SEMINARE
vol. 40 * 2019, no. 4, p. 45-55
DOI: http://doi.org/10.21852/sem.2019.4.03

Fr. Jan Kazimierz Przybyłowski[1]
Cardinal Stefan Wyszyński University in Warsaw
ORCID ID: 0000-0002-8814-0504

SUBJECTIVE AND PERSONAL DIMENSION OF HEALTHCARE IN PASTORAL THEOLOGICAL REFLECTION

Abstract

The aim of the article is to indicate new possibilities of health protection from the perspective of pastoral theology. The Church's teaching on the protection of human life and health is very rich. It should also be pointed out that the Church supports all social initiatives to reform health care, especially is humanisation and personalisation, which can lead to better care for the sick, but also create new opportunities in the field of health prevention, in promoting healthy lifestyles and in supporting the pursuit of daily life hygiene. Thanks to the humanisation and personalisation of health care, it will be more effective to deformalize it, so that money, profit or savings do not obscure the most important goal: to provide comprehensive care for the sick person. The good of an ill person is body health and mental balance, but the greatest gift is always to be close to God, according to the principle that people are closest to God when they give health to other people.

Keywords: health care, pastoral theology, Church, humanization, personalization, faith

PRZEDMIOTOWY I PODMIOTOWY WYMIAR OCHRONY ZDROWIA W PERSPEKTYWIE TEOLOGICZNOPASTORALNEJ

Abstrakt

Celem artykułu jest wskazanie nowych możliwości ochrony zdrowia z perspektywy teologii pastoralnej. Nauczanie Kościoła na temat ochrony życia i zdrowia człowieka jest bardzo bogate. Kościół popiera wszelkie inicjatywy społeczne służące reformie ochrony zdrowia, zwłaszcza jej humanizację i personalizację, co może przełożyć się na lepszą opiekę nad ludźmi chorymi, ale też stworzy nowe możliwości w dziedzinie profilaktyki zdrowotnej, w propagowaniu zdrowego stylu życia i wspieraniu działań na rzecz przestrzegania zasad higieny życia na co dzień. Dzięki humanizacji i personalizacji służby zdrowia bardziej skuteczne będą działania na rzecz jej odkomercjalizowania, aby pieniądz, zysk lub oszczędności nie przesłaniały najważniejszego celu: otoczenia kompleksową opieką osoby chorej. Dobrem osoby chorej jest zdrowie ciała i równowaga psychiczna, ale największym darem jest być zawsze blisko Boga, według zasady, że ludzie są najbliżej Boga, gdy dają zdrowie innym ludziom.

Słowa kluczowe: ochrona zdrowia, teologia pastoralna, Kościół, humanizacja, personalizacja, wiara

[1] Fr. Jan Kazimierz Przybyłowski received the title of theology professor on 25 January 2011; since 2002, head of the Department of Pastoral Theology and Auxiliary Sciences at UKSW; author of several dozen scientific articles and several books. E-mail: j.przybylowski@uksw.edu.pl.

Introduction

Contemporary pastoral theology (applied) may deal with the most complex problems of human life and activity, since it has employed the recent scientific developments and research accomplishments. Applied theology assumes that secular science itself that comprises social or humanistic research, and most of all, broadly defined empirical study, would neither entirely explain the human life, nor the importance of the created reality. This proves impossible due to both substantive and methodological reasons. Once the research, as well as scientific inquiry and reflection are performed within the exclusive area of empirical study, the aesthetic sensitivity and mental ability to perceive the sense and the purpose of things disappear.[2] Revelation and Magisterium are the main foundations of applied theology. As Pope Francis indicates, classical religious texts may propose sense for all the epochs, as they have the motivational power that constantly opens new horizons. This leads to the fundamental question: Is it reasonable and enlightened to dismiss certain writings simply because they arose in a context of religious belief? (Francis 2013a, 256). Doctrine and practical axiology, which are subject of research of other disciplines, represent a significant field of applied theology studies. The ethical principles and norms apprehended by reason can always reappear in different forms and find expression in a variety of languages, including religious language (Francis 2015, 199). In the past, disregard for Truths of Revelation was apparent in theological studies, which was, however, affected by cultural limitations of different eras. Today, applied theology focuses more on greater awareness of ethical and spiritual legacy, hence acknowledging our roots enables improved comprehension of the surrounding world and humans, as well as favourable reaction to current needs (Francis 2015, 200).

