> For it seems to me that you only pardon the sins that you don't really think sinful. You only forgive criminals when they commit what you don't regard as crimes, but rather as conventions. So you tolerate a conventional duel, just as you tolerate a conventional divorce. You forgive because there isn't anything to be forgiven. . . . Go on your own primrose path pardoning all your favorite vices and being generous to your fashionable crimes; and leave us in the darkness, vampires of the night, to console those who really need consolation; who do things really indefensible, things that neither the world nor they themselves can defend; and none but a priest will pardon.[3]

The Catholic who is privileged to defend the Church and its teaching against a book such as our anti-Catholic agitator is said to be preparing will have the opportunity to show' how the Church works consistently with its own divine teaching to the effect that sins are forgiven in the sacrament of penance through a definite juridical absolution. The confessor must know what a sin is in order to exercise his absolving power. The Church does not exempt its confessors from the study' of any material which they will need to know in order to perform their sacerdotal works for the glory of Christ.

There are certain faults which almost completely nullify the value of those works of Catholic polemic which they infect. The most glaring of these is the tendency to use the polemic itself as an instrument to score a point against some rival viewpoint within the Catholic Church itself. Thus Newman's *Letter to the Duke of Norfolk* was ostensibly a defense of the Church against the charges leveled against it by the English politician, Gladstone. Unfortunately, however, Newman himself fashioned it also as a kind of side attack on his Catholic fellow-countrymen who had worked for the definition of papal infallibility in the Vatican Council.[4]* As a result the booklet lost most of its effectiveness as a statement of Catholic doctrine and as a defense of the Catholic Church. Occasionally, even now, we see this procedure repeated, and always with disastrous results for the presentation of Catholic truth.

3 Chesterton, *The Secret of Father Brown (New* York; Dodd, Mead and Company, 1935), p. 803.

4 Cf. the article "John Henry Newman and the X7atican Definition of Papal Infallibility," in *AER,* CXHI, 4 (Oct. 1945), 300-320.

Another weakness in some contemporary Catholic polemic is the tendency to interpret every outburst against the Catholic Church as an attack against all religion. Some non-Catholic groups have used a variation of this tactic as a highly effective debating procedure. The Catholic controversialist, however, is not primarily concerned with cleverness in repartee, but with truth. An attack against the true Church of Jesus Christ should be looked upon and dealt with for what it is. The defender of Catholic truth will only weaken his position if he gives the impression that the struggle for Christ in this world is in some way a joint concern of the Catholic Church and of other religious societies. The Church and the Church alone is Christ's kingdom, His Mystical Body on earth. Any effective defense of the Church or of its teachings must take explicit cognizance of this paramount truth.

In his paper, "Clements of Modern Religious Controversy," Bishop John Cuthbert Hedley, O.S.B., considered Catholic polemical writings chiefly from the point of view of converts who might be brought into the Church by means of it.[5] This, of course, will always be an important aspect of this type of work. There is, however, still another function of this labor which must be kept in mind. The Catholic polemist, in setting forth the truth about points which have been misstated by enemies of the Church is likewise defending and protecting the faith of those within the fold of Christ. These children of God's household will profit also from a vigorous and accurate defense of Catholic truth.

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5 In *AER,* XVI, 3 (March, 1897), 241-53.

Mission Intention

"Mission, Threatened by Atheists" is the Mission Intention for the month of January, 1950.

SHOULD WE SUPPORT SOCIALIZED MEDICINE?

