. April 28th, 2022.
<https://quadrant.org.au/magazine/2022/05/the-biomechanics-and-efficacy-of-covid-vaccines/>

¹¹³ **Dr Paul Alexander. Extensive Efficacy Studies that Rebut Vaccine Mandates. October 28, 2021**
<https://brownstone.org/articles/16-studies-on-vaccine-efficacy/>

principles of informed consent; the lack of design, research and evidence that covid vaccines reduce transmission nullified any such justification.

In addition, by the time of the mandatory vaccine rollout in Australia, in October 2021, it was recognised that covid was an illness that was not a significant risk to most people, especially the young and healthy^{114 115 116} and the covid vaccines carried significant health risks, including death, for some recipients.^{117 118 119 120 121 122} This knowledge further underscores the unethical, and arguably illegal, decisions to mandate and coerce the Australian populace to receive the covid vaccines.

Conclusion

It is difficult to underestimate the significance of the covid pandemic era and the decision to abandon the ethical foundation stone of voluntary informed consent in response to the Covid SARS-Cov-2 pandemic.

The physical and psychological harms that have resulted from this and the loss of trust and faith in the authorities and experts who made such decisions or enforced or supported them will reverberate for some time into the future, necessitating ongoing reflection and some form of accountability to heal and overcome the damage that has been caused.

The almost universal alignment of institutions, including hospitals, universities, schools and other agencies, both within and without the Catholic Church, with the spirit of abandoning the guiding principle of voluntary informed consent for medical interventions is a considerable concern. As was the almost complete lack of alternative voices,

¹¹⁴ WHO Health Topics, covid-19 March 9th 2020. “Most people infected with the virus will experience mild to moderate respiratory illness and recover without requiring special treatment...”
https://www.who.int/health-topics/coronavirus?utm_source=substack&utm_medium=email#tab=tab_1
(First published March 9th 2020, cited and still current 28th April 2024)

¹¹⁵ John P A Ioannidis, Jay Bhattacharya, covid-19 antibody seroprevalence in Santa Clara County, California, *International Journal of Epidemiology*, Volume 50, Issue 2, April 2021, Pages 410–419, <https://doi.org/10.1093/ije/dyab010>

¹¹⁶ Australian Government, Department of Health and Aged care: Coronavirus (covid19) at a glance infographic collection A collection of infographics providing a quick view of the coronavirus (covid-19):
<https://www.health.gov.au/resources/collections/coronavirus-covid-19-at-a-glance-infographic-collection>

¹¹⁷ Polack, FP, Thomas, SJ, Kitchin, N *et al* (2020) Safety and Efficacy of the BNT162b2 mRNA covid-19 Vaccine. *N Engl J Med* **383**: 2603-15.

¹¹⁸ Thomas, SJ, Moriera, ED Jr, Kitchin, N *et al* (2021) Safety and Efficacy of the BNT162b2 mRNA covid-19 Vaccine through 6 Months. *N Engl J Med* **385**: 1761-73.

¹¹⁹ Fraiman, J, Erviti, J, Jones, M *et al* (2022) Serious adverse events of special interest following mRNA covid -19 vaccination in randomized trials in adults. *Vaccine* **40** (40): 5798-5805.

¹²⁰ Tindle, R. (2024) Long covid: Sufferers can take heart. *AJGP* **53**(4): 238-240
<https://www1.racgp.org.au/getattachment/3df64026-f1f3-425c-8d3c-7bd16044e3d6/Long-covid-Sufferers-can-take-heart.aspx>

¹²¹ AstraZeneca formally admits that its covid-19 vaccine can cause rare side effect. 30th April 2024.
<https://www.leighday.co.uk/news/news/2024-news/astrazeneca-formally-admits-that-its-covid-19-vaccine-can-cause-rare-side-effect/>

¹²² React19.org Published Science Database. <https://react19.org/science>

objections or dissent, to this development, especially in Australia, likely because of the considerable legal and social pressure which was wielded to achieve conformity.

The Australian Catholic Medical Association was one of the few organisations to raise objections and ethical concerns about the decisions to override freedom of conscience and abandon voluntary informed consent in Australia during this time. And, as far we know, the only healthcare organisation within the Church in Australia to publicly do so.¹²³

In highlighting these significant failings, we do not necessarily advocate the attribution of blame to individuals or institutions, nor indeed retribution, but we do look forward to more open public discussions, transparent public, private or government inquiries, and legal and judicial scrutiny of the decisions made during the covid pandemic in Australia and throughout the world.

By these processes we will hopefully better understand the chain of events and mechanisms that underpinned the sudden and almost universal abandonment of voluntary informed consent and the previously accepted norms of medical ethics in Australia and across the world during this time.

We acknowledge however, that a thorough examination of the details and causal factors of the decision-making processes which led to the undermining of medical ethics, as described in this paper, may take many decades to reveal and comprehend. Nevertheless, such enquiries should commence and continue, especially in the face of what appears to be an active forgetfulness that is taking hold.

In closing, we maintain that the upholding of the centrality of voluntary informed consent in the practice of ethical medicine should be championed by leaders within the Catholic Church, especially its bioethical experts, by calling for the cessation of all ongoing covid vaccination mandates in Australia and across the world.^{124 125}

¹²³ Links to some ACMA public statements and interventions can be accessed via the ACMA August 2024 newsletter: <https://www.cmanews.org/so/06P4gYWol?languageTag=en&cid=e01c113f-d5e8-4962-94d3-ce9ff010324d>

¹²⁴ Covid vaccine mandates have been revoked for healthcare workers in the Northern Territory (June 2022), Queensland (September 2023), Western Australia (April 5th 2023), NSW (May 16th 2024). Victoria and South Australia still maintain their covid vaccine mandates for healthcare workers (as of May 26th 2024): <https://7news.com.au/news/covid-19-vaccine-mandate-scrapped-for-healthcare-workers-in-nsw-c-14691257>

¹²⁵ <https://www.legalaid.vic.gov.au/covid-19-mandatory-vaccines-and-work> “The law no longer says you must be vaccinated to work outside your home, except in certain industries, such as healthcare. [However] your employer can only say you must be vaccinated if you are required to work outside your home or ask for proof that you have been vaccinated, **if it is reasonable to make your workplace healthy and safe. If it is reasonable, and you refuse, you could lose your job.** What is reasonable depends on the type of work you do and the risks if you are not vaccinated.” (Victoria LegalAid website, cited 27/4/2024)

And finally, we would like to encourage closer relationships and more formal engagements between moral and theological philosophers, bioethicists and the Catholic medical personnel who possess the relevant clinical and subject matter expertise to better respond to future ethical challenges in the medical and public health arena.

We hope that through such relationships a more robust defence of Catholic bioethics can be achieved, avoiding the recurrence of the errors of the recent past and provide better informed ethical guidance as a service to the Catholic lay faithful and the mission of the Universal Church.

Appendix 1

On transmissibility of infection and covid vaccines

“Therefore, health authorities’ claims that vaccines prevent transmission are not supported by the evidence. The claim that they reduced transmission applied to some extent for earlier variants such as the Alpha variant but no longer applied for the Delta variant dominant in the latter part of 2021, and the Omicron variant present in Australia since December 2021. The medical basis for mandates evaporated by mid 2021 and the rationale for vaccinating children to save grandparents was disproven before the early 2022 provisional authorisation for children. This is separate to the mandates being challenged on human rights and religious grounds.”

– Associate Professor Peter Parry. Document 12. Terms of Reference Y parts (ii) & (v): Lack of protection against infection and transmission. Pages 351- The People's Terms of Reference. 1 February 2024, COVID-19 Royal Commission- Additional Documents- Answers to Questions on Notice.

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/COVID19RC47/Additional_Documents?docType=Answer%20to%20Question%20on%20Notice

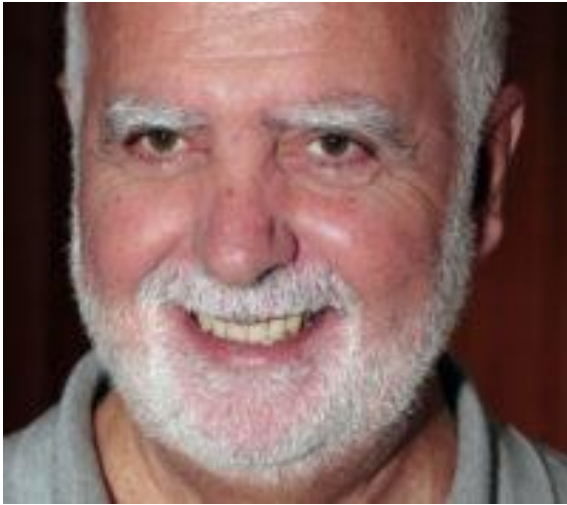
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IL SUICIDIO ASSISTITO IN SVIZZERA E L'“EFFETTO WERTHER”

Ermanno Pavesi



Dr. Ermanno Pavesi, n. nel 1947, dopo la maturità classica laurea in medicina (1973) e specializzazione in psichiatria (1977) all'Università di Modena, Italia. Ha esercitato la professione soprattutto in cliniche psichiatriche della Svizzera tedesca, tra l'altro come Aiuto alle cliniche delle università di Basilea e Zurigo, è stato vice-primario del centro psichiatrico del Cantone Appenzello Esterno.

Docente emerito di psicologia alla Gustav-Siewerth-Akademie in Bierbronnen in Germania, alla Theologische Hochschule di Coira, Svizzera, e del seminario della Fraternità san Pietro a Wigratzbad, Germania.

Socio fondatore dell'associazione Alleanza Cattolica.

Segretario della Associazione svizzera dei medici cattolici e della Federazione europea delle associazioni dei medici cattolici (FEAMC) e segretario generale e cassiere della Federazione internazionale delle associazioni dei medici cattolici (FIAMC).

Autore di alcune monografie e di numerose pubblicazioni su temi di psicologia, Umanesimo rinascimentale, Martin Lutero e la Riforma protestante, per lo più con un approccio apologetico.

1. La legislazione svizzera

In Svizzera le leggi che riguardano il suicidio risalgono al Codice penale del 1942.

Istigazione e aiuto al suicidio sono contemplati dall'articolo 115 del Codice Penale Svizzero (CPS), che recita: *«Chiunque per motivi egoistici istiga alcuno al suicidio o gli presta aiuto è punito, se il suicidio è stato consumato o tentato, con una pena detentiva sino a cinque anni o con una pena pecuniaria».*

Per decenni la formulazione, per sé piuttosto vaga, dell'articolo 115 non ha posto problemi particolari: si trattava di casi rari e occasionali e poteva proteggere chi inconsapevolmente aveva fornito i mezzi usati per un suicidio, come il medico che aveva prescritto dei farmaci o chi avesse prestato un'arma. La legge perseguiva penalmente solo chi istigava o prestava aiuto al suicidio per motivi egoistici, come scrive il teologo e medico svizzero Alberto Bondolfi: *«L'art. 115 del Codice penale svizzero che disciplina e parzialmente reprime questa pratica era stato formulato in un momento in cui non esistevano ancora organizzazioni che prestavano regolarmente un aiuto al suicidio. La sua formulazione è estremamente scarna e si limita a formulare le condizioni di non punibilità di questa condotta, evidenziando solo quella particolarità che lo rende invece una condotta delittuosa. Affinché l'aiuto al suicidio possa essere considerato un atto delittuoso esso deve essere caratterizzato da "motivi egoistici". L'espressione, a prima vista non necessariamente univoca, è stata interpretata dal Tribunale Federale, massima istanza giudiziaria del Paese, come "motivo pecuniario"»*¹²⁶.

Dato che l'art. 115 reprime esplicitamente solo l'aiuto al suicidio prestato *«per motivi egoistici»*, *«"more negationis", lascia impunito l'aiuto prestato per motivi altruistici»*¹²⁷. Negli ultimi decenni organizzazioni come *Exit*, *Dignitas* e *lifecircle*, nate in Svizzera con la finalità di offrire assistenza al suicidio, hanno potuto interpretare a proprio favore la vaghezza della norma di legge.: *«Il fatto che l'aiuto al suicidio assistito - scrive Alberto Bondolfi - avesse preso una forma organizzata non ha provocato alcun cambiamento legislativo e quindi il campo di applicazione e l'interpretazione dell'art. 115 si è trovata molto ampliata, ben al di là delle intenzioni di coloro che avevano formulato a suo tempo questa disposizione di legge»*¹²⁸. La legislazione svizzera, infatti, non prevede particolari condizioni per chi chiede aiuto al suicidio, per esempio una malattia incurabile o una sofferenza insopportabile, e non pretende né l'intervento di un medico per la valutazione del caso, né la sua partecipazione attiva al suicidio.

Lo stesso studioso sottolinea che si tratta di una soluzione *«non medicalizzata»*, e di fatto la maggioranza dei suicidi in Svizzera avviene con l'aiuto di organizzazioni *«[...] fuori da un contesto medico, con l'unico punto di contatto dato dalla necessità di una ricetta*

¹²⁶ ALBERTO BONDOLFI, *Il suicidio assistito in Svizzera. Ultimi sviluppi e scenari per il prossimo avvenire*, in *L'Arco di Giano. Rivista di Medical Humanities*, anno XXV, n. 95, inverno 2018, pp. 65-73 (pp. 68-69); scaricabile dal sito web <<https://archive-ouverte.unige.ch/unige:10187>>, p. 67. In alcuni casi anche aiuto al suicidio per odio, cattiveria o vendetta è stato considerato come dettato da un motivo egoistico.

¹²⁷ *Ibid.*, p. 68.

¹²⁸ *Ibid.*, p. 70.

*per poter ottenere la sostanza letale che porti velocemente alla morte senza provocare dolori particolari»*¹²⁹. In questa situazione nasce il contrasto tra la Federazione dei medici svizzeri, la FMH (*Foederatio Medicorum Helveticorum*) e le organizzazioni per l'assistenza al suicidio che in nome dell'autodeterminazione ritengono che la volontà del candidato suicida sia sufficiente, che non sia necessaria alcuna indicazione medica e che il medico si dovrebbe limitare a compilare la ricetta per la sostanza letale, mentre per la FMH non è etico che un medico prescriva un farmaco, e ancor più se letale a scopo di suicidio, senza alcuna indicazione medica.

2. Assistenza al suicidio: le direttive della Federazione dei Medici Svizzeri

La FMH ha adottato direttive sul suicidio assistito elaborate dalla Accademia Svizzera delle Scienze Mediche (SAMW-ASSM) e, come nel caso di altre direttive, anche queste sono vincolanti per i propri membri¹³⁰.

«Si considerano assistenza al suicidio gli atti che vengono compiuti con l'intenzione di consentire a una persona capace di discernimento di porre fine alla propria vita, in particolare la prescrizione o la consegna di un farmaco a scopo di suicidio.

*Il ruolo più autentico del medico nel contesto del fine vita e del decesso consiste però nell'alleviare i sintomi e nell'accompagnare il paziente. Non rientra tra i suoi compiti offrire spontaneamente l'assistenza al suicidio né è tenuto a fornire tale aiuto. L'assistenza al suicidio non è un atto medico in relazione al quale i pazienti potrebbero avanzare una pretesa, benché sia un atto ammissibile dal punto di vista giuridico»*¹³¹.

Il testo descrive quattro condizioni nelle quali, secondo queste direttive, l'aiuto medico alla realizzazione del desiderio di suicidio sarebbe accettabile in termini medico-etici. Il sussistere delle prime due condizioni deve essere confermato da una terza persona indipendente, che non deve essere obbligatoriamente un medico: 1) *Capacità di discernimento*: il paziente è capace di discernimento in relazione al suicidio assistito. In casi dubbi o di disturbi psichici capacità di discernimento e possibilità terapeutiche devono essere valutate da un medico specialista. 2) *Volontà autonoma*: il desiderio di porre fine alla propria vita è ben ponderato, persistente e non influenzato da pressioni esterne. Per accertarsene, il medico deve svolgere con il paziente almeno due colloqui

¹²⁹ *Ibid.*, p. 71.

¹³⁰ Cfr. SAMW-ASSM, *Direttive medico-etiche. Come confrontarsi con il fine vita e il decesso*, Accademia Svizzera delle Scienze Mediche (ASSM), Berna 2018 — approvate dal Senato dell'ASSM il 17-5-2018 con modifiche approvate con delibera del Senato il 25-11-2021 — nel sito web <https://www.palliative-ti.ch/wp-content/uploads/2020/05/direttive_assm_fine_vita_e_decesso.pdf>.

¹³¹ *Ibid.*, p. 25.

approfonditi a distanza di un minimo di due settimane l'uno dall'altro; se necessario, in caso di dubbio a questi possono aggiungersi anche altri colloqui. 3) *Sofferenza grave*: Non ostante la difficoltà di verificare oggettivamente il grado di sofferenza del paziente, il medico deve essere convinto della sua insopportabilità, condizione ineludibile per l'assistenza medica al suicidio: «*Non è accettabile in termini medico-etici, ai sensi delle presenti direttive, l'assistenza al suicidio prestata a persone sane*»¹³². 4) *Valutazione di alternative*: il medico deve cercare, discutere e proporre opzioni terapeutiche o soluzioni di aiuto e sostegno.

Questa posizione è messa in discussione tanto dalle associazioni che offrono assistenza al suicidio, quanto da nuove tendenze in bioetica.

3. Le critiche delle associazioni per il suicidio assistito alle direttive della FMH

La FMH ha considerato l'assistenza medica al suicidio giustificabile in termini medico-etici, ma ha posto chiari limiti. È categoricamente esclusa per persone sane, ma anche per le persone malate non è sufficiente che il paziente soffra di una patologia e sostenga l'insopportabilità della sua situazione: è il medico, viceversa, che deve convincersi della credibilità delle affermazioni del paziente. Nel caso in cui il desiderio di morire è sintomo di un disturbo psichico, come in alcuni casi di depressione, l'opzione proposta non è il suicidio ma una terapia. Nella revisione del testo delle *Direttive* è stata inoltre introdotta la clausola di due colloqui alla distanza di almeno due settimane, ciò che evita un certo automatismo: il medico non può essere chiamato a partecipare all'assistenza al suicidio di un paziente che non aveva mai visto prima e all'ultimo momento, a suicidio già deciso, compilare una ricetta. Associazioni per il suicidio assistito sono critiche nei confronti delle direttive medico-etiche, che pur riconoscendo che l'aiuto al suicidio è «*un atto ammissibile dal punto di vista giuridico*»¹³³ dichiara che: «*Il suicidio assistito non è un atto medico che i pazienti possono pretendere*»¹³⁴. Le associazioni hanno intrapreso anche azioni legali contro queste direttive.

4. Dall'etica medica alla bioetica

Alla nascita della bioetica negli anni Settanta del secolo scorso hanno contribuito soprattutto teologi e medici cattolici che, in disaccordo con l'enciclica *Humanae vitae* del 25 luglio 1968, hanno voluto elaborare un'etica medica indipendente dal Magistero e dalla teologia cattolica. Nonostante alcuni autori, come il card. Elio Sgreccia (1928-

¹³² *Ibid.*, p. 27.

¹³³ *Ibid.*, p. 25.

¹³⁴ *Ibid.*, p. 26.

2019), abbiano difeso i valori cattolici nella bioetica, la tendenza prevalente è stata non solo il loro progressivo abbandono ma anche il progressivo appiattimento su posizioni laiciste¹³⁵.

Il medico Edmund Pellegrino (1920-2013), dal 1978 al 1982 presidente della *Catholic University of America* di Washington e suo primo presidente laico, ha giustificato la trasformazione della bioetica con il fatto che i progressi della medicina presentano nuove sfide etiche in una società pluralistica e che non sarebbe possibile ammettere l'esistenza di valori morali assoluti riguardo a ciò che è bene o male. Non sarebbe quindi possibile «un deciso ritorno ai fondamenti classici dei valori etici, sia che si tratti del diritto naturale, del kantismo, dell'utilitarismo, della dialettica o di una fede basata su una rivelazione. Un tale disperato tentativo di trovare fondamenti ultimi per il comportamento morale e culturale sarebbe reazionario e negatore dell'emancipazione e della libertà»¹³⁶. Solamente il paziente saprebbe ciò che è bene per lui e la sua scelta sarebbe vincolante per il medico: «Dal punto di vista 'moderno' noi non possiamo sapere ciò che è bene per il paziente senza conoscere i suoi desideri. La scelta del paziente è un bene semplicemente perché lui lo desidera. Per fare il bene del paziente noi dobbiamo fare il bene che lui desidera»¹³⁷.

La trasformazione della bioetica è stata descritta con precisione da uno degli esponenti più importanti della bioetica moderna, il professore Tristram Engelhardt Jr. (1941-2018), cresciuto cattolico ma diventato membro della Chiesa ortodossa del Texas: «La bioetica cristiana è servita come un passaggio intermedio per la nascita di una bioetica laica»¹³⁸. Engelhardt descrive anche la «[...] comparsa della bioetica cristiana e la sua eclissi nel predominio a livello mondiale di una bioetica filosofica e secolare»¹³⁹, e ammette che «Dopo una breve fioritura, la bioetica cristiana è diventata simile alle sue versioni secolarizzate»¹⁴⁰. Secondo Engelhardt una bioetica cristiana che non cerchi l'omologazione con la bioetica laica mostrerebbe un carattere settario e offenderebbe lo spirito ecumenico¹⁴¹, proprio perché «ciò che di cristiano c'è nella bioetica cristiana

¹³⁵ Cfr. il mio articolo *Sviluppi critici della bioetica*, in *Cultura&Identità. Rivista di studi conservatori*, anno XV, n.s., n. 39, luglio 2023, pp. 4-10; nonché il mio articolo *Le origini umanistiche della bioetica*, *ibid.*, anno XV, n. 42, dicembre 2023, pp. 7-13.

¹³⁶ EDMUND PELLEGRINO, *Ethik, Bioethik und Medizinethik*, in *Bioethik in den USA. Methoden, Themen, Positionen*, a cura di Hans-Martin Sass, Springer, Berlino 1988, pp. 21-35 (p. 22).

¹³⁷ *Ibid.*, p. 181.

¹³⁸ TRISTRAM ENGELHARDT JR., *The foundation of Christian Bioethics*, Swets & Zeitlinger, Lisse 2000, p. 12.

¹³⁹ *Ibid.*, p. XIII.

¹⁴⁰ *Ibid.*, p. XVII.

¹⁴¹ *Ibid.*, p. 1.

costituiva di per sé un problema»¹⁴², una tesi piuttosto paradossale per un trattato di bioetica cristiana. Il cambiamento dell'etica riguarda anche il suicidio assistito: “La nuova cultura secolare cosmopolita sollecita la religione a riorientare il suo impegno. [...] la religione dovrebbe aiutare operatori sanitari e famigliari ad accettare la scelta di chi utilizza il suicidio assistito”¹⁴³.

5. Suicidi ed “effetto Werther”

Nel 1974 il sociologo David Phillips ha definito “effetto Werther” il fenomeno di suicidi provocati dalla descrizione di suicidi reali o fittizi nei mezzi di comunicazione di massa, da allora questo termine si è affermato nella letteratura scientifica¹⁴⁴. L'espressione si riferisce ai suicidi che hanno seguito la pubblicazione nel 1774 del libro *I dolori del giovane Werther* di Johann Wolfgang von Goethe che racconta, in forma romanzata, il suicidio di un giovane che si era tolto la vita a causa di un amore infelice¹⁴⁵. Importanti per l'Effetto Werther sono il modo in cui un suicidio viene descritto e l'identificazione con la persona che si è tolta la vita. Una descrizione troppo ‘empatica’ dei motivi di un suicidio che tende a comprenderli, se non a giustificarli, può indurre persone che si trovano in un’analoga situazione a considerare il suicidio come una scelta razionale e a prenderlo seriamente in considerazione, superando remore culturali e religiose. Anche una descrizione del metodo utilizzato può facilitare l’imitazione.

6. La sindrome pre-suicidaria

Nel 1949 lo psichiatra austriaco Erwin Ringel ha esaminato con i suoi collaboratori tutte le 745 persone ricoverate dopo un tentativo di suicidio nella clinica psichiatrica dell’Università di Vienna e ha riscontrato tre costanti nella condizione psichica di queste persone nel periodo precedente il tentativo: 1) una *Einengung*, cioè una condizione di chiusura esistenziale; 2) un’aggressività repressa rivolta contro se stessi; 3) fantasie di suicidio. La presenza contemporanea di questi tre sintomi costituirebbe per Ringel una sindrome, precisamente la “sindrome pre-suicidaria”¹⁴⁶. Ringel ha pubblicato questa ricerca in un’opera dal titolo “Il suicidio. Esito di uno sviluppo psichico patologico.

¹⁴² *Ibid.*, p. 14.

¹⁴³ *Ibid.*, p. 312.

¹⁴⁴ Cfr. DAVID P. PHILLIPS, *The influence of suggestion on suicide: substantive and theoretical implications of the Werther Effect*, in *American Sociology Review*, vol. 39, n. 3, giugno 1974, pp. 340-354.

¹⁴⁵ Cfr. HOLGER STEINBERG, *Der “Werther-Effekt”. Historischer Ursprung und Hintergrund eines Phänomens*, in *Psychiatrische Praxis*, vol. 26, 1999, pp. 37-42.

¹⁴⁶ ERWIN RINGEL, *Der Selbstmord. Abschluss einer krankhaften psychischen Entwicklung. Eine Untersuchung an 745 geretteten Selbstmördern* [Il suicidio. Esito di uno sviluppo psichico patologico. Una ricerca su 745 tentativi di suicidio salvati], Maudrich Vienna-Düsseldorf (Germania) 1953. Cfr. pure il mio *Tentativi di suicidio e loro prevenzione. La sindrome presuicida e la sua evoluzione*, in *Renovatio. Rivista di teologia e cultura*, anno XXV, n. 1, Genova gennaio-marzo 1990, pp. 110-125.

La decisione di togliersi la vita viene descritta come l'esito di uno sviluppo psichico patologico in cui la persona si sente in una situazione che sembra sempre più invivibile, il suicidio non viene però vissuto solamente come liberazione ma anche come una perdita. L'ambivalenza che ne risulta viene influenzata da molti fattori tanto a favore quanto contro il suicidio.