The issue of healthcare, regarding both subjective (medical) and personal (theological) dimension, shall be discussed in the pastoral theological perspective. The distinction between them may be briefly determined as it follows: 1) subjective view: concepts of health and disease, treatment, medical health care; 2) personal view: a healthy man and a sick man, providing care for a suffering man, individuals serving the sick. It must be emphasized that the above mentioned perspective does not undermine the personal characteristics of medical care, but it only represents the scientific approach, to examine the new possibilities of the prior distinction.

[2] „Nor is the light of faith, joined to the truth of love, extraneous to the material world, for love is always lived out in body and spirit; the light of faith is an incarnate light radiating from the luminous life of Jesus. It also illumines the material world, trusts its inherent order and knows that it calls us to an ever widening path of harmony and understanding. The gaze of science thus benefits from faith: faith encourages the scientist to remain constantly open to reality in all its inexhaustible richness. Faith awakens the critical sense by preventing research from being satisfied with its own formulae and helps it to realize that nature is always greater. By stimulating wonder before the profound mystery of creation, faith broadens the horizons of reason to shed greater light on the world which discloses itself to scientific investigation." (Francis 2013a, 34)

1. Faith in illness – hope for recovery

Both health and illness may be discussed in medical and religious language (which in the following article shall be equivalent to the language applied in pastoral theology). The basis for the idea has been formed by the truth that "man too is God's gift to man. He must therefore respect the natural and moral structure with which he has been endowed" (John Paul II 1991, 38).

„Illness is a monastery with its own rules, asceticism, silence, and inspiration" (Albert Camus). Thus critical events such as an illness, or a real life-threatening situations are likely to trigger spiritual development, which has been confirmed by the results of tests conducted on cancer patients. The spiritual development following the illness led to enhanced closeness with others, creating a balanced life, affirmation of life and courage in the face of death (Heszen and Sęk 2007, 72-73). Therefore, an illness is not only a „new condition" of a human body, but it appears to be an entirely new existential situation, and primarily a new mental and spiritual state of a sick person. There is also a positive aspect of gifting the sick individual, since some goodness can be found in a severe disease: „you will get weak, but your spirit will get stronger" (Leo Tołstoj).

Psychosomatic integrity of a man, as well as his orientation towards God, prove that illness is not only inscribed in his existential, but also eschatological vocation. Since the whole man suffers from an illness, the signs of disease contain the knowledge of spiritual side of the person's life. It is often observed that body manifests what the spirit or soul cannot demonstrate in any other manner. Illness itself, or rather its symptoms, convey information on the person. Thus, disease may constitute one of the most significant sources of self-knowledge (Gembala 1998, 106), enabling the sick individual to take plausibly best actions, both in terms of his physical as well as spiritual health, and therefore have impact on effective treatment of body and psyche.

The medical perspective (subjective) comprises clearly negative connotations: ultimately it is the dysfunction of natural processes of human organs, or the factors of his psyche. Effective treatment involves restoring primary condition of organs, or achieving mental balance.

From the theological (personal) point of view, illness may be approached in the perspective of positive decomposition, which causes irregularity or organ failure, concurrently enabling human to discover the value of life, health, redefine mindset, appreciate spiritual qualities, changing life goals and open to other people. Life and health are gifts from God, yet a great number of humans recognize the „wonder" of life and value of health while facing an illness or life-threatening situations.

Therefore, the question of faith, understood from the existential and religious perspective remains between both the areas (subjective and personal). The beginning of recovery starts, when a sick person believes in their disease (existential

faith). The first sign of the illness is fear and attempt to escape (instinctive avoidance of danger). As long as a sick person rejects the disease not being able to acknowledge the fact, they would not be able to accept the mental support, nor spiritual comfort from the others, which means feeling lonely and isolated with their illness. Consequently, the therapy remains impeded, since the reaction to medicines and medical treatment is likely to bring positive results, inasmuch as the patient remains motivated to recover, and cooperates with healthcare professionals.