The compulsory health insurance program, now pending before Congress, has pointed up what is undoubtedly one of the sharpest issues of our time. In our attempt to combat "galloping Communism" are we slowly but surely falling victims to "creeping Socialism"? It would be tragic indeed if in attempting to quell the flaming faith of totalitarian zealots we ourselves should slip into some basically similar system of collectivism in the shape of a welfare or, if you will, a slave State. For the clergy especially this should constitute a matter of deep concern since the Papal Encyclicals are crystal clear in their condemnation of outright socialism. In an effort toward clarification of this vital question we shall try to offer here a summary review of the main facts and specific issues involved. Other larger and perhaps more interesting phases of the problem lie outside our present scope.[1]

Although the proper care of health is not quite on a par with the ownership of property the principles pertinent to the nationalization of industry, which we have already reviewed, will be helpful in giving us a general picture or pattern of Catholic thought relative to more personal problems.[2] This pattern accords very well with the American tradition which has been to encourage, in

1 One wonders, for instance, how certain aspects of the whole present philosophy of planned security and a completely comfortable society are to be harmonized with the Christian ideal. True, as *Quadragesimo anno* points out and *Divini Redemptoris* repeats, we should strive for a sound economic order in which everyone would have "sufficient to supply all necessities and reasonable comforts" because the higher standard of life thus attained "provided it be used with prudence is not only not a hindrance but is of singular help to virtue." At the same time it would be misleading to over-emphasize mere social and economic remedies in such a way as to convey the impression that these are the primary business of the Church. Actually, in practice, the advocacy of such remedies must ultimately lead to further control by the State. Neil Kevin in *No Applause in Church* has some appropriate remarks in the section "On Putting the Second Commandment First." From the point of view of the opportunity for asceticism in the welfare society his delightful description of how many contemporary daily annoyances can be more irritating than a hair-shirt is also relevant.

2 Cf. "Nationalization and the Catholic Tradition," *AER,* CXXII, 1 (Jan. 1950). The problem of health has, of course, obvious connection with basic living standards, education, etc.

so far as is consonant with social welfare, individuals and groups to solve their own difficulties in their own way. The very variety existing in the different states and regions makes this approach more necessary here than, for instance, in the smaller, tighter countries of Europe. Our political and social history as well as the continuing progress of our free way of life require a broader and more equitable basis for insuring personal and national well-being. It is not in the American spirit to risk the curtailment of basic liberties even in the interest of supposedly greater security. Nevertheless, as we have seen, the increasing complexity of modern life and the enormous power wielded by huge, wealthy organizations seems to necessitate a larger protective rôle on the part of the government than at any time in the past.

SOCIALIZED OR STATE MEDICINE?

It is still true, however, that, as in the case of education, the matter of health is not the government's primary responsibility. Therefore it becomes important to determine what precisely the proposed health measure means. What has been frequently forgotten in the debate so far is that socialized medicine differs from State medicine. Lest Catholics be scared by accusations of near-Socialism we must explain that "socialization" is not necessarily Socialism, much less "nationalization." When any group of individuals promotes a program of medical services designed to mutualize cost and care we have socialized medicine. It may mean a system of free medical practice sponsored, financed by, and responsible to the government but organized, operated, and regulated democratically by the medical and allied professions.

Socialized medicine may thus be a very broad term covering the whole science and art of preventing and curing disease through collective effort with the financial support of social groups and governmental units. It might be said that anything is socialized when it is supported by people as groups according to ability to pay, rather than by individuals according to use. A public library is a socialized institution since it is maintained by the taxpayers. The citizen with the most property pays the largest sum toward its support whereas the school child who occasionally takes out a book pays nothing. Private physicians in a sense socialize medicine when

they charge according to the patient's respective financial status and make the wealthy help pay for the poor.

In the case of State medicine the control is not in the hands of the physicians. Such a system is run by the government for the medical and allied professions. Medical services are furnished by State employees who are paid out of taxes much as public education is conducted by teachers paid from public funds. There are two main differences between State medicine and health insurance. The first concerns means of support, the second, methods of administration. (1) State medicine secures its support from taxation: health insurance from periodic payments of those insured. (2) State medicine implies an organization of medical practitioners working directly for the State. Health insurance would be maintained by the medical societies or insurance companies with State supervision; it is really a plan for private medicine with group support.

True health insurance, paid for by the purchasers, may be voluntary but the social insurance type is compulsory. Otherwise those receiving larger incomes would not be likely to join. When each person is compelled to belong and to pay according to his ability, rather than according to the service he is to receive, this method of support comes very close to being a form of taxation. A system of health insurance enforced by law and supported on the basis of ability to pay is almost State medicine. If the government, in addition to collecting the funds, insists on maintaining rigid supervision of the medical services offered then the system is practically State medicine.