7. Andamento dei suicidi assistiti in Svizzera

Negli ultimi decenni l'attività delle associazioni come *Exit* e *Dignitas* ha avuto una vasta eco, per lo più positiva, in tutti i *media*, cosicché la popolazione svizzera è stata ripetutamente messa a confronto con la questione del suicidio assistito, e la possibilità di ricorrervi è entrata progressivamente nell'immaginario collettivo come opzione accettabile in determinate situazioni. L'andamento dei suicidi negli ultimi due decenni ha confermato le tesi più importanti dell'effetto Werther: la pubblicità data a un determinato tipo di suicidio può provocare emulazione in una misura statisticamente verificabile, in altri termini, provocando un aumento del numero dei suicidi.

L'Ufficio Federale di Statistica ha pubblicato i dati dei suicidi assistiti di persone residenti in Svizzera dal 2003 al 2022: nel 2003 i casi di suicidi assistiti sono stati 187, nel 2008 erano saliti a 253, nel 2013 a 587, nel 2018 a 1.176, nel 2022 a 1.594¹⁴⁷. A questi si dovrebbero aggiungere i casi di suicidi assistiti di persone residenti all'estero. Per il 2023 disponiamo solamente dei dati dell'organizzazione *Exit* della Svizzera tedesca, che comprende anche i cantoni Ticino e Grigioni, ma non la Svizzera francese: 1.252 suicidi assistiti, con l'aumento dell'11% rispetto all'anno precedente¹⁴⁸. Solamente un terzo, precisamente il 31%, delle persone che nel 2023 si sono affidate a *Exit*, erano affette da un tumore allo stadio terminale e, in circa un quarto dei casi, precisamente il 26%, si è trattato di persone anziane con disturbi multipli.

Da circa quarant'anni in Svizzera il numero dei suicidi non assistiti è in lenta ma continua diminuzione. Con il crescente numero di suicidi assistiti si sarebbe potuto aspettare una corrispondente diminuzione di quelli non assistiti, perché persone intenzionate a togliersi

¹⁴⁷ L'11 dicembre 2023 l'ufficio Federale di Statistica (BFS) ha pubblicato una tabella con i suicidi assistiti in Svizzera dal 2003 al 2022, divisi per sesso ed età (fino a 65 anni e più di 65 anni). La tabella è solo in tedesco e francese, a volte si riesce a scaricare solamente la versione tedesca. Cfr. BFS, *Assistierter Suizid nach Geschlecht und Alter*, nel sito web <<https://www.bfs.admin.ch/bfs/fr/home/actualites/quoi-de-neuf.assetdetail.29125048.html>>, 26-2-2024.

¹⁴⁸ Cfr. *Exit: 1252 suicidi assistiti nel 2023, 21 in Ticino*, in *Swissinfo.ch*, 8-2-2024, nel sito web <<https://www.swissinfo.ch/ita/exit%3A-1252-suicidi-assistiti-nel-2023%2C-21-in-ticino/72363515>>. *Exit* ha pubblicato il rapporto 2023 sul suo sito in tedesco <<https://www.exit.ch/artikel/exit-waechst-weiter-mitgliederzahl-auch-2023-markant-gestiegen/>>.

la vita avrebbero potuto ricorrere a una delle associazioni che garantiscono un metodo sicuro e indolore, ma, se questo è successo, lo è stato al massimo in un numero molto limitato di casi. All'aumento dei suicidi assistiti negli ultimi vent'anni non c'è stata una corrispondente diminuzione di quelli non assistiti, c'è stato invece un aumento del numero assoluto di suicidi: nel 2014, per esempio, si sono verificati 1.029 suicidi non assistiti e 742 assistiti, quindi con un totale di 1.771 suicidi¹⁴⁹, mentre nel 2022 ci sono stati 958 suicidi¹⁵⁰ e 1.594 suicidi assistiti con un totale di 2.552 suicidi, in otto anni un incremento di quasi ottocento suicidi¹⁵¹.

8. Conclusione

Con la pratica liberale per il suicidio assistito in Svizzera non c'è stato un cambiamento della modalità di suicidio, cioè una diminuzione di quelli non assistiti a favore di quelli assistiti, ma tale pratica ha avuto piuttosto l'effetto di aumentare considerevolmente il numero dei suicidi assistiti che ogni anno sono cresciuti di una percentuale a due cifre e con aumento del numero totale dei suicidi.

Non tutti i problemi sono risolti: per *Exit* è fondamentale che la persona interessata possa decidere che cosa è insopportabile o inaccettabile per sé¹⁵². Questo significa che il medico dovrebbe prescrivere una sostanza letale senza poter verificare la capacità di intendere e di volere dell'aspirante suicida e se la decisione può essere considerata espressione della volontà della persona e non di una crisi o di uno stato d'animo passeggero o accertare se si tratti di una fase depressiva o una momentanea instabilità emotiva. Una richiesta inaccettabile dal punto di vista medico-etico.

¹⁴⁹ Cfr. BFS, *Statistica delle cause di morte 2014. Suicidio assistito e suicidio in Svizzera*, nel sito web <<https://www.bfs.admin.ch/bfs/it/home/statistiche/salute/stato-salute/mortalita-cause-morte/specifiche.assetdetail.3902307.html>>.

¹⁵⁰ Cfr. BFS, *Cause di morte specifiche*, nel sito web <<https://www.bfs.admin.ch/bfs/it/home/statistiche/salute/stato-salute/mortalita-cause-morte/specifiche.html>>.

¹⁵¹ La ricerca e la comparazione dei dati statistici sui suicidi e sui suicidi assistiti sono anche in Svizzera difficili, perché devono essere raccolti da fonti differenti che a volte riportano unicamente quelli che si riferiscono a singoli anni.

¹⁵² Cfr. *EXIT, Exit auf einen Augenblick* (Exit a colpo d'occhio), nel sito web <<https://www.exit.ch/verein/exit-auf-einen-blick/>>.

EL DIÁLOGO DEL CUERPO Y LA SEXUALIDAD

María Victoria Roqué Sanchez*, **Lluís Giner Tarrida****, **Ignacio Macpherson Mayol*****

* Profesora del Máster de Bioética, Facultad Ciencias de la Salud, Universidad Católica San Antonio de Murcia

** Profesor de Odontología Integrada, Facultat d'Odontologia, Universitat Internacional de Catalunya

*** Profesor de Bioética, Facultat d'Humanitats, Universitat Internacional de Catalunya

La persona y su dimensión sexual

La experiencia humana a lo largo de la vida es, en su esencia, un proceso de cambio, avance, retroceso, error, aprendizaje y transformación. Sin embargo, siempre se mantiene anclada en una identidad vivencial que tiene una vocación de permanencia y estabilidad, aunque con un grado de flexibilidad. Esta identidad puede adaptarse a los cambios en el tiempo, el lugar, las relaciones y las rupturas, y permanece más allá de los estilos de vida que se elijan, las apariencias, los cambios sociales y las heridas que fracturan a las personas. La identidad es imborrable, siempre renace, siempre hay un resquicio por el que los fundamentos y las certezas del ser personal vuelven a emerger, posibilitando el encuentro con el propio ser.

La problemática actual de la identidad y la corporalidad humana está íntimamente vinculada con la diferencia sexual. Sin un enfoque integrador de la experiencia sexual, no es posible comprender ni la riqueza de significado del cuerpo en su funcionalidad orgánica e irreductible, ni la complejidad de la sexualidad humana. En la actualidad, asistimos a una tematización de la sexualidad sin precedentes, que se presenta de manera tanto teórica como práctica, de una forma que no tiene comparación con ninguna otra etapa de la historia. Como apunta Anatrella, "durante estos últimos cuarenta años, se ha puesto en marcha un sistema de representaciones de la sexualidad que codifica una identificación con las preferencias sexuales marginales, valora la expresión de las pulsiones parciales y neutraliza la dimensión subjetiva de la sexualidad, convirtiéndola en una simple realidad pública" (1).

Una de las características que distingue a las generaciones actuales es el paso de una sexualidad privada a una sexualidad pública. Nos encontramos ante una sexualidad cada

vez más exhibida y menos significativa, caracterizada por una inflación visual y lingüística que despoja a la persona de su intimidad. Este fenómeno provoca la pérdida de sensibilidad y delicadeza, generando un cambio profundo no solo en las costumbres sociales, sino también en el ethos personal. La normalización de relaciones sexuales fuera del matrimonio, el aumento de comportamientos previamente estigmatizados, las violaciones en grupo y la pederastia son ejemplos claros de cómo la sexualidad ha sido desnaturalizada.

El sexo, convertido en un objeto de consumo y el cuerpo como herramienta de autorrealización, colapsan la capacidad relacional del ser humano. Así, “el hombre queda abandonado a sus impulsos y sentimientos, encerrado en sí mismo, sin encontrar en la sexualidad un lugar de relación con el otro ni un camino para descubrir su propia identidad” (2). Esta paradoja, como señala Mary Eberstadt, se manifiesta en que la generación más experimentada sexualmente es también, probablemente, la más analfabeta en cuestiones de sexualidad (3).

En los últimos 50 años, la historia de Occidente ha sido testigo del ascenso de un modelo de liberación sexual que, aunque sus orígenes pueden rastrearse antes del siglo XX, ha condicionado profundamente la deconstrucción de la sexualidad en la actualidad. Este proceso ha sido impulsado por la confusión entre lo sexual y lo amoroso, la disociación entre afectividad y sexualidad, y la identificación de la sexualidad exclusivamente con el placer, reduciendo el cuerpo personal a un cuerpo funcional. Como consecuencia de este enfoque, influenciado por los medios de comunicación como el cine, la música, la publicidad y las figuras populares, muchos individuos contemporáneos no han logrado reconocer las cualidades genuinas de las relaciones interpersonales ni desarrollar una dimensión afectiva adecuada.

Las ideas sobre la libertad sexual absoluta ya habían sido formuladas de manera explícita entre las décadas de 1920 y 1930. Sin embargo, debido a la fuerte oposición que encontraron en los regímenes totalitarios de la época (fascismo, nazismo, comunismo), estas propuestas no pudieron prevalecer en la década siguiente. No obstante, comenzaron a resurgir de manera casi inadvertida después de 1945, alcanzando una expansión significativa después de 1960, con una fuerza y alcance que siguen vigentes hasta nuestros días (4).

Para comprender mejor el contexto de la situación actual, es esencial considerar algunas de las teorías y críticas que han influido en la concepción moderna del matrimonio y la familia. Sin embargo, es pertinente señalar que el concepto de "sexualidad" abarca un

campo semántico que fácilmente se extiende a otros ámbitos, como el matrimonio, el amor, la familia y las relaciones conyugales.

En primer lugar, se deben señalar las aportaciones de filósofos contemporáneos que han influido en la reflexión sociocultural sobre la sexualidad. Algunos la consideran un producto histórico y cultural, mientras que otros la entienden como una realidad natural, un hecho bio-psicológico invariable y constante. En segundo lugar, es necesario examinar el trabajo alarmante de autores que han promovido estudios científicos basados en teorías erróneas o fraudulentas. Finalmente, no podemos pasar por alto la influencia de instituciones internacionales que han promovido la implementación de una visión distorsionada de la sexualidad humana, contribuyendo a una concepción reduccionista y desencarnada del ser humano, con repercusiones significativas en la vida moral tanto a nivel personal como social.

El sustrato filosófico de la revolución sexual

Desde los primeros estudios de Malinowski (1884-1942) y Margaret Mead (1901-1978) hasta mediados de la década de 1970, la sexualidad fue considerada como una necesidad primaria tanto del individuo como del grupo, y la familia era vista como la respuesta institucional universal a esta necesidad. La sexualidad se percibía, por un lado, como una fuerza social, y por otro, como un fenómeno modelado por la cultura de la sociedad.

Para Schopenhauer, la sexualidad es una realidad omnipresente y problemática en la historia individual y colectiva. El amor sexual, lejos de ser un producto cultural, se presenta como un sentimiento profundamente arraigado en la naturaleza. Según este enfoque, el amor se reduce a lo físico, y la relación conyugal se entiende como un acto metafísico esencial, orientado hacia la procreación de nuevos seres (5). En su visión, los individuos son meros instrumentos de la perpetuación de la especie, para la cual la verdadera vida es la de la especie misma, que tiene existencia eterna. Schopenhauer considera al matrimonio una trampa que la naturaleza tiende, especialmente a los varones, y es comprensible su oposición a la monogamia (6).

En la obra de Nietzsche, la sexualidad está presente de manera constante, aunque se enfoca de manera predominante en el sexo femenino, a menudo con un tono misógino. En *La gaya ciencia*, por ejemplo, un aforismo afirma que "las mujeres son hermosas si se ven desde lejos". La sexualidad, para Nietzsche, forma parte de los aspectos más inmediatos de la vida, pero, al mismo tiempo, refleja una lucha continua entre los sexos. Siguiendo la influencia de Hobbes, Nietzsche describe la relación entre hombres y mujeres como una guerra eterna, una antítesis de la naturaleza, caracterizada por un odio

mortal y un desprecio mutuo en el que la cultura tiene escasa influencia (7). En *Fragmentos póstumos*, Nietzsche expresa un total desprecio por el matrimonio, considerándolo la "relación sexual más falsa" y el fin de las "breves locuras" del amor. La procreación, para él, es vista como un proceso para reunir las características de ambos progenitores en una síntesis superior. Nietzsche concibe la sexualidad como un mecanismo supraindividual de evolución, y su antagonismo hacia el cristianismo le lleva a afirmar que ha corrompido la sexualidad, describiéndola como impura: "Sólo el cristianismo, que se basa en el resentimiento contra la vida, ha hecho de la sexualidad algo impuro, ha arrojado basura sobre el comienzo de nuestra vida" (8).

Igualmente, cabe destacar la obra de Herbert Marcuse (1898-1979), figura central de la revolución cultural occidental de los años sesenta, uno de los pensadores más influyentes en la reconfiguración de la sexualidad en la modernidad. Su propuesta se fundamenta en una relectura del erotismo, asumiendo la tesis freudiana de que la sexualidad obedece al principio del placer (9). Marcuse aboga por la reconciliación entre el principio del placer y el principio de la realidad, pero para que ambos principios converjan, sostiene que deben cumplirse dos condiciones fundamentales. Primero, la realidad debe ser radicalmente transformada; y segundo, el placer debe expresarse de una manera diferente a como lo hace en la sociedad contemporánea. Ambas condiciones están directamente vinculadas a la liberación sexual (10).

La propuesta de Marcuse se presenta como una llamada a una revolución racional que aboga por una sexualidad sin normas ni restricciones sociales. Según su visión, la eliminación de estas restricciones conduciría a una sociedad más creativa y feliz. Para alcanzar este supuesto paraíso, Marcuse propone un "juego libre" de la sexualidad, que no solo debe abarcar el cuerpo, sino también el trabajo. En este contexto, la actividad laboral debe ser entendida no como una función estrictamente productiva, sino como la expresión libre y participativa de los individuos. Sin embargo, con el paso del tiempo, Marcuse se da cuenta de que no solo no ha logrado liberalizar el amor, sino que la visión reduccionista de la sexualidad ha transformado el eros en una "sexualidad localizada", limitada a las "zonas erógenas inmediatas". Esta perspectiva no solo ha fallado en eliminar la represión sexual, sino que ha conducido a la degradación del eros, convirtiendo el sexo en un objeto de consumo y reduciéndolo a una función estratégica del mercado.

Como última referencia, debemos citar a Simone de Beauvoir (1908-1986), influyente pensadora existencialista y marxista, que desempeñó un papel igualmente crucial en la

transformación de las ideas sobre la sexualidad y la opresión femenina. En su obra, Beauvoir amplía la crítica marxista de la opresión de clases al señalar una opresión aún más radical: la del sexo femenino. Su famosa declaración “¡No naces mujer, te hacen mujer!” refleja su visión de que la identidad femenina no es algo natural, sino una construcción social impuesta por los hombres. Para Beauvoir, el ser de la mujer no está dado, sino que es una construcción social que debe ser liberada (11).

Según su perspectiva, el acceso de las mujeres a una sexualidad liberada era esencial, lo que implicaba romper con la esclavitud de la maternidad. Para Beauvoir, el embarazo representaba una mutilación, ya que el feto era considerado un invasor que le robaba a la mujer su individualidad, un mero fragmento de carne. Así, se hacía imprescindible la anticoncepción y el aborto. Para lograr una verdadera liberación, la mujer debía construirse a sí misma de forma radicalmente autónoma del hombre, de los demás y de Dios. En su visión, la relación entre amante y amado no era una expresión de la comunicación entre dos libertades, sino que representaba una forma de alienación. Por tanto, para alcanzar una igualdad plena, Beauvoir sostenía que era necesario reconocer a la mujer como sujeto libre, igual al hombre, y abogaba por la eliminación de la institución del matrimonio.

Estas propuestas, aunque profundamente influyentes, provocaron una reevaluación radical de las normas tradicionales sobre la sexualidad, la familia y las relaciones de género. Beauvoir, Marcuse y otros autores, desde perspectivas diferentes, contribuyeron a la redefinición de la sexualidad humana, poniendo en cuestión los fundamentos mismos de la moralidad y la estructura social que habían regido el mundo occidental durante siglos. La sexualidad, lejos de ser solo un aspecto biológico o moral, se convirtió en un campo de batalla cultural y filosófico que sigue moldeando las concepciones contemporáneas del individuo, la libertad y el amor.

El sustrato científico de la revolución sexual

Con la figura de Sigmund Freud, se produjo un cambio fundamental en la percepción de la sexualidad dentro del pensamiento occidental y en su relación con la vida humana. Freud, el padre del psicoanálisis, utiliza el binomio formado por el principio de placer y el principio de realidad para interpretar la dinámica pulsional. El principio de placer, que conduce a placeres momentáneos y efímeros, es contrarrestado por el principio de la realidad, que busca la obtención de una estabilidad futura más segura.

Freud radicaliza este principio al afirmarlo como la pulsión humana fundamental, a la que la razón está subordinada, y lo identifica con la pulsión sexual o libido. Según Freud, esta

pulsión es más amplia que las demás y la denomina eros o pulsión de vida. Al estudiar su funcionamiento, su objetivo era demostrar que la sexualidad se encuentra en el origen de todos los procesos humanos, y que constituye el blanco primario de la represión (12).

El subconsciente, ese ámbito oculto tras la conciencia, es el verdadero motor del ser humano, y gira en torno a los deseos sexuales reprimidos. Freud, al explicar el funcionamiento de la pulsión sexual, sostiene que la sexualidad es el principio rector que gobierna todas las capas de los impulsos y deseos humanos, aunque sin ningún referente real fuera de la economía de la libido. Este enfoque reemplaza la visión de un ser humano configurado para fines más elevados, colocando el deseo sexual como la fuente motivacional primordial de la existencia humana.

Desde sus primeros trabajos hasta los últimos momentos de su carrera intelectual, Freud estuvo profundamente fascinado por el enigma de la sexualidad. Argumentó que la perversión estaba presente incluso en las personas sanas y que el camino hacia una sexualidad madura y normal no comienza en la pubertad, sino en la temprana infancia. Se le considera el máximo exponente del pansexualismo, ya que interpretaba todos los fenómenos humanos como manifestaciones del deseo sexual. Sin embargo, a lo largo de su carrera, Freud reconoció que no logró comprender plenamente la naturaleza de la pulsión sexual. Un error fundamental de su teoría fue la concepción de la realidad como algo contrario al placer, su enemiga natural.

En este proceso de reconfiguración de la sexualidad, también es relevante el impacto de Wilhelm Reich (1897-1970), otro psicoanalista y revolucionario sexual que desempeñó un papel crucial en la hipersexualización de la sociedad occidental. Discípulo de Freud, aunque posteriormente crítico de algunas de sus ideas, Reich introdujo el concepto de "psicoanálisis revolucionario", centrado en el autoerotismo, la represión sexual y el papel social de la sexualidad. Para Reich, la satisfacción sexual, identificada con la felicidad, estaba siendo obstaculizada por la sexualidad ligada a la reproducción y al matrimonio monógamo. En su obra *La revolución sexual* (1936), Reich argumenta que el ser humano solo puede alcanzar su realización en el terreno de la libertad sexual, y que para ello es necesario eliminar instituciones como el matrimonio, la familia, la iglesia y la moral sexual tradicional. Según Reich, solo una revolución social podría garantizar la satisfacción sexual plena para toda la población, mientras que la represión sexual sería la causa de las enfermedades psicológicas y sociales que aquejan a la humanidad. De acuerdo con su teoría, todas las desgracias de la vida humana desaparecerían si las

personas pudieran satisfacer sus deseos sexuales sin ningún tipo de limitación o represión (13).

En esta misma línea cabe citar a Alfred Kinsey, biólogo estadounidense y especialista en entomología, reconocido como el "padre de la sexología". En 1948 y 1950 publicó sus influyentes obras *Comportamiento sexual en el varón* y *Comportamiento sexual de la mujer*, respectivamente. Estos estudios se convirtieron en bestsellers, pero, a pesar de su extensa exposición (más de 1600 páginas), ninguno de sus textos aborda el amor. Estas publicaciones han tenido un impacto profundo en la concepción occidental sobre la sexualidad, moldeando creencias y entendimientos contemporáneos en torno a este tema. Kinsey defendió que todos los comportamientos sexuales considerados "desviados" eran, en realidad, normales, mientras que la heterosexualidad exclusiva se veía como una anomalía, producto de inhibiciones culturales y condicionamientos sociales (14).

A pesar del rotundo éxito de sus libros, pronto surgieron cuestionamientos acerca de la validez de los datos empíricos que respaldaban sus conclusiones. La American Statistical Association emitió una evaluación crítica, y científicos de diversas partes del mundo demostraron que los hallazgos de Kinsey carecían de rigor científico. La muestra utilizada era claramente sesgada, pues incluía a un alto número de prisioneros, exhibicionistas, pedófilos y agresores sexuales, y su metodología llegó a incorporar prácticas aberrantes, como la estimulación sexual de niños menores de meses. Lo más sorprendente, sin embargo, es que, a pesar de las pruebas de fraude y la nula fiabilidad de sus investigaciones, aún hoy algunos sexólogos lo citan como un referente serio, respaldado por instituciones gubernamentales e internacionales como la International Planned Parenthood Federation y el Population Council, ambas vinculadas a organizaciones como la Fundación Rockefeller, la Fundación Ford, el Banco Mundial y el Fondo Monetario Internacional.

La influencia de Kinsey va más allá de una simple permisividad: su rechazo hacia la persona humana y el amor condujo a una sexualización integral del ser humano, propiciando un reduccionismo antropológico aberrante y patológico. Sin embargo, las decisiones políticas y sociales continúan basándose en sus falacias. Una élite política, ideológica y financiera ha impuesto estas ideas a la sociedad, con un claro trasfondo antagónico hacia la familia tradicional.

A lo largo de las décadas, los seguidores de sus teorías han logrado infiltrarse en universidades, partidos políticos, medios de comunicación y organismos de salud pública. Como advierte la periodista estadounidense Marguerite A. Peeters, este movimiento ha

logrado "deconstruir la realidad, la naturaleza, la cultura, la civilización, la tradición, la autoridad, el estado de derecho, la figura del padre, la verdad, el bien y el mal, la personalidad individual y la felicidad personal". El movimiento se expandió rápidamente, coincidiendo con la globalización económica y la apertura de fronteras políticas, provocando una revolución cultural mundial (15).

El sustrato social de la revolución sexual

Si bien las revoluciones se originan tradicionalmente desde las bases sociales hacia las élites, la revolución sexual ha contado con el impulso de las élites políticas y sociales. En este contexto, una figura fundamental en la deconstrucción de las estructuras morales y sexuales de Occidente fue Margaret Sanger (1879-1966). Su contribución a la revolución sexual y feminista no puede ser subestimada. Sanger se propuso “liberar” a la mujer de la “esclavitud de la reproducción”, sosteniendo que la mujer debía ser dueña de su propio cuerpo y su sexualidad, teniendo la libertad de disponer de ella según su propio deseo. Según Sanger, cada niño debía ser deseado, planificado, elegido, porque solo una raza libre puede nacer de madres libres, no de madres esclavas. Fundó la Federación Internacional para la Planificación Familiar (IPPF), una institución clave en la promoción de la anticoncepción y el control de la natalidad.

Por otro lado, en 1948, la Declaración Universal de los Derechos Humanos de las Naciones Unidas proclamó derechos universales para proteger la dignidad, libertad e igualdad de los seres humanos, así como las instituciones naturales como la familia y el matrimonio. Sin embargo, estos principios han sido gradualmente reformulados. La ONU de 1948, que surgió como garante de la paz mundial, no es la misma que la de 1989 ni la de 2024. Organismos internacionales y sus agencias, así como los parlamentos nacionales y europeos, han utilizado su poder para reemplazar los principios morales universales derivados de la imagen judeocristiana del ser humano por los postulados de la postmodernidad, promoviendo una “nueva ética mundial”. En este contexto, se ha intentado redefinir el concepto de derechos humanos, impulsando la negación de la identidad sexual binaria de hombre y mujer, la eliminación del matrimonio y la familia, la legalización del aborto como derecho humano, el feminismo radical y la perspectiva de género. En este sentido, la Organización Mundial de la Salud (OMS) ha proclamado que la "salud sexual se fundamenta en la expresión libre y responsable de las capacidades sexuales que promuevan el bienestar armonioso, tanto personal como social", y que no se limita simplemente a la ausencia de disfunciones o incapacidad. Para alcanzar estos

objetivos, afirman, es crucial que se reconozcan y fomenten los derechos sexuales de todos los individuos.

En este contexto se enmarca uno de los factores que más ha influido en los aspectos fundamentales de las relaciones humanas, como es la difusión masiva de la píldora anticonceptiva. Esta innovación ha permitido que mujeres fértiles controlen su fertilidad con un éxito cercano al 100%. La contracepción moderna ha transformado la vida y las estructuras familiares de una gran parte de las generaciones nacidas después de su invención. Ningún otro evento en la historia reciente ha tenido consecuencias demográficas y sociales tan extremas, modelando tanto la conducta como el pensamiento de millones de personas.