Apart from purely medical procedures, process of treatment requires religious faith in recovery. Faith in God teaches how to come to terms with an illness or even death, and at the same time gives hope that the disease could be cured, thus a man could recover (beat disease and avoid the risk of death).

Possibility to link both the dimensions of healthcare should be indicated. Clinical model of health comprises the thesis by a French surgeon R. Leriche (1879-1955) who argues that „health is life lived in the silence of the organs" (Verspieren 1989, 279). The above mentioned interpretation of health has been defined as the classical concept of health, provided by WHO in 1948: „Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Litwiejko 2010, 14). The new idea was proposed by the WMA in 1978: „Health is the longest, self-reliant, active and creative life led without illnesses or disabilities, or lived with such in case they cannot be eliminated" (Wróbel 1999, 148). This has been supplemented by the Ottawa Charter in 1986: „Health is a major resource for social, economic and personal development and an important dimension of quality of life" (Chłap 1997, 369).

Analysis of the above mentioned definitions proves that their authors were seeking balance between individual and social dimension of health. They are all, however, clearly defined in a very subjective manner, thus an ill person „plays second fiddle". Although according to the concepts health is presented as more than mere condition of the body, there is no clear human reference, as to the individual created and saved by God. Dehumanization along with depersonalisation of healthcare may have been the main cause of the phenomena. John Paul II claimed that the concepts formed by the contemporary society tend to be far from the truth and question God, as they believe this would be the method to confirm the pre-eminence of a man for the sake of ostensible freedom, as well as complete and unrestrained development. Thereby, ideology deprives human of his constitutive dimension of a man created in the image and likeliness of God. This severe mutilation constitutes a real threat to humans, as it leads to perception that is bereft of transcendence (Jan Paweł II 1999, 2).

The definition of health, in addition to biological and psychological factors, should also involve the spiritual needs of human. The boundaries between them are clear due to human integrity. Thus, it is assumed that a physically and mentally healthy person can use their cognitive, emotional and volitional skills in both individual and social life (Stawiszyński 2006 42-44). However, to achieve entirely

human action, sustainable focus on goodness, beauty and truth (transcendental values) that are fulfilled by personal God, as the Creator and Saviour of humans and the world is required (James 2001, 42).

This is where the question of moral values, comprised by constitution of health approached in a personalistic dimension, arises. In fact, there is a natural synergy between health and morality. John Paul II emphasized that morality is linked to moral duty, which is related with human freedom to do good. That, nevertheless continuously requires discovering the truth, hearing the Word of God, and implementing it. (Wojtyła 1985, 199; Sztaba 2011, 30-61). Moreover, every man possesses an inborn moral instinct that enables recognition of natural moral rules. This is a set of norms ingrained in the human nature, which objectively determines the existing moral order, and define the conscious, rational and free respect by a man (Ślipko 2002, 282). This moral aspect of life incorporates care for health, influenced by interpersonal relationship, as well as relations with the surrounding world and Transcendence (Marek 2009, 210-211).

Once the personal transcendent perspective of health is given priority, the overall issue of treatment becomes ultimately modified: not only is it „fixing" the organs, but also healing the „whole" man; it is not merely physical, mental and social well-being, but also restoring the balance and harmony comprising life, health and human vocation to develop God's gift. This would be more than empowering man to attain active and creative life, as this builds faith in God and His healing power, bringing „little" hope for recovery and „great" hope for eternal life.

Undermining or even rejecting the right of a sick person to auto-transcendence along with focus on Transcendence is one of the most serious causes of objectification of relations between patient and medical care institutions. This is manifested by, i.a. popularizing medical interference of manipulative nature, which on numerous occasions is related with rejection and challenging fundamental ethical issues. The above mentioned issue regards manipulation of human fertility and gender identity, as well as some forms of medical experiments conducted on people. Taking this aspect into account, the care of Church for human health adopts an entirely new approach. The main concern is humanisation and personalisation of medicine, along with sensitizing human conscience to a man dignity, sanctity of life and health of value affirmation (Wróbel 2007, 1057).