HISTORY AND BACKGROUND

Another popular misconception is that socialized medicine is something entirely new. Actually it has been advocated and tried in one form or another and in various parts of the world for almost a century. As far back as 1864 Russia established a rather complete system of State medicine for the rural districts. In the past, when the Soviet Union was somewhat more accessible to foreigners, it was studied by American physicians and some, notably Dr. Sigerst of Johns Hopkins, seemed to regard it as satisfactory. Germany experimented with it on a large scale when, in 1883, Bismarck introduced comprehensive social and health insurance for industrial workers. Dater it was extended to commercial employees

and agricultural laborers. Medical care was, in fact, free—at least in the sense that the patient made no direct payment for the service. The entire cost came out of a fund raised by general taxation. The German system spread to Austria in 1888 and was introduced in France in a modified form in 1918. Later the Scandinavian countries followed and in South America Chile has had compulsory insurance since 1927.

In England, under Lloyd George, a national health insurance act was passed in 1911. In more recent times the Beveridge Report presented a comprehensive system of social planning but it did not decide the question as to whether a national health and hospital service should be established and maintained by the State. Under the present Labor government, however, "panel medicine" was set up. At first opposed strenuously by the British Medical Association it is said that now most physicians are sufficiently satisfied with it not to desire a return of the old "rugged individualism."[3] The doctors are paid according to the number of patients cared for each year at the rate of $2.16 per patient. It is, of course, too soon to pass judgment on a system still in the throes of its growing pains but already costs have increased at such a rate as to be alarming. The Health Minister has found it necessary to reduce expenses by imposing a twenty-five per cent cut on dentists and by slashing $38,000,000 from the hospital budget. While theoretically the patient may change doctors at will, in practice it appears that such a transfer requires the permission of his former physician and the approval of a government board.

New Zealand enacted extensive social security legislation in 1938 which covered all phases of health. The New Zealand system also has a pension clause. With a doctor's certificate one can get on the pension list, at least temporarily, and sometimes for life. The annual cost is $60 per person. It is levied as a direct tax of five and

[8] On a recent visit to England the writer observed that while there was considerable "griping" about the loop-holes in the new system, e.g. the fact that production of free "spectacles" lagged behind to the tune of more than a million and a half with the result that before they were delivered the prescription already needed to be changed, nevertheless, there was no thought of going back to the past. It is also indicative of the modern temper that the recent defeat of the Labor party in New Zealand was made possible only because their opponents pledged themselves to retain most of the existing social welfare program.

a half cents out of every dollar paid in wages and the balance comes out of a general fund. It is, perhaps, worth noting that Ireland still pursues the traditional program of personal medicine with, however, free "dispensaries" to provide medical care for those unable to pay. Care is thus provided for the poor while insurance is compulsory for the working classes. An Irish physician, writing recently in *Studies,* points out that the preservation of this doctor-patient relationship is "both the true expression of our individualistic outlook and a far humaner basis than the card-index and the case-number which has so benumbed much of modern continental practice."

From time to time it had been suggested that one or other of these European plans be introduced into the United States. The chief objection thus far has been that economic and social conditions are different in America. The various states have not sufficient uniformity to warrant that any system yet devised would be successful in meeting the needs of the country as a whole. It was assumed that the development of sickness insurance would have to be on a local rather than on a national level, and the basic contention of the American Medical Association has been that the promotion of public health and medical care are primarily local responsibilities. The determination of needs and the administration of affairs should be in the hands of local authorities. Grants in aid and technical assistance may be received from State and Federal Government sources but not the determination of policy.

The United States Government held a conference in July, 1938, to discuss a new and better system for the distribution of medical care to the poor. One hundred seventy-one delegates from various professions were present. In the following year Senator Wagner of New York introduced the National Health Act or, as it is sometimes called, the Wagner Health Bill. The bill was based upon the findings of the Health Conference and was intended to fill the gaps in the Social Security Act.