En 1947, el sociólogo Zimmerman ya predecía los profundos cambios que afectarían a la sociedad estadounidense, prediciendo una crisis de valores dentro del matrimonio y la familia: "Estados Unidos alcanzará la fase final de una gran crisis familiar entre ahora y finales de siglo, una crisis similar a las ocurridas en Grecia y Roma" (16). Entre los pensadores que han analizado de manera profunda la revolución sexual se encuentra el filósofo Augusto Del Noce. Según este autor, la revolución sexual ha fracasado desde sus inicios por la falta de una base filosófica sólida, careciendo de soluciones de recambio (26). No es casual que, de esa época, no quede ningún pensamiento válido desde el cual construir o enriquecer la relación social ni ofrecer una perspectiva para un proyecto de vida. En su obra *L'erotismo alla conquista della società* (1970), Del Noce aborda la revolución sexual en sus raíces, vinculándola con el ateísmo y adoptando, en gran medida, los criterios de este pensamiento. Ante la debacle de las grandes ideologías del siglo XX, como el comunismo, el nazismo y el fascismo, el ateísmo emergió en su segunda fase como un totalitarismo incruento y omnipresente, consolidando el auge de una sociedad consumista y opulenta. En este nuevo orden, el ideal izquierdista de la emancipación del proletariado fue reemplazado por la liberación de cualquier forma de represión. Así, la transgresión pasó a ser vista como un signo de progreso. De esta manera, la revolución sexual encarna la sociedad del bienestar en su expresión más pura, un bienestar que busca satisfacer los instintos individuales sin distinguir entre los más básicos y necesarios o los más refinados y esporádicos.

No obstante, no todos los enfoques sobre la revolución sexual coinciden en sus efectos. Como señala un autor contemporáneo, "para mí no hay duda de que la revolución sexual de las décadas de los 60 y 70 ha mejorado la calidad de vida de la mayoría de los estadounidenses" (17). El proceso de transformación ha sido, sin duda, asombroso; la

revolución sexual se ha presentado como un modo de vida que permite a cada individuo ejercer su libertad sin ninguna restricción. A finales de los años 60, el mensaje de liberación sexual caló hondo en las mentes de los jóvenes, impulsándolos hacia una sexualidad sin límites ni impedimentos. De lo que antes se consideraba extraño y peligroso, la sexualidad se convirtió en una actividad lúdica y recreativa, fuente de placer y reducida a una mera función biológica.

La transformación que ha tenido lugar en las últimas décadas no ha sido una revolución violenta, sino un cambio silencioso y cultural. Los ajustes y modificaciones han sido poco visibles en su manifestación, ya que, como señala Peeters, "la fachada institucional se mantuvo en pie [...] los cambios de valores, de mentalidades y de estilos de vida se produjeron dentro de las instituciones, las empresas, las culturas, las familias y las religiones" (15). Esta evolución podría ilustrarse con la famosa frase de Descartes *larvatus prodeo*, es decir, avanzar mientras me oculto tras una máscara.

Las consecuencias de la revolución

Hasta ese momento, las revoluciones anteriores no habían logrado modificar profundamente lo que constituía el fundamento de la sociedad: la identidad de las personas. La idea de la naturaleza humana se mantenía intacta, y con ella, la concepción tradicional de la sexualidad y las instituciones del matrimonio y la familia, vistas como realidades inmutables, dadas por siempre (18). Pero la concepción de la sexualidad que se transmitió en la revolución sexual fue la de una pura energía, una cuestión de genitalidad. Para vivirla plenamente, se debía liberarla de todas las ataduras que la reprimían, como el matrimonio y la distinción sexual, así como de la fecundidad no deseada, que impedía una práctica sexual espontánea. En este nuevo estado de cosas, la revolución sexual instauró una triple fractura: entre sexualidad y matrimonio, entre sexualidad y procreación, y entre sexualidad y amor. Como señala el sociólogo Zygmunt Bauman, este proceso ha dado lugar a una visión fluida de la sexualidad, caracterizada por la incapacidad de formar vínculos estables (19). Según los pensadores franceses Jacques Attali y Stéphanie Bonvicini, las nuevas formas de experimentar la sexualidad han dado lugar a relaciones de amor más auténticas, aunque, reconocen, también más frágiles. Entre estas se incluye el poliamor, en el que cada individuo mantiene múltiples relaciones sentimentales y sexuales de manera simultánea (20).

La revolución sexual prometió un cambio radical en las relaciones humanas, sugiriendo que bastaba con expresar la sexualidad con libertad para alcanzar una existencia más profunda. Sin embargo, cincuenta años después, la decepción es evidente: la mayoría de

las personas no ha logrado una mejor forma de comunicación ni de relación. Como señala el filósofo Hadjadj, "¿dónde estamos hoy? Los pulmones siguen sirviendo para respirar, el estómago sigue con su función digestiva. Pero ¿y el sexo? Sería un error responder que su fin es la procreación. Tampoco sus otros destinos se sostienen. ¿Puede decirse que se limita a la relación entre hombre y mujer? ¿Se puede pensar siquiera que está relacionado principalmente con la carne? ¿Debemos concluir que está ahí solo para suscitar nos preguntas?". Según Hadjadj, "la explosión de sexo equivale a su desaparición", y con firmeza advierte que "en realidad, no se le puede encontrar" (21). La revolución sexual, en efecto, ha despojado al sexo de su profundidad y sentido, reduciéndolo a una experiencia vacía, anónima y desvinculada de la procreación, el afecto y el amor. Como apunta Anatrella, este tipo de relaciones son solo "parejas transitorias de almohada" (PTA), y se viven como un desgarramiento interior, un fallo y un colapso de la persona (23). Además, como destaca la socióloga Mary Eberstadt, el peso de esta revolución recae especialmente sobre los más jóvenes y vulnerables (22). Si bien la combinación de los sexos puede ser fácil, la verdadera comunión, en cambio, es difícil. La revolución sexual ha afectado profundamente los aspectos más esenciales de las relaciones humanas, especialmente en el ámbito matrimonial, socavando la tarea compartida, trascendental, que tienen los hombres y mujeres: proteger a los niños.

La raíz de la cuestión I: la identidad

La inquietud acerca de la identidad humana es una preocupación universal: no solo nos interesa descubrir quiénes somos, sino también quiénes son los demás. Esta búsqueda, que atraviesa diversas dimensiones del ser, plantea múltiples interrogantes que afectan nuestra concepción del ser humano y de su identidad. En un momento decisivo de su vida, San Agustín reflejaba esta inquietud cuando escribió: "yo mismo me convertí para mí en un gran interrogante" (23). El ser humano no puede vivir en la incertidumbre perpetua; su necesidad de comprender y valorar su identidad personal es esencial, pues le permite reconocer su conciencia de sí mismo, aquello que lo caracteriza y lo distingue de los otros, otorgándole un modo único y singular de vivir su existencia.

La identidad es ese rasgo esencial que, pese a las transformaciones internas y externas, permanece inmutable; aunque el mundo a nuestro alrededor cambie, la persona sigue siendo la misma, aunque no idéntica. Un claro ejemplo de esto lo encontramos en el caso de una persona con Alzheimer: aunque no reconozca a su hijo o a sí misma, sigue siendo esa persona, tal como señala Burgos: "La persona es un ser consistente que resiste el paso de los años y los días" (24). Elementos como el lugar de nacimiento, la apariencia física

o la identidad étnica son características fundamentales e ineludibles de la identidad; aunque no dependen directamente de la voluntad de la persona, algunas de ellas pueden modificarse con el tiempo, como ocurre con la cirugía estética o el cambio de nombre. Sin embargo, estas modificaciones no alteran la esencia de la persona. Según Bauman, la identidad es como una realidad tallada en la roca, una base sólida con la que nacemos, pero que, al mismo tiempo, es dinámica y se configura a través de nuestras acciones y relaciones. La identidad personal no es estática, sino que puede mejorarse y perfeccionarse de diversas maneras a lo largo de la vida (25).

En la actualidad, somos testigos de una creciente dificultad para vivir y entender la identidad personal. Según Bauman, esta confusión se debe a un cambio radical en las coordenadas histórico-culturales que han afectado profundamente la formación de una identidad madura. La identidad, que antes se concebía como una realidad estable, ha pasado a ser una realidad fluida, que puede descomponerse y recomponerse de manera indefinida. Esta "liquidez identitaria" se manifiesta en un continuo proceso de cambio, que afecta nuestras dimensiones físicas, psíquicas, corporales, morales y de salud (26). La vida, fragmentada en instantes desconectados, se convierte en una sucesión de deseos inmediatos, sin un verdadero protagonista que le dé coherencia. De este modo, se llega a la anulación de la persona y de sus diferencias esenciales, viviendo en la superficie, sin profundidad interior. Aunque esta banalidad existencial, marcada por lo efímero, se presenta de manera atractiva y novedosa, se ocultan el engaño y el sufrimiento que acompañan a la inseguridad existencial que produce (27).

La desorientación identitaria se ve marcada por la convergencia de dos enfoques de pensamiento que, desde perspectivas aparentemente opuestas, contribuyen a la confusión sobre la naturaleza de la identidad (28). Por un lado, la modernidad entiende la identidad como autoconsciencia, lo que implica una negación, en cierto modo, de las diferencias y los vínculos que enriquecen la experiencia humana. Por otro lado, la postmodernidad rechaza esa absolutización de la conciencia, interpretando la identidad como la raíz de todos los conflictos. En su lugar, la identidad se ve sustituida por una pluralidad de diferencias. Este fenómeno lleva a una desestabilización de las fronteras identitarias, tornándolas borrosas y precarias.

En la dinámica postmoderna, el rechazo no se dirige a la noción abstracta de identidad, sino que apunta a identidades concretas, como el matrimonio, la familia o el género. En este contexto, asistimos a un proceso de deshumanización, un movimiento pendular que oscila entre el individualismo insolidario y un conglomerado de diferencias

despersonalizadas, que terminan por fragmentar al ser humano. Ambos fenómenos, tanto los de la modernidad como los de la postmodernidad, favorecen el desarraigo y la desorientación del individuo, dificultando aún más su comprensión de sí mismo.

Es preciso señalar que sin diferencias no existiría identidad, solo homogeneidad, uniformidad e igualitarismo. Sin embargo, el desprecio por la identidad priva a los individuos de puntos de referencia fundamentales: morales, culturales, sociales y religiosos. La diferencia, defendida por los postmodernos, es presentada como el ámbito de la libertad, la oportunidad y la independencia de cualquier vínculo, deseos y construcciones sociales. En este enfoque, todo lo que existe es visto como una construcción social, sujeta a un cambio constante, lo que da lugar a la posibilidad de que cada individuo elabore y disuelva su identidad, se reinvente continuamente a partir de sus experiencias, deseos e impulsos. De este modo, se crea un ser sin raíces ni vínculos, un conjunto inconexo de experiencias desprovistas de continuidad y sentido, que no encuentran anclaje en una identidad personal definida a lo largo de la biografía (29).

La desorientación y distorsión de la identidad personal han dado lugar a una crisis profunda que afecta tanto al individuo como a sus relaciones interpersonales. Los síntomas de esta crisis son numerosos: la confusión respecto al sentido de la vida, la falta de pertenencia, la incapacidad para distinguir entre realidad y deseo, la negación de la propia identidad, que puede llevar a alterarla o, en su defecto, a adoptar identidades ajenas. La señal más expresiva y preocupante de esta crisis, como señala Malo, es la relación conflictiva del individuo con su condición sexuada, ya que esta no solo constituye el origen de la identidad personal y sus diferencias, sino que también da lugar a seres irrepetibles que son expresión de la unión entre dos modos de ser persona, hombre y mujer (28).

El descubrimiento de la identidad personal no debe entenderse como un proceso aislado; al contrario, es un proceso que se realiza en constante diálogo con los demás y con el mundo. La identidad no se construye en solitario, sino que depende en gran medida de las relaciones y vínculos que la persona establece. La experiencia humana incluye momentos de discordancia interna, como el arrepentimiento, la enfermedad, la perplejidad, el autoengaño y la decepción, situaciones en las cuales las relaciones humanas se convierten en puntos claves para el autodescubrimiento y la autoafirmación. Como afirma Charles Taylor, necesitamos las relaciones no tanto para definirnos, sino para realizarnos plenamente (30).

Sin embargo, no todas las relaciones son iguales en cuanto a su valor formativo. Lo esencial es que la unión sea integradora y libre, pues hoy en día, con frecuencia, se confunden relaciones asimilativas o posesivas con la integración genuina de las identidades. Un ejemplo claro de ello es la relación entre hombre y mujer, la cual pierde su sentido si no se comprende que la identidad de cada uno de ellos es completa y acabada por sí misma, aunque, al mismo tiempo, se necesita la relación con el otro para conocerse de manera plena. Este encuentro entre identidades diferentes revela a cada una de ellas su propia identidad.

De ahí que sea imposible eliminar o eludir la identidad personal sin afectar negativamente al crecimiento de otras identidades y al carácter mismo de las relaciones interpersonales. Como sostiene Malo, cuanto más se respetan y valoran las diferencias, más se favorecen las identidades y mejoran las relaciones. Esto es posible, señala, siempre que se entienda la identidad personal como una integración de la corporalidad, la autoconciencia y la diferencia, especialmente en relación con la alteridad, con la identidad del otro (28).

La raíz de la cuestión II: la corporalidad

Para abordar la compleja relación que actualmente existe entre la persona y su cuerpo, es necesario considerar, en primer lugar, dos respuestas predominantes que han marcado el debate contemporáneo. La primera perspectiva concibe el cuerpo como un mero objeto, uno más entre tantos, una realidad material que puede ser manipulada y transformada a voluntad del individuo. Este enfoque, característico de una concepción dominadora de la realidad, omite una verdad fundamental: el cuerpo no es solo una estructura física, sino también una expresión, un lenguaje, y una visibilidad de la persona misma. La segunda posición sostiene que la libertad no es algo independiente de la persona, sino que está intrínsecamente vinculada a ella. En este marco, la libertad y la persona coinciden, lo que implica una actitud de reconocimiento, acogida y respeto hacia la realidad del ser humano en su totalidad. Esta segunda perspectiva es la que se defiende en este análisis, ya que, como se afirma, "si nuestro cuerpo está llamado a ser espiritual, ¿no debería su historia ser la de una alianza entre el cuerpo y el espíritu?" (31).

La existencia humana como un ser mixto no es algo evidente, y la relación entre el cuerpo y la persona no es idéntica. El cuerpo no es, en un sentido estricto, la persona misma, sino que le pertenece; el cuerpo es, en cierto modo, de la persona, pero no se reduce a la persona. No es simplemente el "yo" encarnado, ya que forma parte de la naturaleza humana, pero no agota su ser. La solución a este dilema se encuentra en una tesis dual que sostiene que, en la unidad del ser humano, permanece la dualidad. El ser humano es

el lugar donde se unen los contrarios, pues en su naturaleza única coexisten lo espiritual y lo material. En este sentido, el alma humana, de naturaleza espiritual, se expresa en el cuerpo. Como bien afirma Karol Wojtyla, "el hombre no es el cuerpo, solo lo tiene"(32), pero no en el sentido de una mera posesión material. El cuerpo humano no es simplemente un objeto que se posee, sino que es una extensión de la persona misma, un cuerpo que "yo vivo" y no "en el que vivo" de manera impersonal.

El cuerpo es una manifestación integral de la identidad personal, no puede ser tratado como un simple "cuerpo" prescindible, sino como una realidad en la que la persona se encuentra a sí misma, inseparable de la identidad personal, de tal manera que uno no puede ser comprendido sin el otro. El cuerpo humano está permeado por el alma; es un cuerpo "espiritualizado", que trasciende su dimensión material. Como señala Gabriel Marcel, el cuerpo no es algo que elegimos o decidimos, sino que está dado en relación con otros desde el principio, en un entramado de significados compartidos (33).

Se puede afirmar que "yo soy mi cuerpo", pero esto no implica que "yo sea solo mi cuerpo". La relación entre cuerpo y persona es indisoluble, pero no puede reducirse únicamente a la dimensión material. Al mismo tiempo, debemos afirmar que "yo soy estas relaciones en las que me encuentro inmerso desde mi origen"(34), pues vivir en el cuerpo y vivir relacionamente son una misma realidad. Así, no se cuestiona la objetividad ni la validez científica o tecnológica en el estudio del cuerpo, sino que se critica su insuficiencia como única consideración. No se introduce en el mundo un cuerpo genérico de la especie *Homo sapiens sapiens*, sino un cuerpo personal que trasciende la especie humana misma (35).

En la persona humana, lo corpóreo y lo espiritual están diferenciados, pero no pueden ser separados. Como afirma Hadjadj, "una relación puramente física es también una relación verdaderamente espiritual" (36), porque el cuerpo humano es, en su naturaleza más profunda, un cuerpo espiritualizado. El significado del cuerpo trasciende la biología; es el lugar donde se manifiesta el alma, el dinamismo propio de la libertad humana, y su capacidad para buscar la verdad (37). Ya los filósofos presocráticos consideraban al cuerpo como un microcosmos que reflejaba no solo la materialidad física, sino también las dimensiones psíquicas y espirituales del ser humano.

El cuerpo, en su interacción con el mundo exterior, también revela nuestro ser interior. A través de él, la persona interioriza lo exterior, haciendo visible lo invisible, mostrando nuestras emociones, deseos, pensamientos y voluntad. A la vez, el cuerpo exterioriza lo interior, de él surge lo que estaba oculto, haciendo visible lo invisible. El cuerpo se

convierte así en el lenguaje del espíritu, un medio por el cual la persona se comunica consigo misma y con los demás.

Finalmente, el cuerpo es personal no solo porque pertenece a la especie *Homo sapiens sapiens*, sino porque requiere del reconocimiento y acogida por parte de los otros. El cuerpo humano exige, en última instancia, gratuidad y el don de sí, pues solo a través del otro se puede alcanzar su plena comprensión. Este reconocimiento mutuo permite que la persona se realice en su totalidad, integrando lo material y lo espiritual en una unidad indisoluble.

El cuerpo no es una realidad sobre la que se pueda disponer a voluntad, como si fuera cualquier objeto; es mucho más que eso. La concepción moderna del cuerpo, reflejada en el lema "Yo soy dueño de mi cuerpo y con él puedo hacer lo que quiera", revela una visión profundamente cartesiana, dualista y reduccionista. Este enfoque considera al cuerpo como una mera cosa, algo que se puede poseer y manipular, omitiendo así su vínculo esencial con la persona. La cosificación del cuerpo, tratándolo como un objeto que se puede usar y descartar, está lejos de comprender su verdadera naturaleza como expresión de la persona.

La manera en que tratamos nuestro cuerpo afecta nuestra autorrealización personal. Cuando se establece una relación sexual, por ejemplo, en la que "la juntura de las carnes no llega hasta los corazones", como señala HadJadj, se disocian el cuerpo y el "yo", como si el cuerpo fuera algo ajeno. Esta desconexión violenta la esencia misma de la persona, que integra de manera indisoluble su inteligencia, afectividad, corporeidad y sexualidad. El cuerpo no es un mero "habitat" que puede ser diseñado y manipulado a voluntad, sino que es una parte intrínseca de nuestra identidad (36).

Cuando el cuerpo se ve como una cosa, se instrumentaliza y se convierte en un objeto accesible. Como advierte Roland Barthes, el cuerpo se convierte en "el cuerpo pornográfico", desbocado e imprevisible, un objeto expuesto sin ningún tipo de respeto. Esta cosificación del cuerpo influye profundamente en la manera en que la persona se comporta y se entiende a sí misma. Ortega y Gasset señala gráficamente que el tigre no puede "destigrarse", pero el ser humano tiene la capacidad de deshumanizarse. Esta distorsión de la realidad humana, por tanto, siempre tiene consecuencias, ya sea de manera consciente o no. Como expresa Llano, hay algo profundamente torpe en poner la vida solo en el sexo, un acto que se convierte en auto-maltrato y una manifestación de la deshumanización (38).

La raíz de la cuestión III: la dualidad sexual

La sexualidad humana encierra un profundo misterio que no puede reducirse a lo meramente corporal o afectivo. Es un aspecto inseparable de la persona, que forma parte de su riqueza y está intrínsecamente ligado a la unidad y a la identidad personal. La sexualidad no solo da origen a seres irrepetibles, sino que también es expresión de la unión entre los dos modos fundamentales de ser persona: el hombre y la mujer. Es, por tanto, una realidad compleja que atraviesa y caracteriza todas las dimensiones del ser humano: biológica, psicológica, espiritual y cultural. Cada una de estas dimensiones posee su propia consistencia y significado, y la pluralidad de elementos que intervienen en ellas genera el riesgo de absolutizar, menospreciar o considerar separadamente algunos de sus aspectos. Como observa el filósofo Hadjadj, "el hombre no es un monstruo hecho de piezas encajables, que va acumulando y reprimiendo los legados de los animales inferiores. Lo que en él hay de más primitivo ya es humano" (21).

Hoy en día, a partir de la década de los 90, la ideología predominante que ha configurado uno de los paradigmas más elaborados sobre la sexualidad es la teoría del género. Esta teoría interpreta la sexualidad exclusivamente desde una perspectiva cultural y niega la dimensión biológica intrínseca a la persona. Según este enfoque, lo relevante no es el sexo, sino el género, desvinculado de la anatomía. La teoría del género desconoce la diferencia sexual, promueve la libre elección y decisión sobre la orientación sexual, prioriza la satisfacción sexual individual – con o sin la presencia del otro – y apoya la total separación entre la sexualidad y su capacidad generadora. Esta visión omite el papel esencial que el cuerpo desempeña en el proceso de sexualización, sometiéndolo completamente al discurso cultural y convirtiéndolo en un objeto maleable. La antropología reduccionista que subyace en esta teoría, con su enfoque materialista y dualista, no solo resulta insuficiente, sino que es incapaz de integrar adecuadamente las realidades carnales y espirituales del ser humano. Además, provoca una fragmentación de la persona, dejándola en una situación de desvalimiento e incongruencia.

Las teorías de género han puesto de manifiesto un aspecto esencial de la sexualidad humana: su distinción fundamental con respecto a la de los animales. A diferencia de estos, la sexualidad humana no depende exclusivamente de la genética, sino que está profundamente influenciada por las primeras experiencias personales, la relación con los otros, la educación recibida, la cultura, y la sociedad en general. En efecto, como se ha señalado, la sexualidad humana dista mucho de ser un simple instinto; se trata de una dimensión plenamente personal, libre y responsable. Si bien es diferente a la de los animales, no es completamente ajena a ella. Existen elementos corpóreos y psíquicos

comunes, como la distinción psico-corporal entre macho y hembra, las funciones reproductivas, nutricionales y el cuidado de la prole. Sin embargo, el papel que ocupa la sexualidad en la vida del animal y en la existencia humana es, en un sentido radical, incomparable.

En este contexto, es esclarecedora la distinción que el filósofo Julián Marías establece entre sexo o carácter sexual y sexuado o condición sexuada (39). El sexo, en su sentido biológico, genético o somático, remite a una condición común tanto al ser humano como a los animales y muchas plantas. Este concepto tiene dos significados: en primer lugar, como actividad sexual, alude a un tipo de reproducción e intercambio genético (aunque, como sabemos, en especies inferiores existe reproducción sin sexualidad y por ende, sin intercambio genético); y en segundo lugar, implica la existencia de dos sexos con órganos más o menos diferenciados y las actividades correspondientes. No obstante, en el ser humano, a diferencia de los animales, se da una liberalización funcional del sexo: no es solo una función biológica. Esto se manifiesta en dos aspectos: primero, en el retraso de la edad fértil y, segundo, en la emancipación de los ciclos de celo característicos de los animales (40). En consecuencia, en el ser humano se suprime la subordinación del individuo a la especie. Además, el ser humano es el único animal que posee una conciencia clara del nexo entre el acto sexual y la procreación. Así, cuando el hombre realiza el acto sexual, es consciente de estar abierto a la posibilidad de la procreación.

En cuanto a la condición sexuada, este posee un sentido más profundo. Hace referencia a la doble condición con la que se realiza la vida humana: como varón o mujer. Este concepto implica, con respecto al animal, una diferencia que afecta todas las dimensiones de la vida humana a lo largo de su existencia: biológica, afectiva, racional, volitiva, y especialmente relacional. La condición sexuada del ser humano es vivida en la unión existencial entre hombre y mujer, y, a través de esta unión, con otras personas. No hay aspecto en la vida del ser humano que no esté condicionado por el hecho de ser hombre o mujer. Mientras tanto, lo sexual, aunque relevante dentro de la condición sexuada, es una faceta limitada de la vida humana. Como bien explica Julián Marías, "la actividad sexual es una reducida provincia de nuestra vida, muy importante pero limitada, que no comienza con nuestro nacimiento y suele terminar antes de nuestra muerte, fundada en la condición sexuada de la vida humana en general, que afecta a la integridad de ella, en todo tiempo y en todas sus dimensiones" (39).

En consecuencia, la sexualidad humana no debe ser reducida al sexo corporal. La condición sexuada es mucho más abarcante; pertenece al ser humano de manera

intrínseca, permanente y totalizadora. Afecta a la raíz misma de la condición humana, al núcleo íntimo de la persona en cuanto tal, y se vive sin excepción en varón y mujer. Esta condición influye tan profundamente en la persona que, al tomar decisiones sobre ella — por ejemplo, en la entrega total en el matrimonio—, se decide también sobre la propia persona. Esto se debe a que los valores inscritos en la sexualidad están estrechamente ligados al valor de la persona humana. Son valores personales, no meramente instrumentales. De este modo, podemos comprender cómo la función de la sexualidad contribuye a la realización personal a partir de la propia condición sexuada.

Aunque la sexualidad posee un significado profundamente personal, reducirla exclusivamente a lo personal y suprimir la condición sexual, conlleva también una forma de despersonalización. Esto se debe a que se excluye una dimensión esencial y radical de la persona. “Toda realidad, incluso las más alejadas de la sexualidad, como comer, resolver un problema matemático, contemplar un paisaje, rezar o experimentar un peligro, se vive desde la instalación del sexo y desde una perspectiva que no puede reducirse a la otra” (39). De esta manera, la sexualidad no se limita a estar ubicada en el cuerpo como algo aislado, ni se restringe únicamente a los órganos genitales, ni mucho menos se puede concebir como algo de lo que se pueda prescindir en cualquier momento. Está en el orden del ser, no en el de su tener. La sexualidad embarga integralmente al ser humano, influyendo en la manera en que se enfrenta al mundo y a los demás, moldeando sus reacciones hacia otros seres humanos, hombres y mujeres. A través de nuestro cuerpo se inician relaciones fundamentales de filiación, fraternidad, amistad, cooperación laboral y paternidad.