2. Role of Church in personalisation of healthcare – humanisation and personalisation

Quality of life in the social perspective depends greatly on efficient healthcare. Country and the three authorities: legislative, executive, and in a number of cases judiciary, play a vital role in organising the structure of medical care. Government of particular countries take responsibility for organisation of healthcare, and have impact on form and method of health protection, determining its personal, social

and economic character, as well as institutionalising that conditions free access to fundamental and professional medical benefits. In a broader sense, the liability for man's health shall be taken by international organisations (UN, FAO, WHO) and politicians, whose resolutions determine the global standards of health and medical care, and have impact on improvement of life conditions, hygiene, work, leisure and food supplies for the entire population.

Despite a great number of initiatives on a global scale, objectification of healthcare has caused major problems related with everyday existence. Hence, hidden actions, aiming at undermining personal dignity, right to live of the sick, elderly or disabled persons, which may lead to acceptance and validation of euthanasia, have been widely observed. Therefore, it must be highlighted that not a single individual shall lose their dignity, regardless their medical condition and situation. People who are terminally ill, as well as the elderly or the disabled, possess and preserve the same dignity as the healthy individuals, since neither illness nor old age disqualify a person and challenge personal dignity (Wróbel 1999, 149-153). Natural value of life and health and even more so, their transcendent dimension constitute the sufficient foundation for duty and right to care for its condition and taking numerous actions improving health (prophylaxis, prevention, therapy, recuperation). This implies the duty and right to look after one's health (personal responsibility), and the right to receive proper medical care, which is the subject of distributive justice (Wróbel 2004, 30-37).

Lack of personalisation of healthcare poses threat to health and life of millions of people on a global scale. Famine is one of them. Malnutrition affects physical, emotional and mental development and may lead to a number of diseases such as diabetes, obesity, or anaemia. Modern science outlines the notion of „hidden hunger" or „undernutrition". These are the states connected with lack of one or several basic elements of a balanced diet, such as amino acids, mineral salts, or vitamins, which could cause deficiency of nearly forty elements in the body that are indispensable to health preservation (Sobolewski 2007, 47-48).

Inaction of politicians and the rich on famine is the case of high-severity malpractice (John Paul II 1980, 11). According to FAO, the problem of famine and malnutrition affects over 850 million people, which means that one person starves to death every 3,5 seconds. Children are mostly affected, as over 5 million of under 5-year-olds die of famine and malnutrition each year (Koperek 2007, 13). This phenomenon existing mainly in developing countries, is related to vulnerability to disease and general body weakness, and may influence man's medical condition (Szuppe 2007, 34).

The issue of famine and malnutrition has been raised by the Magisterium of Church, and the situation, where people starve to death, has been fiercely condemned. It is underlined that any manifestations of materialism, despite a number of declarations, may negate human values (John Paul II 1980, 11). A man has right to decent life, and this consequently incorporates right to nourishment.

Stance of the Holy See remains clear: famine and malnutrition should not exist, as the natural resources, along with the amount of food produced in the world could satisfy the needs of the entire population (Francis 2013a, 53, 191). By no means could policy which limits the population's growth be excused (Francis 2015, 50).

The other major problem on the global scale is the water scarcity. It is estimated that over a billion people in the entire world still has no access to sanitary systems. That is an urgent need as most bacteria, which pollute water and cause diseases, come from animal or human waste and sewage. Constant protection of water reservoirs against industrial pollution is a priority task.

The condition of health of human population is also determined by consumption of numerous harmful stimulants, such as alcohol (which is the third in the world, and the second in Europe most common cause of deterioration of health and premature death, therefore WHO considers it to be a harmful substance, of which even the smallest amount might constitute risk for health), nicotine, drugs (John Paul II 1991, 36), „designer drugs". The foregoing addictions represent not only serious health conditions, but also social, family and professional issues. Moreover, they may cause spiritual damage or moral guilt (Bołoz 1997, 91-128).