Toward the end of 1948 Oscar Ewing, the Federal Security Administrator, submitted a report to the President on the state of the nation's health and on plans to raise the national health level during the next decade. The report recommended that "further rapid improvement in national health can be achieved only by concerted

effort and that the need for increased Federal action is imperative....."[4]

TERMS OF PROPOSED MEASURE

Now we come to the heart of the present controversy—the National Health Program requested by the President which, following his special message on April 22, 1949, was submitted as an improved comprehensive health bill by eight Senators and two Congressmen. We shall try to see both what is expressed and what is implied in this bill. In its wording, at least, it guarantees that payments for benefits shall be in proportion to incomes, and persons "shall, therefore, obtain services as a right and not as a charity." This aspect is lauded by its proponents on the ground that subsidies to voluntary plans for those unable to pay premiums would necessarily involve the indignities of a "means test" and thus be a reversion to "the outmoded charity principle."

The bill also theoretically guarantees patients free choice of doctors and it is inferred that many will have this privilege for the first time who have hitherto been prevented by their economic condition. Furthermore, "physicians and other professions furnishing services to them shall be assured freedom in the practice of their profession and assistance in maintaining high standards, and that the administration of this act shall be based upon the American principle of decentralization." Administrative responsibility is to be placed "in the hands of local bodies representing both those who pay for and those who render services, and operating within the framework of plans made by the several states." One wonders in this connection what will happen to volunteer non-profit plans which may appear to be in competition with the state medical societies? In England Catholic hospitals were, presumably, exempt by special privilege. Are we to have a repetition of the so-called "divisive" effects of public versus private education here with Catholics once again in the unjust position of having to bear a double burden?

Of course, and again in theory, there is the banning of "discrim-

[4] *The Nation's Health. A Ten Year Program.* By Oscar R. Ewing. (Washington, D. C.: U. S. Government Printing Office, 1948), p. 12.

inations because of race, color, or creed." What a hackneyed meaningless phrase that has become! It is said that the private relationship that should exist between doctor and patient will be scrupulously protected. Also that all the people will be completely protected, but this sounds too much of a panacea to be interpreted literally. Grants are promised to professional schools for research and aid to under-doctored areas in the form of ambulance services and subsidies, all of which could and should be forthcoming without benefit of any such comprehensive scheme as is proposed. Again and again it is insisted that government control will be at a minimum and that the net result will be stimulation of high quality medical care. All this may indeed be genuine wishful thinking as far as the blueprint is concerned but will it be translated into reality with the actual operation of the plan?

ARGUMENTS IN FAVOR

A summary review of the reasons given for and against the new health measure may prove helpful at this stage. The affirmative position generally stresses the points already mentioned, namely: (1) the comprehensiveness of the plan; (2) the completeness of its coverage; (3) the high quality of the care offered; and (4) the lack of loopholes in administration.

(1) It is asserted that eighty-five million Americans have now no protection against crippling sickness costs. On the basis of present statistics voluntary plans are considered inadequate as hospitalization insurance is carried by only 27 million people and hospitalization insurance plus physician's services in hospital by approximately the same number while only 3% millions have really comprehensive, including preventive, care. Moreover *it is* claimed that the voluntary plans, since they have no sliding scale of payments to match salary, would be forever beyond the reach of the middle-income group which needs protection most.

(2) Voluntary health insurance, it is said, can cover only part of the subscriber's annual sickness bills. Hospitalization insurance, such as *the Blue* Cross, covers only 21 per cent of the average family's medical expenses and *the Blue Shield,* which includes

physician's services in a hospital, only 35 per cent.[3] Neither do these provide for check-ups, inoculations, and preventive care. Medical services, on the other hand, provided by the community, or government at the public expense, can be as complete as is necessary or desirable. Both the financial burden and the social stigma attaching to those forced to accept present-day free sendees would vanish as also the evils of self-diagnosis, self-medication, and patent medicine, because of the easy access to competent advice and service.