La raíz de la cuestión IV: la relación amorosa

A lo largo de la historia, las respuestas dadas sobre la sexualidad humana han sido diversas, especialmente en el contexto del intenso y encarnizado debate contemporáneo. En épocas anteriores, bajo la influencia de tendencias maniqueas y puritanas, la sexualidad fue vista con sospecha, negada o ensombrecida en su importancia, tratándose incluso como una amenaza para la naturaleza espiritual del hombre. En estos enfoques, la sexualidad se reducía a un dato biológico, ordenada exclusivamente a la procreación. En este sentido, el valor de la sexualidad residiría en el desarrollo natural de sus funciones y procesos, en su efecto transitivo, favoreciendo la vida social y permitiendo el desarrollo de la especie. Paradójicamente, esta visión empobrecedora de la sexualidad se concentraba en lo genital y en las facultades generativas, considerando el placer sexual como una mera recompensa por la ardua tarea de engendrar y educar.

En oposición, algunos sostienen que habría sido mejor para el ser humano si no hubiera existido la atracción sexual. Su razonamiento se fundamenta en la idea de que la sexualidad complica en exceso la existencia humana, altera la vida personal, e introduce un caos que desestabiliza el orden. Para estos pensadores, la sexualidad se percibe como una experiencia inquietante que perturba la paz interior del individuo.

En este contexto, se dificulta enormemente reconocer el sentido original de la sexualidad humana y la atracción que esta conlleva, al disociar las significaciones del acto unitivo. Para algunos, la atracción sexual se percibe como un invasor que despoja al ser humano de su control, mientras que otros la reducen a un simple goce hedonista o a la mera utilidad procreativa. Estas tres visiones utilitaristas intentan controlar la sexualidad, pero en el proceso ocultan el misterio profundo que encierra. La transformación del sentido específico de la sexualidad, reduciéndola al principio del placer o al imperativo procreador, ha conducido a la pérdida del sentido de la diferencia sexual, a su desnaturalización y a su descorporización (41).

Al disociar el espíritu de la carne, la sexualidad deja de ser un misterio para convertirse en un simple problema. Como señala el filósofo Gabriel Marcel, es crucial hacer esta distinción. Un problema, afirma Marcel, es algo que se presenta como un obstáculo en el camino, una dificultad objetiva cuya solución depende de la técnica, como podría ser el caso de un problema fisiológico. En contraste, el misterio trasciende toda técnica. Se trata de una realidad con la que nos encontramos comprometidos, una dificultad que no tiene solución racional y que no se puede describir de manera objetiva, pues no está ante nosotros como un problema, sino dentro de nosotros. Un misterio, por tanto, no se puede comprender de inmediato; no por falta de claridad, sino porque contiene una luz excesiva. No podemos mirarlo directamente, pero desea revelarse, y es necesario aproximarse a él con paciencia, de manera lenta y respetuosa (42).

Es posible negar el misterio o reducirlo a una interpretación positivista, tratándolo como lo desconocido, o incluso atribuirle un sentido romántico que lo relega a lo místico. También se puede confundir con un enigma que representa oscuridad, como sucede con el “problema del mal” o el “problema de la sexualidad”. La actitud correcta ante el misterio, según Marcel, consiste en reconocerlo, acogerlo y acercarse a él con una actitud reflexiva, en un esfuerzo por lograr una recogida interior. Tal como señala Cencini, el misterio busca comunicarse, y nuestra mirada limitada debe adaptarse a su grandeza y profundidad (43).

¿Cómo, entonces, podemos conocer la verdad de la sexualidad si la planteamos desde el misterio, cuando esta realidad toca la esencia misma del ser humano? No se trata de "algo" que la persona enfrente y pueda objetivar; su sentido escapa a una conceptualización inmediata y directa. La experiencia misma del amor sexual entre hombre y mujer nos revela que no se vive desde las razones que los individuos encuentran, sino desde la atracción que experimentan. La reflexión teórica parece estar fuera de lugar. Sin embargo, la misma atracción señala, por un lado, la apertura ontológica del hombre y, por otro, una realidad misteriosa. Así, el camino más adecuado para desvelar su sentido es escuchar la experiencia. Es ella quien nos hablará de su significado, de la verdad de la experiencia erótica, que se configura como deseo del otro (eros) y en el don de sí mismo (ágape). Por lo tanto, la sexualidad no puede reducirse a una simple relación entre objeto y sujeto. Como expresa Pieper, un tanto exageradamente, el amor erótico es la única atadura capaz de mantener unidos el sexo y el ágape (44).

La sexualidad humana afecta a la corporalidad de manera profunda, pero también la dimensión psicológica se impone al mostrar la intensa atracción que une al hombre y a la mujer, haciendo posible una relación nueva en la vida de las personas. Según Cafarra, esta atracción no es únicamente física; surge de la necesidad de superar la propia pobreza antropológica a través de la unidad con el otro (45). La persona busca una plenitud que se alcanza en la complementariedad. Es la dimensión erótica de la sexualidad, a través de la recíproca atracción y deseo, la que permite que la persona perciba la necesidad del otro sexo como algo más profundo, permitiéndole captar la belleza del ser amado y descubrir la correlación de los valores masculinos y femeninos a medida que se sienten y experimentan. De aquí nacen la ternura, el afecto y la pasión.

Aparece, así, el tercer aspecto de la sexualidad: la dimensión espiritual. La persona, al reconocer en el otro no solo lo que le completa sino el valor y la belleza que hacen digno de ser amado, descubre que merece el don de sí mismo. Esta dimensión espiritual une la dimensión física y la psíquica. La dimensión erótica no se suprime, sino que se eleva al nivel del lenguaje personal. Igualmente, la dimensión física no se elimina; llegar a ser una sola carne implica hacer visible y realizar el don de la persona. Por lo tanto, los tres aspectos esenciales de la sexualidad—biológico, psicológico y espiritual—están profundamente conectados entre sí (45).

Nuestra condición sexuada impregna, de manera profunda, nuestra vivencia de la actividad sexual como una relación interpersonal. Esto distingue la condición sexuada de cualquier otra, ya que se trata de una condición transitiva, orientada siempre hacia la otra

condición sexuada. En este contexto, la relación sexual, por más íntima que sea, no conduce a una identificación total de la persona con la otra. La persona no se disgrega ni se absorbe completamente en la relación. Tampoco la relación es un fenómeno automático o instintivo que simplemente sigue impulsos. Se trata de un acto típicamente humano, querido y realizado por la inteligencia, el corazón y la voluntad. Es, en definitiva, el hombre concreto quien decide entrar en relación, uniéndose al otro.

El hombre y la mujer, en su realidad sexuada, se reconocen como deficientes respecto de sí mismos, experimentando la necesidad del otro no solo en el plano sexual, sino en la totalidad de su ser sexuado—hombre o mujer. Esta diferenciación sexual, que señala la recíproca complementariedad, está dirigida hacia la comunicación interpersonal y, por ende, a la perfección tanto de uno mismo como del otro, es decir, a sentir, expresar y vivir el amor humano. En efecto, como se ha señalado anteriormente, el ser humano se entiende a sí mismo en presencia de la persona del sexo opuesto.

A partir de estos principios, podemos afirmar que la sexualidad es un don de sí mismo. Lo que buscan hombre y mujer, en su raíz más profunda, no es únicamente el placer, sino la plenitud y la fecundidad. La respuesta afectiva ante el otro no se limita al bien placentero, sino que también busca que ese bien sea verdadero. El deseo sexual no es un deseo simple; refleja la interioridad de la persona, su complejidad y su unidad. Como señala Platón, el deseo es algo del alma (46). Se busca el placer carnal, pero este incluye algo más: un deseo de posesión de los valores humanos ligados a la masculinidad y la feminidad, un deseo de reconocimiento del otro. El deseo sexual, en su núcleo, contiene un elemento de reciprocidad que está profundamente enraizado en la dimensión biológica asimétrica, que remite intrínsecamente al otro. Si no fuera así, sin la correlación con el otro, el placer aislado quedaría reducido a una mera excitación sensual, infrahumana y saciada.

Siguiendo esta línea, Noriega subraya que el deseo de sentir placer implica, en cierta medida, un conocimiento sensible que también conlleva un conocimiento espiritual. El hombre, en su "sentir", busca su plenitud humana, la desea, la anhela y la experimenta. Y, con contundencia, afirma que el deseo sensible esconde en sí un deseo espiritual. De hecho, aunque el deseo sexual sacia y contiene una perfección, esta no es total ni definitiva, pues en él se esconde un deseo de algo más grande: una forma de amar y ser amado que trasciende lo físico y se proyecta hacia una realización más profunda (47).

La solución de la cuestión: redescubrir a la persona y su capacidad de amar

La persona humana constituye una fuente inagotable de asombro y reflexión y, a lo largo de la historia, nunca ha dejado de despertar el interés más profundo. Es una llamada constante, un desafío permanente para comprender las razones que fundamentan su grandeza, para desvelar el enigma de su ser y para protegerla frente a las violaciones que atentan contra su dignidad.

Ahondar en la persona es un ejercicio de descubrimiento de su condición irrepetible y singular (48). Cada ser humano es único, y su identidad no puede ser reducida a un simple ejemplar de la especie. La persona no es una realidad ya acabada; por el contrario, es un ser inconcluso, una construcción dinámica que transita hacia su realización plena a lo largo de toda su existencia. Aunque cada individuo es irrepetible e inconfundible, la persona humana está siempre en proceso, orientada hacia la consecución de una plenitud que aún no ha alcanzado. Este anhelo de perfección es inherente a nuestra naturaleza, una carencia que recorre de punta a punta nuestras vidas y que nos impulsa a buscar realidades que puedan satisfacer esa necesidad de completitud interna (49).

La pregunta inmediata es cómo alcanzar esa perfección. No podemos realizarnos plenamente ni en el plano físico ni moral sin la relación con los demás. En palabras de Gabriel Marcel, "una voz secreta que no puedo acallar me asegura que, en efecto, si los otros no son, yo tampoco soy [...]; si los otros se me escapan, yo también me escapo de mí mismo" (42). Esta reflexión pone en evidencia que la persona no puede entenderse de manera aislada, sino que su existencia se define en relación con los otros.

El aislamiento interior, el individualismo y la autonomía absoluta son caminos que conducen al fracaso humano. Como señala Emmanuel Mounier, "todas las locuras manifiestan un fracaso de la relación con el otro" (50), lo que lleva a una alienación tanto del ser como de la identidad personal. La relación interpersonal, por tanto, no se reduce a una mera convivencia, sino que es una relación profunda de donación y recepción, de ser para el otro, de querer el bien del otro. Esta comprensión de la relación humana resalta la importancia de una ética que prioriza la entrega mutua y el reconocimiento de la dignidad del otro.

En este contexto se descubre que la realidad humana es inseparablemente masculina o femenina. Por ello, el hombre es una persona masculina y la mujer, una persona femenina. Sin embargo, esta comprensión no debe reducirse a una existencia separada de hombres por un lado y mujeres por otro, como sugiere el mito platónico del ser andrógino, que plantea que la división entre varones y mujeres es resultado de la *hybris* humana y de la misericordia divina que permite su reencuentro a través del acto sexual. La explicación

antropológica más coherente se encuentra en el relato bíblico del Génesis, que propone una creación originaria del hombre y de la mujer (Adán y Eva) con vistas a su unión y multiplicación.

Este enfoque no implica, sin embargo, que hombres y mujeres existan como dos entidades separadas, cada una con características completamente distintas, como comúnmente se acepta. Tal visión omite un aspecto fundamental: varón y mujer son personas llamadas a una relación de reciprocidad. Ser varón significa estar referido a la mujer, y ser mujer implica estar referida al varón. Se trata de una entrega mutua. El hombre descubre en el cuerpo de la mujer, y viceversa, una posibilidad de nueva relación y de presencia mutua: la relación sponsal. De hecho, sin la mujer, el hombre, aunque posea un cuerpo masculino, no sería persona masculina en su totalidad, sino únicamente persona humana. Para entender su masculinidad como tal, necesita la alteridad; el hombre es consciente de su identidad masculina a través de la diferencia femenina, y viceversa.

Es cierto que la condición masculina tiene asociados una serie de caracteres específicos, al igual que la condición femenina posee otros rasgos distintos. Sin embargo, el carácter principal de la condición sexuada es la referencia mutua. Como afirma Julián Marías, no se trata simplemente de una diferencia, sino de una vinculación, una polaridad, que hace que ninguna de estas formas exista sin la referencia a la otra (39).

El cuerpo humano, en su realidad misma, remite a otra persona sexuada de manera diferente. Aunque la sexualidad no agota todas las formas de relación que existen entre los seres humanos, es, sin embargo, una vía fundamental de manifestación y comunicación, un medio a través del cual el ser humano expresa, siente y vive el amor. Como afirma Janssens, “el significado más profundo de la sexualidad humana radica en una relación que impacta de manera especial en todas las relaciones de la persona” (51). En este marco, la persona humana se distingue del mundo de las cosas, que pertenece al ámbito impersonal del “ello”. La naturaleza espiritual de la persona está orientada hacia la relación de amor, entrega y comunión con los demás. La norma personalista subraya que la persona humana es un ser cuyo sentido profundo solo puede ser comprendido en el contexto del amor. Mounier, como fundador del personalismo, lo expresa de manera rotunda: “el acto de amor es la certeza mayor del hombre, el cogito existencial irrefutable. Yo amo, entonces el ser existe y la vida vale (la pena de ser vivida)” (50).

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¿CUÁNDO NACIÓ REALMENTE LA BIOÉTICA?

Dr. José María Simón Castellví

Introducción

Se suele afirmar repetidamente y a veces acríticamente que la Bioética es una ciencia relativamente nueva y que nació en 1970 de la mano del bioquímico y oncólogo norteamericano Van Rensselaer Potter. Sin embargo, la substancia, materia o asignatura de ésta creo fue muy anterior.

El término “Bioética” es claro y afortunado; al igual que lo es el de “Biojurídica”, acuñado por María Dolores Vila-Coro, filósofa, jurista y académica siempre atenta a los avances científicos y a los problemas de la humanidad, que conocí personalmente y de la que aprendí tanto. También tienen su interés aunque no son perfectos los llamados Principios fundamentales de la Bioética: los principios de autonomía, de beneficencia, de no maleficencia y de justicia. Soy de los que creen que este principalismo es claramente insuficiente. Por otra parte, se dice que la Bioética es la Ética del siglo XXI.

El Juramento de Hipócrates, la Oración de Maimónides o el Código de Hammurabi (quizá el primer conjunto de leyes de la Historia) contienen elementos muy interesantes para la Bioética pero hay que admitir que no se pueden considerar una ciencia o una asignatura.



“Elementos de Moral Médica” (1831)

Pero, veamos, en 1831 se publicó en Barcelona el libro “Elementos de Moral Médica o Tratado de las obligaciones del médico y del cirujano” en el que “se exponen las reglas de conducta moral y política en el ejercicio de la profesión”. Su autor fue el Dr. D. Félix Janer, catedrático de Clínica interna en el Real Colegio de Medicina y Cirugía de Barcelona y socio de varias academias. Se imprimió con licencia por la imprenta de Joaquín Verdaguer, calle del Gobernador, nº 10.

En el prólogo se afirma: “Si entre nosotros hace falta tal tratado (de Moral Médica), ¿cómo no sería útil una obra que enseñase del modo correspondiente á los facultativos el mas cabal desempeño de sus obligaciones, y les trazase la senda que deben seguir para ejercer su tan delicado como espinoso ministerio con virtud y honor?”

En el Capítulo I trata del objeto, necesidad y ventajas de la Moral Médica. El texto contiene algunas variaciones respecto a la ortografía castellana actual pero es perfecta y cómodamente comprensible. Se lee con gusto. En un párrafo de este primer capítulo se dice que las obligaciones propias de la profesión médica se han llamado los *Oficios* del Médico, quien cumpliéndolas del modo correspondiente, se porta también según corresponde hacia Dios, el estado, los enfermos, su profesión y sus profesores, y por fin hacia sí mismo. La Moral Médica es el complemento de las Instituciones médicas y quirúrgicas que sin duda serían completamente imperfectas sin ella.

El Capítulo II trata de las bases y motivos de la Moral Médica, y afirma que se fundan en la moral religiosa y en la moral natural. Su argumentación es de sentido común y no necesariamente atada a la práctica de una religión concreta: “el médico o el cirujano que con una medicina dada oportunamente ó una operación practicada con mano diestra han restituido un hijo querido al seno de su desolada madre (...) que con su muerte iba a quedar sumida en la más horrorosa indigencia, no pueden ménos de presentarse radiantes de gloria y dignidad (...)”. “Puede servir cada dia á ilustrar, amplificar y perfeccionar la metafísica, la moral y la legislación (...)”.

En otros capítulos se habla de la certeza de la Medicina (un barrunto de lo que hoy llamamos “Medicina basada en la evidencia”), de las dificultades, de las obligaciones, del modo de visitar, del modo de recetar, del modo de percibir los honorarios, del modo de relacionarse con los colegas o farmacéuticos, del modo de tratar a los débiles... ¿No nos hallamos ya ante un corpus doctrinal de lo que más tarde se llamaría “Bioética”?

Asociaciones profesionales basadas en la Ética Médica

Bajo el ímpetu del Papa León XIII (1878-1903) nacieron las dos primeras asociaciones de médicos católicos. En 1884 nació la de Francia (de la mano del Dr. Le Bèle) y en 1884-1886 la de Barcelona (de la sabia mano del Dr. Anguera). Esta segunda, pronto se llamaría Hermandad Médico-Farmacéutica de San Cosme y San Damián. Los miembros de las mismas tenían como máxima preocupación demostrar que no había contradicción entre la Ciencia y la Revelación. Que eran compatibles la investigación, la asistencia y la docencia, con la más exquisita fidelidad a la Doctrina y a la Tradición.

“El sentido católico de las ciencias médicas” era la revista editada por la junta directiva, formada, entre otros, por el Dr. Anguera, presidente, i por el Dr. Josep Blanc i Benet, tesorero, experto en Deontología Médica y famoso higienista de biografía amplia e importantes publicaciones. El Dr. Blanc fue el alma de la publicación durante 25 años, hasta su muerte el 6 de marzo de 1923.

El último presidente de la Hermandad y amigo personal y de mi familia, el Dr. Josep Maria Massons I Esplugues fue el primer presidente de Metges Cristians de Catalunya (Médicos Cristianos de Catalunya), aun existente. La Hermandad tuvo grupos en Barcelona, Valencia, Palma de Mallorca, Madrid. La última que he conocido ha sido la Hermandad Médico-Farmacéutica de Burgos-Madrid, con el Dr. Alejandro Ridruejo como presidente y con Don Raúl Berzosa –hoy obispo- como consiliario.

La asociación de Barcelona fue capaz que enviar delegados varias veces al año a las reuniones de junta directiva europea y a todos los congresos europeos. También consiguió enviar delegados y ponentes a las juntas directivas internacionales y a los congresos mundiales. De hecho, fue capaz de organizar dos de estos: en 1974 (con el título de “La libertad de los hijos de Dios”) y en 2006 (“Médicos católicos, globalización y pobreza”). En este último año, por primera vez en la historia, se organizó una exposición internacional sobre Medicina misionera. Hubo también, amén de sesiones generales y continentales, diversos simposios paralelos: de Psicólogos católicos, sobre procesos de beatificación y canonización, de médicos jóvenes, de ecumenismo en la Medicina.

<http://fiamcbarcelona2006.org/fiamc.asp?IDIOMAPAG=ES>

A aquellas asociaciones profesionales médicas católicas pronto les seguirían muchas otras, incluso fuera de Europa, como la de Buenos Aires. Junto con la Jerarquía de la Iglesia estos consorcios, hermandades o asociaciones, contribuyeron a configurar algunos códigos de conducta para los profesionales sanitarios en diversos países.

El 9 de abril de 1904, el Papa Pío X (1903-1914) recibió en audiencia a más de 300 médicos de Francia, España, Bélgica, Italia, Países Bajos, Suiza, Luxemburgo, Canadá, etc. Dentro del primer encuentro internacional de médicos católicos en Roma.

En 1924, bajo Pío XI, el Secretario de Estado Pietro Gasparri y Mons. Eugenio Pacelli apoyaron la creación en París del Secretariado Internacional de Médicos Católicos. Desde entonces todos los papas han enviado siempre mensajes o han recibido en audiencia a los congresos europeos o internacionales de médicos católicos. Especialmente prolífico fue Pío XII (80 mensajes a los médicos). Juan Pablo II compuso para nosotros la “Oración del Médico Católico” y aprobó la “Promesa del Médico Católico”:

<http://www.fiamc.org/faith-and-prayer/priere-du-medecin-catholique-prayer-of-the-catholic-doctor/>

“Principios morales y práctica médica” (1897)

En 1897, Benziger Brothers, publicó en inglés en los Estados Unidos el libro de Charles Coppens titulado “Principios morales y práctica médica”. Trataba de los orígenes de la Jurisprudencia médica, de la craneotomía, del aborto, de las enfermedades venéreas, del hipnotismo... Y daba claves estrictamente católicas pero también claves legales y de ética general. Me dicen colegas médicos mayores que este libro tuvo un gran impacto en la medicina de la época y que muchos profesionales lo buscaban para consultarlo incluso muchos decenios después de su publicación.

“Las Ciencias Médicas (criterio católico)” (1916)

En 1916 se publicó en Barcelona el libro “Las Ciencias Médicas (criterio católico)”, que empezaba con una conferencia dada por el Dr. José Blanc y Benet en la Liga Barcelonesa de Higiene Escolar. Fue editado por Tipografía Perelló, calle Pelayo, 20, Apartado 547. Trataba sobre aspectos médicos diversos, como divulgación y de temas que hoy englobaríamos en la Bioética. Entre sus numerosos autores, cito algunos que recuerdo de otros libros o revistas: Rafael Álvarez de Toledo Valero, Agustín Bassols y prim, Luis Cicera y Salse, Guy Larroche, Joaquín Morera Pujol, Agustín Pérez Bufill, Antonio Vallejo Nájera, Manuel Massó Barraquer...

En los años 90 los herederos de la Hermandad crearon la Fundación Doctor Blanc i Benet para apoyar la investigación y la divulgación de la Ética Médica. Durante años apoyó la publicación de revistas, libros y materiales audiovisuales. También se implicó en la organización y financiación de jornadas de formación para médicos y otros profesionales sanitarios.

“Deontología y Técnica profesional” (1928)

En 1928, bajo la dirección de Emilio Sergent, la Editorial Pubul publicó en Barcelona un volumen titulado “Deontología y Técnica profesional. La vida del médico. Formación práctica”, del Dr. Pablo le Gendre, del Hospital Lariboisière. El autor se quejaba en la introducción de que hasta hacía poco nunca la enseñanza de la Deontología había figurado en los programas de formación médica.

En la asignatura de Medicina Legal se habían tratado algunas cuestiones como el secreto médico, el charlatanismo o la responsabilidad. Pero hacía falta enseñar a los médicos sobre sus derechos y sus deberes. El libro es tan completo como interesante incluso para un médico de hoy. Habla de la vocación a la Medicina, del aprendizaje y sus dificultades, ¡de la necesidad de la formación continuada!, de los hospitales, de los testamentos, de algunas asignaturas, de cómo expresarse como médico, etc. Y solo en un capítulo, sí, habla también de la moral médica.

Otras publicaciones

En 1941 la Sociedad de Educación Atenas publicó el libro “Medicina y moral. Cuestiones morales modernas relacionadas con la medicina” del religioso J. García F. Bayón. Trataba sobre la eutanasia, la embriotomía, la anticoncepción, la sífilis, el matrimonio, la licitud de la continencia conyugal periódica...

En 1954, la Librería Editorial Argos de Barcelona publica el libro de Luigi Scremin “Diccionario de moral profesional médica”. En la introducción aborda un aspecto muy importante (del que se trata a menudo en Bioética). Veamos: “Pero a las “nociones morales” es menester darles un fundamento; y cuando se habla de fundamento acude a la mente la consideración del filósofo: “predicar la moral es fácil, darle un fundamento es difícil”. Trata sobre temas candentes ayer y hoy: aborto eugenésico, aborto indirecto, aborto por indicación social, aborto terapéutico... En el último apéndice se pregunto si son los médicos materialistas. Y concluye que no.

El ejemplar número 43 de la revista Philos (Madrid, 1956), órgano de expresión de la Federación de Hermandades Médico-Farmacéuticas de San Cosme y San Damián, contiene un elogio del padre Antonio Castro, famoso por tratar los temas de ética médica entre los profesionales de aquella época. También habla de la partenogénesis, del parto sin dolor, de la vida del médico. Como curiosidad, diré que la revista contiene publicidad de la industria farmacéutica. Espasmopaver, Bronquiasmol, Sulfalergial, Anemihepat, Enzimogastrol, Frenotensina, Viteínas...

En estos libros y revistas se tratan de una manera sistemática y bajo un denominador común sobre el comienzo de la vida humana, sobre su transmisión, sobre su final, sobre

los requerimientos del médico para con los enfermos –especialmente los más débiles o niños- y sobre las responsabilidades del médico ante otros colegas, las enfermeras, los farmacéuticos o ante la sociedad.

Conclusión

Así pues, basándome en mi propia Impresión Clínica Global (Clinical Global Impression, Spilker, 1994), los textos a mi alcance, los libros que poseo y los colegas de diversas partes del mundo con los que he podido hablar durante tantos años de estudio y de servicio en instituciones internacionales, he de concluir que la Bioética empezó realmente muchos años antes de lo que se afirma.

FORMAZIONE DEL PENSIERO DI KAROL WOJTYŁA

Silvija Vasilj



Data e luogo di nascita: Ljubuški (BA)

2001/2008 Pontificia Università San Tommaso d'Aquino (Angelicum), Roma

Dottorato in Filosofia (summa cum laude). Sezione Antropologica.

Titolo: *Oggettività e soggettività della persona nell'opera "Persona e atto" di Karol Wojtyła.*

Moderatore: Prof. Horst Seidl.

2000/2004 Pontificia Università Gregoriana, Roma.

Corso di lingua Latina, quarto livello con Padre Reginald Foster.

1997/2000 Pontificia Università San Tommaso d'Aquino (Angelicum), Roma.

Licenza in Filosofia. Sezione Storica.

Titolo: *La teoria della partecipazione nell'opera "Persona e atto" di Karol Wojtyła*

Moderatore: Prof. Adalberto Cardona, O.P.

1995/1997 Pontificia Università San Tommaso d'Aquino (Angelicum), Roma.

Baccalaureato in Filosofia.

- Traduzioni per le lingue: Croato, Inglese e Italiano.
- Assistente del Congresso Accademico *Nostalgia dell'altro. La spiritualità di Giorgio La Pira* organizzato dalla Pontificia Università San Tommaso d'Aquino (Angelicum), Roma.
- Assistente della Conferenza Stampa su "Beloved", un programma di formazione per i promessi sposi e sposati, dell'Augustine Institute, presso l'Università Pontifica della Santa Croce, Roma.
- Assistente Amministrativo presso lo Studio Medico *Paci* a Roma.