Both life and health are the core values of human existence, thus Church is one of the entities, whose concern is to protect man's well-being. Its mission, with regard to Creation and Salvation does not only meet the religious and spiritual needs of the faithful, but it also turns to external conditions of human life. The teachings of the Catholic Church, based on Revelation and actions taken in accordance with the Gospel, contain synergy between care for human life and health, and services of ecclesial community.

Church intensifies the actions which aim at proclaiming and disseminating the biblical vision of a human, who was created and saved by God. It is the fundamental truth, as debates on what the personal existence and a man as a human is, are held while raising numerous issues, related with the perspective of the beginnings of human life, abortion, in vitro fertilisation, terminal illness, exhausting treatment, euthanasia, death, medical experiments, eugenics, legal status of a person, sanctity of human life, and value along with meaning of health (Sadowski 2007, 12-13; Rudman 1997, 3).

The Church, in its Magisterium highlights that life is a great gift from God, which was given "on loan" to a man, and will be accounted for by the Creator. Not only is the life a personal asset, but it should also serve the whole human community (Nagórny 1998, 25). This applies to health as well. Life holds both the salvific and eschatological value. This means that, the eternal fate of a human is determined during his very existence. Disregard for life and care for health may thus lead to risk of being deprived of the possibility of salvation.

According to Chruch, human life is sacred, hence must be protected from the moment of conception, until the natural death. No man has right to take away other person's life, nor to cause damage or lead to deterioration of health of other

people (John Paul II 1995, 57). Any attempts on the life or health are considered "serious crimes" and shall be subjected to rigorous moral scrutiny.

Apart from the Church, families may play a vital role in humanising and personalising health protection (Nagórny 1999, 13-14). Church's teachings stress and support the great impact of marriage and family in the process of shaping right health attitudes. It should be highlighted that family is a primary environment of human life, and has major impact on socialisation process. On the basis of the conducted study results, it can be concluded that the family contribution to health amounts to 75%, whereas in the face of an illness or disability to 86%. Relation between family and health shall be considered in three main areas: 1) the impact of family on health of its members, 2) role of family in the face of an illness and 3) the impact of an illness on the whole family. Illness causes significant changes in family life, both for the organisation of the entire family as well as individual members. Since a sick person is usually not able to fully perform their functions or duties, such must be taken up by the others. Consequently, this leads to reorganising the life and functioning of the entire family (Taranowicz 2002, 105-112).

Personalisation and humanisation of health set priority tasks for medical staff. All the individuals working in healthcare, doctors in particular, are urged to constant humanisation of medicine, as well as preserving the dignity of their profession, according to "Deontological ethics" (Naczelna Izba Lekarska 2003, art. 2; Biesaga 2006, 20-25; Moń 2009, 175-184). These are, first and foremost, the doctors who are at the top medical staff, and should unceasingly maximise their professional development, improving their skills and avoiding being stuck in a rut, which might be dangerous for a patient. Approaching the patient should be determined by honest conscience, wisdom and absolute honesty. Doctors are also obliged to develop and cultivate the spiritual values, which constitute the indispensable part of their vocation. As the Magisterium of Church implies, work of a doctor is not merely a profession, but they should also remain loyal to tradition of this profession of public trust, nurturing their vocation. Serving the sick, they are urged to ensure respect for dignity of human body that must not be treated in an instrumental or commercial way, under any circumstances (Jan Paweł II 1998, 232).

It must be stressed that Church supports any social initiatives, which trigger the reforms of healthcare, with main focus on humanisation and personalisation, as they could furthermore improve care for the diseased and open new opportunities for preventive healthcare as well as propagate healthy lifestyle and maintain proper provisions of hygiene. Humanisation and personalisation of healthcare intensify actions performed to stop commercialisation, so that money, profits or savings would not disrupt achievement of the main objective, namely providing complex health care for the patient. Healthy body along with psychological balance are the assets of a sick person, the greatest gift, however, is to remain close to God, according to the principle that "people get closest to God, when they give health to others".