(3) Moreover, the professionals themselves will benefit from this public financing. There will be no need of competition : there will be no over-supply or unemployment resulting from unequal distribution of personnel; and they will no longer be harassed by the problem of income since it is assured by the government.

The economic and professional assurance that is inherent in public service; the definite compensation; the permanent tenure of office enforced by civil service law ; the security of old age and disability through pension retirement; the regular and orderly condition and hours of service; the assured opportunities for rest, recreation, and travel; the opportunities for advancement ; for further professional study, for research, for public education, public and preventive medicine, are but a few of the innumerable advantages of a publicly provided and supported medical service, which are denied today to most of the professional workers in the health service.

(4) There will be no danger to professional freedom since all medical matters will be left strictly in the hands of the doctors. Neither will there be any infringement of the patient's right to privacy. He may go to a doctor of his own choosing or change doctors, supposedly, at will. Sound administration requires a division of responsibility between the professionals who provide the health services and the consumers who pay for them. To deny the public its proper voice in the administration of voluntary programs is to invest medical societies with all the powers of a monopoly and

5 Agnes E. Meyer in an address entitled, "A Sound National Health Program," reprinted from *The Washington Post,* Nov. 14, 1948, claims that "the Blue Shield, which is dominated by doctors, has no standards of medical care, whereas the best cooperative insurance groups under lay control have succeeded in establishing standards over the opposition of the medical profession" (pp. 7 f.).

none of the checks against the abuse of that power. (And yet, as the British physician, Lord Horder, pointed out in a recent address, only the doctors really know what is good, and what is not good, medicine.) Ewing, in rejecting voluntary insurance, concludes that three factors, the inadequacy of benefits offered, of the number of people covered, and of the distribution of coverage, outbalance all others.[6]

THE NEGATIVE SIDE

Impressive as these arguments may be in theory we cannot overlook the fact that there are also some serious objections to the proposed measure. Since it would be impossible even to outline them here in any detail we must be content to summarize them under three headings: (1) bureaucracy; (2) politics; (3) regimentation.

(1) If the plan were enacted medical authorities say most doctors would choose the fee-basis method of payment. This, naturally, would require vastly more records and administrative machinery. Despite the protests of non-interference (like Shakespeare, one suspects too much protesting here!) there would have to be regulations under Federal direction for checking and paying claims. The load would become so great that the system of compensation would eventually move to the capitation method, as in Britain. This practically makes the doctors public functionaries working on government salary. Physicians say that during the last war they feared the tyranny of paper work more than bullets, bombs, or disease. It would, in fact, be impossible for them to look after the details of administration in addition to their purely professional duties. The cost of a huge army of officers, investigators, auditors, and clerks would be added to the budget and the whole project would fall into the clutches of bureaucracy.

(2) For the abuses which the plan would abolish it would substitute political control which in turn, would lead to even graver evils. The handling of government forms, records, and cards necessary for the myriad medical services and drugs required would not only be a waste of tax money. Past experience indicates the ever-present danger of graft and corruption. Political control in medicine is especially dangerous since it places the mass of the people, who may need medical attention but know little about re-

6 Cf. Ewing, *op- cit.,* p. 88.

quirements and results, entirely at the mercy of non-medical dispensers of public health. Consequently some authoritative studies, such as that contained in the report of the Brookings Institution, oppose the government health insurance plan as revolutionary and dangerous, tending to freeze policies and eventually retard medical progress?

(2) It follows immediately that the result is likely to be regimentation in various forms. The doctor's offices, already overcrowded, would become veritable assembly lines. One can easily imagine how hypochondriacs would take advantage of this free attention![8] The standardization might necessarily extend itself to diagnosis and prescriptions in some such form as: all those who suffer from headaches take so-and-so. But headaches can arise from different causes and the doctor himself would, in all probability, suffer most. In short, the service would inevitably tend to become soulless.