- Guida dei pellegrini e coordinatrice in Italia e Croazia.
- Assistente nella Biblioteca della Pontificia Università San Tommaso d'Aquino (Angelicum).
- Direttrice Esecutiva, lavoro amministrativo, organizzazione Congresso 2022, ecc. della FIAMC (World Federation of the Associations of Catholic Doctors), Palazzo San Calisto, 00120 Città del Vaticano.
- Direttrice Esecutiva della CICIAMS (The International Catholic Committee of Nurses and Medico-Social Assistants), Palazzo San Calisto, 00120 Città del Vaticano.
- Collaboratrice della Radio Vaticana, Sezione Croata.
- Corsi: "History of Modern and Contemporary Philosophy" all' "Angelicum", A.A. 2009/2010, 2011/2012, 2013/2014, 2015/2016, 2017/2018, 2019/2020, 2021/2022, 2023/2024; "Propedeutic Course to the Study and the Philosophical Language", A.A. 2009/2010 – 2017/2018; 2020/2021, "Moral Philosophy" all' "Angelicum", A.A. 2014/2015 – 2017/2018 – 2021/2022, 2022/2023–2023/2024, 2024/2025 e "Filosofia Teoretica", Istituto Euromediterraneo, Tempio Pausania – OT, Sardegna, A.A. 2014/2015; Introduction to Philosophy all' "Angelicum", A.A. 2021/2022; Introduction to Study all' "Angelicum", A.A. 2021/2022.
- Presidente e Censore di diverse tesi di laurea e licenza all'Istituto di Scienze Religiose all' "Angelicum".
- Presidente e membro di commissione degli esami sintetici all'Istituto di Scienze Religiose all' "Angelicum".
- Ricercatrice, lavoro e organizzazione eventi nella redazione della Rivista AHC (Annuario Historiae Conciliorum), Pontificia Università della Santa Croce.
- Ricercatrice e lavoro nella redazione della Rivista IE (Ius Ecclesiae), Pontificia Università della Santa Croce.
- Articolo: *Edward Schofield: medievalist and curator (1925-2009)* in: 42 AHC (2010) 431-432.

Esistono due tappe importanti nella formazione del pensiero filosofico di Karol Wojtyła. Nella prima tappa egli s'incontra con la filosofia classica e con il tomismo, e nella seconda con la fenomenologia: «La mia personale impostazione filosofica si muove, per così dire, tra due poli: il tomismo aristotelico e la fenomenologia. [...] Furono quindi due le tappe nel mio itinerario intellettuale: la prima consistette nel passaggio dalla letteratura alla

metafisica; la seconda mi portò dalla metafisica alla fenomenologia. Fu questo il mio banco di lavoro scientifico».¹⁵³

Come si sono svolti questi incontri? Che ruolo hanno avuto per la formazione del suo pensiero filosofico? In quest'articolo cercheremo di rispondere a queste domande. In tal modo, scopriremo l'origine del pensiero filosofico di Wojtyła, che ci introduce anche al suo pensiero teologico.

Sarà, quindi, prima di tutto la formazione filosofica di Wojtyła, vista nel suo contesto storico, ad attirare la nostra attenzione in questo articolo, e in modo particolare i suoi inizi, dove la sua filosofia acquisisce le sue prime fondamenta.

Per ottenere una visione completa di questo periodo della sua vita, usufruiremo primariamente delle due fonti autobiografiche, dove Wojtyła, in prima persona, ci racconta la sua vita, con una particolare attenzione alla sua vocazione sacerdotale¹⁵⁴ e all'impegno scientifico e pastorale.¹⁵⁵ Queste due fonti autobiografiche non essendo esaurienti dal punto di vista della sua formazione intellettuale, noi cercheremo di ricostruirla attraverso le opere biografiche di diversi autori, che con le loro dettagliate descrizioni ci permetteranno di raggiungere anche una visione più completa della sua vita intellettuale.

1. AMBIENTE FAMILIARE-CULTURALE

Prima di vedere come si è svolto il primo incontro di Wojtyła con la filosofia classica e con il tomismo, presenteremo la sua vita a partire dalla sua nascita, insieme al suo ambiente familiare-culturale; dopo di che porremo in evidenza il periodo del liceo, caratteristico per la sua passione per letteratura e teatro; e, infine, daremo uno sguardo generale alla sua formazione accademica e, in pratica, allo studio della filologia polacca. La nascita di Karol Józef Wojtyła avvenne a Wadowice¹⁵⁶ il 18 maggio del 1920. La sua città natale, importante per la storia e cultura polacca, era una piccola cittadina di provincia e si manteneva amministrando le campagne circostanti, con fiere, mercati, artigianato ed industria. Wadowice divenne città già nel 1327 ed apparteneva ai Piasti di Slesia. La sua importanza all'epoca era caratterizzata dagli scambi mercantili tra la capitale del regno polacco e la Slesia.¹⁵⁷

¹⁵³ GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondatori, Milano 2004, pp. 73-76.

¹⁵⁴ ID., *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996.

¹⁵⁵ ID., *Alzatevi, andiamo!*, Mondatori, Milano 2004.

¹⁵⁶ Cfr. GIOVANNI PAOLO II, *ibid.*, p. 65.

¹⁵⁷ Cfr. MIECZYSLAW MALINSKI, *Le radici di Papa Wojtyła: biografia scritta da un amico*, trad. di A. D'Ugo, Borla, Roma 1980, p. 5.

Questa città, nel periodo della nascita di Wojtyła, era ricca di tradizioni culturali, e conserva ancora oggi con cura le testimonianze del suo grande passato. La popolazione di questa città è aperta, infatti, alla cultura e agli avvenimenti politici e religiosi sia privati sia pubblici.¹⁵⁸

La famiglia di Karol, che abitava in questa città, era una famiglia cattolica praticante. Dai genitori, Karol Wojtyła ed Emilia Kaczorowska, egli ottenne, quindi, una solida educazione cristiana. Suo padre era un ufficiale di grado inferiore, «mite d'aspetto e quasi umile nel comportamento».¹⁵⁹ Ordine, Legalità, Dio, Famiglia e Patria erano le «cinque pietre miliari del suo mondo morale».¹⁶⁰

Karol, appena nato, ricevette da sua madre il diminutivo Loluś, che in seguito diventò Lolek; soprannome con il quale si presentò diverse volte anche all'università.¹⁶¹ Lolek, ragazzino di grande vitalità,¹⁶² all'età di sei anni incominciò a frequentare la scuola elementare con successo sin dal primo giorno, ottenendo i voti migliori.¹⁶³ L'amore per la lettura si notava ben presto in Karol: «Già da bambino mi piacevano i libri, alla cui lettura mi aveva abituato mio padre. Era solito sedersi accanto a me e leggermi, ad esempio, Sienkiewicz o altri scrittori polacchi».¹⁶⁴

Ben presto, prima di compiere il suo ventunesimo compleanno, Karol perse tutti i familiari. La sorella secondogenita morì durante la sua infanzia. All'età di nove anni venne a mancargli sua madre. Perdettero il fratello maggiore all'età di dodici e suo padre prima del suo ventunesimo compleanno.

Nella sua opera autobiografica *Alzatevi, andiamo!*, Wojtyła ci fa intuire il dolore e la solitudine sentiti dopo la mancanza della sua mamma: «Dopo la morte di mia madre, eravamo rimasti noi due: lui e io».¹⁶⁵ Questi momenti difficili della sua vita hanno sicuramente contribuito al rafforzamento del suo carattere personale¹⁶⁶ e lo hanno fatto diventare una persona più forte e decisa.

¹⁵⁸ Cfr. MIECZYSLAW MALINSKI, *ibid.*, pp. 6-7.

¹⁵⁹ ENRICO NASSI, *Karol Wojtyła; la biografia*, Shakespeare and Company, Roma 1995, p. 11.

¹⁶⁰ ENRICO NASSI, *ibid.*, p. 13.

¹⁶¹ Cfr. TAD SZULC, *Pope John Paul II: The Biography*, Scribner, New York 1995, p. 63.

¹⁶² Cfr. ENRICO NASSI, *Karol Wojtyła; la biografia*, Shakespeare and Company, Roma 1995, p. 16.

¹⁶³ Cfr. TAD SZULC, *Pope John Paul II: The Biography*, Scribner, New York 1995, p. 65.

¹⁶⁴ GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondatori, Milano 2004, p. 74.

¹⁶⁵ GIOVANNI PAOLO II, *ibid.*, p. 74.

¹⁶⁶ Cfr. TAD SZULC, *Pope John Paul II: The Biography*, Scribner, New York 1995, p. 17.

2. PASSIONE PER LETTERATURA E TEATRO

2.1. Il periodo del liceo

Nel gennaio del 1931 Karol iniziò a frequentare il liceo-ginnasio statale Maresciallo Wadowita.¹⁶⁷ Durante questo periodo lesse molti libri, tra cui le opere dei grandi poeti romantici dell'Ottocento polacco e dei grandi scrittori nazionali e stranieri.¹⁶⁸ Fu il poeta Emil Zegadłowicz ad avere un certo influsso nel periodo del liceo ed anche in seguito, ma un ruolo ancora più significativo per Karol lo ebbero i poeti come: Adam Mickiewicz (1798-1855), Juliusz Słowacki (1803-49) e Zygmunt Krasiński (1812-59). I critici e i successori di questi grandi poeti furono Cyprian Norwid¹⁶⁹ (1821-83) e Stanisław Wyspiański (1869-1907). Questi personaggi¹⁷⁰ sono considerati dal popolo polacco come persone di grande valore, perché difensori dell'anima della nazione negli anni durissimi delle divisioni.¹⁷¹

Il Romanticismo polacco ebbe un'estrema importanza per la cultura polacca. Il movimento, come tutta la letteratura nazionale dell'epoca, sembra essere stato ispirato dal particolare anelito alla libertà, dalla naturale sensibilità nei confronti del valore del sacrificio, dalla convinzione che i veri valori umani siano difficili e richiedono fedeltà ed impegno per andare oltre i propri limiti.

A sedici anni Karol divenne membro del circolo teatrale scolastico e scelse di diventare attore e drammaturgo, con il desiderio di raggiungere il successo e lasciare un'impronta innovativa nella storia del teatro. Durante questo periodo fu, infatti, preso dalla passione per la letteratura, in modo particolare per quella drammatica e per il teatro.¹⁷² Il suo amore per il teatro si è concretizzato anche per merito di Mieczysław Kotlarczyk. Questo, insegnante di lingua polacca, fu un artista, animato da idee profonde, regista teatrale e

¹⁶⁷ Cfr. ROCCO BUTTIGLIONE, *Il pensiero dell'Uomo che divenne Giovanni Paolo II*, Mondadori, Milano 1981, p. 41.

¹⁶⁸ Cfr. MIECZYSLAW MALINSKI, *Le radici di Papa Wojtyła: biografia scritta da un amico*, trad. di A. L. D'Ugo, Borla, Roma 1980, pp. 10-11.

¹⁶⁹ *Che questi grandi poeti abbiano giocato un ruolo importante anche per il suo pensiero filosofico, lo dimostra il fatto, quando Wojtyła riprese la frase di Norwid: «Il bello è tale, per rendere affascinante il lavoro/il lavoro, perché si risorga» (Cyprian Kamil Norwid, Promethidion, Dialogo I) nel suo articolo: Il problema del costituirsi della cultura attraverso la praxis umana in "Rivista di Filosofia Neoscolastica", 69 (1977), p. 519.*

¹⁷⁰ Nel suo libro autobiografico *Alzatevi, andiamo!* (p. 21), Giovanni Paolo II si ricorda di nuovo di questi poeti polacchi, informandoci che la cripta di poeti, nella cattedrale di Wawel, contiene le tombe di Mickiewicz, Słowacki e Norwid.

¹⁷¹ Cfr. ROCCO BUTTIGLIONE, *Il pensiero dell'Uomo che divenne Giovanni Paolo II*, Mondadori, Milano 1981, p. 44.

¹⁷² È stato suo padre ad esortarlo alla continua conoscenza della letteratura di valore, e a non ostacolarlo nel suo interesse per il teatro. (Cfr. GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondadori, Milano 2004, p. 74).

teoretico del teatro della parola. Kotlarczyk mostrava la potenza dell'arte, che aveva un grande compito: formare la società e svilupparla spiritualmente e moralmente.¹⁷³

2.2. Lo studio della Filologia polacca

Superato l'esame di maturità nel maggio del 1938, Karol intraprese gli studi di Filologia polacca nella Facoltà di Filosofia presso l'Università Jaghellonica, situata a Cracovia,¹⁷⁴ dove si trasferì insieme a suo padre. Riuscì a terminare soltanto il primo anno accademico, perché il 1° settembre 1939 scoppiò la seconda guerra mondiale e le lezioni furono interrotte.¹⁷⁵

La scelta dello studio della Filologia polacca fu motivata, senz'altro, da una forte predisposizione verso la letteratura. Già durante il primo anno universitario, Karol si sentì attratto dagli studi linguistici, s'interessò alla grammatica descrittiva del polacco moderno e, nello stesso tempo, all'evoluzione storica della lingua, con un particolare interesse per il vecchio ceppo slavo. Grazie allo studio della lingua, gli si aprirono davanti orizzonti completamente nuovi, che lo introducessero nel «mistero stesso della parola».¹⁷⁶

Alma Mater Jaghellonica è la più antica Università della Polonia, risale al 1364. Le sue cattedre furono «affidate a gente provata, scelta fra i migliori, che vive a lungo e con caparbietà, crescendo negli aneddoti, abitudini e stranezze».¹⁷⁷ Ebbe tra le sue matricole anche Nicola Copernico e Vladimir Lenin.¹⁷⁸ «Da questa Università vennero in Italia Copernico e altri, i quali dettero le impronte storiche alla cultura cristiana e umanistica».¹⁷⁹

Durante il breve periodo universitario, Wojtyła si rivolse alla lettura, e specialmente a quella drammatica di vari autori. Leggeva Shakespeare, Molière e i poeti polacchi: Norwid, Wyspiański e Aleksander Fredro. Tuttavia, più che dalla letteratura, Wojtyła fu preso dalla passione di diventare attore, di calcare il palcoscenico e spesso pensava a quali ruoli li sarebbe piaciuto impersonare.¹⁸⁰

¹⁷³ Cfr. GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 11.

¹⁷⁴ Questa città è per tradizione un vivace centro di studi accademici (Cfr. GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondadori, Milano 2004, p. 78).

¹⁷⁵ Cfr. GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 11.

¹⁷⁶ GIOVANNI PAOLO II, *ibid.*, p. 11.

¹⁷⁷ MIECZYSLAW MALINSKI, *Le radici di Papa Wojtyła: biografia scritta da un amico*, trad. di A. L. D'Ugo, Borla, Roma 1980, pp. 6-7.

¹⁷⁸ Cfr. GREG BURKE, *John Paul II, An Invitation to Joy*, Simon & Schuster, Callaway 1999, p. 209.

¹⁷⁹ KAROL WOJTYŁA, *Il problema del costituirsi della cultura attraverso la praxis umana in "Rivista di Filosofia Neoscolastica"*, 69 (1977), p. 514.

¹⁸⁰ Cfr. GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondadori, Milano 2004, p. 75.

A causa della guerra, però, la vita di Wojtyła e di tanti altri suoi compagni cambiò radicalmente e, così, finì presto il periodo degli studi di Filologia polacca. Tuttavia, nonostante le difficoltà del momento, egli non cessa di interessarsi alla letteratura e compose i suoi primi lavori letterari: «Finiva così nella mia vita il periodo degli studi di Filologia polacca e cominciava la fase dell'occupazione tedesca, durante la quale inizialmente tentai di leggere e scrivere molto. Proprio a quest'epoca risalgono i miei primi lavori letterari».¹⁸¹

Karol, nonostante tutto, rimane in contatto con il teatro della parola, animato nella clandestinità dallo stesso Kotlarczyk, trasferitosi a Cracovia. Egli ebbe l'onore di avere come ospite nella propria casa il professore, e ci descrive i privilegi di questa convivenza e in cosa consisteva questo teatro della parola. I due, Karol e il professore, portando avanti questo progetto, si rendevano conto anche del pericolo, delle possibili conseguenze legate a questa loro impresa:

«Condividendo la stessa casa, potevamo non solo continuare i nostri discorsi sul teatro, ma anche tentarne attuazioni concrete, che assumevano appunto il carattere di teatro della parola. Era un teatro molto semplice. La parte scenica e decorativa era ridotta al minimo; l'impegno si concentrava essenzialmente nella recitazione del testo poetico. Le recite avvenivano davanti ad un ristretto gruppo di conoscenti e di invitati, i quali avevano uno specifico interesse per la letteratura ed erano, in qualche modo, degli "iniziati". Mantenere il segreto intorno a questi incontri teatrali era indispensabile; si rischiavano altrimenti gravi punizioni da parte delle autorità d'occupazione, non esclusa la deportazione nei campi di concentramento».¹⁸²

L'impegno principale del teatro della parola consisteva nella recitazione del testo poetico. Wojtyła, anche se alle spalle aveva solo poche recite, ruoli da comprimario, un po' di regia e l'abbozzo di un dramma d'ispirazione biblica,¹⁸³ recitando riusciva ad ottenere un certo successo, in quanto era prestante e dotato di una bella voce. I suoi discorsi piacevano al pubblico, perché avevano lo stile e il ritmo di un testo recitato. Riusciva a sedurli con la voce e con il gesto – lo sapeva e ne provava piacere.¹⁸⁴ Gli applausi che riceveva gli davano inoltre il coraggio di recitare in pubblico anche le proprie poesie.¹⁸⁵

¹⁸¹ GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Vaticano 1996, p. 14.

¹⁸² GIOVANNI PAOLO II, *ibid.*, pp. 16-17.

¹⁸³ Cfr. ENRICO NASSI, *Karol Wojtyła; la biografia*, Shakespeare and Company, Roma 1995, p. 23.

¹⁸⁴ Cfr. ENRICO NASSI, *ibid.*, p. 20.

¹⁸⁵ Cfr. ENRICO NASSI, *ibid.*, p. 24.

Prima di tutto, Karol dovette imparare a parlare, a muoversi sulla scena e a sapersi comportare. Per questa ragione, all'inizio, gli furono affidate le parti irrilevanti. Dal professore gli venne trasmesso il vero mistero del parlare, gli fu mostrato il sacro carattere, la forza e la potenza dell'arte. Karol, in tal modo, scoprì l'importanza di saper pronunciare bene una parola, una frase, un periodo, una domanda. Imparò a trasmettere attraverso un'adeguata pronuncia il più profondo significato della parola. Il maestro attingeva ai più grandi autori della drammaturgia: Słowacki, Wyspiański, Zeromski, e Karol ben presto fu in grado di interpretare le parti principali, le più importanti. Termina così il periodo delle discussioni, dei discorsi ed arriva il tempo della creazione. La sua interpretazione di Kirkor in *Balladyna* di Słowacki, secondo l'opinione degli intenditori locali, è passata alla storia del teatro di Wadowice. Karol non solo recitò ma, sotto la guida del suo insegnante, curò anche la regia del dramma *Zygmunt August* di Wyspiański, in cui interpretò il ruolo principale.¹⁸⁶

Siamo nel 1939 e in questo periodo Wojtyła scrisse diverse poesie di carattere riflessivo,¹⁸⁷ che furono pubblicate solo nel 1950. Sempre nel 1950 uscì la sua prima poesia nella rivista settimanale *Tygodnik Powszechny*¹⁸⁸ con lo pseudonimo di Andrzej Jawien. Infatti, compose la sua prima poesia *Sulla tua tomba bianca* nel 1939, dedicata alla madre e nello stesso anno l'inno *Magnificat*. Secondo alcuni studiosi, durante questo periodo, compose anche altre poesie, però di queste non ne rimane traccia. I suoi lavori letterari dello stesso e vicino periodo sono: *David* (1939), *Giobbe* (1940) e *Geremia* (1940).

Che si trattasse di una vera passione per la letteratura nel caso di Wojtyła e specialmente per il teatro, e che la sua vita potesse esser stata diversa, se non ci fosse stata la guerra, ce lo testimoniano le sue parole: «Se non fosse scoppiata la guerra e la situazione non fosse radicalmente cambiata, forse le prospettive che gli studi accademici di Lettere mi aprivano dinanzi mi avrebbero assorbito completamente».¹⁸⁹

Passando gli anni, la vita di Wojtyła cominciò a distinguersi da quella dei suoi coetanei. La sua predisposizione alla letteratura, l'amore per il teatro, la capacità di esprimersi, sia

¹⁸⁶ Cfr. MIECZYSLAW MALINSKI, *Le radici di Papa Wojtyła: biografia scritta da un amico*, trad. di A. L. D'Ugo, Borla, Roma 1980, pp. 11-12.

¹⁸⁷ Cfr. MIECZYSLAW MALINSKI, *ibid.*, Roma 1980, p. 77.

¹⁸⁸ Questa rivista settimanale apparve per la prima volta nel 1945, sotto la direzione di Jerzy Turowicz. Per la cultura polacca un'altra rivista altrettanto importante è *Znak*. Si creò, intorno a queste due riviste, un importante movimento di cui fece parte anche Wojtyła. A queste riviste si riconosce il merito d'aver contribuito alla maturazione del pensiero filosofico di Wojtyła (Cfr. ROCCO BUTTIGLIONE, *Il pensiero dell'Uomo che divenne Giovanni Paolo II*, Mondadori, Milano 1981, pp. 56-57.).

¹⁸⁹ GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondadori, Milano 2004, pp. 74-75.

nelle sue poesie sia sul palco scenico, lo condussero verso una vita impegnativa e vissuta pienamente, la quale si arricchiva sempre di più con le nuove esperienze. Importante in questo momento fu anche il lavoro fisico, che ebbe un'importanza rafforzativa ed ispiratrice per la sua vita futura.

2.3. La prima esperienza di lavoro

Nell'autunno del 1940, per evitare la deportazione e i lavori forzati in Germania, Karol, mantenendo sempre il contatto con il teatro rapsodico, iniziò a lavorare come operaio in una cava di pietra, collegata con una fabbrica chimica chiamata Solvay. Questa era situata a Zakrzówek, circa mezz'ora dalla sua casa di Dębniaki. Su quella cava scrisse in seguito una poesia:¹⁹⁰ *La cava di pietra*.

Le parole di Wojtyła ci testimoniano quanto sia stato importante per lui il contatto con il mondo di lavoro:

«Soltanto più tardi, da sacerdote, durante gli studi a Roma, imbattendomi attraverso i miei compagni del Collegio Belga nel problema dei preti-operai e nel movimento della Gioventù Operaia Cattolica (JOC), compresi che quanto era diventato così importante per la Chiesa e per il sacerdozio in Occidente – il contatto con il mondo del lavoro – io l'avevo già iscritto nella mia esperienza di vita».¹⁹¹

3. LA VOCAZIONE SACERDOTALE – IL PRIMO INCONTRO CON LA FILOSOFIA

Karol, durante questo periodo estremamente difficile per tutta l'umanità, momento in cui il male sembrava essere più forte del bene, continua lavorare nella stessa fabbrica ed intanto maturava la sua vocazione. Nel 1942 decise di entrare nel seminario di Cracovia, consapevole del fatto che una tale scelta potesse causargli delle conseguenze pericolose, perché in quel momento il seminario, come tante altre istituzioni, funzionava clandestinamente. Quando la notizia arrivò al professore Kotlarczyk, egli rimase sorpreso e dispiaciuto, perché, secondo lui, Karol sprecava il suo talento teatrale: «Quando informai Mieczysław Kotlarczyk della mia decisione di diventare sacerdote, mi disse: “Che cosa stai facendo? Vuoi sprecare il tuo talento?”».¹⁹²

Per il suo cammino della formazione sacerdotale ebbe un ruolo importante l'Arcivescovo Metropolita di Cracovia, il Principe Adam Stefan Sapieha, che era un grande uomo, venerato da tutti e nobile d'animo e di sangue, e che, «durante l'occupazione tedesca,

¹⁹⁰ Cfr. GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 15.

¹⁹¹ GIOVANNI PAOLO II, *ibid.*, pp. 30-31.

¹⁹² GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondadori, Milano 2004, p. 75.

aveva saputo tenere alto l'onore della Nazione, manifestando la propria dignità in modo chiaro per tutti». ¹⁹³ Dalla sua nobile personalità s'irradiava la figura del vero padre, ¹⁹⁴ che si curava di tutti quelli che gli stavano attorno. Il Principe fu d'appoggio sia spirituale sia materiale per tutti i seminaristi, e così pure per Wojtyła, con il quale condivideva la residenza. Per la prima volta s'incontrarono quando Karol frequentava ancora il ginnasio. In occasione della sua visita alla parrocchia di Wadowice, Karol fu scelto, infatti, fra tutti gli altri compagni per porgergli il benvenuto.

La scelta decisiva di abbracciare il sacerdozio portò Karol ad un cambiamento radicale della sua vita e del suo ritmo. Non proseguì gli studi della Filologia polacca, ma s'iscrisse alla Facoltà di Teologia della stessa Università Jaghellonica, mantenendo sempre il lavoro da operaio. ¹⁹⁵ Gli anni della formazione sacerdotale, dedicati allo studio della filosofia e alla teologia, furono vissuti altrettanto in modo clandestino e incompleto, «normale fu l'anno accademico 1945/46». ¹⁹⁶

All'età di ventidue anni Wojtyła s'incontra con una nuova disciplina dello studio, che poi diventerà la base e il centro d'interesse della sua vita intellettuale futura. Durante questo periodo il suo pensiero filosofico prende consistenza.

Il giovane professor Kazimierz Kłósak, specializzato in filosofia naturale, fece leggere a Wojtyła il manuale di metafisica: *Ontologia czyli Metafizyka* (Ontologia o Metafisica) scritto da Kazimierz Wais. ¹⁹⁷ Questo testo, propedeutico per la filosofia scolastica, e specialmente per quella di San Tommaso d'Aquino, lasciò perplesso Karol a causa della sua complessità. Egli cominciò, però, pian piano ad addentrarsi nel significato della filosofia, nel modo di pensare filosofico, nel senso dei principi della filosofia classica e scolastica. Wojtyła iniziò, così, a capire l'esattezza di categorie della realtà, come la sostanza e gli accidenti, l'esistenza e l'essere. I concetti scolastici gli chiariscono, con crescente precisione, la realtà in cui finora era vissuto e le cui questioni non l'avevano impegnato fino ad allora. Tanti altri interrogativi divennero per lui sempre più

¹⁹³ GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 25.