Conclusions

The objective of the following article was to present new possibilities to personalise healthcare from the pastoral theological perspective. The Catholic Church as the natural „body" defines major objectives to be accomplished. The Magisterium of the Church contains numerous developments regarding the area of life protection and human health. Therefore, raised issues should be selected carefully in order to constitute the best representations of exemplification.

The following article adopts the lateral method, thus contains less reflection of the exploratory nature. Nevertheless, the conducted analysis supports the idea that the primary objective of humanisation and personalisation of health protection and care, should be restoring the proper position of a human in the entire system. This poses new challenges to the Catholic Church that reorganises its mission and salvific functions, according to the rule that "a man is the way of the Church" (John Paul II 1979, 13-21).

Further study should also be given to new challenges that incorporate seeking ways of due respect for human life and health, whose source is human dignity and related rights. Medical knowledge does not provide sufficient information on the major causes of illnesses, as it only makes a diagnosis and decides on adequate treatment; nor does preventive medicine, although it defines the notion of health and indicates how to remain healthy. What is necessary, for and foremost, is the new „medical" anthropology which would be grounded in the simple truth that life is naturally directed at death: *La vie, c`est la mort* - „Life is death" - Claude Bernard (1813-1878) (Ratzinger 2005, 244; Rees 2016, 110). When the Church proclaims Christ, pointing that death is only a transition to new life, it opens the new perspective of intensified and effective dialogue between medicine and religion, which although display different attitudes to health, are both focused on the created and redeemed man.

References:

Biesaga, Tadeusz. 2006. „Kodeks Etyki Lekarskiej." *Medycyna Praktyczna* 9: 20-25.

Bołoz, Wojciech. 1997. *Życie w ludzkich rękach*: *podstawowe zagadnienia bioetyczne*. Warszawa: ATK.

Chłap, Zbigniew. 1997. „Przymierza medycyny dla ochrony człowieka – w duchu Evangelium vitae." In Jan Paweł II. *Encyklika Evangelium vitae. Tekst i komentarze*, edited by Tadeusz Styczeń and Janusz Nagórny, 365-378. Lublin: KUL.

Francis. 2013a. *Encyclical "Lumen fidei"*.

Francis. 2013b. *Apostolic Exhortation "Evangelii Gaudium"*.

Francis. 2015. *Encyclical "Laudato si"*.

Gembala, Bronisław. 1998. „Zdrowie jako zadanie duchowe." *Communio* 18: 105-123.

Heszen, Irena and Halina Sęk. 2007. *Psychologia zdrowia*. Warszawa: Wyd. Naukowe PWN.

James, William. 2001. *Doświadczenia religijne*. Translated by Jan Hempel. Kraków: Wyd. Nomos.

Jan Paweł II. 1998. „W służbie zdrowia i życia ludzkiego". Słowo Ojca Świętego do chirurgów polskich (11.02.1992). In *W trosce o życie. Wybrane Dokumenty Stolicy Apostolskiej*, edited by Krzysztof. Szczygieł, 231-233. Tarnów: Wyd. Biblos.

Jan Paweł II. 1999. *Przesłanie do uczestników Zgromadzenia Plenarnego Papieskiej Rady ds. Kultury „Chrześcijański humanizm"*. Accessed: 25.05.2019. https://opoka.org.pl/biblioteka/W/WP/jan_pawel_ii/przemowienia/pr_kultury_19111999.html.

John Paul II. 1979. *Encyclical "Redmeptor hominis"*.

John Paul II. 1980. *Encyclical "Dives in Misericordia"*.

John Paul II. 1991. *Encyclical "Centesimus annus"*.

John Paul II. 1995. *Encyclical „Evagelium vitae"*.

Koperek, Jerzy. 2007. „Prawo dzieci do wyżywienia i wolności od głodu." In *Dzieci głodujące i bez imienia*, edited by Jarosław Różański, 7-18. Warszawa: Wyd. Papieskich Dzieł Misyjnych.

Litwiejko, Alicja. 2010. *Podstawy zdrowia publicznego w aspekcie prawno-społecznym*. Wrocław: Wrocławskie Wydawnictwo Oświatowe.