TOWARD A SOLUTION

While one naturally tends to admire the idealism manifested by many proponents of the plan we must be on guard against utopian dreams. The fact is that complete medical service for all is an objective extremely difficult to realize. State medicine elsewhere has worked no miracles. It is one thing to admit that the nation's health is in serious condition (although it is not as deplorable as sometimes described since about 80 per cent of the people receive good medical care) but it is quite another to claim that only a compulsory system can provide a satisfactory solution.[9] It is recognized that, generally speaking, the rich and the poor fare well enough in this respect. It is a question mainly of providing for middle-income families and for rural districts. The leaks and gaps in the present system certainly require attention but the system itself need not necessarily be scrapped. Nationalization means getting things the hard way. It is like taking over a hotel simply because you can't get a room for the night!

7 Cf. G. W. Bachman and Lewis Merriam, *The Issue of Compulsory Health Insurance* (Washington, D. C., 1948).

8 In Britain a nominal charge per visit has been recently imposed on each patient in an effort to prevent this.

9 According to Ewing every year *325,000 die who* could be saved by existing knowledge and skills. Cf. *op. cit.,* p. 1.

We have already seen the general principles governing Catholic thought in this matter.[10] The government charged with promoting the general welfare certainly has some responsibility for the maintenance of proper health standards.[11] Therefore it should supply help where needed and it has, in fact, been doing this. To supplement the present aid, the American Medical Association, at its 1949 Convention, offered to sponsor a twelve-point health program. This would set up an independent national health agency, establish a national science foundation, and encourage rapid extension of voluntary hospital and medical care insurance. In addition, it recommends the establishment of a medical care authority in each State to administer and distribute government funds as well as extension of hospital and diagnostic facilities and the expansion of public health education.

The Catholic tradition, here or elsewhere, is that the function of government is to aid and encourage but not to replace and control. It shall step in only when individuals and voluntary groups fail to do the job. Universal well-being is not to be expected from the State's activity, says Pope Pius XI:

> Just as it is gravely wrong to take from individuals what they accomplish by their own initiative and industry and give it to the community, so also it is an injustice and at the same time a grave evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organizations can do. For every social activity ought of its very nature to furnish help to the members of the body social, and never destroy or absorb them.[12]

Therefore, as in the case of education and in economic matters, health is not the primary responsibility of the government.

10 Cf. "Nationalization and the Catholic Tradition," *AER,* CXXII, 1 (Jan. 1950).

11 It is not so much the principle of taxation for health insurance which is opposed as the monopoly which would result under the government system. Cf. *A Voluntary Approach to a National Health Program* (St. Louis, Mo.: The Catholic Hospital Association), p. 8.

12 *Quadragesimo anno,* New Translation. (Washington, D. C.: National Catholic Welfare Conference, 1942), par. 79. This warning of the Holy Father was literally verified recently when the Royal Commission on Population urged the British Government to give free advice on birth control under the National Health Service.

The Church has as its long range objective the creation of a new society in which the emphasis will be on having less needy for the benefits than more benefits for the needy. Meanwhile it is realistic enough to recognize that something must be done immediately to patch up the evils of the existing order. Hence its advocacy of a family wage. As far back as 1919 the Bishop's Program for the United States stipulated that "wages should be high enough to make possible that amount of saving which is necessary to protect the worker and his family against sickness, accident, invalidity and old age." It is interesting also that the Hierarchy adds that "those women who are engaged in the same tasks as men should receive equal pay for equal service."

Pope Pius XI in *Atheistic Communism* insists that

> Social justice cannot be said to have been satisfied as long as workers are denied a salary that will enable them to secure proper sustenance for themselves and their families ... as long as they cannot make suitable provision through public and private insurance for old age, for periods of illness and unemployment.[13]

The present Holy Father is even more specific. In his address to the Italian workers in 1944 he asks for a salary which will not only be sufficient to cover the living expenses of a family but which will make it possible to rear healthy, nourished children as well as to foresee and forestall times of stress, sickness, and old age. The State, whose duty it is to promote the common good should supply support "through social institutions such as insurance and social security societies."