¹⁹⁴ Fu un «testimone imparagonabile del mistero della paternità. [...] Provavo per lui un sentimento di grande fiducia e posso dire che lo amavo, come lo amavano gli altri sacerdoti». (GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondadori, Milano 2004, pp. 103-105.)

¹⁹⁵ Cfr. GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 21.

¹⁹⁶ GIOVANNI PAOLO II, *ibid.*, pp. 22-23.

¹⁹⁷ Casimiro Wais fu il precursore del rinnovamento tomistico (1934), docente di filosofia cristiana nelle rispettive Università di Cracovia e di Leopoli e coautore di ampi manuali eclettici sulle diverse branche della filosofia. (Cfr. ANTONI STEPIEN, *La filosofia tomistica nella Polonia contemporanea*, in "Sapienza", 21 (1968), p. 501.)

importanti, più fondamentali ed urgenti.¹⁹⁸ «venne il momento della letteratura filosofica e teologica. Come seminarista clandestino, ricevetti il manuale di metafisica del professor Kazimierz Wais di Leopoli. Don Kazimierz Kłósak mi disse: “Studialo. Quando l’avrai imparato, darai l’esame”. Per alcuni mesi mi addentrarai in quel testo. Questa esperienza segnò una svolta nella mia vita: davanti a me si aprì un mondo nuovo».¹⁹⁹

Il passaggio dalla letteratura poetica, da quella drammatica, alla lettura filosofica e teologica segnò una svolta nella vita di Wojtyła ed egli si trovò senz’altro d’avanti ad un mondo nuovo. Il suo primo incontro con la filosofia, e particolarmente con la metafisica, lasciò le sue tracce visibili nel suo pensiero filosofico, poiché la metafisica diventerà il fondamento di tutto il suo pensiero filosofico.

4. LA FORMAZIONE TOMISTA E LA TESI DOTTORALE IN TEOLOGIA

Dopo i due anni previsti dello studio della filosofia, Wojtyła si dedica allo studio della teologia. La fonte principale di tali studi furono le opere di San Tommaso d’Aquino. I suoi volumi con i rispettivi commenti sono stati gli strumenti di studio, da dove Wojtyła imparava «la teologia, per così dire, dal centro di una grande tradizione teologica».²⁰⁰

Wojtyła fu ordinato sacerdote il 1° novembre 1946 dal cardinale Sapieha nella cappella²⁰¹ del Palazzo vescovile di Cracovia e sarà lo stesso cardinale ad indirizzarlo a Roma per proseguire gli studi di teologia. Nello stesso anno, dunque, s’iscrisse al *biennium ad lauream*²⁰² presso l’Università Pontifica di San Tommaso d’Aquino. L’anno seguente consegue la Licenza in Teologia e nel 1948 discute la tesi dottorale.

Prima di partire per Roma, Wojtyła aveva iniziato di scrivere un lavoro, ispirandosi da San Giovanni della Croce, sotto la direzione di Prof. Ignacy Różycki, che fu il docente presso l’Università di Cracovia. Questo lavoro divenne in seguito la sua tesi dottorale, completata poi all’Angelicum sotto la guida del Prof. Garrigou Lagrange con il titolo: *Doctrina de fide apud S. Joannem a Cruce*.²⁰³

¹⁹⁸ Cfr. MIECZYSLAW MALINSKI, *Le radici di Papa Wojtyła: biografia scritta da un amico*, trad. di A. L. D’Ugo, Borla, Roma 1980, pp. 41-42.

¹⁹⁹ GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondadori, Milano 2004, pp. 75-76.

²⁰⁰ GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 24.

²⁰¹ Questa fu per Wojtyła non soltanto un luogo di preghiera ma anche d’ispirazione, dove scrisse diverse opere tra cui *Persona e atto*: «Nella cappella privata non soltanto pregavo, ma rimanevo anche seduto e scrivevo. Lì scrissi i miei libri, tra cui la monografia *Persona e atto*. Sono convinto che la cappella è un luogo da cui proviene una particolare ispirazione». (GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondadori, Milano 2004, pp. 75-113.)

²⁰² Cfr. GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 60.

²⁰³ *La dottrina della fede nel pensiero di San Giovanni della Croce*.

Una delle figure dominanti all'interno della Facoltà di Teologia dell'Angelicum fu proprio il padre Reginald Garrigou-Lagrange O.P. Wojtyła ricevette da lui una formazione rigidamente tomista in senso tradizionale sia in filosofia sia in teologia, grazie alla sua eccezionale conoscenza del tomismo; oltre a questa è stato anche uno studioso attento di San Giovanni della Croce. A proposito degli studi del tomismo, Wojtyła testimonia: «durante gli studi a Roma, approfondii la conoscenza della *Summa Theologiae* di San Tommaso d'Aquino».²⁰⁴

Del maestro Lagrange, che fu e resta un luminare non solo dell'Angelicum, ma anche della teologia dogmatica e spirituale del nostro tempo, sono ammirabili la sua intelligenza limpida ed acuta, il fervore e il vigore del suo insegnamento, specialmente intorno ai temi fondamentali della dottrina cattolica e del tomismo.²⁰⁵

La tesi dottorale di Wojtyła fu scritta in lingua latina, lingua in cui all'epoca erano tenute anche le lezioni alle Università Pontificie. Oltre a questa, Karol conosceva: il tedesco, lo spagnolo e il francese. Wojtyła scrive: «All'inizio del luglio 1948 discussi la tesi di dottorato all'Angelicum e subito dopo mi misi sulla strada del ritorno in Polonia».²⁰⁶ La tesi venne formalmente confermata, anche se già ammessa all'Angelicum, alla Università Jaghellonica nella cattedra di Teologia Morale del reverendo professore Władysław Wicher.²⁰⁷

Anche se fu breve il periodo di studio a Roma, rimane per Wojtyła un'esperienza indimenticabile: «Non potrò mai dimenticare le sensazioni di quei miei primi giorni romani, quando nel 1946 cominciai ad introdurmi nella conoscenza della Città Eterna».²⁰⁸ Oltre che dedicarsi agli studi ha utilizzato il periodo romano per una conoscenza approfondita della città eterna: «I due anni di studi, conclusi nel 1948 con il dottorato, furono anni di un intenso imparare Roma».²⁰⁹

5. INCONTRO CON LA FENOMENOLOGIA

²⁰⁴ GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Mondatori, Milano 2004, p. 76.

²⁰⁵ Cfr. RAIMONDO SPIAZZI, *Professori del sacerdote Karol Wojtyła nella facoltà di teologia dell'Angelicum negli anni 1946 – 1948*, in AA. VV., *Fede di Studioso e Obbedienza di Pastore, Atti del Convegno sul 50° del Dottorato di K. Wojtyła e del 20° del Pontificato di Giovanni Paolo II*, a cura di E. Kaczyński, Millennium Romae, Roma 1999, pp. 342-343.

²⁰⁶ GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 67.

²⁰⁷ Cfr. MIECZYSLAW MALINSKI, *Le radici di Papa Wojtyła: biografia scritta da un amico*, trad. di A. L. D'Ugo, Borla, Roma 1980, p. 64.

²⁰⁸ GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 60.

²⁰⁹ GIOVANNI PAOLO II, *ibid.*, p. 61.

Dopo il suo ritorno a Cracovia, Wojtyła ebbe un incarico pastorale nella parrocchia di San Floriano che, però, durò solo per alcuni anni, perché nel 1951 l'Arcivescovo Eugeniusz Baziak, che era succeduto nel governo dell'Arcidiocesi di Cracovia al Cardinale Sapieha, lo indirizzò piuttosto verso il lavoro scientifico. Egli dovette prepararsi «per l'abilitazione alla libera docenza in etica e in teologia morale»²¹⁰ e, così, si mise a scrivere il suo secondo dottorato.

Con la sua abilitazione iniziò un altro periodo importante per la formazione del suo pensiero filosofico, durante il quale Wojtyła si dedica all'elaborazione del sistema etico di Max Scheler. Quest'ultimo ha costruito il suo sistema filosofico sulla base del metodo fenomenologico. Wojtyła elaborando il sistema etico scheleriano s'incontra, quindi, anche con la fenomenologia. «Fu un incontro che ha influenzato profondamente la sua originale filosofia dell'uomo, sviluppata negli anni successivi».²¹¹

Come avvenne quest'incontro con il sistema etico scheleriano? Quale fu il problema principale del suo lavoro scientifico? Quanta rilevanza ha avuto questa dissertazione filosofica per la formazione del suo pensiero filosofico?

5.1. L'incontro con il sistema etico di Max Scheler

È stato don Ignacy Różycki, il professore di dogmatica all'Università Jaghellonica, a proporre a Wojtyła l'argomento della sua tesi di abilitazione *Ocena możliwości zbudowania etyki chrześcijańskiej przy założeniach systemu Maksa Schelera* (Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler) e a creargli la base per questo lavoro scientifico; più tardi lo incoraggiò²¹² a sostenere l'esame di abilitazione, svolgendo un ruolo analogo a quello del relatore.²¹³

Iniziò così per Wojtyła il periodo dell'elaborazione del sistema etico di Max Scheler,²¹⁴ dedicandosi concretamente ad una profonda analisi della sua principale opera *Der Formalismus in der Ethik und die materiale Wertethik* (Il formalismo nell'etica e l'etica materiale dei valori). L'opera di Scheler venne pubblicata in due parti: la prima nel

²¹⁰ GIOVANNI PAOLO II, *ibid.*, p. 73.

²¹¹ JAROSLAW MERECKI, *Introduzione: verso l'etica empirica e normativa*, in K. Wojtyła, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 252.

²¹² Ricordiamoci che, oltre a proporgli l'argomento del secondo dottorato, sotto la direzione del Prof. Różycki, Wojtyła iniziò a scrivere, prima di partire per Roma, un lavoro, ispirandosi da San Giovanni della Croce, completato poi come il suo dottorato in teologia.

²¹³ Cfr. GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Libreria Editrice Vaticana, Città del Vaticano 2004, pp. 76-77.

²¹⁴ Il filosofo tedesco Max Scheler visse negli anni 1874-1928. Nato dalla madre ebrea e il padre protestante, divenne cattolico e ricevette il battesimo nel 1899. Scheler ha studiato sotto Dilthey, Eucken e Weber.

volume I (1913) e la seconda nel volume II (1916). Wojtyła traduce Il formalismo in lingua polacca durante il periodo dell'elaborazione del sistema scheleriano;²¹⁵ l'opera che «contiene un'esposizione completa del sistema etico di Max Scheler»²¹⁶ ed esprime, quindi, «gran parte delle posizioni che caratterizzano in modo essenziale l'insieme del suo pensiero filosofico».²¹⁷

Nella sua opera Scheler mirava «soprattutto a fondare, in termini rigorosamente scientifici e positivi, l'etica filosofica facendo riferimento a tutti i principali problemi che si pongono in tal senso come essenziali».²¹⁸ Egli costruisce il suo sistema etico, basato sull'esperienza, partendo da un'analisi critica dell'etica formale di Kant e, in effetti, dà vita ad un nuovo sistema etico dei valori materiali,²¹⁹ ad una etica materiale. Elaborando il proprio sistema, Scheler, infatti, «cerca di prendere decisamente le distanze dai fondamenti dell'etica kantiana della pura forma e di basarsi sulla materia etica».²²⁰

Scheler e Kant concepiscono, quindi, l'etica partendo dai presupposti completamente opposti. Per Kant la condizione della moralità è la legge come forma dell'agire. L'indirizzo della volontà viene stabilito in Kant dalla pura ragion pratica e il valore morale dell'atto non deriva dall'oggetto, da nessun bene o scopo verso cui è diretto l'atto; da nessuna materia, da nessun valore materiale, perché, secondo Kant, questo condurrebbe inevitabilmente all'eudemonismo pratico.²²¹ Nell'etica kantiana «l'atto etico si riduce a compiere il dovere perché è il dovere (*Pflicht aus Pflichtum*), dunque a compierlo per il solo rispetto della legge».²²² Il dovere appare, infatti, come l'essenza della moralità. L'etica di Kant è, quindi, un'etica di carattere normativo e non empirico. Scheler, al contrario, difende il carattere empirico dell'etica e rigetta quello normativo; nel suo sistema etico si basa sulla materia etica; quindi l'origine del valore etico di un atto bisogna cercarla nell'oggettivo. Il valore etico è, appunto, il valore materiale ossia oggettivo.

²¹⁵ Cfr. GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Libreria Editrice Vaticana, Città del Vaticano 2004, p. 76.

²¹⁶ KAROL WOJTYŁA, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 267.

²¹⁷ MAX SCHELER, *Prefazione alla seconda edizione*, in M. Scheler, *Il formalismo nell'etica e l'etica materiale dei valori*, a cura di Giancarlo Carosello, Edizioni San Paolo, Milano 1996, p. 7.

²¹⁸ MAX SCHELER, *Prefazione alla prima edizione*, in M. Scheler, *Il formalismo nell'etica e l'etica materiale dei valori*, a cura di G. Carosello, Edizioni San Paolo, Milano 1996, p. 9.

²¹⁹ Cfr. MAX SCHELER, *Osservazione preliminare*, in M. Scheler, *Il formalismo nell'etica e l'etica materiale dei valori*, a cura di G. Carosello, Edizioni San Paolo, Milano 1996, pp. 26-27.

²²⁰ KAROL WOJTYŁA, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 268.

²²¹ KAROL WOJTYŁA, *ibid.*, p. 267.

²²² KAROL WOJTYŁA, *ibid.*, pp. 267-268.

L'importanza del dovere nell'etica scheleriana viene esclusa o minimizzata, viene integrata invece nella vita morale dell'uomo la sfera emozionale.²²³

Il sistema etico dei valori materiali costruito da Max Scheler ha avuto un certo successo, soprattutto grazie al suo contatto con la scuola fenomenologica. Egli «attorno al 1908 prese conoscenza della filosofia di E. Husserl, autore dell'opera *Logische Untersuchungen*, che conteneva una ben definita posizione fenomenologica».²²⁴

Insieme a Roman Ingarden, Edith Stein²²⁵ ed altri filosofi, Scheler fece parte della scuola fenomenologica di Gottinga, dove rappresentava «la figura con cui si identificano i giovani fenomenologi che, pur avendo in Husserl il comune punto di riferimento accademico, di fatto colgono in Scheler il filosofo in grado di recepire e articolare le crisi e le speranze che li animano».²²⁶

Scheler accolse la posizione fenomenologica per le sue ricerche filosofiche che, però, andavano per un altro binario, diverso dagli interessi di Husserl; questi introduceva la fenomenologia nei problemi teoretici, mentre Scheler li introduceva in quelli della filosofia pratica.²²⁷ Nella sua prefazione alla prima edizione del *Formalismo*, Scheler segnala sia il punto d'unione sia quello di separazione dalla scuola fenomenologica; da una parte l'importanza del metodo fenomenologico²²⁸ e dall'altra la diversa visione del mondo:

²²³ KAROL WOJTYŁA, *ibid.*, p. 268.

²²⁴ KAROL WOJTYŁA, *ibid.*, p. 272.

²²⁵ Cfr. PETER HEBBLETHWAITE, *Husserl, Scheler and Wojtyła: A Tale of Three Philosophers*, in "Heythrop Journal", 27 (1986), p. 442.

²²⁶ GIANCARLO CORONELLO, *Saggio introduttivo*, in M. Scheler, *Il formalismo in etica e l'etica materiale dei valori*, San Paolo, Milano, p. 66.

²²⁷ Cfr. KAROL WOJTYŁA, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 272.

²²⁸ Fu durante il periodo del 1900-1 quando apparve l'opera *Logische Untersuchungen* (Le ricerche logiche) di Edmund Husserl (1859-1938); in essa si trovano le prime tracce della fenomenologia e del suo metodo. Nel suo saggio *La donna*, Edith Stein, spiegando diversi metodi di ricerca scientifica, spiega in modo generale anche quello fenomenologico: «Condividendo con la scuola fenomenologica – cioè con la scuola di E. Husserl – la convinzione che il procedimento della filosofia è, per principio, diverso da quello delle scienze positive; che può contare su di una funzione conoscitiva propria e che precisamente per questo gli è possibile presentare quei dati che sono la base necessaria delle altre scienze, ai quali esse, per contro, non possono giungere: segnare i limiti del loro campo di conoscenza, indicandone i mezzi conoscitivi e i metodi adatti. La fenomenologia ha definito questa funzione conoscitiva particolare come intuizione o contemplazione dell'essenza. Sono espressioni troppo cariche di storia, e perciò esposte ad interpretazioni errate. Io con esse intendo la funzione conoscitiva che di fronte agli oggetti concreti ne mette in rilievo – per così dire – la loro struttura universale, la quale per esempio, ci permette di dire cosa sia una data cosa: una pianta, un animale, un uomo soprattutto; o quale sia il senso di questi nomi. Ciò che qui chiamiamo intuizione, è strettamente connesso a quello che nella filosofia tradizionale veniva chiamato astrazione». (EDITH STEIN, *La donna: il suo compito secondo la natura e grazia*, Città Nuova, Roma 1968, p. 190).

«Dobbiamo agli importanti lavori di Edmund Husserl la coscienza metodologica dell'unità e del senso dell'atteggiamento fenomenologico che unisce i collaboratori dello *Jahrbuch*²²⁹ al di là delle diverse visioni del mondo o delle singole posizioni filosofiche concrete. Anche le presenti ricerche riflettono pertanto in alcuni tratti essenziali l'orientamento dei lavori del direttore dello *Jahrbuch*. Ma per quanto concerne il modo di concepire, comprendere e realizzare quest'atteggiamento nonché, a fortiori (fortiori), per quanto riguarda la sua applicazione agli insiemi dei problemi qui trattati, l'autore si sente in obbligo di reclamare, per ogni singolo punto, una responsabilità esclusiva ed una esclusiva paternità».²³⁰

Come Husserl, Scheler «vede nella fenomenologia un pensiero determinato esclusivamente dalla correlazione al problema (dal «ritorno alle cose»), non quindi una scuola di pensiero, né una metodologia filosofica codificata».²³¹ Egli adopera il metodo fenomenologico nelle sue ricerche, che gli «consente di ampliare notevolmente l'ambito delle correlazioni eidetiche a priori, anche per l'etica, al di là delle sfere a priori del puro pratico formale»²³² kantiano. Secondo Scheler, la fenomenologia ha una funzione etico-conoscitiva, non si tratta di percepire la pura forma del fenomeno, ma il valore in esso contenuto. La fenomenologia risulta, quindi, come un metodo d'indagine filosofica con un indirizzo «realistico», applicato alla vita etica.

Nella sua analisi fenomenologica, Scheler cerca proprio di mostrare come i valori e la loro gerarchia siano dati alla persona nell'esperienza di tipo emozionale. Le emozioni possiedono, infatti, il carattere intenzionale: ci mettono in contatto con i loro propri oggetti, cioè con i valori.

Max Scheler critica, come abbiamo già visto, nella sua opera «quanto ritiene sia erroneo nelle posizioni kantiane ponendo ovunque positivamente in risalto i fatti nella loro verità»²³³ e, contemporaneamente, sostiene che l'etica kantiana rappresenti «quanto di più perfetto possediamo come etica filosofica formulata con discernimento rigorosamente

²²⁹ Scheler fu uno dei cinque curatori dello *Jahrbuch für Philosophie und Phänomenologische Forschung*, l'annuario voluto da Husserl come organo del movimento fenomenologico (Cfr. GIANCARLO CORONELLO, *Saggio introduttivo*, in M. Scheler, *Il formalismo in etica e l'etica materiale dei valori*, San Paolo, Milano 1996, p. 66.).

²³⁰ MAX SCHELER, *Prefazione alla prima edizione*, in M. Scheler, *Il formalismo nell'etica e l'etica materiale dei valori*, a cura di G. Carosello, Edizioni San Paolo, Milano 1996, pp. 3-4.

²³¹ GIANCARLO CORONELLO, *Saggio introduttivo*, in M. Scheler, *Il formalismo in etica e l'etica materiale dei valori*, a cura di G. Carosello, Edizioni San Paolo, Milano 1996, p. 68.

²³² Cfr. MAX SCHELER, *Prefazione alla prima edizione*, in M. Scheler, *Il formalismo nell'etica e l'etica materiale dei valori*, a cura di Giancarlo Carosello, Edizioni San Paolo, Milano 1996, p. 9.

²³³ MAX SCHELER, *ibid.*, p. 2.

scientifico».²³⁴ Quello che il formalismo kantiano impedisce alla filosofia è, secondo lui, di pervenire ad una concreta ed evidente dottrina dei valori etici, della loro gerarchia e delle norme che vi si fondano, e di inserire i valori etici nella vita dell'uomo.

Scheler ci svela lo spirito che caratterizza la sua opera etica, e cioè quello di un rigoroso assolutismo etico e dell'oggettivismo. Definisce la sua posizione inoltre come «intuizionismo emotivo» e come «apriorismo materiale» esprimendo il suo lavoro come un «nuovo tentativo di personalismo»:

«Lo spirito che caratterizza la presente etica è quello di un rigoroso assolutismo etico e dell'oggettivismo. La posizione dell'autore può venir definita inoltre come “intuizionismo emotivo” e come “apriorismo materiale”. L'autore ritiene infine che al principio basilare esposto nel presente lavoro, per cui tutti i valori, ivi compresi quelli reali e quelli della comunità e delle organizzazioni impersonali, debbano essere subordinati ai valori della persona sia talmente importante da definire il suo lavoro anche come “nuovo tentativo di un personalismo”».²³⁵

A partire dalla pubblicazione del *Formalismo*, l'autonomia etica e l'oggettività dei valori hanno fatto notevoli progressi nel mondo filosofico, riducendo l'importanza delle correnti situazionistiche e psicologiche dell'etica, nonché del formalismo di Kant e dell'unilateralità dell'idea di dovere nell'etica: «Il tradimento della gioia e dell'amore, intese come fonti originarie e profonde di ogni essere e diventare etici – che dobbiamo rimproverare al falso eroismo del dovere e del lavoro così diffusamente insegnato in Germania e nell'ambito della filosofia tedesca a partire da Kant – viene lentamente smascherato quale ingannevole orientamento di base di una forma di ethos affermatasi nel corso della storia».²³⁶

A partire dal 1921, il Formalismo di Max Scheler ha esercitato un notevole influsso sulla cultura filosofica tedesca, sui giovani ricercatori del tempo, suscitando numerose e varie critiche «in quattro settori della ricerca: 1. nell'ambito di una teoria generale dei valori (assiologia), dal quale proviene peraltro la maggior parte delle critiche; 2. nell'ambito ristretto dell'etica e della dottrina degli atti dello spirito etico; 3. nell'ambito della sociologia; 4. nell'ambito della psicologia e della pedagogia».²³⁷

²³⁴ MAX SCHELER, *ibid.*, p. 2.

²³⁵ Cfr. MAX SCHELER, *Prefazione alla seconda edizione*, in M. Scheler, *Il formalismo nell'etica e l'etica materiale dei valori*, a cura di Giancarlo Carosello, Edizioni San Paolo, Milano 1996, p. 8.

²³⁶ MAX SCHELER, *Prefazione alla terza edizione*, in M. Scheler, *Il formalismo nell'etica e l'etica materiale dei valori*, a cura di Giancarlo Carosello, Edizioni San Paolo, Milano 1996, p. 9.

²³⁷ MAX SCHELER, *ibid.*, p. 14.

5.2. La questione dell'adattezza del sistema etico di Scheler per interpretare l'etica cristiana

Dopo aver visto come si è svolto l'incontro di Wojtyła con il sistema etico di Max Scheler, con la sua fenomenologia "realistica", e dopo aver avuto un'idea generale su tale sistema, accostiamoci alla tesi di abilitazione di Wojtyła dove, appunto, viene analizzato il sistema etico scheleriano.

Perché Wojtyła si dedica all'elaborazione dell'etica scheleriana? Come fu applicato il suo sistema etico nella sua ricerca? Egli, prima di tutto, esamina tale sistema, per ricavarne le sue premesse principali, fa poi un confronto di queste con l'etica cristiana. Il frutto della sua elaborazione fu la tesi di abilitazione: Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler. Il compito principale di essa, evidente già dal titolo, consisteva nello studio di una possibile applicazione dell'etica dei valori materiali di Max Scheler all'etica cristiana. La sua elaborazione, quindi, di carattere analitico-comparativo, mirava a rispondere alla domanda fondamentale della sua ricerca: «se e quanto il sistema creato da Max Scheler sia adatto ad interpretare l'etica cristiana». ²³⁸ Wojtyła "valutava", infatti, la possibile applicazione del sistema scheleriano all'etica cristiana.

Per l'etica cristiana Wojtyła intendeva «le verità etiche che sono state rivelate da Dio e dalla Chiesa date come principi di comportamento morale. Esse sono contenute nelle fonti della Rivelazione, cioè nella Sacra Scrittura e nella Tradizione». ²³⁹

Se Wojtyła s'accorge di una possibile applicazione, doveva esserci, quindi, qualche legame che intercorra tra il sistema di Scheler e l'etica cristiana, che, appunto, ha ispirato il suo tentativo. Prima di intraprendere la sua valutazione, Wojtyła ci mostra i contenuti dell'etica scheleriana, che potevano attirare l'attenzione anche dei pensatori cattolici.

Esistono diverse ragioni per cui il sistema etico costruito da Max Scheler si riallacci all'etica cristiana. Prima di vedere quali sono, teniamo presente che Scheler si è convertito al cattolicesimo e mentre scriveva il Formalismo era ancora praticante.

Quali sono, dunque, questi punti di tangenza fra le fonti dell'etica cristiana e il sistema di Scheler? Il primo consiste nel fatto che tutti i due sistemi etici tendono a collegare gli atti umani con l'oggettivo e a ricavare da esso il valore morale. Un altro punto importante,

²³⁸ Cfr. KAROL WOJTYŁA, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 439.