Marek, Zbigniew. 2009. „Moralność człowieka wyrazem zdrowia wewnętrznego." In *Edukacyjne przestrzenie zdrowia*, edited by Zbigniew Marek and Magdalena Madej-Babula, 209-222. Kraków: Wyd. WAM.

Moń, Ryszard. 2009. „Moralne źródła deontologii lekarskiej." *Warszawskie Studia Teologiczne* 22: 175-184.

Naczelna Izba Lekarska. 2003. *Kodeks Etyki Lekarskiej*. Accessed: 25.05.2019. http://www.nil.org.pl/_data/assets/pdf_file/0003/4764/Kodeks-Etyki-Lekarskiej.pdf.

Nagórny, Janusz. 1998. „Wartość życia ludzkiego z perspektywy encykliki „Evangelium vitae"." *Roczniki Teologiczne* 3: 19-38.

Nagórny, Janusz. 1999. „Społeczny charakter troski o życie i zdrowie." *Roczniki Teologiczne* 3: 5-22.

Ratzinger, Joseph. 2005. *Dogma and Preaching. Applying Christian Doctrine to Daily Life*. San Francisco: Ignatius Press.

Rees, Tobias. 2016. *Plastic Reason. An Anthropology of Brain Science in Embryogenetic Terms*. Oakland: University of California Press.

Rudman, Stanley. 1997. *Concepts of Person and Christian Ethics*. New York: Cambridge University Press.

Sadowski, Mirosław. 2007. „Godność człowieka – aksjologiczna podstawa państwa i prawa." *Wrocławskie Studia Erazmiańskie* 1: 8-28.

Sobolewski, Zbigniew. 2007. „Caritas Polska wobec głodujących dzieci." In *Dzieci głodujące i bez imienia*, edited by Jarosław Różański, 45-51. Warszawa: Wyd. Papieskich Dzieł Misyjnych.

Stawiszyński, Tomasz. 2006. „O zdrowiu psychicznym, czyli nie bardzo wiadomo o czym." *Zeszyty Karmelitańskie* 3: 42-44.

Sztaba, Mariusz. 2011. *Troska bł. Jana Pawła II o etyczno-moralne podstawy życia społecznego*. Kraków: Wyd. Benedyktynów „Tyniec".

Szuppe, Paweł. 2007. „Głód – przyczyny i rozmiar zjawiska." In *Dzieci głodujące i bez imienia*, edited by Jarosław Różański, 31-38. Warszawa: Wyd. Papieskich Dzieł Misyjnych.

Ślipko, Tadeusz. 2002. *Zarys etyki ogólnej*. Kraków: Wyd. WAM.

Taranowicz, Iwona. 2002. „Rodzina a problemy zdrowia i choroby." In *Zdrowie i choroba. Wybrane problemy socjologii medycyny*, edited by Jarosław Barański and Włodzimierz Piątkowski, 105-115. Wrocław: Oficyna Wyd. ATUT, Wrocławskie Wyd. Oświatowe.

Verspieren, Patrick. 1989. „Leben, Gesundheit, Tod." In *Neue Summe Theologie*, t. 2: *Die neue Schöpfung*, edited by Peter Eicher, 275-305. Freiburg-Basel-Wien: Verlag Herder.

Wojtyła, Karol. 1985. *Osoba i czyn*. Kraków: Polskie Towarzystwo Teologiczne.

Wróbel, Józef. 1999. *Człowiek i medycyna. Teologicznomoralne podstawy ingerencji medycznych*. Kraków: Wyd. Księży Sercanów.

Wróbel, Józef. 2004. „U źródeł myśli bioetycznej Jana Pawła II w 25-lecie pontyfikatu." *Roczniki Teologiczne* 3: 22-42.

Wróbel, Józef. 2007. „Eklezjalny wymiar troski o zdrowie człowieka." In *Scio cui credidi. Księga Pamiątkowa ku czci Księdza Profesora Mariana Ruseckiego w 65. rocznicę urodzin*, edited by Ireneusz S. Ledwoń, 1046-1062. Lublin: KUL.