In line with this general philosophy three important Catholic agencies, the NCWC Bureau of Health and Hospitals, the National Conference of Catholic Charities, and the Catholic Hospital Association have made public a statement called *A Voluntary Approach to a National Health Program.* The statement, which warns against the monopoly that would inevitably result from a government system of compulsory health insurance wisely notes that "a right approach to the problem depends not only on a correct analysis of the concrete situation, but also on a correct social philosophy."

13Divini Redemptoris, in *Five Great Encyclicals* (New York: The Paulist Press, 1939), p. 196.

Bishop Karl J. Alter, in a foreword, describes the discussion as revolving in large part around the issue of an exclusive and compulsory government health system versus private and voluntary efforts supported by government assistance instead of control. "Many competent authorities fear that an exclusive state system under a compulsory tax will necessarily involve a loss of freedom for the voluntary health agencies and put an end to private initiative to the ultimate detriment of the health of the nation."[14] Society, he says, is a much broader concept than the State which, indeed, has a definite responsibility; but voluntary agencies also have a right "to exercise an important function in planning as well as executing such a program. Monopoly means control; partnership means freedom."

The Catholic program is based on the principle of subsidiarity mentioned in our previous article. With a view to safeguarding moral and social principles which should underlie the problem of national health as well as the proper autonomy of hospitals and professional groups it is recommended that a division of health be created within the Federal Security Administration composed of nine members; three physicians, three hospital administrators (one a nurse), and three representatives of the public. Similar health councils should also be established at state and local levels. This program would also cover dentists, nurses, practical nurses, and other professional personnel. It is unnecessary to elaborate further on it here as the details are easily available. The main advantage from our point of view is that "under localized sponsorship and administration, health care by pre-payment of cost on a universal basis could be obtained by all residents of a state. At the same time, there would be developed a strong incentive to utilize the voluntary systems and extend this coverage."[15]

For the sake of brevity and clarity we shall conclude with the following observations from the Catholic point of view:

14 Cf. *A Voluntary Approach* etc. Foreword by Bishop Alter, pp. 3 f.

15 *Ibid.,* p. 19. Cf. also, in reference to combining public and private action in a democratic society, *Voluntary Social Services: Their Place in the Modern State,* edited by A. F. C. Bourdillon (London Methuen and Co., Ltd., 1945).

(1) Physical health, important though it be, is not the highest good. If it were we might ask—even on the purely human level—why nearly a million of our citizens, the flower of our manhood, were but recently sacrificed on the battlefields of the world? It was, of course, a recognition of the fact that there are certam principles the defense of which is more important than human health or even life itself. Incidentally, if only the untold millions now lavished on the race for armaments and weapons of destruction could be channelled into a universal health program we might succeed in creating, if not a brave new world, at least one that would be, under God, reasonably strong and free.

(2) We must not blindly oppose every co-operative endeavor for mass health protection. Instead, however, of authoritarian, over-centralized plans for a Federally dominated organization with a top-heavy bureaucracy we favor a decentralized national health program which, based on sound principles and recognizing the elementary rights of every citizen, is at the same time dynamic in the sense of being responsive to local and changing community needs. This is in accordance with the thoroughly American and Catholic tradition of Federal, State and community co-operation and is the best check for "the frightful impersonality of the centrifugal forces that make for socialism."

(3) There is involved here also, in addition to the democratic method of approach, a proper philosophy of the human person. Scholastic psychology, as distinct from Platonism, will permit no complete divorce between the soul and the body. It is, therefore, an over-simplification to assign temporal aspects to the State and spiritual to the Church. Their interests necessarily overlap in the sense that the latter is concerned with physical health—witness, for example, the effects of Extreme Unction—and the former ought to be anxious to promote the virtues without which good citizenship is impossible. Besides, the body is the temple of the Holy Spirit. Therefore it is more than a matter of costs and organization. It is the spirit that vivifies. One thinks in this connection of Mr. Dooley's famous dictum: "Hinnissy, if the Christian Scientists had more science or the doctors more Christianity you'd be safe with either provided you had a good nurse." *Caritas Christi urget nos.* We must try to re-orient the present outlook more in terms of total well-being which includes the eternal. The surest curb for

the totalitarian potentials latent in so many contemporary movements is to stress anew the final indestructibility of the human person inherent in the true Christian notion of immortality.