²³⁹ Cfr. KAROL WOJTYŁA, *ibid.*, p. 298.

dove il sistema etico di Scheler si riallaccia in modo evidente al contenuto etico delle fonti rivelate, è la definizione dei valori etici come valori personali. Anche l'invito alla sequela del modello etico per raggiungere la perfezione morale, cioè il più alto valore della persona, rappresenta un altro punto comune dei due sistemi. Un altro fattore molto importante sia per l'etica cristiana sia per quella scheleriana è l'idea dell'amore, che nella dottrina cristiana è il più grande comandamento e nel sistema di Scheler l'origine più profonda dei valori etici:

«Già per la sua fondamentale tendenza a collegare realmente con l'oggettivo gli atti umani e a ricavare da esso il loro valore morale, il sistema di Scheler ha potuto attirare l'attenzione dei pensatori cattolici. Ci si sono però trovati certi dati ancora più particolari, che richiamano un immediato accostamento all'etica cristiana, specialmente al contenuto etico del Vangelo. Scheler, cioè, evidenzia in particolar modo nel suo sistema l'importanza dell'amore per la persona e il ruolo della sequela di un modello etico per il complesso della vita morale».²⁴⁰

L'etica di Scheler rappresenta, secondo Wojtyła, dunque, un possibile alleato dell'etica cristiana, che non può accettare il formalismo assoluto dell'etica kantiana.²⁴¹ I dati dell'etica scheleriana, che richiamano un immediato accostamento all'etica cristiana, forniscono una piena illustrazione e comprensione del contenuto dell'etica cristiana? Si adatta il sistema etico costruito da Max Scheler alla formulazione scientifica dell'etica cristiana? Contiene «già una compiuta elaborazione dell'etica cristiana o magari di alcune sue problematiche?».²⁴² Wojtyła mira a ricavare «il contributo che il suo sistema etico di tipo fenomenologico può dare alla formazione della teologia morale».²⁴³ Si tratta «di definire il grado di adeguatezza (adattezza) del sistema di Scheler all'interpretazione dell'etica cristiana».²⁴⁴

Queste domande essenziali contengono, in pratica, lo status quaestionis della sua abilitazione. Nella parte conclusiva del suo lavoro, Wojtyła risponde ad esse in forma di

²⁴⁰ KAROL WOJTYŁA, *ibid.*, p. 268.

²⁴¹ Cfr. ROCCO BUTTIGLIONE, *Il pensiero dell'Uomo che divenne Giovanni Paolo II*, Mondadori, Milano 1981, p. 78.

²⁴² Cfr. KAROL WOJTYŁA, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 268.

²⁴³ GIOVANNI PAOLO II, *Dono e mistero: nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 104.

²⁴⁴ KAROL WOJTYŁA, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in KAROL WOJTYŁA, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 298.

due tesi. Queste sono importanti per capire come si conclude la sua ricerca e, in modo particolare, per tracciare le idee principali che dominano l'etica scheleriana.

La prima tesi conclusiva del suo lavoro comporta una risposta negativa. Nonostante i punti di tangenza fra i due sistemi, a causa delle premesse emozionalistiche, Wojtyła giudica il sistema di Scheler come un sistema non adatto per l'interpretazione scientifica dell'etica cristiana: «Il sistema etico costruito da Max Scheler fondamentalmente non si adatta alla formulazione scientifica dell'etica cristiana. Benché, infatti, attraverso la definizione dei valori etici come valori personali si riallacci in modo evidente al contenuto etico delle fonti rivelate, però, per effetto delle sue premesse fenomenologiche ed emozionalistiche non è sufficientemente adeguato ad una piena illustrazione e comprensione scientifica di quel contenuto. In particolare poi non basta alla loro comprensione teologica, indispensabile dato che esse sono fonti rivelate e stabiliscono un oggetto di fede soprannaturale».²⁴⁵

Secondo Scheler, i valori etici, come abbiamo già visto, sono anche valori personali, e si manifestano nella persona. Quest'ultima percepisce il valore etico affettivamente-intenzionalmente "in sé". La persona, in più, si sperimenta come origine dei valori etici.²⁴⁶ «Una tale concezione del rapporto tra la persona e i valori etici la consentono le premesse fenomenologiche teorico-pratiche».²⁴⁷ Con queste, però, non si può cogliere e oggettivare il fattivo rapporto della persona con i valori etici. Non ci dicono nulla sul modo in cui gli atti derivano fattivamente dalla persona. «Così, dunque, la verità fondamentale dell'etica cristiana, che proclama la persona umana causa efficiente del bene e del male morale dei suoi atti, non si può propriamente cogliere e obiettivare con l'aiuto del sistema di Scheler».²⁴⁸ Egli ha cancellato il carattere normativo dei valori etici e, a causa di questo, esiste un distacco dei valori dalla fattività della persona. Secondo l'etica cristiana, questo rapporto fattivo si esprime negli atti della coscienza. Il vero motivo perché Scheler non riesce ad oggettivare questo rapporto sta oltre la sua fenomenologia, e cioè nelle sue premesse emozionalistiche. Una vera esperienza etica, dunque, non consiste nell'attività della persona, ma piuttosto nella percezione affettiva-intenzionale dei valori etici: «Scheler nel suo sistema ha decisamente cancellato il carattere normativo degli atti etici, e questa è la comprensibile conseguenza del distacco dei valori etici dalla fattività della

²⁴⁵ KAROL WOJTYŁA, *ibid.*, p. 439.

²⁴⁶ KAROL WOJTYŁA, *ibid.*, p. 441.

²⁴⁶ KAROL WOJTYŁA, *ibid.*, p. 440.

²⁴⁷ KAROL WOJTYŁA, *ibid.*, p. 441.

²⁴⁸ KAROL WOJTYŁA, *ibid.*, p. 441.

persona. Questo è tanto più sorprendente in quanto l'atto stesso della coscienza come esperienza della persona è oggetto di esperienza fenomenologica. Se Scheler-fenomenologo attraverso l'analisi dell'atto della coscienza non giunge al rapporto fattivo della persona rispetto ai valori etici, questo deve avere qualche motivo oltre alla sua fenomenologia. Il motivo sta nelle sue premesse emozionalistiche».²⁴⁹

Nella seconda tesi conclusiva del suo lavoro, Wojtyła ci mostra invece l'aspetto positivo dell'etica scheleriana. Anche se il sistema di Scheler non ha potuto procurarci la fondamentale interpretazione dell'etica cristiana, Wojtyła ne riconosce la sua funzione ausiliare per il lavoro scientifico sull'etica cristiana e nell'analisi dei fatti etici sul piano fenomenologico sperimentale.

«Benché il sistema etico creato da Scheler non si adatti fundamentalmente ad interpretare l'etica cristiana, però ci può essere collateralmente d'aiuto in un lavoro scientifico sull'etica cristiana. Ci facilita cioè l'analisi dei fatti etici sul piano fenomenologico sperimentale».²⁵⁰

Wojtyła esprime, quindi, un giudizio negativo sul sistema etico scheleriano, però, ne riconosce l'importanza del suo metodo fenomenologico. Egli condivide il postulato fondamentale di Scheler, secondo cui l'etica deve partire dall'esperienza.²⁵¹ Il difetto della proposta di Scheler consiste nel non aver esaurito tutte le risorse del metodo fenomenologico nell'esplorare l'esperienza morale.²⁵²

«Di più, oltre che dal punto di vista semplicemente teoretico, il metodo fenomenologico, nella rielaborazione che Scheler ne fa, ha una grande utilità propriamente pastorale e apostolica. Esso permette di rinvenire il valore nell'analisi dell'esperienza comune e partendo da essa. Tale metodo quindi toglie all'etica la rigidità propria di un sistema di comandi assoluti che non nascono dal vissuto del soggetto, e, al contrario, fa dell'individuazione del valore l'essenziale punto di chiarificazione dell'esperienza personale».²⁵³

²⁴⁹ KAROL WOJTYŁA, *ibid.*, p. 441.

²⁵⁰ KAROL WOJTYŁA, *ibid.*, p. 446.

²⁵¹ Cfr. JAROSLAW MERECKI, *Introduzione: verso l'etica empirica e normativa*, in K. Wojtyła, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 256.

²⁵² Cfr. KAROL WOJTYŁA, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in KAROL WOJTYŁA, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 449.

²⁵³ Cfr. ROCCO BUTTIGLIONE, *Il pensiero dell'Uomo che divenne Giovanni Paolo II*, Mondadori, Milano 1981, p. 78.

Wojtyła ricorda che il sistema di Scheler è comunque un sistema filosofico «costruito secondo le premesse della fenomenologia e dell'assiologia, che deve servire a cogliere e a spiegare tutti i fatti morali e tutti i contenuti etici e non solo a costruire una elaborazione dell'etica cristiana».²⁵⁴ Anche se esistono i punti di tangenza tra i due sistemi, Wojtyła ci ricorda che Scheler stava elaborando il proprio sistema etico e non intendeva fare semplicemente un'interpretazione dell'etica cristiana. Usa la Sacra Scrittura come punto di confronto al suo sistema, cioè per dimostrarne la veridicità delle sue premesse etiche. Wojtyła discusse la tesi di dottorato nel novembre del 1953. Questa fu, in pratica, l'ultima abilitazione per la cattedra di libera docenza nella facoltà di Teologia dell'Università Jaghellonica, prima che venisse soppressa dalle autorità comuniste. I correlatori di Wojtyła furono don Aleksander Usowicz, il teologo don Władysław Wicher e Stefan Świeżawski. Grazie all'aiuto di quest'ultimo nell'autunno del 1954 Wojtyła inizia ad insegnare all'Università Cattolica di Lublino.²⁵⁵

Oltre al pensiero di Scheler, Wojtyła s'interessava anche del pensiero filosofico di Edith Stein, allieva di Husserl; leggeva i suoi scritti, tra cui in particolare: *Essere finito ed eterno*.²⁵⁶ Un'altra figura importante, verso la cui filosofia Wojtyła trovò interesse, fu quella di Roman Ingarden. Lo conosceva personalmente e cercava di mantenere con lui i rapporti mentre stava a Cracovia.²⁵⁷ Ingarden era all'epoca uno fra i personaggi più importanti della vita intellettuale di Cracovia²⁵⁸ ed aiutò Wojtyła nel suo consolidamento con la fenomenologia. Anche Ingarden era uno dei primi allievi di Husserl e si distinse dal suo maestro per l'interpretazione "realistica" della fenomenologia, invece di quell'idealistica. Manifestò un particolare interesse per l'intuizione dei valori della vita etica ed estetica, il suo modo di intendere la fenomenologia si avvicina molto a quello di Max Scheler.²⁵⁹ Ingarden mostra l'interesse per l'antropologia e l'etica, usa la fenomenologia in funzione etica piuttosto che in funzione eidetico-conoscitiva, non per

²⁵⁴ KAROL WOJTYŁA, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 297.

²⁵⁵ Cfr. GIOVANNI PAOLO II, *Alzatevi, andiamo!*, Libreria Editrice Vaticana, Città del Vaticano 2004, pp. 76-77.

²⁵⁶ Cfr. GIOVANNI PAOLO II, *ibid.*, p. 73.

²⁵⁷ Cfr. GIOVANNI PAOLO II, *ibid.*, p. 73.

²⁵⁸ Cfr. JAROSŁAW MERECKI, *Introduzione: verso l'etica empirica e normativa*, in K. Wojtyła, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 252.

²⁵⁹ Cfr. ROCCO BUTTIGLIONE, *Il pensiero dell'Uomo che divenne Giovanni Paolo II*, Mondadori, Milano 1981, pp. 59-60.

percepire la forma del fenomeno, ma il valore in esso implicato. Secondo lui, la fenomenologia è, piuttosto che una compiuta filosofia, un metodo di indagine filosofica che può essere applicato agli ambiti più diversi e può incontrarsi con le più diverse filosofie.²⁶⁰

Possiamo ringraziare Wojtyła di aver messo a fuoco il problema in Scheler, che sorge dalla separazione dei valori etici dalla fattività della persona.

Intanto occorre domandarci pure se il problema non sia provocato dall'impostazione della fenomenologia husserliana, che ritiene l'essere ontologico delle cose e dell'uomo come mera fattività (già con "la prima riduzione fenomenologica"), il che conduce alla separazione dei fenomeni emozionali etici dalla "fattività della persona", che in verità è l'essere ontologico della persona, assieme alla sua essenza. E in questo si basa, tradizionalmente, la normatività dell'etica. Questa base normativa è adesso messa in questione, come annota Karol Wojtyła.

5.3. I due pilastri della filosofia wojtyliana

Wojtyła dedicandosi, quindi, all'analisi del sistema etico elaborato da Max Scheler, si trovò davanti ad un nuovo orizzonte, sconosciuto fino allora. La sua formazione aristotelico-tomista fu arricchita dal metodo fenomenologico. Quest'ultimo insieme alla metafisica, verrà adoperato nei suoi scritti nel corso di tutta la sua carriera filosofica: «A questo lavoro di ricerca devo veramente molto. Sulla mia precedente formazione aristotelico-tomista si innestava così il metodo fenomenologico, cosa che mi ha permesso di intraprendere numerose prove creative in questo campo».²⁶¹

Wojtyła, dunque, si sente debitore in tutti i suoi studi, oltre alla metafisica tomistica, anche alla fenomenologia "realistica". Egli si appropria del metodo fenomenologico valorizzando la particolare costruzione, che sulla base di quel metodo Scheler ha compiuto.²⁶² Questo incontro con la filosofia scheleriana e, quindi, con il metodo fenomenologico, è significativo per le sue seguenti ricerche filosofiche.

Lavoro scientifico di Wojtyła su Max Scheler è interessante non soltanto dal punto di vista storico, cioè per coloro che si interessano dello sviluppo del suo pensiero filosofico, «ma soprattutto perché già in esso possiamo trovare le stesse intuizioni fondamentali, che, poi, saranno sviluppate nei testi dedicati all'etica e all'antropologia filosofica. Inoltre, chi vuol

²⁶⁰ Cfr. ROCCO BUTTIGLIONE, *ibid.*, pp. 77-78.

²⁶¹ GIOVANNI PAOLO II, *Dono e mistero nel 50° del mio sacerdozio*, Libreria Editrice Vaticana, Città del Vaticano 1996, p. 104.

²⁶² Cfr. ROCCO BUTTIGLIONE, *Il pensiero dell'Uomo che divenne Giovanni Paolo II*, Mondadori, Milano 1981, p. 80.

comprendere fino in fondo la filosofia della persona presentata in *Persona e atto* e il suo metodo, non può non prendere in considerazione il confronto di Wojtyła con il pensiero di Scheler». ²⁶³ Nel suo lavoro possiamo già percepire alcuni concetti chiave della sua filosofia della persona, e soprattutto il concetto di atto, che diventerà per Wojtyła una sorta di finestra verso l'interiorità della persona. ²⁶⁴

Analizzando la formazione del pensiero filosofico wojtyliano e le sue origini, abbiamo visto, dunque, i due passaggi importanti. Il primo consiste nel passaggio dalla letteratura e teatro alla filosofia classica e tomistica; il secondo da quest'ultima alla fenomenologia. Alla fine possiamo concludere che le due correnti filosofiche rappresentano i due pilastri del suo sistema filosofico.

Conclusione

Alla fine di questo articolo sulla formazione del pensiero filosofico di Karol Wojtyła, vogliamo sottolineare le sue idee portanti. La sua impostazione filosofica è composta da due tappe: quella metafisico-tomista e quella fenomenologica. Per comprendere queste, abbiamo fatto un percorso che inizia coll'ambiente culturale vivo, seguito dall'amore per la letteratura e il teatro, dagli studi linguistici nel contesto della guerra, dall'importante esperienza del lavoro e dalla vocazione all'sacerdozio, il periodo durante il quale l'autore s'incontra con la filosofia classica e tomista.

Studiando all'Università Jaghellonica di Cracovia, la più antica di Polonia, avendo tra le mani l'opera *Ontologia o Metafisica* del precursore del rinnovamento tomistico il Professore Kazimierz Wais, la propedeutica per la filosofia scolastica, Wojtyła acquista, grazie a professor Kazimierz Kłósak, una solida formazione del pensiero classico-tomista, che sarà uno degli assi portanti del suo pensiero filosofico.

La sua formazione tomista s'approfondisce anche grazie alla sua prima tesi di Dottorato in Teologia all'Angelicum, sulla dottrina della fede in san Giovanni della Croce, sotto la guida del professore Garrigou Lagrange.

Dopo un breve periodo dell'incarico pastorale, scrivendo la sua seconda tesi di Dottorato, inizia per Wojtyła la seconda tappa della formazione del suo pensiero filosofico. Attraverso lo studio e l'elaborazione del sistema etico di Max Scheler, egli s'incontra anche con il metodo fenomenologico di Husserl. Quest'ultimo e la sua formazione

²⁶³ Cfr. JAROSLAW MERECKI, *Introduzione: verso l'etica empirica e normativa*, in K. Wojtyła, *Valutazioni sulla possibilità di costruire l'etica cristiana sulle basi del sistema di Max Scheler*, in K. Wojtyła, *Metafisica della persona; tutte le opere filosofiche e saggi integrativi*, a cura di G. Reale e T. Styczeń, Bompiani, Milano 2003, p. 251.

²⁶⁴ Cfr. JAROSLAW MERECKI, *ibid.*, p. 257.

classico-tomista si rifletteranno nelle ricerche filosofiche future di Wojtyła, in particolare nel testo di *Persona e atto*.

Possiamo constatare che tutti gli interpreti, specializzati nelle opere di Karol Wojtyła, convengono nel valutare positivamente la sua elaborazione delle esperienze soggettive concrete della persona, attraverso il metodo fenomenologico.

Si possono apprezzare questi studi empirici/fenomenologici dell'autore sulla persona come completamento della dottrina tomista sull'uomo, che si concentra solo sulla sua essenza definita in concetti universali.

Tuttavia, con quegli studi empirici si aggiunge un vivo interesse filosofico nella stessa essenza che, considerata in chiave fenomenologica personalista, viene ricercata piuttosto nelle esperienze personali. Ciò apre un certo confronto con la dottrina tomista, che si articola praticamente nell'interpretazione del *suppositum*. Infatti, Wojtyła introduce questo termine scolastico andando oltre la fenomenologia.

Mentre in San Tommaso il *suppositum* indica proprio il lato oggettivo dell'uomo come persona, nella prospettiva personalista di Wojtyła il *suppositum* assume l'aspetto soggettivo dell'uomo quale persona.

Le esperienze soggettive individuali e la conoscenza intellettuale in concetti oggettivi universali si svolgono su due piani conoscitivi diversi, non devono dunque contrastarsi. L'essenza è proprio l'oggetto della conoscenza intellettuale universale.

L'oggetto dell'analisi fenomenologica delle esperienze, invece, conduce piuttosto alla personalità, che si sviluppa concretamente in ciascun individuo. Mentre la persona né è il fondamento statico ontologico cui si è dedicata l'antropologia tomista universale in concetti universali.

Karol Wojtyła nella sua principale opera filosofica: *Persona e atto* intende presentare la dottrina sulla persona. Quest'ultima è pervenuta dalla tradizione antica e medievale: con la definizione di Boezio e la sua ripresa in San Tommaso.

Tuttavia, nei nostri tempi il concetto tradizionale di persona come "sostanza individua di natura razionale" è stato abbandonato e sostituito dal cosiddetto personalismo, fondato da E. Mounier, perché sembrava troppo "oggettivistico", non soddisfacente la soggettività della persona.

Intanto, fra i personalisti si è formato un indirizzo di filosofi cattolici che non volevano abbandonare la definizione boeziano-tomista (anche perché fa parte del Magistero della Chiesa), bensì combinarla con le analisi personaliste, svoltesi con il metodo descrittivo della fenomenologia di E. Husserl.

Anche il filosofo Card. Karol Wojtyła si annovera fra i personalisti cattolici. Nel suo trattato *Persona e atto* si pone il compito di conciliare la dottrina tradizionale di persona con quella recente personalistica.

Infatti, le due dottrine, la concezione statica della persona, fondata sull'antropologia ontologica, e la concezione dinamica, che si concentra sullo sviluppo dinamico della personalità, avvalendosi della descrizione fenomenologico-psicologica, sono in contrasto.

L'autore dedica uno speciale interesse al termine tomista di *suppositum* per aggiungere al suo significato oggettivo anche un significato soggettivo. Wojtyła segue, infatti, nelle sue ricerche il programma "da qualcosa (il reale, l'ente) a qualcuno (il soggetto, la persona)". Tuttavia ci poniamo la domanda se si può conciliare la teoria tomista sulla persona con quella fenomenologico-personalista. Questo è un tema fondamentale per i tempi d'oggi, dove la persona umana rischia di essere misinterpretata e di perdere il suo posto primario in tutta la creazione sia divina che umana.

DELIBERATELY CEASING HYDRATION AND NUTRITION WITH THE AIM TO END LIFE. A BRIEF CATHOLIC PERSPECTIVE



The Author

My name is Lotte Voets. I am a medical specialist in Geriatric and Palliative Care in The Netherlands. In daily life I work in long-term settings with patients suffering from dementia and I take care of people with limited life-expectancy in a hospice.

I studied Medicine at Erasmus University Rotterdam and I got an MA degree in both *Religion in Contemporary Society* (Leiden University) and *Ethics of Care* (Tilburg University). In 2022 I finished the MSc *Palliative Care* (King's College, Cicely Saunders Institute, London). Since then, I have worked in two palliative care settings, one of them specialised in patients with disabilities, psychiatric diseases and addictions.

At this point I am about to finish my baccalaureate Religious Studies at the Pontifical Lateran University in Rome with a thesis on the Mercy of Christus Medicus. Since I became a Catholic in 2014, I intend to unify the beautiful and loving teachings of the Church on human life with daily practice and science.

Introduction

In recent decades, the Netherlands have considered themselves a guiding country on various ethical topics and in particular on end-of-life issues. In the series of euthanasia, physician assisted suicide (PAS) and “completed life”²⁶⁵ another option was presented in

265 “Completed Life” is a literal translation of the Dutch concept of “Voltooid Leven”. It refers to an active ending of life using the technique of euthanasia or physician assisted suicide. In the latter there needs to be a medical diagnosis supporting the argument of endless and unbearable suffering. With the concept of “Completed Life”, a political party D66 suggested to broaden the possibility of active termination of life in healthy people that considered their lives to be completed (without support of a medical diagnosis). Extensive research has been done on this topic, and up until now there is no law

January 2024, in a revised guideline “*Care for People who Stop Eating and Drinking to Hasten the End of Life*”.²⁶⁶ It can be seen as a new practical option in which one desires to control and actively hasten the end of life. Compared to euthanasia and physician assisted suicide (PAS), the concept of *Deliberately Ceasing Hydration and Nutrition with the Aim to End Life* (DCHN) will falsely seem to offer a mild ethical alternative and will present new medical, moral and pastoral challenges in the Netherlands. In this article I will argue that DCHN has similar ethical and moral implications as (assisted) suicide.

DCHN and its ethical implications

Revised Guideline

In January 2024, the guideline “*Care for People who Stop Eating and Drinking to Hasten the End of Life*” was presented in The Netherlands by the Royal Dutch Medical Association (KNMG).²⁶⁷ The revision of the first guideline “*Care for People who consciously Refrain from Eating and Drinking to Hasten the End of Life*”²⁶⁸ (2014) showed three major changes: 1. the addition of practical handouts for health care professionals, 2. the abandonment of the minimum age of 60 years,²⁶⁹ 3. the usage of the word “stopping” or “ceasing” instead of “refraining from” to emphasize the deliberate aspect of the act.²⁷⁰ In 2025 the KNMG published a brochure for patients and relatives: “To stop eating and drinking to die earlier”.²⁷¹

Definition DCHN

allowing this practice.

266 Translation of Dutch Guideline KNMG, “Zorg voor mensen die bewust afzien van eten en drinken om het levenseinde te bespoedigen”, 2024 <https://www.knmg.nl/download/handreiking-zorg-voor-mensen-die-stoppen-met-eten-en-drinken-om-het-levenseinde-te-bespoedigen-1>. Online English version: “Caring for people who stop eating and drinking to hasten the end of life: Online available <https://www.knmg.nl/download/guide-caring-for-people-who-stop-eating-and-drinking-to-hasten-the-end-of-life>

267 KNMG: Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (Royal Dutch Medical Association)

268 KNMG, “Zorg voor mensen die bewust afzien van eten en drinken om het levenseinde te bespoedigen”, 2024. English translation “Caring for people who stop eating and drinking to hasten the end of life.” Online available: <https://vgvz.nl/wp-content/uploads/2018/08/Handreiking-Zorg-voor-mensen-die-bewust-afzien-van-eten-en-drinken-om-het-levenseinde-te-bespoedigen-2014.pdf>.

269 This age limit was kept because it was suspected that patients with relatively good physical condition would face a difficult pathway. This still appears to be the case based on additional studies. Younger people seem to be more likely to suffer from underlying mental illnesses, with generally good physical health. No scientific support is added to clarify the abandonment of the minimum age. It seems that the lack of clear scientific evidence for a cut-off point based on age has resulted in the abandonment of minimum age, potentially trying to avoid age discrimination.

270 Terms such as “voluntary”, “refuse” or “withhold” do not adequately express self-choice and even suggest the passive withholding or withholding of fluid/nutrition by third parties.

271 In Dutch: ‘Stoppen met eten en drinken om eerder te overlijden’ <https://www.knmg.nl/download/publieksbrochure-stoppen-met-eten-en-drinken-om-erder-te-overlijden>

The definition of DCHN is important because its description has substantive and ethical implications. In English literature the term 'voluntarily stopping eating and drinking', the abbreviation VSED is also used²⁷². In this article it is chosen to use the term “deliberate” to emphasize the explicit intention of the patient, “ceasing” to point the definite character of the act²⁷³. The term “hydration” and “nutrition” is used as all forms of oral intake are mentioned in the definition (including artificial administration), not solely “eating” and “drinking” in the strict sense of the word.

What is DCHN not?

DCHN is emphatically not the gradual reduction of oral intake due to an underlying disease or old age. Phenomena like reduced appetite, nausea, anorexia-cachexia syndrome and deterioration of the digestive system can influence the oral intake in a negative way until it is finally stopped. This is, however, part of the natural course of life. Nor is DCHN a temporary refraining from hydration or nutrition as mentioned in (religious) fasting or hunger strikes. In both conditions the aim is a transcendent one (religious or ideological); causing death is not the aim.

So, what is DCHN?