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Fifty Years Ago

The Leading article in *The American Ecclesiastical Review* for February, 1900, is a lengthy review of a work by Fr. E. Dubois, C.SS.R., entitled *De Exemplarismo Divino.* The author of the review has given his article the heading: "A Recent Encyclopaedia of Theology." The purpose of the work in question is to point out that God, in the Trinity of Persons, is the efficient, exemplary and final cause of all reality. Fr. Siegfried praises the book highly, designating it as a "modern *Summa."* . . . Fr. C. Coppens, S.J., defends an article which he had contributed to the December, 1899, issue, denouncing Freemasonry in the United States as hostile to the Catholic Church. He derives his information mostly from the writings of Albert Pike, whose life he summarizes in this present article. . . . This issue carries another instalment of *Luke Delmege,* from the pen of Canon Sheehan, of Ireland. . . . Fr. A. Kroll contributes an article in praise of the virtue of eutrapelia, intended to encourage especially among priests the spirit of gaiety and cheerfulness. ... In the *Analecta* appears a letter from Pope Leo XIII to Msgr. William H. O'Connell, Rector of the American College in Rome, congratulating the College on its fortieth anniversary. . . . The Conference section contains a response of the Sacred Congregation of the Inquisition, given in 1869 to the Archbishop of Quebec, and recently republished in the *Analecta Ecclesiastica.* He had asked if a previous decree, issued for England, requiring the integral confession of sins on the part of converts being rebaptized conditionally, was a universal law; and the answer was in the affirmative. . . . There is also a letter from an irate subscriber, complaining that a question he had submitted had not been answered after four months, and demanding that his name be taken from the roll of the subscribers. The editor's answer states that the *Review* gives no guarantee that all questions will be answered, either in print or by letter.

F. J. C.

RECENT DOGMATIC THEOLOGY

Undoubtedly, the most important and significant theological controversy that has arisen in recent years is that which centers around the relation between the natural and the supernatural. This controversy was occasioned by a book entitled *Surnaturel,* written by Fr. Henry de Lubac, S.J.[1] The work is intended primarily as an historical study of the meaning of the sujærnatural. Yet the author devotes considerable space to the explanation and the defense of his theological ideas. The fundamental theme of Fr. de Lubac is that the beatific vision, though it is supernatural, is the normal and only possible destiny of an intellectual being. Man can therefore have an absolute—not merely conditional—desire of supernatural beatitude as something to which his nature is destined. However, since *de facto* the attainment of this goal surpasses the natural powers of man, the desire of the beatific vision is inefficacious with respect to man's own abilities. But God freely grants man the means of arriving at his end, supernatural grace. Fr. de Lubac believes that in this manner the doctrine of the gratuity of grace is sufficiently safeguarded. A state of pure nature, in which man would be destined to a merely natural end he believes to be impossible. And he holds that this concept of the supernatural expresses the mind of St. Thomas and actually represents the true and traditional Catholic thought.

Confronted with the fact that the Church condemned certain propositions of Baius which seem to be identical with his denial of the possibility of a state of pure nature,[2] Fr. de Lubac contends that the error of Baius consisted in the theory that man in his primitive state of innocence was not dependent on the bounty of God, and had rights in commutative justice to supernatural gifts which God bestowed on him. There is no proposition in the list of those condemned by the Church, he says, whose contradictory asserts the possibility of an order in which man would have a purely natural end. It was the notion of a *debitum,* a strict obligation on the part of God toward man, that Pope Pius V condemned in the writings of Baius.

1 *Études Historiques* (Paris: Aubier, 1946). Cf. *SER,* CXVII. 6 (Tune, 1947), 482.

2 Cf. *DB,* 1021, 1023, 1024, 1026.