The definition given of DCHN is *the decision taken by a person to stop eating and drinking for the purpose of hastening the end of life.*²⁷⁴ This includes deliberately refusing food and drink that is offered and deliberately refusing artificial administration of food and fluids.²⁷⁵ In the scientific literature, the definition of DCHN is described as follows: *'the act of a voluntarily and deliberately deciding to stop eating and drinking for the primary purpose of hastening death due to persistent unacceptable suffering'.*^{276 277}

Target population

In principle this option was offered to people in terminal stages of disease, and sometimes

272 In Dutch the term BSTED is used, derived from “Bewust Stoppen met Eten en Drinken”

273 “Stopping” compared to “ceasing” can be used also in a temporarily context. Ceasing shows the definite character that represents the intention.

274 In the current definition the word “hasten” implies a condition causing approaching end of life. However, since patients younger than 60 years and patients with mainly psychiatric pathologies are included “hastening” end of life can be seen as a euphemism since end of life would not be near without DCHN.

275 KNMG, “Zorg voor mensen die stoppen met eten en drinken om het levenseinde te bespoedigen”, 2024, p 19-21.

276 Ivanović N, Büche D, Fringer A. Voluntary stopping of eating and drinking at the end of life - a 'systematic search and review' giving insight into an option of hastening death in capacitated adults at the end of life. BMC Palliat Care. 2014 Jan 8;13(1):1. doi: 10.1186/1472-684X-13-1. PMID: 24400678; PMCID: PMC3893440. The English-language literature tends to use the term "voluntar(ily) stopping eating and drinking".

277 Artificial fluid and/or nutrition: nasogastric tube, PEG or PRG catheter, subcutaneous or intravenous administration

in elderly patients. However in the revised guideline the minimum age of 60 years was abandoned. The definition of patient started as *a person with "classifiable disease" or a "condition that a doctor classifies as a disease or combination of diseases and complaints"*. Now it is broadened to *people that in the future will be a patient due to DCHN and therefore are entitled to receive palliative care*.

*A person needs to have capacity to start DCHN.*²⁷⁸ In principle, people that are incapacitated regarding their intake due to mental illnesses (e.g. anorexia nervosa), disabilities or cognitive disease (e.g. dementia) are in principle excluded from DCHN.

*The guideline distinguished three groups: 1. Elderly patients in relatively good health without a death wish, but an explicit wish to avoid further deterioration, 2. Elderly patients in poor health, increasing dependency on others or small social network and a persistent death wish, and 3. People with chronic psychiatric conditions, variable death wish, often younger and in better physical health. The latter often experienced resistance by health care professionals and next of kin. The first group met most significant resistance from next of kin*²⁷⁹.

*Limited research has been done on prevalence or incidence of DCHN in the Netherlands, but a 0,5-1,7% of Dutch mortality is estimated to be caused by DCHN. However, different definitions have been used (including refraining oral intake in terminal stages of disease). In 60%, a serious physical illness played a role, in 12-30% incipient dementia, and in about 25%, an accumulation of age-related diseases or so-called "completed life" problems were described. In 19-45% of cases, there was a rejected or unexecuted euthanasia request.*²⁸⁰

Reasons for DCHN

278 Capacity in Dutch context is when a patient is able to receive and understand the provided information about his/her medical condition, prognosis and optional treatments and is capable to express his/her choice.

279 Bolt EE, Pasman HR, Onwuteaka-Philipsen BD. Patients Who Seek to Hasten Death by Voluntarily Stopping Eating and Drinking: A Qualitative Study. *Ann Fam Med*. 2023 Nov-Dec;21(6):534-544. doi: 10.1370/afm.3037. PMID: 38012037; PMCID: PMC10681697.

280 KNMG, "Zorg voor mensen die stoppen met eten en drinken om het leven te beëindigen", 2024, p.19-21 (English version. p. 15). Note that in the Dutch context euthanasia or PAS can be performed when sufficient evidence for suffering based on underlying physical or mental illnesses is provided. In the case of euthanasia or PAS a physician has to decide whether to respond to a request based on the experienced suffering of the patient combined with their own judgement, or conscientious objection. In DCHN a person, to some extent, can decide to start without the consent of the physician. See further: Hagens M, Snijders MC, Evenblij K, Onwuteaka-Philipsen BD, Pasman HRW. Experiences with counselling to people who wish to be able to self-determine the timing and manner of one's own end of life: a qualitative in-depth interview study. *J Med Ethics*. 2021 Jan;47(1):39-46. doi: 10.1136/medethics-2019-105564. Epub 2019 Dec 23. PMID: 31871263; PMCID: PMC7803911.

Several considerations are cited as contributing to the decision to DCHN (Table 1):²⁸¹

1. Physical suffering: pain, shortness of breath, nausea and/or vomiting, and general weakness or fatigue,
2. Increased dependence: disability due to reduced mobility, blindness or deafness; inability to take care of oneself, (fear of) incontinence; sense of (or fear of) being a burden to others, "loss of dignity", or "disempowerment".
3. Psychological, social or spiritual suffering ("demoralisation"): gloom, loneliness and/or perceived meaninglessness of life
4. Wanting to be in control ("control of time and place of dying"): desire to be in control of dying, desire to die at home and/or be done with life.

	Chabot 2007 n=97	Bolt 2015-1 and 2 n=99
Somatic		
Weakness or fatigue	53%	60%
Pain	38%	18%
Breathlessness/fear of suffocation	10%	9%
Physical deterioration		51%
Other physical complaints		8%
Psychic		
Depressed	10%	16%
Fear		3%
Social		
Loneliness	11%	15%
Loss of a loved one		8%
Dependency		
Dependency	38%	32%
Not wanting to inconvenience others	22%	15%
Disability/immobility	23%	30%
No longer able to live independently		7%
Loss of dignity/self		
Loss of dignity	56%	29%
Cognitive decline or loss of communication		11%
Demoralisation		
Having no purpose in life	43%	38%
Suffering with no prospect of improvement		41%
Control of dying		
Completed life	59%	40%
Loss of direction	25%	27%

* multiple answers possible

Figure 1: Table 1 Reasons for patients to hasten end-of-life by stopping eating and drinking

Pathophysiology

DCHN is ultimately based on the idea that if fluid and nutrition are withheld long enough,

281 KNMG, "Zorg voor mensen die stoppen met eten en drinken om het levenseinde te bespoedigen", 2024, p.25. (English edition, p 18, 22

the body – and consequently the person - will die.²⁸²

*Hydration is considered to be more fundamental in predicting life expectancy than nutrition since the majority of our body consists of water. The guideline suggests that most people using less liquids than 50mL per day will eventually die within two weeks. Limited research suggests that elderly people have a reduced experience of thirst or dry mouth. Therefore it seems that DCHN in younger people is more difficult to sustain.*²⁸³

Although limited research has been done on deliberate ceasing nutrition (mostly research in hunger strikes), it is considered that after a few days 1. the feeling of hunger seems to disappear (possibly due to ketones), 2. the body through production of endorphins provides its own pain relief, and 3. increasing numbness and eventually loss of consciousness would occur due to dehydration and declining kidney function.²⁸⁴

Course of DCHN

There are a limited number of studies that have examined the course of DCHN. The median time to death was 13 days (7-27 days).²⁸⁵ Bolt et al (2015) found a shorter median time to death of 7 days.²⁸⁶ This population appeared to be significantly older and was relatively frail with underlying diseases. Other studies report a median time to death of 10 days²⁸⁷, 11.5 days²⁸⁸, 14 days²⁸⁹ (6-24 days).

The majority of people died within 1-3 weeks when nutrition was stopped and hydration was less than 50mL per day²⁹⁰ Patients who survived longer than 19 days continued to

282 KNMG, “Zorg voor mensen die stoppen met eten en drinken om het levenseinde te bespoedigen”, 2024, p. 21-25. Normal energy metabolism is based on glucose through the burning of carbohydrates and fats. In strict fasting without intake of any nutrition the body switches to draw on its own reserves. This occurs initially by glycogenolysis, which releases glucose from the liver. Then by gluconeogenesis, which releases glucose from the conversion of amino acids, lactate and pyruvate. Next, fatty acids are broken down and ketone bodies are (acetone, acetoacetate, beta-hydroxy-butyric acid) formed. In the final stage, body proteins of the muscles and liver are also broken down.

283 KNMG, “Zorg voor mensen die stoppen met eten en drinken om het levenseinde te bespoedigen”, 2024, p. 21-25.

284 KNMG, “Zorg voor mensen die stoppen met eten en drinken om het levenseinde te bespoedigen”, 2024, p. 21-25.

285 Chabot (2007) Median: 50% of patients died within 13 days. NB from the table it can be seen that 19/27 patients died within 15 days.

286 Bolt EE, Hagens M, Willems D, Onwuteaka-Philipsen BD. *Primary care patients hastening death by voluntarily stopping eating and drinking*. Ann Fam Med. 2015 Sep;13(5):421-8. doi: 10.1370/afm.1814. PMID: 26371262; PMCID: PMC4569449.

287 LOWERS J, HUGHES S, PRESTON N. *Experience of Caregivers Supporting a Patient through Voluntarily Stopping Eating and Drinking*. J Palliat Med. 2021 Mar;24(3):376-381. Lowers 2021-2.

288 Collected caseload according to the guide (p.37), range of 6-24 days. English edition guideline, p. 21.

289 EPEL-MEICHLINGER J, STÄNGLE S, MAYER H, FRINGER A. *Family caregivers' advocacy in voluntary stopping of eating and drinking: A holistic multiple case study*. Nurs Open. 2022 Jan;9(1):624-636.

290 KNMG, “Zorg voor mensen die stoppen met eten en drinken om het levenseinde te bespoedigen”, 2024, p.19-21

drink more than 50mL daily. The guideline, therefore, concludes that with an intake of 50mL or more, the patient is unlikely to die within 18 days. Remarkably, palliative sedation was used in 28% of the cases.²⁹¹

Ethical considerations

The guideline contains an ethical section which is limited and has no broad perspective on life. In a secularised context, the guideline provides the following approved values: “right to self-determination”, “autonomy” (“desire to take matters into your own hands”), option “without euthanasia” (no need of a physician), “a certain path to death”, “opportunity to choose time and place of death”. It is even considered that restarting oral intake to treat thirst or hunger sensation is unwanted as this will lead to life, which is an unwanted outcome.

According to the legal substantiation of the guideline DCHN is a form of self-determination with the values of "respect for privacy" and the right to "bodily integrity"²⁹².²⁹³

Catholic Reflection

Human Dignity found in the Image and Likeness of God

Catholic moral theology, and specifically bioethics, harks back to the intrinsic dignity that human beings have based on the human image of being created in the image and likeness of God.²⁹⁴ This intrinsic dignity does not depend on one's health or condition, nor on dignity granted by others.²⁹⁵ The mandate to sustain life is thus covered by the general norm and applies from moment of conception to the natural end of life.²⁹⁶ From this follows the inviolability of human life and any act that actively and/or directly terminates life violates it.²⁹⁷ From a Catholic perspective, man can enter into a relationship with God,

291 Bolt EE, Hagens M, Willems D, Onwuteaka-Philipsen BD. *Primary care patients hastening death by voluntarily stopping eating and drinking*. Ann Fam Med. 2015 Sep;13(5):421-8. doi: 10.1370/afm.1814. PMID: 26371262; PMCID: PMC4569449.

292 Article 10 of the Dutch Constitution & Article 8 ECHR

293 Article 11 of the Dutch Constitution

294 Cf Gen 1:26-27

295 DICASTERY FOR THE DOCTRINE OF THE FAITH, *"Dignitas Infinita"* (2 April 2024), Vatican City State

296 W.J. EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Handbook of Catholic Medical Ethics. Responsible healthcare from a Catholic perspective"*, Parthenon, Almere, 2010, p.433; English edition EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Manual of Catholic Medical Ethics"*, Connor Court Publishing, Ballarat, 2014, pp.561-595. NB "general norm" means that sustaining life is the starting point, it is not the absolute goal. See also: PONTIFICAL COUNCIL FOR THE PASTORATE IN HEALTH CARE *"New charter for healthcare workers" (translated from Italian: Nuova carta degli operatori sanitari)*, Vatican City, 2019, 144.

297 PONTIFICAL COUNCIL FOR THE PASTORATE IN HEALTH CARE, *"New charter for healthcare workers" (translated from Italian: Nuova carta degli operatori sanitari)*, Vatican City, 2019. 165,168-171.

"his origin and final goal", and man's ultimate goal is "salvation".²⁹⁸ While the belief is that man will find his fulfilment in God, this does not mean an exclusive right to a blissful life. It defines human beings as relational beings, standing in relationship with God and other people.

Morality of DCHN from a Catholic Perspective

Another inference of this view of man is that man, as the pinnacle of creation, is distinguished from other creatures by reason. As a result, he is able to know God's order of creation and focus on what is truly good for him. The ability to be able to do and choose the good lies in man's nature in which the so-called "natural law" is instilled. The freedom of the will that flows from human nature, together with this law, confers to a human being a responsibility²⁹⁹ to do what is good for his or her human nature. In this article, the focus was limited to the patient's perspective and response of the health care professional.

The morality of human acts depends on three elements³⁰⁰

1. the selected object³⁰¹
2. the intended purpose or intention³⁰²
3. the circumstances of the act³⁰³

A morally good act needs all three elements to be good: the "*goodness of the object, of the purpose and of the circumstances*".³⁰⁴ A bad object or intention can spoil the morality of the act.

In assessing DCHN as a moral act from the patient's perspective, we will contrast the aforementioned elements.

Object

The chosen object in DCHN is the deliberate ceasing nutrition and hydration with the intention of dying. In itself, refraining from nutrition or hydration is not an immoral action. It can fit, for example, the reduced appetite in illness or old age, or be a

298 Cf Mat 5:2-12

299 "*Freedom is the ability to act or not to act, and thus to perform free acts of its own accord. It reaches its perfection when it is directed towards God, the supreme good*". "Freedom characterises actual human acts. It makes man responsible for the acts he voluntarily performs". "The accountability or responsibility for an act can be reduced or removed by ignorance, violence, fear and other psychological or social factors. (CCC1744-1750)

300 CCC1750

301 A good on which the will consciously focuses, see also CCC 1751

302 Intention is "the movement of the will towards the goal"; the final term of action, see also CCC 1752

303 Circumstances (including consequences) are "secondary elements of a moral act", they determine any aggravating or mitigating/reducing responsibility.

304 CCC1755, CCC1760

(temporary) expression of (religious) fasting or hunger strike. In general, hydration and nutrition are basic interventions that help the body of a person to sustain, and are therefore considered to be proportional.

In the Dutch guideline, however, oral intake is considered a futile (medical) treatment that can be stopped, since the outcome of life is no longer wanted. Catholic moral theology and particularly bioethics defends the argument that one can forgo "non-proportionate means".³⁰⁵ This concept was developed at a time when more medical treatment options were emerging and life could be prolonged as a result.³⁰⁶ Eijk defines proportionality in this context as follows: *"the omission of life-extending treatment resulting in the death of the patient is ethically equivalent to euthanasia when the advantages and disadvantages are proportionate to each other"*.³⁰⁷

In other words: in the case of someone wanting DCHN, while not having an underlying illness or temporary transcendent perspective, oral intake remains proportional by definition. Not offering eating and drinking is therefore neglect, which is a morally bad action.

In this way, the "concept of proportionality" with regard to DCHN, as used by the new guideline is opposite to the Catholic perspective: in the guideline administration of hydration and/or nutrition are extra-proportional interventions when life has become an unbearable outcome and death is the aimed result. This is contrary to Catholic morality as further elaborated in the next paragraph.

Intention

The purpose of DCHN is explicitly stated, namely *"to hasten the end of life"*. It is thus an

305 W.J. EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Handboek Katholieke Medische Ethiek"*, Parthenon, Almere, 2010, pp. 430-431. English edition EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Manual of Catholic Medical Ethics"*, Connor Court Publishing, Ballarat, 2014, pp.561-595.

306 This concept was developed at a time when more medical treatment options were emerging and life could be prolonged as a result. However, this raised new ethical dilemmas as to whether "letting die" (cf. by abstaining from treatment) was not equivalent to "active life-ending" (cf. by euthanasia). According to the handbook *"Katholieke Medische Ethiek"* (Eijk, 2010), applying the proportionality principle to medicine includes the following:

From the 16^e century, Catholic moral theologians drew the distinction between "ordinary" and "extraordinary" means of sustaining life; with "ordinary means" being compulsory, while "extraordinary means" remained optional. As technical possibilities shifted, some treatments became more commonplace and the terminology "ordinary" or "extraordinary" proved inappropriate. The choice of terminology "proportionate" or "non-proportionate" included the "estimation of relationships between the various positive and negative effects of medical treatment". See also: W.W.J. EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Handboek Katholieke Medische Ethiek"*, Parthenon, Almere, 2010, pp. 430-432. English edition EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Manual of Catholic Medical Ethics"*, Connor Court Publishing, Ballarat, 2014, pp.561-595 (Definition on p. 566).

307 EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Handboek Katholieke Medische Ethiek"*, Parthenon, Almere, 2010, pp. 432-433. English edition EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Manual of Catholic Medical Ethics"*, Connor Court Publishing, Ballarat, 2014, pp.561-595.

active pursuit of death. The terminology “to hasten” suggests that life expectancy is already short due to underlying illnesses, and will be hastened by DCHN. However, DCHN is also suggested to patients without underlying classifiable diseases that would cause immanent death. Especially in patients suffering from mental illnesses, where general physical health and proportionality of oral intake can be generally assumed. In the latter case “to hasten” would be a euphemism; the clear objective of DCHN is to end life.

From the perspective of Catholic medical ethics, actively ending life is contrary to the intrinsic dignity of human beings and the universally inspired natural law that takes life as the "general norm".^{308,309} Since the active pursuit of death can never be a good goal, the intention or purpose of DCHN is also intrinsically evil. Since Catholic medical ethics is based on universal values, this statement is not only a conclusion for Catholic believers, but valid for all people.³¹⁰ Therefore advising or recommending DCHN, primarily or as an alternative to euthanasia, is a form of collaboration with evil.

Circumstances

The guideline lists several factors that people cite as reasons for DCHN. These include different forms of physical, psychological, social or spiritual suffering. Different forms of suffering can reduce moral responsibility. Some, however, particularly mention the desire to take life so as to take death into "one's own hands". The latter argument reinforces moral responsibility as an act performed deliberately and consciously.

Catholic Response

From the perspective of Catholic moral theology, there is a clear moral rejection of DCHN as a practical option: Both as to embrace this option for patients as a possibility to hasten or to pursue the end of life, as, to offer this option as a healthcare professional to patients with a death wish. Various Dutch professional associations for doctors and nurses have laid down codes of conduct and professional codes that allow for conscientious objection³¹¹ but will suggest and request to refer a patient to a colleague.

308 EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Handboek Katholieke Medische Ethiek"*, Parthenon, Almere, 2010, p. 433. English edition EIJK, L.J.M. HENDRIKS, J.A. RAYMAKERS, *"Manual of Catholic Medical Ethics"*, Connor Court Publishing, Ballarat, 2014, pp.561-595.

309 DICASTERY FOR THE DOCTRINE OF THE FAITH, *"Dignitas Infinita"* (2 April 2024), Vatican City State

310 A side note to the above is that hoping for an accelerated death in itself is "not impermissible". Circumstances and suffering can sometimes make people long for dying. Nevertheless, the assessment of morality is ultimately not about inner considerations, feelings, strivings or thoughts, but about the intention of concrete actions.

311 the possibility of invoking conscientious objection is not laid down in Dutch law

Apart from the moral theology and official pathways, it is probably more fruitful to look with the loving eyes of Christ. DCHN is very often an expression of sincere experienced suffering. Clearly there is a cry for help. Apart from physical or mental suffering, often social or existential suffering is present. From an integral approach to (palliative) care, it is important to pay attention to the whole person, especially when people express a death wish. Healthcare workers are *"ministers of life" and "never (...) instruments of death" and thus have the task of "guaranteeing life, watching over it to unfold and develop throughout the span of existence, respecting the plan designed by the Creator"*.³¹² Health care professionals are called to take care of the whole person and confirm the human dignity even when people themselves do not experience this.

However, some people will have a persistent wish and act for DCHN. And although the decision of a person to start DCHN may be morally rejected, it is not for the healthcare professional to reject the patient as such. One is therefore not obliged to force a person to restart oral intake as the person himself has freedom and responsibility. If a person will persist in DCHN one can offer (palliative) care, but should be hesitant to provide palliative sedation that will reduce capacity. Apart from provision of (palliative) care, one always be a testimony of the love, hope and closeness of Christ in (personal) prayer.

Conclusion

Based on both object and intention, DCHN is immoral. First, **stopping a proportioned intervention** of nourishment and/or hydration as the object of DCHN **is immoral**. Secondly, **the explicit aim of the intervention of DCHN is to end life, which is immoral**. The circumstances may mitigate (through suffering) or aggravate (deliberately wanting direction over life) the patient's responsibility. As such, DCHN **is morally equivalent to suicide**. In suicide one chooses a certain means to end ones life. Because of the slower nature of DCHN, it can be considered an "indirect suicide".

Although DCHN is morally rejected by Catholic moral theology, it still is a possibility now in The Netherlands. Conscientious objection can be expressed by health care professionals. Moreover, it might be an occasion to be a witness as “ministers of life”. By practicing an integral approach confirming the intrinsic dignity of life, one can be a testimony of the love, hope and presence of Christ.

312 DICASTERY FOR PROMOTING INTEGRAL HUMAN DEVELOPMENT, *"New charter for healthcare workers"* (translated from Italian: *Nuova carta degli operatori sanitari*), Vatican City, 2019. 167

ADDENDUM. «HUMANAE VITAE». A SCIENTIFIC PROPHECY

4th January 2009

By José María Simón Castellví

President of the World Federation of Catholic Medical Associations (FIAMC)

The Federation over which I have the honour of presiding has recently published an official document to mark the fortieth anniversary of the publication of the encyclical letter *Humanae Vitae*, by Pope Paul VI, of venerable memory. This hundred-page document is a highly technical work containing three hundred citations, mostly taken from specialised medical journals.

The document has come into being after many months of intense research and data collection. It is fitting to recall the person responsible for its publication, the Swiss doctor, Rudolf Ehmann, who spent the same number of months drafting the document as there are in the gestation period of any human pregnancy. Never before has similar work been produced, from the medical point of view, given the way in which we, as doctors, are accustomed to working and writing. In addition to being well written, the original German text is also extremely interesting. However, what are the keys to its reading? Does it contribute anything new to the Church or to society? Its author should be considered an expert, and one who is suitably qualified to assess important aspects of contraception. Written in accordance with scientific requirements, and well grounded regarding obstetrics and gynaecological aspects, it reached two conclusions that should not go unnoticed, neither within the Church nor beyond.

First, it irrefutably demonstrates that the most widely used anovulatory contraceptive in the industrialised world, containing a low dose of oestrogen and progestin hormones, works in many cases as an anti-implantation agent as it expels the forming human embryo. The embryo, in early stages of development, is something more than just an egg cell. The embryo grows in such a continuous, coordinated and gradual manner that, should nothing prevent it from doing so, it will emerge from the maternal womb in just nine months, ready to devour litres of milk. This anti-implantation effect is accepted in the scientific literature, which even shamelessly uses the term ‘embryonic loss rate’. Curiously, however, this information is seldom disclosed: It is recognised by researchers and is included in the prospectuses of pharmaceutical contraceptive products.

Another interesting aspect concerns the devastating ecological effects of the tons of hormones that have been released into the environment over the last few decades. We

have enough data to affirm that one reason for the considerably high levels of male infertility in the West (increasingly lower sperm counts) is the environmental pollution caused by products such as the 'pill'. We are dealing here with a situation that is clearly detrimental to the ecosystem, and one which should exact further explanations from pharmaceutical companies. The other side effects of oestrogen and progestin combinations are widely recognised. The World Health Organisation's International Agency for Research on Cancer, based in Lyons, in its press release on 29th July 2005, noted the carcinogenic nature of combined oestrogen-progestin oral contraceptives and classified them as Group One carcinogens.

The saddest part of all this is that, in terms of regulating fertility, these products are unnecessary. Natural family planning (NFP) methods are equally effective and, in addition, respect the 'nature of the person'.

On the sixtieth anniversary of the Universal Declaration of Human Rights, it can be said that artificial contraception violates at least five important human rights: the right to life; the right to health; the right to education; the right to information (its diffusion is carried out to the detriment of information on natural methods); and the right to equality between the sexes (women almost always bear the responsibility for contraception issues).

FIAMC has been committed to science and truth since its very founding. Therefore, we study and raise discussion on both the main effect as well as the side effects of these drugs. Our activities, however, extend beyond examining contraceptive products which have consistent side effects or even those which are of little or no effect. Our work goes much further than that.

Sexuality is a wonderful God-given gift within the Sacrament of Matrimony. It unites husband and wife so much that any external element that comes between them is an illegitimate third party. Spouses give of themselves wholeheartedly, and do so also in terms of their own reproductive capacity. If a new life is not possible, for serious reasons, conducting sexual relations during non-fertile periods should form part of conjugal intimacy, which must always be both satisfying and serve as a bond between husband and wife. To those who see some of the documents of the Church as a compendium of prohibitions, I strongly recommend that they read the civil, criminal or commercial codes of some Western countries, which are full of prohibitions. I do not dispute their appropriateness, but I do believe that those same codes are based on the fundamental premises of personal and commercial freedom, geared towards people's happiness and to the efficiency of companies and which, ultimately, justify certain prohibitions. The

Church holds sexuality in great esteem and I believe, through acquiring correct habits and education, that life may become easier and that certain limits, which do indeed exist, may be viewed positively.

We, as Catholic doctors, are fully aware that much more should be invested in maternity; and more, also, invested in human resources, education and financial resources. The *Humanae Vitae* doctrine has not been followed because, among other reasons, it has been rejected by too many doctors.

Turning the question around may help us to see the extent to which Pope Paul VI was in actual fact prophetic. Had he accepted the ‘pill’, would we, today, be able to prescribe with a clear conscience some of the products that we now know to have an anti-implantation effect? The prestige of doctors enables them to offer couples alternatives to artificial contraception. The relationship between doctor and patient is strong enough that it is unlikely to be broken easily; not even by a dissident theologian. However, to avoid this from happening, we should provide doctors with more and better training and information on issues of fertility.

I believe that, as Catholic doctors, we will continue to develop our profession. Nevertheless, given the current situation – with slow progress, numerous reservations and the millions of people who are involved – I would respectfully ask the Church to create a special commission on *Humanae vitae*.

4th January 2009 · *Osservatore Romano*

Promemoria: FIAMC Document on *Humanae vitae* – F.I.A.M.C.